The Right to Healthcare in African Countries: Nigeria in View-A Moral Appraisal

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ABSTRACT This article which is based on a true life occurrence in Nigeria was used to discuss the right to minimum healthcare in African countries. Individual and state responsibilities on how to actualize minimum healthcare in that part of the world were discussed. Ways of reducing poverty in African countries in order to achieve basic healthcare in African countries were also discussed in this article. One of such ways is for African leaders to treat the issue of access to basic healthcare in ways they would normally address security issues in that continent.

INTRODUCTION

This essay is based on an incident that happened a few years ago in a small village in Edo State of Nigeria. Lucky, a 12-year old boy was asked to put on the lantern used to illuminate their home and surrounding (the village has no electricity). In his attempt to light the lantern, he discovered that there was no kerosene in it. So he decided to put kerosene into it. Unfortunately, his father had used the can normally used to store kerosene to purchase petrol for some other purpose. This was unknown to Lucky, and indeed to anyone else. Lucky took the can and emptied its content (petrol) into the lantern. His efforts ended up in an explosion which severely burnt him.

Lucky was taken to a Government General Hospital some kilometers away from his village. Fortunately for him, he would survive if adequate care and required expertise were provided. After ten days in hospital, Lucky's mother who was looking after him complained to her son that she could not understand why Lucky could be so inconsiderate as to allow her to continue to waste her time in the hospital while her co-wives tended to their farms and made money at the village market. After four days of her incessant complaints, Lucky told the physician who was caring for him that he would like to go home. The physician in turn told Lucky and his mother that going home at that moment was inconceivable, as Lucky's situation was still considered critical. Lucky's mother however opined that if her son wanted to go home, it will be okay with her. She did not inform the physician that she had all the time applied psychological pressure on him (Lucky) to leave the hospital (the focus of this article is not on decision-making capacity of minors).

Lucky was reluctantly discharged by his doctor. He was usually left at home all day while others went about their business. At night his father applied some sort of local treatment, and among the concoction used was alligator pepper (believed to effective in the prevention of infections) which was quite painful. After six days at home and the application of his father's concoction, Lucky's health deteriorated with high fever. Two days later he died. His burns had been infected. He was only discharged from the hospital to die.

ISSUES ARISING

The issues that come to the fore in analyzing Lucky's case should be taken seriously. This is because there are millions of Lucky on the African continent. It is a problem that must be addressed by Africa and Africans. However, the problem must not be left to Africans alone. It is a problem the West and other parts of the world must also assist Africans in dealing with. This is because health care is better enhanced in collective health. Some of the issues that readily come to mind are: parental duties and responsibility; the concept of justice; the right to health care and the general problem of poverty in Africa which often culminates in waste of human lives.

PARENTAL DUTIES AND RESPONSIBILITY

It is important to indicate *ab initio* that the West must not stand to watch the avalanche waste

of human lives in Africa if our common humanity is to have any meaning. However, the first step must be taken by Africans themselves. It is not uncommon to find men in Africa with several wives and innumerable number of children. It was reported that Africa's annual population growth rate was 3.2% which is rather high (The Economist 1991). There is the saying amongst the Edo speaking people of Nigeria, put literary: 'He who gives birth to many children will have much to eat'. The thinking was and still is, of about twenty children sired by a man, one or two would become successful through their own hard work or sheer luck. But no one seems to realize that with many children come more attendant responsibilities. For instance, Lucky's father had seventeen children as at when the narrated incident happened, he may have had more by now. In consonance with common-sense, we tend to appreciate more of those things we have in limited quantity. It will be difficult for a parent with two or three children to allow one of his children to die from preventable diseases or from manageable health conditions. Whereas a parent with ten children may care less if one of his children dies. Lucky was just one of many children.

It would seem many parents in Africa are unaware of the enormous responsibility associated with child-rearing. Duties towards our children (and indeed to others and society) actually emphasise us *Homo sapiens*. Peschke (1992) puts it more aptly when he states that: 'The responsibility of parents for their children arises from the fact they have given life to them and that the young human beings come helpless into the world, entirely dependent on their loving care'. He explains further that, while the responsibility of parents towards their children is primary and fundamental, on the other hand, the responsibility of the state towards children is secondary and subsidiary (Peschke 1992). In like manner, Molinski (1969) argues that people should only have children they can afford to educate and rear in a responsible way befitting of the human species. This means that child-rearing among other things must include the provision of adequate (at least minimum) health care, which visibly expresses the premium humans place on human life.

In traditional African society, human life is regarded as important and which must not be wasted. According to Iroegbu (1994), traditional African societies 'have the human person as prior, central and end-point in techno-development valuations and engagements.' While Mbiti (1969) describes African societies as 'an extremely anthropocentric ontology in the sense that everything is seen in terms of its relation to man'. Thus in line with the African notion of the human person, there is unqualified respect for human life in the traditional African setting. Iroegbu (1994) aptly illustrates this when he states that, '…almost all societies have respect for life, Africans have a deep reverential deference for life. Its beginning is elaborately celebrated in pregnancy, birth, naming and initiation ceremonies. Its growth and continuity is feasted in adulthood, and adolescence rites and communal festivities. Its end is buoyantly *celebrated in death, and funeral festivities'*.

Iroegbu (1994) adds that 'conversely to touch a person's life, starkly put, to shed blood, especially innocent blood is the greatest evil on earth'. At this point, it is also important to add that death occasioned by irresponsible action or inaction, may be equated to directly causing death. In other words, individuals who give birth to children (be they Africans, Easterners or Westerners) they never plan to cater for (which includes health care) may be considered as irresponsible.

In the traditional African setting, communities play significant roles in the welfare of individuals. Community spirit in traditional Africa is aptly described by Uchendu (1965), in Igbo (of Nigeria) cosmology that: 'Almost from the first, the individual is aware of his dependence on his kin group and his community. He also realizes the necessity of making his own contribution to the group to which he owes so much'. This is because for the African, the community is the placenta from which the individual derives his/her existence and sustenance.

Among the Esan people of Nigeria, community values are expressed through the various social organizations or other wise known as age grades (Ukpan 1984) such as: the Egbono-efalen (path-sweepers), egbonoghele otunene (the great grade). And everyone belonged to one grade or the other. The various age grades are directly responsible for the welfare of her members, and where the problem at stake (such as a serious health condition) was beyond the scope of an age grade, the elders are consulted on how to address the problem at the community level. Community values and involvements are easily noticeable in most African societies. In the light of this, one is forced to wonder what went wrong

with the African traditional value system which regards the sanctity and respect for human life as supreme. Cases such as Lucky's emanate from the gradual departure from traditional values and the embrace of individualism which is alien to African tradition and culture. In years gone by, community members would have rallied round Lucky's mother in the care of her son. But it would seem the gradual erosion of such traditional value is occasioned by the current economic circumstances of most African countries. Some of those circumstances are beyond the control of Africans, while others are self-imposed.

POVERTY

In polygamous marriages (polygyny is applicable to most African societies) the responsibility of rearing children often rests on wives. Wives fed, took care of and sent their own children to school. When mothers cannot cope with the responsibility of bringing up their children, such children looked after themselves and sometimes after their mothers. Children went about this task by undertaking menial jobs and hawking wares on the streets. In the process, many of those children die from some kind of infection or got knocked down by vehicles (sometimes to their deaths) while hawking wares on the highways. This way of life promotes poverty.

For instance, one of the reasons Lucky's mother was anxious to take her son out of hospital was because of the accumulating hospital bills which she could not afford to pay. Most rural dwellers and indeed many urban residents in Nigeria and in most African countries live in absolute poverty. Robert McNamara (1976) one time President of the World Bank defines absolute poverty as '…a condition of life so characterized by malnutrition, illiteracy, disease and, squalid surroundings, high infant mortality and loss life expectancy'. This is presently the circumstances of most people in African countries. According to Singer (1979): '… by the most cautious estimates, 400 million people lack the calories, protein, vitamins and minerals needed for a normally healthy life. Millions are constantly hungry….Children are worst affected…15 million children under five die every year from the combined effects of malnutrition and infection'. Over a period of three decades, the situation has not improved; rather, it has only deteriorated. The bulk of hungry and disease infested population are in sub-Saharan Africa. For example, infant mortality rate in Nigeria per thousand is 112 in 1997 and life expectancy 52 (Makanjuola 2002). This state of affairs is and should be unacceptable to anyone anywhere. This is why affluent countries must play effective role in addressing poverty in developing (African) countries. And such assistance must incorporate the promotion of health and health care in African countries. This is because 'helping is not, as conventionally thought, a charitable act which is praiseworthy to do, but not wrong to omit, it is something everyone ought to do' (Singer 1976). This is why the 'live boat' ethics orchestrated by the leaders of the European Union (EU) is not the way to go, if the economic situation in African countries is to be ameliorated.

Political leaders of the EU are of the opinion that migration of poor people must be restricted, in order to curtail the 'spread' of poverty to EU countries. This is being achieved by stringent immigration laws. They reason that it is better and safer to send grants (often under unfavourable conditions and much below the recommended percentage of the United Nations) to poor countries. Grants to poor (African) countries are not the solution to the problem of poverty. Investment (in the short term) and capacity building (in the long term) are the possible ways of addressing the problem of poverty in African countries.

Grants, loans and debt relief/forgiveness cannot help African countries out of its entrapped poverty. Grant donors such as the World Bank and International Monetary Fund must take peculiarities of countries into consideration before grants or loans are doled out. This means that significant questions such as: Would such grants get to targeted populations? What sort of government is in place in that country? How have previous grants/loans to such countries been utilized? What are the physical structures in place in such countries that would enable such grants/loans achieved optimum result? These questions are important, because often times, grants and loans secured from affluent countries and organization are misappropriated or out rightly stolen by African political leaders. In such cases, grants are simply recycled and round tripped to private bank accounts in Europe and North America. Though donor (rich) countries cannot be held responsible for the gross corruption among African leaders, but rich countries may and indeed should be held responsible for

allowing such leaders get away with ill-gotten wealth hidden in bank accounts in their (affluent) countries. This is because corruption in African countries is responsible for the vulnerable state of African economies; this translates into inadequate health care resources in poor (African) countries.

JUSTICE AND HEALTH RESOURCES ALLOCATION

The idea of justice according to Bird (1967) can be stratified into three, which are first '… justice is a social norm, that is, a directive for guiding men in their actions towards one another. The second note is that justice is approbative in the sense that…judging an action to be just manifests approval of that action. Third, justice is obligatory in that judging a certain course of action to be just entails that a person in the like situation ought to do the same thing'. Bird's third idea of justice is more encompassing, as it brings elements of the first and second into the idea of the third. However, the problem with this idea of justice is that because a person considers an action to be just does not necessarily mean s/he would perform the same acts in similar circumstances. Besides, while the idea of justice may be regarded as an objective concept which could be applied in any culture, however, justice is not an abstract item in the 'sky', as its application is usually amongst people. This means an idea of justice cannot be extricated from the culture where it needs to be put to use. In the light of this and for our purpose, the fair allocation of health care resources in African countries has to be based on the African notion of justice.

In order to appreciate the African concept of justice, it is useful to succinctly indicate the general perception of what make up the general notion of traditional African morality. According to Omoregbe (1989) of Nigeria in West Africa, '…morality in African traditional thought is essentially interpersonal and social, with a basis in human well-being. For the African is, traditionally, his brother's keeper and is concerned about his well-being'. Wiredu (1983) of Ghana in West Africa supports Omoregbe's view when he states that African morality is founded on rational reflection as it pertains to the welfare of every member of the community. This means that it would be impossible to define the human person in the African context in isolation of that person's relationship with his kindred and community. This is because a person's life is intertwined with that of his community. This is derived from the fact that African ethics is communal in outlook. It defines moral precepts and values which Africans abide by consciously or unconsciously in their day to day living.   But this is not unexpected as the African self is defined within the framework of the community. This means that the realisation and actualisation of the self is expected to be through and within the community and not outside of the community. It is against this background one would have expected African communities to rationally and conscientiously address the case of millions of Luckys in Africa, despite the scarcity of (health) resources in most African countries.

Health resources as with all other resources are always in limited supply. How well we manage the allocation of scarce resources to achieve optimum good make all the difference. According to Edge and Randall (1999), the allocation of health care resources may be divided into macro and micro allocations. They used this distinction to highlight questions raised by this stratification as: [M]acro allocation problems are demonstrated in such questions as: what kinds of health care will be available? Who will get it and on what basis? How will the costs be distributed? Who will deliver the services? Who controls these issues? Micro allocation is the more personal determination of who will receive scarce resources, such as intensive care, beds, advanced technology, or organ transplantation'. However, most health conditions such as malaria, diarrhoea, tuberculosis etc that kill millions of Africans are inexpensive to treat and do not require the use of advanced technology. Hence, the focus of this paper is on relatively minor diseases that claim the lives of Africans on daily basis. For instance, Lucky's case only required his burns to heal properly for him to live. His mother got him out of hospital because she was too poor to keep him there, as she was too poor to stay away from the farm and their local market for a few weeks, hence Lucky died. Like Lucky, most people in African countries have no access (cannot afford) to minimum health care.

As already stated above, many Africans die annually from malaria and tuberculosis which can be treated with as little as between two to thirteen dollars respectively. It was reported by UNICEF (1994) that 'in less developed countries, tuberculosis will claim over 30 million lives in the next decade'. This means there is the need for African

countries to priotise their resources in favour of health care and education and at the same time abhor financial corruption. This will allow for a fair and just distribution of resources in the African continent. This is because while it is the moral responsibility of affluent countries to alleviate poverty in African countries, but such countries cannot be blamed for the relatively minor medical conditions that kill millions of people in Africa, as the treatment of such minor conditions can be sustained by the economies of most African countries if African political leaders can abstain from financial corruption. As it currently stands, African political leaders are yet to demonstrate the required political will and honesty needed in addressing the problem of basic and primary health care issues in that continent. Nor do they seem to realise that every member of a given society has the right to health care.

RIGHT TO HEALTH CARE

The right to health care is implicitly linked with the right to life, and most people will agree that the right to life is fundamental. If that be the case, then human life needs to be protected and preserved. The life (that of the rich or poor) involved is immaterial. But there are no rights without limitations; hence, it then becomes relevant to know the minimum healthcare a member of a given society is entitled to, but such entitlement must not be evaluated on the basis of one's ability to pay for basic healthcare. According to Thomson (1977), 'Valuation of life in terms of hard cash may be essential in establishing damages and compensation in a court of law, but in a doctor's surgery or in a hospital all that counts is life, irrespective of whatever market price may be attached to it'. This means that the status, worthiness and input value of human life is of no consequence in the provision of health-care. This is because 'human life has special value because humans are self-aware, rational, autonomous, purposeful moral beings with hopes and ambitions' (Kushe 1987). It is against this background that the moral evaluations of the minimum healthcare people on the Africa continent are entitled to will be discussed.

Lucky (whose case is similar to that of millions of people in Africa) belonged to the category of people who may be considered as minimally advantaged in a given society/community. Hence his case remains our case study for the purpose of this paper. The question that requires an answer is: If Lucky had access to minimum healthcare? If not, was his right breached? Apparently, Lucky did not have access to decent and minimum health care though he had access to a health institution. He and his parents could not afford the cost of care hence he died. In which case, it could then be argued that his right to minimum healthcare was breached. This is because by the virtue of a person's citizenship in a given community, such a person ought to have some basic rights, such as right to minimum healthcare. For instance, it is usually not in doubt that it is the responsibility of the state to provide security for lives of citizens and from undue molestation. In like manner, access to minimum healthcare ought to be considered as weighty as matters of security, as everyone ought to have the right to non-extraordinary healthcare. What is considered as ordinary and extra-ordinary healthcare should be determined by healthcare delivery system a country's economy can genuinely sustain. But any country which holds a blanket policy where her citizens can only access healthcare on the basis of their ability to pay cannot be said to be a just and fair society. In fact, the under-current reason for social security is primarily to protect the poor, weak and vulnerable. The vulnerable are those who are usually unable to promote and protect their own interests. The African continent must adhere to the pursuance of this objective. This is possible if resources are properly harnessed and justly distributed.

Sequel to appropriate harnessing of resources and responsible use of same, there is the need for political leaders in the African continent to review their micro health policies. This could be achieved by setting up a health insurance scheme which is deliberately designed to favour people who are minimally advantaged in a given African country. Such health insurance scheme should be financially sustained by the state. This ought not to be a problem in most African countries as such practice is in consonance with the traditional African extended and kindred family system. This system is a traditional tool designed to support members in need. According to Iroegbu (1994), the African extended family system provides 'mutual help at the material level'. Such a scheme will advance the promotion of healthcare amongst the economically deprived population in African countries.

Despite the potential achievements that might accrue from such an insurance scheme, much more could be achieved in Africa if the issue of

poverty alleviation is keenly addressed in that continent. This is where affluent countries must play significant roles. It is a known fact that one of the fallouts of poverty is poor nutrition. This in turn translates into poor health which places pressure on health care resources. One of the sure ways of poverty alleviation is through investment.

This implies that wealthy countries must necessarily invest in African countries. Grants and loans to African countries may never be the way forward for the eradication of poverty in African countries. Rather, investment in that continent will enhance their economy and provide employment; the combination will translate (in general terms) into better nutrition and improved health for people in that continent. But even more urgent than investment is the need for Western countries to help prevent and stop financial corruption amongst African leaders which has more or less become institutionalized.

In the mean time, Western countries allow corrupt African leaders get away with financial corruption while they (Western countries) look the other way. If this trend continues, then the Western world cannot claim that they are not in some kind of conspiracy with African politicians to 'kill' millions of Africans from poverty induced diseases. This is because there is no significant difference between killing and letting die.

However the Western world may wish to enhance the economic plight of the African continent, Africans must themselves take their destiny in their own hands. One way of doing so, is to restrict the number of children they reproduce. It is only then such parents will be in a position to responsibly perform their parental duties. No one can help us do this and we can and should be able to do this for ourselves. After all, self-help remains the most reliable form of help.

CONCLUSION

It is possible for the African continent to make minimum healthcare available to her citizens if certain simple things are taken into consideration. One, Africans need to resort to their once cherished traditional values which consist of unqualified respect for human life, the extended family system, communal living etc. Two, African political leaders must abhor financial corruption in public (and indeed private) life. Three, affluent countries must as a matter of urgency situate substantial investment in African countries as that will enhance the standard of living in that continent. If affluent countries insist on doling out grants and loans instead of investing in that continent, then it becomes the attendant responsibility of such affluent countries to ensure that monitoring structures are in place to enable such grants achieve their desired goals. These factors would enable most people in the African continent have access to minimum (non-extraordinary) health care. If that happens, then a major developmental stride as it relates to health care would have been taken, after all, 'caring for the sick is a prime moral and cultural principle' (Sass 2004).

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