PROTECTION OF THE RIGHT TO HEALTHCARE OF PEOPLE INFECTED WITH EBOLA VIRUS DISEASE (EVD): A HUMAN RIGHTS-BASED APPROACH

DISSEMINATION SUBMITTED IN FULFILLMENT OF THE REQUIREMENTS OF THE LL.M DEGREE AT THE UNIVERSITY OF VENDA

BY

GLORIA CHIDIMMA NWAFOR

STUDENT No: 14008862

SCHOOL OF LAW
SOUTH AFRICA

PREPARED UNDER THE SUPERVISION OF

MAIN SUPERVISOR: PROFESSOR G.N.K. VUKOR-QUARSHIE

CO-SUPERVISOR: Ms. P.P. LETUKA

2016
DECLARATION

I, GLORIA CHIDIMMA NWAFOR, student number 14008862, hereby declare that this dissertation for the LL.M degree at the University of Venda hereby submitted by me, has not been submitted previously for a degree at this or any other University, and that it is my own work in design and execution, and that all reference materials contained therein have been duly acknowledged.

STUDENT

Signature…………………………………. Date……………………………………

MAIN SUPERVISOR

Signature…………………………………. Date……………………………………

CO-SUPERVISOR

Signature…………………………………. Date……………………………………
DEDICATION

To all the Ebola victims in the West African Nations, who died as a result of the failure by the States to respect, fulfill and protect the right to healthcare of the right bearers in times of public health emergencies, most especially to the late Dr Stella Ameyo Adadevoh who raised a red flag when attending to a Liberian patient at the First Consultant Hospital in the Nigeria’s main commercial city, Lagos, in July 2014.

And to the Almighty God who has given me the strength to work and has made this dream a reality.
ACKNOWLEDGEMENT

I am grateful to God for the good health and intellectual strength that were necessary to complete this LLM dissertation.

The writing of this dissertation has been one of the most major academic challenges I have ever had to face in my career. Without the support, patience and guidance of the following people, this study would not have been completed:

My darling husband, Professor Anthony O. Nwafor, without whom this accomplishment would not have materialized. Your love, support and constant patience have taught me so much about sacrifice. Thank you so much.

My lovely children Chidimma and Arize-Anthony (Jr), who missed out on a lot of Mom’s time and had to endure a little bit of hunger when there was no food on the table while I sought intellectual enrichment. Thank you so much for your understanding and prayers throughout this research work. I want you to know that I love you both.

Prof GNK Vukor-Quarshie who undertook the task of being my main supervisor in spite of his many other academic engagements. Your wisdom, knowledge, patience, comments, suggestions, editing skills and commitment to the highest standards inspired and motivated me. I am particularly enthralled by your commitment to ensuring the completion of this work as you prepare for your final and well deserved exit from the University of Venda. Thank you so much Prof, and may God continue to guide you in all your feature endeavors.

I wish to thank my co-supervisor, Mrs Puleng P. Letuka, for her time, motherly advice, patience and guidance in the course of this research work. Without you, it would have been virtually impossible to get it right. Thank you so much ‘M’e.

And to all those who have in one way or the other lent their support to me towards the accomplishment of this task, I am most grateful. Suffices to state that, in spite of the assistance received from other sources in the course of this research work, all errors, mistakes or defects which may be found in this work are inadvertently mine.
### ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIR</td>
<td>All India Reports</td>
</tr>
<tr>
<td>All E.R</td>
<td>All England Law Reports</td>
</tr>
<tr>
<td>All N.L.R</td>
<td>All Nigeria Law Reports</td>
</tr>
<tr>
<td>AC</td>
<td>Appeal Cases Reports</td>
</tr>
<tr>
<td>App</td>
<td>Application</td>
</tr>
<tr>
<td>Art</td>
<td>Article</td>
</tr>
<tr>
<td>ACHPR</td>
<td>African Charter on Human and Peoples’ Rights</td>
</tr>
<tr>
<td>ACRWC</td>
<td>African Charter on the Rights and Welfare of the Child</td>
</tr>
<tr>
<td>AU</td>
<td>African Union</td>
</tr>
<tr>
<td>CRH</td>
<td>Centre for the Rights to Health</td>
</tr>
<tr>
<td>CC</td>
<td>Constitutional Court</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
</tr>
<tr>
<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>CERD</td>
<td>Convention on the Elimination of All Forms of Racial Discrimination</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>Ch</td>
<td>Chancery</td>
</tr>
<tr>
<td>Ed</td>
<td>Edition</td>
</tr>
<tr>
<td>Et al</td>
<td>And others</td>
</tr>
<tr>
<td>ECOWAS</td>
<td>Economic Community of West African States</td>
</tr>
<tr>
<td>ECtHR</td>
<td>European Court of Human Rights</td>
</tr>
<tr>
<td>EVD</td>
<td>Ebola Virus Disease</td>
</tr>
<tr>
<td>HC</td>
<td>High Court</td>
</tr>
<tr>
<td>HRBA</td>
<td>Human Rights-Based Approach</td>
</tr>
<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
</tr>
</tbody>
</table>
ICESCR:  International Covenant on Economic, Social and Cultural Rights

Ibid:  Ibidem (above)

ILO:  International Labour Organization

LFN:  Laws of the Federation of Nigeria

NGO:  Non-governmental organization

NCLR:  Nigeria Constitutional Law Reports

NMLR:  Nigeria Monthly Law Reports

NWLR:  Nigeria Weekly Law Reports

PP:  Pages

PPE:  Personal Protective Equipment

SERAP:  Socio-Economic Rights and Accountability Project

SA:  South Africa

SARS:  Severe Acute Respiratory Syndrome

SCC:  Supreme Court Cases

UDHR:  Universal Declaration of Human Rights

UNCHR:  United Nations Centre for Human Rights

WHO:  World Health Organization
# TABLE OF CASES

<table>
<thead>
<tr>
<th>Case</th>
<th>Year</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abacha and Others v Fawehinmi</td>
<td>2000</td>
<td>[2000] 6 NWLR (pt. 600) 228</td>
</tr>
<tr>
<td>Adewole &amp; Ors. v Alhaji Jakande &amp; Ors</td>
<td>1981</td>
<td>1 NCLR 262 (HC)</td>
</tr>
<tr>
<td>Attorney-General of Botswana v Unity Dow</td>
<td>1998</td>
<td>1 HRLRA 1 at 122</td>
</tr>
<tr>
<td>Alvarez v Caja Costarricense de Seguro Social Exp</td>
<td></td>
<td>5778-V-97 No 5934-97(SC)</td>
</tr>
<tr>
<td>Allpass v Mooikloof Estates (Pty) Ltd t/a Mooikloof Equestrain Centre</td>
<td>2011</td>
<td>(2) SA 638 (LC)</td>
</tr>
<tr>
<td>Bolam v Friern Hospital Management Committee</td>
<td>1957</td>
<td>2 All ER 118 at 122</td>
</tr>
<tr>
<td>Badejo v Federal Minister of Education and Others</td>
<td>1996</td>
<td>8 NWLR (pt 464) 15</td>
</tr>
<tr>
<td>Bristol and West Building Society v Mothew</td>
<td>1998</td>
<td>Ch 1 at 18A</td>
</tr>
<tr>
<td>Bank of Tokyo v Karmon</td>
<td>1987</td>
<td>AC 45 at 64</td>
</tr>
<tr>
<td>B and Others v Minister of Correctional Services</td>
<td>1997</td>
<td>50 BMLR 206 SA HC</td>
</tr>
<tr>
<td>Chatterton v Garson</td>
<td>1981</td>
<td>1 QB 432 at 443</td>
</tr>
<tr>
<td>Chester v Afshar</td>
<td>2004</td>
<td>UKHL 41</td>
</tr>
<tr>
<td>Dawood and Another v Minister of Home Affairs and Others</td>
<td>2000</td>
<td>(3) SA 936 (CC)</td>
</tr>
<tr>
<td>EN and Others v Government of RSA and Others</td>
<td>2007</td>
<td>1 BCLR 84(D)</td>
</tr>
<tr>
<td>Ex Parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa</td>
<td>1996</td>
<td>4 SA 744 (CC)</td>
</tr>
<tr>
<td>Extrasure Travel Insurance Ltd v Scattergood</td>
<td>2003</td>
<td>1 BCLC 568</td>
</tr>
<tr>
<td>Festus Odafe &amp; Others v Attorney General of the Federation and Others</td>
<td>2004</td>
<td>AHRLR 205 (NgHC2004)</td>
</tr>
<tr>
<td>Flores v Southern Peru Copper Corporation</td>
<td>2003</td>
<td>343 F.3d 140 (2d Cir. 2003)</td>
</tr>
<tr>
<td>Filartiga v Pena-Irala</td>
<td>1980</td>
<td>630 F.2d 876 (2d Cir. 1980)</td>
</tr>
<tr>
<td>Federal Republic of Nigeria v. Anache</td>
<td>2004</td>
<td>14 WRN 1</td>
</tr>
<tr>
<td>Georgiana Ahamefule v Imperial Medical Centre &amp; Dr. Alex Molokwu</td>
<td></td>
<td>(Unreported decision of High Court of Lagos State, Ikeja, Suit no. ID/1627/2000)</td>
</tr>
<tr>
<td>Garuba and Others v Lagos State Attorney General and Others</td>
<td>1992</td>
<td>8 NWLR (pt 257) 85</td>
</tr>
</tbody>
</table>
Government of RSA and others v Grootboom and others 2001 (1) SA 46 (CC)

Hague v Williams [1962] 181 Atlantic Reporter 2d 345

Hoffmann v South African Airways 2001 (1) SA 1 (CC)

Hamel v Malaxos 25, Nov.1993, No:730-32-00037929 (Unreported)

Hurtado v. Switzerland App. No.17549/90 (ECtHR) (January 28, 1994)

International Pen and Others (on behalf of Ken Saro Wiwa) v Nigeria (2000) AHLR 212 (ACHPR 1998)

Jedah v Horace (1916) 2 LLR 63

Jansen Van Vuuren v Kruger1983 (4) SA 842 (AD) at 31

KH and Others v Slovakia App. No. 32881/04 (ECtHR) (April 28, 2009)

Keenan v. United Kingdom App. No. 27229/95 (ECtHR) (April3, 2001)

Le Roux and Others v Dey 2010 (4) SA 210 (SCA)

Minerva Mills Ltd & Ors v. Union of India & Ors, AIR 1789 1981 SCR (1) 206 1980 SCC (3) 625

Mark v Seattle Times 96 WN 2nd 473, 635 P.2d 1081 (1981)

MS v Sweden App. No.20837/92 (ECtHR) (August 27, 1997)

Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo [2001] 7 NWLR (pt 711) 206 SC

Minister of Health and Others v Treatment Action Campaign and Others 2002 (5) SA 721 (CC)

MX of Bombay Indian Inhabitant v M/s ZY and another AIR 1997 (Bombay) 406

Olafisoye v Federal Republic of Nigeria [2005] 51 WRN 52

Okogie and Others v Attorney General of Lagos State (1981) 1 NCLR 218

Ogugu v State [1994] 9 NWLR (pt 366) 1


Pachim Banga khet Majoor Samity v State of West Bengal(1996) 4 SCC 37

Prosecutor v Charles Ghankay Taylor Case No. SCSL-03-01-A


Prosecutor v Furundiija, No IT-95-17/1-T, 11153-54 (Dec. 10, 1998)
Pt. Parmanand Katara v Union of India and Others AIR 1989 SC 2039

Pearce v United Bristol Healthcare NHS Trust [1999] PIQR 35 at 49

Registered Trustees of the Socio-Economic Rights and Accountability Project v Universal Basic Education Commission Suit NO: ECW/CCJ/APP/0808

Roche v United Kingdom App. No.32555/96 (ECtHR) (October19, 2005)

R v Cambridge Health Authority, ex parte B [1995] 2 All ER 129 (CA) 2002 (5) SA 721 (CC)

Roe v Wade 410 US 113

R v Morgentaler [1988] 1 SCR 30


Soobramony v Minister of Health, KwaZulu-Natal 1998 1 SA 765 (CC)

S v Makwanyane 1995 (3) SA 391 (CC)

Shalabi and Another v Minister of Home Affairs and Others 2000 (3) SA 936 (CC)

Sideway v Bethlem Royal Hospital [1985] AC 871

The Registered Trustees of the Constitutional Rights Project (CRP) v The President of the Federal Republic of Nigeria and Others (1994) 4 Journal of Human Rights Law and Practice 218

Thomas and Another v Minister of Home Affairs and Others 2000 (3) SA 936 (CC)

Tenteah v Republic of Liberia (1940) 7 LLR 63

Transbridge Trading Co. Ltd v Survey International Ltd [1996] 4 NWLR (Part 37) 576 at 596-597

Ultraframe (UK) Ltd v Fielding [2005] EWHC 1638 (Ch)

Valentine Ayika v Republic of Liberia ECW/CCJ/APP/07/11

X v Y [1988] 2 All ER 648 (QBD) 653

Zimbabwe Lawyers for Human Rights and Another v Zimbabwe 2008 (AHRLR) 120

Z v Finland App. No.22009/93 (ECtHR) (February 25,1997)
TABLE OF STATUTES

NATIONAL INSTRUMENTS
The Constitutions of Liberia (1986)
The Nigerian National Health Bill, 2014

REGIONAL INSTRUMENTS
Economic Community of West African States (ECOWAS Treaty) 1975

OTHER INTERNATIONAL INSTRUMENTS
The convention on the Right of Child, (CRC) 1989
The International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966
The International Covenant on Civil and Political Rights (ICCPR), 1966
The Convention on Elimination of All Forms of Discrimination against Women (CEDAW), 1979
The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), 1984
The Convention on the Elimination of All Forms of Racial Discrimination (CERD), 1965
The Committee on Economic, Social and Cultural Rights General Comment No 20, Non-discrimination in Economic, Social and Cultural Rights (2009)

The Committee on Economic, Social and Cultural Rights, General Comment No 14 (2000)

The World Medical Association’s Declaration of Lisbon on Rights of the Patient (Lisbon Declaration), 1981


The Maastricht Guidelines on violations of Economic, Social and Cultural Rights (Maastricht Guidelines) 1997

The Universal Declaration of Human Rights (Universal Declaration), 1948

The Versailles Treaty (1919)

World Health Organization (WHO) 1946
# TABLE OF CONTENTS

Declaration

Dedication

Acknowledgement

Abbreviations and Acronyms

Table of cases

Table of Statutes

Table of Contents

Abstract

## CHAPTER ONE: ................................................................. 1

**INTRODUCTION** ............................................................. 1

1.1 BACKGROUND TO THE STUDY ..................................... 1

1.1.1 Meaning of EVD ...................................................... 2

1.1.2 Evolution of EVD ..................................................... 3

1.1.3 Human Rights of People Infected with EVD .................. 6

1.1.4 Human Rights-Based Approach ................................ 9

1.2 Statement of problem ................................................... 12

1.3 Aim and Objectives ..................................................... 13

1.3.1 Broad Aim ............................................................. 13

1.3.2 Specific Objectives ................................................... 13

1.4 Research questions ..................................................... 14

1.5 Hypothesis ................................................................. 14

1.6 Scope of the research ................................................... 14

1.7 Justification of the work ............................................... 15

1.8 Literature Review ........................................................ 15

1.9 Research Methodology ............................................... 18

1.10 Ethical consideration .................................................. 19

1.11 Definition of technical concepts ................................... 20

1.11.1 Discrimination ....................................................... 20

1.11.2 Dignity ................................................................. 20

1.11.3 Stigma ................................................................. 21

1.11.4 Health ................................................................. 21

1.11.5 Healthcare ............................................................ 21

1.11.6 Healthcare provider ............................................... 21
ABSTRACT

Human rights are those inalienable rights of an individual by virtue of being a human being. They are guaranteed by various domestic and international instruments. This research argues that despite the existence of these instruments and wide acceptances of international human rights standards that seek to protect the right to healthcare, the people infected with Ebola Virus Disease (EVD) are victims of a wide range of constraints to their right to healthcare as a result of the failure by the governments of the respective nations where the impacts of the EVD are mostly felt to discharge their obligations under those instruments. The rights of the people infected with EVD are often violated because of their presumed or known EVD status, causing them to suffer both the burden of the disease and the social burden of discrimination and stigmatisation which could deter the infected persons from accessing available treatment. This would invariably contribute to the spread of the disease. The research further exposes the dilemma posed by the EVD to the healthcare system, where healthcare providers are caught between the rock of self-preservation from a highly virulent disease and the hard place of discharging their Hippocratic Oath which prescribes ethical guidelines for the discharge of the duties of the medical profession. The present research, which is novel in the field of medico-legal research, seeks to proffer answers to this conundrum.

Keywords: Ebola, Victims, Healthcare, Human rights, Nigeria, Liberia, Guinea, Sierra Leone.
CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

A country’s healthcare system is the combination of resources, organisation, financing and management that culminate in the delivery of health services to the population. A healthcare system has many facets which include patients, families and communities, Ministries of health, health providers, and health service organisations. The primary purpose of the healthcare system is to promote, restore and maintain health.\(^1\) Human beings and the communities throughout history have always strived to cater for their health needs by using indigenous medicines and the knowledge available from healers, either at home or in small facilities. Religious leaders have also played an important role in the provision of healthcare through the art of healing which is often intertwined with religious belief.\(^2\)

The recognition of health in modern times as a basic human need and a social right as stated in numerous national and international instruments entails significant roles and responsibilities for the governments. The global political developments following the First World War supported the move towards health as a human right. The Versailles treaty of 1919 which led to the establishment of the International Labour Organisation (ILO) emphasised the principle of “peace through social justice” and promoting social security against various hazards, including sickness and injury. The United Nations Universal Declaration of Human Rights, 1948 (Universal Declaration) states that everyone has a right to a standard of living for the health and wellbeing of himself and his family, including medical care and necessary services.\(^3\) The constitution of the World Health Organization (WHO) which was adopted in its First World Assembly in 1946 recognises in the preamble the attainment by all peoples of the highest possible level of health and states that “Governments have responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures”.

\(^3\) See s 25(1) of the Universal Declaration.
National governments play a crucial role in the development of the health systems as part of the sovereign functions which include governance, providing health system infrastructure and training of the necessary healthcare providers.\textsuperscript{4} Government’s responsibilities in these areas of health are fulfilled through the ministries of health and other related ministries and agencies. The level of efficacy of a nation’s health system is tested in times of emergencies. The diagnosing of Ebola Virus Disease (EVD), a highly infectious disease, in the West African sub-region has thrown a massive search-light on the ability of the affected countries’ health systems to respond to health related emergencies. This dissertation examines from human rights perspective how the governments in the countries of Nigeria, Liberia, Sierra Leone and Guinea in particular responded to the public health crises that EVD has engendered.

This chapter lays the foundation of the work, dealing with preliminary issues such as the meaning and evolution of the EVD, the background for the protection of human rights of people infected with EVD, scope and justification of the work, methodology, statement of problems, aim and objectives of the research, research questions and the hypothesis on which the work is based, literature review, limitation of study, ethical consideration and the general structure of the work are also discussed.

1.1.1 Meaning of EVD

Ebola virus disease (EVD) is described as a disease of humans and other primates caused by the Ebola virus.\textsuperscript{5} Ebola virus is classified by virologists as a member of the Filoviridae viral Family of RNA viruses, which are characterized by the long, thin filaments seen in micrograph images. The virus is said to be named after the Ebola River where the virus was first discovered in the Democratic Republic of Congo.\textsuperscript{6}

\textsuperscript{5} ‘Ebola virus disease’ available at \url{http://en.wikipedia.org/wiki/Ebola_virus_disease} (accessed 3 September 2014); see also ‘Ebola virus definition- Infectious Disease Center :Information on Infection’ Medicine Net.com available at \url{http://www.medters.com/script/main/art.asp?articlekey=6518} defined Ebola virus as a notoriously deadly virus that causes fearsome symptoms, the most prominent being high fever and massive internal bleeding.
\textsuperscript{6} ‘Ebola Virus’ available at \url{https://microbewiki.kenyon.edu/index.php/Ebola-virus} (accessed 3 September 2014); See also JH Kuhn et al’ ‘Proposal for a revised taxonomy of the family Filoviridae: Classification, names of taxa and viruses, and virus abbreviations’ (2010) 155 (12) Archives of Virology 2083-130.
Different types of Ebola virus have been isolated by experts in the field among which are Zaire, Sudan, and Ivory Coast Ebola virus, named after the respective countries in Africa in which the strains were found. There is also another strain of the virus called Reston Ebola virus which infects non-human primates. This was first discovered in an outbreak in Reston, Virginia, United States of America in 1989. New strains of the Ebola virus have continued to emerge. For instance, the outbreak of the disease in Bundibugyo District of Uganda in 2007 was attributed to a new strain of the virus by the US-based Center for Disease Control.7

1.1.2 Evolution of EVD

The first incidence of the EVD in humans was discovered in August 1976, in Yambuku, a small rural village in Mongala District in the northern Democratic Republic of the Congo (then known as Zaire),8 and later spread to the surrounding area in Sudan, where 284 people were infected with 151 recorded deaths.9

The spread of the disease in the DRC was traced to one Mabalo Lokela, a village school headmaster, who had toured an area near the Central African Republic border along the Ebola River between12-22 August 1976. He died of Ebola disease on the 8 of September, 1976 barely three weeks after the manifestations of the symptoms of the disease. A number of other cases were subsequently reported, and almost all were centered on the Yambuku mission hospital where the index case had received medical attention, and others who had contacts with infected


persons. A total of 318 cases of infection resulting in 280 deaths, 88% fatality rate, were recorded at the time in the DRC.\textsuperscript{10}

The initial outbreak of the disease in the DRC was contained with the help of the World Health Organization in collaboration with the Congolese air force who ensured the quarantining of infected villagers and isolated suspected cases, sterilizing medical equipment, and providing protective clothing.\textsuperscript{11} The virus responsible for the outbreak of the disease in the DRC was initially thought to be the Marburg virus\textsuperscript{12} but was later identified as a new type of virus related to Marburg, and named after the nearby Ebola River.\textsuperscript{13}

\subsection*{1.1.2.1 The West African 2014 Ebola Outbreak}

The outbreak of Ebola virus in the West African region was first reported in Guinea in March 2014 following the death of a two year old child who was infected with the disease.\textsuperscript{14} The virus rapidly spread to the neighbouring countries such as Liberia and Sierra Leone. The WHO report in April 2014, showed 157 suspected and confirmed cases in Guinea, 22 suspected cases in Liberia, and 8 suspected cases in Sierra Leone.\textsuperscript{15} By the month of July 2014 the disease was exported into Nigeria through a Liberian-American, Patrick Sawyer, who travelled by air from


\textsuperscript{12} Marburg virus is a haemorrhagic fever virus of the Filoviridae family of viruses, first noticed and described during small epidemics in the German cities Marburg and Frankfurt and the Yugoslav capital Belgrade in the 1960s; See JH Kuhn et al ‘proposal for a revised taxonomy of the family Filoviridae: Classification, names of taxa and viruses, and virus abbreviations’ (2010) 155 (12) Archives of Virology 103.


\textsuperscript{14} ‘Guidelines for Evaluation of US Patients Suspected of Having Ebola Virus Disease’ CDC 2014 available at http://emergency.cdc.gov/han/han00364.asp (accessed 5 September 2014). See also ‘Ebola pandemic’ available at http://en.wikipedia.org/wiki/Ebola_virus-epidemic-in-West_Africa where it was also reported that the first human case of the Ebola virus disease leading to the 2014 outbreak was a 2 year old boy who died on 6 December 2013 in the village of Meliandou, Gueckedou prefecture, Guinea. His mother, 3 year old sister and grandmother then became ill with symptoms consistent with Ebola infection and died. People infected by those victims spread the disease to other villages (accessed 11 September 2014).

Liberia to Lagos in Western Nigeria. Senegal has also witnessed the spread of the virus as confirmed by that country’s Health Minister Awa Marie Coll Seck. The virus was traced to an infected person that arrived from the neighbouring country Guinea. The disease has also spread to Mali through a 70-year-old imam who was brought to the capital, Bamako, from Guinea. United States of America and Spain are now among the list of nations that have witnessed the spread of this virus.

As the spread of the disease continues in the region, so is the death rate. As of November 2014 the WHO reported a total of 5,459 deaths out of 15,551 cases of infected persons. Some experts believe that these figures are grossly understated as many families of the infected persons are reluctant to report cases, a factor which is not unconnected with the incidences of stigmatization and discrimination against infected persons and their close relatives.

The state of the disease in the Liberian capital Monrovia was described by the Doctors without Borders as “catastrophic” and “deteriorating daily”. They reported that fear of Ebola among staff members and patients have shut down much of the city’s health system which has resulted in leaving many people without treatment for other conditions. The WHO had declared the epidemic an international public health emergency.

---

19 CDC confirmed on September 30, 2014, through laboratory tests, the first case of Ebola to be diagnosed in the United States in a person who had travelled to Dallas, Texas from Liberia. The patient did not have symptoms when leaving Liberia, but developed symptoms approximately five days after arriving in the United States available at www.cdc.gov/vhf/ebola/2014.../united-states-imported-case.html (accessed 7 October 2014).
It is noted that the Ebola crisis has discombobulated traditional healthcare protocols. The Ebola virus has been reported to cause infections for healthcare providers who come into contact with bodily fluids from infected victims. Incidents such as these are reported as a reason for some healthcare providers such as doctors and nurses showing reluctance and lack of professionalism in dealing with people infected with EVD. This naturally creates a need to examine the challenges faced by the government and healthcare providers in fulfilling their healthcare obligations as a result of the Ebola crisis. This is the subject at the heart of the next discussion.

1.1.3 Human Rights of People Infected with EVD

The term human rights may be used either in an abstract and philosophical sense, as denoting a special kind of moral claim that all humans may invoke, or more pragmatically, as the manifestation of these claims in positive law, for example as constitutional guarantees that serve as the basis to hold governments accountable under national legal processes.

Human rights are in some circles discussed, albeit erroneously, as synonymous with constitutional rights. This perhaps stems from the general perception that every right is enforceable in law. The word ‘right’ means that to which a person has a just and valid claim, whether it be land, a thing, or the privilege of doing or saying something. ‘Human’ pertains to having characteristics of, or the nature of mankind. Human rights are thus rights which all persons (mankind), everywhere, and at all times, have by virtue of being mortal and rational creatures. They are inherent in every human by virtue of his humanity. They are fundamental rights owned by every human being and are defined in national and international human rights

24 Frans Viljoen, International Human Rights Law in Africa 2nd ed (United Kingdom: Oxford University Press, 2012) p 3. See also David P Forsythe, Human Rights in International Relations 2nd ed (New York: Cambridge University Press, 2006) p. 3 where human rights are widely considered to be those fundamental moral rights of the person that are necessary for a life with dignity and as the means to a greater social end; the legal system that tells us at any given point in time which rights are considered most fundamental in society.
instruments and codes.\textsuperscript{26} When human rights have been ratified and acceded to in international agreements or legislated for in national legal systems, they also become legal rights.\textsuperscript{27}

The Universal Declaration of Human Rights which was proclaimed by the United Nations General Assembly in December, 1948 is historically the foundational instrument upon which various human rights legislation are predicated. The influence of the Universal Declaration on later international and national instruments and law has been so far-reaching that it has been variously described as the "Magna Carta of the world, the cornerstone of United Nations and a common language for all humanity."\textsuperscript{28} The Universal Declaration which has as one of its objectives, the recognition of the inherent dignity, equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world.\textsuperscript{29}

The provision of adequate healthcare for the citizens by the state is a fundamental human right which is indispensable to the realization and exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. Article 25(1) of the Universal Declaration provides 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 necessary social services”.\textsuperscript{30} Although the Universal Declaration is not a treaty, it has been widely accepted.\textsuperscript{31} The norms therein declared have metamorphosed into customary international law as they are regularly encountered in state practices and national statutes. Indeed, almost all the norms contained in the Universal Declaration have been transmuted into binding standards in the International Convention on Civil and Political Rights (ICCPR) and International Convention on Economic, Social and Cultural Rights (ICESCR).

The right to healthcare of people infected with EVD is particularly susceptible to violations in the healthcare settings especially where there are inadequate healthcare facilities to address

\textsuperscript{26} Ames Dhai and David McQuoid- Mason, \textit{Bioethics, Human Rights and Health :Law, Principle and Practice} (Cape Town: Juta & Co Ltd, 2011) p. 36.

\textsuperscript{27} Ibid.


\textsuperscript{29} See the Preamble to the Universal Declaration of Human Rights 1984 (Universal Declaration).

\textsuperscript{30} Universal Declaration of Human Rights, General Assembly Resolution 217A(111)10\textsuperscript{th} December 1948.

situations of health emergencies such as EVD. For instance, it was reported that in Nigeria the healthcare providers abandoned Ebola patients and walked away from an Ebola treatment Center (the Infectious Disease Hospital) in Yaba, Lagos.\(^{32}\) The healthcare providers allegedly claimed that they abandoned the patients because of what they perceived as the lack-lustre attitude of their country’s health officials to the plight of the Ebola patients who were quarantined at the Center. The Ebola patients were reportedly housed in a dilapidated and abandoned building at the Center without quality care, functioning water supply and no air conditioning facilities. The families of the patients had to cater for them and pay for some drugs and oxygen.\(^{33}\) It is submitted that abandoning a patient in the hospital by healthcare providers for whatever reason constitutes an infringement by the healthcare providers of the right to healthcare of the patient.

In Liberia, Guinea, and Sierra Leone the victims of the disease are reportedly quarantined in make-shift shelters without adequate provisions of treatment facilities and other amenities of life.\(^{34}\) Restrictions were also imposed on individual’s houses, neighbourhoods, villages, and in some cases the entire administrative districts.\(^{35}\) All these are done under the guise of preventing the spread of the disease in the communities.

International human rights law, as observed by Human Rights Watch, has set down a benchmark that states should observe for the quarantining of persons in times of public health emergency as follows:

[R]estrictions on human rights in the name of public health or public emergency meet requirements of legality, evidence-based necessity, and proportionality. Restrictions such as quarantine or isolation of symptomatic individuals must, at a minimum, be provided for and carried out in accordance with the law. They must be strictly necessary to achieve a legitimate objective, the least intrusive and restrictive available to reach the objective (sic), based on scientific evidence, neither arbitrary nor discriminatory in application, of limited duration, respectful of human dignity, and subject to review. When quarantines are imposed, governments have absolute obligation to ensure access to food, water, and healthcare.\(^{36}\)


\(^{33}\) Ibid.


\(^{36}\) Ibid.
It will be argued in this study that the quarantine imposed on the victims of EVD and others by the respective governments in the affected countries did not comply with the international protocol as set out above. This amounts to a violation of the rights to freedom of movement and liberty of the affected persons. This research study advances the view that people infected with EVD are entitled to the protection of their human rights, especially the right to healthcare, as provided in various national and international human rights instruments.

1.1.4 Human Rights-Based Approach

According to the office of the United Nations High Commissioner for Human Rights, a human rights-based approach is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It concretely integrates the norms, principles, standards of the international human rights system into policies, plans and process of development. 37 Schmidt-Traub is of the view that human development and human rights are close enough in motivation and concern to be compatible and congruous, and they are different enough in strategy and design to supplement each other fruitfully. 38

A human right-based approach inter alia, essentially requires empowering people to know and claim their rights, and invariably increasing the ability and accountability of individuals and institutions that are responsible for respecting, protecting and fulfilling rights. This entails giving people greater opportunities to participate in shaping the decisions that impact on their human rights. It also entails increasing the ability of those with responsibility for fulfilling rights to recognize and know how to respect those rights, and ensure that they are held accountable. 39

A human right-based approach to healthcare means integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of health-related policies.

and programmes. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that healthcare systems are made accessible to all. The principle of equality and freedom from discrimination is central, including discrimination on the basis of sex and gender roles.40

The right to health which today means the right to the highest attainable standard of health, was first reflected in the WHO’s constitution. It has been firmly endorsed in a wide range of international and regional human rights instruments. The most authoritative interpretation of the right to health is outlined in article 12 of the International Convention on Economic, Social and Cultural Rights of 1966, (ICESCR) which has been ratified by approximately 150 countries.41 Article 12(1) of the ICESCR provides that the state parties to the Covenant shall recognize the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. Article 12(2)(c) of ICESCR enjoins the state parties to take steps necessary for the prevention, treatment and control of epidemic, endemic, occupational and other diseases. Article 12(2)(d) further enjoins state parties to have in place measures that would create conditions which would assure medical service and medical attention to everyone in the event of sickness. Although the language of these provisions do not seem mandatory, they lay down the threshold by which state parties could ensure the realization of the right to health of their citizens through the provision of adequate healthcare facilities while at the time ensuring the welfare of other citizens in times of pandemic.

In May 2000 the UN Committee on Economic, Social and Cultural Rights, which monitors the Covenant, adopted General Comment No. 14, on the right to health that further clarifies the nature, scope and content of the right to health.42

The realization of the right to healthcare and other health-related human rights requires policies and plans to be systematically integrated to further these rights. The right to healthcare is

40 ‘Human Rights-Based Approach to Health’ available http://www.who.int/trade/glossary/story054/en/ (accessed 9 September 2014); See International Federation of Health and Human Rights Organisations ‘A right based approach to health’ available at http://www.ifhthro.org/health-a-human-rights/a-rights-based-approach-to-health (accessed 9 September 2014) where it was stated that the main effect of a human rights approach to health is that it re-frames basic health needs as health rights. In other words, becoming healthy and remaining so is regarded not merely as a medical, technical economic problem, but as a question of social justice and concrete government obligations.


42 Ibid. The details of the General Comment No 14 are set down and discussed in chapter two. p 29.
recognized in several core international and national constitutions. Among the international instruments that provide for such rights are the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). These instruments shall be discussed later in this work.

General Comment No.14 highlights the right to health as an inclusive right extending not only to timely and appropriate healthcare 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.43

Similarly, General Comment No.14 explains that the four elements of availability, accessibility, acceptability and quality (AAAQ) are essential to the enjoyment of the right to health by all.44 These four elements will be discussed below. A human right-based approach focuses on capacity development, both of duty bearers to meet their obligations and of individuals to claim their rights. Governments have been identified as duty bearers that are responsible for meeting human rights standards regardless of whether the services are provided by the private or public sector.45

Viljoen observed that governments have four major tiers of obligation towards human rights which are to; respect, promote, fulfill and protect human rights.46 The obligation to respect human rights requires the state to refrain from interfering with the enjoyment of this right, for example, refrain from limiting access to healthcare services or marketing unsafe drugs. The obligation to protect this right demands that states should legislate against unwarranted intrusion on the rights of the bearers by third parties. The obligation to fulfill the right requires positive measures by the state to ensure the direct enjoyment of a right by the right bearers and which would entail, in the context of healthcare system, the building and equipping clinics and providing medication for the sick. The obligation to promote the right requires states to enable

44 General Comment, Ibid.
45 Schmidt-Traub (note 38 supra) 79.
46 Viljoen (note 24 supra) 6.
people to exercise rights in the longer term, for instance by education and awareness raising about rights.47

1.2 Statement of the problems

In the aftermath of the EVD outbreak, numerous alarming reports and articles highlighting the plight of the EVD victims claim that people infected with EVD are highly stigmatized and discriminated against in the society. Other reports assert that some EVD victims are virtually treated as outcasts with no one showing any inclination to having dealings or contacts with them.48 If those reports are true, the tragic conclusion may be reached that in spite of the protections afforded by international and national human rights instruments, the rights to dignity of the infected persons are violated. From the reports, it also emerged that a person infected with EVD sometimes risks isolation by his or her family, friends, and more, once a disclosure of that person’s EVD status is made.49 This offends the victim’s freedom from discrimination. The Ebola virus epidemic has obviously created great challenges for the state in fulfilling its obligation to provide healthcare to the citizens. In times of epidemic and health emergencies, the state has to balance the rights of affected individuals against the need to protect the rest of the society from a highly virulent and contagious disease. The legitimate issue to address in this context is whether the limitations placed on the right of the individual victims, such as restrictions on their liberty, is justified from the perspective of protection of the wider society.50

The fear and stigma surrounding EVD infection result in the infected persons not seeking expert medical advice or aid until they manifest the symptoms of the disease. Most of the people infected with EVD only become aware of their status at the health facilities when they are already sick. The fear of being stigmatized or isolated may also cause people to conceal their

---

47 Ibid.
50 It is axiomatic that human rights are not absolute. The South African Constitution of 1996, for example, contains in section 36, an elaborate list of circumstances under which the rights adumbrated in the Bill of Rights may be limited.
illness.\textsuperscript{51} It has also been observed that appearance of medical teams in protective suits has sometimes exacerbated the fear of the virus\textsuperscript{52} and making people to be afraid of going to the hospital.

Another problem people infected with EVD encounter is discrimination. People infected with EVD are discriminated against by healthcare providers. It has been reported that the panic surrounding the Ebola virus has affected healthcare providers and has led to discrimination against patients suspected of being infected.\textsuperscript{53}

1.3 Aim and Objectives

1.3.1 Broad Aim

This research work is aimed at ascertaining the extent to which the governments in the affected states of Nigeria, Liberia, Sierra Leone and Guinea respectively fulfill their human rights obligations to ensure the protection of the citizen’s right to healthcare especially in times of emergencies as witnessed by the outbreak of EVD.

1.3.2 Specific Objectives

To achieve this aim, the following specific objectives would be pursued:

- To examine and discuss the various existing international and national human rights instruments that guarantee protections of the right to healthcare for people infected with EVD and find how these could be harnessed to give such persons some sense of humanity.
- To evaluate from the perspective of human rights, the attitude of healthcare providers and the society generally towards people infected with EVD.
- To determine whether the limitations placed on fulfilling human rights in times of health emergencies are reasonable and legitimate.


To make appropriate recommendations and suggestions that would help to protect the right to healthcare of people infected with EVD.

1.4 Research questions

To accomplish the aim and objectives expressed above, the following research questions will be addressed:

- What are the existing international and national instruments for the protection of the rights of people infected with EVD?
- To what extent is the right to healthcare of people infected with EVD protected in countries affected by EVD?
- To what extent does the treatment given by healthcare providers to the people infected with EVD comply with or promote the miscellany of rights such as the right to dignity, confidentiality etc, guaranteed under relevant human rights instruments?
- Are the limitations placed on human rights in times of health emergencies reasonable and legitimate?

1.5 Hypothesis

The research is based on the hypothesis that the states affected by EVD; Nigeria, Liberia, Sierra Leone and Guinea, are unable to respect, fulfill and protect the right to healthcare of the victims in times of public health emergencies such as that witnessed with the outbreak of the EVD in those West African nations.

1.6 Scope of the research

This work basically addresses human rights issues relating to the right to healthcare as it affects people infected with EVD. The researcher is, however, cognisant that the rights of the victims of EVD are intricately interwoven not only with those of the healthcare providers who could also be infected in the course of attending to the victims as well as that of society at large. In dealing with the right to healthcare related matters, various international and national human rights instruments will be discussed with the aim of discovering the extent of compliance by the states in dealing with the challenges faced in delivering healthcare in times of public health emergency caused by Ebola epidemic.
1.7 Justification of the work

The fatality rate amongst Ebola victims and the ease with which the virus is contracted have struck humanity with trepidation. The attitude of the government agencies and healthcare providers seems to be more directed at self-preservation than caring for the victims. There are reported issues of gross infringement of human rights, right from the process of identification or screening of persons, forced confinement of both suspected and actual victims and the treatment of people infected with EVD. The work seeks to address these issues of human rights infringement and government responsibilities in providing healthcare facilities in times of emergency as created by the outbreak of EVD.

1.8 Literature Review

The review of existing literature at the beginning of a work of this nature enables the researcher to provide a proper background to the intended work. By discovering and analysing the existing works in the chosen field of research, the researcher is able to find support for the hypothesis and discover gaps which must be filled in the course of the research. The depth of research to be conducted in a work of this nature depends on available literature, the review of which the researcher will presently undertake.

The late South African President Nelson Mandela in an address to the United States Congress observed that every woman, man and child is entitled to the human rights prescribed in the Universal Declaration of Human Rights and other agreements that make up the international Bill of Rights. These include, among others, the right to healthcare, food, clothing and housing. He was of the view that nation states that have agreed to these basic human rights have a legal and moral obligation to guarantee and realise these rights for all people. Correlatively, legal duty bearers of these rights and must honour their obligations to their citizens. Likewise all people are rights holders who are entitled to the rights set out in the human rights agreements.

---

Susser is of the opinion that the right to health is a particularly unique and changing right because it is often expressed as a positive right, where society bears an obligation to provide certain resources and opportunities to the general population. Susser further sets out four provisions that he sees as covered under the right to health, namely; equitable access to health and medical services, a good faith social effort to promote equal health among different social groups, means to measure and assess health equity, and equal socio-political systems to give all parties a unique voice in health advocacy and promotion.

While Susser’s discussion centers on healthcare as a positive right, Paul argues that the right to health also encompasses certain negative rights such as protection from discrimination and the right not to receive medical treatment without the recipient’s voluntary consent. However, Paul concedes that some positive rights, such as the responsibility of society to pay special attention to the health needs of the under-privileged and vulnerable citizens, are included in the right to health. The works by both writers are obviously focused on the status of the right to health, ie, whether positive or negative in nature. The present writer is of the view that the right to health is both positive and negative. However, for the purposes of this study, attention will be paid to the state’s obligation to provide healthcare to the citizens especially in times of emergency.

Farmer addresses the issue of unequal access to healthcare in his article. He discusses the growing gap between the populations receiving health interventions and the ones that are not. The poor and under-privileged members of the society are generally disadvantaged in the healthcare delivery. The high cost of medicine and treatment make them inaccessible to the poor countries and the citizens. He states that excellence without equity looms as the chief human rights dilemma of healthcare in the 21st century. The present researcher agrees with Farmer that the poor and less privileged in the society are at a disadvantage in terms of accessing and affording the limited available healthcare facilities especially in the developing

---

nations. This work further interrogates the state’s obligations to ensure that such gaps are filled by providing adequate healthcare facilities for the citizens.

Annas,\textsuperscript{58} argues that where involuntary quarantining was used to control the severe acute respiratory syndrome (SARS) outbreak in Southern China, it was largely ineffective because it caused people to mistrust authorities and to stay away from treatment facilities, making the epidemic harder to control. According to Annas, medical practitioners and aid workers addressing the spread of Ebola virus in West Africa have reported great difficulties in earning the trust of the local communities. People distrust these outsiders dressed in spacesuits. They hear that people die when they go to quarantine and treatment facilities. He is of the opinion that if submission to quarantine was forced in this climate of fear, it must be assumed that it could drive vulnerable persons further away, restraining the ability of healthcare providers to control the virus spread. Annas emphasises the need to respect voluntary submission to treatment as a right of the sufferer, extracted through education and compassion, not fear, force and stigma. While the work by Annas is interestingly specifically focused on the control of the spread and treatment of victims of EVD, this writer goes further to examine the state responsibilities in ensuring that the human rights of the victims of the EVD especially in the area of healthcare delivery are respected and protected.

The Socio-Economic Rights and Accountability Project (SERAP)\textsuperscript{59} advocates for a rights-based approach to healthcare for millions of disadvantaged Nigerians to control and combat the Ebola virus disease. According to the organization, the Ebola outbreak provides an opportunity for the government to formulate a coherent health policy that is based on human rights principles and publicly supports the inclusion of a legally enforceable right to healthcare in the constitution. It is worthy of note that at present the provision of healthcare does not fall within the enforceable human rights under the Nigerian Constitution of 1999. The provisions on healthcare fall under


chapter II of the Constitution which deals with the principles of state policies and directives which are not justiciable. This shall be discussed in greater details in chapter two of this work.

In the present research, the researcher will argue that people infected with EVD are entitled to the right to healthcare as prescribed in the Universal Declaration of Human Rights and the other agreements that make up the international Bill of Rights. Turning away persons infected with EVD from treatment centers infringes their rights to life and healthcare. Quarantining Ebola patients without their consent as well as the denial of treatment also infringes on their right to healthcare and right to life.

1.9 Research Methodology

Research is a systematic process of collecting, analysing, and interpreting information (data) in order to increase our understanding of a phenomenon about which we are interested or concerned. There are basically two approaches to research, namely: research methodology and research methods. Research methodology is the strategy that outlines the way one goes about undertaking a research project. On the other hand, research methods identify means or modes of data collection. The researcher will adopt the mixed method of data collection and analysis, ie, qualitative research methods and doctrinal approach.

Qualitative research method aims to gather an in-depth understanding of human behaviour and reason that govern such behaviour. Qualitative method investigates the why and how of decision making, not just what, where, when. On the other hand doctrinal research is the research into doctrines. It involves analysis of case law and statutory provisions by application of the power of reasoning.

The highly virulent nature of EVD is a strong constraining factor on the researcher having access to the primary victims of the disease and treatment centers which are spread across various cities in the affected countries. The researcher will as such rely on secondary data. The sources of information would include anecdotal evidence, newspaper reports, recorded and

---

reported interviews granted by the victims, their relatives and healthcare providers, NGO reports, reports from the WHO, UN, AU, Doctors without Borders, and others who have either directly or indirectly had contacts with the victims of EVD in the affected countries.

The data collected will be thematically analysed by grouping them under identifiable legal concepts and themes. Thereafter the relevant legal principles and doctrines would be applied in discussing these themes. These would enable the researcher to ascertain their legal implications in seeking solutions to the research questions.

1.10 Ethical consideration

Ethics are moral principles which guide the conduct of human affairs. They affect how people make decisions and live their lives. Research ethics involve the application of fundamental ethical principles to a variety of topics in research. The University of Venda policies on research ethics provide that the rights and welfare of all who participate as subjects in University research activities are of primary importance. It is mandatory that the participants be afforded the opportunity to protect themselves and should participate only by consent freely given after having received adequate information about the research.

This research work will, however, not involve human participants having direct contacts or interactions with the researcher in form of interviews. It will rely entirely on secondary data which are sourced mostly from the internet. The sources of information would include newspaper reports, recorded interviews granted by victims, their relatives and healthcare providers, NGO reports, reports from the WHO, UN, AU, Doctors without Borders, and others who have either directly or indirectly had any contacts with the victims of EVD in the affected countries.

The researcher will however meticulously guard against plagiarism. All materials consulted and utilised in the course of the research shall be duly acknowledged.

---

1.11 Definition of technical concepts

It is always important in works of this nature to explain at the initial stage the meanings ascribed to words which are used in the work. This is in realisation of the fact that some words could bear technical meanings, i.e., meanings which could be different from the manner in which they are ordinarily understood. Such words are often encountered in various fields of specialisation which include law.

1.11.1 Discrimination

The word ‘discrimination’ is derived from the Latin word ‘*discriminare*’ which means to separate, to distinguish, or to make a distinction. The word was popularised after the American civil war as referring to prejudicial treatment of an individual based solely on their race, or membership of a socially undesirable group or category.\(^{65}\) For the purpose of this work the word ‘discrimination’ is used to reflect unfair and prejudicial treatment to which the people infected with EVD are subjected.

1.11.2 Dignity

At common law dignity which was derived from the Latin word ‘*dignitas*’ concerns the individual’s own sense of self-worth which extends to a variety of personal rights such as right to privacy. However, under the constitutional dispensation the value of human dignity is not only concerned with individual sense of self-worth but constitutes an affirmation of the worth of human beings in the society. It includes the intrinsic worth of human beings shared by all people as well as the individual reputation of each person built upon his or her own individual achievements.\(^{66}\) For the purpose of this work the word dignity is used to suggest that people infected with EVD are denied their self-worth and innate values as human beings.

---

\(^{65}\) Anthony Giddens et al *Introduction to Sociology 7th ed* (New York: W W Norton and Company Inc 2009) p.324 ; See also article 1 of the Convention on the Elimination of All Forms of Discrimination against Woman (1976) which defines discrimination as any distinction, exclusion or restriction made on the basis of various grounds which has the effect or purpose of impairing or nullifying the equal enjoyment or exercise of human rights and fundamental freedoms.

\(^{66}\) Drucilla Cornell et al *The Dignity Jurisprudence of the Constitutional Court of South Africa* Vol I (New York: Fordham University Press,2013)78 where dignity is defined as respect for the intrinsic worth of every person should mean that individuals are not to be perceived or treated merely as instruments or objects of the will of others.
1.11.3 Stigma

Stigma is a Greek word that in its origins referred to a type of marking or tattoo that was cut or burned into the skin of criminals, slaves or traitors in order to visibly identify them as blemished or morally polluted persons. These individuals were to be avoided or shunned, particularly in public places. In modern times stigma is often associated with discrimination and human rights and has been defined in various ways. It has been defined for example as an attribute that is deeply discrediting and proposes that the stigmatized person is reduced from a whole and usual person to a tainted discounted one. Crocker et al indicated that stigmatized individuals are believed to possess some attributes or characteristics that convey a social identity that is devalued in a particular social context. The word stigma is used in that context in this work.

1.11.4 Health

Health is defined in the medical dictionary as a condition of physical, mental, and social well-being and the absence of disease or other abnormal condition.

1.11.5 Healthcare

Healthcare is defined in the medical dictionary as the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.

1.11.6 Healthcare provider

This is defined as an individual, institution or agency that provides health services to health care consumers.

---

1.11.7 Life

Macmillan dictionary\textsuperscript{73} defines life as the period of time from someone birth until death. Life has also been defined as the condition that distinguishes animals and plants from inorganic matter, including the capacity for growth, reproduction, functional activity, and conditional change preceding death.\textsuperscript{74} The concept of life in human rights context is not restricted to the distinction between life and death as generally understood, but extends to the obligation imposed by law on the state to provide all the necessary amenities of life, especially healthcare facilities, to the citizens.\textsuperscript{75}

1.11.8 Quarantine

Merriam Webster dictionary\textsuperscript{76} defined quarantine as the period of time during which a person or animal that has a disease or that might have a disease is kept away from others to prevent the disease from spreading.

1.12 Limitations of study

Ebola virus disease is a relatively new phenomenon. Not much has been written on the virus which is presently ravaging the human life. Scientists are burning a lot of midnight candles in the laboratories searching for cure for the disease while the legal experts are at pains in defining the relationships between the healthcare providers and the human rights of the victims of the disease. All the existing works so far are scattered in pieces of materials found mostly on the internet. The researcher relies significantly on those materials with due regard to their inherent defects in terms of authenticity.

\textsuperscript{73} Macmillan Dictionary available at www.macmillandictionary.com/dictionary/british/life (accessed 30 May 2014). Life has also been defined as the interval of time between birth and death available at www.thefreedictionary.com/life (accessed 7 June 2014).

\textsuperscript{74} Available at www.oxforddictionaries.com/definition/english/life (accessed 6 June 2014).

\textsuperscript{75} See Francis Mullin v Union Territory of India, AIR 1979 CS 746; Francis Corolie v Union Territory of Delhi, AIR 1981 SC 748 at 753 per Bhagwati J.

\textsuperscript{76} 'Quarantine- Definition and more from the free Merriam' available at www.merriam-webster.com/dictionary/quarantine (accessed 21 September 2014); Quarantine also be defined as enforced isolation or restriction of free movement imposed to prevent the spread of contagious disease available at www.thefreedictionary.com/quarantine (accessed 21 September 2014); Quarantine has also been defined as a system of measures maintained by governmental authority at ports, frontiers, etc., for preventing the spread of disease available at www.dictionary.reference.com/browse/quarantine (accessed 21 September 2014).
No research study of this nature can ever reach a level of perfection. The inherent shortcomings of the researcher as well as the difficulties in collecting and analysing materials in the course of the research could affect the final outcome of the work. For instance, the research relies entirely on secondary sources in sourcing information and collecting data on the research questions as the researcher cannot gain access to the EVD treatment Centers in the affected countries or have direct contacts with the victims due to the virulent nature of the disease.

1.13 Overview of Chapters

In pursing the objectives set out in this research work, this dissertation is divided into five component chapters.

CHAPTER ONE: INTRODUCTION.

This chapter covers the meaning, meaning and evolution of the EVD, the background for the protection of human rights of people infected with EVD, scope of the work, justification, methodology, statement of problems, aim and objectives of the research, research questions and the hypothesis on which the work is based, literature review, limitation of study, ethical consideration and the general structure of the work are also discussed.

CHAPTER TWO: RIGHT TO HEALTHCARE OF PEOPLE INFECTED WITH EVD.

In this chapter, the work examines the various national and international human rights instruments that relate to the protection of the right to healthcare, in the four countries chosen for this study, i.e., Nigeria, Liberia, Sierra Leone and Guinea.

CHAPTER THREE: THE LEGAL RELATIONSHIP BETWEEN HEALTHCARE PROVIDERS AND THEIR PATIENTS.

This chapter deals with the legal relationship between healthcare providers and their patients, with particular reference to persons infected with EVD. The basis of the relationship is traced from the oath of practice which demands utmost selfless service and confidentiality from the healthcare providers in their relationships with their patients. Relevant statutory instruments
imposing restrictions on the rights of the patients for the protection of the healthcare providers and the wider society shall also be discussed.

**CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS**

In this chapter the data collected are presented and legally analysed to assess the extent to which the right to healthcare of persons infected with EVD are protected in countries under focus.

**CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS.**

This chapter contains the conclusion, highlighting the major points of the study and makes recommendations and suggestions towards a comprehensive legal position on the rights of the people infected with EVD.
CHAPTER TWO

THE RIGHT TO HEALTHCARE OF PEOPLE INFECTED WITH EBOLA VIRUS DISEASE (EVD)

2.1 Introduction

In this chapter, the researcher examines the various international and national human rights instruments that relate to the protection of the right to healthcare, especially as affect the people infected with EVD, in the light of possible infringement as well as the resulting controversies and challenges in the affected countries.

2.2 The right to health under International law

2.2.1 Scope of the right

The right to health which subsumes the right to healthcare constitutes a fundamental human right the preservation of which is indispensable to the attainment of life with dignity. This right has as its components the enjoyment by the individual of a legally acceptable standard of physical and mental health. Internationally, the right to health was first articulated in the 1946 Constitution of the World Health Organization (WHO) whose preamble defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The preamble further states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.77

The right to health was later included in the founding document of the international human rights movement, the Universal Declaration of Human Rights (Universal Declaration), which provides in article 25(1) thereof that “everyone has the right to a standard of living adequate for the health

---

77 The Constitution of the WHO was adopted by the International Health Conference, held in New York from 19-22 June 1945; opened for signature on 22 July 1946 by the representatives of 61 states, 14 UNTS 185. See also article 55 of the United Nations Charter, which provides that the United Nations (UN) shall promote, among others, solutions of international economic, social, health, and related problems.
and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services".78 These imports of the right to health have received acceptance under various other international and regional treaties as well as national and domestic instruments.79 In spite of this seemingly universal recognition and acceptance of the right to health, it has been described in some judicial quarters as being insufficiently definite to constitute a rule of customary international law in line with some of the norms contained in the Universal Declaration.80 This was also the view of the US court in Flores v Southern Peru Copper Corporation81 where an action was instituted by some Peruvian citizens against a US Corporation alleging that pollution from the corporation’s copper mining, refining, and smelting operations in and around Ilo, Peru caused plaintiffs’ or their decedents’ severe lung disease. The plaintiffs claimed that defendant’s conduct violates the law of nations or, when limited to non-treaty law, customary international law. In particular, they asserted that defendant infringed upon their customary international law “right to life,” “right to health,” and right to “sustainable development.” The court in dismissing the case held that the plaintiffs failed to establish a violation of customary international law, i.e., that they had not “demonstrated that high levels of environmental pollution within a nation's borders, causing harm to human life, health, and development, violate well-established, universally recognized norms of international law.”82

But in Filartiga v Pena-Irala,83 the US appeal court held that freedom from torture was guaranteed under customary international law. In that case, the Filártiga family brought an action in the US court in which they contended that on March 29, 1976, their seventeen-year-old son, Joelito Filártiga, was kidnapped and tortured to death by the defendant. All parties were living in Paraguay at the time, and the defendant was the Inspector General of Police in Asunción, the capital of Paraguay. Later that same day, police brought Dolly Filártiga, (Joelito’s sister), to see the body, which evidenced marks of severe torture. The Filártigas claimed that Joelito was tortured in retaliation for the political activities and beliefs of his father Joel Filártiga.

---

78 Universal Declaration of Human Rights, General Assembly Resolution 217A(111) 10th December 1948.
81 343 F.3d 140 (2d Cir. 2003).
82 Ibid.
83 630 F.2d 876 (2d Cir. 1980).
Filártiga brought murder charges against Peña and the police in Paraguay, but the case was inconclusive.

In 1978, Dolly Filártiga and (separately) the defendant came to the United States. The Filártigas lodged a civil complaint in the U.S. courts, brought forth by the Center for Constitutional Rights, for Joelito’s wrongful death by torture, asking for damages in the amount of $10 million. They argued that defendant’s actions had violated the United Nations Charter, the Universal Declaration of Human Rights, and customary international law, among other instruments. The petitioner claimed the U.S. courts had jurisdiction to hear the case under the Alien Tort Statute, which grants district courts original jurisdiction to hear tort claims brought by an alien that have been "committed in violation of the law of nations or a treaty of the United States". The district court dismissed the case citing precedents that limited the function of international law to relations between states. On appeal, the circuit court, while upholding the plaintiff's case, ruled that freedom from torture was guaranteed under customary international law. The appellate court observed that "[t]he torturer has become – like the pirate and slave trader before him – hostis humani generis, an enemy of all mankind".

There is no doubt that the rule against torture has attained such international acceptance to the extent that it is at present regarded in international law as a peremptory norm or *jus cogens*, that is, a norm that enjoys a higher rank in the international legal hierarchy than treaty law and even "ordinary" customary rules.\(^84\) The refusal, however, of the US court in *Flores’ case* to accept the right to health as a precept of customary international law has attracted some criticisms from writers. Delaney\(^85\) for instance, had while expressing disapproval with the decision in *Flores’ case*, especially with regard to the court’s application of the concept of customary international law, observed that customary international law is "composed only of those rules that States universally abide by, or accede to, out of a sense of legal obligation and mutual concern," and has been established by referencing treaties, multinational declarations and decisions, and international legal scholarship. It is submitted that there seems to be no basis in present times

\(^84\) See *Prosecutor v Furundiija*, No IT-95-17/1-T, 11153-54 (Dec. 10, 1998) where The International Criminal Tribunal for the Former Yugoslavia (ICTY), held that "the *jus cogens* nature of the prohibition against torture articulates the notion that the prohibition has now become one of the most fundamental standards of the inter-national community". See also Dinah Shelton, ‘Normative Hierarchy in International Law’ *The American Journal of International Law* Vol. 100, No. 2 (Apr., 2006), pp. 291-323.

for not elevating the right to health to the status of customary international law considering the level of its universal acceptance although the extent of the obligation adopted or accepted by individual states in its application could vary from one state to the other. The court in Flores’ case would almost certainly have decided differently if it had viewed the concept of customary international law especially as relates to the right to health in this light.

Various other international instruments following the footsteps laid by the Universal Declaration have made strong statements on the obligations of the state parties to ensure the provisions within available resources of healthcare facilities to the citizens.

The International Covenant on Civil and Political Rights (ICCPR) which was adopted by the UN General Assembly in 1966 does not contain specific provisions safeguarding the right to health however, several provisions on human rights incorporated in the ICCPR are directly or indirectly linked to a person’s enjoyment of the right to health. Those provisions of the ICCPR which are directly linked to the right to health include the right to not be subjected to torture or to cruel, inhuman or degrading treatment or punishment, the right to not be subjected without free consent to medical or scientific experimentation.

The ICCPR also embodies other provisions on human rights and freedoms which if duly observed by the state would ensure healthy living by the citizens. Such provisions include those relating to the right to non-discrimination, the right to life, the right to liberty and security of person, and the right to privacy.

Under the United Nations system, the most comprehensive provision on the right to health is found in article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) which provides that the state parties to the Covenant must recognize the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. Article 12(2)(c) of ICESCR enjoins the state party to take steps necessary for the prevention, treatment and control of epidemic, endemic, occupational and other diseases. The Covenant

---

86 The ICCPR was adopted by the United Nations General Assembly on 16 December 1966 and entered into force on 23 March 1976.
87 See articles 7 and 8 of the ICCPR.
88 See articles 2-9 of the ICCPR.
89 The ICESCR was adopted on the 16 December 1966; see GA Res 2200(XXXI), UN Doc A/6316 (1966) 993 UNTS 3, entered into force 3 January 1976.
further enjoins state party to have in place measures that would create conditions which would assure medical service and medical attention to everyone in the event of sickness.\textsuperscript{90} Although the language of these provisions does not seem mandatory, they lay down the threshold by which state party could ensure the realization of the right to health and healthcare of their citizens through the provision of adequate healthcare facilities. The extent of non-compliance by the government of respective countries in focus are illustrated by the paucity of healthcare facilities reportedly provided by government at the designated treatment centers for the Ebola victims as shown in chapter four.

The Committee on Economic, Social and Cultural Rights (CESCR), an organ of the United Nations, authorized to monitor compliance by the state parties with the ICESCR, had issued ‘General Comments’ on the right to health, among others, which provide authoritative guidance on how state parties to the Covenant are expected to implement their treaty obligations.\textsuperscript{91} The scope and content of the right to health is summarized by General Comment No 14 as follows: “The right to health must be understood as the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.”\textsuperscript{92} This suggests that the observation and preservation by state of this highly important human right demands from the state not just the ensuring of available and accessible healthcare facilities, but also the provision of those essential amenities that guarantee a healthy living for the citizens. Although the General Comments are not binding on the state party to the Covenant, they, however, constitute primary points of reference which clarify the scope of the rights and provide the necessary guidance to the state parties in complying with their obligations under the ICESCR especially as relates to the right to health.\textsuperscript{93} They fall within the group of international instruments described as soft law.\textsuperscript{94}

The Committee on ESCR in General Comment No 14 defines the obligations that a state party has to fulfill in order to implement the right to health at the national level as follows:

\begin{itemize}
    \item[90] Art 12(2)(d) ICESCR.
    \item[92] General Comment No 14 para 9.
    \item[93] Cheluchi Onyemeluwe ‘Access to Anti-retroviral drugs as a component of the right to health in international law: Examining the application of the right in Nigerian jurisprudence’ (2007) 7 African Human Rights Journal 446 at 454.
    \item[94] Dinah Shelton (note 81 supra) p 319, who defines ‘soft law’ as any international instrument other than a treaty that contains principles, norms, standards, or other statements of expected behaviour.
\end{itemize}
2.2.1.1 The obligation to Respect
The obligation to respect requires states to refrain from interfering directly or indirectly with the right to health in any manner that could be injurious to the wellbeing of the individual. This obligation requires that states parties refrain from denying or limiting access to healthcare services; marketing unsafe drugs; imposing discriminatory practices relating to women’s health status and needs; and abstain from enforcing discriminatory practices as a state policy.95 Thus, any discriminatory allocation of treatments or funding for treatments would constitute a violation of the obligation to respect the right to health. The right of a person to health is respected only when such person is consulted and his/her consent obtained before any action is taken that could deny or limit the provision of basic treatments to the affected person.96

2.2.1.2 The Obligation to Protect
The obligation to protect requires states to prevent third parties from interfering with the right to health. States parties to the ICESCR have an obligation under international law to protect the enjoyment, accessibility and affordability of basic treatments from direct or indirect infringement by pharmaceutical companies and other third parties. In General Comment No 14, the ESCR Committee clarified that the obligation to protect includes, inter alia: adopting legislation or other measures to ensure that private actors conform with human rights standards when providing healthcare or other services (such as regulating the composition of food products); controlling the marketing of medical equipment and medicines by private actors; ensuring that privatization does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; protect individuals from acts by third parties that may be harmful to their right to health.97

2.2.1.3 The Obligation to Fulfill
Every state party to the ICESCR has an obligation to fulfill the right to health. The obligation to fulfill requires states parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to

---

95 General Comment No 14 para 34.
97 General Comment No 14 para 35.
adopt a national health policy with a detailed plan for realizing the right to health. This obligation entails also that the state should take positive measures that would enable and assist individuals and communities to enjoy the right to health.  

While all the rights under the ICESCR are meant to be achieved through progressive realization, states have some minimum core obligations which must be immediately effected. These immediate obligations include the guarantees of non-discrimination and equal treatment, as well as the obligation to take deliberate, concrete and targeted steps towards the full realization of the right to health, such as the preparation of the national public health strategy and plan of action. Progressive realization means that states have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health.

There are basically four essential elements identified in the General Comment No 14 that constitute the components of the state party obligations in the observance of the right to health, which are; availability, accessibility, acceptability and quality.

The concept of availability constitutes a demand on the state party to ensure within their respective available resources, the provision of functioning public health and health-care facilities, goods and services, as well as programmes, in sufficient quantity. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the state party's level of development. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related facilities, trained medical and professional personnel receiving competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs. These demands of availability on the state party are not insurmountable by those countries in the West African sub-region which are presently writhing under the pangs of the Ebola pandemic. The situation simply demands the appropriate channeling of the state resources to

---

98 General Comment No 14 para 36.
100 Ibid.
101 General Comment No 14 para 12.
102 General Comment No 14 para 12(a).
address the needs of the citizens and plugging leakages often encountered in the procurement of the state facilities. The absence of basic healthcare facilities and trained healthcare providers which are noticeable in many West African countries are incidences of long years of neglect by those governments of their obligations to the citizens. In many of these countries, there are no safe and potable drinking water and sanitation facilities especially in those areas occupied by the dominantly economically disadvantaged groups of the states’ population. The alarming spread of a highly virulent disease such as Ebola, in such an environment is thus inevitable.

The demands of accessibility require that health facilities, goods and services have to be made available to everyone without discrimination, within the territory of the state party. There are four components of accessibility as enunciated in the General Comment. The first is that health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population without discrimination. Secondly, the available health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with infectious disease such as the EVD in the present context. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to health buildings and facilities for persons with disabilities. Thirdly, health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health; have to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. An equitable healthcare delivery system demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households. Fourthly, accessibility includes the right to seek, receive and impart information and ideas concerning health issues without an encroachment on the individual’s right to confidentiality.103

Incidentally, there cannot be accessibility without availability. In most of the West African nations which are presently being ravaged by the Ebola pandemic, healthcare facilities and other

103 General Comment No14 para12(b).
amenities associated with the preservation and protection of the right to health are sparsely distributed, and are mostly located in those parts of the city which are occupied by the economically privileged members of the society. Advanced healthcare facilities are simply inaccessible to the majority of the citizens who are not so economically empowered. There are very little state subsidies for healthcare facilities where available, hence the high prevalence of the EVD pandemic among the less privileged members of the society.

Acceptability relates to the provision of health services that are culturally and ethically acceptable to all.\(^{104}\) This would require the preservation of some of the traditional health facilities which are duly recognized and acceptable to the members of the community. The role of the state in such circumstances would be to elevate some of the rudimentary practices to the level of modernity in order to enhance their efficacy in the delivery of healthcare services. It is not uncommon to discover that in some of the West African countries affected by the EVD, some of the infected persons still patronize those traditional health institutions either due to the lack of better alternatives or simply because of cultural beliefs in the efficacy of such institutions.

Aligned to the demands of cultural acceptability is the fourth requirement which is that of quality of healthcare. Quality demands that health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, \textit{inter alia}, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, as well as adequate sanitation.\(^{105}\) It is not uncommon to find expired drugs on the open shelves of the drug dealers and hawkers on the streets in some of the West Africa nations. Some state agencies such as the National Agency for Food and Drug Administration and Control (NAFDAC) in Nigeria are known to have been engaged in a long drawn battle with such fake and adulterated drug dealers.\(^{106}\) The presence of those expired and scientifically untested and unapproved drugs on the shelves of the drug dealers which are readily available and accessible by those in need of healthcare certainly contribute to the inability of the affected countries to control the spread of an infectious disease such as Ebola. The appalling state of

\(^{104}\) General Comment No 14 para12(c)
\(^{105}\) General Comment No14 para12(d).
\(^{106}\) Nigeria leads in fight against fake drugs - NAFDAC DG available at \url{www.vanguardngr.com/.../nigeria-leads-in-fight-against-fake-drugs-nafd} (accessed 25 April 2016)
health facilities as revealed by the incidence of Ebola in some of these West African nations which incidentally are all signatories to the various international human rights instruments under discussion constitute a strong indictment on the governments of those countries for their inexcusable failure to implement the guidelines provided by the General Comments No 14 to improve on the state of their healthcare facilities for the benefit of the citizens.

The Convention on the Elimination of All Forms of Racial Discrimination (CERD) also contains provisions recognizing the right to health. Article 5(iv) stipulates that states have an obligation to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone to equality before the law in the enjoyment of the right to “public health, medical care, social security and social services”.107

In addition to these general international instruments are some others which are meant to protect the disadvantaged persons in the society. Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)108 imposes an obligation on the state parties to take all appropriate measures to eliminate discrimination in the field of healthcare in order to ensure, on the basis of equality between men and women, access to healthcare services, including those related to family planning. The position adopted by CEDAW is understandable as the instrument is basically geared at the protection of women and it is meant to address those situations where women are required to obtain consent of their spouse before some medical procedures are administered to them.

The Convention on the Rights of the Child (CRC) provides under article 24 that “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services.”109

---


108 CEDAW was adopted on 18 December 1979 by the United Nations General Assembly and entered into force on 3 September 1981.

109 CRC was adopted and opened for signature, ratification and accession by the General Assembly resolution 44/25 of November 1989, entered into force on 2 September 1990.
Similarly, the Convention on the Rights of Persons with Disabilities (UNCRPD) contains provisions recognizing the right to health. Article 25 provides that states must recognize that persons with disabilities have the “right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.” States parties shall take all “appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.”110 The extent to which these instruments apply to the West African countries under focus shall be examined later in this discourse.

2.3 The Right to Healthcare under the Regional Instruments

A number of African regional instruments acceded to by the countries in the West African sub-region which are presently struggling to mitigate the deadly impacts of EVD on their citizens also provide for the right to health. Those instruments impose obligations on the state parties to ensure the provision of adequate healthcare facilities to prevent epidemic and endemic diseases. The African Charter on Human and Peoples’ Rights’ (African Charter)111 stands out as the most important human rights instrument operating on the African continent.112

Article 16 of the African Charter sets out the right of every individual to enjoy the “best attainable state of physical and mental health” and declares that states parties shall take “the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.” The African Charter on the Rights and Welfare of the Child (ACRWC)113 also recognizes health as a human right in Article 14. The Charter stipulates measures to be undertaken by the state in the fulfillment of the right to health which includes the provision of nutritious food and safe drinking water, as well as adequate healthcare. Article 14(2) of the Protocol to the African Charter on the Rights of Women in Africa (Women’s Protocol) enjoins the

111 The African Charter was adopted by the OAU (now AU) in Nairobi, Kenya, on 27 June 1981 and entered into force on 21 October 1986.
state parties to provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas. The applicability of these instruments to the respective West African countries in focus depends on the extent of their recognition by the internal laws of those countries as would be revealed shortly. Where the application of any of these instruments is made obligatory by the internal laws of such state, it is arguable that the mere lack of resources by the state to fulfill its obligations under the Charter is simply not sufficient excuse for non-compliance. In any event, as observed by Robert Goff LJ in *Bank of Tokyo v Karmon* (Note) “we are not concerned with economics but with law. The distinction between the two is, in law, fundamental.”

2.4 The right to health under National law

Added to the plethora of international and regional instruments are a significant number of national legislation in the West African nations vesting rights on the citizens and imposing obligations on the governments to ensure the provision of healthcare facilities that would enable the state to combat health related emergencies such as the EVD. The work shall now proceed to consider the right to healthcare under the national laws to ascertain the extent of their applicability and effectiveness in dealing with the right to healthcare in Nigeria, Serra Leone, Liberian and Guinea.

2.4.1 Nigeria

The 1999 Constitution of Nigeria embodies provisions of socio-economic and fundamental rights in Chapters II and IV respectively. Section 17(3) of the Constitution found in Chapter II provides *inter alia*:

The State shall direct its policy towards ensuring that:
(c) the health, safety and welfare of all persons in employment are safe-guarded and not endangered or abused;
(d) there are adequate medical and health facilities for all persons.

---

115 *Zimbabwe Lawyers for Human Rights and Another v Zimbabwe* 2008 (AHRLR) 120 (ACHPR 2008) para 72. See also the case of *B and Others v Minister of Correctional Services* [1997] 50 BMLR 206 SA HC; *EN and Others v Government of RSA and Others* [2007] 1 BCLR 84(D).
116 [1987] AC 45 at 64.
Incidentally, this provision falls under the fundamental objectives and directive principles of state policy which is believed by some writers to have been taken outside judicial scrutiny by the Constitution. This position is founded on section 6(6)(c) of the Constitution which provides that the judicial powers vested in accordance with the foregoing provisions of this section;

(c) shall not, except as otherwise provided by this Constitution, extend to any issue or question as to whether any act or omission by any authority or person or as to whether any law or judicial decision is in conformity with the Fundamental Objectives and Directive Principles of the State Policy set out in Chapter II of this Constitution.

The question that must be immediately asked is whether socio-economic rights contained in Chapter II of the Constitution are justiciable. In other words, does section 6(6)(c) of the Nigerian Constitution obviate judicial enforcement of socio-economic rights? It is the view of the present writer that the proviso "except as otherwise provided by this Constitution" must be given its full meaning and intendment in the context. The judicial support for this view is found in the case of *Federal Republic of Nigeria v. Anache* where Niki Tobi JSC emphasised that section 6(6)(c) is qualified by the phrase, ‘except as otherwise provided by this Constitution’. The justiciability of Chapter II is thus not entirely foreclosed. Similarly, in *Olafisoye v Federal Republic of Nigeria* the Nigerian Supreme Court held that the non-justiciability of section 6(6)(c) of the Constitution is neither total nor sacrosanct as the subsection provides a leeway by the use of the words, ‘except as otherwise provided by this Constitution’. This means that if the Constitution otherwise provides in another section, which makes a section or sections of Chapter II justiciable, it will be so interpreted by the courts. Thus in *Okogie and Others v Attorney General of Lagos State* the Nigerian Court of Appeal held that the plaintiff’s right to own and operate a private institution of learning is guaranteed under section 36 of the Constitution and is accordingly enforceable notwithstanding that the responsibility for the provision of educational opportunities is vested in the government under section 18 which falls within the directive principles of state policy.

---


119 Emphasis added.

120 [2004] 14 WRN 1 at 61.
121 [2005] 51 WRN 52.
The restriction imposed by the Constitution on the justiciability of Chapter II has compelled recourse to international and regional instruments by persons seeking to enforce their socio-economic rights in Nigeria. Nigeria operates a dualist legal system which demands that international instruments ratified by Nigeria shall be domesticated to confer on such instruments the force of law in Nigeria. The International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the African Charter on the Rights and Welfare of the Child, have not been incorporated into Nigerian domestic law and are therefore incapable of being sources of enforceable obligation in Nigeria. The African Charter has been incorporated into Nigerian law by the African Charter on Human and Peoples’ Rights (Ratification and Enforcement) Act 1983 (Ratification Act). Section 1 of the Ratification Act provides as follows:

As from the commencement of this Act, the provisions of the African Charter on Human and Peoples’ Rights which are set out in the Schedule to this Act shall, subject as thereunder provided, have force of law in Nigeria and shall be given full recognition and effect and be applied by all authorities and persons exercising legislative, executive or judicial powers in Nigeria.

Thus while the Constitution restricts the courts intervention on any breach by the government of the provisions in Chapter II thereof, the Ratification Act opens all the doors for the citizens to litigate such matters under the African Charter. This view is strengthened by the mandatory provision in article 1 of the African Charter that: “The Member States of the Organisation of African Unity [African Union] parties to the present Charter shall recognise the rights, duties and freedom enshrined in this Charter and shall undertake to adopt legislative or other measures to give effect to them”. It is on the basis of this mandate that the Ratification Act was enacted and enforced by the courts even during military regimes that had suspended the operations of the constitution and ousted the powers of the courts.

One example of that line of cases is Abacha and Others v Fawehinmi. In that case the respondent, a legal practitioner, was arrested without warrant at his residence on Tuesday 30

123 Sec 12(1) of the 1999 Constitution of Nigeria which provides that ‘No treaty between the Federation and any other country shall have the force of law except to the extent to which any such treaty has been enacted into law by the National Assembly’.


January 1996 at about 6 am by six men who identified themselves as operatives of the State Security Service (SSS) and policemen, and taken away to the office of the SSS at Shangisha where he was detained. At the time of arrest the respondent was not informed of, nor charged with, any offence. He was later detained at the Bauchi prison. In consequence, he applied through his counsel, to the Federal High Court, Lagos, for the enforcement of his fundamental rights under the African Charter. The trial court declined jurisdiction on the ground that Decree no 2 of 1984 which confers power on the Inspector General of Police to detain any person had ousted the jurisdiction of the court. This decision was upheld by the Court of Appeal. On further appeal to the Supreme Court, Ogundare JSC while delivering the judgment which reversed the decisions of the lower courts, pronounced on the status of the African Charter as well as the effect of the Ratification Act as follows:

Where …the treaty is enacted into law by the National Assembly, as was the case with the African Charter which is incorporated into our municipal (ie domestic) law by the African Charter on Human and Peoples’ Rights (Ratification and Enforcement) Act Cap 10 Laws of the Federation of Nigeria 1990 (hereafter is referred to simply as Cap 10), it becomes binding and our courts must give effect to it like all other laws falling within the judicial powers of the courts. By Cap 10 the African Charter is now part of the laws of Nigeria and like all other laws the courts must uphold it. The Charter gives to citizens of member states of the Organisation of African Unity [African Union] rights and obligations, which rights and obligations are to be enforced by our courts, if they must have any meaning…. No doubt Cap 10 is a statute with international flavour. Being so, therefore, I would think that if there is a conflict between it and another statute, its provision will prevail over those of that other statute for the reason that it is presumed that the legislature does not intend to breach an international obligation. To this extent I agree with their lordships of the Court below that the Charter possesses a greater vigour and strength’ than any other domestic statute. But that is not to say that the Charter is superior to the Constitution…. Nor can its international flavour prevent the National Assembly or the Federal Military Government from removing it from our body of municipal laws by simply repealing Cap 10. Nor also is the validity of another statute necessarily affected by the mere fact that it violates the African Charter or any other treaty.126

Implicit in the pronouncement of the Supreme Court is that the African Charter and the Military Decree or Constitution of Nigeria operate on parallel levels. Although the Decree or Constitution remains the supreme law of the country, the provisions of the African Charter are not impaired simply because there is a conflict between such provisions and the Constitution or Decree as the case may be. The only occasion in which the operation of the African Charter could be suspended is by express provision to that effect in the Decree or Constitution. The validity of the African Charter and its applicability in Nigeria during the military regime was upheld by the

Supreme Court on the ground that the Ratification Act was not specifically suspended by the military decree. This again appeared in Ogundare JSC’s decision as follows:

Be it noted that while Chapter IV of the Constitution was suspended for the purpose of the Act, no mention was made of Cap 10 which was then already in existence. I would think that Cap 10 remained unaffected by the provisions of section 4(1). A treaty is not deemed abrogated or modified by later statute unless such purpose has been clearly expressed in the later statute.\footnote{127}{Ibid para 22.}

Having so stated, his lordship came to the conclusion that since section 1 of the Ratification Act was never suspended or repealed by any of the Constitution (Suspension and Modification) Decrees enacted between 1983 and 1999; it remained in force throughout this period. The position then is that the courts' jurisdiction to give full recognition and effect to the African Charter remained unimpaired.\footnote{128}{Ibid para 23. The suggestion by AA Oba, ‘The African Charter on Human and Peoples’ Rights and ouster clauses under the military regimes in Nigeria: Before and after September 11’ (2004) 2 AHRLJ 275-302 that ‘in Abacha v Fawehinmi, the Supreme Court declared the African Charter ineffective against decrees generally and ouster clauses in decrees in particular’, does not reflect the position of the court in that case.}

The Court of Appeal had earlier similarly held in that case that the provisions of Cap 10 (The African Charter on Human and Peoples' Rights Act) of the Laws of the Federation 1990 are provisions in a class of their own. While the Decrees of the Federal Military Government may over-ride other municipal laws, they cannot oust the jurisdiction of the Court whenever properly called upon to do so in relation to matters pertaining to human rights under the African Charter. They are protected by the international law and the Federal Military Government is not legally permitted to legislate out of its obligations.\footnote{129}{Ibid para 5. Emphasis supplied.}

Similarly, in \textit{Ogugu v State}\footnote{130}{[1994] 9 NWLR (pt 366) 1.} the Supreme Court held that Nigeria having adopted the African Charter on Human and Peoples’ Rights as part of her municipal law, the provisions of that Charter are enforceable in the same manner as those of Chapter IV of the 1999 Constitution. Even before the Supreme Court intervention, some Nigerian judges with dynamic disposition had pronounced on the enforceability of the African Charter during military regime. In Garuba and Others v Lagos State Attorney General and Others\footnote{131}{[1992] 8 NWLR (pt 257) 85. See also \textit{The Registered Trustees of the Constitutional Rights Project (CRP) v The President of the Federal Republic of Nigeria and Others} (1994) 4 Journal of Human Rights Law and Practice 218.} Longe J while granting an injunction restraining the execution of the applicants pending their appeal observed that:

\begin{quote}
The African Charter on Human Rights, of which Nigeria is a signatory, is now made into our law by Act of 1983…. Even if its aspect in our Constitution is suspended or ousted by any provision of our local law, the international aspect of it cannot be unilaterally abrogated . . . by signing international treaties, we have put ourselves on the window of the world, we cannot
\end{quote}
unilaterally breach any of the terms without incurring some frowning of our international friends.

The recourse to the African Charter has created room for the courts in Nigeria to enforce the provisions of socio-economic rights especially the right to healthcare as contained in the Charter. In *Festus Odafe & Others v Attorney General of the Federation and Others* the applicants who were detainees at the Kirikiri maximum security prison in Lagos contracted HIV while in detention and were denied the right to treatment by the prison officials. In an action for the enforcement of their fundamental rights under the Nigerian Constitution and the African Charter, the court held that the denial of treatment to the four prisoners violated section 8 of the Nigerian Prison Act of 1972 and article 16 of the African Charter. Nwodo J of the Federal High Court of Nigeria Port Harcourt Division re-emphasised the obligation of the government in the enforcement of socio-economic rights, especially the right to health, under the African Charter as follows:

The government of this country has incorporated the African Charter on Human and Peoples’ Rights Cap 10 as part of the law of the country….The Charter entrenched the socio-economic rights of a person. The Court is enjoined to ensure the observation of these rights. A dispute concerning socio-economic rights such as the right to medical attention requires the Court to evaluate state policy and give judgment consistent with the Constitution. I therefore appreciate the fact that the economic cost of embarking on medical provision is quite high. However, the statutes have to be complied with and the state has a responsibility to all the inmates in prison, regardless of the offence involved, as in the instant case where…the applicants…have been in custody for not less than two years suffering from an illness. They cannot help themselves even if they wanted to because they are detained and cannot consult their doctor. I therefore…order the authorities…[to] relocate the applicants after the precondition has been complied with, to a hospital in accordance with section 8 of the Prison Act.

In *Georgiana Ahamefule v Imperial Medical Centre & Dr. Alex Molokwu* Idowu J held that the failure by the defendants to provide the plaintiff proper medical care as a result of her HIV status amounted to a violation of her right to health as protected by the African Charter.

The Protocol to the African Charter on Human and Peoples’ Rights of 1998 which established the African Court on Human Rights opened another avenue for the enforcement of fundamental

---

rights, especially the socio-economic rights of those citizens of African nations whose countries' constitution does not provide for the enforcement of such rights. The decision of the African Commission on Human and Peoples' Rights in *International Pen and Others (on behalf of Ken Saro Wiwa) v Nigeria* lends credence to this assertion. In that case, Saro Wiwa, a writer and environmental rights activist, together with eight others, were sentenced to death for their social crusade activities in Ogoniland in the Niger Delta region of Nigeria. While in detention awaiting execution, Saro Wiwa's health deteriorated to the point that he required medical attention. The Nigerian government denied him access to treatment in spite of the prison doctor's recommendations. The African Commission held that Saro Wiwa's right to health under article 16 of the African Charter was violated by the Nigerian government. In arriving at this decision, the Commission stated as follows:

The responsibility of the government is heightened in cases where an individual is in its custody and therefore someone whose integrity and well-being is completely dependent on the actions of the authorities. The state has a direct responsibility in this case. Despite requests for hospital treatment made by a qualified prison doctor, these were denied to Ken Saro Wiwa, causing his health to suffer to the point his life was endangered. This is a violation of article 16.

In a similar decision of the African Human Rights Commission in *Purohit & More v The Gambia* the Commission emphasised that the:

Enjoyment of the human rights to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realization of all the other fundamental human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind.

The accession by Nigeria to the Treaty of Economic Community of West African States (ECOWAS Treaty) opened a new vista in the enforcement of socio-economic rights in West Africa and Nigeria in particular. Article 4 of the Revised Treaty of the ECOWAS, 1993 provides for the applicability of the provisions of the African Charter on Human and Peoples' Rights to member states of the ECOWAS. The ECOWAS Court is one of the organs of the Community.

---

137 Article 16 of the ACHPR provides that "(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 9(4) of the Supplementary Protocol to the Court of 2005 confers jurisdiction on the court to adjudicate on applications concerning the violation of human rights that occur in member states of ECOWAS. In Registered Trustees of the Socio-Economic Rights and Accountability Project v Universal Basic Education Commission, the ECOWAS court pronounced on the effect of the domestication of African Charter by Nigeria on the jurisdiction of the court as follows:

The Court has jurisdiction over human rights enshrined in the African Charter and the fact that these rights are domesticated in the municipal law of the Federal Republic of Nigeria cannot oust the jurisdiction of the Court. Second defendant's reliance on Article 9(1)(a)(b) and (c) of the Supplementary Protocol of the Court to argue that the Court does not have subject-matter jurisdiction over human rights issues is misconceived as they failed to take cognizance of the entire provisions of Article 9. In law, an enactment must be read as a whole. This Court clearly has subject matter jurisdiction over human rights violations in so far as these are recognized by the African Charter on Human and Peoples' Rights, which is adopted by Article 4(g) of the Revised Treaty of ECOWAS.

In Socio-Economic Rights and Accountability Project v Nigeria, the ECOWAS Court considered among others things whether it had the jurisdiction to adjudicate a claim involving the right to education under the African Charter. The complainant, SERAP, initiated the case due to lack of adequate implementation of Nigeria's Basic Education Act and Child's Rights Act of 2004. The government of Nigeria argued that the educational objective in the Constitution of Nigeria is non-justiciable and that SERAP lacked standing since it was not directly affected by these laws. In dismissing those arguments, the ECOWAS Court noted that a violation of the right to education under Article 17 of the ACHPR was alleged by the claimants and that by virtue of Article 9(4) of the Supplementary Protocol which grants the Court jurisdiction to determine cases of violations of human rights in member states of ECOWAS and Article 4(g) of the Revised Treaty of ECOWAS incorporating the African Charter on Human and Peoples' Rights into that treaty, "it is well established that the rights guaranteed by the African Charter are justiciable before this Court." The Court dismissed the Government's contention that education is "a mere directive policy of the government and not a legal entitlement of the citizens". The court concluded that "the contention of the Government that the right to education is not justiciable as it falls within the directive principles of state policy cannot hold." The Court noted a distinction between the recognition of education within the domestic legal framework of Nigeria

---

140 Suit NO: ECW/CCJ/APP/0808.
and the human right to education in the ACHPR to which Nigeria is a state party and concluded that the domestication of the ACHPR cannot oust the court’s jurisdiction.

Implicit in these decisions is that the domestication of African Charter while essential in conferring jurisdiction on the national courts to adjudicate on issues of human rights violations under the Charter, is certainly of no relevance where those rights are sought to be enforced at the regional courts. Thus the West African nations that have not domesticated the African Charter but are parties to the ECOWAS treaty are subject to the jurisdiction of the ECOWAS Court. On the other hand, the domestication of the African Charter while affirming the jurisdiction of the national courts does not oust the jurisdiction of the regional courts to adjudicate on the violations of human rights under the Charter.

The need to afford access to the members of the society in general to the courts to vindicate their rights which is often expressed as public policy consideration is also a strong factor for the courts not to lightly accept any ouster of their jurisdiction in holding the government accountable on the issue of the enforcement of socio-economic rights especially the right to health. The spread of Ebola in the West African sub-region has exposed the appalling state of healthcare facilities in the sub-region with the attendant degradation of human life to an abysmal level. Some media reports carried pictures of infected persons being conveyed to the make-shift health centres in wheel barrow in the absence of medical ambulance, and some are dumped on the ground and without any shelter awaiting imminent death. These are evidence of gross failure by the government in discharging its responsibilities to the people. Why should such government not be held accountable even if the obligation to provide healthcare is set down as the directive principles of state policy? Akinola Aguda, a Nigerian eminent jurist, expressed a concern with such a stance as follows:

I feel much concerned to think that the directive principles are to be regarded as mere ideal, a utopia, the arrival of which the citizen can only pray and hope for, but in respect of which he can hope for no assistance whatsoever from the courts. If this were so, then wherein lies the expectations and hopes for a bright future for the teeming millions of our people who manage to survive at near starvation level.

---

142 See Barkhuizen v Napier 2007 (5) SA 323(CC) para 58
The directive principles of state policy are a form of social contract between the state and the citizens. The language of the Constitution clearly indicates the existence of an obligation on the part of the state to fulfill the set objectives.\textsuperscript{144} Section 13 of the Constitution provides that “It shall be the duty of all organs of government... to conform to, observe and apply the provisions of this Chapter of this Constitution”. The judiciary as an ‘organ of government’ will be reneging on its responsibility by failing to uphold compliance with the tenor of the provision simply because section 6(6)(c) of the same Constitution seem to have a restraining effect. What is needed is some level of judicial activism in the interpretation process. This was espoused by Kayode Esho JSC in \textit{Transbridge Trading Co. Ltd v Survey International Ltd}\textsuperscript{145} where he observed that:

It would be tragic to reduce Judges to a sterile role and make an automation of them. I believe it is the function of Judges to keep the law alive, in motion, and to make it progressive for the purpose of arriving at the end of justice, without being inhibited by technicalities, to find every conceivable, but acceptable way of avoiding narrowness that spells injustice. Short of being a legislator, a Judge, to my mind, must possess an aggressive stance in interpreting the law.

Such creative stance was adopted by Akinola Aguda JA while sitting on the Court of Appeal bench of Botswana in \textit{Attorney-General of Botswana v Unity Dow}.\textsuperscript{146} The court gave effect to the human rights provisions in the African Charter which was ratified but not domesticated by Botswana. He said:

In this regard I am bound to accept the position that this country will not deliberately enact laws in contravention of its international undertakings and obligations under those regimes. Therefore the Court must interpret domestic statutory laws in a way as is compatible with the State’s responsibility not to be in breach of international law as laid down by law creating treaties, conventions, agreements and protocols within the United Nations Organization and the Organization of African Unity.

While this interpretative approach is recommended for the judiciary, it must be emphasised that the merger of both Chapters II and IV of the Constitution is long overdue in Nigeria as the military governance of the past which usually relied on such ouster legislative clauses to implement dictatorial policies has since succumbed to the overriding democratic process.

\textsuperscript{144} The importance of the directive principles was emphasised by the Indian Court in \textit{Minerva Mills Ltd & Ors v. Union of India & Ors}, AIR 1789 1981 SCR (1) 206 1980 SCC (3) 625 where it was stated that “[t]hey project the high ideal which the Constitution aims to achieve. They are so fundamental in the governance of any country. In fact, there is no sphere of public life where delay can defeat justice with more telling effect than in the non-implementation of the Directive Principle”.

\textsuperscript{145} [1996] 4 NWLR (Part 37) 576 at 596-597.

\textsuperscript{146} (1998) 1 HRLRA 1 at 122.
Nigeria should at present adopt the South African Constitutional style which encompasses the socio-economic, civil and political rights under an enforceable Bill of Rights that is embodied in the South African Constitution of 1996.147 The South African Courts’ interpretation and applications of the provisions of the Bill of Rights contained in Chapter II of that Constitution are geared to a progressive realisation of the substance of the protected rights. The South African Constitutional Court initially exhibited some reluctance in the enforcement of the right to healthcare as seen in Soobramony v Minister of Health, KwaZulu-Natal148 where the plaintiff suffering from renal failure was denied the right to emergency medical treatment under section 27(3) of the Constitution on the ground that state’s scarce resources should be applied for the greater public benefit. Chaskalson P in the judgment made statements which if taken on their face value would have reduced the application of some of the provisions in the Bill of Rights to mere directive state policy, as is the case under the Nigerian Constitution, where he said:

The Constitution is forward-looking and guarantees to every citizen fundamental rights in such a manner that the ordinary person-in-the-street, who is aware of these guarantees, immediately claims them without further ado and assumes that every right so guaranteed is available to him or her on demand. Some rights in the Constitution are the ideal and something to be strived for. They amount to a promise, in some cases, and an indication of what a democratic society aiming to salvage lost dignity, freedom and equality should embark upon. They are values which the Constitution seeks to provide, nurture and protect for a future South Africa.149

Some clarity was however given to this expression by Sachs J who in a concurring opinion stated as follows:

In a case such as the present which engages our compassion to the full, I feel it necessary to underline the fact that Chaskalson P’s judgment, as I understand it, does not merely “toll the bell of lack of resources”.150 In all the open and democratic societies based upon dignity, freedom and equality with which I am familiar, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care.151

---

148 1998 1 SA 765 (CC).
149 Ibid, para 42.
150 Quoted in R v Cambridge Health Authority, ex parte B [1995] 2 All ER 129 (CA) at 137c-d where the first instance court quashed the decision of a local health authority refusing to provide expensive treatment for a seriously ill child saying that “the responsible authority . . . must do more than toll the bell of tight resources.” The appeal Court overturned his decision.
151 1998 (1) SA 765 (CC) para 52.
This explanation offers a rational basis for the decision in Soobramoney. The rational part lies in the need to spread scarce resources to benefit the majority of those in need and not just an individual or a few individuals. However, there is still need for caution in adopting such an approach as the provisions in the Bill of Rights are meant to protect the rights of the individual as such and not collective or group rights. Hence the court’s concern should be what is beneficial to the party before the court and not what an unforeseeable group of persons may require.

Interestingly, there are some other Constitutional Court decisions that pronounced on the right to health and other socio-economic rights which did not adopt a similar approach as in Soobramoney’s case. In B and Others v Minister of Correctional Services four HIV-positive prisoners sued the Minister of Correctional Services for failing to provide them with anti-retroviral treatment claiming the failure amounted to a violation of their right to adequate medical treatment. The Minister of Correctional Services argued that providing anti-retroviral treatment to relevant prisoners was beyond the resources of the prison. The High Court held that the government was required to provide anti-retroviral treatment to those for whom it has been medically prescribed and that failure to do so would be a violation of their right to adequate medical treatment under the Constitution. Despite the government’s argument of monetary constraints, the Court reasoned that prisoners were entitled to anti-retroviral treatment at government’s expense because they had no access to resources to obtain alternative medical treatment while in prison and were more likely to be exposed to opportunistic infections while in prison.

In Minister of Health and Others v Treatment Action Campaign and Others the Constitutional Court reaffirmed the justiciability of the socio-economic rights by emphasizing in that case that the “question is not whether socio-economic rights are justiciable. Clearly they are. The question is whether the applicants have shown that the measures adopted by the government to provide access to healthcare services for HIV-positive mothers and their new born babies fall short of its obligations under the Constitution”. The court conceded that it was legitimate for the

---

152 [1997] 50 BMLR 206 SA HC, See also EN and Others v Government of RSA and Others [2007] 1 BCLR 84(D).
government to ascertain the efficacy, safety and possible resistance to Nevirapine in preventing mother-to-child transmission of HIV before making it widely available in the country. While accepting that directing the government to provide the anti-retroviral drug could have some budgetary implications, the court found that the needs of children are most urgent and their inability to have access to nevirapine profoundly affects their ability to enjoy all rights to which they are entitled under section 27 of the Constitution. The court therefore ordered that restrictions on access to Nevirapine be removed and that the use of Nevirpine be permitted and facilitated where it is medically indicated.154

The case of Government of RSA and others v Grootboom and others155 has made a significant impact as a reference point in buttressing the extent of the Constitutional Court’s favourable disposition to the enforcement of the socio-economic rights in South Africa. Yacoob J emphasised the extent of the State’s obligations and the corresponding rights of the citizens where he said:

This case shows the desperation of hundreds of thousands of people living in deplorable conditions throughout the country. The Constitution obliges the State to act positively to ameliorate these conditions. The obligation is to provide access to housing, health-care, sufficient food and water, and social security to those unable to support themselves and their dependants. The State must also foster conditions to enable citizens to gain access to land on an equitable basis. Those in need have a corresponding right to demand that this be done.

In Abacha v Fawehinmi156 the Supreme Court articulated the pressing need for Nigeria and the judiciary in particular to follow the dynamism exhibited by the courts in other jurisdictions in upholding the tenor of the human rights instruments where it observed that; “[w]e cannot afford to be immuned from the progressive movements manifesting themselves in international agreements, treaties, resolutions, protocol and other similar understanding as well as in the respectable and respected voices of our learned brethren in the performance of their adjudicating roles in other jurisdiction”.

155 2001 (1) SA 46 (CC).
2.4.2 Guinea

Guinea is a French speaking country in West Africa and a member of the United Nations and the African Union. It has ratified many UN Human Rights Conventions and thus has made binding international commitments to adhere to the standards laid down in the human rights documents. The international human rights instruments which are ratified by Guinea and are relevant to this work include ICCPR, ICESCR, CRC, CEDAW, and CERD, at the regional and sub-regional levels Guinea has ratified the African Charter\(^{157}\) and the ECOWAS Treaty.\(^{158}\) All the international instruments ratified by Guinea are declared in article 151 of the Guinea Constitution as having an authority superior to that of the domestic laws from the time of their publication. This is, however, subject to the right of reciprocity. In other words, Guinea does not require the domestication of international instruments to make them enforceable in the country. The only reservation is that other states should accord similar respect to international agreements with Guinea. As a former French colony with a civil law tradition, law reporting and judicial precedents are not common in Guinea, hence the difficulty in finding reported decisions of courts on the human rights instruments ratified by Guinea.

The Constitution of the Republic of Guinea which was proclaimed in 2010 recognizes the right to healthcare.\(^{159}\) This right is found under Title II of the Constitution which embodies the Fundamental Freedoms, Duties and Rights of the Citizens. Unlike in Nigeria, there is no distinction between the fundamental and directive principles of state policy, and the fundamental rights of the citizen. The pattern adopted by the Constitution is similar to the South African Constitution of 1996 that adequately guarantees the socio-economic rights, including the right to healthcare, of the citizens.\(^{160}\)

Article 15 of the Constitution which embodies this right provides as follows: “Each one has the right to health and to the physical well-being. The State has the duty to promote them, to fight against the epidemics and the social calamities [fléaux].” This provision does not only embody


\(^{158}\) ECOWAS Treaty (note 139 supra).


\(^{160}\) Constitution of South African (note 147 Supra).
the right of the citizens to healthcare, but also states the extent of the responsibilities of the State in ensuring the availability of a functional healthcare system. The Constitution seeks to ensure that the citizens are fully aware of the existence of their rights under the Constitution and other international instruments ratified by Guinea by providing in Article 25 thereof that the “State has the duty to assure the diffusion and the teaching of the Constitution, of the Universal Declaration of the Rights of Man of 1948, of the African Charter of the Rights of Man and of Peoples of 1981 as well as of all international instruments duly ratified relative to Human Rights”. The Constitution in article 93 establishes the Constitutional Court which it vests unlimited jurisdiction to guarantee the exercise of the fundamental rights of the human person and of the public freedoms. Article 99 of the Constitution provides that “[t]he Orders of the Constitutional Court are without recourse and impose themselves on the public powers and on all the administrative, military and jurisdictional authorities, as well as on any natural or juridical [morale] person”. In other words the decisions of the Constitutional Court on these matters are final as there is no higher authority to entertain appeals on such matters. These provisions reflect a high level of commitment by the government and the people of Guinea in ensuring the fulfillment of the obligations of the government to the people under the Constitution especially as relates to the provision of a sustainable and efficient healthcare system within the capacity of the government.

The Republic of Guinea’s human rights records seem to be in contradiction to the liberal constitutional provisions. Reports by human rights organizations show that while the law prohibits discrimination based on race or ethnicity, discrimination by the country’s three major ethnic groups; the Peuhl, Malinké and Soussou, in employment and place of residence is common. Ethnic clashes between the Peul and the Malinké continued in 2012, including during the September riots. Societal discrimination against women is common. While women have legal access to land, credit, and business, inheritance laws and the traditional justice system favor men. Rape and sexual harassment are prevalent but underreported due to fears of stigmatization. Security personnel openly raped over one hundred women during the 2007 and 2009 crackdowns. Advocacy groups are working to eradicate the illegal but nearly ubiquitous practice of female genital mutilation. Although the government made efforts to combat human trafficking in 2012, fewer than a quarter of those cases investigated were ultimately submitted to
the courts. Courts lack staff and financial resources, leading to impunity for perpetrators of human rights violations and difficulties for victims seeking redress.

The prison system suffers neglect, mismanagement, and lack of resources. Toilets did not function, and prisoners slept and ate in the same space used for sanitation purposes. Access to drinking and bathing water was inadequate. Wells ran dry in the dry season, and electric pumps, such as the one in Conakry Prison, did not function. In 2009 a foreign observer reported that inmates in Siguiri Prison in the northeast of the country lacked access to medical care, adequate food and water, and legal representation—a situation that was common in prisons throughout the country.

NGOs reported endemic malnutrition throughout the prison system, which did not deliver food or medicine to inmates. Prison directors relied on charities, the International Committee of the Red Cross (ICRC), and NGOs to provide food for inmates. Due to the efforts of such groups, no prisoners in Conakry Prison died of malnutrition during the year. Prisoners reported eating one small meal a day consisting primarily of rice and sauce. Some inmates relied on assistance from families or friends to maintain their health, but relatives often abandoned prisoners due to the difficulty and cost of travel to the prisons. Guards often demanded bribes in exchange for delivering food to inmates and routinely confiscated food.

Inmates were not tested for HIV/AIDS upon entry into the prisons, and no statistics on HIV/AIDS infection rates were kept; however, local NGOs estimated that 15 percent of the prison population was infected. Lack of medicine in prisons, combined with endemic malnutrition and dehydration, made infection or illness life threatening. In several regions prisoners with tuberculosis were held together with uninfected inmates.

National organizations worked to end the stigma associated with HIV/AIDS. Most victims of stigmatization were women, who were frequently abandoned by their families after their

---

163 Ibid.
164 Ibid.
165 Ibid.
husbands died of AIDS. Doctors and health workers routinely disregarded medical confidentiality standards resulting in widespread distrust of testing.\textsuperscript{166}

The Republic of Guinea is the first West African nation that witnessed the recent outbreak of EVD which occurred in December 2013. The WHO reports suggest that as of 7th December 2014 the country had recorded about 2339 cases and 1454 deaths.\textsuperscript{167} The outbreak of EVD in Guinea reveals weaknesses in the country’s healthcare system.\textsuperscript{168} According to World Bank data, Guinea had just 1 healthcare worker per 10,000 people in 2010.\textsuperscript{169} The absence of adequate functional healthcare system in that West African nation is certainly not on account of any deficiencies on the enabling law. The right to healthcare as contained in the Guinean Constitution imposes obligations on the government to ensure that the healthcare needs of the citizens, especially in times of emergencies as seen with the outbreak of Ebola, are adequately in place to combat such endemic disease. The inability of the Government of Guinea to control the spread of the EVD in the country is an indication of the government’s failure or neglect of its constitutional obligations to the nation.

2.4.3 Sierra Leone

Sierra Leone has ratified a number of the international and regional human rights instruments earlier discussed. Records available at the Human Rights Library of Minnesota show that Sierra Leone has ratified the following human rights instruments: ICCPR, ICESCR, CRC, CEDAW, and CERD among others, at the regional level Sierra Leone has ratified the African Charter\textsuperscript{170} and the ECOWAS Treaty.\textsuperscript{171} The UN Human Rights report of 2014 indicates that Sierra Leone is in transition and still facing challenges with the implementation of the human rights obligations contained in the ratified international instruments. Sierra Leone relies heavily on international

\textsuperscript{171} ECOWAS Treaty (note 159 supra).
donations for rebuilding the country and enhancing its human rights protection mechanisms.\textsuperscript{172} As a member of ECOWAS and a party to the sub-regional treaty, Sierra Leone subscribes to the jurisdiction of the ECOWAS Court especially on the issues of human rights violations as contained the African Charter. In \textit{Emmanuel Akpo and Another v G77 South South Healthcare Delivery Programme and The Republic of Sierra Leone}\textsuperscript{173} the plaintiffs in their pleadings averred that by a meeting held on 1\textsuperscript{st} August 2005 by the Nigerian medical team deployed to the 2\textsuperscript{nd} defendant under the agreement with the 1\textsuperscript{st} defendant, showed that the terms of their contracts were not fulfilled which caused them to suffer from several damaging treatments including an allegation of fact that inadequate facilities were provided which were violations of their human rights. The defendants challenged the jurisdiction of the court to hear the case. The court held that the examination of the pleadings as filed discloses that the grievances of the plaintiffs centered on an alleged breach of contract and violation of human rights which raises an interesting and very important point about access to justice by Community citizens and the jurisdiction of the court.

The African Charter that is subsumed in the revised Treaty, 1993 of the ECOWAS is the \textit{grundnorm} of the Community’s framework. Article 5 of the said Charter provides for the protection of the citizens from violation of their human rights against inhuman conditions and treatment. Article 9(4) of the Protocol of the Court as amended confers jurisdiction on the court to determine cases of violation of human rights that occurred in any member state. In the instant case, the violation was said to have occurred in Sierra Leone, a member state of the Community. As to the question of access to this court, article 10 of the Protocol of the Court as amended grants access to individuals on application for relief for violation of their human rights. Thus the court found that the plaintiffs rightly approached the court for relief on human rights violation but not on the aspect of a breach of contract.

The Constitution of the Republic of Sierra Leone of 1991\textsuperscript{174} adopted the Nigerian pattern which separates the socio-economic rights from the civil and political rights of citizens. The socio-

\textsuperscript{173} ECW/CCJ/RUL/04/08.
economic rights, including the right to health, are found in Chapter II of the Constitution Section 8(3)(d) thereof provides that the state shall direct its policy towards ensuring that “there are adequate medical and health facilities for all persons, having due regard to the resources of the State”. The non-justiciability of this provision is unequivocally settled by the Constitution which provides in section 14 as follows:

Notwithstanding the provisions of Section 4, the provisions contained in this Chapter shall not confer legal rights and shall not be enforceable in any court of law, but the principles contained therein shall nevertheless be fundamental in the governance of the State, and it shall be the duty of Parliament to apply these principles in making laws.

Section 4 of the Constitution imposes an obligation on all organs of government and all authorities and persons exercising legislative, executive or judicial powers to conform to, observe and apply the provisions of Chapter II. The implication of section 14 therefore is that non-compliance with those important obligations of the state to the citizens, including the failure by the state to ensure the provision of adequate medical and healthcare facilities, has no legal consequences under the domestic law of Sierra Leone.

As a state party to various international human rights instruments earlier discussed, Sierra Leone has assumed obligations under those instruments to take positive steps towards ensuring the protection of socio-economic rights guaranteed by those treaties. However, Sierra Leone, like Nigeria, operates a dualist system of laws, which demands that the treaties ratified by the country must also be domesticated to have a binding municipal force. There is nothing on record suggesting that any of the existing international instruments has been domesticated by Sierra Leone.

Sierra Leone is one of the worst affected countries in the 2013 Ebola outbreak in West Africa. As of 9th December 2014 Sierra Leone had recorded around 2033 deaths and 8273 confirmed cases of infected persons. It is on record that Sierra Leone does not have adequate health facilities or medical professionals to confront the challenges posed by the outbreak of the

EVD. The weakness of the health system in Sierra Leone is identified as one of the causes of the continuing Ebola crisis in that country. Before the Ebola outbreak, the country had just 120 doctors for a population of about 6 million, the death of 10 of them from Ebola means that the country has lost 8% of its doctors since the spread of the virus to the country. The government cannot absolve from the death of this doctors being a reflection of a failure by the government to provide protective gear for the healthcare providers attending to the Ebola victims. Doctors at the hospitals in Sierra Leone had gone on strike in protest over inadequate equipment to fight the epidemic ravaging the impoverished country. The civil war that ravaged Sierra Leone from 1991 to 2002 destroyed the country's infrastructure including its health systems. Many clinics that had been established by the government were completely demolished; a lot of healthcare providers left the country because of fear or to look for greener pastures. Even before the war, the Sierra Leone health system was under performing, with high levels of out of pocket spending coupled with the lack of efficient and effective service delivery, this shifted health seeking behaviour towards traditional healers and drug peddlers. This tendency was further fuelled by the destruction of the health system during the war that persisted in the post-conflict phase which resulted in the indictment and conviction of a number of civilian actors including Charles Taylor of Liberia who was prosecuted for crimes against humanity and other serious violations of international humanitarian law. The ugly side of the developments in Sierra Leone is that on the face of all these man-made and natural disasters which the country has been confronted over the years, the government of Sierra Leone has not deemed it fit to enshrine an enforceable provision for the protection of the citizens right to health, or domesticate any of the existing international and regional instruments that guarantee the protection of the socio-economic rights of the people. However, at the moment Sierra Leoneans could enforce their socio-economic rights, especially the right to healthcare, through the process provided by the ECOWAS Court.

178 Ebola crisis: Sierra Leone doctors go on strike over inadequate equipment available at https://www.google.co.za/?gfe_rd=cr&ei=YsrMUFuFa3d8gflUjDoBA&gws_rd=ssl#q=Ebola+crisis:+Sierra+Leone+doctors+go+on+strike+over+inadequate+equipment (accessed 11 December 2014).
180 See Ebola crisis (note 178 supra).
181 Ibid
182 WHO| Sierra Leone's long recovery from the scars of war available at www.who.int/bulletin/volumes/88/10/10-031010/en/ (accessed 11 December 2014).
183 Prosecutor v Charles Ghankay Taylor Case No. SCSL-03-01-A.
2.4.4 Liberia

Liberia is a signatory and has ratified a number of international treaties and conventions stated above among which are ICCPR, ICESCR, CRC, CEDAW, and CERD, at the regional and sub-regional levels Liberia has ratified the African Charter\textsuperscript{184} and the ECOWAS Treaty.\textsuperscript{185} However, international treaties signed and ratified by Liberia have to be domesticated for them to have the force of law in the country. This means that in order to become part of the national legal system or order, international treaties have to be approved and adopted by the legislature.\textsuperscript{186} The 2011 UN report on the application of international human rights instruments in Liberia shows that most of the human rights instruments ratified by Liberia are not yet domesticated hence denying those instruments having force of law in that country.\textsuperscript{187} However, as a state party to the ECOWAS Treaty, Liberia subscribes to the jurisdiction of the ECOWAS Court. The court’s jurisdiction is set out in Article 9 of the 1991 Protocol which states that the court “shall ensure the observance of law and the principles of equity in the interpretation and application of the provisions of the Treaty.” The Court has ruled that this includes jurisdiction over human rights cases. This principle was codified by ECOWAS Supplemental Protocol of 2005, which states that the Court has jurisdiction to hear human rights cases and expands the admissibility rules to include disputes between individuals and their own member states.

In Valentine Ayika v Republic of Liberia\textsuperscript{188} Liberian Drugs Enforcement Agency Agents arrested Mr. Valentine Ayika at the Roberts International Airport in 2006 for not declaring over 500,000 United States Dollars they found strapped to his body. Mr. Ayika, who was subsequently deported from Liberia, sued Liberia at the ECOWAS Court for confiscating his money and the infringement of his fundamental right under the African Charter. In ruling in favour of Ayika, the Court said that while it was true that Mr. Ayika violated the laws of Liberia by not declaring the money before entering the country, it was not proven that he was involved in money laundering. The Court also ruled that Liberia should pay 20,000 United States Dollars to the Plaintiff to cover the cost he incurred during the trial, and return Mr. Ayika’s passport which was seized.

\textsuperscript{185} ECOWAS Treaty (note 171 supra).
\textsuperscript{188} ECW/CCJ/APP/07/11.
Liberia has had a turbulent recent history with the record of mass destruction of lives and essential amenities of life due to the internecine civil unrest and struggle for power among the political leaders of the country. The post-civil war Liberia has however shown some glimpse of hope in the area of respect and protection of human rights with a fairly stable democratic government now in place.\(^{189}\) The Liberia’s Constitution of 1986\(^{190}\) does not guarantee the right to healthcare as an enforceable right. The provision that mentions health in the Constitution is found in article 8 which provides: “The Republic shall direct its policy towards ensuring for all citizens, without discrimination, opportunities for employment and livelihood under just and humane conditions, and towards promoting safety, health and welfare facilities in employment.” The explanation in the marginal note indicates that this provision encompasses the citizens’ right to healthcare. Article 8 is under Chapter II of the Constitution which is classified as the General Principle of National Policy. Article 4 of the Constitution states that all the provisions contained in Chapter II are mere guidelines for the formulation of legislative, executive and administrative directives, policy-making and their execution. The implication of this provision is that article 8 neither creates any obligation on the part of the government nor confers any rights on the citizens. Chapter III of the Constitution, however, embodies justiciable provisions on the protections of fundamental human rights such as the right to life and the protection of human dignity. The safe-guarding of these rights would certainly entail an obligation on the state to ensure the availability of those amenities that make life worth living. The provision of adequate healthcare facilities and a functional health system are indispensable to the preservation of human life with dignity.

In the Indian case of *Paschim Banga Khet Mazdover Samity v State of West Bengal*\(^{191}\) the Plaintiff complained of denial of medical aid in government hospitals. The Supreme Court of India held that the primary function of the State was to secure the welfare of its people and that providing adequate medical facilities for them was a part of the obligation. The court, in holding that there had been a violation of the right to life under Article 21 and awarding compensation,

---


\(^{191}\) (1996) 4 SCC 37.
stated that the right to emergency medical care formed a core component of the right to health, which in turn was recognized as forming an integral part of the right to life. Similarly, in *Pt. Parmanand Katara v Union of India and Others*\(^\text{192}\) the Supreme Court held that Article 21 imposed obligations on the government to preserve human life and specifically that government hospitals and government doctors had duties to save lives through medical assistance. Furthermore, the court held that the duty was of paramount importance, and that no State action, law, regulation, or procedure could delay or prevent government doctors from fulfilling their duty to preserve life.

The unseverable bond between the provision of access to treatment and the preservation of life was again recognised by the Indian Supreme Court in *Pachim Banga khet Majoor Samity v State of West Bengal*\(^\text{193}\) where the court held that a denial of the right to emergency medical care constitutes a violation of the right to life guaranteed under Article 21 of the Indian Constitution. Similarly in *Alvarez v Caja Costarricense de Seguro Social*\(^\text{194}\) the Supreme Court of Costa Rica emphasised that:

> In a state of law, the right to life, and in consequence the right to health, receives particular attention. Any economic criterion that pretends to annul the exercise of such rights must cede in importance … because without the right to life all of the other rights are useless … Of what use are all other rights and guarantees, the institutions and programs, the advantages and benefits of our system of liberties, if even one person cannot count on having the rights to health and life guaranteed?

The Liberian courts have shown some dynamism in upholding the constitutional rights of citizens in other respects even to a revolutionary extent. For instance, in *Jedah v Horace*\(^\text{195}\) the Supreme Court of Liberia outlawed the practice of trial by ordeal (TBO) by which a number of individuals accused of being witches are required to submit to sassywood (a form of TBO that involves drinking a poison brew that often results in death). The court annulled TBO on the basis that it violated a suspect’s right against self-incrimination, a right protected under the Liberian Constitution, by holding inter alia:

> While it is provided that the native and district courts shall administer the native customary law, we cannot admit the legality of a proceeding which is evidently intended to extort a confession from the accused, and which is in conflict with the organic law of the state, which

\(^{192}\) AIR 1989 SC 2039.

\(^{193}\) (1996) 4 SCC 37.

\(^{194}\) Exp 5778-V-97 No 5934-97(SC).

\(^{195}\) (1916) 2 LLR 26 at 63.
declares that "no person shall be compelled to give evidence against himself." … Any custom, which panders to the superstition of the natives of the country is, in our opinion, contrary to the genius of our institutions and should therefore be discouraged.

Similarly, in Tenteah v Republic of Liberia,\textsuperscript{196} in an appeal by five individuals convicted by a circuit court of murdering a person suspected of stealing a goat, the Supreme Court again upheld the ban; it held that TBO was unconstitutional and illegal. The Court emphasised:

It would appear that the decedent died as a result of the doing of the appellants of an illegal act; for, decedent having being accused of having stolen a goat, no effort was made to ascertain the truthfulness or falsity of the action by any legal evidence, but rather resort was had to the illegal and abominable method of trial by ordeal which this court has repeatedly held to be unconstitutional and therefore illegal.

This judicial stance should serve as an impetus for the courts in Liberia to borrow a leaf from those foreign jurisdictions that have upheld the right to healthcare as an ingredient of the enforcement or preservation of the right to life. The right to life is recognised as a fundamental right under article 11(a) of the Liberian Constitution. The preservation of life demands the provision of adequate functional healthcare facilities. The state should therefore not be absolved from neglect of the country’s healthcare system simply on account of the provision of Article 4 of the Constitution that sets down this important state obligation as a mere guideline for the implementation of state’s policy as failure by the state in that regard affects the citizen’s right to life.

Liberia has recorded the greatest number of casualties with about 3,290 deaths and 7,797 cases as of 9 December, 2014 since the outbreak of Ebola in West Africa.\textsuperscript{197} The state of the disease in Liberia’s capital, Monrovia, was described by the Doctors without Borders as ‘catastrophic’ and ‘deteriorating daily’.\textsuperscript{198} The 2014 Ebola outbreak exposed the weaknesses in the Liberian healthcare delivery system. For example, just 18 percent of Ebola patients were treated in hospitals or other health facilities.\textsuperscript{199} The healthcare system in Liberia is highly dependent on support from Agencies and NGOs, which currently implement more than 90% of health service delivery. Access to basic and secondary health care services is still a major

\begin{footnotesize}
\textsuperscript{196} (1940) 7 LLR 63 at 65.
\end{footnotesize}
problem as more than 75% of the population has no access to referral care services such as essential and emergency obstetric care.\textsuperscript{200} It is on record that Ebola patients in Liberia, particularly in the capital Monrovia, were left to die because there was no space for them in the hospitals.\textsuperscript{201} It is in Liberia that an Ebola victim was shown being conveyed to one of the make-shift treatment centers in a wheel barrow, yet Liberia is a country governed by the Constitution which protects the citizen’s right to life and human dignity. There is no doubt that the long years of war and armed conflicts in Liberia so much decimated the healthcare system in that country, but the government of the day seems too slow in the rebuilding effort. The emergency situation created by the outbreak of the Ebola pandemic in Liberia and the inability of the country to cope with the challenges exposes the decay in the healthcare system due to the long years of neglect by the government of its obligations to the citizens.

\textbf{2.5 Chapter Conclusion}

The three West African countries at the center of the Ebola outbreak have at least one thing in common, ie, weak healthcare systems. The healthcare systems in Sierra Leone, Liberia and Guinea were barely functional before the Ebola outbreak. Strong healthcare systems are key to a successful response to Ebola and other infectious diseases. Guinea, Liberia and Sierra Leone do not have the staff and systems required to halt the outbreak on their own. The fact that many African leaders go abroad to receive treatment shows they do not have confidence in the healthcare systems of their own countries. Why America’s healthcare system can stop Ebola, even though other countries could not, is that the United States has the necessary resources and facilities to make the system work. By contrast, the worst affected countries in this outbreak; Guinea, Liberia and Sierra Leone, all lack those resources. Their systems do not work, and that has left thousands of people in danger of extermination from this disease. The three West African countries at the center of the Ebola outbreak were very slow in reacting to the disease. It took Guinea three months to react to the disease. Nigerian government reacted quickly when the disease showed up in the country. This was done by quarantining suspected cases, tracing and monitoring people who had been in contact

\textsuperscript{200} Liberal Health Sector Needs Assessment available at \url{http://who.int/hac/donorinfo/cap/Liberia_compendium_Jan06.pdf} (assessed 10 August 2015).

\textsuperscript{201} ‘Left to Die: Liberia’s Ebola Victims Have Nowhere to Turn as Treatment Centers Overflow’ available at \url{https://news.vce.com/article/left-to-die-liberias-ebola-victims-have-nowhere-to-turn} (accessed 9 September 2014).
with Ebola patients and educating the public on how to protect themselves. The failure of the Nigerian government, as will shortly be exposed, lies mainly in the treatment meted out to those in the quarantine centres. The governments of the affected West African countries are under obligation to provide adequate healthcare system for people infected with EVD. They failure on the part of governments to provide adequate healthcare for the people infected with EVD infringes on their right to healthcare as provided for in those countries' respective constitutions and under the international human rights instruments.

Chapter three deals with the relationship between healthcare providers and their patients, with particular reference to persons infected with EVD. The bases of the relationship are traced from the oath of medical practice which demands utmost selfless service and confidentiality from the healthcare providers in their relationships with their patients.
CHAPTER THREE

THE LEGAL RELATIONSHIP BETWEEN HEALTHCARE PROVIDERS AND THEIR PATIENTS

3.1 Introduction

This chapter deals with the relationship between healthcare providers and their patients, with particular reference to persons infected with EVD. The basis of the relationship is traced from the oath of medical practice which demands utmost selfless service and confidentiality from the healthcare providers in their relationships with their patients. The limitations imposed by law on the protection of the patient’s rights are carefully discussed. It is considered appropriate to state at the onset that for the purposes of the underlying discussions, a healthcare provider is an individual, institution or agency that provides health services to healthcare consumers.202 On the other hand a patient is any recipient of healthcare services. The patient is most often ill or injured and in need of treatment by a doctor, advanced practice registered nurse, psychologist, podiatrist, or other healthcare provider.203 For the purposes of this work, however, discussion is restricted to the relationships between the doctor and the patient.

3.2 Doctor-patient relationship

From ancient times, physicians have recognized that the health and wellbeing of patients depend upon a collaborative effort between physician and the patient. Patients share with doctors the responsibility for their own healthcare. The patient-physician relationship is of greatest benefit to the patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physician in a mutual alliance.204 The physician-patient

203 ‘Patient’ available at http://en.wikipedia.org/wiki/patient (accessed 14 January 2015); A patient is a person who is waiting for, is receiving, or has already received healthcare services at a hospital or clinic. One can be an in-patient (a person admitted overnight or longer in a hospital), or can also be an outpatient (a person who is examined, treated and goes away without having to sleep in hospital).
204 ‘Opinion 10.01-Fundamental Elements of the patient-Physician Relationship’ available at www.ama-assn.org/ama/pub/physician.../medical.../opinion1001.page (accessed 4 February 2015); The patients’ satisfaction

62
relationship is central to the practice of healthcare and is essential for the delivery of high-quality healthcare in the diagnosis and treatment of disease.\textsuperscript{205} The relationship of a physician and a patient is based on trust and gives rise to physician’s ethical obligations to place patient’s welfare above his/her own self-interest and above obligations to other groups, and to advocate for the patient’s welfare. It is the type of relationship described as fiduciary.\textsuperscript{206}

Defining the term fiduciary is problematic because a definition cannot capture the subtleties of fiduciary responsibility. In \textit{Bristol and West Building Society v Mothew}\textsuperscript{207} Millett LJ defined a fiduciary as “someone who has undertaken to act for or on behalf of another in a particular matter in circumstances which give rise to a relationship of trust and confidence.” The central idea is that a fiduciary is an actor who is “required to look after the interest(s) of....others with vigilance, dedication and selflessness.”\textsuperscript{208} Fiduciary duty entails abnegation, that is, both loyalty and selflessness.\textsuperscript{209} Within the scope of fiduciary undertakings, fiduciary duty negates the ordinary freedom of fiduciary actors to pursue self-interest. In \textit{Mothew’s case} Millett LJ emphasised that:

\begin{quote}
The various obligations of a fiduciary merely reflect different aspects of his core duties of royalty and fiduciary. Breach of fiduciary obligation, therefore, connotes disloyalty or infidelity. Mere incompetence is not enough. A servant who loyally does his incompetent best for his master is not unfaithful and is not guilty of a breach of fiduciary duty.\textsuperscript{210}
\end{quote}

In order for the physician to make accurate diagnosis and provide optimal treatment recommendation, the patient must communicate all relevant information about an illness or injury. This may require the discussion of sensitive information, which would be embarrassing or

\begin{itemize}
\item with an encounter with healthcare services is mainly dependent on the duration and efficiency of care, and how empathetic and communicative the healthcare providers are. It is favoured by a good physician –patient relationship. Also, patients who are well informed of the necessary procedures in a clinical encounter, and the time it is expected to take, are generally more satisfied even if there is a longer waiting time see Michael Pulia ‘Simple Tips to Improve Patients Satisfaction’ (2011) 18 (1) American Academy of Emergency Medicine 18-19.
\item [1998] Ch 1 at 18A.
\item Abnegation is defined as renunciation of one’s interest in favour of the interest of another available at abnegation - definition of abnegation by The Free Dictionary www.thefreedictionary.com/abnegation (accessed 3 February 2015).
\item Mothew’s case (note 207 supra) 18E-F.
\end{itemize}
harmful if it were known to other persons. The promise of confidentiality permits the patient to trust that information revealed to the physician will not be further disseminated. The expectation of confidentiality derives from the public oath which the physician has taken, and from the accepted code of professional ethics.\textsuperscript{211} Physicians are generally obliged to refrain from divulging information which their patients have passed to them in confidence to third parties.\textsuperscript{212}

3.3 Medical ethics and the law

Medicine is a highly regulated profession practiced by men and women of untrammelled intellectual esteem who enjoy the unequivocal confidence of their patients. The quest to curtail abuses of such confidence and to ensure optimal exercise of dexterity by the physician in the care for his or her patient necessitated the formulation of some moral code of conduct, some of which have over the years metamorphosed into rules of law, to serve as guides in directing the services of the physician to his or her patient.\textsuperscript{213} These bodies of moral rules are simply referred to as the ethics of the profession or rules of professional conduct. The earliest of such medical ethics is embodied in a statement attributed to a great physician, Hippocrates, who at present times is referred to as the father of modern medicine, and whose statement is administered as an Oath to practitioners of medicine.\textsuperscript{214} The Hippocratic Oath states in part as follows:

I swear ...that, according to my ability and judgment, I will keep this Oath and this contract:...Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption,...Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private. So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate.\textsuperscript{215}

The World Medical Association has made some modifications to this Oath to bring it in line with the practice and language of modern medicine but without losing the precepts. The modified version, otherwise referred to as the Geneva Declaration of 1949, enjoins the physician to

\textsuperscript{211} JO Mary Ludwing and Wylie Burke ‘Physician –Patient Relationship’ University of Washington School of Medicine, Ethics in Medicine available at http://depts.washington.edu/bioethx/topics/physpt.html (accessed 14 January 2015).

\textsuperscript{212} Odensi & Nwafor (note 206 supra) 250.


\textsuperscript{214} Ibid.

maintain utmost respect for human life from time of conception, even under threat, and not to use his medical knowledge contrary to the laws of humanity.\textsuperscript{216}

Healthcare providers operate on a foundation of ethical principles, namely beneficence (doing good), non-maleficence (do no harm), and justice (just distribution of finite resources).\textsuperscript{217} Beneficence is the most prominent principle that comes into play in considering treatment of patients with Ebola. It refers to a provider’s duty to help patients, so long as the patient’s initial complaint falls within the provider’s scope of practice.\textsuperscript{218} A healthcare provider has an ethical and professional duty to address a patient’s needs, as long as the patient’s diagnosis or when the patient’s initial complaint, on the face of it, falls within the provider’s scope of practice.\textsuperscript{219} Refusing to do so is not consistent with the ethical principle of beneficence. The risk of disease transmission, the grounds on which healthcare providers are most likely to refuse to treat Ebola patients, does not preclude healthcare providers from the principle of beneficence. Under this ethical medical principle, healthcare providers are obligated to treat patients with highly infectious disease.\textsuperscript{220} The basis of ethics, according to Swami Vivekananda is to become more and more selfless: “Whether men understand it or not, they are impelled by that power behind to become unselfish. That is the foundation of morality. It is the quintessence of all ethics, preached in any language, or any religion, or by any prophet in the world. Be thou unselfish”, Not ‘I’, but ‘Thou - that is the background of ethical codes.”\textsuperscript{221}

In the West African nations affected with Ebola, healthcare providers are reported to have abandoned the victims in preference for the preservation of their own lives. Respite only came to the victims with the intervention of mostly international volunteer organisations some of

\begin{footnotesize}
\begin{itemize}
\item[216] Nwafor (note 213 supra)179.
\item[218] Ibid.
\end{itemize}
\end{footnotesize}
whose personnel actually paid with their lives to save the Ebola victims. Some reasons have been adduced as to why healthcare providers prefer their own interests to that of the patients among which are that: (i) a large initial investment is required to set up a clinic, a hospital or a medical institute; and it is thought appropriate to charge heavy fees from the patients as a means of recovering the cost; (ii) increased awareness in the patient community about their legal rights. Thus, doctors are conscious of the legal implications of any negligence in treating the patients. Where actions are instituted by the patients, legal fees to be paid by the doctor could be substantial and hence the hospital charges are high; (iii) the patient approaches a doctor with mixed feeling of faith and fear, of hope and hostility. This inevitably leads to distorted doctor-patient relationship with high chances of exploitation; (iv) many doctors do not (or cannot) offer the best line of treatment to the patients; (v) some doctors are ill-trained. They themselves are not fully aware of recent advances in the treatment and management of the disease; and (vi) many doctors do not have standard treatment facilities in their own clinics or hospitals. Although some of these reasons may seem significantly compelling, they are not sufficient to override the underlying ethical obligation of the physician which is selfless service to the patient.

3.4 Patient care and human rights

Patient care refers to the prevention, treatment, and management of illness and the preservation of physical and mental well-being through services offered by health professionals. More specifically, patient care consists of services rendered by health professionals (or non-professionals under their supervision) for the benefit of patients. Patient care is a discrete and important aspect of the right to healthcare that merits attention and scrutiny as a human right issue.

Human rights in patient care refer not just to entitlements for actual patients, but to legal, ethical, and human rights standards in the provision of care that concern health providers and the entire

---

Apart from the ethical standard which demands that healthcare providers should place the interests of the patient above personal interests, it is internationally recognised that patients are by law entitled to some basic empowerment rights such as information, consent, free choice, privacy and confidentiality, rights to a remedy for abuses, and rights of access to services, in the course of their dealings with the healthcare providers.227 These components of human rights constitute a critical part of the provision of quality and appropriate healthcare aimed at attaining the highest standard of health.

The call for the protection of patients' rights is a movement that is growing globally to make governments and healthcare providers more accountable for providing access to quality healthcare services.228 Patients' rights are an integral component of human rights. They promote and sustain beneficial relationships between patients and healthcare providers. The role of the patients' rights therefore is to reaffirm fundamental human rights in the healthcare context by according patients humane treatment. The need to protect and promote the dignity, integrity, and respect of all patients is now widely accepted.229 To this end, the WHO predicts that the articulation of patients’ rights will in turn make people more conscious of their responsibilities when seeking and receiving or providing healthcare. This will ensure that patient-provider relationships are marked by mutual support and respect.230

Patients' rights vary in different countries and in different jurisdictions, often depending upon prevailing cultural and social norms. Different models of the patient-physician relationship, which can also represent the citizen-state relationship, have evolved. These have informed the particular rights to which patients are entitled. In North America and Europe, for instance, there are at least four models which depict this relationship, namely: the paternalistic model, the informative model, the interpretive model, and the deliberative model. Each of these suggests

---

227 Ibid.
229 Benson Oduor Ojwang, Emily Atieno Oguta and Peter Maina Matu ‘Nurses’ impoliteness as an impediment to patients’ rights in selected Kenyan hospital’ (2010) 12 (2) Health And Human Rights 101.
different professional obligations of the physician toward the patient. For instance, in the paternalistic model, the best interests of the patient as judged by the clinical expert are valued above the provision of comprehensive medical information and decision-making power to the patient. The informative model, by contrast, sees the patient as a consumer who is in the best position to judge what is in her own interest, and thus views the doctor as chiefly a provider of information. There continues to be enormous debate about how best to conceive of this relationship, but there is also growing international consensus that all patients, including those infected with Ebola, have a fundamental right to privacy, to the confidentiality of their medical information, to consent to or to refuse treatment, and to be informed about relevant risk to them of medical procedures. 231

A vast and severe range of human rights violations occur in the process of patients care. In response to the growing concerns about these abuses of patients’ rights in many parts of the world, the concept of ‘human rights in patient care’ evolved as a framework for monitoring healthcare providers, analysing abuses and holding accountable the violators of such rights. 232 Respect for patient’s dignity and autonomy are the keys to a cordial relationship between the healthcare provider and the patient.

3.5 Patients’ care and right to dignity

Human dignity refers to one’s self-esteem, self-regard and self-respect. Dignity is concerned with how individuals feel, think and behave in relation to the worth or value of themselves and others. To treat persons with dignity is to treat them as being of worth, in a way that is respectful of their diversity, as valued individuals. 233 When a person’s dignity is interfered with, the person feels degraded, embarrassed and humiliated. 234 On the contrary, when dignity is respected persons feel in control, valued, confident, comfortable and able to make decisions for

232 Jonathan Cohen (note 225 supra) 7.
themselves.\textsuperscript{235} In healthcare situations, dignity may be promoted or diminished by the physical environment; organisational culture; by the attitudes and behaviour of healthcare providers and others and by the way in which care activities are carried out. Healthcare providers are under obligation to treat all patients in all settings and of any health status with dignity, and dignified care should continue after death.\textsuperscript{236}

The Universal Declaration of Human Rights was pivotal in popularizing the use of ‘dignity’ or ‘human dignity’ in human rights discourse.\textsuperscript{237} The importance of respect for human dignity as a human right draws from the events proceeding and up to the Second World War where millions of Jews were used for human experiment, tortured and killed by agents of Adolf Hitler. The world was alarmed by the horrendous dehumanisation of humanity in the torture chambers created by Hitler. This galvanised global action leading to the recognition of the need for the protection of human dignity by the United Nations.\textsuperscript{238}

The UN Universal Declaration of Human Rights which embodies a universally accepted framework for the protection of human rights recognizes that the inherent dignity and the equal and inalienable rights of all members of the human family are the foundations of freedom, justice and peace in the world. Article 1 of the Universal Declaration states that all human beings are born free and equal in dignity and in rights.\textsuperscript{239} The Universal Declaration links dignity with other fundamental rights. Article 22 provides that everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Various other international and national human rights instruments have followed the lead by the Universal Declaration in upholding the inextricable relationship between human rights and

\textsuperscript{235} Dignity and me – RCN \url{www.rcn.org.uk} › ... › CPD online learning › Dignity in health care (accessed 27 January 2015).

\textsuperscript{236} Ibid


\textsuperscript{239} Universal Declaration of Human Rights, General Assembly Resolution 217A(111) 10\textsuperscript{th} December 1948.
human dignity. The ICESCR states in its preamble that human rights derive from the inherent dignity of the human person. The ICCPR recognizes that all human rights derive from the inherent dignity of the human person. Article 10 of the ICCPR provides that all persons deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the human person. The African Charter contains provisions recognizing the right to dignity in article 5 which states that every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man, particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited. The constitutions of Nigeria, Serra Leone, Liberian and Guinea, respectively recognize the inherent dignity of the human person. Section 34(1) of the Nigerian Constitution specifically provides that every individual is entitled to respect for the dignity of his person, and as such prohibits the subjecting of individuals to torture or to inhuman or degrading treatment; slavery or servitude; and to perform forced or compulsory labour. The constitution of the Republic of Guinea seems more forceful in its pronouncement on the dignity of human person. Article 5 of the Constitution declares that “[t]he human person and their dignity are sacred. The State has the duty to respect them and to protect them.”

Although the constitutions of Sierra Leone and Liberia respectively did not expressly use the word ‘dignity’ in their provisions, the prohibitions of torture, inhuman and degrading treatment as provided in those constitutions are obviously aimed at the protection of human dignity. Inferences could be drawn from the South African courts pronouncements to buttress this point. In *S v Makwanyane* O Regan J stated that “[r]ecognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern. This right therefore is the foundation of many of other rights that are specifically entrenched [in the Bill of Rights].” In *Le Roux and Others v Dey* Harms DP observed that:

> The term ‘dignity’ covers a number of concepts in... the Constitution, but in the present context we are concerned with the plaintiff’s sense of self-worth. Melius de Villiers spoke of inborn right to the tranquil enjoyment of one’s peace of mind and the valued serene condition in one’s social or individual life which

---

240 Similar provisions are contained in ss 19 and 20 of the Sierra Leonean Constitution of 1991, and article 12 of the Liberian Constitution.
241 See also article 6 of the Constitution which prohibits torture, inhuman and degrading treatment.
242 1995 (3) SA 391 (CC) para 328.
has been violated when one is subjected to offensive and degrading treatment, or exposed to ill-will, radicle, disesteem or contempt.

In the consolidated cases of Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others\textsuperscript{244} Corbett CJ stated that under the South Africa constitutional order, the recognition and protection of human dignity is the foundational constitutional value. Descending to the inhuman treatment of the black population during the apartheid era, the judge observed that:

\begin{quote}
The value of dignity in our constitutional framework cannot… be doubted. The Constitution asserts dignity to contradict our past in which human dignity for black South Africans was routinely and cruelly denied. It asserts it too to inform the future, to invest in our democracy respect for the intrinsic worth of all human beings. Human dignity therefore informs constitutional adjudication and interpretation at a range of levels.
\end{quote}

Dignity has thus been described as the \textit{grundnorm} of the South African Constitution.\textsuperscript{245} Patients have equal worth as every other human being irrespective of the nature of the disease which the patient is afflicted. They should be treated as persons able to feel, think and behave in relation to their own worth or value. Although Ebola is recognised as a highly infectious disease, the victims should not be treated as outcasts in the society. Conveying a victim of Ebola in a wheelbarrow or being dumped in a house or abandoned at make-shift healthcare centre as reported in some countries at the initial outbreak of the EVD are all acts of infringement on the victims’ right to dignity.\textsuperscript{246} Even the dead should be buried with dignity and not cast into the ‘evil forest’ as an accursed being or fed to the dogs, practices exposed by the anecdotal evidence presented in the next chapter.

\subsection*{3.6 Patient care and the right to information}

The right to information is an internationally recognised human right. It applies to every person who seeks to receive or impart information on a subject matter of interest. The ICCPR recognizes the right to information in Article 19(2) which provides that everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{244} 2000 (3) SA 936 (CC) para 35.
\item \textsuperscript{245} See Druccila Cornell, Stu Woolman, Sam Fuller, Jason Brickhill, Michael Bishop and Diana Dunbar, \textit{The Dignity Jurisprudence of the Constitutional Court of South Africa} Vol I (New York, Fordam University Press, 2013) 7.
\item \textsuperscript{246} Man transports a possible victim of the Ebola virus in a wheelbarrow on Thursday at the Ebola treatment center at Island Hospital in Monrovia, Liberia. (Oct 2, 2014.) Available at \url{http://earthsquare.net/7759} (accessed 15 May 2015); See also Ebola Patients Abandoned, Health Team Down Tools- Health- Nairaland' available at \url{http://www.nairaland.com/1862229/ebola-patients-abondoned-health-team} (accessed 9 September 2014).
\end{itemize}
\end{footnotesize}
information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice. In relation to women, article 10(h) of CEDAW enjoins state parties to provide access to specific educational information to ensure the health and well-being of families, including information and advice on family planning. Article 9(1) of the African Charter provides that every individual shall have the right to receive information. More specific provisions on health related information are found in the Convention on Human Rights and Biomedicine which provides in article 10(2) that everyone is entitled to know any information collected about his or her health.\textsuperscript{247} The World Medical Association’s Declaration of Lisbon on Rights of the Patient (Lisbon Declaration) states that the patient has the right to receive information about himself/herself recorded in any of his/her medical records, and to be fully informed about his/her health status including the medical facts about his/her condition.\textsuperscript{248} A patient’s right to be informed constitutes an essential part of healthcare accessibility.\textsuperscript{249}

In many cases, patients, except perhaps the few enlightened ones, are often unaware of their rights, including the right to information on their health conditions and the right to access their medical records. The healthcare providers who are motivated by financial gains are not always disposed to providing information to the patients on reasonable treatment options, the available alternatives and the likely benefits and risks of proposed treatment and non-treatment. In \textit{KH and Others v Slovakia}\textsuperscript{250} the applicants who could not conceive after consultations with the gynaecologists hospitals suspected that they were sterilised and demanded for their medical records. The hospitals refused to release their medical records to their authorised legal representatives or to allow them to obtain copy of the documents. The European Court held that the hospitals refusal amounted to a violation of the rights of the women to information and access to justice.


\textsuperscript{248} The Declaration of Lisbon was adopted in 1981 by the 34th World Medical Assembly at Lisbon. The preamble states that while a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patients autonomy and justice. This Declaration represents some of the principal rights of the patient that the medical profession endorses and promotes. Available at \url{http://www.wma.net/en/30publications/10policies/l4/} (accessed 25 April 2015). (The Declaration of Lisbon).

\textsuperscript{249} See CESCR General Comment No 14 para 12.

\textsuperscript{250} App. No. 32881/04 (ECtHR) (April 28, 2009).
Similarly, in *Roche v United Kingdom*\(^{251}\) the defence establishment had conducted a research into chemical weapons for the UK’s armed forces, including tests of gases on humans and animals. The applicant, a serviceman, complained that he was not given adequate information about the tests performed on him. The Court found that the State has not fulfilled the positive obligation to provide an effective and accessible procedure enabling the applicant to have access to all relevant and appropriate information that would allow him to assess any risk to which he had been exposed during his participation in the tests.

There is a controversy in the medical field on the extent of information which a physician is required to disclose to the patient. This is premised on the fact that consent of the patient is required before administering treatment, and consent cannot be real without adequate information. Pattinson observed that it would be impractical for the law to require a doctor to disclose all the known risks of a procedure to all patients. A patient is not usually in a position to understand or absorb all that information, or resolve conflicts in professional opinion. Conversely, a patient who knows nothing about a procedure cannot be said to have consented to it. The law requires something between these two extremes.\(^{252}\) Brazier suggests that within a reformulated fiduciary relationship “the doctor’s duty would be to make available to the patient that information that it seems likely that individual patients would need to make an informed choice on treatment.”\(^{253}\)

The judiciary has descended into the arena of this dispute. In *Chatterton v Garson*\(^{254}\) Bristow J held that once the patient is informed in broad terms of the nature of the procedure which is intended, and gives his consent, that consent is real. In *Sideway v Bethlem Royal Hospital*\(^{255}\) the House of Lords held that a doctor need only disclose such information as would be disclosed by a reasonable body of medical opinion. The supports the view earlier expressed by McNair J while addressing the jury in *Bolam v Friern Hospital Management Committee*\(^{256}\) where

\(^{251}\) App. No.32555/96 (ECtHR) (October19, 2005).


\(^{254}\) [1981] 1 QB 432 at 443.

\(^{255}\) [1985] AC 871.

\(^{256}\) [1957] 2 All ER 118 at 122.
he stated that “[a] doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical man skilled in that particular art.”

The views of the courts in these cases promote the concept of medical paternalism which prefers the opinion of the physician on what is best for the patient. This judicial approach has however witnessed a reverse in the more recent cases. In *Pearce v United Bristol Healthcare NHS Trust*257 Lord Woolf observed, in a majority decision of the European Community Court, that “if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk.” This position was approved by the House of Lords in *Chester v Afshar*258 where Lord Steyn stated that “[i]n modern law medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery.”

The preferred position, it is submitted, is that the physician should disclose to the patient, especially when the patient in conscious, all the medical procedure that would enable the patient to give an informed consent to a particular mode of treatment. A physician who assumes a paternalistic position in deciding what is good for the patient could be exposing himself/herself to a legal action that might arise from such conduct. There are reports showing that EVD victims were usually quarantined at specific locations and with little or no medical care. Some were reported to have escaped or attempted to escape from such confinements.259 This suggests that the victims were neither informed nor consented to such confinements. This constitutes acts of infringement of the right of the victims to be informed by the healthcare providers and the state.

258 [2004] UKHL 41 para 16.
3.7 Patient care and right to privacy and confidentiality

The word ‘privacy’ evolved from the Latin word ‘privatus’ meaning; apart from the state; peculiar to one’s self; of or belonging to an individual; private’. In the simplest sense, ‘right to privacy’ connotes the right to control information about oneself. The right to privacy is the epicentre of all human freedoms and rights. It has become so important that it is a recurring provision in various international human rights instruments and constitutions of different countries.

The ICCPR contains provisions recognizing the right to privacy in Article 17(1) which provides that “[n]o one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation”. Similarly, the CRC provides in article 16(1) that “[n]o child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation”.

At the national level, the Nigerian National Health Bill, 2014 provides in paragraph 26 (1) that all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential. The constitutions of Nigeria, Sierra Leone, Guinea and Liberia all embody provisions on the protection of the right to privacy. Section 37 of the Nigerian Constitution, for instance, provides that the privacy of citizens, their homes, correspondence, telephone conversations and telegraphic communications is hereby guaranteed and protected. The courts have accommodated various situations within the ambit of privacy. In Mark v Seattle Times the Supreme of Washington held that the protectable interest in privacy generally involves at least four distinct types of invasion, namely: intrusion, disclosure, false light and appropriation. In relation to medical jurisprudence, the right of a woman to have an abortion has been upheld as a right to privacy. Similarly, the right to

---

261 JHF Shattuck, Rights of Privacy (USA, National Textbook Co 1977) 13.
262 Odunsu & Nwafor (note 212 supra) 251.
263 See similar provisions under s 22 of the Sierra Leonean Constitution, arts 12 and 16 of Guinean and Liberian Constitutions respectively.
privacy has been adopted to justify the right of a minor to receive contraceptive.\textsuperscript{266} In \textit{Georgina Ahamefula v Imperial Medical Centre}.\textsuperscript{267} the Lagos High Court held that an unauthorized testing of the plaintiff’s HIV status without consent was unlawful being an interference with an individual’s privacy and encroachment on bodily integrity.

In the realm of medical law and ethics, the right to privacy translates to medical confidentiality. Confidentiality is one of the core tenets of medical practice. In the daily exercise of his functions the physician receives private communications from the patient which the physician is bound to keep secret and in confidence.\textsuperscript{268} The need for medical confidentiality is recognised by various international instruments and medical ethics. The UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No 14 recognises that the need for the public to be informed should not impair the right to have personal health data treated with confidentiality.\textsuperscript{269}

In other words, the patient’s right to the preservation of health related information supersedes the public interest in this context. The World Medical Association Declaration of Lisbon on the Right of the Patient (Declaration of Lisbon) states that “[a]ll identifiable information about a patient’s health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be kept confidential even after death,”\textsuperscript{270} The Convention on Human Rights and Biomedicine provides in Article 10 that everyone has the right to respect for private life in relation to information about his or her health.

There are good reasons for insisting that information given to the physician by the patient be preserved. Firstly is the right of the patient to medical autonomy. Secondly are the likely consequences which unguarded disclosure of information may have on the patient. In cases of information which may expose the patient to stigmatization and discrimination, the patient could be treated as an outcast in the society.\textsuperscript{271} In \textit{Jansen Van Vuuren v Kruger}\textsuperscript{272} Harms AJA observed that:

There are in the case of [highly infectious disease] special circumstances justifying the protection of confidentiality. By the very nature of the disease, it is essential that persons who

\textsuperscript{266} \textit{Carey v Population Services International} 431 US 678 (1977).
\textsuperscript{267} Suit No.ID/16272000 (September 27, 2012). (Lagos State High Court).
\textsuperscript{268} See Odunsi & Nwafor (note 262 supra) p 253.
\textsuperscript{269} General comment No 14 para 12.
\textsuperscript{270} Declaration of Lisbon para 8.
\textsuperscript{271} See Odunsi & Nwafor (note 268 supra) pp 253-254.
\textsuperscript{272} 1983 (4) SA 842 (AD) at 31.
are at risk should seek medical advice or treatment. Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others which may lead to increased anxiety, depression and psychological conditions.

Thirdly is the need to afford the patient an opportunity to give health information freely and confidently to the physician. This is recognised by the British Medical Association guidance where it is stated as follows:

Confidentiality is an essential requirement for the preservation of trust between patients and health professionals…. Patients should be able to expect that information about their health which they give in confidence will be kept confidential unless there is a compelling reason why it should not. There is also a strong public interest in maintaining confidentiality so that individuals will be encouraged to seek appropriate treatment and share information relevant to it.273

Fourthly is the preservation of public interest which is assured when a patient seeks medical solution to ailments. This was recognised in X v Y274 where Rose J said:

In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients will not come forward if doctors are going to squeal on them. Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care.

Patient’s privacy and confidentiality are often infringed by healthcare providers. Some acts of infringement include (i) allowing access to patient’s medical information to all hospital staff, including those not involved in the individual patient’s care. A patient’s health information should not be accessible to every healthcare giver in a healthcare center. A nurse whose role is to vaccinate a patient, should not ordinarily have access to that patient’s private mental health records as the information is not relevant to the treatment being provided at that moment. (ii) Conducting medical examinations under public conditions. Privacy and confidentiality are crucial for patients seeking diagnosis and treatment of illnesses with which stigma is attached, such as EVD.275 The testing of persons for Ebola virus at public places and in the public glare infringes on patient’s confidentiality.


274 [1988] 2 All ER 648 (QBD) 653 para a-b. See also Hague v Williams [1962] 181 Atlantic Reporter 2d 345 at 349 where the court held that “[a] patient should be entitled freely to disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfilled.”

The right to confidentiality of health information should not interfere with the right to access of private health information. While a holder of private health information is prohibited from sharing that information with anyone who is not essential to providing health care to the patient, the holder must grant the patient access to their private health information upon the patient’s request. Patients have the right to access their own health information and to control how such information is shared with other persons. The right to confidentiality of private health information, as well as the right to accessibility of private health information are patient’s rights and should be respected by the healthcare providers.276

In *Jansen Van Vuuren v Kruger* 277 a medical practitioner had disclosed the HIV status of his patient at a golf game after an explicit request by the patient to keep the information confidential to other health practitioners. The patient instituted proceedings claiming that the medical practitioner owed him a duty of confidentiality in relation to any information relating to the plaintiff/patient's medical conditions.

The patient argued that he had suffered an invasion of his privacy and had been injured in his rights of personality. The medical practitioner contended that he had a social and moral duty to make the disclosure to the other health practitioners and that they had a reciprocal social and moral right to receive the information and apply due diligence when again dealing with or treating the plaintiff.

Harms AJA held that AIDS is a dangerous condition, but that on its own does not detract from the right of privacy of the afflicted person, especially if that right is founded in the doctor-patient relationship. A patient has the right to expect due compliance by the practitioner with his professional ethical standards: in this case the expectation was even more pronounced because of the express undertaking by the first defendant. The practitioners were not at risk and there was no reason to assume that they had to fear a prospective exposure. In consequence, the judge concluded that the communication to the practitioners was unreasonable and therefore unjustified and wrongful.

276 Ibid.
277 1993 4 SA 842 (AD).
The court further emphasised that the duty of medical practitioners to respect the confidence of their patients is not merely an ethical duty but also a legal duty recognised by South African common law.

In *MS v Sweden*\textsuperscript{278} the Court held that the protection of personal data, particularly medical data, is of fundamental importance to a person’s enjoyment of his or her right to respect of private and family life. It was further held that respecting the confidentiality of health data is vital and crucial not only to the privacy of the patient but also to preserve his or her confidence in the medical profession and in the health services in general.

In *Z v Finland*\textsuperscript{279} the court emphasised that “[w]ithout such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community.”

The non-observance of privacy and confidentiality in the screening and treatment of Ebola victims is one of the reasons that have driven infected persons underground and hence contributed to the spread of the disease in the affected countries.\textsuperscript{280} Screening is often done in public. Those who manifest symptoms of the disease are separated from others in the public glare.\textsuperscript{281} The emaciated bodies of the victims are often shown on public television where they are isolated with very little medical attention and awaiting their eventual death. Even the dead are not spared this unnecessary exposure as men in medical protective gear are often shown conveying such bodies to the designated burial places. These conducts have adverse impacts on the families of such victims who are usually avoided as the disease is said to be transmissible by body contacts. It is submitted that unless persons infected with the EVD are assured of their privacy and confidentiality, the victims will not be willing to voluntarily submit themselves for testing and treatment.

\textsuperscript{278}App. No.20837/92 (ECtHR) (August 27, 1997).
\textsuperscript{279} App. No.22009/93 (ECtHR) (February 25,1997)para 95.
The preservation of the patient’s right to privacy and confidentiality is however not an absolute right. There are grounds prescribed by law and medical ethics which are recognised by the courts imposing limitations on the protection of patient’s confidentiality. This is discussed later in this chapter.

3.8 Patient care and right to non-discrimination

The UN Committee on Economic, Social, and Cultural Rights defines discrimination as any “distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of covenant rights”. A person is discriminated against when he is treated differently from others and in a manner that undermines his humanness. Discrimination is often associated with stigma. The quest by law to prevent discrimination is necessitated by the stigma attached to people who are given inhuman or degrading treat. Stigma is a powerful and discrediting social label that radically changes the way individuals view themselves and are viewed as persons. People who are stigmatized are usually treated as outcast or shameful for some reasons and as a result are shunned, avoided, discredited, rejected, restrained or penalized. Reports have shown that the fear and stigma surrounding EVD infection results in people not seeking expert medical advice until they manifest the symptoms of the disease. The fear of being stigmatized or isolated may also cause people to conceal their illness. It has been reported that the panic surrounding the Ebola virus has affected healthcare providers and has led to the discrimination against patients suspected of being infected. The social hardship suffered by people who are stigmatized is one of the reasons for the provision of the right to non-discrimination.

It should be emphasised that acts of discrimination offend international and national human rights instruments. The ICCPR provides in Article 26 that: “All persons are equal before the law.

---

and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”. In the same vein, Article 2(2) of the ICESCR provides that the States Parties to the Covenant undertake “to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”. Also Article 2 of the African Charter provides that: “Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, color, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status”.

The phrase ‘or other status’ has been interpreted by the CESCR General Comment No 20 to include health status. “Health status refers to a person’s physical or mental health”. The CESCR enjoins states parties should ensure that a person’s actual or perceived health status is not a barrier to realizing the rights under the Covenant. The Constitutions of Nigeria, Sierra Leone, Liberia and Guinea also embody provisions against discrimination.

It is observed in the General Comment that the protection of public health is often cited by states as a basis for restricting human rights in the context of a person’s health status. However, many such restrictions are discriminatory, for example, when HIV status is used as the basis for differential treatment with regard to access to education, employment, healthcare, travel, social security, housing and asylum. The courts in South Africa have similarly held that discrimination on ground of health status (especially on HIV status) is unlawful. In *Hoffmann v South African Airways* Ngcobo J said:

---

286 General Comment No. 20 para 33.
287 Ibid.
288 See ss 42 and 27 of the Nigerian and Sierra Leonean Constitutions respectively, as well as arts 18 and 8 of the Liberian and Guinean Constitutions respectively.
289 General Comment No 20 para 33.
290 2001 (1) SA 1 (CC) para 28. See also *Allpass v Mooikloof Estates (Pty) Ltd v/a Mooikloof Equestrain Centre 2011* (2) SA 638 (LC).
Society has responded to [the plight of those living with HIV] with intense prejudice. They have been subjected to systemic disadvantage and discrimination. They have been stigmatized and marginalized.... Society’s response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received... any discrimination against them can, to my mind, be interpreted as a fresh instance of stigmatization and I consider this to be an assault on their dignity. The impact of discrimination on HIV positive people is devastating. It denies them the right to earn a living. For this reason, they enjoy special protection in our law.

Although the medically established mode of transmission of HIV is not the same as Ebola, the Ebola patients should not be discriminated against, especially in the provision of healthcare, simply on account of the health condition. What is needed is the balancing of the interests of the patient with those of the wider society as stated by the Indian court in *MX of Bombay Indian Inhabitant v M/s ZY and another* as follows:

Taking into consideration the widespread and present threat of this disease [HIV/AIDS] in the world in general … the State cannot be permitted to condemn the victims …many of whom may be truly unfortunate, to certain … death. It is not in the general public interest and is impermissible under the Constitution. The interests of the [victims] … and the interests of the society will have to be balanced in such a case.

In *Hamel v Malaxos* it was held that a physician must not deny treatment to patients because their medical condition may put the physician at risk. If a patient poses a risk to the physician’s health or safety, the physician should take all available steps to minimise the risk before providing treatment or making other suitable alternative arrangement for providing treatment.

This decision perhaps justifies the wearing of protective gear by healthcare providers attending to the EVD patients. Though there is always the need for the protection of the wider society as suggested by the above decisions and discussed later in this chapter, there is however no justification for abandoning such patients or confining them in their homes or in designated healthcare centres without medical facilities and as such condemning them to a certain death.

3.9 Patient care and freedom from torture and cruel, inhuman, and degrading treatment

Article 7 of the ICCPR provides that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free
consent to medical or scientific experimentation. Similarly, Article 5 of the Universal Declaration provides that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. At the regional level, the African Women’s Protocol in Article 4(1) prohibits all forms of exploitation, cruel, inhuman or degrading punishment and treatment. There are also provisions under the constitutions of Nigeria, Sierra Leone, Guinea and Liberia respectively on similar terms as the above international instruments.293

In Keenan v. United Kingdom294 the European Court of Human Rights stated that ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3.295 The assessment of this minimum is relative: it depends on all the circumstances of the case, such as the duration of the treatment, its physical and/or mental effects and, in some cases, the sex, age and state of health of the victim.

The denial of healthcare to incarcerated persons even on account of commission of crime has been held by the courts to amount to torture, cruel and inhuman treatment. This was the position unanimously adopted by the European Court in Hurtado v. Switzerland296 where the court held that the state’s failure to provide timeous medical treatment to the detained applicant was an act of inhuman and degrading treatment.

Such denial of medical care could also constitute an infringement on the right to healthcare of the incarcerated person. In Festus Odafe & Others v Attorney General of the Federation and Others297 the applicants who were detainees at the Kirikiri maximum security prison in Lagos contracted HIV while in detention and were denied the right to treatment by the prison officials. In an action to enforce their fundamental rights under the Nigerian Constitution and the African Charter, the court held that the denial of treatment to the four prisoners violated section 8 of the Nigerian Prison Act of 1972 and article 16 of the African Charter. Nwodo J of the Federal High Court of Nigeria Port Harcourt Division re-emphasised the obligation of the government in the

293 See ss 34(1)(a) and 20 of Nigerian and Sierra Leonean Constitutions respectively, arts 6 and 21(e) of Guinean and Liberian Constitutions respectively.


296 App. No. 17549/90 (ECtHR) (January 28, 1994).

enforcement of socio-economic rights, especially the right to health, under the African Charter as follows:

The government of this country has incorporated the African Charter on Human and Peoples' Rights Cap 10 as part of the law of the country….The Charter entrenched the socio-economic rights of a person. The Court is enjoined to ensure the observation of these rights. A dispute concerning socio-economic rights such as the right to medical attention requires the Court to evaluate state policy and give judgment consistent with the Constitution. I therefore appreciate the fact that the economic cost of embarking on medical provision is quite high. However, the statutes have to be complied with and the state has a responsibility to all the inmates in prison, regardless of the offence involved, as in the instant case where…the applicants…have been in custody for not less than two years suffering from an illness. They cannot help themselves even if they wanted to because they are detained and cannot consult their doctor. I therefore…order the authorities…[to] relocate the applicants after the precondition has been complied with, to a hospital in accordance with section 8 of the Prison Act.298

Similar decisions have been reached by the African regional courts such as the African Commission on Human and Peoples' Rights and the ECOWAS court. The decision of the African Commission on Human and Peoples' Rights in International Pen and Others (on behalf of Ken Saro Wiwa) v Nigeria299 lends credence to this assertion. In that case, Saro Wiwa, a writer and environmental rights activist, together with eight others, were sentenced to death for their social crusade activities in Ogoni land in the Niger Delta region of Nigeria. While in detention awaiting execution, Saro Wiwa's health deteriorated to the point that he required medical attention. The Nigerian government denied him access to treatment in spite of the prison doctor's recommendations. The African Commission held that Saro Wiwa's right to health under article 16 of the African Charter was violated by the Nigerian government. In arriving at this decision, the Commission stated as follows:

The responsibility of the government is heightened in cases where an individual is in its custody and therefore someone whose integrity and well-being is completely dependent on the actions of the authorities. The state has a direct responsibility in this case. Despite requests for hospital treatment made by a qualified prison doctor, these were denied to Ken Saro Wiwa, causing his health to suffer to the point his life was endangered…. This is a violation of article 16.300

Similarly, in Purohit & More v The Gambia301 the Commission emphasised that the:

Enjoyment of the human rights to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realization of all the other fundamental

300 Article 16 of the ACHPR provides that "(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."
301 (2003) AHLRA 96 at 108.
human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind.

The victims of Ebola were reportedly confined in their homes or at designated health centres without quality care, functioning water supply and no air conditioning facilities. The families of the patients had to cater for them and pay for some drugs and oxygen.\textsuperscript{302} In \textit{Keenan v. United Kingdom}\textsuperscript{303} the European Court had emphasised that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them.

There is therefore an enhanced responsibility on the governments of the affected countries to ensure that the health need of the victims of EVD who are quarantined or confined at designated centres are fully addressed. Failures on the part of the government to provide medical care for EVD patients in such confinements constitute torture and cruel, inhuman, and degrading treatment, and also an infringement of the right to healthcare of the victims.

\textbf{3.10 Limitation of patients’ rights}

The human rights-based approach to patient care draws from standards contained in the international and national human rights framework, which are often mirrored in regional treaties and national constitutions. It differs from patients’ rights, which codify particular rights that are relevant only to patients. Human rights standards apply to all stakeholders in the delivery of healthcare including the patients, care providers and the society in general.\textsuperscript{304} This could be a complex issue especially when the healthcare provider is confronted with the choice of preservation of self and the wider society as against the interests of the patient. This is the kind of dilemma which a physician is faced with when attending to a patient with a highly virulent and infectious disease such as Ebola. Although the physician is enjoined by the ethics of his profession to prefer the interests of the patient above self-interest, it should be noted that

\textsuperscript{302} Ebola Patients Abandoned, Health Team Down Tools- Health- Nairaland’ available at \url{http://www.nairaland.com/1862229/ebola-patients-abandoned-health-team} (accessed 9 September 2014); See also ‘Nigeria Hasn’t Given Priority To Ebola Treatment, Abandons Nano Silver Treatment’ available at \url{http://www.nursingworldnigeria.com/2014/08/nigeria-hasn-t-given-priority-to-e} (accessed 9 September 2014).

\textsuperscript{303} App. No. 27229/95 (ECtHR) (April 3, 200).

human rights are not absolute rights. There are rooms created by law and ethics for derogation from those rights in the interests of the wider society.

In the area of maintaining of confidentiality, for instance, a physician’s obligation to a patient’s confidentiality is not absolute. Situations do arise where the harm in maintaining confidentiality is greater that the harm brought about by divulging confidential information. The guiding question for the physician in such a dilemma is: will lack of this specific information about this patient put a specific identifiable person at a high risk of serious harm? The answer to this question which the physician provides subjectively guides his decision in a given situation.

Historically, the physician’s public interest role was in the control of serious crimes. Avory J alluded to this in 1914 as follows:

There are cases where the desire to preserve [the confidential relation which exists between a medical man and his patient] must be subordinated to the duty which is cast on every good citizen to assist in the investigation of serious crime.

The modern medical practice has, however, recognised that it is generally ethically justified to disclose a diagnosis to the public health authorities if the risk to the public has the following features: the risk is high in probability; the risk is serious in magnitude; and the risk relates to an identifiable individual or group.

Ethical issues apart, there are various statutory instruments that limit the human rights of the patient in preference for the protection of the public. Article 9(1) of the ICCPR, for instance, provides that: “Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law”. Similarly article 6 of African Charter provides that: “Every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law.” The law generally recognised that liberty of a person could be

---

306 Odunsi & Nwafor (note 271 supra) 258.
restricted where a crime has been committed. In the area of healthcare, the restriction of liberty of the patient could take the form of quarantine in order to prevent the spread of an infectious disease such as EVD. Such a restriction is justified if it complies with the protocol laid down under international human rights law.

International human rights law, as observed by Human Rights Watch, has set down a benchmark that states should observe for the quarantining of persons in times of public health emergency as follows:

Restrictions on human rights in the name of public health or public emergency meet requirements of legality, evidence-based necessity, and proportionality. Restrictions such as quarantine or isolation of symptomatic individuals must, at a minimum, be provided for and carried out in accordance with the law. They must be strictly necessary to achieve a legitimate objective, the least intrusive and restrictive available to reach the objective (sic), based on scientific evidence, neither arbitrary nor discriminatory in application, of limited duration, respectful of human dignity, and subject to review. When quarantines are imposed, governments have absolute obligation to ensure access to food, water, and healthcare.309

The quarantine imposed on the victims of EVD and others by the respective governments in the affected countries did not comply with the international protocol as set down above. Victims were reported to have been confined in their homes and healthcare centres with little or no existing health facilities.310 Such confinement where it fails to satisfy the basic international protocol, though could be seen as protecting the societal interests, constitutes an infringement of the individual’s right to healthcare.

At the national level, the constitutions of Nigeria, Sierra Leone, Guinea and Liberia respectively, recognise limitations to the human rights provisions. Section 45(1) of the Nigerian Constitution is highly encompassing in that regard. It provides as follows:

Nothing in sections 37, 38, 39, 40 and 41 of this Constitution shall invalidate any law that is reasonably justifiable in a democratic society
(a) in the interest of defence, public safety, public order, public morality or public health; or
(b) for the purpose of protecting the rights and freedom of other persons.311

311 See also s 15 of the Sierra Leonean Constitution, Arts 24 and 11 of the Guinean and Liberian Constitutions respectively.
The courts have given judicial support to these constitutional provisions which are aimed at the protection of the overriding interests of the society. In *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*\(^{312}\) Ayoola JSC, while recognising a patient’s autonomy founded on the constitutionally guaranteed right to liberty, privacy and freedom of thought, conscience and religion, held that those can be eroded:

> [w]here they impinge on the right of others or where they put the welfare of the society or public health in jeopardy. The sum total of the rights of privacy and of freedom of thought, conscience and religion which an individual has… is that an individual should be left alone to choose a course for his life, unless a clear and compelling overriding state interest justifies the contrary.

In *Soobramony v Minister of Health, KwaZulu-Natal*\(^{313}\) the South African Constitutional Court alluded to the need to spread scarce state resources to benefit the majority of those in need and not just an individual or a few individuals in the enforcement of socio-economic rights. This again reflects the balancing of public interest with that of the individual.

There is nothing wrong with that as the individual also needs a safe community to survive. It must however always be borne in mind that human rights are individual rights as given by law, any derogation from such rights in preference for public interests should as such adhere strictly with the specified protocol contained in the enabling law to accord it legitimacy.

### 3.11 Chapter Conclusion

The healthcare providers have legal and ethical duties to address a patient’s needs that fall within the healthcare provider’s scope of practice. Refusing to do so is not consistent with the ethical principle of beneficence. During the recent Ebola outbreak in the West African nations, healthcare providers were reported to have shown some reluctance, if not outrightly refusing, to treat infected patients. In Nigeria, the doctors were reported to have gone on strike based on unresolved issues with the government. Even as Ebola reached Nigeria, the doctors refused to suspend the strike and resume their duties. Technically, these doctors were refusing to treat all patients, not just Ebola patients. This poses the ethical question; whether the doctors could rightly have gone on strike during the outbreak of a deadly disease such as Ebola. Some nurses in Liberia and Sierra Leone were reported to have refused to work at their clinics or hospitals.

\(^{312\text{[}}}^{312}\text{[2001] 7 NWLR (pt 711) 206 SC at 244.}\)

\(^{313}\text{[}}}^{313}\text{1998 (1) SA 765 (CC).}\)
They alleged that there were insufficient amounts of needed supplies (masks, boots, gloves, hand sanitizer) available and that isolation protocols for infected patients were not being followed. They were afraid of contracting Ebola and would not return to work.

Although the healthcare providers need to stay alive in order to attend to the needs of the patient, there seems to be so much emphasis on self-preservation and welfare of the healthcare providers in the affected countries than the interests of the patients. This is contrary to the medical ethics espoused by the Hippocrates Oath.

The preservation of the patients' interests and protection of their rights are however not absolute demands on the healthcare providers and the state. There is always the issue of overriding public interests which could justify the curtailment of such rights. Both international and national instruments that provide for the rights of the patient also permit such derogation for the protection of public interests. It is however important that necessary protocols be followed where the patients' rights are curtailed. For instance, the disclosure of the patient's confidential information by the healthcare provider must be discreetly done and only in situations where there is an identifiable person who is at risk of being infected and the patient has declined to make such disclosure or grant consent to the healthcare provider to disclose. The state should ensure that those in quarantine are fully informed of the reason for placing restrictions on their movement. They should be provided with adequate medical facilities and other amenities to keep them in good health. A blanket lock down of the entire community without food or water and medical facilities, simply on suspicion of the spread of EVD as reported in some of the affected countries cannot be justified under the existing instruments.

The next chapter discusses specific issues of infringement of the rights of the victims of the EVD as collected from reported evidence in the four West African nations under focus.
CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter discusses specific issues of infringement of the rights of the victims of the EVD as collected from reported evidence in the four West African nations under focus. The data collected is presented and legally analysed to ascertain the extent to which the right to healthcare of the persons infected with EVD are protected or otherwise violated in the countries under focus. Attempt is made, as far as possible, to categorise the reported incidents under recognisable legal concepts as would make the analysis more appreciable from the human rights perspective which is the concern of this work. It must be noted right from the start that the reported incidents are not and cannot be exhaustive in this work, but a number of such reports which are collected mostly from secondary sources are analysed. The reliance on secondary sources, as earlier explained in the first chapter, is dictated by the obvious difficulty, if not impossibility, of gaining access to the primary sources and individuals in the four different countries on which this study is based. The virulent nature of the disease is also an important constraint in assessing the primary sources considering that the researcher is not equipped with any protective measures as would guarantee the health of the researcher in the course of undertaking such inquiries. More importantly is the fact that the focus of the work is purely human rights based and compliance or otherwise could be ascertained and analysed from anecdotal evidence and other credible sources of information such as the reports from various international human rights organisations, national and international non-governmental organisations, and reports from national and international media houses.

In categorising the reports under the various legal themes for the purpose of the human rights based analysis, human rights concepts such as discrimination, stigmatization, privacy, dignity, quarantine and issues of healthcare bear the same meaning as earlier defined in the preceding chapters of this work. For the purposes of clarity, however, the presentation of data and analysis that follows in the individual countries under focus will be preceded by highlighting the essential
elements in each of the legal themes under which the discussions are undertaking. Perhaps, it would be appropriate to state at the onset that the data collected are not evenly spread in all the themes. The issues of discrimination and stigmatization seem to be overwhelmingly identifiable in all the countries under discussion when compared to the available anecdotal evidence under the other themes. This could be explained as arising from the fact that issues of discrimination and stigmatization are witnessed in every facet of human endeavour, including social and occupational relationships, unlike the issues discussed under the other themes which are more case specific.

4.2 Theme One: Discrimination and Stigmatization

The UN Committee on Economic, Social and Cultural Rights defines discrimination as any “distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of covenant rights”.314 A person is discriminated against when he is treated differently from others and in a manner that undermines his humanness. Discrimination is often associated with stigma. The quest by law to prevent discrimination is necessitated by the stigma attached to people who are given inhuman or degrading treatment. Stigma is a powerful and discrediting social label that radically changes the way individuals view themselves and are viewed as persons.315 People who are stigmatized are usually treated as outcasts or shameful for some reasons and as a result are shunned, avoided, discredited, rejected, restrained or penalized. The social hardship suffered by people who are stigmatized is one of the reasons for the provision of the right to non-discrimination. The reported accounts of the victims of Ebola which border on issues of discrimination and stigmatization in the West African nations under discussion are overwhelming. This is understandable as issues of discrimination and stigmatization are observed in the homes, community, place of work and the society at large, and are very often associated with the level of ignorance and beliefs as would be exposed by the narratives that follow.

4.2.1 Nigeria

In Nigeria reports show that the Ebola victims, their families and those who have come in contact with the infected persons are virtually treated as outcasts with no one showing any inclination to having dealings or contacts with them. It does not seem to be of relevance that the victims have been cured of the infection or dead, as the families and relatives of those persons are not spared from the stigma associated with that infection.

Reports have shown that the members of the family of a late nurse, Obi Justina Ejelonu, who died from the Ebola virus disease (EVD) on August 14, 2014, have had to battle with discrimination and stigmatization since her death. In a report by Sahara Reporters, a Nigerian based media house, Ms Onyinye Lovelyn Anugwolu, an elder sister to late Justina, who works for a Women’s Non-Governmental Organization (NGO) at Enugu in the South Eastern part of Nigeria, narrated the experience of the family since the death of Justina where she stated that her (Onyinye’s) husband, parents and sisters are facing public humiliation and incredible pressure. She explained that people have started treating them as if all of them were EVD carriers. Onyinye said that her husband had been sent away from work and is currently on a compulsory leave, as his colleagues and superiors fear he might have contacted the EVD himself. All these were happening in spite of the fact that Onyinye and her immediate family did not have any personal contact with their late sister as shown in the following passage where she said:

I haven’t seen her [Justina] since October last year. We have not been in touch with each other…Obi Justina Ejelonu spent her last days in Lagos, not in Enugu.317

Onyinye further lamented that her family was not allowed to participate or even witness the burial of her late sister due to the fear of the spread of the virus. However, Onyinye was consoled by the fact, as she believed, that her sister’s experience could bring relief to the members of the society as in her words:–

Wherever my sister is, her soul will be at peace for bringing her plight to illuminate and force the government to act against Ebola.318

317 Ibid.
318 Ibid.
In another report by UNICEF published on the 30 September 2014, Martins, whose mother, a nurse, who treated an Ebola victim, was diagnosed with the disease, recounted the experience of the family. He stated that after his mother was taken to hospital with symptoms of Ebola, he and his brother were medically monitored for 21 days, the maximum incubation period of the Ebola virus. They were not infected, but Martins said that the situation had a profound impact on their lives. They were virtually living in the hotel outside their home due to the fear of stigmatization. According to him:

"We couldn't go back to the house. People knew what happened over there. We knew they would start stigmatizing us. Friends stayed away. People complained [we] had gone to church "to spread the disease...It was really horrible, hearing something like that. Can you imagine that?"

When Martins' mother eventually died of the Ebola disease and was cremated, Martins said the family had wanted to bury the ashes in their village but the village leaders would not allow even the sterile ashes to enter their community. Martins' brother, Princewell was quoted in the report as saying:

"The way they [leaders] respond is, 'Keep it there, don't take that in here, don't come and bury it here.'"

This shows that even the innocuous ashes of the dead victim could become a potent instrument of stigmatisation.

Another report from the Globe and Mail captures the experience of Mr Dennis Akagha, 32, who was working as a marketer with an oil and gas company when he contracted Ebola while caring for his sick fiancée, Justina Ejelonu, a nurse with First Consultant Hospital Lagos. This was the hospital where the first Ebola incident was recorded in Nigeria when late Patrick Sawyer, the Liberian-American diplomat, who brought this disease to Nigeria, was admitted to the hospital.

---

320 Ibid
Akagha, who visited his late fiancée at the Ebola Isolation Ward in Lagos several times before she died, was infected with the virus. He survived after five days of treatment. Recounting the pains of the stigma he faced, he said:

I couldn’t buy food outside, because people were not willing to sell to me. I had to walk five kilometres just to find food to buy and then come back home to eat and sleep. I couldn’t have a haircut, some people didn’t and still do not want to shake my hands.\(^\text{322}\)

Akagha also lost his job as a marketer in the oil and gas company. According to him:

I lost the job as a result of being infected with EVD. That was where the stigmatization started.\(^\text{323}\) A lot of persons were staying away from me – my friends, my neighbours – they were running away from me. In fact, some were suggesting to the landlady to evict me out of the house.\(^\text{324}\)

Another reported account from a healthcare provider who was a survivor of the Ebola virus further highlights the plight of the Ebola victims and suspected carriers of the disease in Nigeria. Kelechi Enemuo is a medical practitioner who lost her husband to Ebola. She stated that ever since her discharge from the isolation ward, where she was quarantined for 10 days, life had not remained the same. Narrating her emotion-laden experience at the isolation ward in Lagos, Nigeria, Enemuo said she fought to stay alive:

For the first 12 hours I spent at the hospital, I was on my own. It was a long night. Then it was confirmed that I also had Ebola because of the contact I had with my husband.

I knew that only God could save me and that I had to build my faith. I had to stay positive. I had a baby I had to go back to. She was just three weeks old when I left for the Ebola ward. I knew I had to come back. She had just lost her father and she couldn’t afford to lose her mother. I stayed focused. I had to stay alive.

I was all alone for the most of the time. I did all they asked me to do, observed everything, and I prayed all the time and believed that I would come out of it alive. I never thought of giving up. I used to practise how I would walk through the exit of the ward when I would be told that I was Ebola-free. Thankfully, I was declared free of Ebola after 10 days in the isolation ward.\(^\text{325}\)

Unknown to her, her exit from the Ebola isolation ward was only the entrance into a world of stigmatisation and uncertainties. She has had to face public ridicule simply by being married to Enemuo, another medical practitioner, who after his death, was publicly criticized for treating a

\(^{322}\) Ibid.


\(^{325}\) Ibid.
patient, Olubukun Koye, who allegedly escaped surveillance in Lagos. She defended the actions of her late husband as follows:

We didn’t know Koye had Ebola. My husband had never met Koye before he came to Port Harcourt. But, both of them had a mutual friend. I wasn’t too happy when I learnt that Koye was being attended to in a hotel. My husband explained that there was no bed space in his clinic and that Koye was being treated for malaria. I didn’t think twice about it because he also made house calls. He didn’t know Koye had Ebola.

Apart from being criticized for being married to the doctor that treated an Ebola patient, the Dr Enemuo has also been accused of killing her husband by her in-laws and some members of the public and is as such stigmatised and discriminated against. She said:

I’ve been facing accusations. I was accused of killing my husband. I’m a private person; I’m not one to start discussing my issues on the pages of a national newspaper. I have nothing to hide. My husband died of Ebola but people are saying I killed him. I am not guilty of anything. The only thing I’m guilty of is marrying their brother and son. I know I’m still being talked about everywhere, especially in Port Harcourt. But I am coping. I take one day at a time.

Chinyere Enemuo, a sister to the late Dr Enemuo, and a graduate of geology and mining from the University of Jos, said though Ebola killed her brother, she still carries the burden. After being declared Ebola-free at the quarantine centre, a promising job opportunity which she was actively pursuing suddenly slipped from her grips as the prospective employers have refused to employ her. She said:

When I go to submit my curriculum vitae and employers see my surname, they ask if I am related to Enemuo. Once I say yes, that’s the end. I have gone to more than 10 places searching for a job. Sadly, there is no job for me because of the Ebola issue. I left my job as a secretary because I didn’t want one of my uncles who worked at the place to be stigmatized.

Chinyere also noted that her family members had not been spared similar treatment.

It has affected my late brother’s hospital business, his family and our personal lives. Stigmatization has destroyed the family; some of our relations were suspended from work because of it. One of our cousins, a teacher, was suspended from work and was never recalled.

Due to the stigma, Chinyere said her marriage plans almost got truncated.

---

327 Ibid.
328 Ibid.
My late brother was the first of eight children. Following his death, the landlord and some tenants warned us not to come to visit our parents. It almost consumed my wedding plans. I wouldn’t have blamed my husband if he had decided to call it off, as there was pressure on him to do so because everybody was running away from me. My husband has had enough difficulties and stigmatization because of me.\textsuperscript{329}

The healthcare facilities where the Ebola victims are admitted and treated are not spared the public odium and stigma associated with the disease. The Samstel Clinic and Maternity, a health facility established by the late Dr Ikechukwu Enemuo, is now reported to be a shadow of its old self. The hospital, which occupies a two-story building in Rumuokoro, River State of Nigeria, was one of the most patronized around the area until Enemuo’s death from the Ebola disease. Reports show that the clinic has been deserted by patients. Only 14 of its 53 workers are left. The 25-bed hospital with its empty wards and scant equipment looked desolate.\textsuperscript{330}

The workers at the hospital also recounted their experience. They stated that they are still being stigmatized despite the fact that the hospital was decontaminated and declared free of Ebola. Mr. Emmanuel Abiola, who said he had been the operations manager of the hospital for about five years, lamented its dwindling finances.

> The stigma has reduced our patients drastically. Everywhere used to be bustling with patients, but now, the number has reduced significantly. We used to make millions of naira in a month, now it’s less than N100,000. “Our salaries have not been paid for three months. We are working because we don’t want his legacy to die. Enemuo was a vibrant person who impacted people. We haven’t had any form of compensation. The government should come to our aid.” \textsuperscript{331}

Amara, a nurse who worked at Good Heart Medical Consultants, the hospital where Dr. Ikechukwu Enemuo was diagnosed of Ebola, told Sunday Punch that her roommate moved out of the apartment they shared.\textsuperscript{332}

> I have had to deny that I work at the hospital because the stigmatization was unbearable. My roommate started acting funny when she heard that one of the patients in the hospital had Ebola. She stayed away from me and I had to find somewhere else to stay for a while.

Amara’s roommate suffered a worse fate. Amara said, hiding her tears:

\textsuperscript{329} Ibid.
\textsuperscript{330} Ibid.
\textsuperscript{331} Ibid.
\textsuperscript{332} Ibid.

Even though I left the house for her, she also had a bitter dose of stigmatization. When the information got to her office that she was staying with me, she was immediately sacked. I felt very bad and angry at the same time. I blamed myself for my friend’s predicament. Amara’s colleagues at Good Heart did not fare much better. Wisdom Okwu, a medical doctor, who also attended to the late Enemuo, said, “Those who knew where I worked, including my neighbors, asked me to stay away.”

According to the Sunday Punch Newspaper:

When our correspondent asked a taxi driver to stop in front of Good Heart Medical Consultants, at GRA, a high brow area in Port Harcourt, the driver and other passengers looked at him quizzically. “Is this where you want to alight?” the driver asked.

Dr Eze Nwuafor, a cardiologist at the hospital, said:

When you mention Good Heart, many behave as if that name alone can infect someone with Ebola. You find taxi drivers sometimes asking passengers coming here if they are going to ‘that Ebola hospital.’

Dr Nwuafor stated that many of the over 300 registered patients at the hospital had gone. “Over 70 per cent of our regular patients have not come back because of Ebola.” He said:

These negative stories are being propagated by health workers, nurses and doctors, who for their own reasons would rather want this hospital to go under. At a point, it got so bad that when cheques were presented in the bank, some bank workers were scared of touching them. In fact, some banks had to tell their staff who had been to Good Heart in the last three months to stay away. It was that disturbing.

The Nigerian government has expressed concern over issues of discrimination and stigmatization associated with Ebola. The Lagos State Commissioner of Health, Dr Jide Idris, was reported to have cautioned against these negative societal attitudes towards the victims of Ebola where he said:

The social problem being faced by discharged cases has been reported to the government. These range from stigmatization, eviction from their accommodation, being asked to stay away from work and termination of employment. We have had cases of employers just terminating the employment of their workers who were just mere contacts, not even suspected cases. We believe this is unfair and we feel this impedes on their fundamental human rights. Now, the Ministry of Justice will take the matter up. Anybody, whether a discharged patient or a contact followed up, who feels stigmatized, can petition the Ministry of Justice and the Attorney General of Lagos State and the government will take that matter up on their behalf. Stigmatization will reverse the gains so far made in the containment and management of this outbreak. People who come down with Ebola may not come out and this may jeopardize not

333 Ibid.
334 Ibid.
335 Ibid.
336 Ibid.
only their lives, but their family members and other people they come in contact with. That’s why it is essential that people should stop that.\(^{337}\)

The concern expressed by government commissioner serves as a confirmation of the reports presented on the accounts of the victims and their relatives on the societal attitude towards them. The disturbing part is that this trend still exists even after Nigeria has been declared Ebola free by the World Health Organization. It is submitted that public enlightenment is urgently needed and appropriate punishment should be meted out to those involved in this flagrant infringement of the human rights of the victims of Ebola.

4.2.2 Liberia

Reports from Liberia show that Ebola victims and their families are being discriminated against and stigmatized even after they have survived the scourge as is the case with their counterparts in Nigeria. While some people are welcomed back into their communities after they have recovered, many are shunned due to fear of contagion.\(^{338}\) Owners of houses would not grant them accommodation, and employers would not hire them. Taxi drivers who are aware of the Ebola status would not give them a lift, and even commercial barbers refused to cut their hair without gloves.\(^{339}\) Although these could be seen as good precautionary measures, it is submitted that persons who have survived the virus infection deserve to be reintegrated into the society and be treated in the same manner as every other member of the community.

A recent study by the World Health Organization where 62 survivors from the city of Monrovia were interviewed about their post-recovery experiences, 80% of them said they now struggle with stigma and discrimination.\(^{340}\) One of the victims, Ms Vivian Rogers, 40, who lost seven relatives to the epidemic before contracting the infection but survived, lamented her plight in a reported interview after she was relieved from her duty post by her employer. She said:


\[^{340}\] Ibid
I feel that I have been ostracized. I am so sad because I am used to working. They are paying me, but I am not working and not being useful... I don't know whether they are afraid of me. But I know I am no threat.\footnote{Ibid.}

In another report by the Voice of America on the plight of the Ebola victims in Liberia, Joseph Taylor, a 48 years old man, who was suspected of being infected with the Ebola virus after the death of his wife from the disease, stated that:

People wanted to stone me, but I said I will fight this and I will make it. So today, I am happy that I am among you again. You can be around me. You are my friends. I forgive everybody.\footnote{Ibid.}

It was reported that Melvin Korkor thought the hardest fight had already been won after he survived the infection. Weeks after contracting Ebola, most likely from a sick patient, Korkor, a Liberian doctor, was able to walk out of a treatment centre in Lofa with a clean bill of health, according to the Voice of America report.\footnote{They survived Ebola. Now they are shunned available at http://www.washingtonpost.com/news/to-your-health/wp/2014/08/13/they-survived-ebola-now-they-are-shunned/ (accessed 12 May 2015).} But since leaving the hospital, Korkor has been fighting another difficult battle: Overcoming Ebola survivor stigma which he told a Liberian radio station "is worse than the fever."\footnote{Ibid.} As Korkor walked around the campus of Cuttington University recently, passers-by avoided him and students and friends avoided hugs and handshakes. "I am happy Dr Korkor has returned but I am totally not convinced he is Ebola free," one student was quoted as saying. "I will shake his hands after 21 days" said another student. "I will greet him from a distance" said yet another.\footnote{Ibid.}

Hellen Morris is an Ebola survivor. She lost her husband and seven of her family members, including her parents, to Ebola in August 2014. She narrates to the Doctors Without Borders the challenges of trying to live after battling the disease.

My life is torn apart. I lost my husband and I have no one to console me. Everyone around me is afraid of me, even though I have beaten Ebola. It's a difficult life to live when friends and family neglect you because of an illness you did not purchase. I've been evicted from the family house where my husband and I lived before his death. With no home or sustainable

source of income, I struggle to care for my children alone. Now, I am staying with a friend until I raise some money to rent an apartment where my children and I can move in.\textsuperscript{346}

Liberia’s Chief Medical Officer, Dr Bernice Dahn, was quoted in the same report where she acknowledged the fate of Mr Taylor and many others who are discriminated against by the community. She offered words of assurance that Ebola survivors do not constitute any health risk to the community. She said:

What happened to him [Mr. Taylor] has happened to many others, in other communities. Today we all know that people who come in contact with infected people can actually be safe. They can live in the community again and go about their normal duty.\textsuperscript{347}

In spite of the assurances from the Chief Medical Officer, various members of the community where the victims live are still unwilling to associate with those known survivors of the disease. Mariam Camara, a market woman, demonstrates this cold attitude of the community towards the victims of Ebola where she said:

At first they told us it was not a curable disease. Then, after some time, we also learned that there are people who are cured of it. But me personally, when there are people that are cured, I am still scared. It truly frightens me. A sickness that kills people indiscriminately, without a cure - that is not reassuring in my opinion. So I am frightened.\textsuperscript{348}

The researcher submits that the above reported accounts are reflections of fear borne out of ignorance or lack of information. Unfortunately the survivors of the Ebola virus have been made to bear the brunt which manifests mostly in the forms of stigmatization and discrimination. The government bears the obligation to ensure that the members of the public are adequately informed of the status of the victims who have survived this infection.

4.2.3 Guinea

In Guinea the fear and stigma related to the disease are becoming increasingly visible. Many residents are limiting their movements, refusing to venture too far from their homes. “This is a common reaction,” says Amanda McClelland, emergency health officer with the International

\textsuperscript{346} My Life is Torn Apart”: Living in the Aftermath of Ebola available at \url{http://www.doctorswithoutborders.org/article/%E2%80%9Cmy-life-torn-apart%E2%80%9D-living-aftermath-ebola} (assessed 14 May 2014).


Federation of Red Cross and Red Crescent Societies (IFRC). Dr Facely Diawara, head of the health department at the Red Cross Society of Guinea affirmed the statement of McClelland as follows:

People have never experienced anything like this before, in Guinea as well as in West Africa. The fact that Ebola is a new disease in this region which is highly infectious and contagious, also contributes to the fear and stigma attached to it.

Ebola victims and their families are being stigmatized, though they are now declared completely free of the disease, people are afraid to come near them or to have anything to do with them. A Guinean doctor who recounted his experience to the Associated Press would not disclose his identity because of the fear of stigmatization. He was reported as follows:

Thanks be to God, I am cured. But now I have a new disease: the stigmatization that I am a victim of. This disease (the stigma) is worse than the fever. Now, everywhere in my neighbourhood, all the looks bore into me like I’m the plague.

Another victim of stigmatization in Guinea is Kadiatou Fanta. It was reported that when Kadiatou Fanta tried to return to her life in Guinea months after recovering from the virus, she found it to be vastly different from her pre-Ebola existence. Her boyfriend no longer took her calls, according to the Associated Press. The professors at the medical school where she studied refused to have her in class.

I still haven't taken my exams while my classmates have moved on to the next level. [Fanta told the AP]. The professors said they were going to grade me by telephone.

The Associated Press reported that Fanta eats alone and sleeps alone. Even her own family members are afraid to touch her.

Ebola has ruined my life even though I am cured, [Fanta said]. No one wants to spend a minute in my company for fear of being contaminated.

It was reported that Fanta Oulen Camara, a 24 year old school teacher, spent two weeks in hospital fighting for her life against Ebola virus but her darkest days came after she was cured of the disease and returned to her home in Guinea. According to her:

350 Ibid.
352 Ibid.
Most of my friends stopped visiting. They didn't speak to me. They avoided me. I wasn't allowed to teach anymore.

Dr Oulare Bakary, was infected while treating patients in March 2014. In his reported account:

Everyone has been facing stigma and rejection. We needed to send a message to the people about the epidemic and also the possibility to be cured. It's not only the survivors of Ebola, it's their friends and families who are the collateral damage.\(^{354}\)

The interview with Saa Sabas, an Ebola survivor who now volunteers for the Red Cross Society of Guinea, was conducted for CNN by Moustapha Diallo from the International Federation of Red Cross and Red Crescent Societies.\(^{355}\) After he survived but before being sent home, Sabas was tested for the disease on three occasions and was issued a certificate of survival. The certificate was proof that he was safe and could return to his normal life without risk of infecting his community. Saba recounted his experience to the reporter as follows:

They also visited my family, the leaders and elders of my community to inform them that I had recovered and I was no longer contagious. Despite this, I was stigmatized. When I went back to school, some of my friends avoided me, but it's getting better.\(^{356}\)

It was reported by Reuters that Jamila, 24, got a cold reception when she returned home after 12 days in isolation ward battling the Ebola virus in her hometown of Conakry, Guinea’s capital.\(^{357}\) Though she survived, Jamila was fired from her job as a philosophy teacher because her school feared she would infect her students. She spoke on condition that her surname should not be published to hide her full identity because of fear of further stigmatisation.

People looked at me like I’d come back from the dead, like I was a zombie,[said Jamila, who now does part-time work for Medecins Sans Frontieres, the Geneva-based medical charity].Nobody except my relatives wanted anything to do with me anymore.\(^{358}\)

The families of those who died from Ebola face similar problems. Aziz Soumah, a 30 year old engineer, who lives in a suburb of the Guinean capital, said his family was forced to move after his brother died from Ebola infection. This is his reported account:\(^{359}\)


\(^{354}\) Ibid.


\(^{356}\) Ibid.


\(^{358}\) Ibid.
I went to pray at the mosque. As soon as I entered, all the worshippers left the mosque. I was alone. No one around me.

These accounts again reflect the need for public enlightenment on the status of the survivors and relatives of the Ebola disease. A recent report by the US Centre for Disease Control suggests that it is only through sexual intercourse that the survivors of the EVD could transmit the disease in about six months after they have been cured. Mere body contacts with such survivors do not impose any risk to the third party.360

4.2.4 Sierra Leone

In Sierra Leone, Ebola survivors and their families are not spared the odium which their counterparts in the other West African nations are subjected to. Even when the victims have fully recovered, people are still afraid to come near them or to have anything to do with them. Sulaiman Kemokai, 20, was released from an Ebola treatment center after spending 25 days there. He lamented that in spite of his recovery, some members of his community are still reluctant to have any physical contact with him.361

Senessieh Momoh, a driver taking part in a conference organized by state authorities, the UNICEF and the US Centers for Disease Control, and representing thirty-five former Ebola patients in Sierra Leone’s eastern city of Kenema, stated as follows:

We survivors are being treated as lepers to be shunned by the community in which we have grown up. People who had been our friends and whom we had shared palm wine with no longer wanted to be with us. Even when I showed the community elders my Ebola-free certificate, they just shook their heads. I am happy that the conference is taking place as it will help to change people’s thinking about us.362

A recent UNICEF survey of 1,400 households across Sierra Leone found that Ebola survivors suffered high levels of stigma and discrimination.363 James Gebbeh, a farmer in Sierra Leone

---


363 Ibid.
who survived the diseases after being confined at the treatment center for two months, said that:

When I returned to the community, I was rejected by people I had known for far too long. I am no longer allowed to fetch water from the well and I solely depend on food from charitable agencies.364

Douda Fullah watched five members of his family die in an Ebola ward. The first was his father who was a lab technician, followed by his stepmother, his grandmother, a two-year-old brother and a 13-year-old sister. According to him, the harsh irony of being an Ebola survivor is that, instead of being treated as a victim who needs support at the time of familial devastation, he has been shunned by neighbours and parents' friends who believe that he still carries the virus. In his words as reported by the Guardian:

Friends of mum and dad, I don’t remember any of them coming to my house since Ebola. They don’t come very close to me … neighbours stand 10ft away … it’s really, really stigmatizing. Just imagine … you have lost your relatives, especially your parents, and they don’t come near you. They are still afraid.365

4.3 Legal Analysis

The writer now proceeds to analyse the human rights implications of the experience of Ebola victims in the four West African nations on the theme under discussion. It is submitted that treating people differently in the community on account of their health conditions amounts to discrimination. Though persons are not compelled by law to interact with others, the exclusion of a person from the benefits or privileges enjoyed by others on account of that person’s perceived health status amounts to discrimination. Such conduct whether by the government, community or individuals is not permissible under the law except when it is done for the protection of the larger societal interests. This does not seem to be the case from the reports of the victims as narrated above as the experience of Ebola victims with discrimination and stigmatization continues well after they have been given a clean bill of health. The social hardship suffered by people who are stigmatized is one of the reasons for the provision of the right to non-discrimination. It should be emphasised that acts of discrimination offend international and national human rights instruments.

364 Ibid.
For emphasis, reference is made once more to Article 26 of ICCPR which provides that “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”. In the same vein, Article 2(2) of the ICESCR provides that the States Parties to the Covenant undertake “to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”. Article 2 of the African Charter also provides that: “Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status”.

Although the above provisions emphasise mainly the state’s obligations towards the citizens, it is submitted that they can also be used to strengthen delictual actions against individuals for impairment of dignity. In *Le Roux and Others v Dey*366 Harms DP, in an action in delict, stated that:

The term ‘dignity’ covers a number of concepts… [including] the plaintiff’s sense of self-worth…the inborn right to the tranquil enjoyment of one’s peace of mind; and the valued and serene condition in one’s social or individual life which has been violated when one is subjected to offensive and degrading treatment, or exposed to ill-will, ridicule, disesteem or contempt.

This decision confirms that discrimination and stigmatization, could, to the extent that they undermine a person’s self-esteem be actionable against an individual as a delictual wrong for impairment of dignity.

The phrase ‘or other status’ has been interpreted by the CESCR General Comment No 20 to include health status. “Health status refers to a person’s physical or mental health”.367 The CESCR enjoins states parties to ensure that a person’s actual or perceived health status is not

---

367 General Comment No. 20 para 33.
a barrier to realizing the rights under the Covenant.\textsuperscript{368} The Constitutions of Nigeria, Sierra Leone, Liberia and Guinea also embody provisions against discrimination.\textsuperscript{369} Thus, denying the victims of Ebola their basic rights and needs in the society amounts to a violation of their right against discrimination as protected by law. In \textit{Hoffmann v South African Airways},\textsuperscript{370} Ngcobo J of the South African Constitutional Court, while denouncing discrimination against persons living with HIV, said:

\begin{quote}
Society has responded to [the plight of those living with HIV] with intense prejudice. They have been subjected to systemic disadvantage and discrimination. They have been stigmatized and marginalised…. Society’s response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received… any discrimination against them can, to my mind, be interpreted as a fresh instance of stigmatisation and I consider this to be an assault on their dignity. The impact of discrimination on HIV positive people is devastating. It denies them the right to earn a living. For this reason, they enjoy special protection in our law.
\end{quote}

Although the medically established mode of transmission of HIV is not the same as Ebola, the Ebola patients should not be discriminated against, especially in the provision of healthcare, simply on account of their health condition. What is needed is the balancing of the interests of the patient with those of the wider society by taking into consideration the impact which the preservation of the patient’s right would have on the wider society. This was emphasized by the Indian court in \textit{MX of Bombay Indian Inhabitant v M/s ZY and another}\textsuperscript{371} as follows:

\begin{quote}
Taking into consideration the widespread and present threat of this disease in the world in general … the State cannot be permitted to condemn the victims …many of whom may be truly unfortunate, to certain … death. It is not in the general public interest and is impermissible under the Constitution. The interests of the [victims] … and the interests of the society will have to be balanced in such a case.
\end{quote}

In \textit{Hamel v Malaxos} \textsuperscript{372} it was held that a physician must not deny treatment to patients because their medical condition may put the physician at risk. If a patient poses a risk to the physician’s health or safety, the physician should take all available steps to minimise the risk

\begin{footnotes}
\begin{enumerate}
\item \textsuperscript{368} Ibid.
\item \textsuperscript{369} See ss 42 and 27 of the Nigerian and Sierra Leonean Constitutions respectively, as well as arts 18 and 8 of the Liberian and Guinean Constitutions respectively.
\item \textsuperscript{370} 2001 (1) SA 1 (CC) para 28. See also \textit{Allpass v Mooikloof Estates (Pty) Ltd t/a Mooikloof Equestrain Centre} 2011 (2) SA 638 (LC).
\item \textsuperscript{371} AIR 1997 (Bombay) 406 at 431.
\end{enumerate}
\end{footnotes}
before providing treatment or making other suitable alternative arrangement for providing treatment.

It is an accepted medical practice for doctors to refer patients to the hospitals where they could have access to more advanced medical facilities or to be treated by more skilled professionals rather than an outright rejection of such patients. Although the spread of the disease in Nigeria was mainly by the healthcare providers in the course of discharging their obligations to the patients, the records suggest that in most cases the contracting of the infection by the doctors and nurses were borne out of ignorance as they were not able to diagnose their patients’ Ebola status early enough to enable them to adopt the necessary precautionary measures. It is thus not just the risk but the ignorance or lack of skill of the healthcare providers that facilitated the spread of the disease. The risk factor should therefore not be an excuse for doctors to avoid their obligations to the patients.

Though there is always the need for the protection of the wider society as suggested by the above decisions, such as the wearing of protective gear by healthcare providers attending to the EVD patients, there is however no justification for abandoning Ebola victims or confining them in their homes or in designated healthcare centres without medical facilities. The harm which could arise from the acts of discrimination and stigmatization as shown by the decision in Hoffman’s case are real. Some of the victims may opt to conceal their Ebola status in order to avoid being stigmatized and discriminated against. This will obviously cause more harm to the wider society. The safer route is to administer appropriate treatment to the identified victims and provide them with a sense of belonging in the society. This will encourage others to disclose their status and which invariably guarantees protection for the wider society.

4.4 Theme Two: Dignity

Human dignity refers to one’s self-esteem, self-regard and self-respect. Dignity is concerned with how individuals feel, think and behave in relation to the worth or value of themselves and others. To treat persons with dignity is to treat them as being of worth, in a way that is respectful

of their diversity, as valued individuals.\textsuperscript{374} When a person’s dignity is interfered with, the person feels degraded, embarrassed and humiliated.\textsuperscript{375} On the contrary, when dignity is respected persons feel in control, valued, confident, comfortable and able to make decisions for themselves.\textsuperscript{376} In healthcare situations, dignity may be promoted or diminished by the physical environment; organisational culture; the attitudes and behaviour of healthcare providers and others and the way in which care activities are carried out. Healthcare providers are obliged to treat all patients in all settings and of any health status with dignity, and dignified care should continue after death.\textsuperscript{377} The presentation that follows reflects on the manner in which the victims of the EVD are treated by the healthcare providers and the society generally in the four West African nations in focus. The reported available evidence is not however as wide spread as is the case of stigmatization and discrimination earlier discussed. In most cases however, the issues of discrimination and stigmatization could also constitute an encroachment on a person’s right to dignity.

4.4.1 Nigeria

At the height of the Ebola outbreak in Nigeria, some victims were reportedly housed in a dilapidated and unhygienic building at the Ebola treatment centre (the Infectious Disease Hospital) in Yaba, Lagos. The Centre lacked basic medical facilities and there were very few medical personnel attending to them.\textsuperscript{378} Boyo-Ekwueme, a pathologist, who worked at the Centre lamented the plight of the victims in a reported interview as follows:\textsuperscript{379}

\begin{quote}
We are not fighting anybody. We are simply giving voice to the voiceless. Those people in isolation at the IDH cannot voice out these concerns. Let them have basic treatment. It shouldn’t be as if we just stood there and abandon them and watch them die one by one. They are human beings. That female doctor is a patriotic Nigerian and she needs to be helped. You people (journalists) should go there and see the surroundings where they are being treated. You would wonder if these are human beings who still have relatives. They are just being left on their own. Nobody is counselling them. They are just there as if
\end{quote}
they have been forgotten. We should remember that they didn't ask to contract Ebola and it can happen to anybody. We are appealing for international help for these health workers.

It is submitted that keeping or abandoning a patient in an environment as depicted by this report constitutes a gross infraction of the patient's right to dignity. The government that created the designated treatment centre bears the obligation to ensure that every patient brought to the centre receives appropriate medical attention.

4.4.2 Liberia

An Ebola victim in Liberia was shown by a media house as he was being conveyed in a wheelbarrow to the Ebola treatment centre at Island Hospital in Monrovia. Sick persons should ordinarily be moved in an ambulance or hospital stretchers and not wheelbarrows. Such practice undermines the value of the human person.

In Liberia some dead bodies of the victims of Ebola disease were left on the streets to be eaten by dogs in some of the communities. It was reported by the New Dawn, a local newspaper in Liberia, that the Liberian government buried bodies of those suspected to have died from Ebola in Johnsonville Township, outside of Monrovia in shallow graves. Dogs were reportedly seen pulling the bodies out of the graves and eating the remains. Alfred Wiah told the New Dawn that the attention of the government’s Health Ministry was drawn to these incidents but that the officials did not do anything about it. He was quoted as saying:

We are very disappointed in the Health Ministry, especially the government that took an oath to defend and protect us. To see them act in such manner is unacceptable and we’ll never allow the government to come to bury any longer. They will be resisted by us because I think the government has failed to protect us. Why bring Ebola bodies and not bury them well?

Other reports have shown that allowing dogs to feed on the carcasses of the deceased could contribute to the spreading of the Ebola virus disease. Stephen Korsman, a medical virologist at the University of Cape Town, was reported by News 24 as saying that dogs can be infected with

---

the Ebola virus but that the infection appears to be asymptomatic. This means, he said, that
dogs won’t get sick, but they still could carry a potential risk through licking or biting.382

Relatives of Ebola victims in Liberia were reported to be dragging the bodies of the dead out of
their homes and dumping them on the streets in a bid to avoid being quarantined.383 This
conduct followed a series of measures announced by the government aimed at containing the
spread of the disease, including shutting down schools, imposing quarantines on victim’s homes
and tracking their friends and relatives. Lewis Brown, Liberia’s Minister of Information captured
the fear of the local community that gave rise to such conduct where he said:

    locals had started dragging their loved ones’ bodies onto the streets out of fear that the new
government regulations would risk their own health. With less than half of those infected surviving
the disease, many Africans regard Ebola isolation wards as death traps.384

4.4.3 Sierra Leone

The health workers in Sierra Leone were reported to have dumped bodies of the victims of
Ebola on the streets outside the hospital while protesting the failure by the government of Sierra
Leone to pay bonuses for handling Ebola victims, as demanded by the healthcare providers.
Abdul Wahab Wan, the head of the district Ebola Response Team, stated that the bodies which
include those of two babies were abandoned in the eastern town of Kenema, three of them at a
hospital entrance to stop people from gaining access to the hospital.385 Sidi Yahya Tunis, the
spokesman for the National Ebola Response Centre acknowledged this conduct of the health
workers which he described as inhumane and completely unacceptable.386

4.4.4 Guinea

Guinea does not have many recorded cases of violations of human dignity of the Ebola victims.
This is not however suggesting that the victims were given better treatment in Guinea than in
the other West African nations as human casualty recorded in Guinea in the outbreak of the

382 Ibid.
383 Now Ebola victims are left to rot in the streets: Terrified relatives dump them outside for fear of catching deadly
(assessed 16 May 2015).
384 Ibid.
386 Ibid.
pandemic was quite enormous. The WHO reports suggest that as of 7th December 2014 the country had recorded about 2339 cases and 1454 deaths. The researcher, however, coming from English speaking background could not identify some of the reports which are mostly recorded in French, the locally spoken language in Guinea.

In one of such reports given in English language, an Ebola victim was said to have laid helplessly on the street of Canakry in Guinea’s capital for almost five hours without medical assistance while passers-by went about their daily routine due to fear of infection. According to Amidou Camara: “I called the police and when they came they said they were going to call the doctors but up till now nobody has come here.” It was not shown whether this victim was eventually given any medical attention. It is submitted that the humanness of a person abandoned on the street for whatever reason is demeaned. Such a person is deprived of self-worth on account of a disease which he has no control over. It is the obligation of the state to ensure that the human right of such a person is protected by being given appropriate medical attention.

4.5 Legal Analysis

The UN Universal Declaration of Human Rights recognizes that the inherent dignity and the equal and inalienable rights of all members of the human family are the foundations of freedom, justice and peace in the world. Article 1 of the Universal Declaration states that all human beings are born free and equal in dignity and in rights. The Universal Declaration links dignity with other fundamental rights. Article 22 provides that everyone, as a member of society, has the right to social security and is entitled to the realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

389 Ibid.
390 Universal Declaration of Human Rights, General Assembly Resolution 217A(111) 10th December 1948.
Various other international and national human rights instruments have followed the lead taken by the Universal Declaration in upholding the inextricable relationship between human rights and human dignity. The ICESCR states in its preamble that human rights derive from the inherent dignity of the human person. The ICCPR recognizes that all human rights derive from the inherent dignity of the human person. Article 10 of the ICCPR provides that all persons deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the human person. The African Charter contains provisions recognizing the right to dignity in article 5 which states that every individual shall have the right to the respect of the dignity inherent in a human being. All forms of exploitation and degradation of man, particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited. The constitutions of Nigeria, Serra Leone, Liberian and Guinea, respectively recognize the inherent dignity of the human persons. Section 34(1) of the Nigerian Constitution specifically provides that every individual is entitled to respect for the dignity of his person, and as such prohibits the subjecting of individuals to torture or to inhuman or degrading treatment.391 The Constitution of the Republic of Guinea seems more forceful in its pronouncement on the dignity of human person. Article 5 of that Constitution declares that “[t]he human person and their dignity are sacred. The State has the duty to respect them and to protect them.”392

Although the constitutions of Sierra Leone and Liberia respectively, do not expressly use the word ‘dignity’ in their provisions, the prohibitions of inhuman and degrading treatment as provided in those constitutions are obviously aimed at the protection of human dignity. In the South African human rights context, dignity has thus been aptly described as the grundnorm of the Constitution.393

The denial of healthcare to incarcerated persons even on account of commission for crime has been held by the courts to amount to torture, cruel and inhuman treatment which translates into an infringement of the right to dignity. This was the position unanimously adopted by the European Court in Hurtado v. Switzerland394 where the court held that the state’s failure to...

---

391 Similar provisions are contained in ss 19 and 20 of the Sierra Leonean Constitution of 1991, and article 12 of the Liberian Constitution.
392 See also article 6 of the Constitution which prohibits torture, inhuman and degrading treatment.
394 App. No.17549/90 (ECtHR) (January 28, 1994).

112
provide timeous medical treatment to the detained applicant was an act of inhuman and degrading treatment.

Such denial of medical care could also constitute an infringement of the right to healthcare of the incarcerated person and as such impinging on the person’s dignity when viewed from another perspective. In Festus Odafe & Others v Attorney General of the Federation and Others\(^{395}\) the applicants who were detainees at the Kirikiri maximum security prison in Lagos, contracted HIV while in detention and were denied the right to treatment by the prison officials.

In an action for the enforcement of their fundamental rights under the Nigerian Constitution and the African Charter, the court held that the denial of treatment to the four prisoners violated section 8 of the Nigerian Prison Act of 1972 and article 16 of the African Charter. Nwodo J of the Federal High Court of Nigeria Port Harcourt Division re-emphasised the obligation of the government in the enforcement of socio-economic rights, especially the right to health, under the African Charter as follows:

> The government of this country has incorporated the African Charter on Human and Peoples’ Rights Cap 10 as part of the law of the country. The Charter entrenched the socio-economic rights of a person. The Court is enjoined to ensure the observation of these rights. A dispute concerning socio-economic rights such as the right to medical attention requires the Court to evaluate state policy and give judgment consistent with the Constitution. I therefore appreciate the fact that the economic cost of embarking on medical provision is quite high. However, the statutes have to be complied with and the state has a responsibility to all the inmates in prison, regardless of the offence involved, as in the instant case where...the applicants...have been in custody for not less than two years suffering from an illness. They cannot help themselves even if they wanted to because they are detained and cannot consult their doctor. I therefore...order the authorities...[to] relocate the applicants after the precondition has been complied with, to a hospital in accordance with section 8 of the Prison Act.\(^{396}\)

Similar decisions have been reached by the African Regional Courts. The decision of the African Commission on Human and Peoples’ Rights in International Pen and Others (on behalf of Ken Saro Wiwa) v Nigeria\(^{397}\) lends credence to this assertion. In that case, Saro Wiwa, a writer and environmental rights activist, together with eight others, were sentenced to death for their social crusade activities in Ogoni land in the Niger Delta region of Nigeria. While in detention awaiting execution, Saro Wiwa’s health deteriorated to the point that he required medical attention. The Nigerian government denied him access to treatment in spite of the


\(^{396}\) Ibid paras 37-39.

prison doctor’s recommendations. The African Commission held that Saro Wiwa’s right to health under Article 16 of the African Charter was violated by the Nigerian government.

The researcher forcefully contends that patients have equal worth as every other human being irrespective of the nature of the disease which the patient is afflicted. They should be treated as persons able to feel, think and behave in relation to their own worth or value. Although Ebola, unlike HIV, is recognised as a highly infectious disease which is transmissible by mere body contact, victims brought to the government designated treatment centres are deemed to be in the custody of such government. Abandoning such victims in the designated treatment centres as reported in Nigeria undermine their dignity as human beings. It is the responsibility of the government to ensure that medical ambulances are made available to the public to deal with cases of healthcare emergencies. Conveying a victim of Ebola in a wheel barrow as was witnessed in Liberia, instead of medical ambulance or being dumped in a house without any medical attention as was the case in Sierra Leone at the initial outbreak of the EVD, are all acts of infringement on the victims’ right to dignity. Even the dead should be buried with dignity. It is not dignifying to dump bodies of Ebola victims on the streets and allow dogs to feed on them as was reported in Liberia.

4.6 Theme Three: Privacy and Confidentiality

Privacy may broadly be defined as freedom from unauthorised intrusion and includes the right to control information about oneself. The importance of the right to privacy has made it a recurring provision in various international human rights instruments and constitutions of different countries. In the realm of medical law and ethics, the right to privacy translates to medical confidentiality. Confidentiality is one of the core tenets of medical practice. In the daily exercise of his functions the physician receives private communications from the patient which the physician is bound to keep secret and in confidence. The relationship of a physician with a patient is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above their own self-interest and above obligations to other groups, and to advocate for their patients’ welfare. It is the type of relationship described as fiduciary.

398 JHF Shattuck, Rights of Privacy (USA, National Textbook Co 1977) 13.
399 Odunsi & Nwafor (note 306 supra) 251.
400 See Odunsi & Nwafor (note 399 supra) p 253.
401 SB Odunsi and AO Nwafor (note 400)pp253-254
West African nations in focus do not show any respect for the privacy of the victims of Ebola by their handlers.

### 4.6.1 Nigeria

It was reported that at Murtala Muhammed International Airport in Lagos passengers were openly screened to determine whether their body temperature was abnormal. Those who manifested symptoms of the disease were separated from others in the public glare.\(^{402}\) This practice of screening passengers at the airport was explained by Yakubu Datti, general manager of corporate communications, Federal Airports Authority of Nigeria, as follows:

> What we do is, the airlines must first, at the point of departure, ensure that they do not board passengers with the ailment. And on arrival here, even before the arrival, we have the manifest of the passengers that are coming, and they have forms to fill as they arrive. We have a medical team from the ministry of health under the port services that inspects their medical history and also have some equipment where they check without having personal contact. And all that is done on arrival even before the immigration. And if there is any suspicious passenger, the passenger goes to this holding area, which we have provided for further investigation, or interrogation. After which, if it is established that he’s a carrier, we have a quarantine area where the patient will be quarantined for necessary action.\(^{403}\)

Although this is obviously a commendable effort on the part of the government to contain the spreading of the disease, it is submitted that this measure could have been more discreetly executed by providing tents at the airport where passengers would be directed to be privately tested and the result made known only to such passenger without unnecessary public exposure.

Further reports showed that the homes of suspected Ebola victims were invaded without notice by government officials who forcefully took away the suspected victims from their homes in manners that created scenes for public viewing. According to Dr Kelechi Enemuo, who lost her husband to Ebola and was taken away from her home on suspicion of having been infected with the disease:

> I was still mourning my husband when one morning, health workers came to my house. I had to leave with them because they needed to quarantine everyone that had contact with an


\(^{403}\) Ibid.
Ebola victim. Everyone on my street was outside watching the ambulance and the medical personnel dressed in their protective gear. They saw me enter the ambulance.\textsuperscript{404}

The consequences of such open arrest of the victims and suspected victims was not lost on the medical practitioner as she lamented that life has become more difficult for her since her release from the treatment center due to the attendant stigma and discrimination which she has had to live with ever since then.

4.6.2 Guinea

The same episode which occurred in Nigeria was recreated in Guinea. A report from the World Health Organisation shows that at Conakry International Airport passengers were screened to determine whether their body temperature was abnormal. Only passengers whose body temperatures were less than 38 degrees Celsius were permitted to enter a departing aircraft while those who were above 38 degrees were separated from others in the public.\textsuperscript{405}

The manner in which the Ebola victims were being handled led to mistrust between the victims and the healthcare providers to the extent that many of the infected persons preferred to suffer quietly at their homes than visit the limited available health facilities in the country. Local resident Tairu Diallo buttressed this attitude of the victims in a report where he said:

\begin{quote}
People living in this neighbourhood refused to seek medical help and instead stayed at home, trying to alleviate their symptoms with drugs bought at a pharmacy. People think doctors at hospitals inject patients with a deadly poison. If we have a stomach ache we don't go to hospital because doctors there will inject you and you will die.\textsuperscript{406}
\end{quote}

Marc Poncin who was working with the French NGO Médecins Sans Frontières corroborated this lack of trust between the healthcare providers and the community which was hindering the

work of the group where he stated: “We are seeing a lot of mistrust, intimidation and hostility from parts of the population.”

In Guéckédou, a town in southern Guinea, 24 patients with suspected cases of Ebola fled a Médecins Sans Frontières treatment center, and villages in Guinea’s southeast Forest Region were reported to have shut out healthcare providers by blocking off roads and bridges. A report by New York Times showed that in the village of Wabengou, Doctors Without Borders were prevented from entering the community by residents who placed a tree on the road to block outsiders. They also attacked an official delegation from Conakry by rushing at their cars, banging on the vehicles and brandishing machetes. Marcel Dambadounou the Chief of Wabengou was quoted as having said: “We don’t want them in there at all. We don’t accept their presence at all. They are the transporters of the virus in these communities.”

4.6.3 Sierra Leone

The scene at the Sierra Leonean airport was not different. It was reported that at Freetown International Airport passengers were screened to determine whether their body temperature was abnormal. Those who manifested symptoms of the disease were separated from others in the public glare. Ben Potter, project manager for the monitoring team, seemed to justify this lack of respect for the privacy of the air travelers where he said:

I would rather they stopped someone because they were overly cautious, rather than not stop someone with Ebola and let them go on a plane.

In Sierra Leone many patients do not trust the healthcare providers due to the failure of the healthcare providers to respect the victims’ privacy and confidentiality. There is a widespread fear and mistrust by locals about the intentions of the doctors and healthcare workers to the

408 Ibid.

According to a local news report in Sierra Leone:

> Thugs forced their way into a building in Sierra Leone’s capital of Freetown, assaulting and threatening staff and making off with a pregnant woman who escaped on the back of a motorcycle in the midst of a summer downpour. But the woman wasn’t a criminal, and the place she fled wasn’t a prison. She was a potential victim of the massive Ebola outbreak that has hit West Africa, and she was fleeing the hospital where she had been brought for treatment.\footnote{Ibid.}

The foreign doctors were accused of administering lethal injections to the Ebola patients or harvesting their organs for sale in Europe. “As a result,” Inter Press Service reports, “doctors and nurses in the hospitals have been attacked and many nurses are not wearing their uniforms on the way to work for fear of being attacked in the streets.”\footnote{Why Are Potential Ebola Victims Attacking the Doctors Trying to Save Their Lives available at http://www.takepart.com/article/2014/07/24/why-are-potential-ebola-victims-attacking-health-workers-trying-save-their-lives (accessed 22 May 2015).}

\subsection*{4.6.4 Liberia}

It was reported that at the Liberian International Airport in Monrovia, passengers were treated in similar manner as in the other West African nations. They were screened publicly and separated from one another based simply on their body temperature. A nurse, Gloria Nelson, narrated to the AFP reporter the procedure adopted at the airport in screening passengers as follows:

> As passengers come in, we give them their forms. Each passenger fills in their own form, we take their temperature, they wash their hands and they go in. When your temperature is high, we take you to the secondary area for questioning that will enable us to determine the next step.\footnote{Liberia’s international airport battles to contain Ebola available at http://news.yahoo.com/liberias-international-airport-battles-contain-ebola-145033834.html (accessed 22 May 2015).}

As in Guinea, the reports showed that the breakdown of trust due to the failure by the healthcare providers to preserve the confidentiality of the victims gave rise to the rejection of the healthcare providers by the communities. The healthcare providers were reported to have been assaulted and threatened by people who believe the disease does not exist, or that the healthcare providers themselves were spreading it. The victims do not trust the healthcare
providers. Healthcare providers trying to screen for the virus were reportedly chased away by villagers armed with knives, swords, and stones.416

4.7 Legal Analysis

The manner in which the people infected with EVD were reportedly treated, especially the failure by the healthcare providers to protect and respect the privacy and confidentiality of the victims, contributed to the breakdown of trust between the victims, the communities and the healthcare providers. The non-observance of privacy and confidentiality in the screening and treatment of Ebola victims is one of the factors that has driven infected persons underground and hence contributed to the spread of the disease in the affected countries. Screening is often done in public. The process of identifying the potential victims simply by the level of their body temperature seems arbitrary as body temperature exceeding the medically prescribed normal level could result from various causes other than Ebola.

Those who manifest symptoms of the disease were separated from others in the public glare without any regard to their confidentiality. The emaciated bodies of the victims were often shown on public television where they are isolated with very little medical attention and awaiting their eventual death. Even the dead were not spared this unnecessary exposure as men in protective suit were often shown conveying such bodies to the designated burial places. These conducts have adverse impacts on the families of such victims who are usually avoided as the disease is said to be transmissible by body contact. It is submitted that the adoption of discreet way of diagnosing the disease would be more in consonance with the acceptable medical practice in protecting a patient’s confidentiality.

At the South African OR Tambo International Airport, for instance, passengers were required to fill forms supplying information on their health status and their contact details. The forms were returned to the health officials at the Airport who study the information and contact or trace the passenger where there is need and without necessarily exposing such a person to public ridicule. This is certainly more in tandem with the preservation of a person’s medical confidentiality than the approach adopted in the West African nations.

416 Ibid.
The ICCPR contains provisions recognizing the right to privacy in article 17(1) which provides that “[n]o one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation”. Similarly, the CRC provides in article 16(1) that “[n]o child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation”.

At the national level, the constitutions of Nigeria, Sierra Leone, Guinea and Liberia all embody provisions on the protection of the right to privacy. Section 37 of the Nigerian Constitution, for instance, provides that the privacy of citizens and their homes guaranteed and protected.\footnote{See similar provisions under s 22 of the Sierra Leonean Constitution, arts 12 and 16 of Guinean and Liberian Constitutions respectively.}

In \textit{Mark v Seattle Times}\footnote{96 WN 2\textsuperscript{nd} 473, 635 P.2d 1081 (1981).} William J of the Supreme of Washington held that the protectable interest in privacy generally involves at least four distinct types of invasion, namely: intrusion, disclosure, false light and appropriation. It is submitted that the undue exposure given to the victims and suspected victims of Ebola constitute an encroachment on their right to privacy and confidentiality. Such an encroachment by way of disclosure of the status of an infected person, or the casting of false light by showing such a person on the public television are all acts of invasion or intrusion on a person’s privacy.

There are good reasons for insisting that a patient’s privacy and confidentiality should be respected. Firstly is the right of the patient to medical autonomy. Secondly are the likely consequences which unguarded disclosure of information may have on the patient. In cases of information which may expose the patient to stigmatisation and discrimination, the patient could be treated as an outcast in the society.\footnote{See Odunsi & Nwafor (note 401 supra) pp 253-254.} In \textit{Jansen Van Vuuren v Kruger}\footnote{1993 (4) SA 842 (AD) at 31.} Harms AJA alluded to some of these reasons as follows:

\begin{quote}
There are in the case of [highly infectious disease] special circumstances justifying the protection of confidentiality. By the very nature of the disease, it is essential that persons who are at risk should seek medical advice or treatment. Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others
\end{quote}
which may lead to increased anxiety, depression and psychological conditions.

Thirdly is the need to afford the patient an opportunity to give health information freely and confidently to the physician. This is recognised by the British Medical Association guidance where it is stated as follows:

Confidentiality is an essential requirement for the preservation of trust between patients and health professionals…. Patients should be able to expect that information about their health which they give in confidence will be kept confidential unless there is a compelling reason why it should not. There is also a strong public interest in maintaining confidentiality so that individuals will be encouraged to seek appropriate treatment and share information relevant to it.421

In Jansen Van Vuuren v Kruger422 Harms AJA observed that the mere fact that AIDS is a dangerous condition does not detract from the right to privacy of the affected person especially if that right is founded in the doctor-patient relationship. The only medically recognized compelling reason for detracting from this obligation is where the doctor’s obligations to society would be of greater weight than his obligations to the individual.423 This would justify a disclosure made to a person who is directly at risk of being infected with the disease with which the patient is diagnosed, but certainly not the disclosure of medical information to the public at large.424

Fourthly is the preservation of public interest which is assured when a patient seeks medical solution to ailments. This was recognised in X v Y425 where Rose J said:

In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients will not come forward if doctors are going to squeal on them. Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care.

It is submitted that unless persons infected with the EVD are assured of their privacy and confidentiality, the victims will be reluctant to voluntarily submit themselves for testing and

422 1993 (4) SA 842 (AD) at 37-38.
423 Ibid at 15.
424 See PD v Dr Nicholas Harvey [2003] NSWSC 487.
425 [1988] 2 All ER 648 (QBD) 653 para a-b. See also Hague v Williams [1962] 181 Atlantic Reporter 2d 345 at 349 where the court held that “[a] patient should be entitled freely to disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfilled.”
treatment. This will occasion harm, not just to the victims, but also to the society as a whole as the timeous dictation of infections will be hindered by the concealment of the victim’s statue.

4.8 Theme Four: Quarantine

Quarantine is defined as enforced isolation or restriction of free movement imposed to prevent the spread of contagious disease. International human rights law, as observed by Human Rights Watch, has set down the bench mark that states should observe for the quarantining of persons in times of public health emergency as follows:

Restrictions on human rights in the name of public health or public emergency meet requirements of legality, evidence-based necessity, and proportionality. Restrictions such as quarantine or isolation of symptomatic individuals must, at a minimum, be provided for and carried out in accordance with the law. They must be strictly necessary to achieve a legitimate objective, the least intrusive and restrictive available to reach the objective (sic), based on scientific evidence, neither arbitrary nor discriminatory in application, of limited duration, respectful of human dignity, and subject to review. When quarantines are imposed, governments have absolute obligation to ensure access to food, water, and healthcare.

It is on record that governments of the West African nations in focus created treatment centers at the peak of the Ebola outbreak where various victims of the disease were quarantined. Available reports suggest that those treatment centers were grossly short of the international standard as stated above for the confinement of victims of infectious disease such as Ebola. Some were restricted in their private homes without food or water, and certainly without any healthcare facilities. Although the affected West African nations may hinge their inability or failure to ensure the availability of healthcare facilities in the designated quarantine centres on scarce state resources, court decisions have shown that this cannot be an exculpating factor for the non-fulfillment of this important state obligation. This was alluded to by Robert Goff LJ in Bank of Tokyo v Karmon where he observed that “we are not concerned with economics but with law. The distinction between the two is, in law, fundamental.”

427 Ibid.
4.8.1 Nigeria

It was reported that the Lagos house where a nurse died of Ebola, the five families that live in the building, 26 people in all, were been quarantined while they were being investigated for possible signs of the disease. Three of the men living in the house lost their jobs while in confinement. Community members who used to come into the compound to draw water from the well stayed away, even though the house was decontaminated the day that the nurse was taken to the hospital. One of the elderly persons in the house was reported by Reuters as lamenting their condition as follows:

We’re hungry-o, People won’t sell us food, they won’t take our money. It’s three days now since we’ve eaten and we’re hungry.430

According to the reporter:

The families in the compound were not receiving any assistance. When they told me that they had not eaten anything for three days because nobody would sell them any food…that really tugged at my heartstrings.431

In the area of healthcare facilities at hurriedly designated treatment centres where most of the infected persons were officially quarantined, those centres as shown by reports were mostly dilapidated and abandoned building lacking with little or no medical facility, functioning water supply and no proper ventilation facilities. The families of the patients bore the responsibilities of caring for their sick ones both in terms of their feeding and provision of necessary medications and sanitary needs.432 Ladi Okuboyejo, a medical practitioner, captured the appalling state of the quarantine facility in Lagos where he observed that there was a dearth of requisite drugs and basic medical supplies needed by the victims adding that the poor general sanitary condition of the isolation facility was despicable. He said:

If a health facility doesn’t have light, doesn’t have water and the sanitary system is not working properly then we have got a problem. Now the patients are critically ill and their condition is getting worse by day. People, including some medical personnel, are now running away from them. The reality is that the disease is beyond our capacity to handle in this country. The

---

431 Ibid.
international community needs to rise up to our aid. The victims are not being properly treated...we cannot handle it. 433

The dearth of healthcare facilities at the treatment centres was compounded by the healthcare providers who went on strike at the peak of the health crisis situation created by the outbreak of Ebola. Incidentally some of the healthcare providers were reported as protesting against lack of the necessary healthcare facilities at the treatment centres. 434

The researcher submits that lack of healthcare facilities in the West Africa nations could be addressed through the prioritization of state needs. The healthcare needs of the people should be place at the top level of the needs of the state. States cannot rely on the international community to provide their healthcare needs as the obligations on the international community in this regard are merely moral and not legal in substance.

It was this appalling state of the quarantine facility that compelled some of the victims at the centre to explore possible means of escape from the centre. It was reported that an Ebola patient fled from the quarantine centre and passed the disease to a doctor, who subsequently infected at least two other people. 435 Lagos State Commissioner for Health, Dr Jide Idris, told Punch Newspaper correspondents in Lagos that people in the isolation ward could die if they were not well managed, adding that government needed more hands. Identifying lack of adequate health officials as a major challenge to containing the spread of the virus, he said,

Because of the fear of Ebola, everybody seems to be scared, nobody wants to assist, which is a major challenge. It is even more so for the treatment isolation ward. It’s a major problem because a lot of people ran away, especially when the nurse died. 436

4.8.2 Sierra Leone

The government of Sierra Leone, like its Nigerian counterpart, had similarly created centers for quarantining of Ebola victims. Those centers were in reality no more than places of confinement where the victims were abandoned to die slowly but surely from the disease. Some victims were

436 Ibid.
as such force to escape from those centers. The system put in place by the government for the feeding of those in quarantine was dysfunctional. Jeanne Kamara, the director of the Sierra Leonean based Christian Aid Charity Organization was reported to have captured the state of affairs in one of the quarantine centers at Kailahun housing about 2,100 people, as follows:

Thousands of people in Sierra Leone are being forced to violate Ebola quarantines to find food because deliveries are not reaching them. This is a huge concern. People infected with Ebola are desperately searching for food and are in turn exposing others to the disease. They are jostling with people in the market and infecting others through bodily contact. We urgently have to provide food to those who need it to prevent the risk of further spread.\(^{437}\)

An Ebola victim who escaped from a detention centre said, while eating biscuits hungrily: “Food is not given to me since I was put into that place and I’m hungry; I need food right now.”\(^{438}\) The UK based Telegraph News reported that most of the Ebola victims quarantined were not being attended to. One of the victims was quoted as having said:

We are at the Ebola Treatment Unit and no one is taking care of us. Last night several patients died. Those who can walk are trying to escape by climbing over the fence.\(^{439}\)

It was reported by the Guardian Newspaper that even the designated hospitals where the victims were confined had inadequate healthcare facilities to fight the epidemic.\(^{440}\) The AFP correspondent had quoted a doctor in Sierra Leone as expressing a reluctance with some of her colleagues to turn up for work in those hospitals due to lack of the essential treatment facilities for the Ebola victims.\(^{441}\)

Sierra Leone like Nigeria also witnessed industrial action by the healthcare providers at the peak of the Ebola crisis which aggravated the healthcare situation of the victims in quarantine. The healthcare providers were reported to have embarked on strike in protest against inadequate healthcare facilities at the quarantine centres as well as the non-payment of risk allowances by the government to the medical personnel. The Junior Doctors Association in


\(^{441}\) Ibid.
Sierra Leone was quoted as saying: “We have decided to withhold our services until a proper and more conducive atmosphere is created for us to continue work.”

Some 30 nurses at the Mabenteh Hospital in the town of Makeni said they had been refusing to work because of “the non-payment of risk allowance” by the government. A spokesman for the nurses, Henry Conteh, told public radio: “We are not going to attend to any patients who are already admitted and will not accept any new cases until we are paid. The matter is serious and needs to be settled urgently.” These reports are reflections of the failure by the state to fulfill its contractual obligations to the healthcare providers by ensuring that they are paid what is due to them. Unfortunately, it is the victims of Ebola who are abandoned and without medical care that bear the brunt of the industrial dispute. In human rights context, the government as the employer of the healthcare providers is in breach of the human rights of the patients to healthcare.

4.8.3 Liberia

The government of Liberia similarly created quarantine centers where victims were camped with little or no government assistance. It was reported by the Monrovia Inquirer that Ebola victims at the ELWA Ebola Isolation Center were leaving the camp due to lack of food. This was disclosed at the National Ebola Task Force Meeting held at the Ministry of Foreign Affairs in Monrovia. The Health Minister, Walter Gwenigale, said he had received several calls from the center that the people were hungry and needed food. According to Dr. Gwenigale:

> based on this latest report, most of the victims are now leaving the center which is a major threat to several communities in which those leaving are going. I'm getting calls every day of the lack of food; the people say they are hungry and I understand that there is food there but I'm getting these calls every minute.

A suspected Ebola patient was shown on Sky News causing panic in a market in Monrovia when he left a clinic to find food. A woman could not hold back her sympathy for the hungry

---

patient where she said "The patients are hungry, they are starving. No food, no water. The government needs to do more. Let Ellen Johnson-Sirleaf [the President of Liberia] do more."446

The treatment centres which were used as quarantine facilities for the Ebola victims were bereft of essential healthcare facilities to fight the epidemic. The few available healthcare workers would not attend to the victims for the fear of their own safety due to weak infection control, lack of training and access to personal protective equipment. There were few isolation units and lab testing facilities for Ebola at the centres.447

In the midst this health crisis in that country, Liberia’s nurses from the country’s largest hospital went on strike demanding for higher salaries and equipment to protect them from the Ebola virus.448 John Tugbeh, spokesman for the nurses at John F Kennedy hospital in Monrovia, said the nurses would not return to work until they were supplied with personal protective equipment (PPE), paid risk exposure allowances. He said:

From the beginning of the Ebola outbreak we have not had any protective equipment to work with. As a result, so many doctors got infected by the virus. We have to stay home until we get the PPEs. We need proper equipment to work with [and] we need better pay because we are going to risk our lives.449

Doctors in Liberia were also reported to have embarked on strike over unpaid bonuses and non-conducive working conditions.450 All these industrial disputes occurring at the peak of the Ebola outbreak compounded the health conditions of the quarantined victims and contributed to the death of some who could have survived in a more efficient treatment centres equipped with modern healthcare facilities and personnel.

449 Ibid.
450 Liberian doctors strike, food prices spike as West Africa struggles to contain Ebola outbreak available at http://uk.reuters.com/article/2014/09/02/uk-health-ebola-idUKKBN0GX11A20140902 John Tugbeh, spokesman for the strikers at John F Kennedy hospital in Monrovia, said the nurses would not return to work until they were supplied with personal protective equipment (PPE), the hazardous material-style suits which guard against infectious diseases (accessed 2 June 2015).
4.8.4 Guinea
In Guinea it was reported that those quarantined at the isolation centres were not given proper medication because of lack of medical facilities and equipment.\textsuperscript{451} The World Health Organisation report on the quarantine situation in Guinea showed that Ebola treatment centres functioned more to isolate people than to provide care to patients.\textsuperscript{452} UNMEER also reported a growing incidence of families leaving their quarantined homes due to a lack of food and non-food items.\textsuperscript{453}

Some of the victims were not informed of their Ebola status at the isolation ward. The WHO report shows that the victims,

\begin{quote}
[W]ere not told they have Ebola until late in their treatment. They were very sick and suffering from heat in difficult conditions, and they will never forget that they saw 2 of their uncles succumb to Ebola in front of their
\end{quote}

\textsuperscript{454}

It was reported that the hospitals that served as official quarantine centres for the victims of Ebola had inadequate healthcare facilities to fight the epidemic; equipment such as, disease surveillance mechanisms, the public sanitation, and the education and communications infrastructure were all in short supply at those hospitals.\textsuperscript{455} Frieden an official of Doctors Without Borders, lamented on the situation of the treatment centres in Guinea and was quoted as having said: \textit{[this is] the scariest thing I’ve heard. For the first time since the outbreak began, there were not enough beds for sick patients in treatment centres in the capital city of Conakry.”} \textsuperscript{456}

4.9 Legal Analysis
The provision of adequate healthcare for the citizens by the state is a fundamental human right which is indispensable to the realisation and exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life

\textsuperscript{453} Ibid.
in dignity. The right to healthcare of people infected with EVD is particularly susceptible to violations in the healthcare settings especially where there are inadequate healthcare facilities to address situations of health emergencies such as EVD. The healthcare facilities in the four West African nations in focus were seriously challenged at the outbreak of EVD. Virtually all the nations as shown by available reports were unable to shoulder the demands of an emergency situation created by Ebola both in terms of human and technical needs of the time.

Article 25(1) of the Universal Declaration provides 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 necessary social services". Although the Universal Declaration is not a treaty, it has been widely accepted, and the norms therein declared have metamorphosed into customary international law.

Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides that the state parties to the Covenant shall recognize the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Article 12(2)(c) of ICESCR enjoins the state parties to take steps necessary for the prevention, treatment and control of epidemic, endemic, occupational and other diseases. The Covenant further enjoins state parties to have in place measures that would create conditions which would assure medical service and medical attention to everyone in the event of sickness. Although the language of these provisions does not seem mandatory, they lay down the threshold by which state parties could ensure the realization of the right to health of their citizens through the provision of adequate healthcare facilities.

It is acknowledged that the right to healthcare of a patient in a public health emergency situation is not an absolute right and could be restricted for the protection of the wider public interests. This is permissible under the law. Article 9(1) of the ICCPR, for instance, provides that: "Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law". Similarly, Article 6 of African Charter provides that: "Every individual shall have the right to liberty and to the security of his
person. No one may be deprived of his freedom except for reasons and conditions previously
laid down by law.

At the national level, the constitutions of Nigeria, Sierra Leone, Guinea and Liberia respectively,
recognises limitations to the human rights provisions. Section 45(1) of the Nigerian Constitution
is highly encompassing in that regard. It provides as follows:

Nothing in sections 37, 38, 39, 40 and 41 of this Constitution shall invalidate any law that is
reasonably justifiable in a democratic society
(a) in the interest of defence, public safety, public order, public morality or public health; or
(b) for the purpose of protecting the rights and freedom of other persons.

In the area of healthcare, the restriction of the liberty of the patient could take the form of
quarantine as was done by the West African nations in order to prevent the spread of Ebola.
Such a restriction is justified if it complies with the protocol laid down under international human
rights law. The quarantine imposed on the victims of EVD by the respective governments in the
affected countries did not comply with the international protocol as set down above as shown by
the reports. For example, some victims were reported to have been confined in their homes and
healthcare centres with little or no existing health facilities, food and water. Such confinement
that fails to satisfy the basic international protocol cannot be justified as being for the protection
of the health of the society. The reason for quarantine is not just the seclusion of the victims
from the public but to administer the necessary curative measures that would restore the victims
to their normal way of life in the society. The victims’ interests should thus remain of paramount
concern of the government even under quarantine.

The next chapter contains the conclusion, highlighting the major points of the study and makes
recommendations and suggestions towards a comprehensive legal position on the rights of the
people infected with EVD, as well as measures that could be adopted by the respective
governments of the West African nations to guard against future disease outbreaks.

---

457 See also s 15 of the Sierra Leonean Constitution, Arts 24 and 11 of the Guinean and Liberian Constitutions
respectively.
CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions
This chapter contains the conclusion, highlighting the major points of the study and makes recommendations and suggestions towards a legal position on the rights of people infected with EVD. The chapter also highlights some preventive measures and proactive responses that could be adopted by the respective governments of the West African nations in the event of future disease outbreaks.

Human rights, as discussed in this study, are rights which all persons everywhere, and at all times, have by virtue of their existence as human beings. When human rights instruments are ratified and acceded to in international agreements or legislated for in national legal systems, they are also referred to as legal rights. The protection of human rights is essential to the survival and progress of man in society. The universality and immutability of human rights were depicted in the observation made by Bhagwati J, of the Supreme Court of India, as follows:

Human Rights are as old as human society itself, for they derive from every person's need to realise his [or her] essential humanity. They are not ephemeral, not alterable with time and place and circumstances. They are not the products of philosophical whim or political fashion. They have their origin in the fact of the human condition; and because of this origin, they are fundamental and inalienable. Human rights were born not of humans, but with humans.458

The universal nature of human rights is reflected in their global recognition by various international, regional and national bodies through the instruments of treaties, conventions and laws.

Persons infected with EVD are human beings and as such enjoy protections of their rights under the various national and international human rights instruments. The rights of people infected with Ebola are violated in spite of this body of laws providing for the protection of human rights.

The governments of the affected West African countries are under obligations to provide adequate healthcare systems for people infected with EVD. The failure on the part of governments to provide adequate healthcare for the people infected with EVD infringes their right to healthcare as provided for in those countries’ respective constitutions and under the international human rights instruments.

The study reveals that the victims of EVD are stigmatized and discriminated against in the society. It does not seem to be of relevance that the victims have been cured of the infection. Even families and relatives of dead Ebola victims are not spared from the stigma associated with that infection. It is submitted that the act of discrimination, except when it is justifiable for the protection of the overriding interest of the public, constitutes an infringement of the human rights of the EVD victims. More importantly is that the fear of stigmatization has the propensity of driving the victims underground and as such hindering the effort of the government to effectively control the spread of the disease. It is thus not surprising that incidences of Ebola have continued to manifest in some of the West African nations that had previously received a clean bill of health from the WHO.

Some health workers were reluctant, and in some cases declined, to attend to the EVD victims on the ground of avoiding exposure to the risk of contracting the disease. This researcher considers such conduct on the part of the healthcare providers as unethical and a breach of the Hippocratic Oath which enjoins all healthcare providers not to discriminate against patients on ground of their ailment even at the risk of death.

Reports showed that where the EVD victims were attended to, they were treated with extreme caution and in some cases disdainfully. Such conducts encroach on the dignity of the victims which is guaranteed by the constitutions of the various countries under focus and erode their determination to live. It is submitted that the risk of contracting the infection is inexcusable for these acts of dereliction of duty by the healthcare providers as diligent use of universally acknowledged precautionary measures would greatly obviate the risk where it exists. This researcher believes that the strenuous training received by doctors and nurses towards their qualifications to practice as such should equip them to handle infectious diseases such as Ebola whenever they occur. The Hippocratic Oath enjoins the doctors to place the interest of the patient above personal interest even if it entails the loss of life of such doctor. Running away
from patients with infectious disease in preference for self-preservation as reported in some
countries during the outbreak of Ebola cannot find any justification in the medical practice. Although the doctors have to stay alive to serve the interests of their patients, this can always be guaranteed by adopting any medically recognized protective measures. Incidentally a good number of deaths recorded amongst the healthcare providers at the initial stages of the Ebola outbreak resulted more out of ignorance as to the nature of the ailment than lack of availability of protective equipment for the healthcare providers.

In recognition of the limited resources at the disposal of the developing nations, the constitutions of some of the West African nations approach issues of the state’s obligations in providing healthcare facilities for the citizens as mere policy issue. This invariably entails that non-fulfillment of this obligation by the state concerned is not justiciable.\textsuperscript{459} Those nations’ constitutions, on the other hand, recognise the right to life and dignity of human persons as justiciable rights. It is submitted that the attainment of life with dignity requires the availability of the amenities that make life worth living, and one of the essentials is adequate and accessible healthcare facility. Therefore, arguably, the failure by the West African nations to provide healthcare facilities to the victims of Ebola constitutes an infringement on the victim’s right to life and dignity.\textsuperscript{460}

The researcher submits that the provision of adequate healthcare for the citizens by the state should be treated as a fundamental human right of the citizens. This is because the availability of healthcare facilities is indispensable to the realisation and exercise of other human rights especially the right to life. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realisation of the right to healthcare and other health related human rights require policies and plans to be systematically integrated to further these rights. State needs should be properly streamlined to ensure optimal use of available resources for the most pressing needs of the citizens which healthcare facilities are of paramount importance.

\textsuperscript{459} This may seem in consonance with the provision of art 2(3) of the ICESCR save that the ICESCR restricts its application to non-nationals.

\textsuperscript{460} See the Indian Supreme Court position in \textit{Paschim Banga Khet Mazdover Samity v State of West Bengal} (1996) 4 SCC 37 supra at 58.
The Limburg Principles on the nature and scope of the obligations of state parties to the International Covenant on Economic, Social and Cultural Rights describe a violation of the Covenant as a failure by a state party to comply with an obligation articulated in the covenant. It indicates that these failures could be by acts of commission or omission that is, both not desisting from particular kinds of activity and not fulfilling specific requirements. In addition, the Maastricht Guidelines on violations of Economic, Social and Cultural Rights (Maastricht Guidelines) stipulate that a state party violates the minimum essential level of the right to health if a significant number of its people are deprived of essential primary healthcare.

The research revealed that a large number of people in the West African nations of Liberia, Guinea and Sierra Leone were infected with EVD. A good number of them died not because the disease could not be cured, but simply on account of the failure by those states to fulfill their statutory obligations by providing functional healthcare facilities for the people.

One of the measures adopted by the West African nations to fight the outbreak of the EVD and prevent its spread was to quarantine the victims and suspected victims of the disease. This measure is permissible under Article 12(2)(c) of the ICESCR which enjoins State Parties to adopt measures that would ensure the prevention, treatment and control of epidemic, endemic, occupational and other diseases. It could also be justified under Article 12(3) of the ICCPR which empowers the State to restrict movement of the citizens where it is necessary for the protection of public health. The study, however, revealed that the appropriate international protocols on quarantine were not always observed by the respective West African nations. Victims were shown to have been secluded in makeshift buildings or restricted to their homes without medical facilities, food or water, and basic hygiene. The homes of victims and suspected victims were invaded by government officials without notification and as such encroaching on

462 Maastricht Guidelines para 9. The Guidelines were adopted in Maastricht, the Netherlands, on 22-26 January 1997; According to the Alma-Alta Declaration, primary healthcare includes at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; adequate supply of safe water and basic sanitation; maternal and child healthcare, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and provision of essential drugs. The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care (PHC) on 6-12 September 1978.
their privacy. Suspected victims were literally apprehended and locked up in the designated quarantine centres. The researcher submits that while the act of quarantine *per se* is permissible to prevent the spread of a virulent disease such as Ebola for the protection of the overriding public interest, the human rights of the persons being quarantined should always be protected by the state by observing the prescribed international protocols on quarantine. The treatment meted out to the quarantined victims failed short of Article 12(2)(d) of the ICESCR which enjoins State Parties to create conditions which would assure to all medical service and medical attention in the event of sickness.⁴⁶³

There is a clear and condemnable demonstration of lack of confidence by most African leaders in their nation’s healthcare facilities. The fact that many of them travel to the more advanced nations to seek solutions on health related challenges shows that they do not have confidence in the healthcare systems of their own countries. The weaknesses in the West African nations healthcare systems are manifested by the fact that while in those nations, the Ebola pandemic is said to have no cure, and the victims were subjected to untimely death, in the advanced countries, such as the United States of America, their citizens, who incidentally contracted the Ebola virus from those West African nations, were cured. The American healthcare system is able to stop Ebola because the government has invested in the system to make the system work; the healthcare providers, the facilities and equipment, the disease surveillance mechanisms, the public sanitation, education and communications infrastructure and the public trust are in synergy as an integrated system that is more powerful than the component parts. A gradual incremental channeling of resources to the provision and improvement in the healthcare facilities of the West African nations would enable the states to attain such efficiency as is evident in the healthcare systems of the developed nations.

The researcher, however, holds the view that the outbreak of the EVD in the West African nations is not all about the counting of human losses, it also drew the world’s attention to the appalling state of the healthcare facilities in the West African nations. The WHO was recently reported to have mapped out resources to rebuild the battered healthcare facilities in Guinea,

⁴⁶³ See similarly art 12(3) of the ICCPR which provides that such restrictions must be consistent with the other rights recognized in the present Covenant.
Liberia and Sierra Leone before December 2017.\textsuperscript{464} The government of Germany has also budgeted a substantial amount to assist the West African nations to upgrade their healthcare facilities.\textsuperscript{465} It is hoped that the beneficiary nations would take full advantage of these resources to significantly improve their healthcare facilities. This is enjoined by article 2(1) of the ICESCR which provides that each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, 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 present Covenant by all appropriate means.

5.2 Recommendations

A work of this nature is incomplete without the opinion of the researcher on ways of addressing identified problems and guarding against future occurrences. It is in realisation of these inescapable facts that the researcher makes the following twelve recommendations:

1. The devastating impacts in both human and material terms of the Ebola outbreak in the West African nations demand some level of introspection by the leaders on the state of the healthcare facilities in those nations. The absence of basic healthcare facilities and trained healthcare providers which is noticeable in many West African countries are incidences of long years of neglect by those governments of their obligations to the citizens. In many of these countries, there are no safe and potable drinking water and sanitation facilities especially in those areas occupied by the dominantly economically disadvantaged groups of the states’ populations. The alarming rate of the spread of a highly virulent disease, such as Ebola, in such an environment is thus inevitable. The parlous state of the environment needs to be addressed via prudent and purposive national economic planning and budgeting programme.

2. The idea of the progressive realization of socio-economic rights which the right to healthcare is one, seems to have opened the door for the defaulting states to hinge their inadequacies in the provision of healthcare facilities on the state’s meager resources. The allocation of state resources to the needs of the citizens must be weighed in the order of priorities. Government priorities should be focused on those essential needs for human existence with functional

\textsuperscript{464} Ebola-stricken nations need $700m to rebuild healthcare available at \url{http://m.ewn.co.za/2015/07/07/Ebola-stricken-nations-need-$700m-to-rebuild-healthcare} (accessed 8 August 2015).

healthcare facility as one. The fact that the existing healthcare facilities in the West African nations were unable to meet the healthcare needs of the citizens in the outbreak of Ebola is evidence of the respective nation’s government’s under investment in the health sector. A state that fails to fulfill this human right obligation should not be excused simply on account of meager state resources.

3. The training of healthcare providers in the West African nations on how to address issues of healthcare emergencies is of paramount importance. Majority of the citizens in the West African nations are not in a position to afford the essentials for good living such as food, shelter and clothing. Such people are susceptible to attacks by infectious diseases such as Ebola. Adequately trained healthcare personnel will be in a position to respond quickly in such emergencies.

4. Government should institute elaborate policy on disease control. This should include the establishment of primary disease control centres in the rural communities. An enlightenment programme should be embarked upon to educate all citizens, particularly the rural dwellers on the need to report any strange health related disease in both humans and animals to the nearest disease control centres.

5. Basic education on hygiene should be included in the schools’ curriculum at the primary level where such does not exist. It is believed that such education would equip the citizens at the developmental stages on how to guard against unhygienic habits that create rooms for diseases and infections.

6. In the area of legal reform, it should no longer be acceptable that countries like Nigeria, Liberia and Sierra Leone still have in their respective constitutions provisions on healthcare as mere directive principles of state policy. The existence of the international instruments adopted or ratified by the States are inadequate as they are mostly directory and not mandatory except where they have been specifically domesticated by the affected State such as was done by Nigeria in relation to the African Charter. Issues of healthcare are so fundamental to the survival of the citizens that they should not be treated differently from the right to life. It is submitted that moving issues of healthcare to the fundamental rights provisions of the constitution would enhance the state’s obligation and guarantee the citizens the right of enforcement where there is a breach. Nigeria, Sierra Leone and Liberia should adopt the pattern in the South African
Constitution which encompasses the socio-economic, civil and political rights under an enforceable Bill of Rights that is embodied in the South African Constitution of 1996. The South African Courts’ interpretations and applications of the provisions of the Bill of Rights as contained in Chapter II of that Constitution are geared at a progressive realisation of the substance of the protected rights.

7. The failure by the governments of Liberia and Sierra Leone to domesticate the provisions of the African Charter has created the avenue for the governments of those nations to avoid legal obligations in respect to the right therein created. Parliament in those nations are urged to follow the example of Nigeria in domesticating the African Charter as experience has shown from courts’ decisions that such domestication is invaluable in filling the gaps in the national constitution in the area of the enforcement of human rights, especially the right to healthcare.

8. The right to health should be elevated by states to the status of customary international law considering the level of its universal acceptance. This is justified by the importance of healthcare to the protection of the right to life which is accorded preeminence by State laws and practices. However, the extent of the obligations adopted or accepted by individual states in its application could vary from one state to the other. This would ensure that governments of the respective nations are held accountable even in the absence of such obligations being expressly provided in their domestic laws.

9. Nigeria recently enacted the National Health Bill of 2014 which, among other things, makes it a punishable offence for a medical practitioner to refuse to treat a patient for whatever reason. This is a laudable provision as the Ebola outbreak has shown that part of the conditions that led to the spread and death of many of the victims was the refusal by the healthcare providers to attend to the victims due to the fear for their own safety. Though such fear could be reasonable in the circumstances as a number of doctors and nurses were reported to have died when they contracted the disease from their patients, to balance the interest of the patients and the healthcare providers in the light of the statute, government is urged to provide protective tools for the healthcare providers to deal with infectious diseases. The healthcare providers should also be assured of the government’s interest in their welfare by being provided with health insurance that would cushion the effect of death or losses to their practice and dependants while treating patients in occasions of virulent disease such as Ebola.
10. The ability of the Nigerian government to control the spread of the EVD in that country is a great lesson to other West African nations on the need for a quick response to an outbreak of disease of this nature. While it took Guinea three months to react to the disease, the Nigerian government reacted quickly when the disease showed up in the country. This was done by quarantining victims and suspected cases, tracing and monitoring people who had been in contact with Ebola patients and educating the public on how to protect themselves. These measures greatly assisted in ensuring that the spread of the infection was restricted within identifiable localities in the country. Additionally, West African states should convene a special summit to address collaborative and co-operative efforts to combat future spread of diseases such as EVD with the Nigerian example as a test case.

11. It is on record that those who have been cured of EVD are still being stigmatized and discriminated against in their work places, their communities and even in their relationships, there is thus a need for public enlightenment to assure the communities that those victims of Ebola who are cured no longer impose health risk to the public and should be reintegrated into their work and social activities. Those still living with the disease need help and not stigmatization to enable them overcome their health challenges.

12. The noticeable inadequacies in the development of healthcare facilities in the West African nations make it impossible for those nations to single handedly provide for the healthcare needs of their citizens especially in times of health emergencies. There is therefore the need for international and regional cooperation to build synergy in the areas of healthcare in preparation for the occasions of health emergencies in the African region.

The researcher is of the view that if these recommendations are implemented, the healthcare needs of the people in the West African nations would greatly be improved, the human rights of the victims of EVD would be protected, and precautionary measure would be put in place against future disease outbreaks in the affected nations.
BIBLIOGRAPHY

Books


Martin U. Gasiokwu, *Legal Research and methodology: the A-Z of writing theses and dissertations in a nutshell* (University of Jos, Nigeria: Printed and Published by Fab Anieh, 1994).


**Journal articles**


Benson Oduor Ojwang,, ’Emily Atieno Oguta and Peter Maina Matu ‘Nurses’ impoliteness as an impediment to patients’ rights in selected Kenyan hospital’ (2010) 12 (2) Health And Human Rights 101.

Cheluchi Onyemeluwe ‘Access to Anti-retroviral drugs as a component of the right to health in international law: Examining the application of the right in Nigerian jurisprudence’ (2007) 7 African Human Rights Journal 446 at 454.


**Internet materials**


Ebola-stricken nations need $700m to rebuild healthcare available at http://m.ewn.co.za/2015/07/07/Ebola-stricken-nations-need-$700m-to-rebuild-healthcare (accessed 8 August 2015).


JO Mary Ludwing and Wylie Burke ’Physician –Patient Relationship’ University of Washington School of Medicine, Ethics in Medicine available at http://depts..washington.edu/bioethx/topics/physpt.html (accessed 14 January 2015).


