THAT THEY MAY ALSO BE IN HEALTH AND PROSPER: COVID-19 PANDEMIC AND THE RIGHT TO DIGNITY OF HEALTH WORKERS IN NIGERIA

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Abstract:

The COVID-19 pandemic has wreaked and still wreaking unfathomable havoc across the globe, staggering governments and overwhelming health systems. While several aspects of human life have been greatly impacted by the virus, none is as lethal as its attack on human rights, with much of the scholarly focus on how mitigation measures have impacted a range of rights such as personal liberty, freedom of movement, etc. This article however looks in a different direction, examining how governments in their response to the pandemic have been trampling on the right to dignity of health workers using Nigeria as a case study. The goal of this article is to highlight the conflict between managing a public health emergency and safeguarding such an important right in a

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pandemic, towards propelling changes in the law and policy, in the post COVID-19 era.

Key words: COVID-19, Pandemic, Health, Workers, Dignity, Right & Constitution**.**

1. Introduction

On 23 April 2020, the United Nations (UN) Secretary-General Antonio Guterres, tweeted the following - "*COVID-19 is a public health emergency – that is fast becoming a human rights crisis. People – and their rights – must be front and centre…*".[1]This statement is instructive as it sets out what approach must guide countries in their response to the pandemic. While this statement is correct in all ramification, the reality in the case of health workers who have been at the thick of the battle against virus, has been troubling. As frontline workers, they have practically had the virus in their face, running the gauntlet to rescue individuals seized by COVID-19. In most countries, they have had to work round the clock, running endless shifts as the pandemic ramped up in different waves. As part of measures towards mitigating the virus, some countries embarked on mass recruitment, while at the same time also calling in retired health workers. All in all, the pandemic has been a war-zone experience for this category of citizens.

Nigerian health workers, just like their counterparts across the globe, also had to respond to the COVID-19 call of duty. This call, however has not being without grave concerns. The seeming

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[1] Ryan Kaminski and Cameron Kaufmann, 'Why Human Rights are Central to COVID-19 Response', *UN Foundation*, (24 April 2020), https://unfoundation.org/blog/post/why-human-rights-central-covid-19-response/ accessed 7 September 2020.

unpreparedness of Nigerian government in its response to the pandemic, resulted in the unnecessary loss of lives of these precious ones, thereby rendering their family members bereaved. Several others amongst their colleagues equally had their health put to serious jeopardy due to compounded stress and mental exhaustion. This is not forgetting those in fact got infected with the virus, due to no fault of theirs. While health workers are deemed a part of emergency services of the country, they are also individuals with rights clearly protected under domestic and international law. In particular, much of the omission and commission on the part of the government, resulting in continuing assault on the lives and wellbeing of health workers all in a bid to counter the virus, touches on the fundamental right to dignity of the human person, and in this context, that of the health workers. Importantly, the pandemic has emerged as an era of unprecedented conflict between individual's rights and that of the society.[2] This raises fundamental issues concerning the attitude of the government towards protection of this right in line with its domestic and international obligations.

The focus of this article is to examine the right to dignity of health workers in Nigeria, the extent to which the Nigerian government has discharged its obligation under International Human Rights Law (IHRL), as well as the possibilities for redress going forward. To interrogate these issues, this article focuses on relevant IHRL instruments such as the International Covenant on Civil and

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[2] *See, e.g.*, Gautam Gulati, Colum P. Dunne & Brendan D. Kelly, 'Do COVID-19 Responses Imperil the Human Rights of People with Disabilities' *Health Human Rights Journal* (3 June 2020) <https://www.hhrjournal.org/2020/06/do-covid-19-responses-imperil-the-human-rights-of-people-with-disabilities/> accessed 7 September 2020.

Political Rights (ICCPR),[3] the International Covenant on Economic, Social and Cultural Rights (ICESCR),[4] and the African Charter on Human and Peoples' Rights (ACHPR).[5] It examines these issues within the context of the right to dignity as provided in these instruments, as well as related provisions under the Nigerian Constitution.[6] It wades through a plethora of international instruments both human rights and non-human rights related, which deals with this subject, examining the deliberate protection afforded dignity by the human community. It also explores how this right was largely ignored by the Nigerian government in a bid to respond to the COVID-19 pandemic, the implication on health workers, and possible redress to victims. It argues that deploying health workers to the frontline with their right to dignity seriously compromised, isn't just a violation of this right, but importantly one that triggers a case for remedies. Conclusively, it admonishes the courts to be liberal in their approach in interpreting this right in the light of the COVID-19 pandemic.

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[3] International Covenant on Civil and Political Rights, *opened for signature* Dec. 19, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316, 999 U.N.T.S. 85 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR].

[4] International Covenant on Economic, Social, and Cultural Rights, *opened for signature* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 49, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter ICESCR].

[5] African Charter on Human and Peoples' Rights (ACHPR) 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) (*entered into force* 21 October 1986).African Charter on Human and Peoples' Rights, adopted 27 June 1981 by the OAU Assembly, OAU Doc CAB/LEG/67/3 Rev 5 (1982).

[6] Constitution of the Federal Republic of Nigeria, 1999 [Hereinafter '1999 Constitution'].

2. Impact of COVID-19 on Health Workers – Nigeria in View

1. The Global Space

The COVID-19 pandemic has breached the territorial sovereignty of nearly every country in the world. The virus has been able to find its way to every nook and cranny of the world. As at May it has reached 124 countries,[7] and as the year 2020 inched to a close, the number of cases had passed the 60 million range. According to the European Centre for Disease Prevention and Control, since 31 December 2019 and as at 3 December 2020, the total number of COVID-19 cases stood at 64, 455 619, with 1, 495 430 deaths.[8] In Nigeria, confirmed cases as at same date stood at 67, 838, with number of deaths and discharged cases being 1, 176 and 63, 430.[9]In so doing, it has stretched national health system, even for countries adjudged as having a very strong health sector.[10]Correctly observing the increasing pressure of the pandemic on the global health work force, Adams and Walls notes that this pressure is most noticeable in two key aspects i.e. "*the potentially overwhelming burden of illnesses that stresses health systems capacity and the second is the adverse effect on health care workers, including the*

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7 Ezekiel J. Emmanuel et al, 'Fair Allocation of Scare Medical Resources in the Time of COVID-19' (2020)382 *The New England Journal of Medicine*, 2049-2055 at 2049.

8 ECDPC, 'COVID-19 Situation Update Worldwide as of 3 December 2020', *European Centre for Disease and Control*<https://www.ecdc.europa.eu/en/geographical-distribution-2019-ncov-cases> accessed 4 December 2020.

9 NCDC, 'COVID-19 Nigeria', *Nigeria Centre for Disease Control (NCDC)* (2 December 2020) <https://covid19.ncdc.gov.ng/> accessed 2 December 2020.

10 Oluwatosin W. Akande and Tanimola M. Akande, 'COVID-19 Pandemic: A Global Health Burden' (2020) 27 (3) *Nigeria Postgraduate Medical Journal*, 147 – 155 at 150.

risk of infection".[11] A central feature of the pandemic is its significant impact on health workers in every country where a case has been reported.[12]

The impact of the COVID-19 pandemic on health workers has manifested in different forms. First is the high risk of being infected with the virus, as a result of their close contact with infected persons.[13]The risk they run is compounded by the fact that some patients may come with symptoms not previously in their medical history, while others may just be asymptomatic.[14]They run the same risk when interacting with potentially infected co-workers.[15] Doctors, Nurses and other health workers involved in diagnosis, treatment and care of patients, stand a greater risk of contracting the virus, than ordinary members of the society.[16]For instance, it's been noted that the close proximity between Ophthalmologists and patients during examination such as slit-

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[11] James G. Adams and Ron M. Walls, 'Supporting the Health Care Workforce During the COVID-19 Global Epidemic' (2020) 323 *Journal of American Medical Association*, 1439.

[12] O.A. Onigbinde, O. Babatunde and A.O. Ajagbe, 'The Welfare of Health Workers Amidst COVID-19 Pandemic in Sub-Sahara Africa: A Call for Concern' (2020) 15 *Ethics Medicine and Public Health*, 1 – 4 at 1.

[13] Oluwadamilola A. Adejumo, Oluseyi A. Adejumo & Friday E. Okonofua, 'Rights Versus Responsibilities of Health Care Workers in Nigeria: Changing the Narrative in the COVID-19 Era' (2020) 24 (2) *African Journal of Reproductive Health*, 41 – 45 at 42.

[14] *Ibid.*

[15] Malcolm R. Sim, 'The COVID-19 Pandemic: Major Risks to Healthcare and Other Workers on the Frontline' (2020) 77 (5) *Occupational and Environmental Medicine*, 281 – 282 at 281.

[16] Modesto Leite Rolim Neto, et al, 'When Health Professionals Look Death in the Eye: The Mental Health of Professionals Who deal daily with the 2019 Coronavirus Outbreak' (2020) 288 *Psychiatry Research*, 1 – 3 at 1.

lamp examination, tonometry and direct ophthalmoscopy, may pose a great risk. [17]To minimise rate of infection, health workers are required to be armoured in a PPE. In the US, the Centre for Disease Control (CDC) recommended the use of PPEs such as gowns, gloves, and either an N95 respirator plus a face shield or Powered Air-Purifying Respirator (PAPR).[18]Aside the risk associated with direct contact with infected persons, health workers also run the risk of infection by just working in the hospital environment where they have to interact with surfaces, computers, elevators, etc.[19]Added to the chain, is the risk of patients who earlier been admitted for non-COVID-19 related ailments, been infected with the virus.[20]

Second is the health issues related to the burden of managing COVID-19 patients. Health workers suffer mental and emotional stress by reason of the nature of their work, something symptomatic of previous pandemics.[21] Due to overstress in a burdened health system, they also experience burnout.[22] Much of the work-connected stress is associated with things such as anxiety, depression following countless deaths, and working long shifts

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[17] Mariacristina Parravano, et. al, 'Protect Healthcare Workers and Patients from COVID-19: The Experience of Two Tertiary Ophthalmology Care Referral Centres in Italy' (2020) 9 (2) *Ophthalmology and Therapy*, 231 – 234 at 232.

[18] James G. Adams and Ron M. Walls, 'Supporting the Health Care Workforce During the COVID-19 Global Epidemic' (2020) 323 *Journal of American Medical Association*, 1439.

[19] Lisa Rosenbaum, 'Facing COVID-19 in Italy: Ethics, Logistics and Therapeutics on the Epidermic Frontline'(2020) 382 (20) *The New England Journal of Medicine*, 1873 – 1875 at 1874.

[20] *Ibid.*

[21] Sim (n 15); Adejumo, Adejumo and Okonofua (n 13).

[22] Neto, et al (n 16).

with different demands in the treatment of patients.[23]They also live in constant fear and psychological stress i.e. fear of they themselves transmitting the virus and the several unclear aspects of the virus they are dealing with.[24] In short they are scared for their colleagues, family members, friends, community, etc.[25]

Third is the risk posed by the lack of adequate PPE,[26] which on its part has also aggravated issues of mental health.[27] The shortage of PPEs has caused rationing and the need to allocate medical resources fairly during the pandemic.[28]Fourth, is the microeconomic effect of the pandemic, which extends to the burden of morbidity and mortality.[29] With the pandemic, families of infected persons come under the burden of out-of-pocket health spending related to diagnosis and treatment, where such is not covered by government or where they have no health insurance, and even where there is insurance cover, they still have to bear co-payment and other related costs.[30] This impacts heavily on families of health workers who get infected with the virus. Fifth, is the impact of the pandemic on the family of health workers. In order not to enhance local transmission, many health workers decide to

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[23] *Ibid.*

[24] Haley Ehrlich, Marl McKenney and Adel Elkbuli, 'Protecting our Health workers During the COVID-10 Pandemic' (2020) 38 (7) *American Journal of Emergency Medicine*, 1527-1528 at 1527.

[25] *Ibid* at 1528.

[26] Adejumo, Adejumo and Okonofua (n 13) at 42.

[27] Sim (n 14).

[28] Emmanuel et al (n7).

[29] John E. Ataguba, 'COVID-19 Pandemic, A War to be Won: Understanding its Economic Implications for Africa' (2020) 18 *Applied Health Economics and Health Policy*, 1 – 4.

[30] *Ibid.*

isolate themselves from their family members.[31]Sixth, has to do with extreme situations i.e., when some health workers ultimately lose the battle to the virus. The death of a health worker is a major loss to any health system.

To start with, these are human lives that precious and bear sanctity. Also, the fact that the deceased may be the breadwinner of a family or sole benefactor to several other people, means that this class of persons have also been greatly affected by the pandemic. More so, the loss of a health worker is a loss to the State, given the years of training that goes into developing them in certain medical specialities. The impact of the virus on health workers, particularly in some of the worst affected countries, point to certain irrefutable points i.e., the precarious state of their work, the avoidable hazards they are subjected to, as well as the low threshold of human rights protection they enjoy. In Wuhan where the virus broke out from, almost 4% comprised health workers. In fact, Dr. Li Wenliang, the Chinese Medical Doctor and Ophthalmologist at the Wuhan Central Hospital, who first alerted the world about the virus, himself lost the battle to the virus on 7 February 2020.[32]As at 11 February 2020, 1,716 cases of COVID-19 infections had been confirmed amongst health workers in China and by 16 March 2020, 24 had died from the virus.[33]Also in China, due to the need to put

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[31] Dioscoridi Lorenzo & Chiara Carrisi, 'COVID-19 Exposure Risk for Family Members of Healthcare Workers: An Observational Study' (2020) 98 *International Journal of Infectious Diseases*, 287 – 289.

[32] Eskild Petersen, et al, 'Li Wenliang, A Face to the Frontline Worker: The First Doctor to Notify the Emergence of the SARS-COV-2 (COVID-19) Outbreak' (2020) 93 *International Journal of Infectious Diseases*, 205 – 207.

[33] Wie Li, et al, 'Characteristics of Death Amongst Health Workers in China During the Outbreak of COVID-19 Infection' (2020) 81 (1) *The Journal of Infection*, 147 - 178.

on the PPE, many health workers reportedly avoid drinking water while also wearing adult diapers, which caused some to faint.[34]In the US, mayors of several large and small cities have spoken out about shortage of PPEs, and many urban hospitals such as those in New York City, are finding it difficult to buy necessary medical supplies.[35]In Italy, more infections have been reported amongst health workers than in China.[36]According to reports, as at 26 March 2020, about 5,000 Italian health workers have tested positive to the virus, with 40 losing their lives.[37] As at 5 April 2020the number of infected health workers had increased to 12,252, representing about 10% the health workforce.[38]

2. The Nigerian Situation

The best way to describe response to the pandemic in Africa, is to refer to it as reactive and that of a 'wait and follow' developments in the west. This may not be unconnected with the state of pre-COVID 19 health infrastructures on the continent, which has always been highly suspect. For instance, South Africa one of the few countries with significant investment in its health sector has 0.776 doctors to 1,000 patients, while the continent as a whole has

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[34] *Ibid.*

[35] Douglas Kamerow, 'COVID-19: The Crisis of Personal Protective Equipment in the US' (2020) 369 *British Medical Journal*, 1.

[36] F. Chirico, G. Nucera & N. Magnavita, 'COVID-19: Protecting Health Workers is a Priority' (2020) 41 (9) *Infection Control and Hospital Epidemiology*, 117.

[37] A Burdorf, F. Porru & R. Rugulies, 'The COVID-19 (Coronavirus) Pandemic: Consequences for Occupational Health' (2020) 46 (3) *Scandinavian Journal of Work, Environment and Health*, 229-230 at 229.

[38] Anna Bersano & Leonardo Pantoni, 'On Being a Neurologist in Italy at the Time of the COVID-19 Outbreak', (2020) 94 (21) *Neurology*, 905-906 at 905.

one doctor to about 5,000 people.[39] In the same vein, most African countries have less than one hospital bed per 1000 people.[40] There is also the challenge of adequate medical personnel. In 2013, sub-Sahara Africa was reported to have a deficit of 1.8 million doctors, a shortage that has been attributed to factors such as lack of adequate funding of the health sector, insufficient medical training and occupational migration abroad.[41]While impact of the virus on the continent has been relatively minimal, the story of health workers does not bear similarity with this position. Rather it has toed the same path has their peers across the globe i.e., pain, anguish, fear, a feeling of low appreciation by the state and glaring human rights violations.

Health workers in Africa, have had to operate in the eye of the COVID-19 storm. According to the WHO, COVID-19 infections on the continent has grown to about 203% since May following a spike in community transmission and inadequate PPE.[42] Statistics from the Africa Centre for Disease Control (CDC) shows that as at 9 July, 5.7million tests have been carried out on the continent, posing a 8.9% positivity rate, with South Africa accounting for over 2million of the tests.[43] A major crisis that has however dogged the continent's response to the virus has been the non-availability of requisite testing kits and PPE, which has caused health workers

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[39] Amanze I. Ikwu, et al, 'The Impact of COVID-19 Pandemic on Africa's Healthcare System and Psychosocial Life' 4 (2) *European Journal of Medicine and Natural Sciences*, 57 – 66 at 59.

[40] *Ibid.*

[41] *Ibid.*

[42] Bibi Aisha Wadvalla, 'How Africa Has Tackled COVID-19?' (2020) 370 *British Medical Journal*, 1.

[43] *Ibid* at 2.

in different countries to embark on protest and strike action.[44]They are exposed to the double risk of working under severe strain occasion by the underdeveloped nature of the continent's health systems, as well as the threat posed by COVID-19. As at 9 June 2020, more than 2,000 South African health workers had contracted the disease and by 29 June 2020, the number had increased to more than 3,500 with 34 deaths.[45]

While not leading in terms of COVID-19 infections, Nigeria has had its fair share when it comes to the life-threatening impact of COVID-19 on its health workers. Five key areas identified in which COVID-19 has impacted Nigerian health worker are in terms of PPEs, personnel and welfare, funding, reduced supply of medication and poor information systems.[46] Even though private organisations such has O'Pay and the Jack Ma Foundation donated close to 80,000 masks to the country, health workers still lacked enough PPEs.[47]Months after the breakout of the virus, Nigerian health workers at the frontline have been complaining about lack of PPEs.[48]For example at the Randle Hospital in Surulere Lagos, reports has it that there is a shortage of bandages and gauzes amongst other PPE and in some other facilities, it is alleged that

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44 *Ibid.*

45 Ikwu, et al (n39) at 60.

46 AkindareOkunola, '5 Challenges Facing Health Care Workers in Nigeria as They Tackle COVID-19' *Global Citizen* (9 June 2020) <https://www.globalcitizen.org/en/content/challenges-for-health-care-workers-nigeria-covid> accessed 8 October 2020.

47 *Ibid.*

48 Angela Onwuzoo, 'Fighting a Pandemic without PPE' *Punch Healthwise* (3 August 2020) <https://healthwise.punchng.com/fighting-a-pandemic-without-ppe> accessed 08/10/2020.

patients are asked to actually provide the PPE.[49] Since then doctors have embarked on strike action to protest lack of PPE as well as life insurance especially for their members who died treating COVID-19 patients.[50]

Personnel/Welfare and funding go hand in hand. In the course of the pandemic, health workers have severally threatened and actually embarked on strike actions. Even before the pandemic the country was already suffering from a shortage of personnel, due to low governmental investment in the health sector leading to occupational migration. The challenge of medical brain drain has reportedly seen about 10,000 doctors emigrate between 2016 and 2019.[51]The challenge also extends to other health professionals in the country. According to the President of the Pharmaceutical Society of Nigeria, Sam Ohuabunwa, current statistics showed a ratio of one pharmacist to 50,000 people in the country.[52] It is stated that sometimes for months health workers go on working without pay, such as the case of Medical Doctors in an Abuja

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49 Okunola, (n. 46).

50 Nike Adebowale, 'Doctors Strike, COVID-19 Dominate Health Stories last week' *Premium Times* (13 September 2020) <https://www.premiumtimesng.com/news/top-news/414233-doctors-strike-covid-19-dominate-health-stories-last-week.html> accessed 8 October 2020.

51 Olayinka Omolere, 'The Real Costs and Solutions for Migration of Nigerian Doctors' *Financial Nigeria*, (5 August 2020) <http://www.financialnigeria.com/the-real-costs-and-solutions-for-the-migration-of-nigerian-doctors-blog-564.html> accessed 8 October 2020.

52 Adebayo Folorunsho-Francis, 'Nigerian has ratio of One Pharmacist to 50,000 people – PSN' *Punch Healthwise* (7 October 2020) <https://healthwise.punchng.com/nigeria-has-ratio-of-one-pharmacist-to-50000-people-psn> accessed 8 October 2020.

COVID-19 Isolation centre, who at a time had not been paid for three months.[53]

Lack of adequate sensitisation of the citizenry about the virus leading to nonchalance about its impact, has also made the work of health workers very challenging.[54]The pandemic has been one of mixed messaging and discordant tunes. While the Health Minister Dr. Osagie Ehanire maintains that the issue of PPE has been adequately dealt with, the National Association of Resident Doctors (NARD) continues to lament about the mounting increase in infections and deaths amongst health workers.[55]According to Punch Healthwise, in the 2001 Abuja Declaration African Union (AU) members pledged to allocate at least 15% of their national budget to fund the health sector, however governments in Nigeria have consistently allocated far less than this percentage to the health sector to the chagrin of key stakeholders.[56]The same report notes that, "*Nigeria's health budget for 2018 stood at 340.46 billion naira, which was 3.96% of its N8.6trillion proposed national spending. A breakdown of the health budget showed Nigeria, then estimated to have a population of 186million,*

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53 Jude Egbas, 'How Doctors are Treated Slaves in Abuja COVID-19 Isolation Centers and owed Allowances for Months' *Pulse NG* (29 August 2020) <https://www.pulse.ng/news/local/covid-19-how-abuja-doctors-are-treated-like-slaves-and-owed-for-months-pulse/09ms135>accessed 8 October 2020.

54 Okunola, (n 46).

55 Peter Mwai and Christopher Giles, Coronavirus: How Vulnerable are Health Workers in Nigeria? *BBC News* (17 June 2020) <https://www.bbc.com /news/world-africa-53013413> accessed 8 October 2020.

56 Tobi Aworinde, 'COVID-19 Exposes Nigeria's Wobbling Healthcare System' *Punch Healthwise* (10 May 2020) <https://healthwise.punchng.com/ covid-19-exposes-nigerias-wobbling-healthcare-system> accessed 8 October 2020.

allocated approximately N1, 832. 62 for each citizen".[57] It also observes that, "*of the total N9.45trillion budgeted for 2020 by the Federal Government, N427.3 Billion (4.5%) was allocated to health*".[58]The implication is that in the course of this pandemic, health workers have had to bear the brunt of the virus. It is reported that more health workers have tested positive to the virus in the country than in any other African country, except for South Africa.[59]

At his opening remarks at the World Health Assembly, the WHO Director-General Tedros Adhanom Ghebreyesus noted that a staggering 115,000 health workers have died from the COVID-19 pandemic.[60]In the case of Nigeria, according to reports, as at 22 June 2020 about 910 Nigerian medical doctors were quarantined for been possibly infected with the virus, out of which 239 tested positive.[61]According to the Director-General of the NCDC, Dr. Chikwe Ihekweazu no fewer than 812 health workers have been infected with the virus in Nigeria, while NARD also reported on 17 June 2020 that 10 Medical Doctors in the country have died from the virus.[62]The first of such demise happened on 15 April 2020,

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57 *Ibid.*

58 *Ibid.*

59 Mwai and Giles (n55).

60 Tom De Castella, 'WHO Says at least 115, 000 Health Workers Have Now Died from COVID-19'*Nursing Times* (27 May2021) <https://www.nursingtimes.net/news/coronavirus/who-says-at-least-115000-health-workers-have-now-died-from-covid-19-27-05-2021/> accessed 22 November 2021.

61 Omotade A. Ijarotimi, et al, 'COVID-19 and Obstetric Practice: A Critical Review of the Nigerian Situation' (2020) 151 (1) *International Journal of Gynaecology and Obstetrics*, 17 – 22.

62 Onwuzoo, (n 48).

when an Obstetrician who had been exposed to an infected patient in his private clinic, died of the virus at the Lagos University Teaching Hospital (LUTH).[63]In Lagos, the epicentre of the pandemic in the country, the Commissioner for Health Professor Akin Abayomi reports that the state had also lost 14 health workers to the pandemic.[64]This situation has forced medical as well as health workers' unions in the country to down-tool at different times and embark on strike action. For instance, on 15 June 2020, NARD embarked on a nationwide strike action for one week, with part of the issues being lack of enough PPEs.[65] This is in addition to the fact that, even before the pandemic health workers in the country had frequently down tooled.[66]

Often times while much attention is focused on the obligation of doctors for instance to their patient, not much is said of what is owed them in return.[67] It has however been established that doctors only feel they have an obligation to work, when certain things are in place.[68] For instance, in the context of the COVID-19 pandemic, such things include key reciprocal obligations such as adequate indemnity insurance, provision of PPEs, suitable working hours and adequate rest, priority testing for those who develop symptoms

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63 Ijarotimi, et al, (n 60).

64 DayoOjerinde, '14 Health Workers Have Died from COVID-19 in Lagos, Says Commissioner' *Punch Healthwise* (28 June 2021) <https://healthwise.punchng.com/14-health-workers-have-died-from-covid-19-in-lagos-says-commissioner/> accessed 22 November 2021.

65 Onwuzoo, (n 48).

66 *Ibid.*

67 Stephanie B. Johnson and Frances Butcher, 'Doctors during the COVID-19 Pandemic: What are their Duties and What is Owed to them?' (2021) 47 *Journal of Medical Ethics* 12 – 15 at 13.

68 *Ibid.*

in during the pandemic, access to best available medical cater when they get sick, sufficient sick pay for occupationally acquired ill health, post pandemic mental health support, etc.[69] In addition, it's been rightly noted that just as it is key that COVID-19 patients have access to medical treatment and health care delivery, it is equally important to ensure that the rights of health workers, working at the frontline is correspondingly protected by law and policy.[70]

It is incontestable that the COVID-19 pandemic created unprecedented strain on health systems across the globe.[71] According to Gostin, Friedman and Wetter, "*health facilities do not have the capacity to cope with the expected patient number: they lack enough critical care beds, ventilators, essential medicines, and personal protective equipment for health workers*".[72] No health system in the world was prepared for the outbreak,[73] and the fact that epidemiologists and other experts, were trying to understand the dynamics of the virus as it evolved and the lack of a vaccine, resulted in a situation in which most health systems either became overwhelmed or nearly overwhelmed by its sudden surge. With its sort of blitzkrieg spread, governments had to frantically provide essential hospital materials and medical supplies in immediate response, both for infected persons as well as health workers. The

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69 *Ibid*at 14.

70 Adejumo, Adejumoand Okonofua (n13) at 42.

71 Pedro Baqui et al, 'Ethnic and Regional Variations in Hospital Mortality from COVID-19 in Brazil: A Cross-Sectional Observational Study' (2020) 8*Lancet*, 1018.

72 Lawrence O. Gostin, Eric A. Friedman and Sarah A. Wetter, 'Responding to COVID-19: How to Navigate a Public Health Emergency Legally and Ethically' (2020) 50 *Hastings Centre Report*, 8.

73 Onigbinde, Babatunde and Ajagbe, (n 12) at 2.

fact that the pandemic is global in nature, made this all the most difficult, as governments from different countries competed for scarce medical supplies.

As correctly noted, human rights are not aspirational but represents minimal set of freedoms that everyone shares, whether as workers, citizens or human beings.[74]This state of affairs therefore does not provide a valid excuse for any government to abandon its human rights obligation under international law. It does not permit a government to derogate from a right that is not only fundamental to every individual, but which is directly needful in the effort to combat the pandemic i.e., the right to life with dignity. It has been noted that a nation's readiness to properly respond to any public health crisis, is often a combination of several factors such as adequate facilities for isolation of infected persons, availability of PPEs, proper training of staff in bio-safety matters, diagnostic capacity of key institutions, motivation of health workers, etc.[75] The hazardous state that health workers in Nigeria had to work in, is traceable to the years of neglect that has been the bane of the health sector. For instance, the WHO ranks the country 143 out of 195 member countries with the worst health system.[76] This meant that at the time of the outbreak, the country's health sector lacked the required capacity to protect the right to life with dignity of its health personnel. Rather, it was a matter of scrambling an already stretched system, to mount defence against a rampaging pandemic, with less of this right in view.

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[74] *Ibid.*

[75] *Ibid.*

[76] Augustine A. Onyeaghala and Isiramen Olajide, 'Managing COVID-19 Outbreak in Nigeria: Matters Arising' (2020) 58 (1) *Clinical Chemistry and Laboratory Medicine,* 1645 – 1650.

It is important to state that the least any government can do is to work with the existing situation, towards protecting this right. According to Sheather, Hartwell and Norcliffe-Brown, "*that healthcare workers even in the wealthiest countries have had to work without protective equipment is not just a scandal, it is a violation of their fundamental rights: rights to health, rights to just and favourable conditions of work and rights to life*".[77] The trio further noted that "*figures from the international Council of Nurses quoted by Amnesty indicates that, worldwide, more than 600 Nurses have already died from covid-19. Globally the number of healthcare workers infected could be approaching 200,000*".[78] As additionally observed by Murphy and Whitty, "*the first possible human rights response to public health emergency preparedness is to embrace it, even to acclaim it*".[79] That however does not mean that human rights subjects should be trumped on the bill of combatting a pandemic, not when such right belong to a class of persons put at frightening risk.

For Nigeria, one may argue that the attitude of the government to this right, is reflective of the state of general disdain for human rights protection, except that case of health workers in the country has been most distressing. It is therefore important that there is a conversation around the accountability of government in this wise. However, this only becomes possible when the protection afforded

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[77] Julian Sheather, Arthy Hartwell and Dominic Norcliffe-Brown, 'Serious Violations of Health Workers' Rights during Pandemic' (2020) 370 *British Medical Journal*, 1.

[78] *Ibid.*

[79] Therese Murphy and Noel Whitty, 'Is Human Rights Prepared? Risk, Rights and Public Health Emergencies' (2009) 17 (2) *Medical Law Review*, 219 – 244 at 227.

this right, under domestic and international law is sufficiently understood, to determine whether cases of violation can be indeed be sustained. The important question to ask at this point therefore is "*How is the right to life dignity construed under international law and to what extent has it been violated in the light of Nigerian health workers in this pandemic?*" This next section supplies the necessary answers.

3. Right to Dignity of Health Workers: Nigeria's Obligation under Domestic and International Law

Issues around the extent to which the Nigerian government has protected the right to dignity of health workers in the country within its domestic and international obligation is the focus of this section of the article. Vestner and Rossi have asked what is the place of civil and political rights in a pandemic and whether they should unconditionally give way to other primary values.[80] In responding to this query, they have noted that when values conflict, as it is the case with combatting the COVID-19 pandemic, the difficult task of deciding on what to protect and sacrifice doesn't happen in a legal vacuum but is rather guided by law.[81]The branch of international law directly relevant to this part of the article is IHRL. Essentially, individuals, even though citizens of sovereign states, gained recognition for their rights in international law, through four stages of international law-making, with the first being statements about human rights in the UN Charter;[82] the

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[80] Tobias Vestner and Altea Rossi, 'COVID-19: The Fine Balance under Human Rights Law' *Geneva Center for Security Policy (GCSP)* (17 April 2020) <https://www.gcsp.ch/global-insights/covid-19-fine-balance-under-human-rights-law> accessed 22 November 2021.

[81] *Ibid.*

[82] UN CHARTER, *signed* 26 June 1945, 59 stat. 1031 T.S. Nos. 993, 3 Bevans 1153, (*entered into force* 24 Oct. 1945).

second, the adoption of the UDHR 1948;[83] the third, the ratification of both the International Covenant on Civil and Political Rights (ICCPR) 1966[84] and the International Covenant on Economic Social and Cultural Rights (ICESCR) 1966;[85] and the fourth, the subsequent ratification of other human rights instruments dealing with special class of persons such children i.e. the Convention on the Rights of the Child (CRC) 1989,[86] and women i.e. the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) 1993;[87] amongst others.[88]

This organogram of human rights, with the UN Charter at the top, has emerged as an international bill of rights, much profound than earlier American and French declarations.[89]While on the one hand, a large number of countries have now ratified major human rights treaties and conventions of specialised agencies, these documents have also been greatly enhanced by regional human rights treaties such as the European Convention on Human Rights, American Convention on Human Rights and the African Charter on Human

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83 Universal Declaration of Human Rights, G.A. Res. 217A, at 71, U.N. GOAR, 3d Sess., 1st plen. mtg., U.N. Doc A/810 (Dec. 12, 1948).

84 ICCPR, 1966.

85 ICESCR, 1966.

86 Convention on the Rights of the Child, *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3 (*entered into force* Sept. 2, 1990) [hereinafter CRC].

87 Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Dec. 18, 1979, G.A. Res. 34/180, 34 U.N. GAOR, Supp. No. 46, at 193, U.N. Doc. A/34/46 (*entered into force* Sept. 3, 1981) [Hereinafter CEDAW].

88 Louis B. Sohn, 'The New International Law: Protection of the Rights of Individuals rather than States'(1982) 32*American University Law Review*, 11.

89 *Ibid* at 12.

and Peoples' Rights.[90] Though controversies have, and continue to trail their efficacy, with some seeing them as no more than soft laws or mere guidelines, one overarching perspective is that they have come to be accepted as forming part of Customary International Law (CIL) and therefore binding on States.[91]

In this part of the article, focus would be on the right to dignity of the human person, which has been described as the right to physical and mental integrity.[92]This right will be examined on the basis of the settled position that international law is majorly a state-centric and normative system,[93] which implies that obligation for the protection of this right lies with the Nigerian government. Key issues in this section will also be examined in the light of the intersection between civil-political rights and socio-economic rights. Attention would also be paid to the domestic protection afforded the same right under the Nigerian Constitution. Essentially, in examining Nigeria's obligation under IHRL, attention would be paid to just a few rights, in order to limit the scope of the work. These rights come within the framework of civil and political as well as socio-economic rights.

1. Civil and political rights

A corollary to life, is dignity of the human person. As a matter of fact, that human beings have a right to life, is a reflection of their

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[90] Thomas Buergenthal, 'The Contemporary Significance of International Human Rights Law'(2009) 22 *Leiden Journal of International Law*, 220.

[91] Sohn (n 85) at 12.

[92] Constantin C. Tita and Violeta D. Tita, 'The Right to Life and Right to Physical and Mental Integrity: Pillars of the Security and Protection of the Individual' (2019) 5*Journal of Law and Public Administration*, 118 – 129.

[93] Rein Mullerson, 'Right to Survival as Right to Life of Humanity' (2020) 19 *Denver Journal of International Law and Policy*, 47.

dignity. Human Rights is deemed as rooted in the concept of human nature, an idea which has its roots in the natural law school of jurisprudence, and also cascades down to the concept of natural rights.[94] As it has been correctly argued, this understanding informed the opening statement of the UDHR, which states that, "*recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world*".[95] Apparently, declaring this as the basis on which human rights must be respected, the UDHR notes that, "*all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood*".[96]By its invocation of dignity, the UDHR establishes a sufficient nexus between human nature and the idea of human rights.[97] In Article 5 it states that "*no one shall be subjected to torture, or to cruel, inhuman or degrading treatment of punishment*".[98] Article 7 of the ICCPR reaffirms the same stating 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*".[99] These obligations are binding on the government, given that Nigeria became a state party to the ICCPR on 29 July 1993.

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[94] Tom Finegan, 'The Right to Life in International Human Rights Law', *Backgrounder No. 3464, Richard & Helen Devos Centerfor Religion & Civil Society*(24 January 2020) 3.

[95] *Ibid* at 4.

[96] Article 1 UDHR 1948.

[97] Finegan, (n94) at 4.

[98] UDHR 1948.

[99] ICCPR 1966.

Not only has the pandemic impacted greatly on the dignity of health workers in Nigeria, who as frontline workers come face to face with the virus, the lackadaisical attitude of government towards these workers, is enough to show how much it values this right. Yet in by the combined provisions of Articles 5 of the UDHR and Article 7 of the ICCPR Nigeria has an obligation to protect this class of its citizens. Though, not direct cases of torture, the hazardous state in which these health workers have been made to work is a violation of their right from being subjected to inhuman and degrading treatment and punishment, rights covered by article 5 of the UDHR[100] and article 7 of the ICCPR.[101]Yet, even with the great risk to their life and dignity, the National Health Act (NHA) 2014 forbids health workers from refusing emergency cases.[102] Article 20 (1) states that, "*a health care provider, a health worker or health establishment shall not refuse a person emergency medical treatment for any reason whatsoever*".[103] Section 20 (2) adds that, "*any person who contravenes this section is guilty of an offence and is liable on conviction to a fine of N100,000 (one hundred thousand naira) or to imprisonment for a period not exceeding six months or to both*".[104]The only instances where a patient can be refused, is where such is physically or sexually abusive to the health worker. The meaning of the above provisions is that, even though a Nigerian health worker may not have adequate PPE to protect himself/herself, where a COVID-19 patient is brought into a designated isolation facility, such health worker cannot refuse to attend to the patient. Where then lies the

[100] UDHR 1948.
[101] ICCPR 1966 (n 3).
[102] Adejumo, Adejumo and Okonofua (n13) at 43.
[103] NHA 2014.
[104] NHA 2014.

health workers right to dignity of his/her person? Situations of this nature, is *akin* to throwing a soldier into the thick of the battle, without providing the necessary amour to help him withstand fire from the enemy.

2. Socio-Economic rights

In addition to the above civil-political rights, IHRL also extends to socio-economic rights, with particular emphasis to be placed on the right to safe working environment and health. In this context Article 7 of the ICESCR[105] provides that, "*the State Parties to the present Covenant recognise the right of everyone to the enjoyment of just and favourable conditions of work, which ensure, in particular – safe and heathy working conditions*". Particularly instructive is Article 12 of the ICESCR which state that:

> The State Parties to this present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by State parties to the present Covenant to achieve the full realisation of this right shall include those necessary for - provision for the reduction of stillbirth rate and of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment, and control of epidemic, endemic, occupational and other diseases; creation of conditions which would assure to all medical

[105] ICESCR 1966.

> service and medical attention in the event of sickness.[106]

Nigeria became a state party to the ICESCR on the same day as the ICCPR i.e., 29 July 1993. The implication is that in line with Article 7, the government has an obligation to ensure that health workers engaged for the purpose of combatting the COVID-19 pandemic operate in a '*safe and healthy working conditions*', and also enjoy, '*the highest attainable standard of physical and mental health*'. The government is also obligated to put in place adequate measures for COVID-19 which clearly come under the phrase, '*the prevention, treatment, and control of epidemic, endemic, occupational and other diseases*'. These obligations have clearly not been followed by the government in the course of managing this pandemic. The WHO Coronavirus Disease (COVID-19) Outbreak: Rights, Roles, and Responsibilities of Health Workers,[107] released on 19 March 2020 tried to provide some sort of emergency roadmap for the human rights of health workers in the pandemic.[108]

Amongst others matters, it arms the health worker with rights such as – right to information, instruction and training on occupational safety and health; right to PPE (masks, gloves, goggles, gowns, hand sanitizers, soap and water and cleaning supplies) in sufficient quantity to healthcare and other staff caring for suspected or conformed COVID-10 patients, and to be trained on its use; right to

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[106] Article 12 (1 & 2) ICESCR 1966.

[107] WHO, 'Coronavirus Diseases (COVID-19) Outbreak: Rights, Roles and Responsibilities of Health Workers, Including Key Considerations for Occupational Safety and Health', *World Health Organisations (WHO),* <https://www.who.int/docs/default-source/coronaviruse/who-rights-roles-respon-hw-covid-19.pdf?sfvrsn=bcabd401_0> accessed 22 November 2021.

[108] Adejumo, Adejumo and Okonofua, (n 13) at 43.

technical updates on COVID-19 and provide appropriate tools to assess, test and treat patients and to share infection prevention and control information with patients; right to stay at home and not return to work when there is serious danger to life or health; right to necessary working hours along with breaks; right to compensation rehabilitation as well as treatment when infected with COVID-19; right to access mental health and counselling resources.[109]It been noted that success in implementing these rights will rest largely on the commitment governments demonstrate towards it.[110] However, where such government defaults, what happens? Clearly, in addition to implementation difficulties, holding governments accountable when they default on these rights is bound to be problematic. Nonetheless, though these rights are not exactly the type provided for in existing IHRL instruments, they provide useful insight into how specific COVID-19 related rights, can be extracted from mainstream human rights.

At this juncture, it is important to state that rights in the Nigerian Constitution, are essentially referred to as 'constitutional rights', which in conceptual terms, is distinct from the idea of 'human rights'. The whole gamut of these rights is found in sections 33 – 43, otherwise referred to as Chapter IV of the 1999 Constitution.[111] Nwafor did a brilliant job, laying out this distinction, by stating that while constitutional rights are rights that are enforceable in line with prescribed procedures in the Constitution, human rights do not enjoy such, as certain human rights may not be justiciable.[112]

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[109] WHO, (n107).

[110] Adejumo, Adejumo and Okonofua, (n 13) at 44.

[111] 1999 Constitution.

[112] Anthony O. Nwafor, 'Enforcing Fundamental Rights in Nigerian Courts – Processes and Challenges'(2009)4 *African Journal of Legal Studies*, 2.

Another distinction which he reiterates is the difference in their jurisprudential evolution, which is that while constitutional rights are product of positive law, human rights evolved out of the natural law jurisprudence.[113] He also notes that these constitutional rights are otherwise known as fundamental rights.[114] He recalls the opinion of the court in *Ransome Kuti & Ors v. Attorney-General of the Federation*,[115] which states that:

> Not every civil or legal right is a fundamental right. The idea and concept of fundamental rights both derive from the premise of the inalienable rights of man – life, liberty and the pursuit of happiness. Emergent nations with written constitutions have enshrined in such constitutions some of these basic human rights. Each right that is thus considered fundamental is clearly spelt out.[116]

The relevance of this distinction, is that while this article deals with the human rights of health workers that the Nigerian government has violated in the course of managing the COVID-19 pandemic, a few of these rights such as the right to dignity is clearly enforceable under the Nigerian Constitution. While, a health worker may go ahead to hold government accountable in this respect, there is a lacuna as the remaining rights such as right to health and safe working environment, which fall outside the scope of Chapter IV are left in limbo. This is certainly not in the interest of health workers who have suffered and are now likely to go unremedied. The question to therefore ask is - what further argument can be

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[113] *Ibid.*

[114] *Ibid* at 3.

[115] (1985) 8 NWLR (pt. 6) 211 *per* Oputa, J.S.C.

[116] Nwafor (n 112) at 3.

made for the enforcement of these remaining rights, especially in the light of their ouster under the Nigerian constitution? Should this ouster be enough to preclude health workers from adequate remedies for harm suffered in a pandemic, where government clearly has an international obligation? To address these issues, the next section will consider how the dual regime of enforcement works.

4. Enforcing the Right to Dignity of Nigerian Health Workers violated in the COVID-19 Pandemic

COVID-19 is a novel virus in Nigeria as in other parts of the world. Thus, no Nigerian court as yet, has had the opportunity of hearing any suit on rights violations in the course of the pandemic. This however does not foreclose the possibility of such suit, which are still likely to come up in the post COVID-19 era, if for nothing, but to test the existing constitutional framework. When that happens, the courts mostly likely would be faced with the task of what interpretation to best give to these violations within the established framework of enforcement.

1. Enforcement through extant Constitutional Mechanism

IHRL is applicable in Nigeria, only to the extent that it has been domesticated in line with established constitutional processes. According to Egede, "*Nigeria operates a dualist system, whereby treaties, including those dealing with human rights, cannot be applied domestically unless they have been incorporated into domestic legislation*".[117] This process is found in Section 12 (1) of the Constitution which provides that, "*no treaty between the*

[117] Edwin Egede, 'Bringing Human Rights Home: An Examination of the Domestication of Human Rights Treaties in Nigeria'(2007) 51*Journal of African Law*, 250.

federation and any other country shall have the force of law to the extent to which any such treaty has been enacted into law by the National Assembly".[118] This process necessarily leads to the enactment of an implementing legislation, which makes such treaty enforceable in domestic courts. A notable example is the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act,[119] which is Nigeria's implementing legislation for the African Charter on Human and Peoples' Rights (ACHPR), and one that it has fully domesticated.[120]

Where a domestic implementing legislation has come into place, the rights it covers and other rights under Chapter IV of the Constitution, are enforceable under Section 46 of the Constitution. Following the decision in *Emeka v. Okoroafor*,[121] and in line with Section 46 (1) of the Constitution, an individual who alleges that his right, "*has been, is being or likely to be contravened in any state in relation to him may apply to a High Court in that state for redress*".[122] Section 46 (3) of the Constitution also provides that the Chief Justice of Federation (CJN) may make rules with respect to the procedure of the above court.[123] The procedure for realising the

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[118] 1999 Constitution.

[119] CAP 10, Laws of the Federation of Nigeria (LFN) 1990, commencement date 17 March 1983.

[120] Eghosa O. Ekhator, 'The Impact of the African Charter on Human and Peoples' Rights on Domestic Law: A Case Study of Nigeria'(2015) 41*Commonwealth Law Bulletin*, 256.

[121] (2017) 11 NWLR 410, 478; Ayodele Babalola, 'The Right to Clean Environment in Nigeria: A Fundamental Right?' (2020) 26*Hastings Environmental Law Journal*, 7.

[122] 1999 Constitution.

[123] *Ibid.*

objectives of Section 46 is laid out in the 2009 Fundamental Rights (Enforcement) Procedure Rules, (FREP Rules 2009).[124]

Additionally, the National Health Act (NHA) 2014, provides useful armour for the protection of the health workers rights in Nigeria. Section 21 (2) of the Act provides that, "*subject to any applicable law, every health establishment shall implement measures to minimise – injury or damage to the person and property of health care personnel working at that establishment; and disease transmission*".[125]Though this provision is subject to the Constitution in line with Section 1 (3), where it is not in conflict with any provision of the Constitution, the clause, '*injury or damage to the person and property of health care personnel…and disease transmission'*, can be argued alongside any assertion of violation of right to dignity, by any health worker that has been infected by the COVID-19 virus. It is important to contextualise certain arguments here. Government may argue that it has not 'intentionally' killed any health worker, as to violate their right to life. That argument lacks any basis to stand, as the idea of 'intentional killing' though applicable to the both individuals and the state, the scope of government's obligation is much wider, extending to the protection of lives and property. It is on this basis that Section 14(2) (b), though non-justiciable provides that, "*the security and welfare of the people shall be the primary purpose of government*".[126]

Under the FREP rules, public interest litigation by Civil society organisations (CSOs) is encouraged and the court is enjoined not to

[124] Fundamental Rights (Enforcement Procedure) Rules 2009.
[125] NHA 2014.
[126] 1999 Constitution.

strike out any suit for lack of standing.[127] Health workers who have been victims in the course of this pandemic can therefore approach the court or CSOs can do so on their behalf, and they would not be refused hearing on the basis that they lack standing. Also, courts are also to have respect for IHRL instruments, such as instruments under the African and UN human rights systems.[128] In line with the decisions in *Egbuonu v. Bornu Radio Television Corporation*,[129] and *Briggs v. Harry*,[130] litigants bringing an action under Section 46 of the Constitution, must ensure that both the main and consequential reliefs sought, point to the violation of a right under Chapter IV of the Constitution, which has been deprived by the other party.[131]Also, pursuant to *Benson v. Commissioner of Police*,[132] the Courts are admonished to look beyond legal formalities when hearing such fundamental rights suits and deliver a ruling as soon as possible.[133]

However, even where there is a domestic implementing legislation, the law in Nigeria is that the human rights treaty in question will at best have the same force as a federal legislation and cannot override the Constitution. This position was handed down by the Supreme Court in *Abacha v. Fawehinmi*,[134] where in examining Section 12 (1) of the 1979 Constitution, which is *in parimateria* with Section 12 (1) of the 1999 Constitution, it unanimously held that the 1999 Constitution was superior to the African Charter on

[127] Section 3 (d) – (e), Fundamental Rights (Enforcement Procedure) Rules 2009.
[128] *Ibid*. sec. 3 (a) – (b) ii.
[129] (1997) 12 NWLR 29, 38).
[130] (2016) 9 NWLR 45, 72-73.
[131] Babalola (n121).
[132] (2016) 12 NWLR 445, 446,*per* Rhodes-Vivour, J.S.C.
[133] Babalola (n 121).
[134] (2000) 6 NWLR (Part 660) 228.

Human and Peoples' Rights (ACHPR).[135] On this score a member of the court, Ejiwunmi, J.S.C observed that, "*it is therefore manifest that no matter how beneficial to the country or citizenry an international treaty to which Nigeria has become a signatory may be it remains unenforceable, if it is not enacted into law of the country by the National Assembly*".[136]Elucidating further on this, Egede notes that the Supreme Court's intervention in *Abacha v. Fawehinmi* became necessary in the light of the earlier interpretations, that had been given at the appellate court level, which appeared to suggest that the ACHPR was somewhat superior to the Constitution, thereby deepening the controversy surrounding its applicability.[137] Additionally, he notes that if the Supreme Court had reasoned otherwise in this case, it would have amounted to judicial travesty, since the provisions in the supremacy clause of the Constitution were clear and unambiguous.[138] Additionally, clarifying the position of the Constitution against domesticated human rights treaties by the court, was important given that while the Constitution is only limited to civil-political rights, a treaty such as the ACHPR encompasses both civil-political rights as well as socio-economic rights, presenting a perfect recipe for conflict.[139]

2. Potential Enforcement on the basis of Customary International Law

It is important to state that the above position does not totally shut the door against the implementation of a human rights treaty. Such treaty can apply domestically, if its provisions have developed into

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[135] Egede (n 117) at 253.

[136] (2000) 6 NWLR (Part 660) 356 – 57; Egede, (n 117) at 254.

[137] *Ibid.*

[138] *Ibid.*

[139] *Ibid* at 255.

what is referred to as 'Customary International Law' (CIL).[140] In addition to international conventions and general principles of law recognised by civilised nations, CIL is recognised as one of the sources of international law.[141]This is in line with Article 38 (1) of the Statute of the International Court of Justice (ICJ) which provides for, "*international custom, as evidence of a general practice accepted as law*".[142]The leading case in support of this position is *Federal Republic of Germany v. Denmark and Netherlands (The North Sea Case)*,[143] where the ICJ stated that "*with respect to the other elements usually regarded as a necessary before a conventional rule can be considered to have become a general rule of international law, it might be that, even without the passage of any considerable period of time, a very widespread and representative participation in the convention might suffice itself, provided it included that of States whose interest were specifically affected*".[144]

The following can be deduced from the above analysis - primarily, respect for the human rights of health workers in the COVID-19 pandemic as established in IHRL treaties, depends largely on the legislative force it has received at the domestic level; secondarily, where no such legislation has been enacted, health workers who have become victims by reason of government's abdication of its obligation, may still be able to bring an action before domestic courts, on the ground that the right in question has been accepted as

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[140] *Ibid* at 276.

[141] B.S. Chimni, 'Customary International Law: A Third World Perspective' (2018) 112*American Journal of International Law*, 1.

[142] *Ibid.*

[143] 8 ILM 340 (1969).

[144] 8 ILM at 72; Egede (n 117) at 277.

a general practice by members of the international community. Certainly, on the second point, domestic courts may have their hands full given the continuing tension between established positions under domestic and international law.

As a first step, it has been correctly observed, that the fact that an individual's right to enjoy the highest attainable state of physical and mental health, has featured in several IHRL instruments such as the UDHR, ICESCR, CC and regional treaties in Europe, Africa and the Americas, as well as treaties targeted at eliminating racial and gender-based discrimination, is a pointer to the fact that it is now a generally accepted international human rights norm.[145] However, unlike the civil-political rights, general agreement on the right to health a norm of CIL is deemed as still in process.[146] It would therefore seem that making an argument for enforcement of this right on the basis of CIL may indeed be difficult. One may however argue that there exists appreciable ground to canvass the physical and mental hazards suffered by these health workers as a form of 'torture, inhuman and degrading treatment or punishment'. For example, a doctor who because of heavy shortage of available PPEs had to treat several COVID-19 patients using just one PPE all through and being unable to use the restroom or eat, for the fear of infecting himself or herself, as clearly being subjected to torture and inhuman treatment by the government.

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[145] Adam McBeth, 'Privatising Human Rights: What Happens to the State's Human Rights Duties When Services Are Privatised?'(2004) 5*Melbourne Journal of International Law*, 136.

[146] *Ibid.*

5. Concluding Remarks

This article has examined the issue of right to dignity of Nigerian health workers in the COVID-19 pandemic. It has also shown how the behaviour of the Nigerian government, is a violation of this right under domestic and international law. Clearly, short-changing health workers in terms of their right to dignity, while at the same time expecting a warrior's performance from them as frontline workers, is tantamount to fighting with one hand. No one in a fight, whether attacking or defending, does so with one hand and expects to win. A sound protective framework of the health worker's right, is a major armour in the arsenal of any health system, just as a health worker that enjoys human rights satisfaction, is a major asset in any public health emergency. Not only does such environment complement the ordinary professional training of the health worker, it gives room for the inherent graces of God in them to manifest, something central to really facing a pandemic. This is because human rights are indeed God-given rights and an individual can only operate at his or her best, when such endowment from God finds full expression. An understanding of the tripartite framework of respect, protection and fulfilment of the health worker's right by the State, instils great confidence in a worker, that whatever risk he/she may be exposed to, has not just been significantly mitigated, but that the State cares enough to have provided for any eventuality.

The work of a health worker in a public health crisis is more like a call to national duty or being deployed on a national assignment. Public health crisis given its sweeping nature and potency to quickly overwhelm a country's health infrastructure, requires speedy response, quick thinking, and expert knowledge which makes the place of health workers critical. It is also a high- risk job,

given the need to be on the frontline to combat its spread of a wild virus. Thus, it is a duty with a standard of obligation higher than the regular hospital work. For instance, a health worker that desert his/her work at such a time, is likely to be termed unpatriotic and or perhaps an enemy of the state. These health workers, knowing the risk they face, the stark threat of contracting the virus, still turn up for duty, demonstrating rare courage to battle the virus and treat infected persons. This is similar to a soldier being deployed to the war front to defend the territorial integrity of the nation. It therefore a duty call that demands high national protection commensurate to the dangerous work profile. By putting in place such high protection, government demonstrates its own patriotic side and also leads by example. Anything short of this, can only be seen as state assisted suicide. When such health workers are deployed to the frontline without the necessary personal protective gear, which will ensure that their dignity is not violated, it must be taken that government has abdicated its domestic as well as international obligations, to which accountability must be demanded.