

AN EXAMINATION OF STATE OBLIGATIONS IN SAFEGUARDING THE RIGHT TO HEALTH IN INTERNATIONAL LAW

By

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ABSTRACT

The right to health has emerged as a cornerstone of international human rights law, underscoring the interdependence of human dignity, social justice, and sustainable development. This paper examines the scope and nature of state obligations in safeguarding the right to health under international law. It traces the evolution of the right through key legal instruments such as the Universal Declaration of Human Rights (1948), the International Covenant on Economic, Social and Cultural Rights (1966), and regional frameworks like the African Charter on Human and Peoples' Rights (1981). The paper interrogated the tripartite obligations of states to respect, protect, and fulfil within the context of progressive realization, non-discrimination, and international cooperation. Drawing upon jurisprudence from treaty bodies, regional courts, and domestic case law, the paper revealed that while the normative framework of the right to health is robust, its implementation and enforcement remain fragmented and inconsistent across jurisdictions. Key challenges identified included inadequate domestic incorporation of international norms, weak accountability mechanisms, resource constraints, and political resistance to socio-economic rights adjudication. The paper illustrated how judicial interpretation has progressively defined the content of state obligations while exposing persistent institutional and structural weaknesses. The paper concluded that the realization of the right to health depends on strengthening national legal frameworks, ensuring equitable resource allocation, enhancing judicial and administrative enforcement mechanisms, and fostering international cooperation and accountability.

Keywords: *Right, Health, State, Obligations, International Law*

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1.0 Introduction

The right to health stands as one of the most fundamental yet complex entitlements in the corpus of international human rights law¹. It encapsulates the idea that every human being is entitled to the highest attainable standard of physical and mental health, without discrimination, and that states bear the primary responsibility to create the legal, institutional, and social conditions necessary for its realization². This right is not merely a matter of access to medical care but extends to the underlying determinants of health adequate food, housing, sanitation, safe water, education, and a healthy environment reflecting a holistic conception of well-being and human dignity³.

Historically, the normative roots of the right to health can be traced to the Universal Declaration of Human Rights (UDHR)⁴, which, under Article 25, recognized health as an integral component of an adequate standard of living⁵. The right achieved binding legal status with the adoption of the International Covenant on Economic, Social and Cultural Rights (ICESCR) particularly in Article 12, which obligates state parties to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health⁶. The Committee on Economic, Social and Cultural Rights (CESCR) later elaborated this right in General Comment No. 14 (2000), identifying the tripartite obligations of states to respect, protect, and fulfil and establishing the AAAQ framework (Availability, Accessibility, Acceptability, and Quality) as the benchmarks for

¹ P. Hunt, The human right to the highest attainable standard of health, Bulletin/academic article and UN Special Rapporteur reports (Hunt served as UN Special Rapporteur 2002–2008). https://www.antoniocasella.eu/salute/HUNT_2006.pdf Accessed: 02 November 2025.

² Lawrence O. Gostin, Public Health Law: Power, Duty, Restraint (Revised & Expanded, Univ. of California Press, 2008). (Seminal book linking law, public health and rights.)

Publisher page / details: <https://pure.johnshopkins.edu/en/publications/public-health-law-power-duty-restraint-revised-and> Accessed 02 November 2025.

³ Human Rights: A Reader (anthology) and Mann's key articles on health & human rights (1994–1996).

Example overview/PDF: <https://pmc.ncbi.nlm.nih.gov/articles/PMC2350785/> Accessed: 02 November 2025.

⁴1948

⁵1966

⁶Hunt, P. (Special Rapporteur). (2008). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/7/11). United Nations Human Rights Council. Accessed 03 Nov 2025, <https://docs.un.org/en/A/HRC/7/11>.

assessing compliance⁷. These developments have profoundly shaped global and regional interpretations of the right to health⁸.

Beyond the universal framework, regional human rights systems such as the African Charter on Human and Peoples' Rights⁹ the European Social Charter¹⁰ and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights¹¹ reinforce the normative and legal obligations of states. These instruments collectively illustrate a growing international consensus that the right to health is indispensable to human flourishing and sustainable development. The preamble to the Constitution of the World Health Organization (WHO) ¹²aptly captures this ethos, affirming that “the enjoyment of the highest attainable standard

The jurisprudence of international and regional bodies has been instrumental in interpreting and enforcing state obligations. Landmark cases such as *Soobramoney v. Minister of Health*¹³ *Minister of Health v. Treatment Action Campaign (TAC)* ¹⁴, *Alyne da Silva Pimentel v. Brazil* ¹⁵, and *Purohit and Moore v. The Gambia*¹⁶ have progressively expanded the understanding of state duties in the context of health rights¹⁷. These decisions affirm that while resource limitations are real, states must at least ensure non-discriminatory access to basic healthcare, essential medicines, and emergency services. They also underscore that accountability and judicial oversight are indispensable to safeguarding health-related rights.

Despite these advances, significant challenges persist in the operationalization of the right to health. Many states lack the institutional frameworks, political will, and financial resources necessary for effective implementation¹⁸. Moreover, the influence of global economic policies, intellectual property regimes, and the privatization of health services often constrains state capacity

⁷ African Commission on Human and Peoples' Rights. Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter, 2010.

⁸ *ibid*

⁹ (1981),

¹⁰ (1961, revised 1996),

¹¹ (1988)

¹² 1946

¹³(South Africa, 1997),

¹⁴ (South Africa, 2002),

¹⁵ (CEDAW, 2011),

¹⁶ (African Commission, 2003)

¹⁷ Gruskin, S. (2006). Perspectives on Health and Human Rights_. Routledge. (Accessed: November 3, 2025)

¹⁸ *ibid*

to meet international obligations. This has led scholars to call for a re-examination of international cooperation, shared responsibility, and extraterritorial obligations, particularly in relation to global health governance and the equitable distribution of health resources¹⁹.

In this context, examining state obligations under international law is both timely and necessary. This paper analyses the legal foundations, implementation mechanisms, and enforcement challenges of the right to health, with a view to assessing how effectively states have fulfilled their duties. It explores the evolution of international legal norms, evaluates key jurisprudence and institutional mechanisms, and identifies the structural and policy-related barriers that hinder realization. The paper also highlights the role of international and regional bodies, non-state actors, and civil society in promoting accountability and compliance.

Ultimately, this examination reveals that safeguarding the right to health requires more than legal recognition it demands a holistic approach grounded in human rights principles, including participation, transparency, accountability, and equality²⁰. States must not only refrain from violating health rights but must also actively create enabling conditions for their enjoyment²¹. By bridging the gap between normative commitment and practical implementation, the right to health can move from aspiration to reality, ensuring that every person enjoys the dignity and well-being that international law promises²².

2.0 Concept and Nature of the Right to Health

The right to health is a multifaceted concept grounded in the recognition that health is a fundamental human right indispensable to the enjoyment of all other rights²³. It is not limited to the right to be healthy, but encompasses the right to the highest attainable standard of physical and

¹⁹ Potts, M. (2017). "The role of human rights in advancing global health." *_Health and Human Rights Journal* 19(1), 27-38. (Accessed: November 3, 2025)

²⁰ Yamin, A. E._ (2017). "Power, politics, and the human right to health." *_Health and Human Rights Journal*_, 19(1), 13-26. (Accessed: November 3, 2025)

²¹ *ibid*

²² Marmot, M. (2018). "Health equity and the social determinants of health." *_Lancet*_, 392(10154), 1410-1418. doi: 10.1016/S0140-6736(18)31908-7 (Accessed: November 3, 2025)

²³ Backman, G., Hunt, P., Khosla, R., Jaramillo-Strouss, C., Fikre, M. M., Rumble, C., ... & Vlismas, A._ (2008). "Health systems and the right to health: an assessment of 194 countries." *The Lancet* 372(9655), 2047-2085. doi: 10.1016/S0140-6736(08)61781-5 (Accessed: November 3, 2025)

mental health, as well as access to underlying determinants such as adequate food, safe drinking water, sanitation, housing, education, and a healthy environment²⁴.

This conceptualization originates from Article 25 of the Universal Declaration of Human Rights²⁵ and finds binding expression in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which obliges states to take steps necessary for the “prevention, treatment and control of epidemic, endemic, occupational and other diseases” and to ensure the creation of conditions for medical service and attention for all²⁶.

Hence, the right to health under international law is holistic, inclusive, and interdependent, connecting civil, political, economic, social, and cultural dimensions of human dignity

2.1 International Obligations of State for the Right to Health

The traditional obligations of States parties, in respect of economic, social and cultural (ESC) rights, including the right to health are obligations to respect, protect and fulfill the right within their domestic jurisdiction. This is not to say that the States have no obligation at the international level. Luguard has identified international assistance and cooperation as part of the theoretical underpinnings of the right to health.²⁷ Apart from these, States are also enjoined to respect the enjoyment of the right to health in other States.²⁸ These international obligations of States were first laid out in the United Nations Charter of 1945, particularly in Articles 1(3), 55 and 56. These international obligations were further echoed in the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966 but were elaborated upon by the Committee of Economic, Social and Cultural Rights in the General Comment Number 14. The significance of these international obligations are usually felt whenever there is public health crisis or outbreaks like was recently witnessed with the emergence of the Coronavirus (COVID-19).²⁹ The intentional obligations of States in respect of the right to health at the international level are noted as follows:

²⁴ *ibid*

²⁵ (1948)

²⁶ Universal Declaration of Human Rights._ (1948). Article 25. (Accessed: November 3, 2025)

²⁷ Luguard (n3) 63.

²⁸ Nampewo, Mike and Wolff (n4) 5.

²⁹ F Paddeu and F Jephcott, ‘COVID-19 and Defences in the Law of State Responsibility: Part 1’ (2020) *Blog of the European Journal of International Law* 1.

2.2 International Cooperation and Assistance

States have international obligation to cooperate and assist other States in ensuring the realization of the right to health. This obligation was first laid down in the UN Charter of 1945. This Charter provides that States shall promote international cooperation in solving international problems of an economic, social, cultural and humanitarian character.³⁰ States shall also encourage international cooperation to promote economic and social development, including solutions to health, education and other humanitarian issues.³¹ The Charter also provides that States can call on member States to take joint and separate action in cooperation with the United Nations to achieve the purposes set forth in Article 55.³² These are the foundation for international cooperation and assistance amongst members States to achieve the goals and objectives of the United Nations, including the protection and realization of the right to health. It is noted that there is difficulty with complying with the international obligation for international assistance. In this regard, it is noted thus,

...whilst the UN Charter in Article 1 (3) talks of international cooperation in solving international problems of an economic, social, cultural or humanitarian character, this is wishful thinking and is hard to enforce. When States fail to take part in joint action in co-operation with the organization for the achievement of human rights they can barely be brought to task in accounting for this which further complicates the discussion on duties.³³

A community reading of the preamble to the ICESCR and Articles 2(1) and 12 of the same ICESCR portrays the international obligations of States to ensure co-operation and assistance for the realization of the right to health. The intendment of these provisions of the ICESCR was clarified by the Committee on Economic, social and Cultural Rights in its General Comments Number 3 on the nature of State parties' obligation. In the said Comments, the Committee explained that the intendment of the provisions of the ICESCR apply not only in respect of the resources within a State but also to those available from the international community through international cooperation and assistance. This simply means one State assisting or cooperating

³⁰ UN Charter 1945, art 1(3).

³¹ Ibid, art 55.

³² Ibid, art 56.

³³ Nampewo, Mike and Wolff (n4) 7.

with another State to realize the right to health. This type of assistance usually emanate from developed and wealthy States for the benefit of poor States.³⁴ It sometimes happens during public health crisis or outbreaks like the recent COVID-19 Pandemic.³⁵ Apart from assistance from wealthy or developed States, international organizations like the World Health Organization (WHO) have mandates to provide international cooperation and assistance. According to Rafols,

Due to the difficulties experienced by some States, the IHR provided for a period of five years after coming into force before it would demand these capabilities of all States. The WHO was also directed to provide assistance to member States that need help with putting all of these capacities into place. There is clearly a commitment shared by all the member States for the purpose of facilitating technical cooperation and logistical support in order to strengthen these capacities.³⁶

The implication of the above is that the aim of providing States with international cooperation and assistance in respect of the right to health is to enable those States, especially those without the needed resources, to meet their core minimum target to ensure the protection and promotion of the right to health. This point is aptly captured as follows, ‘... progressive realization does not permit unnecessary delays and States are required at a minimum to show that they are making every possible effort, within available resources (including resources available from the international community through international cooperation and assistance), to better protect and promote all rights. In addition, the CESCR has confirmed that States have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights under the International Covenant on Economic, Social and Cultural Rights...’³⁷

2.3 Sharing Best Practices

States also have international obligation to share best practices toward realizing the right to health with other States to enable the latter States to also realize the right to health within their

³⁴ EA Mok, ‘International Assistance and Cooperation for Access to Essential Medicines’ (2010) 12(1) *Health and Human Rights* 76.

³⁵ Martins Jnr (n22) 48.

³⁶ XP Rafols, ‘International Law and Global Health: An Overview’ (2015) 3 *Paix et Securitie Internationales* 51.

³⁷ Gutterman (n14).

domestic territory. Under this aspect of the obligation, States are under obligation to collaborate with other States to share best practices, research and expertise in order to ensure the realization of the right to health.

According to the WHO Regional Office for Africa, ‘best practice is a technique or methodology that, through experience and research, has proven reliably to lead to a desired result’.³⁸ It went on to state that,

The use of the word ‘best’ should not be considered in the superlative sense. In other words, the term ‘best practice’ is not about ‘perfection’, the ‘gold standard’ or only elements that have been shown to contribute towards making interventions work or successful. Results can be partial and may be related to only one or more components of the practice being considered. Indeed, documenting and applying lessons learned on what does not work and why it does not work is an integral part of ‘best practice’ so that the same types of mistakes can be avoided by other programmes and projects.³⁹

The implication of the above is that once a particular State has through its experience and research found the best way of addressing a particular health problem, the State has obligation to share its procedure and findings so that others can avoid the same mistakes or challenges it experience in the process. Article 20 of the WHO Framework Convention on Tobacco Control 2003 encourages State parties to share information and best practices on tobacco control. Similarly, the Sustainable Development Goal 3 also provides to the effect that States should share information on best practices to achieve the right to health.

According to Ganguly,⁴⁰ States have extraterritorial obligation to realize the right to health in other States, especially those with less resources to realize this right. However, in the case of *Ilascu v Moldova and Russia*⁴¹ the European Court of Human Rights held *inter alia* that such obligation depends largely on the scope of the control of the State in question over the other State

³⁸ WHO Regional Office for Africa, *Guide for Documenting and Sharing ‘Best Practices’ in Health Programmes* (WHO Regional Office for Africa, Brazzaville 2008) 2. <www.afro.who.int/sites/default/files/2017-06/Guide-for-documenting_and_sharing_Best_practice_-_english_o.pdf> access on 2 June 2025.

³⁹ Ibid.

⁴⁰ A Ganguly, ‘Human Rights Obligations: the Extraterritorial Obligation to Realize the Right to Health and Healthcare’ (2023) <<https://ssrn.com/abstract=4228430>> access on 3 June 2025.

⁴¹ (2004) 48787/99, Council of Europe: European Court of Human Rights, 8 July 2004.

where it has this extraterritorial obligation and therefore where there is no effective control, the scope of extraterritorial obligations are reduced.

On the extraterritorial obligation to share information on best practices, the Committee on Economic, Social and Cultural Rights in its Statement of 17 April 2020 stated that since the Coronavirus Pandemic was a global crisis, the provisions of the International Covenant on Economic, Social and Cultural Rights were essential to ensure international assistance to address the virus, sharing information on research done and making provision for medical equipment. It was also stated by the Committee that State parties have extraterritorial obligation to fight against the Coronavirus Pandemic, primarily for developed states, who should not take measures that would prevent or undermine the export of medicines and healthcare equipment to address the virus. This Statement by the Committee highlights the extent of the extraterritorial obligation to respect the right to health. Thus, to ensure the realization of the right to health, especially as the COVID-19 period was concern, the dissemination or sharing of scientific knowledge was paramount.⁴² This aligns with General Comment Number 25 wherein the Committee acknowledged the extraterritorial obligation of States with respect to scientific progress while ensuring that even developing States can benefit from such progress.

The significance of this obligation is critical to the realization and improvement of the protection of the right to health. Where a State has already through its research or scientific examination realized a beneficial information to address a particular health issue, it will not be ideal for others to start from the scratch in respect of addressing the same health issue. It is ideal to share the information so that others can improve on it rather than seek to achieve the same goal of the previous research or scientific analysis.

2.4 Providing Technical Assistance

Providing technical assistance is part of the international obligation of States to provide international cooperation and assistance. It is also an aspect of the extra-territorial obligation of a State in respect of realization of the right to health.⁴³ Providing technical assistance is not only the

⁴² Ganguly (n59) 8.

⁴³ Ibid.

obligation of States but also that of the organs of the UN, their subsidiary organs and specialized agencies. Articles 22 and 23 of the ICESCR provides as follows:

Article 22

The Economic and Social Council may bring to the attention of other organs of the United Nations, their subsidiary organs and specialized agencies concerned with furnishing technical assistance any matters arising out of the reports referred to in this part of the present Covenant which may assist such bodies in deciding, each within its field of competence, on the advisability of international measures likely to contribute to the effective progressive implementation of the present Covenant.

Article 23

The State parties to the present Covenant agree that international action for the achievement of the rights recognized in the present Covenant includes such methods as the conclusion of conventions, the adoption of recommendations, the furnishing of technical assistance and the holding of regional meetings and technical meetings for the purpose of consultation and study organized in conjunction with the Governments concerned.

From the above provisions it could be seen that the obligation of providing technical assistance involves sharing of expertise, capacity building and resource mobilization. Technical assistance can help build the capacity of healthcare systems in developing countries or those without the needed resources to realize the right to health. The organizations saddled with the responsibility of providing technical assistance in this regard include the WHO and the USAIDS.

Providing technical assistance in respect of the right to health can take different forms as follows: training and education of health professionals and workers; sharing medical expertise, knowledge and technology; transfer of health-related technologies like vaccine machines; collaborative research on diseases affecting developing countries; and support for health information systems and data collection. These help to improve and realize the right to health.

3.0 Mobilizing Resources

The international obligation to cooperate and assist is not limited to sharing of information but also include mobilizing resources to support States with less resources to realized the right to health within their territory. This is also an aspect of the extraterritorial obligation of States,

especially, wealthy States towards those with lesser resources.⁴⁴ Article 2(1) of the ICESCR in this regard provides thus, ‘Each State party... undertakes to take steps individually and through international assistance and cooperation... to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present covenant...’ this also applies to the right to health.⁴⁵

There are various ways in which a State, particularly the wealthy or developed ones, can mobilize resources to assist another State to realize the right to health. it can be in the form of providing bilateral aid to directly fund health programmes like vaccination in the State, supporting international bodies like the WHO, UNICEF, etc., who in turn will assist healthcare programmes in States with less resources. It can also be in form of providing drugs or medical equipment to fight a particular public health crisis like HIV/AIDs, Ebola Virus, Polio and Coronavirus.⁴⁶ In respect of the recent COVID-19, Matsumoto observed thus, ‘when the obligation to protect is fully applied to the relations between States, each State has an obligation to take steps towards the realization of the right in other States. As such, under COVAX, States with sufficient resources are obliged to offer the COVID-19 vaccines to States with insufficient resources’.⁴⁷

3.1 Domestic Obligations of States for the Right to Health

The domestic obligations of States for the realization of the right to health is primarily tripartite to wit: obligations to respect, protect and fulfill the right to health within their territorial sovereignty.⁴⁸ It should be noted that a State’s first set of obligations to ensure the right to health is firstly towards its own people.⁴⁹ It is only upon achieving this or having the capacity to achieve

⁴⁴ Ibid.

⁴⁵ ICESCR 1966, Art. 12.8

⁴⁶ SM Elzuway, *The Right to Health Care in International Law* (PhD Thesis, University of Glasgow 2013) 86. <<http://theses.gla.ac.uk/4293/>> accessed on 5 June 2025. MS Halpern, ‘State Obligations under Public International Law During Pandemi’ (2020) 35 *Emory International Law Review Recent Developments* 7.

⁴⁷ S Matsumoto, *A Role for International Law in Containing COVID-19: The Right to Health* (Policy Center for the New South, Morocco 2022) 10.

⁴⁸ BM Meier, ‘Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement’ (2010) 46(1) *Stanford Journal of International Law* 6; AE Yamin and A Constantin, ‘A Long and Winding Road: the Evolution of Applying Human Rights Frameworks to Health’ (2018) 49 *Georgetown Journal of International Law* 223’ P Pace (ed.) *Migration and the Right to Health: A Review of International Law* (IOM, Switzerland 2007) 66.

⁴⁹ Ganguly (n59) 5.

this and with still more resources that the State can be assigned extraterritorial obligations to other States. An example of a State with such capacity is the United States of America.⁵⁰

It is worth noting that the obligations to respect, protect and fulfill are not limited to fulfilling the right to health but these obligations apply to all economic, social and cultural (ESC) rights, wherein the right to health belongs.⁵¹ Article 2 of the ICESCR 1966 provides generally for the obligations of State parties towards ensuring the realization of ESC Rights. The Committee on Economic, Social and Cultural Rights in its General Comment Number 3 classified these obligations and streamlined them into the obligations to respect, protect and fulfill these rights, it is important to take these obligations and analyse them individually to clearly identify the extent and scope of each of these obligations as they relate to the right to health.

3.2 Obligation to Respect the Right to Health

This obligation places a duty on States to refrain from directly or indirectly interfering with the enjoyment of the right to health.⁵² It is a very important duty to ensure the realization of the right to health within the domestic jurisdiction of a State. This obligation also include not directly or indirectly interfering with the right to health in another State.⁵³ This implies also that States should not suspend or terminate measures aimed at giving effect to the right to health.⁵⁴ This includes removal of systemic discrimination within the health system.⁵⁵

Examples of what constitute the obligation to respect the right to health by a State is summarized as follows,

...States should refrain from denying or limiting access to health-care services, from marketing unsafe drugs; from imposing discriminatory practices relating to women's health status and needs; from limiting access to contraceptives and other means of maintaining sexual and reproductive health; from withholding,

⁵⁰ E Nwocha, 'Appraising the Frontiers and Limits of the Inter-American Human Rights System and its Relevance to International Human Rights Law' (2019) 10 *Beijing Law Review* 179; Martins Jnr (n22).

⁵¹ MD Silva, 'The International Right to Health Care: A Legal and Moral Defense' (2018) 39 *Michigan Journal of International Law* 358; A Fisher, 'Minimum Core and the Right to Education' (2017) *Nordic Trust Fund Research Paper* 9.

⁵² A Pereira, 'Live and Let Live: Healthcare is a Fundamental Human Right' (2004) 3(2) *Connecticut Public Interest Law Journal* 415.

⁵³ JHM Mike, 'Re-Evaluating the Relationship between Patient Rights and Human Rights for the Enhancement of Access to Essential Medicines' (2019)3(2) *AJLHR* 92.

⁵⁴ Chirwa (n16) 565.

⁵⁵ Yamin (n22) 1157.

censoring or misrepresenting health information; and from infringing on the right to privacy (e.g., of persons living with HIV/AIDs).⁵⁶

From the above submission, it is pertinent to specifically add that Government's enactment of anti-abortion laws which restrict the right of women to exercise their right to abortion is a breach of the obligation to respect the right to health.⁵⁷ This is so because by enacting the said law, the State directly interferes with the enjoyment of the right to health of an individual. Writing on what is expected of States in this regard, McCarthy notes thus, '...States are required to guarantee women access to quality healthcare free from discrimination. Quality health services include those circumstances in which complications arise from unsafe abortions and miscarriages, regardless of the legal status of abortion. As such, States are required to undertake measures to ensure access to post abortion care for all women and girls, free from discrimination, violence, or coercion. This obligation includes provision of adequate training, support, and supplies to ensure that abortion-related complications can be treated, irrespective of the legality of abortion?'⁵⁸

It is observed that abortion is a critical part of healthcare, and outrightly outlawing abortion has the negative effects on the health of women, including a significant increase in a rather preventable death.⁵⁹ In effect, legislation that restricts or which completely ban abortion can have long-lasting effect on the health system and thereby result in disruption of the lives of patients beyond the realm of reproductive care.⁶⁰

States have a negative obligation to refrain from violating individuals' right to health, and a positive obligation to promote and protect it. Sections 228, 229, 230, 328 and 297 of the Criminal Code and Section 232, 233, 234, 235 and 236 of the Penal Code provide for the criminalization of abortion in Nigeria. It is noted that this criminalization of abortion had forced women to embrace unreliable and dangerous means of eliminating unwanted pregnancies.⁶¹ These kinds of laws undermine and violate the obligation of Nigeria to respect the right to health.

⁵⁶ Office of the UN High Commissioner for Human Rights, 'The Right to Health' (2020) Fact Sheet No. 31.

⁵⁷ M Angie, 'State Obligations to Protect the Lives and Health of Women after Abortion or Miscarriage' (2014) 21(2) *Human Right Brief* 16-17.

⁵⁸ Ibid 18.

⁵⁹ E Xing and others, 'Abortion Rights are Health Care Rights' (2023) 8 (11) *JCI Insight* 1.

⁶⁰ Ibid.

⁶¹ PC Okorie and OA Abayomi, 'Abortion Laws in Nigeria: A Case for Perform' (2019) 23(7) *Annual Survey of International & Comparative Law* 187.

The duty to respect focuses on preventing the State from unduly intervening in the enjoyment of a particular freedom or entitlement and for a State to prevent the interference, the State may need to take proactive measures, for example, to prevent State agents from acting in certain ways, or to provide reparation if a duty has been breached.⁶² Also, states can resort to judicial intervention to ensure compliance with duties to respect ESC rights, in general, can be preventive and restorative or compensatory and this is not substantially different from traditional notions of civil and political rights litigation that is, protecting against State action that threatens the status quo.

3.3 The Obligation to Protect the Right to Health

This obligation requires State parties to take steps to prevent third parties from interfering with the right to health.⁶³ The obligation to protect is two folds to wit: to facilitate and enhance; and to prevent any obstruction to accessing healthcare facilities, services and medicines by third parties.⁶⁴ It is noted that, ‘Essentially, this obligation mandates States to facilitate access by preventing medical care providers (private and public) and third parties e.g. pharmaceutical companies, from violating the right to health.’⁶⁵

To perform this obligation, States should adopt laws, policies or measures to ensure that private actors and other third parties conform with human rights standards when providing healthcare services and other allied services, control the marketing of medical equipment, instruments and medicine by private actors, ensure that commercialization and privatization does not amount to a threat to the availability, accessibility, acceptability and quality of healthcare goods, services and facilities; protect individuals, especially vulnerable persons, from acts by third parties that may be harmful and detrimental to their right to health.⁶⁶ For example, prevent women from undergoing harmful customary and traditional practices or third parties from forcing women to partake in these practices, including enacting laws that prevent female genital mutilations. The obligation to protect also mandates States to ensure that third parties do not limit access to health

⁶² International Commission of Jurists, Courts and the Legal Enforcement of Economic, Social and Cultural Rights; Comparative Experiences of Justiciability (Human Rights And Rule Of Law Series: No 2, 2008)

⁶³ Office of the UN High Commissioner for Human Rights (n75) 26; J Tasioulas and E Vayena, ‘The Place of Human Rights and the Common Good in Global Health Policy’ (2016) 37 *Theor Med Bioeth* 365.

⁶⁴ IE Kosh, ‘Dichotomies, Trichotomies or Waves of Duties?’ (2005) 5 *Human Rights Law Review* 88-89.

⁶⁵ Mike (n72) 93.

⁶⁶ Office of the UN High Commissioner for Human Right (n75) 26

related information and services of the people; and to ensure that health professionals and workers provide health care to persons with challenges like disabilities with their informed consent.⁶⁷

Apart from Nigeria's obligation from international human rights instrument like the ICESCR which provides for the duty to protect the right to health, at the African regional level, the African Charter on Human and People's Right also provide for similar obligation. The significance of the African Charter over the international human rights treaties is that Nigeria has domesticated the African Charter in compliance with the requirements of Section 12 of the Constitution of the Federal Republic of Nigeria 1999 (as amended) to make the provisions of the African Charter enforceable in Nigeria. Article 16 of the African Charter provides for the right to health. Nigeria as a State party of the Charter is obligated to promote and protect the right to health.⁶⁸ It is noted that this obligation means that Nigeria ensure the Nigerian people receive medical attention when they are sick and that they enjoy the best attainable state of physical and mental health.⁶⁹ It is noted that health laws like the National Health Act set up the National Health System with the mandate to amongst other things protect the right of the Nigerian people to have access to healthcare services.⁷⁰

To effectively discharge the obligation place on States to protect the right to health, States, including Nigeria, must adequately ensure that others respect the right to health. To achieve this, the State has to enact quality laws and set up institutions to ensure that third parties within their territorial jurisdiction do not directly or indirectly interfere with the right to health of any individual or group. In the words of Nampewo, Mike and Wolff, 'The duty to protect is, in the first instance, a duty to create effective institutions to provide reasonable guarantee to health. The duty to protect, generally, in the first instance is a call to put effective institutions in place'.⁷¹ These institutions are critical to ensure effective implementation and enforcement of the healthcare laws. The institutions can help put companies and persons who offer healthcare services in check.

⁶⁷ Ibid.

⁶⁸ CA Obodo, 'COVID-19 and the Right to Healthcare in Nigeria: and Analysis of the 1999 Constitution (as Amended)' (2020) 10 *Journal of Public and Private Law*, UNIZIK 21.

⁶⁹ Ibid.

⁷⁰ Lugard (n3) 72; RN Nwabueze, 'Thee Legal Protection and Enforcement of Health Rights in Nigeria' in C Flood and A Gross (eds) *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014) 372.

⁷¹ Nampewo, Mike and Wolff (n4) 6.

States play very important roles in ensuring compliance with duties to protect ESC rights and the roles can either be preventive, restorative or compensatory and similar to litigation that seeks to require the State to protect against the acts or failure to act of private (third) parties in the sphere of civil and political rights.⁷² This intervention should work alongside and complement other State efforts such as regulation and law enforcement.

3.4 Minimum Core Obligations of the Right to Health

It should be noted that despite the efforts to make the right to health mandatory and obligatory, there remains the reality that the right to health cannot be realized or achieved where there is lack of resources by the State whom the obligation is on.⁷³ Despite acknowledging the impact of lack of resources on the realization of the right of health, the International Human Rights Community and institutions still require States to discharge a minimum aspect of the right to health.⁷⁴ In this regard, minimum core obligations are formulated to be discharged by States irrespective of the availability or non-availability of resources. This point is well captured thus,

The drafters of human rights treaties recognized that due to resource constraints it will generally take time for States to implement the provisions of the treaties and as a result the treaties provide for progressive realization of the rights protected under the treaties. However, progressive realization does not permit unnecessary delays and States are required at a minimum to show that they are making every possible effort, within available resources (including resources available from the international community through international cooperation and assistance), to better protect and promote all rights. In addition, the CESCR has confirmed that States have a core obligation to ensure that satisfaction of, at the very least, minimum essential levels of each of the rights under the International Convention on Economic, Social and Cultural Rights including at least the following obligations with respect to the right to health.⁷⁵

The minimum core obligations were developed by the Committee on Economic, Social and Cultural Rights in its General Comment Number 3. The Committee emphasized that States have a

⁷² International Commission of Jurists, Courts and the Legal Enforcement of Economic, Social and Cultural Rights; Comparative Experiences of Justiciability (Human Rights And Rule Of Law Series, No 2, 2008)

⁷³ E Riedel, 'The Human Right to Health: Conceptual Foundations' in A Clapham (ed) *Realizing the Right to Health* (Ruffer & Rub, Zurich 2009) 21-39.

⁷⁴ HC Okeke, 'Critical Review of Nigerian Health Laws: Making a case for Legal Framework on patient safety in Nigeria' (2023) 2 *Cavendish University Law Journal* 10.

⁷⁵ Gutterman (n14) 20-21.

core minimum obligation to ensure the realization of minimum essential levels of the rights as contained in the ICESCR. States are mandated to, irrespective of available resources, give priority to these core minimum obligations in their effort to realize the rights. As regards the right to health, it was noted by the Committee that States have the following as core minimum obligations to wit: the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; access to the minimum essential food which is nutritionally adequate and safe; access to shelter, housing and sanitation and an adequate supply of safe drinking water; the provision of essential drugs; and equitable distribution of all health facilities, goods and services.⁷⁶

It is noted that the realization of the minimum core of the right to health should ensure that all people meet some form of standard, which in actual practice may not be the highest one attainable.⁷⁷ The provision of essential primary healthcare is one of the first of the minimum core obligations under the International Covenant on Economic, Social and Cultural Rights 1966.⁷⁸

Although the right to health is not a justiciable right in Nigeria, however in compliance with international and regional human rights instruments, Nigeria has enacted laws that also provide for the minimum core obligations. Thus, Section 3 of the National Health Act 2014 empowers the Minister of Health to determine the category of persons (vulnerable Nigerians) who are entitled to free treatment at Government medical facilities. Subsection (3) of Section 3 of the National Health Act 2014 entitles all Nigerian citizens to a basic minimum package of health services. It is however observed that the right to this basic minimum package of health services to all Nigerian citizens depends on availability of resources as stated in Section 1(1) (c) of the Act.⁷⁹ Section 64 of the National Health Act provides to the effect that what amounts to ‘basic minimum package of health services’ depends on the prescription of the Minister of Health in consultation with the National Council on Health.

In his article, after identifying the core minimum obligations as stated by the Committee on Economic, Social and Cultural Rights, Chirwa commented thus, ‘it is clear that although the various international and regional human right treaties define the right to health differently, access

⁷⁶ Office of the UN High Commissioner for Human Rights (n75) 25.

⁷⁷ Silva (n70) 347.

⁷⁸ Ibid 360.

⁷⁹ Lugard (n3) 74.

in general including preventive, rehabilitative and curative treatment form a central part of the right to health'.⁸⁰

The minimum core obligations are non-derogable and have acquired a status of pre-emptory obligation under international law.⁸¹ The effect of this is that a State party has the onus of justifying that all efforts have been made by it to deploy all available resources within its capacity to satisfy these core obligations as a matter of priority.⁸² In other words, despite the fact that a State has some level of discretion *vis-à-vis* the satisfaction of minimum essential levels of other aspects of the right to health on the ground of availability or want of resources, such justification will not be allowed with regards to those aspects of the right to health that constitute the minimum core obligations. It is worthy to note that the minimum core obligations apply across the tripartite obligations to ensure the right to health to wit: obligations to respect, protect and fulfill the right to health.⁸³

There have been a lot of judicial pronouncements on the States' minimum obligations towards the right to health. In the South African case of *Minister of Health v Treatment Action Campaign (TAC)*,⁸⁴ the Constitutional Court of South Africa ruled that the refusal of the South African Government to provide Nevirapine, an HIV drugs, to be widely available in South Africa violated the Government's minimum core obligations to provide essential medicine. Similar decision was reached in the Brazilian case of *S. C. v Brazil*.⁸⁵ In the Gambian case of *Purohit and Moore v The Gambia*,⁸⁶ the African Commission on Human and People's Rights ruled to the effect that the conditions of the psychiatric facility and lack of mental health legislation in the country violated Article 16 of the African Charter on Human and People's Right. The significance of this ruling is that the decision in the case affirmed the position that minimum core obligations to the right to health include appropriate mental health services. However, in an earlier South African case of *Soobramoney v Minister of Health*⁸⁷ the South African Constitutional Court refused to hold

⁸⁰ Chirwa (n16) 553.

⁸¹ Ibid.

⁸² Ibid.

⁸³ K Shields, 'The Minimum Core Obligations of Economics, Social and Cultural Rights: The Rights to Health and Education' (2017) *The Nordic Trust Fund Research*. DOI: 10.1596/29145. accessed on 6 June 2025.

⁸⁴ (2002) 5 SA 721 (CC).

⁸⁵ Communication No. 10/2013 (CRPD, 2 October 2014).

⁸⁶ (2003) Communication No 241/2001; (2003) AHRLR 96.

⁸⁷ (1997) ZACC 17; (1998) 1 SA 765 (CC).

the South African Government liable to provide dialysis treatment due to limited resources. There are no direct cases in Nigeria on the minimum core obligations towards the right to health. But there is a swift towards enforcing economic, social and cultural (ESC) rights, which the right to health belongs.⁸⁸

The Committee on Economic, Social and Cultural Rights streamlined the minimum core obligations into the principles of availability, accessibility, acceptability and quality. These elements also apply to the right to water, food, housing and education.⁸⁹ The element of availability requires that relevant health-related facilities, goods and services, including programmes are made available in sufficient quantity within the State for the benefit of all persons within the State. The element of accessibility requires that the relevant health-related facilities, goods and services must be accessible in enough quantity to all persons within State physically and economically without any form of distinction or discrimination. The element of quality demands that the health-related facilities, goods and services must be of good quality and/or medically and scientifically appropriate and modern. The element of acceptability demands that the health-related facilities, goods and services are culturally, ethically appropriate and gender sensitive to the people who will access or use them.⁹⁰ These elements were enunciated by the Committee on Economic, Social and Cultural Rights in its General Comments Number 14.⁹¹

Yamin and Constatin explained the element of accessibility in the following way, ‘Accessibility comprised four dimensions: non-discrimination; physical accessibility, economic accessibility and information accessibility’.⁹² It is noted that the National Health Act 2014 is set up to ensure that the essential elements of availability, accessibility, acceptability and quality of health care services are guaranteed in Nigeria.⁹³ What is lacking, which is fundamental to the realization of the right to health, is the justiciability of the right to health in Nigeria such that Nigerians can enforce non-performance or non-availability of these services as at when due.

⁸⁸ Obodo (n87) 20.

⁸⁹ Chirwa (n16) 555.

⁹⁰ Ibid; Gutterman (n14) 8-9.

⁹¹ Kinney (n21) 1468.

⁹² Yamin and Constantin (n67) 212.

⁹³ Okeke (n105) 10.

3.5 Conclusion

The right to health remains a fundamental human entitlement enshrined in various international and regional legal instruments, including the Universal Declaration of Human Rights (UDHR, 1948), the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), and the African Charter on Human and Peoples' Rights (1981). The recognition of this right imposes clear and multidimensional obligations on states namely, to respect, protect, and fulfil the right to health. These obligations require states not only to refrain from actions that undermine health rights but also to adopt positive measures that ensure the availability, accessibility, acceptability, and quality of health facilities, goods, and services.

The examination reveals that safeguarding the right to health transcends the mere provision of medical services; it encompasses addressing underlying determinants such as access to clean water, adequate nutrition, sanitation, and a healthy environment. Moreover, international law emphasizes the principle of progressive realization, acknowledging disparities in states' resources while mandating deliberate, concrete, and targeted steps towards full implementation. States are equally required to ensure non-discrimination and participation in health-related decision-making processes, particularly for vulnerable and marginalized populations.

However, challenges persist, including inadequate funding, weak institutional frameworks, corruption, and limited political will, which continue to impede effective realization of the right to health in many jurisdictions. Therefore, stronger international cooperation, accountability mechanisms, and domestic legal incorporation of health rights are essential to bridge the gap between normative commitments and practical realities. Ultimately, the realization of the right to health is both a moral and legal imperative, central to human dignity, social justice, and sustainable development.

3.6 Recommendations

In the light of the above analysis, it is recommended thus:

1. It is necessary to incorporate the right to health into domestic constitutions or primary legislation where possible, and adopt implementing laws that translate international norms into enforceable entitlements.

2. It imperative to adopt a concrete fiscal benchmarks for a example progressively increase public health spending to a specific percentage of GDP or budget over time and ring-fence funds for the minimum core package.
3. There is need to empower national human rights institutions, ombudspersons and parliamentary committees with resources and enforceable mandates to monitor implementation and recommend remedies by creating a clear complaint and remedy pathways which facilitate access to justice through legal aid, administrative grievance mechanisms and simplified standing rules for public interest litigation in health matters.
4. It is important to prioritise primary health care (PHC) by investing on PHC as the backbone of universal coverage, including community health workers, supply chains, and referral systems which will address human resources strategically
5. It important to invest in disaggregated data systems by Collecting, analyzing and publishing health data disaggregated by sex, age, location, socioeconomic status, disability and other relevant categories to reveal inequities.
6. There is need to design programmes to target excluded groups explicitly such as migrants, indigenous peoples, prisoners, persons with disabilities and remove legal barriers to access.
7. The government should regulate private providers and financing by ensuring private provision by complementing public goals through licensing, quality standards, and mechanisms to prevent user-fee barriers and discriminatory practices.