

**Just Health Care in Nigeria – The Foundations for
an African Ethical Framework**

By

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Abstract

Countries in Sub-Saharan Africa share at least three things: cultural heritage, a high burden of disease and a low financial commitment to health care. This thesis asks questions of justice about health care systems in Sub-Saharan Africa, in particular Nigeria. The questions are about access to the available health resources and services within African health care systems. While the sub-region as a whole cannot boast of good health care, certain population groups are relatively more disadvantaged. This suggests either or both of two problems: a) that access to basic health care is not proportionate to the populations' needs; and/or b) that the distribution of the available health care resources favour some over others.

Attempts to improve population health have focused on empirical, economic or social strategies. These tend to overlook the ethical dynamics surrounding access to and the distribution of health care. In view of this moral challenge, Norman Daniels has proposed the ethical framework of *Accountability for Reasonableness*, which can provide basic guidelines for just health care reforms in Africa. While his approach has been effective in the United States, the theoretical basis has fundamental value differentials from African ideals of justice.

Starting from Daniels' *Just Health – Meeting Health Needs Fairly*, this PhD study develops an African ethical framework that could inform reforms in African health care systems. Specifically, it establishes four key attributes of the African moral outlook, and three principles of African justice. It further abstracts an African method of ethical analysis: *process equilibrium*. Against this background, the thesis develops a *harmonised framework* of just health care. Daniels' principles are matched with African principles to create a *Just Health Theory*, which is adapted to the Sub-Saharan Africa context. The resulting African principles are mapped onto the health care sector and finally blended into the *Harmonised Framework of Just Health Care*. By combining the insights from Daniels with African values and approaches, it is possible that just health care will be attained in Nigeria and beyond.

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Abbreviations

AFR	Accountability for Reasonableness
ADF	African Development Fund
AH	Attribute of Harmony
AHWO	Africa Health Workforce Observatory
AP	Attribute of Process
AR	Attribute of Reciprocity
ARC	Appeal/Revision Condition
AS	Attribute of Solidarity
CDC	Centre for Disease Control and Prevention
CBSHIP	Community Based Social Health Insurance Program
FMoH	Federal Ministry of Health
FRN	Federal Republic of Nigeria
FSHIP	Formal Sector Social Health Insurance Program
GEPI	Global Polio Eradication Initiative
IMF	International Monetary Fund
NBS	National Bureau of Statistics
NPC	National Population Commission
NHIS	National Health Insurance Scheme
NSHDP	National Strategic Health Development Plan
OECD	Organisation for Economic Cooperation and Development
PC	Publicity Condition
PHC	Primary Health Care
PFR	Prerogative for Responsibility
RC	Relevance Condition
ReC	Regulative Condition
SAPs	Structural Adjustment Programs
TAC	Treatment Action Campaign
TRC	Truth and Reconciliation Commission
TISHIP	Tertiary Institutions Social Health Insurance Program
UNAIDS	United Nations Programme on HIV and AIDS
UNDP	United Nations Development Program

UNFPA	United Nations Population Fund
VCSHIP	Voluntary Contributors Social Health Insurance Program
VGSHIP	Vulnerable Group Social Health Insurance Program
WHO	World Health Organisation

Chapter One: Towards an African Approach to Just Health Care

1.1 Introduction

This thesis belongs to the field of bioethics and aims to provide an African Approach to just health care. Fully developed and global “bioethics can be considered as covering all possible ethical problems that arise or may arise ... in relation to life and living things generally” (Tangwa, 1999, p.222). A more restricted sense of bioethics discusses ethical dilemmas in medicine, health care and biotechnology. The discourse is mostly situated around issues in clinical and health research settings. This thesis is situated in the space between the global and the more restricted senses of bioethics. It develops a bioethical theory, as well as principles to enhance effective and just health service delivery and targeted health research. In this regard, it is concerned with macro-level health care (e.g. access to health care for all) rather than the micro-level (e.g. the doctor-patient relationship).

Health and wellbeing are indispensable concerns for every human society and health care is important for every human person. Questions about the distribution of health care resources and services thus affect everyone. In the event of ill health, the first consideration is often the location of a health care facility, and the type of care sought is often only as important as the health it brings. Where one therapy is ineffective, another is considered, and the process continues until an effective treatment has been found. The health care search assumes that a remedy can be found, and should be available and accessible to everyone who needs it. This assumption is based on the perception that health is paramount, and that whoever seeks health care should be provided with the available treatment. There is a sense in which we believe that health is vitally important, so that we are obliged to make the available remedies accessible to all who need them. And ‘available’ here goes beyond what is available locally, which may be very little. The obligation is important as an ideal, although the reality of health and illness and the nature of access to health care may be very different. A recent World Health Organization (WHO) report showed that 400 million people around the world do not have access even to the most basic health care, and that 6% of people living in low and middle

income countries fall into extreme poverty because of out-of-pocket health care spending (WHO, 2015c).

This thesis is about Africa. When I write “Africa”, I mean countries within the Sub-Saharan Africa region. The main reason being that Northern African countries have a shared Arab heritage that makes them more culturally aligned to the Arab world, given the historical Arab domination of the region. However, countries in Sub-Saharan Africa, although variously colonised by Western countries, do not witness the kind of cultural transformation experienced in North Africa. Hence, they have largely maintained their traditional cultural roots, and these are evident in contemporary social practices. More importantly, the Sub-Saharan region is widely recognised to have shared cultural heritage; which is what I mean by “African” in this thesis. I will not make reference to North African ethical perspectives in the course of my research. This is not to suggest that there are no valuable ethical references from North Africa. Rather, the shared cultural trends in Sub-Saharan Africa make it possible to abstract shared ethical values or principles, which is not the case with North Africa. Whenever it would be over-ambitious to refer to all of Sub-Saharan Africa in this thesis, I will focus on and draw examples from Nigeria.

In traditional African societies, health care was considered a community affair. For instance, a traditional healer had unrestricted access to farmlands or other properties where herbal remedies for particular diseases were to be found (see Tangwa, 2010, p.76-79). Since much of the African context remains largely communitarian, one would expect that such traditional ideals are carried over into contemporary health care practices in Africa. However, despite such traditional African ideals of health care as a common concern, the continent remains infamous for persistently poor population health, especially when compared to Europe, North America, Australia and Japan. On the other hand, Western countries are known to support African countries by providing medical and other related aids. This support is accompanied by the transference of medical knowledge as well as health system design. As a result health care in contemporary Africa is mostly Western-style, or focuses on what Westerners call conventional medicine. At the same time, African traditional medicine is still widely practised alongside Western medicine, mostly in

alleviating conditions that are not known to Western medicine (see Manda, 2008; Omonzejele, 2008). Hence, health care in much of Africa remains a combination of Western medicine and traditional therapeutic approaches. In short, medical syncretism is a common practice in much of the continent.

Nigeria's health care situation presents a specific case where the system is modelled on Western-style health care, yet continues with traditional forms of medicine. As shown in current literature, a good proportion of the population subscribes to both Western and traditional medicine to treat the same ailment, especially where confidence about the efficacy of the former is low (see Tamuno, 2011; Fakeye, Tijani & Adebisi, 2007; Izugbara, Etukudoh & Brown, 2005; Elujoba, Odeleye & Ogunyemi, 2005). Also some Western-style trained practitioners are known to acknowledge traditional medicine, and are disposed to recommend some use of it (Awodele et. al., 2012). Likewise, traditional birth attendants are widely subscribed to in Nigeria, and are recognised for their positive impact on maternal care (see Ofili & Okojie, 2005; Imogie, Agwubike & Aluko, 2002). Efforts are presently underway to integrate traditional medicine into the mainstream Western-style health care system in Nigeria (see Awodele et. al., 2011).

Notwithstanding this consolidated approach to health care, access to quality services remains significantly low or non-existent for most Nigerians. This is despite the country's endowment with vast resources, which if harnessed could make required health care services available to all, as well as develop notable traditional remedies. The inability to properly harness resources towards providing health care for all means that much of the population lacks good health care. The result is an avoidable disparity in access to health care across population groups in Nigeria.

A factor of the dual context of health care in Nigeria – as with other African countries - is that imported Western approaches towards health system improvement may not always be successful. The challenge is further complicated by marked differences from Western settings in the social, cultural and economic conditions around Africa. Therefore, I contend that in order for health care strategies developed in other settings to be effective in Nigeria or other African countries, we must adapt them to local conditions. And where such adaptability is not possible,

then a specific African (or local) approach must be developed in view of the required health care improvement.

In the light of equitable access, this thesis aims to develop an African ethical model for just health care reforms in Nigeria. This will constitute a foundational framework for relevant reforms in other African countries. The ethical framework will be developed against the background of an African theory of justice for health, which will also be developed within the thesis. The African theory of justice for health will outline the general principles that will provide the relevant guidelines in applying the ethical model of just health care. The ethical guidelines will then be translated into practical tools for health care improvement. They will be used to evaluate existing policies and strategic health plans and can also be used to guide the revision of ineffective ones, as well as informing the development of new ones.

The expected outcome of the thesis will be relevant to:

- a) *Health service providers, policy makers and the Federal Ministry of Health in Nigeria*: they are tasked with ensuring that the system provides for the wellbeing of the population through equitable distribution of the available health care services and resources;
- b) *Health care administrators and practitioners in Nigeria*: who largely determine how health care policies and intervention plans are implemented at the grassroots;
- c) *Other African health care systems in view of a) & b) above*: the ethical model's potential impact could extend beyond Nigeria, and constitute a foundational framework for just health care in Africa.

The ethical model developed in this thesis is foundational. This means that while the basic framework will be established, more specific application guidelines or strategic considerations will be the subject of future research.

1.2.0 Background and Contextualisation

In order to see what role justice has towards health care reform in Nigeria, it is important to have some insight into the current situation. Such an exploration will establish the reasons for the underlying disparity that needs equalising. If we acknowledge that some things need to be equalised, then we can see the imperative to identify or develop a relevant ethical framework against which such equalisation can be undertaken. The ethical approach used will be expected not only to present theoretical explanations, but also provide tools that are applicable in real health care situations.

1.2.1 Situational Context

Much has been invested towards improving health care in Nigeria over the past decade, yet a notably positive outcome has not been realised in terms of infrastructural development and population health (FMoH, 2010; Kombe et. al., 2009; WHO, 2014). To cite an example, primary health care in Nigeria is yet to be consolidated, and its development is marred by inadequate facilities, personnel and services (Abosedo & Sholeye, 2014; Ehiri et. al., 2005). Reid (2008, p.663) notes that “despite several attempts at reform over the past 30 years, Nigeria still lacks a clear and coordinated approach to primary health care”. A survey of the Lagos University Teaching Hospital – one of Nigeria’s specialist public hospitals – shows that the children’s ward does not operate on good practice, as children with different health conditions, possibly communicative, are made to share beds (Ogunseye, 2010). As a result of such poor conditions, most parents would wish to use private hospitals which they perceive as providing better services, but most parents are limited by insufficient funds (Ogunseye, 2010). In 2013, workers of the Abuja National Hospital went on strike over what they termed “deplorable conditions militating against enhanced medical services” (Reef & John, 2013).

The quality of care provided in many public health facilities in Nigeria is inadequate (World Bank, 2010; Obijiofor, 2011; Ojo, 2012). Among the many challenges, hospital acquired infections are frequent, and are mostly attributed to the poor surveillance mechanism in the health care system (Ige, Adesanmi & Asuzu, 2011;

Welcome, 2011). Emergency medical services are not readily available, especially for obstetric care and basic trauma life support – with rural health care facilities being among the worst (Oladipo & Durojaiye, 2010; Solagberu et. al., 2009). Where emergency services are available, the quality of care is often less than optimal, as staff are mostly poorly trained (Olukoga et. al., 2010; Ijadunola et. al., 2010). The poor conditions and inadequacy of services provided in public health facilities means that many patients are compelled to seek care in private facilities that promise better conditions, yet charge higher fees. However, much of the population cannot afford the cost of services in private health care facilities. Hence, many are compelled to either trade most of their other needs for private health care, or accept the inadequate care in public facilities.

Therefore, it is not surprising that many individual patients with desperate conditions seek financial support from the general public toward private medical treatment in Nigeria. These cases are frequently reported through various news media, and some patients are known to have received donations from generous Nigerians. To cite an example, the *Tell Magazine* reports on a patient whose financial status has been diminished by his health condition over three years (Adeosun, 2013). He needed a kidney transplant and was required to pay N5 million (approximately £20,000) as an initial payment towards surgery. As he could not afford this sum, he sought financial assistance from any generous citizen. Similarly, a Lagos musician at a point of financial desperation due to his wife's kidney condition organised a concert to raise funds towards private medical treatment (Adeosun, 2011). Many such desperate pleas pervade the media regularly (see appendix I for descriptive narratives of these stories).

Further to the individual appeals for financial support, there are reports of patients being refused emergency medical treatment for failing to provide the stated fees. In May 2015, health workers in one Nigerian state protested over the death of their colleague, who was refused treatment for failing to pay a mandatory medical fee of N3,500/£20 (Kayode-Adedeji, 2015). In 2012, a pregnant woman was reported to have died in a private hospital because she would not be attended to without first paying the stipulated deposit of N20,000/£80 (PMNews 2012). Another man is

reported to have died in a Lagos hospital after being refused treatment over non-payment of N5000/£20 (Onlinenigeria.com, 2013). These represent a fraction of such occurrences within the country (see Appendix II for a descriptive narrative).

The examples above show the situation of many who need health care but lack the financial capacity to access quality or even basic services. As the largest economy in Africa (The Economist, 2014), Nigeria has the capacity to meet the health care needs of its population. However the looming inequity in access to health care for financial or other reasons raises questions about the kinds of reforms being undertaken. The lack of a noteworthy improvement in population health since the “World Health Report 2000” ranked the health system 187 out of 191 in the world (WHO, 2000) leaves much to be desired. But much of the literature on health care reform in Nigeria shows that the present approach towards improving population health focuses on economic and social strategies (see Olayinka & Olugbenga, 2014; WHO, 2014c; Erim, Resch & Goldie, 2012; Uneke et. al., 2010; World Bank, 2010; Omoruan, Bamidele & Phillips, 2009; FMoH, 2009; Kombe et. al., 2009; Dutta et al., 2009; Barnes, Chandani & Feeley, 2008; World Bank, 2004; ADF, 2002). These also show that much effort has been made towards reforms in the past decade, yet health service delivery, accessibility to quality care, and the population’s health status leaves much to be desired (also see NPC & ICF International, 2014; NBS, UNCEF & UNFPA, 2013; NPC & ICF Macro, 2009). The poor state of most public health facilities and the high cost of private health care leaves much of the population with less than minimal access to quality care.

My hypothesis is that an ethical framework must underscore current strategies being deployed toward health care improvement, if they are to be effective. Economic strategies have a tendency to be profit driven, and social strategies can be thwarted by political or class interference. An underlying ethical framework will bolster the relevant strategies towards more just and effective improvements in population health. It will impel equitable access to available health care – as envisioned in traditional African practice - through the relevant economic and social approaches.

Therefore, we need to identify or develop the relevant ethical framework on which the economic and social approaches can be based. Norman Daniels provides a viable ethical framework for health care reform which has been developed over three decades. His ethical approach has been applied to health care reforms in the United States and adopted in a WHO health improvement program. Attempts have also been made to adapt it towards health care reforms in low and middle-income countries (see Daniels, 1985; Daniels, 2008; Daniels, Light & Caplan, 1996; WHO, 2004; Daniels et. al., 2000; Daniels et. al., 2005). As the most established ethical approach to achieve justice in health care, Daniels' framework requires a close consideration regarding its relevance to health care reforms in Nigeria.

1.2.2 Norman Daniels' Just Health Care Approach

According to Daniels, there are good reasons for us to consider a broader bioethics agenda that pursues the improvement of population health, especially for those who enjoy less of it (2006, p.23). He insists that we need to focus on justice in the promotion of effective health care reforms: "justice obliges us to pursue fairness in the promotion of health, but policy needs the guidance of ethics in determining what this means" (Daniels, 2006, p.23). In light of this claim, he develops a theory of justice for health against which one can evaluate or measure actual fairness in health care reforms (Daniels, 2008). Daniels' theory of just health is guided by three basic explanations (Daniels, 2008):

- a) health is of special moral importance because it contributes to the range of opportunities open to us;
- b) health is produced not just by having access to medicine and treatment, but also by accumulated social experience of life conditions; and
- c) we can only meet health care needs fairly under limited resource availability through a fair deliberative process.

Against this background, he develops the framework of *Accountability for Reasonableness* (AFR), which he offers as an ethical tool to legitimise the policy process, as well as guide it towards effective and just health care reform. AFR aims to ensure that in a pluralist society, where reasonable disagreement about

principles that should guide policy are likely, a fair process will help to establish acceptable decisions:

Key elements of fair process will involve transparency about grounds for decisions; appeals to rationales that all can accept as relevant to meeting health needs fairly; and procedures for revising decisions in light of challenges to them... Fair process must also be empirically feasible (Daniels, 2000).

In substantiating the empirical feasibility of the AFR approach, Daniels, Light and Caplan (1996) developed a practical framework, *Benchmarks of Fairness*, which has been used to review the policies and health system reforms in the United States. In addition, Daniels et. al. (2000 & 2005) have attempted to adapt this system towards similar reforms in low and middle-income countries. (A detailed account of Daniels' ethical approach is provided in chapter three).

1.3.0 Limitations of the Established Approach

The above appears to present sufficient reasons for Daniels' ethical approach to be adopted towards relevant health care reforms in Nigeria. Thirty years of developing the approach and designing strategies for its application in countries other than the United States, including low and middle income economies, makes it credible. However, there are two major challenges for its adaptation. In the first instance, it forestalls a contextual limitation, where it presumes universal applicability. Secondly, even if the underlying principles of the just health theory are universally acceptable, the specific design of the ethical framework may not necessarily be universally applicable.

1.3.1 Contextual Limitations

The *just health care* theory underlying Daniels' ethical framework of AFR hinges on the idea of "fair equality of opportunity", which is central to Rawls' theory of "justice as fairness" (see Rawls, 2001, pp.42-55). In view of this principle of justice, Daniels (2008) develops an aligned approach to just health care, which, although developed within the United States' context, he considers to be universally applicable.

However, the *opportunity thesis* developed by Rawls presupposes a liberal society where individuals can pursue their life plans as they may wish to.

Rawls' theorisation has implications for a just health care theory. In the first instance, its prescriptions may be more appreciable in societies that prioritise individual liberty, such as the United States or parts of Europe. However, the just health care approach will have some challenges where the context is communitarian in nature. For, as Tangwa (2001, p.158) has noted, while moral principles may hold good universally and timelessly, their application in particular concrete situations cannot dispense with local perspectives and contexts. Daniels appears to overlook this contextual challenge in attempting to universalise his ethical approach, thereby making the framework more of an imposition over others in the relevant context. Despite this unresolved challenge, Daniels presents the AFR framework as an international guideline towards just health care reform. This appears to disregard the moral perspective of other social contexts that may not subscribe to the values of individual liberty; hence, weakening its promised international capacity. As Tangwa has noted:

The mark of a good international guideline... is that it provides a clear principle of action that is sensitive to both moral agency and moral patients and that it plastically applies equally to all global communities and societies without necessarily attempting to make uniform particular rules of action or foist the particular or peculiar moral dilemmas, quandaries, obsessions and preoccupations of some on all... we need always to keep in mind the context and perspective... of particular actions or procedures. (Tangwa, 2001, p.158).

He concludes that in mapping out ethical guidelines, we need to make appropriate distinctions between the ethics of high-income and low-income countries. Hence, different requirements cannot but be applied in different contexts and at different levels, without resorting to double standards (Tangwa, 2001, pp.158-159).

Given the above considerations, I contend that Daniels' ethical approach in presuming universality, veers towards imposing Western (high-income country) ethical standards on African (low and middle income countries') communitarian

ethical contexts of health care. I also contend that the liberal ethical approach does not align well with the communitarian perspective, and the previous success of the liberal approach in health care reforms may not obtain in communitarian situations. These starting points will be examined further in this thesis. If they are indeed correct, then the relevant ethical framework for just health reforms in Nigeria (or other African contexts) will have to integrate African ethical values and approaches in order to be successful.

1.3.2 The Global Imperative

That Daniels' ethical framework hinges on universal principles and that global institutions like the WHO have adopted it towards solving challenging health care problems in different parts of the world may not necessarily confer on it a global imperative. Consider the case of the Structural Adjustment Programs (SAPs)¹ ineffectiveness towards improving health care in African countries; and on the reverse side, the high population health status in Cuba, which opted for a local approach.

The global economic crisis of the 1980s had an overarching effect on low-income countries, as a result of which high-income donor countries proposed the SAPs, specifically designed by the International Monetary Fund (IMF) and the World Bank (WB) (Logie & Woodroffe, 1993). The SAPs' package included trade liberalisation, currency devaluation, removal of government subsidies and price control, cost recovery in health care and education (Logie & Woodroffe, 1993). African countries, being among the poorest in the world, were obliged to enlist for these programs in order to access loans. The introduction of the SAPs led to a huge depression in the rising health status of some African countries, such as Zambia (Logie & Woodroffe, 1993).

Loewenson (1993) outlines the economic policy measures and the experiences of African countries that adopted the SAPs, in terms of nutrition, health status, and

¹ Structural adjustment programmes (SAPs) consist of loans provided by the International Monetary Fund (IMF) and the World Bank (WB) to countries that experienced economic crises, which they can spend – amongst other things – on improving health care.

health care services. His evidence shows that SAPs were associated with increased food insecurity and malnutrition, rising ill health, and decrease in access to health care for over two-thirds of African countries' populations. Adverse effects of the SAPs on health care, especially in widening the inequality gap have also been described in the literature (see Cobrun, Restivo & Shandra, 2015; Knaji, Kanji & Manji, 1991; Peabody, 1996; Riddell, 1992; Geo-Jaja & Mangum, 2001). Noting that the SAPs were strategically designed to improve the conditions of poor countries, the negative effects for countries that adopted them, especially in health care, shows that the potential for success of an externally created strategy cannot be guaranteed where local conditions and dynamics are overruled.

In the same period that many African countries adopted the SAPs, Cuba turned to a locally developed approach to address its health care problems. While many African countries established cost recovery in health care by introducing user fees, Cuba sustained a non-payment agenda towards ensuring universal health coverage for all of its population (see Brouwer, 2011). The Cuban health care revolution (see Mason, Strug & Beder, eds. 2010; Brouwer, 2011) demonstrates how a locally developed strategy can enhance a sustainable health care reform in a middle-income country, producing better outcomes than the globally acclaimed SAPs. The underlying ethical principle for the sustained reform in Cuba is the view that health is a basic human right, and that the state is responsible for providing health care for all (Feinsilver, 2010, p.25). Recognising that medical benefits alone were not sufficient for a sustained health-sector reform, Cuba saw the provision of universal free education, low-cost housing, guaranteed minimum food rations, and universal social security as paramount (Feinsilver, 2010, p.25).

Accordingly, the key guiding principles of the Cuban health care revolution are: i) equality of access to services, ii) a holistic approach to health care, and iii) community participation in health care initiatives:

Economic access meant universal free service for all. Geographic access required change in the distribution of facilities and personnel to reach all citizens, no matter where they lived. Cultural access meant a decrease in the social class and educational differences between physicians and their

patients... A holistic approach to health not only focuses on the patient as a whole person and not just as a body part, but also integrates prevention, cure, and rehabilitation. Popular participation was envisioned as a means of involving the public, through their community-based organizations... in the planning, administration, and monitoring of health service delivery in conjunction with local level health establishments. (Feinsilver, 2010, p. 25-26).

Contrary to the SAPs' stipulations, including the privatization of health care and the introduction of user fees, Cuba sustained the Alma-Ata² vision by adding new context-specific features to its health care system over the years (Brouwer, 2011). The community-based health care approach has seen Cuba maintain overall health outcomes in terms of mortality that compare well with the United States (Brouwer, 2011). For instance, under-five mortality dropped by more than half in Cuba, from thirteen to six per thousand, while it only fell from eleven to eight in the United States (Brouwer, 2011).

There are two points to consider from looking at the poor health status of many African countries, the SAPs and Cuba's revolutionary strategy:

- a) a widely recognised or universalised approach may not necessarily work in a variety of contexts, especially where the strategies have not been appropriately adapted to local conditions;
- b) a locally developed strategy may be more effective for the local context than an approach which has recorded high successes elsewhere.

Therefore, the lesson may be that even a widely recognised ethical approach, such as the one presented by Daniels, must tread carefully in the corridors of diverse

²The 1978 Alma-Ata Declaration set up an international agenda for developing universal health coverage in all nations, especially in low-income countries: it "emphasised new health delivery systems built around the primacy of primary care, with family practitioners trained to integrate medical treatment with public health initiatives and preventive education" (Brouwer, 2011).

socio-cultural contexts of health care. Specifically, caution is important in bringing the AFR framework to bear on African health care reforms. While it is important to draw from Daniels' strategic framework, this thesis will examine the possibility that we must look to the local form of moral evaluation and modes of ethical analysis that bear on health care. Local meanings would then inform our effective response towards health care, as these also determine what would count as just or fair to the relevant population. In short, I start from the premise that global approaches always originate from designated socio-cultural contexts, and that in considering ethical reforms in African health care systems, we must give priority to African socio-ethical values.

1.4.0 African Ethical Approaches and Just Health Care

In light of the above, we must start from relevant African theories of justice or ethical principles that will inform ethical approaches towards just health care reform in an African context. There is then a need for a specific African ethical framework that will enhance just health care reform in Nigeria, just as Daniels' ethical approach has done for the United States. Therefore, it is important to consider what the existing African ethical theories are, and how these have shaped bioethical theories and ethical approaches in African health care. It is also worthwhile to explore relevant considerations of justice towards health promotion or research in Africa. This has the benefit of providing specific guidelines on how to proceed in adapting Daniels' ethical framework, or developing a viable ethical approach towards just health care reform in Nigeria.

1.4.1 African Ethical Theories

The literature on African ethical theories is scanty due to the narrative rather than the written tradition, compared to what one finds regarding Western ethical theories. For instance, Metz (2007) noted the non-existence of a well-defended general principle grounding moral duties relating to of Sub-Saharan African values:

One finds relatively little that consists of normative theorization with regards to right action, that is, the articulation and justification of a comprehensive ,

basic norm that is intended to account for what permissible acts have in common as distinct from impermissible ones (p.321).

However, foundational steps have been taken by some African scholars to establish comparable theories, abstracting from African moral values. The most prominent theory developed in the African ethics literature is that of *Ubuntu*.

Metz attempted to theorize Ubuntu, as comparable with dominant Western theories, such as Lockean contractualism or the Kantian Categorical Imperative. Metz' synthesis of Ubuntu can be summarized as follows:

An action is right just insofar as it produces harmony and reduces discord; an act is wrong to the extent that it fails to develop community. (Metz, 2007, p.334).

An action is right just insofar as it is a way of living harmoniously or prizing communal relationships, ones in which people identify with each other and exhibit solidarity with one another; otherwise, an action is wrong (Metz, 2010, p.51).

Following Metz's initial attempt, two volumes on African ethics have emerged in which Ubuntu has been variously presented as a moral principle, and a palpable tool for analysing ethical issues in the African continent (see Murove ed., 2009; Nicolson ed., 2008). For instance, Mkhize (2008, p.35-36) explains that harmony is the overarching ethical principle that binds all others together. And Ubuntu is the process by which such balance is sustained within the human community, through interdependence, justice, solidarity of humankind, empathy and caring.

Whilst Metz has achieved more visibility for the theory of Ubuntu, his theorisation appears to be a consolidation of Tutu's (1999) earlier abstraction of the fundamental basis of African morality:

Harmony, friendliness, community are great goods. Social harmony is for us the *summum bonum* – the greatest good. Anything that subverts or undermines this sought-after good is to be avoided like a plague. (p.35).

Gyekye (1997) provides an account of “moderate communitarianism” as representing the foundation of an African moral theory. He presents an ethic that departs from the tendencies of Western liberal approaches which emphasise individual rights to an extreme, while also balancing the overarching reference to community in traditional African moral thought. He establishes that the African communitarian ethos mandates an ethic of duty or responsibility, which trumps “rights” as central in Western ethical theorisation. Bujo (2001) similarly explores the “foundations of an African ethic” where he holds that “palaver”³ is the mode of discovering and justifying norms in African ethics. He presents the African *palaver process*, as an ethical method that is comparable to *discourse ethics* as espoused by Juergen Habermas, or to North American *communitarianism*; yet, distinct from either, given its conception of participation and community in African socio-cultural contexts. Additionally, Wiredu (1992) explores the moral foundation of African culture, establishing *humanism* as a basic African ethical principle; and Ramose (2002) provides the groundwork for the ethics of Ubuntu. A recent African moral theorisation has also been attempted by Masolo (2010) in his book, *Self and Community in a Changing World*.

However, these theorisations have not focused on the possibility of a coherent African theory of justice, even though one can find relevant descriptions in Kinoti’s presentation of the Gikuyu understanding of justice (Kinoti, 2010), and the Igbo understanding in Otakpo (2009). At the same time, one can see some ideals of African justice being employed in practice in the Truth and Reconciliation Commission in South Africa and the Gacaca Courts in Rwanda (see Zyl, 1999; Leebaw, 2003; Gibson and Gouws, 1999; Rettig, 2008; Sarkin, 2001), which will be described in more detail in chapter four. If we consider justice to be important for population health in African contexts, it would be appropriate to develop a coherent theory of African justice on which the African approach to just health care will hinge.

³ Detailed explanation of “palaver” is provided in chapters four and five (see sections 4.2.4 & 5.4.4).

Therefore, a part of chapter four will attempt to establish the foundational features of an African theory of justice.

1.4.2 African Bioethics and Justice

What is presently considered as African bioethics largely addresses ethical issues arising in African health care in the light of the established bioethical theories and principles. The dominant trends in bioethics, which are now accepted as the established theories for bioethics globally, have mostly been developed in the West. They are traceable to the vast literature emerging especially from North America and Europe. Much of the efforts at “African bioethics” have simply taken these established theories and applied them to African problems. In this form, the attempts pass as African bioethics on the grounds that they are either undertaken by Africans or address relevant health care problems in Africa. The current outlook of African bioethics thus appears to be the application of Western bioethical theories to Africa-specific problems. In short, the phenomenon can best be described as “African bioethics in a Western frame” (Tangwa, 2010).

More importantly, if the established bioethical approaches, like patient autonomy and informed consent, are to be specifically relevant in African health care contexts, patients or research participants need relevant access to basic (or the available – in terms of current medical advancement) health care services or resources. We cannot, for instance, talk about patient autonomy when the patient does not have access to the most basic treatments. Likewise, it is difficult to talk about informed consent in health research or medical trials when the participants have desperate health status. Their desperate health conditions already make them vulnerable, and as such they are likely to consent to what their counterparts in Western countries may not consent to.

It becomes imperative to seek just health care for the population, in the first instance. And when this has been established, then we can better engage with the other bioethical considerations. Seeking the relevant bioethical approach towards just health care is thus appropriate starting point. The relevant pathway should seek to abstract specific African ethical values in addressing Africa-specific ethical issues in health care or health research. It should be an appropriate representation of

African bioethics in an African frame. I will show below how the attempts in African bioethics have relied on Western theories, with the most prominent being in health research ethics. I would acknowledge that there are some notable departures from this trend, but they remain few.

1.4.3.1 Health Research Ethics in Africa

Health research ethics is presently the most developed aspect of bioethical considerations in/about Africa. The trend is pronounced in the existing literature on health research ethics in Africa, as mostly developed by scholars of African origin. Among these, Ezeome & Simon (2010) evaluate the ethical implications of the infamous research trial by the pharmaceutical corporation Pfizer, in Nigeria. In establishing the ethical flaws of Pfizer's trial, they employ the international guidelines for conducting research in low and middle-income countries. They make no recourse to how substantive African ethical values should inform these guidelines, given the specificity of the context. Similar routes have been taken by other researchers, as seen in exploratory discussions on: informed consent practices in Nigeria (Ezeome & Marshal, 2009); the promotion of research integrity in Africa (Kombe et. al. 2013); and ethics and researcher identity (Simon & Mosavel, 2011)⁴.

Notwithstanding the huge reliance on established trends, Tangwa (2002) makes a notable shift when he insists that an African methodological approach should be employed in designing the ethical guidelines for medical research trials, especially in the search for HIV/AIDS vaccines. He argues that the peculiarities of African socio-cultural contexts mean that ethical issues in health care and research will be more appropriately addressed by specific African approaches, rather than the reliance on Western theories. To show the African approach in practice, he offers a situation whereby the informed consent form would also require the researcher or clinician

⁴ For further examples, see Ouwe-Missi-Oukem-Boyer et. al. 2013; Nyika et. al. 2009; Molyneux & Geissler 2008; Manafa, Lingegger & Ijsselmuiden 2007; Waterman et. al. 2007; Kass et. al, 2007; Waterman et. al., 2007; Kirigia, Wambebe & Baba-Moussa 2005; Kilama 2005; and Hyder et. al. 2003; Benatar 2002; Bhutta 2002.

to sign that he or she is wholly committed to human or the community's good (Tangwa, 2001, p.162).

This suggestion would integrate the African moral attribute of reciprocity⁵ into the informed consent procedure, which currently aligns with Western theories of patient autonomy. Frimpong-Mansoh (2008) also makes a notable effort to specify the fundamental challenge of informed consent in African socio-cultural contexts of health, but does not develop a relevant, coherent African approach. Finally, the recent trend of "community engagement"⁶ in African health research ethics appears to make a notable shift towards integrating African values in medical research. While it allows wide room for considering local values, it does so only at the secondary level: the fundamental principles of community engagement are not informed by substantive African ethical principles.

1.4.3.2 African Bioethics and Justice in Health Care

Unlike the advancement in research ethics, there is not much about overall *justice* in African health care in the existing literature, especially that focusing on African ethical approaches. Two scholars have made a notable contribution to African bioethics, in terms of integrating the relevant ethical values: Godfrey Tangwa and American-born but South Africa-based Thaddeus Metz. Although they have not focused closely on just approaches to health care, their work can make relevant contributions to the discourse on justice in African health care.

On the one hand, Tangwa (2010, p.9-28) refers to *eco-bio-communitarianism* as the overarching theory for African bioethical considerations. The idea of eco-bio-communitarianism derives from the Nso⁷ moral worldview, which Tangwa claims is fundamentally human-centred, and that its limits are defined by human wellbeing. He argues, for instance, that in health care or health research, the wellbeing of patients or participants are to be prioritised, not simply in their consideration as

⁵ The attribute of reciprocity is discussed in detail in chapters four and five (see sections 4.2.1 & 5.6.3).

⁶ Community engagement is discussed in greater detail in chapter five (see section 5.4.5).

⁷ Nso is a major tribe or ethnic group in Cameroon.

individuals, but as persons whose welfare represents that of the wider human community.

Similarly, Metz (2010) builds on his work on African theorization of right and wrong actions to push the boundaries for African bioethics. He notes that the field of bioethics is replete with applications of utilitarianism, Kantianism and contractualism, which represent Western moral theories. He insists that bioethics is mostly unaware of African theories that can better respond to some issues in bioethics. Hence, he makes some specifications that should be considered as equally viable as utilitarianism or Kantianism, not only in Africa, but also for Western contexts:

- a) *Point of medical treatment*: medical professionals should be obliged to act harmoniously in regard to patients while providing treatment, and to share a sense of self with and act for the good of the patients.
- b) *Free and informed consent*: the default bioethical stipulation is to treat patients and research participants only if they understand the health professional's plan and agree without coercive or exploitative inducement. The African moral theory presents a third explanation, where the sense of harmony and communal relationship obliges health professionals and researchers to genuinely identify with patients and research participants. Meaningfully sharing life with them ultimately leads to transparency of the process and willingness of patients and research participants to share in the ultimate goal.
- c) *Standard of care*: dominant moral theories have difficulty accounting for the intuition that researchers have a non-contractual obligation to aid participants. The favoured African theory explains that "upon identifying with his participants, a researcher has established part of a morally significant relationship that demands respect and hence full-blown realisation in the form of solidarity as well" (p.56).

Metz' explanation of informed consent is similar to Tangwa's (2001) prescription about standards in medical research in Africa (see 1.4.3.1 above). And in view of the standard of care, the process will entail that researchers and participants, or

clinicians and patients, in co-extensively thinking of themselves as *we*, would engage in a common project of restoring health. Hence, the former would share a way of life with the latter, which thereby imposes a special obligation to provide care or engage in research in view of the latter's wellbeing. As will be shown in chapter four, these processes are embedded in key attributes of African moral thought.

With regard to a specific African approach to justice in health care, only Tangwa (2010) and Azetsop (2011) have attempted to consider the relevance of African ethical values in the distribution of health care. Tangwa (2010, p.70-81) observes what he terms as the obsessive emphasis in Western approaches on the place of "rights" in determining the imperative for equity in the distribution of health care resources and services. He recommends that it would be more useful to focus on duty-based approaches, as stipulated by African moral values. Tangwa traces the imperative of duty to the traditional African setting, where health was accorded the highest value, and in which everyone – the whole community – was required to support sick persons with all available resources. If this is carried forward into contemporary health care, he insists, there would be no scarcity of medical or related resources, and questions of inequality in health care will not arise in the first instance. Pogge (2008) and Hollis & Pogge (2008) would affirm Tangwa's claim regarding scarcity with their evidence that there are enough medical resources to provide necessary health care for everyone in the world. I will develop this duty-based approach further in my account of an African approach to just health care.

There has also been recent research on the place of "benefit sharing" with regard to medical research resources. Some of the developments have focused on the question of justice for African communities that contribute to successful research trials, or whose knowledge base substantively informs research and innovation processes. The existing literature mostly argues for the protection of indigenous knowledge about valuable medical resources; and where such knowledge is shared with pharmaceutical companies, for instance, the benefits must be shared appropriately with the former (see Chennells, 2016; Schroeder & Lucas eds., 2013; Wynberg, Schroeder & Chennells eds., 2009). Also, Hollis & Pogge's (2008) *Health Impact Fund* outlines the obligation of justice towards health promotion, which African health

systems would greatly benefit from. The *Health Impact Fund* provides a viable approach to justice that will ensure health improvements for African populations, as well as those in other poor countries around the world. The problem however, remains that these works consider justice from established Western frames; they make little or no recourse to a coherent African approach to justice.

However, since the reality and effects of health care inequality rages on in contemporary Africa, we are obliged to provide relevant solutions. The answers can still be found in the ethical imperatives underlying traditional African health care. We must however, abstract these imperatives and make them relevant to contemporary questions of inequality in health care. A specific African ethical approach to justice in health care or health promotion is yet to be established, as African bioethics endeavours appear to be focused exclusively on the clinical and medical research fields.

1.4.3 African Justice for African Health Care

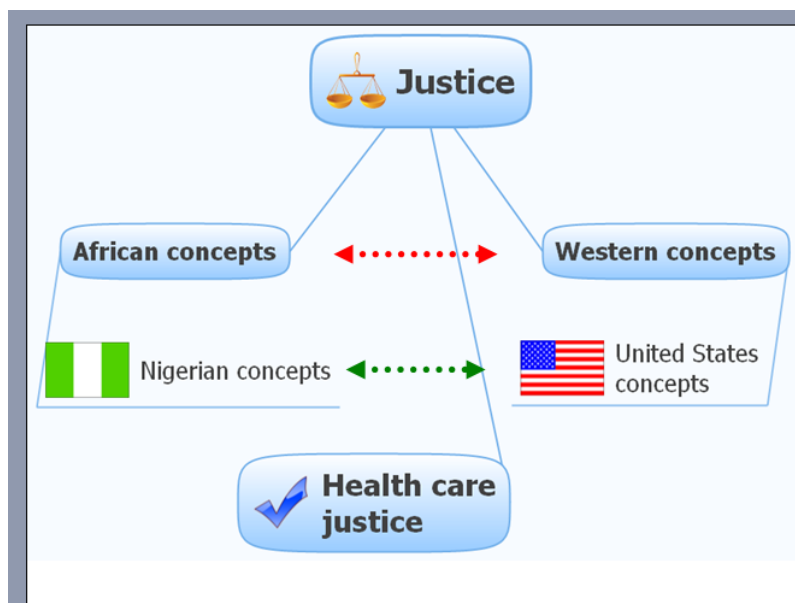
That a coherent African approach to just health care has not yet been established should not be taken as an oversight; it is rather an indication of the enormous task that African bioethics must approach. What exists in the current literature should serve as a platform towards further research on broader issues, especially those relating to justice in population health. As Tangwa (2015) notes, there is a vast area of research in African bioethics which still lies fallow, including ethical considerations in: biodiversity, disease and treatment, poverty and disease, medical practice, health care and professionalism, and biomedical research. As a possible way forward, Azestop (2011, p.12) suggests integrating elements of solidarity, especially those of mutuality and interdependence, in considering effective strategies for health promotion in Africa.

Thus, my motivation to develop an African ethical approach to just health care represents the appropriate next step for research in African bioethics. It presents a foundational investigation on justice and the distribution of health care resources and services in Africa, from an African ethical standpoint. Its distinguishing feature is that ethical approaches to population health within the continent should be informed by particular principles of African justice. Although I have noted earlier

that my “African” perspective will be limited to the Sub-Saharan region, I would note here that even this is too large to be covered in a single PhD thesis. Hence, I will mostly focus on one country, Nigeria – which is a small portion of Africa – as an appropriate starting point.

Nigeria will provide the specific context of health care on which considerations of justice will be made. It will also provide the socio-ethical background to determine the viability of the developed African approach to just health care. If this initial attempt is successful in establishing a relevant theory and setting up relevant ethical strategies, the specifications could then be adapted to other health care settings within the Sub-Saharan African region. As shown in the figure below, my analysis will involve a conceptual comparison between African and Western thought in a bid to establish the relevant African approach to justice in health care.

Figure 1.1 Levels of Conceptual Investigation



As a mode of proceeding, chapter two will provide an analysis of Nigeria’s context and health care situation. The point will be to determine the various dimensions of health inequalities in population health, and the corresponding inequity in access to health care for different population groups. I make relevant comparisons with the

United States' context, which is markedly different. Having established the nature of health care inequalities in chapter two, chapter three will consider an established approach to just health care that can address the questions of justice raised. It will explore Normal Daniels' ethical approach, which presents the most coherent theory of justice for health care in the current literature. My aim will be to consider its specific benefits for effective and just health care reforms in Nigeria, and potentially for the Sub-African region.

The thesis seeks to establish an African approach to just health care. Since Daniels' established approach is rooted in a Western framework – which is considered to be the global frame of reference – one would anticipate some difficulty regarding its feasibility in an African context of health care, like Nigeria. Hence, in chapter four, I will explore an African moral framework with the aim of abstracting the relevant conceptions of justice. I will identify the major ethical attributes and establish the basic principles of justice that emerge from the African moral framework. I will present these as the foundation for establishing two things: an African ethical method, and an African theory of justice for health care. I will harmonise these two dimensions in chapter five to provide an African ethical framework of just health care.

Since much of the work in this thesis remains at the conceptual level, I have considered it necessary to explore some practical implications for the developed ethical framework. Hence, in chapter six, I identify a specific health care policy in Nigeria for which I provide an ethical review in the light of the newly developed framework of just health care.

1.4.4 On the Question of an African Approach to Just Health Care

What is African about African approach to just health care? When is an approach to just health care African? Is an approach to just health care African when, or because, it is done by Africans? Is it African when, or because, it is done in Africa? Or is it African when, or because, it is done about Africa? For an approach to be African, it is not sufficient that it is done by Africans. Africans engage with other Western approaches, yet, this does not make those approaches African. Hence, that an approach to just health care is done by Africans does not necessarily make it African.

In order for the approach to be African, it is not sufficient that it is done in Africa. Western approaches are done in Africa, but this does not make them African; that the approach is done in Africa does not necessarily make it African. Likewise, for the approach to be African, it is not sufficient that it is done about Africa. Western approaches are done about Africa, but this does not make them African; that the approach is done about Africa does not necessarily make it African.

One way to determine what is African about an African approach to just health care is to look at why a Western approach like the ND Account may be called Western. If, as I have stated, it is true or correct that an approach does not qualify as African simply for being undertaken by an African, then it follows that a Western approach may not be so-called simply on account of being done by Westerners. Secondly, if it is true that an approach explored in Africa is not sufficient to make it African, then it follows that Western approaches are not so-called simply for being done in the West. Thirdly, if it is true that an approach does not qualify as African simply on the grounds that it considers Africa, then a Western approach may not be so-called simply because it is done about the West.

Western approaches, like the ND Account, are primarily called Western because they originated from the West. Historically, Western approaches: (i) originated from the West; (ii) were developed by Westerners; (iii) were done by Westerners; (iv) were done in the West; (v) and were done about the West. Among these five historical facts, only the first and second facts remain constant, the third, fourth and fifth facts are no longer constant. Currently, the facts remain that Western approaches (i) originated from the West (ii) and were developed by Westerners. But Western approaches are no longer done: (iii) by Westerners *alone*; (iv) in the West *alone*; (v) and about the West *alone*.

Consequently, “the principle of origination” is the main determinant of what makes an African approach to just health care African. The main idea about the *principle of origination* (a concept I am currently developing with another colleague, Frank A. Abumere) is that the context from which an approach emerges is significant in defining it as belonging to that context. For instance, one can say that what is Western is that which originates from a Western context, or that which is Chinese

originates from China. Hence, I refer to the ND Account as a Western approach because it originates from the West (United States). Accordingly, an African approach to just health care should have its foundation in African socio-ethical contexts.

1.5.0 Case Studies

To illuminate the conceptual work, I will refer to three case studies throughout the thesis, as outlined below. The first two cases derive from Nigeria and South Africa, and the third cuts across West Africa. Despite having occurred over a fifteen year period, all three cases reveal a trend that raises a particular question of justice in population health within the continent, which has not been previously addressed. The trend shows that the question cannot be a mere coincidence, but rather indicative of a deep-seated ethical dimension of population health. While the first two cases arise within a typical population health situation, the third has both public health and research ethics dimensions. However, a closer look will show that the more basic question is that of the distribution of the health care benefits, even under the research scenario. In what follows, I shall present a descriptive summary of the events. Specific details will be provided and analysed throughout the thesis.

1.5.1 Case I: The Polio Boycott in Nigeria

In 2002, it was reported that parents were refusing to let their children take the polio vaccine in parts of northern Nigeria (Raufu, 2002). Northern Nigeria has a dominant Muslim population. The reaction followed a campaign to consolidate the Global Polio Eradication Initiative (GPEI), as the polio virus remained endemic in Nigeria years after GPEI was launched by the WHO in 1988 (Jegade, 2007; Chen, 2003). In 2003, political and religious leaders in three northern Nigerian states brought the polio vaccination campaign to a halt by calling for a mass boycott (Jegade, 2007; Yahya, 2007). The reasons brought forward for the boycott were that the vaccines were allegedly contaminated with anti-fertility agents and HIV, as part of a Western plot to depopulate Nigeria (Jegade, 2007; Yahya, 2007). The claim was affirmed by a respected physician who was also head of a prominent Islamic group: “we believe that modern day Hitlers have deliberately adulterated the oral polio vaccines with anti-fertility drugs and... viruses which are known to cause HIV and

AIDS” (cited in Jegede, 2007, p.418). A renowned Islamic scholar insisted that while there is nothing wrong with polio vaccines, deep-seated suspicion of Western policies against Muslims constituted a major reason for the boycott (IRIN, 2013).

The pharmaceutical company, Pfizer, which had earlier conducted a contentious trial in the same region, was the main supplier of the vaccines being used:

For many people in Northern Nigeria, [the] anxieties... made sense in relation to past incidents concerning alleged malpractices in the meningitis vaccine delivery in 1996, when families accused... Pfizer Inc. of using an experimental drug on patients without fully informing them of the risks. (Yahya, 2007, p.189).

The experimental drug killed 11 children and left many others with varying disabilities. Pfizer has recently paid compensation to the surviving victims and families of those who were killed (McNeil, 2011).

A government intervention followed the boycott, with a committee set up to assess the safety of the polio vaccine (Jegede 2007; Yahya, 2007). Several laboratory tests were conducted to determine whether the claims were true. These were conducted independently both by the government’s committee and the Supreme Council for Sharia in Nigeria, as a way of ensuring transparency (Jegede 2007; Yahya, 2007). After 16 months, the political and religious leaders agreed to the immunization procedure only on the condition that Biopharma, an Indonesian pharmaceutical company, would be the new supplier of the polio vaccine (Yahya 2007). In July 2015, Nigeria became eligible to be taken off the WHO’s list of countries where polio is endemic, having marked a polio-free year (Kelland, 2015b).

1.5.2 Case II: South Africa’s HIV/AIDS Policy Controversy

Between 1999 and 2002, the South African government adopted a policy by which it refused to implement HIV/AIDS prevention and treatment regimens (Chigwedere et. al. 2008; Fassin and Schneider 2003). The decision had a vast effect on the population:

...more than 330,000 lives... were lost... Thirty five thousand babies were born with HIV, resulting in 1.6 million person-years lost by not implementing a mother-to-child transmission prophylaxis program using nevirapine. (Chigwedere et. al., 2008, p. 1)

The government offered an alternative that focused on poverty alleviation, palliative care, traditional medicine and adequate nutrition (Butler, 2005). The policy not only denied the important truths about the virus-nature of HIV/AIDS, but also restricted the supply of antiretroviral (ARV) drugs to public health facilities, making ARV drugs unavailable to patients – whether rape survivors, HIV positive mothers or health workers who were accidentally exposed to the virus (Fassin and Schneider, 2003). Hence, ARV drugs were technically not accessible to the poorer population. At the same time, Botswana and Namibia – two of South Africa’s neighbours with similar HIV/AIDS prevalence rates – were providing ARV treatments to citizens (Joachim and Sinclair 2013). They achieved 85% and 71% treatment coverage respectively, by 2005 (Chigwedere et. al., 2008).

The reason for the South African government’s disparate action was in line with the claims by “*AIDS dissidents*” that HIV was not the actual cause of AIDS and that the ARV drugs were toxic and dangerous to the health of patients (Chigwedere et. al. 2008; Butler, 2005). Another reason was the high cost of rolling out comprehensive HIV/AIDS drug-based prevention and treatment plans, which the government claimed it could not afford (Overy 2011).

A mass protest followed the government’s decision to restrict the drug-based prevention and treatment regime for HIV/AIDS, led by the Treatment Action Campaign (TAC) group – a non-governmental organisation in South Africa (Overy, 2011). TAC adopted various strategies in its campaign for treatment access, including: negotiation with the government, public mobilisation, and legal action, following the due process of South Africa’s constitutional law (Overy, 2011). TAC won a law-suit in both the High Court and the Constitutional Court of South Africa, which ordered the government to make ARV treatment available to its population and to design a roll-out plan (Fassin & Schneider, 2003; Overy, 2011). A reversal in the government’s policy has since seen a rise in the budget allocated to HIV/AIDS

prevention and treatment with the implementation of two public health policies: a) the provision of ARV drugs to pregnant women who are HIV-positive, to reduce mother-to-child transmission; and b) national distribution of the drugs to those living with HIV and AIDS (Overy, 2011). By 2012, 20 million South Africans had been tested for HIV/AIDS, the number of ARV treatment facilities around the country had increased to 3000, and an estimated 1.7 million people were on ARV treatment (Joachim & Sinclair, 2013).

1.5.3 Case III: The Ebola Virus Disease in West Africa

Between 2014 and 2015, six countries in West Africa – Guinea, Liberia, Sierra Leone, Nigeria, Senegal and Mali – were affected by the wild spread of the Ebola Virus Disease, which caused many deaths (Fall ed., 2015). By May 2015, a cumulative total of 27,165 cases and 11,115 deaths were recorded (Fall ed., 2015). While declaring the disease an international public health emergency in 2014, the WHO considered it “...the largest, most severe, most complex outbreak of the Ebola virus disease in history” (WHO, 2014c, p. 1). Unlike previous outbreaks which were easily contained, the West African epidemic spread rapidly across national borders, and presented imminent risks even to people in other continents (BBC, 2015).

Researchers traced the outbreak to a two-year-old toddler who died in December 2013 in a village in Guinea; and by June 2014, the epidemic was out of control, crossing borders into neighbouring Liberia and Sierra Leone (BBC, 2015), stretching available health care resources significantly. The disease made its way to Nigeria when medical consultant arrived in Lagos airport from Liberia in July 2014, and all future cases were traceable to him (Egbejumi-David, 2014).

The disease spread rapidly within the West Africa region. Despite several appeals from charitable agencies working in the affected countries, the world stood by and watched (Dale, 2014; Branswell, 2015; Regan, 2015). The Western world only woke up to the urgency of the situation when a number of foreign health workers were infected with the virus, especially when one case was diagnosed on United States soil (BBC, 2015).

At the onset of Ebola, there was neither a known cure nor a vaccine, and the average fatality rate was around 50% (WHO, 2015b). The spread of Ebola was made worse by the ease of the disease's transmission, through simple human-to-human contact, with the symptoms taking up to 21 days to emerge (WHO, 2015b). Having identified potential vaccines, the WHO gave some waivers to allow trial vaccines to be used for health workers in the frontline, and urged pharmaceutical companies to develop effective vaccines for public use (WHO, 2014c; Sayburn, 2014). Early in 2015, Ebola vaccine trials were scheduled to take place in Africa and Europe, targeting 1,200 and 600 volunteers respectively (Kelland, 2015; BBC, 2015b).

Attempts at a Phase I trial in Ghana sparked a public protest in May 2015, and the vaccine trial process had to be halted (Kpodo, 2015; Osam, 2015; Segbefia, 2015; Kwakofi, 2015). The suspension was based on a foreseeable gap in public knowledge about the vaccine, and concerns about including Ghana – which had recorded zero Ebola cases – in the early trial phase (Kpodo, 2015; Osam, 2015; Segbefia, 2015; Kwakofi, 2015). There was notable social media outrage and general opposition to the trial. It was reported that the Ghana Academy of Arts and Sciences had earlier cautioned about the trial in Ghana, and had urged the government to engage the communities and individuals being considered before approving the trial (Osam, 2015). Another trial conducted in Guinea has since shown the Merck Ebola vaccines to be very effective (Callaway, 2015; CNBC, 2015). Nigeria was declared Ebola-free in October 2014 (WHO, 2014f); and Liberia also passed the forty-two days no-case period in May 2015, thus marking the end of the outbreak for the country (WHO, 2015e).

Having outlined the cases above, I shall proceed with the main investigation of this thesis.

Chapter Two: Contextual Backgrounds of Just Health Care

2.1.0 Introduction

Health and illness occur within specific contexts and under a given set of conditions. The nature and distribution of health care are influenced by social factors and the nature of prevailing diseases. In setting out to establish the foundations for an African ethical approach to just health care, as may be applied in Nigeria, this thesis draws from the widely cited framework as variously developed by Norman Daniels. Daniels' approach to just health care is primarily informed by the United States' context, which varies widely from Nigeria. In the search for an appropriate approach to just health care reforms in Nigeria, Daniels' (2008) ethical framework may offer useful guidelines; yet, simply importing it may not offer specific solutions to the varied health system issues. For while there may be some similarities in the nature of health care problems between the two countries, they are also markedly different in Nigeria and the United States. While not discounting the wider relevance of the ethical approach for Nigeria, it suffices to note that the generic framework would require specific groundings in light of the contextual conditions of the different countries. For example, an approach that is effective in Thailand may not necessarily work for Nigeria or Venezuela. Hence, considering an effective ethical approach for Nigeria's health care will require significant adjustments against the relevant contextual background, such as socio-cultural dynamics and socio-economic conditions. It should also account for the nature of the population's health, and the kind of services available to them.

In order to determine the dynamics of the relevant ethical approach for Nigeria, it is appropriate to understand the background conditions against which health care is undertaken. Three background conditions are paramount: the social context, health burden, and governance of and resource distribution for health care. Considering these features will not only present the kinds of ethical challenges envisaged and the specific expectations of the population, but will also outline the nature of the obligations of the health care system. This chapter will explore the social context against which health care in Nigeria takes place; the nature and status of the

population's health; and the state of health service delivery in the country. The analysis will be undertaken in the light of the United States' context, thereby providing a relevant comparison for an already established ethical framework of just health care. For instance, while the United States is a high income country and an OECD⁸ member state with high standards of health service delivery, Nigeria is a low-middle-income country with relatively low standards of health care delivery (WHO, 2014). Since the ethical framework being considered was first designed for the United States, the contextual comparisons should help illustrate the similarities that warrants adopting it, and the variances that call for a modified ethical approach.

2.2.0 Social Context of Health Care

The social settings of any given context significantly determine the health status of the population and the distribution of relevant health care, as findings on the social determinants of health have shown (WHO, 2011c). For instance, the tropical climate in Nigeria provides a suitable breeding ground for mosquitoes, which in turn makes malaria endemic in the country. In order for a strategic approach for just distribution or equitable access to health care to be effective, the relevant social context will require significant consideration. In edging towards a framework for just health care in Nigeria, the relevant social features to consider will include: the natural environment and political organisation, cultural values and religious beliefs, population distribution and standard of living, and the socio-economic situation of the country. Together these constitute a fundamental determinant of the population's health and the kind of health care accessible to them.

2.2.1 The Natural Environment and Political Organisation

The natural setting and institutional structure of a country bear on the health status of its population. For example, low levels of resources and poor institutional infrastructure in a country, such as in Somalia (see WHO, 2014d), will adversely affect the kind of health care that the population can get, and could considerably reduce their health status – in a similar way Nigeria's tropical conditions imply high

⁸ OECD: Organisation for Economic Cooperation and Development (WHO, 2012a, p.5).

malaria burden. These conditions vary for different contexts and have varying implications for health care. Hence, there is a need to understand the natural setting, the kind of available resources and the institutional structure in Nigeria, in order to proffer a relevant approach for just health care.

2.2.1.1 *Geographical Settings and Climatic Conditions*

Located along the South Atlantic coast of West Africa, Nigeria is bordered on the west by Benin Republic, on the north by Niger Republic, and on the east by Chad and Cameroon (see figures 2.1.1 & 2.1.2 below). Nigeria is a beautiful country with diverse climatic conditions and topography: marked by plains in the North, lowlands in the South, and plateaus and hills in the Central region (Falola, 2001). The northern plains extend from Sokoto in the West to Borno in the East; the lowlands traverse the South-Western region, covering the Cross River basin in the South-East; and the highlands extend from the central Jos-Plateau region, through the Adamawa highlands in the North-East, to the Obudu Plateau and Oban Hills in the South-East (National Population Commission, NPC, & ICF International, 2014). The typical climatic conditions are tropical with variable rainy and dry seasons across the country, providing greener vegetation in the south and dry savannah grassland in the north (Udo & Falola, 2015). The climate is generally similar to those of other countries within the tropical regions of Sub-Saharan Africa (see Dickson, 2015).

Figure 2.1.1 What does Nigeria look like?

(<http://www.mapsofworld.com/nigeria/>)



Figure 2.1.2 Where in the world is Nigeria?

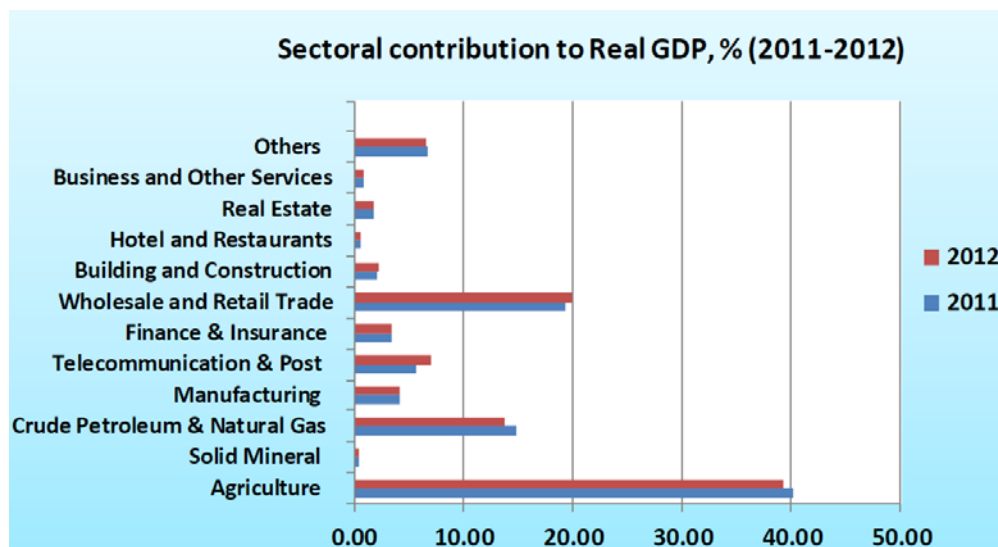
(<http://exploringafrica.matrix.msu.edu/>)



2.2.1.2 *Natural Resources*

Nigeria is endowed with rich agricultural land and a variety of natural resources, ranging from crude oil and natural gas to solid minerals, much of which is yet to be exploited (Federal Ministry of Information, FMoI, 2012). Crude oil and natural gas remain the largest sources of revenue for the country, leading to an under-exploitation of other resources. With proven oil reserves estimated at 36 billion barrels and over 100 trillion cubic feet of natural gas, Nigeria produces approximately 1.6 million barrels of oil per day, and is the fifth largest oil exporter to the United States (FMoI, 2012). However, these account for only approximately 15% of real GDP for the country (National Bureau of Statistics, NBS, 2013), as shown in figure 2.2.1 below. The agricultural sector contributes an estimated 40% of real GDP and two-thirds of employment in the country, and a significant fraction of non-oil growth of approximately 10% (NBS, 2013; FMoI, 2012).

Figure 2.2.1 Sectoral Contribution to Real GDP Growth in Nigeria, 2011-2012 (NBS, 2013, p.7)



2.2.1.3 *Political organisation and administration*

Nigeria has a federal system of government, consisting of three arms: the Executive arm is made up of the Presidency and the Federal Executive Council; the Legislature

consists of the Senate and House of Representatives; and the Judiciary interprets the law (NBS, 2012). The government also flows in three tiers, consisting of the federal, state and local governments, with each tier running autonomously from the other. These together form policies and establish laws that affect the health and wellbeing of the population. This is similar in many respects to the United States' system of government, which also consists of three arms (executive, legislative, and judicial branches) and three tiers (federal, state, and local governments) (Harris, 2015). The three tiers of government provide a framework through which policies are formulated and implemented, especially those relating to health care (Kombe et. al., 2009). For instance, the three tiers of government constitute the three levels by which public healthcare is administered. These include:

- a) primary care facilities, corresponding to the local level of governance, consisting of health centres, dispensaries, and clinics, providing general preventive, curative, promotional and pre-referral care;
- b) secondary care facilities, aligned with the state level, consisting of general hospitals that provide medical and laboratory services and other specialised services such as surgery, and serving as referral centres for primary health facilities; and
- c) tertiary facilities, under the auspice of the federal government, consisting of specialist and teaching hospitals, and federal medical centres with full expertise and technological capacities. They serve as referral centres for both primary and secondary facilities, and provide specialised training for health care practitioners (Kombe et. al., 2009).

The institutional structure creates a framework for proper checks and balances in the health care system. It also shows in principle that the government is involved in the provision of health care to various sections of the population. However, this appears not to be the case, as will be shown in subsequent sections. Likewise, policy regulation and provision of services will be shown to be at a bare minimum, when compared to other health care systems like the United States.

2.2.2 People and Culture

The cultural practices and norms, and the religious beliefs of a people affect their views about health and illness, and bear on their attitude towards health care and the kind of care they may seek. For instance, given the strong presence of traditional cultures and religious affiliations in Nigeria, it is common to find people seeking care or healing from traditional healers or prayer houses. Hence, it is important to gain insight into the cultural norms, values and beliefs that bear on health care in the country. This will inform a more context specific approach to just health care.

2.2.2.1 Ethnic Diversity

While both Nigeria and the United States are culturally diverse, these diversities are variously defined. Nigeria's ethnic diversity is defined along tribal lines, with over 250 ethnic groups having distinguishable languages, norms and cultural practices (Udo & Falola, 2015). Among these, three ethnic groups are predominant, namely: Hausa-Fulani, Igbo, and Yoruba. Each ethnic group occupies a specific territory within the country to which it claims rights of inheritance (ibid). For instance, it is common in Nigeria to find someone who has lived all his life in a northern town claiming a southern origin, simply for being of the same ethnic group as those in the South. The wide ethnic diversity has also been a source of conflict, as there have been clashes between some tribal groups in recent history, and tensions still exist between others. With urbanisation, however, there has been significant integration among the various ethnic groups, as marriages are now common between persons of different tribal/ethnic origins.

On the other hand, the United States' ethnic diversity is mostly defined along racial lines. The racial differentiations are a consequence of the country's long history of immigration, which has attracted people from all parts of the world (Perez & Hirschman, 2009). Among the larger ethnic/racial groups in the United States are: Ethnic European-American, African-Americans, Hispanics, Asian Americans, Middle Easterners, and Native Americans that have traditional rights claims to some of the country's territories (Naisbitt, Flaum, & Handlin, 2015). The complex nature of immigration and racial integration means that many United States' citizens can no longer trace any discernible ethnic identity and describe themselves only as

Americans (ibid). While the traditional ethnic categorisation is still intact in Nigeria, the racial and ethnic differentiations in the United States have been mostly integrated – they are constantly changing with new American identities emerging regularly (see Perez & Hirschman, 2009).

The wide ethnic diversity in both Nigeria and the United States suggests that similar ethical strategies could be employed towards just health care delivery. However, the ethnic configurations have varying implications for the perceptions of health and illness, the approaches to health care, and what a just service delivery would mean for persons in the two contexts. In Nigeria, for instance, some tribal or ethnic practices and norms may pose challenges for health service delivery or the manner in which they are sought. It is still a common practice for Nigerians to refer some illnesses to traditional healers, medicine men, or spiritual healers. While people often turn to these alternative remedies when Western medicine has failed them, it is not always the case that they would have sought the relevant health service beforehand.

2.2.2.2 *Religious Diversity*

Religious views play a major role in the perceptions of health and wellbeing, and largely determine the acceptability of available health care services (Oluwabamide & Umoh, 2011; The Bravewell Collaborative, 2015). For example the Jehovah's Witnesses have a popular radical view on some medical procedures, like the absolute rejection of blood transfusion. Also the events leading to the rejection of the polio vaccines⁹ in Northern Nigeria, had a strong Islamic influence, given the bases for the action. What measures should we take to save the life of a child needing blood transfusion, whose parents are faithful Jehovah's Witnesses, and how can we curb polio in the face of a strong faith-based refusal of the vaccines? Where they exist, religious beliefs should be given relevant consideration in designing a suitable

⁹ see polio case in chapter one

approach towards just health care. It is important, therefore, to appreciate the religious diversity in Nigeria, in view of its significant bearing on health care.

Beside the complexity of tribal differences and ethnic integration, Nigeria is also divided along religious lines. Christianity and Islam are the two major religions in the country, each constituting approximately 45% of the population, with the remaining 10% practicing various forms of Traditional Religions¹⁰ (FMoI, 2012). The Muslim population is concentrated in the Northern and South-Eastern parts of the country, while Christians are concentrated in the Southern and middle-belt regions (Falola, 2001). Both religions have various sects, with some holding extreme religious views, such as those leading to the recent Boko Haram¹¹ insurgency in the country. Practitioners of traditional religions are spread across the country, given that these mostly follow from the traditional practices of specific ethnic groups.

Like Nigeria, the United States has a variety of religious practices, with the Christian population dominating; only approximately one-sixth of the population is not Christian (Naisbitt, Flaum, & Handlin, 2015). The diversity of denominations means a difference in religious affiliations, even amongst the Christians, and recent immigration has increased the Muslim, Buddhist and Hindu presence in the United States (ibid). Unlike the United States, Nigeria has only Christianity and Islam as major imported religions, and the traditional religions are strongly embedded in the people's culture and history.

¹⁰ Traditional religions in Nigeria constitute modes of spiritual practices among various ethnic groups, and entail beliefs in supernatural forces, and ancestor worship. While the fundamental features are the same, the modes of practice vary among different tribes. (See Idowu, 1973 and Magesa, 1997).

¹¹ Boko Haram is a terrorist Islamic group in Nigeria, fighting to create an Islamic Caliphate in the Northern part of the country. "Boko Haram promotes a version of Islam which makes it "haram", or forbidden, for Muslims to take part in any political or social activity associated with Western society. This includes voting in elections, wearing shirts and trousers or receiving a secular education. Boko Haram regards the Nigerian state as being run by non-believers, even when the country had a Muslim president - and it has extended its military campaign by targeting neighbouring states. The group's official name is Jama'atu Ahlis Sunna Lidda'awati wal-Jihad, which in Arabic means "People Committed to the Propagation of the Prophet's Teachings and Jihad". (Chothia, 2015)

In light of the similar religious diversities in both Nigeria and the United States, a relevant ethical approach to health care would seek ways that address such religious influences and the implications for health care. The Jehovah's Witnesses strong footing in United States, with an estimated population of 8.2 million (Jehovah's Witnesses, 2015), means that ethical challenges such as blood transfusion will persist. Also the killing of health workers by Boko Haram in northern Nigeria (Madu, 2013) shows a similar challenge to health service delivery, implying the need to include religious dimensions in ethical deliberation.

2.2.2.3 Cultural Values and Family Life

Like religion, cultural and family values variously influence the delivery and effectiveness of health care services. For example, it is a common understanding that Nigerian families have a direct responsibility for the care of ill members, which greatly influences or determines the kind of health care that individuals get. Hence, the place of family is significant to any relevant approach toward just health care. The Nigerian culture reflects great changes in inherited traditions and adaptations to imported norms (Udo & Falola, 2015). Hence, Nigeria can be regarded as a melting pot of culture, languages and religions, but not in the same sense as the United States (see Sigsbee, 2011, p.2). In spite of Nigeria's diversity, general cultural and social trends are obvious within the country, especially in family life, gender roles, social norms, and customs (see Falola, 2001, p.117ff).

One obvious societal feature that is observable to anyone visiting Nigeria is the strong presence of family links or circles to which most people belong. According to Udo & Falola (2015), family is a central institution in Nigerian society in both urban and rural areas, and births, weddings and funerals create avenues where families meet to deliberate on important issues. The size of a Nigerian family is generally bigger than the American nuclear family (Falola, 2001, p.126-132). The sense of family extends beyond spouses and children and includes other relations, such as, uncles, aunts, grandparents, cousins, and others linked by marriage ties:

For African peoples the family has a much wider circle of members than the word suggests in Europe or North America... the family includes children,

parents, grandparents, uncles, aunts, brothers and sisters who may have their own children, and other intermediate relatives... The family also includes the departed relatives... [who are] alive in the memories of their surviving families, and are thought to still be interested in the affairs of the families they once belonged in their physical life... African concept of family also includes the unborn members who are still in the loins of the living. They are the buds of hope and expectation, and each family makes sure that its own existence is not extinguished.” (Mbiti, 1990, p.104-105).

Family and kinship are interchangeable terms since the idea of family often refers to kinship:

Kinship is reckoned through blood ties and betrothal – engagement and marriage – and controls social relationships between people in a given community: “the kinship system is like a vast network stretching laterally in every direction, to embrace everybody in a given local group... This means that every individual is a brother or sister, father or mother, grandmother or grandfather... or something else to everyone... everybody is related to everybody else.” (Mbiti, 1990, p. 102).

Being extended in nature, family consists of people from different generations having close ties, thereby extending the expectations and responsibilities of each member.

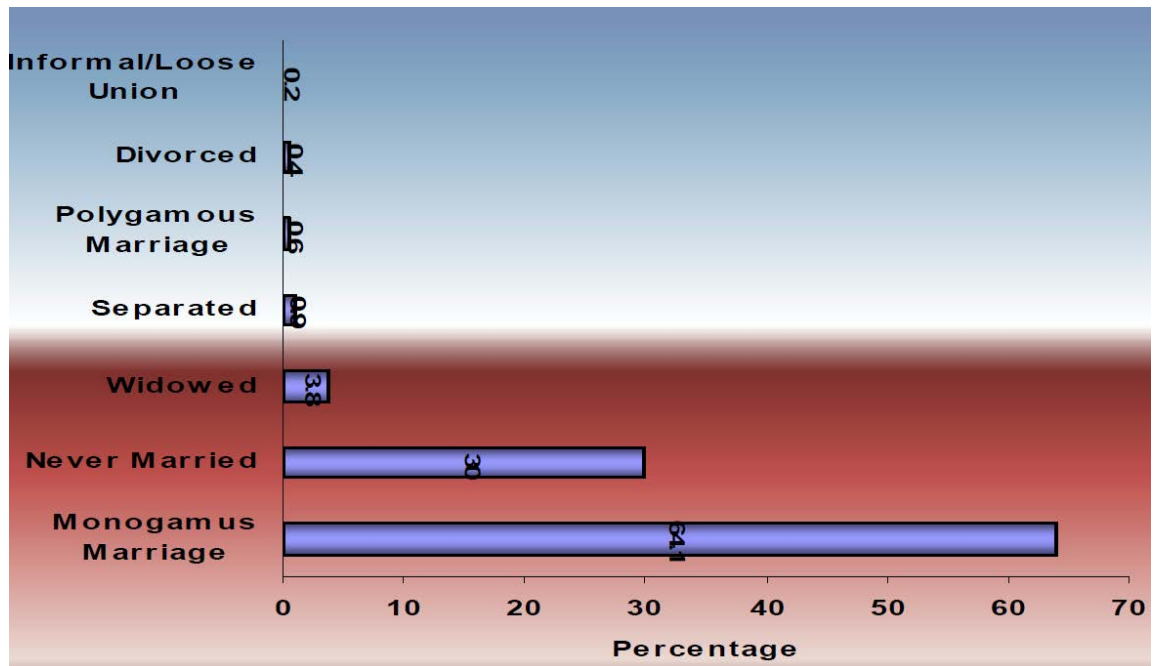
Marriage, being the foundation of family, is emphasised in Nigerian culture, and children are often raised within families by their parent, grandparents and/or other relations, in a joint effort. According to Falola (2001):

“Marriage confers respect and status ... [it] unites not just the couple but their lineages and clans... [For it is] conceived as an instrument joining two extended families, forming alliances among different kinship groups (p. 119).

While marriages in traditional Nigerian society experienced greater stability than in contemporary times, the divorce rate is still not as high as in Western societies (see figure 2.2.2 below). As with other African societies (see Salm & Falola, 2002; Gyekye,

1996; Mbiti, 1990), family, kinship and clans are significant, and effectively determine or influence the success of individuals and their defined roles and responsibilities.

Figure 2.2.2 Percentage Distribution of Marital Status in Nigeria (NBS, World Bank & UNDP, 2010, p.16)



The Nigerian family, as in many other African cultures, still serves as a welfare and insurance agency for its members, especially in raising children, caring for the sick and the elderly, training its young members and securing jobs when the need arises (Udo & Falola, 2015). It is common knowledge that families are responsible for the financial burden of their children’s entire education, from basic to tertiary, and the family is often the first point of financial remedy in urgent health care issues for its members. Family members are expected to make financial or other contributions towards emergency or chronic medical care, which are expensive and coverage is often not available. This has been necessitated by the lack of universal health coverage in the country, leading to a reliance on the traditional value of collective family support: “... there is a carryover from the past when commitment to a group ensured collective survival ... [and] the basic ideas of socialization still reject individualism”. (Falola, 2001, p.129-130).

Without intending to overstate the case, it may suffice to note that American society is founded on the idea of liberty, deriving from the mass immigration that makes it “*the Great Melting Pot*”, blending cultures, languages and religions to form a single national identity” (Sigsbee, 2011, p.2). According to Azerrad & Anderson (2015):

The preamble of the constitution of the United States contains what may well be the clearest and most concise description of the principal purpose of the American project: to “secure the Blessings of Liberty to ourselves and our Posterity. (p.1)

They highlight four attributes sustaining American culture and society: limiting constitutional government, flourishing and strong families, vibrant civil society with free markets, and a culture that promotes virtue. American culture emphasises the opportunity of individuals within society, which is highlighted by the capacity of Americans to pursue happiness, both individually and in a community (Azerrad & Anderson, 2015). In light of the central place of individual liberty in the American culture, “the research on opportunity underscores the central importance of a good education to future success”, and with many Americans needing college-level skills to advance, student loans are variously provided (Burke & Butler, 2015). This ensures that Americans are able to access the available opportunities, in order to have equal chances of pursuing their life plans in greater liberty:

Citizens develop a taste for independence, cultivate their judgement, and learn how to exercise their freedom in a responsible manner... we learn to improve our own lot and address problems... through our own initiative...” (Azerrad & Anderson, 2015, p.3).

With regard to family life, Azerrad & Anderson (2015, p.1-4) note the centrality of family and community in American culture, which is similar to the importance accorded to it in Nigerian culture. However, they observe a decline in family life, specifically referring to the erosion of marriages, the unravelling of communities, and a rise in government dependence, which they claim have weakened the American social fabric (ibid). Also Lopez (2015) claims that there is a coarseness in the society and a rending of the real ties that bind Americans together, given that

only about half of Americans are currently married, and half of American children spend time outside of a married household: “our brotherly social safety net is fraying, and we now look to government instead...” (ibid, p.1).

It is important to note that while family values and traditional cultural and communitarian norms have great influence on the lives of individuals in Nigeria, American society espouses the liberty and independence of individuals. And although family is central in both contexts, the basic understanding of family is different, and the expectations and responsibilities of individuals towards their families (and vice versa) vary significantly. Therefore, in health care, the influence or emphasis of family would be different, as different kinds of family values will bear on the health care seeking behaviours in each context. These variances should be given specific consideration in edging towards a relevant approach to just distribution of health care resources, and in determining what just health care means in each context.

2.2.3 Demography and Socio-economic Conditions

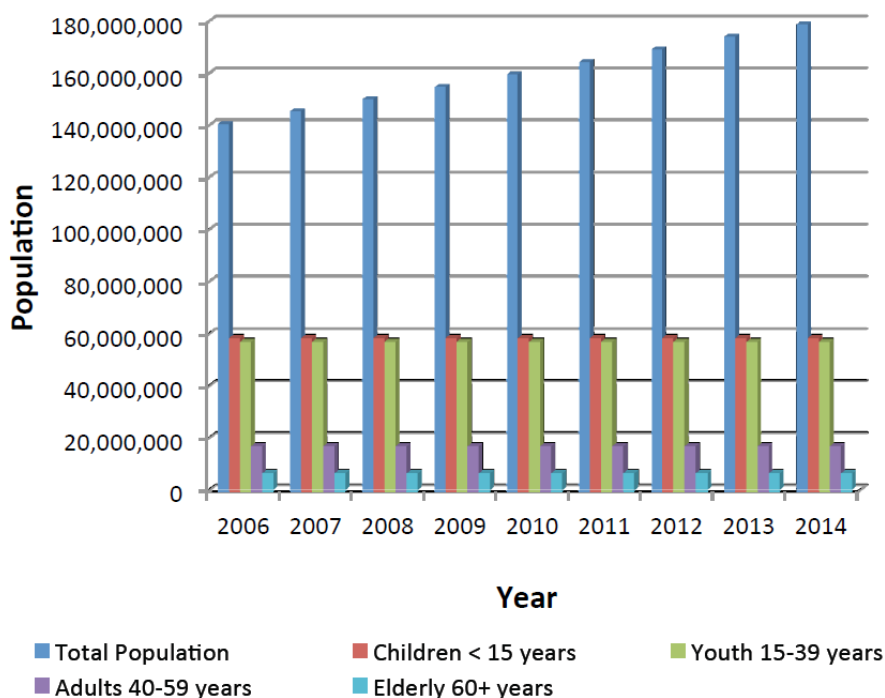
Beyond socio-cultural features and the natural environment, the nature and distribution of the population and their living conditions also bear on their health and the kind of health care they can get. In Nigeria for instance, people in urban areas tend to have better access to health care facilities than those in rural areas, and the health status of those with higher levels of education are generally better than those with less or without education (NPC & ICF International, 2014, p.117ff). Thus, in considering an ethical approach towards just health care in Nigeria, it is important to account for the nature and distribution of the population, educational status, and the average living conditions. These will situate the ethical framework within a real life context, where people seeking health care may require varying considerations.

2.2.3.1 Population Distribution

Nigeria’s population is estimated to be 169 million, making Nigeria the most populous country in Africa (WHO, 2014a, p.165-175). Nearly half of the population is aged under fifteen years, and less than one-twentieth (4%) is over sixty years old

(see figure 2.2.3 below). Additionally, about half of the population lives in urban areas, and the other half in rural settings (WHO, 2014a, p.170-171).

Figure 2.2.3 Nigeria’s Population and Specific Population Categories, 2006-2014 (NBS, 2014, p.1), Demographic Statistic Bulletin 2013



As may be observed from figure 2.2.3 above, the total number of children and elderly persons are about equal to those of working aged person, 15 to 59 years. The age distribution suggests that, on average, approximately one person is dependent on each economically active person – where the dependence ratio is understood as the total population of those aged 0-14 and over 65, matched with those aged 15-64 (NBS, World Bank & UNDP, 2010, p.14-15). This suggests a high burden of care on most persons, as is also evident in the high unemployment and poverty rates in the country (see 2.2.3.3).

The United States although approximately ten times the size of Nigeria in terms of total land area (see figure 2.2.4 below) has a total population of about 318 million, which is only around twice that of Nigeria (NationMaster.com, 2013). There is an equal proportion of the population aged under fifteen and over sixty years old, 20%

and 19% respectively; and 83% of the population is said to live in urban settings (WHO, 2014a, p.172-173).

Figure 2.2.4 If Nigeria were placed inside the United States (Ifitwerehome.com, 2015)



Some implications for health care in Nigeria are that in the distribution of services greater consideration will be given towards the care of the young population than the elderly, since the proportion of the latter is comparatively low. Also, since around half of the population living in rural areas has relatively lower access to health care, ethical considerations might expect to give a high priority to providing them with the relevant services. Thus, while both countries have large total populations for which we may employ similar ethical dynamics, Nigeria's population distribution raises different issues in just health care than the United States'.

2.2.3.2 Education

Access to formal education is closely linked to the nature of population distribution and has a relative bearing on access to health care. According to the Nigeria Demographic Health Survey (NDHS) 2013:

The educational level of household members is among the most important characteristics... because it is associated with many factors that have a

significant impact on health seeking behaviours, use of contraception, and children's health status. (NPC & ICF International, 2014, p.23).

Accordingly, the educational status of the population constitutes an important determinant for the kind of health care that is accessible to them and the kind of demands that people would make for their own health care. An educated or literate population will have easier access to vital information about health and the relevant services that are available than an uneducated or non-literate one. Data from Nigeria's health survey variously supports this claim (see NPC & ICF International, 2014, p.117ff).

Nigeria's literacy status compares poorly with that of the United States. For instance, Nigeria has an adult literacy rate of 51% and net primary school enrolment of 58% (WHO, 2014a, p.171). On the other hand, the United States' adult literacy stands at 99% with net primary school enrolment at 93% (Measures of America, 2015). Given the link between education and health, the implications of illiteracy will be greater in Nigeria. Hence, the relevant ethical framework for just health care for Nigeria will also seek to address the illiteracy problem in order to ensure equity in access to health care information.

2.2.3.3 *Standard of living*

Like education, the living conditions of a population will bear on the kind of health care they seek and what services may be available to them. These should inform a relevant ethical strategy for guaranteeing acceptable measures for distributing health care. The Harmonised Nigeria Living Standard Survey 2009/10 puts the average household size at 5.8 persons with an average figure of 7 in some parts of the country (NBS, World Bank & UNDP, 2010, p.15-16). Highlighting the rate of vulnerability in the population, the survey shows that 4.6% of young persons (under 18 years) have lost both parents; three-quarters of them live in rural areas and only one-quarter live in urban areas (ibid).

Related to family size is average household income and poverty levels, which do not reflect the natural and human endowments in the country. Nigeria's Poverty Profile

2010 shows that the proportion of Nigerians living in poverty has increased significantly over the past three decades, from 17.1 million persons in 1980 to 112.47 million in 2010, as shown in figure 2.2.7 below. In percentage terms, the relative poverty rate was estimated at 69% of the total population, as shown in figure 2.2.7a. Specifically, the rural population is most affected, given the higher poverty ratio (see figure 2.2.8 below).

Figure 2.2.7 Population in poverty in Nigeria (NBS, 2012, p.12)

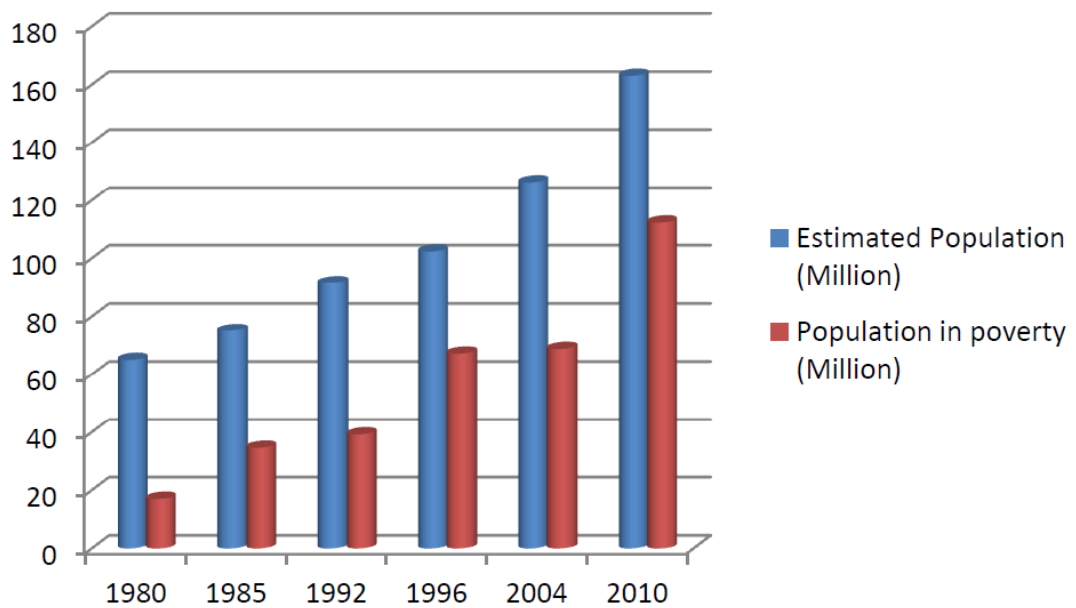


Figure 2.2.7a National Poverty Incidence 2003/2004 and 2009/2010¹² (NBS, 2012, p.15)

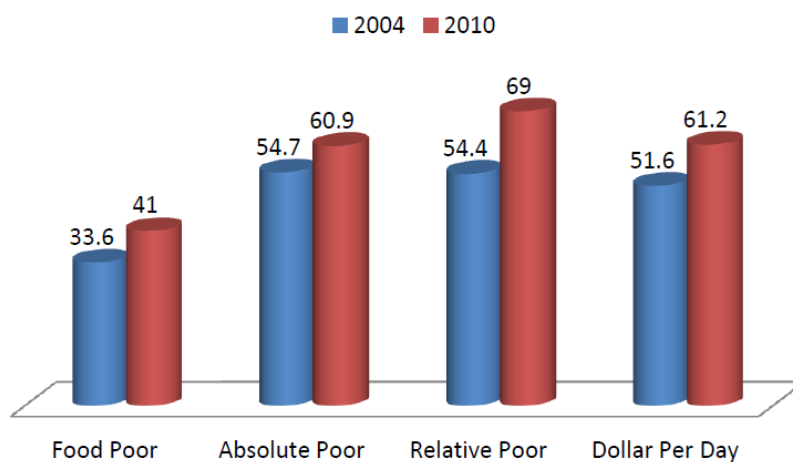
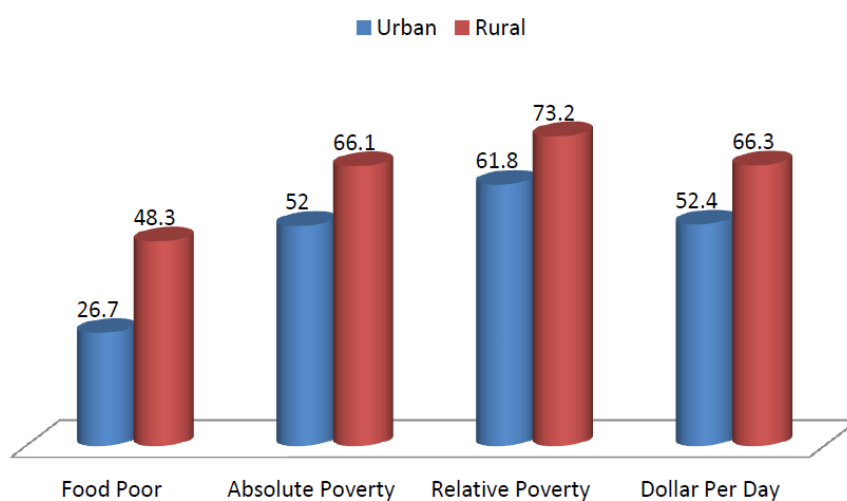


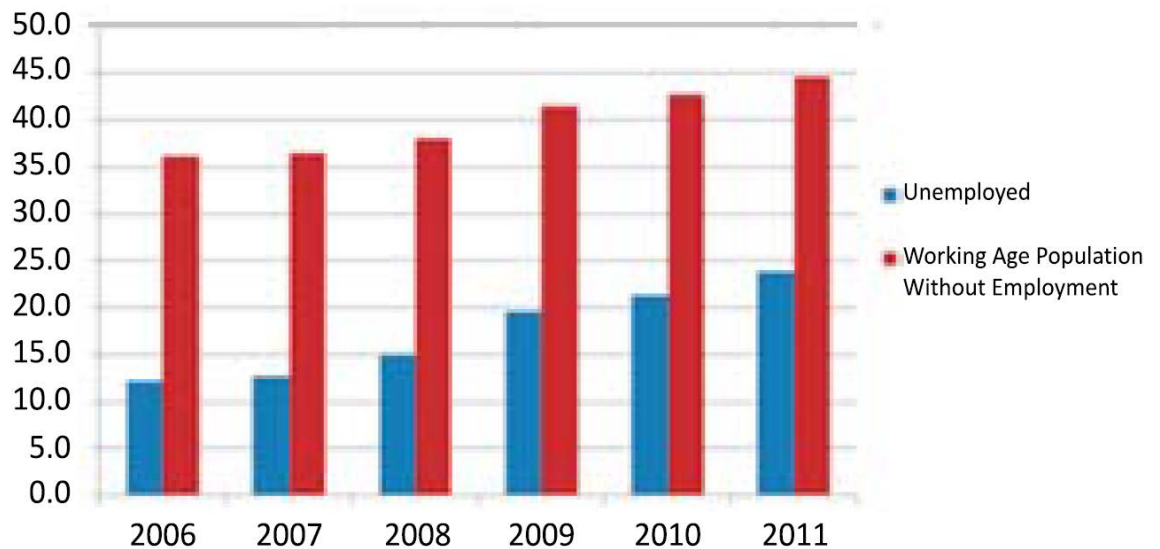
Figure 2.2.8 Percentages of Urban-Rural incidence of Poverty in Nigeria (NBS, 2012, p. 16)



¹² Relative Poor, also referred to as moderate poor, includes households or persons whose income or expenditure is more than one-third but less than two-thirds of the total per capita income or expenditure; Absolute or extreme poor are those whose with less than one-third of per capital income or expenditure; Food poor refers to the population with less than 3000 calorie intake per day; and Dollar per day poor refers to the population living on less than US\$1 a day (NBS, 2012, p.13-14)

The rate of poverty is made more complex by a correspondingly high rate of unemployment and underemployment in the country, as shown in figure 2.2.9 below.

Figure 2.2.9 Unemployment in Nigeria 2006-2011 by % of working age population (World Bank, 2013, p.10)



By comparison, living standards in the United States are relatively better than those in Nigeria. The United States is a high income OECD country with a GDP of US\$16.77 trillion in 2013 (World Bank, 2015). While the poverty index in Nigeria has seen significant increase over the years, the official poverty rate in the United States decreased between 2012 and 2013 (DeNevas-Walt & Proctor, 2014, p.1). The average American household income per annum is estimated at US\$51,939, with the poorest household category earning US\$26,425 (ibid, p.6) – also see figure 2.3.1. The relative poverty rate in 2013 stood at 14.5% (see figure 2.3.2). Figure 2.3.3 also shows varying rates between different age categories, showing lower rates for the working population group.

Figure 2.3.1 Real Median Household Income by Race and Hispanic Origin in the USA: 1967-2013 (DeNavas-Walt & Proctor, 2014, p.6)



Figure 2.3.2 Number in Poverty and Poverty Rate in the USA: 1959-2013 (DeNavas-Walt & Proctor, 2014, p.12)

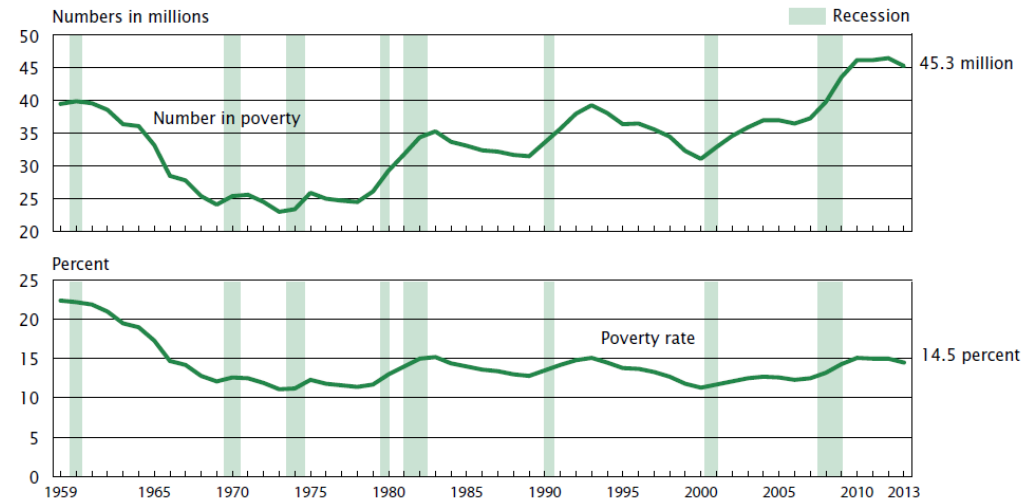
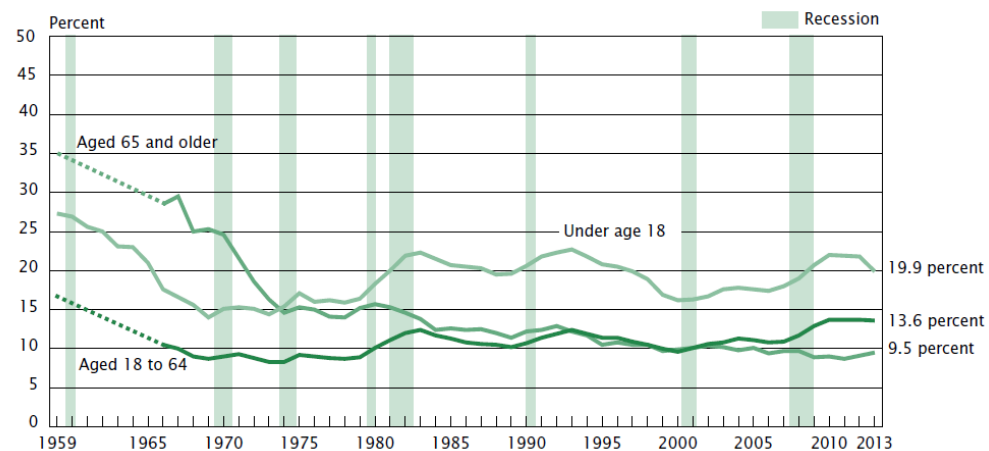


Figure 2.3.4 Poverty Rates by Age, USA: 1959-2013 (DeNavas-Walt & Proctor, p.14)



It is evident from the charts above that the United States' poverty rate has remained basically stable over the past thirty years. On the contrary, Nigeria has seen a continuous and rapid rise in poverty within those years. Given these figures, the average living standards of American families would be significantly higher than Nigerian ones. Also persons considered poor in the United States may not count as poor on a dollar-per-day rating. Hence, the majority of Nigeria's population that is unable to afford or access basic health care, is far-removed from what obtains in the United States. Except for complex or expensive medical procedures, United States households will more easily cushion the financial burden of basic health care than in Nigeria. While the relevant ethical approach will seek to address poverty differentials in both countries, Nigeria's approach will have a higher poverty-focus.

2.2.3.4 Social welfare system

Access to basic health care in Nigeria is compounded by the absence of a social welfare system, universal health coverage or a relevant policy to this effect. The policy initiative is only recently being considered, following a dormant bid in the National Assembly (Okafor, 2012; Mbu, 2002). Since a higher proportion of the population is considered poor and unable to afford health care, a welfare system is needed to provide coverage. The absence of a welfare scheme means that there is a high dependence on family circles for health care coverage:

...family serves as a welfare and insurance agency to the needy, the jobless, the elderly, and the sick ...the family organises and distributes resources to help members... [and is also] responsible for creating the opportunities for ceremonies, leisure and education. (Falola, 2001, p. 117-8).

It is common in Nigeria to find that families take sole responsibility for the health care of their members, whether by purchasing private health insurance or directly paying for health care. Hence, families with low income or earnings bear a higher financial burden.

The United States on the other hand, has an established social welfare system. US Social Security Programs provide coverage for much of its population, especially

disabled and elderly persons, children under 18 years old, and dependent parents, widows or widowers; temporary assistance to unemployed persons; various health insurance and health services; and food and housing assistance (Social Security Administration, 1997). While not assuming absolute or equal coverage for all, the social welfare system alleviates poverty for citizens, and this bears on the kind of health care that the population get (Stanton & Rutherford, 2006).

In light of the above, the demands for health care coverage will be markedly different in the two countries. While just health care in the United States will seek fairer regulations for the coverage that is already available, it will need to focus on establishing relevant coverage in Nigeria, in the first instance. The current social welfare situation in Nigeria thus requires a different ethical framework for the distribution of health care from what may be viable in the United States.

2.3.0 Health Status of the Population

Further to the social context influencing health care, the health status of the population also complicates the demands on and expectations of the health system. The nature of prevailing diseases will largely determine the kind of obligations for care that the system would be liable to provide with regards to justice. These obligations may not be unrelated to the background social and natural conditions, and as such a course for just health care should not consider the population's health status in isolation from the social context described in 2.2. It becomes paramount to consider the nature and condition of the population's health in Nigeria, in order to determine what approaches to justice will better address its particular health care situation.

The natural, political and socio-cultural environment as well as the demography and socio-economic conditions, largely determine the nature of a population's health. In effect, the health status of a population determines the nature of demands and expectations for health care and the subsequent obligations or responsibility of the system. Various features may be considered in establishing the health condition of a given population and the kind of health care services that may be required. In regard to just health care, specific health indicators offer a viable tool for assessing

the wider scope of the situation. Among the many health indicators for Nigeria, child health and mortality underscore the need for basic health care for the vulnerable population. Also the indicators for communicable diseases show the degree of pressure that the health care system is subjected to and the urgency by which the situation must be addressed. Further still, the amount of resources committed to health care in light of the proportion of the disease burden on the population raise serious questions of justice.

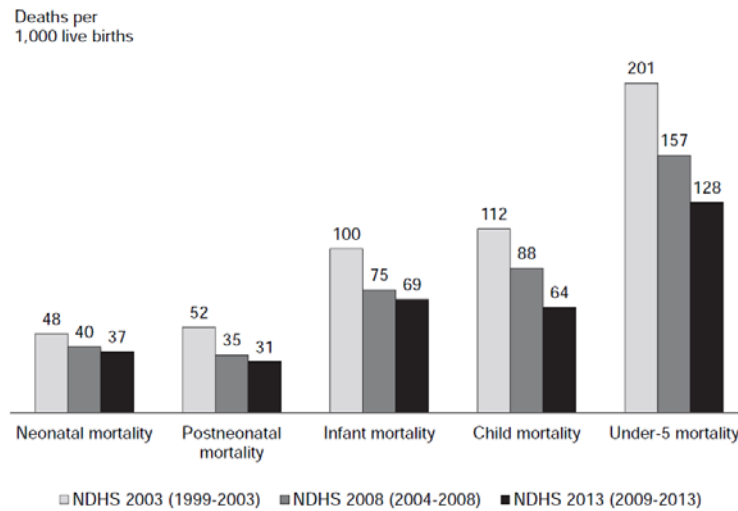
2.3.1 Health of the Vulnerable Population

The measure of a system's quality could be determined by the extent to which it provides for its vulnerable populations. Children and women (especially pregnant women and nursing mothers) are regarded as vulnerable groups. Hence, in Nigeria's context of health care, they become a measure by which to determine the basic health status of the population. Accordingly, child and maternal mortality rates, being relevant health indicators, present a clearer picture of the actual situation.

2.3.1.1 Child Health and Mortality

The health condition of children offers a valuable indication about the general health of the population and the extent to which the latter can access quality health care services. Accordingly, the state of child health and rate of mortality among Nigerian children will offer insight into the population's health. The Nigeria Demographic Health Survey (NDHS) 2013 shows that "...one in every fifteen Nigerian children dies before reaching age one, and one in every eight do not survive to their fifth birthday" (NPC & ICF International, 2014, p. 117). This is in spite of a 26% and 31% respective decline in the mortality rates over the past fifteen years (ibid). The figure below shows the variations in Nigeria's infant and child mortality rates over the past fifteen years, representing the number of deaths recorded in every 1000 live births, or for every 1000 children reaching the age of five.

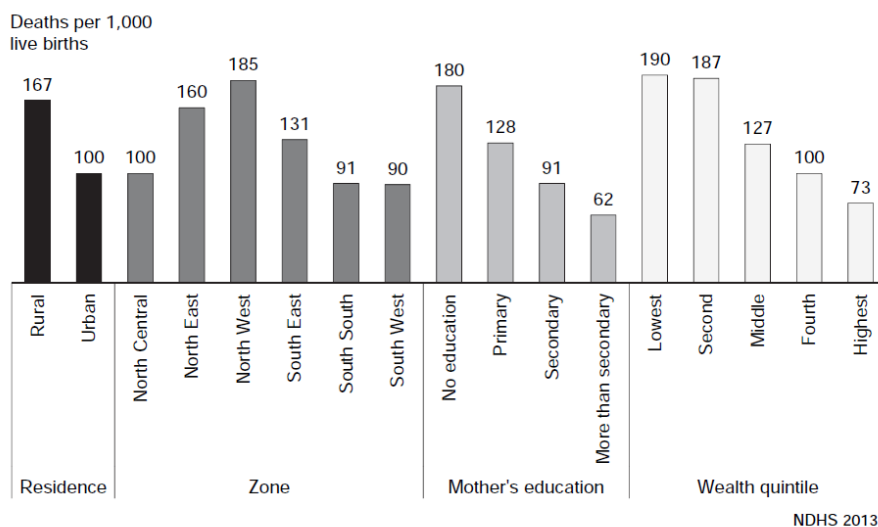
Figure 2.3.5 Trends in Childhood Mortality¹³, Nigeria: 1999-2013 (NPC & ICF International, 2014, p.119)



By comparison, in the United States, only approximately 6 out of every 1000 children are estimated to die before their first birthday, and only 7 in every 1000 by age five (WHO, 2014a). These figures show that child survival rates in the United States are significantly higher than those in Nigeria. One would therefore conclude that access to basic health and other medical resources for children in the United States is considerably better than in Nigeria. One implication is that there is either an absence of quality basic health care available to children in Nigeria or access to such services is limited. This point is highlighted by the disparity in the mortality rates between children from different residential settings, geographical regions, parents' educational levels, and income groups in Nigeria, as shown in figure 2.3.6 below.

¹³ Neonatal mortality is the probability of dying within the first month of life; post neonatal mortality is the probability of dying after the first month, but before the first birthday; infant mortality is the probability of dying before age one; child mortality refers to the probability of dying between the first and fifth years of life; and maternal mortality refers to pregnancy related deaths, whereby a woman dies while she is pregnant or within 42 days of the termination of her pregnancy, irrespective of the cause of death (NPC & ICF International, 2014, p. 117, 273)

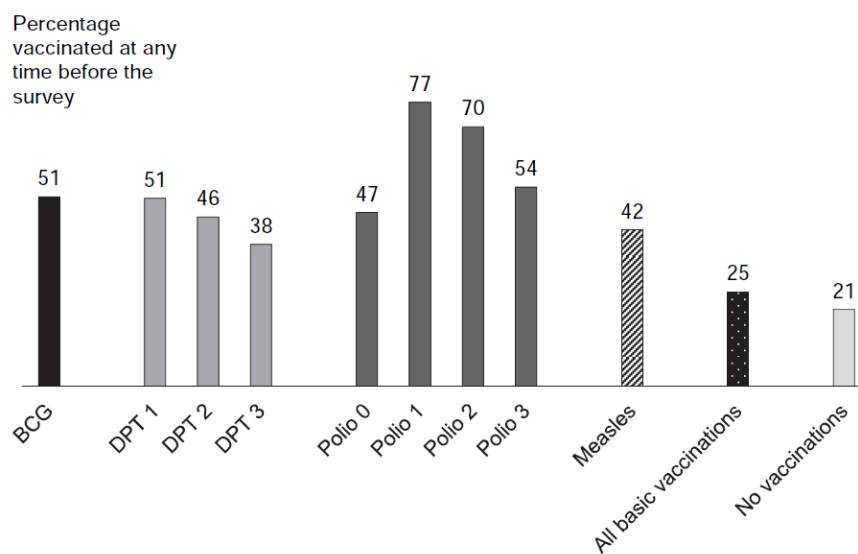
Figure 2.3.6 Under-5 Mortality by Socio-economic Characteristics ((NPC & ICF International, 2014, p. 121)



As has been shown in section 2.2, the nature of the population's distribution, educational level and socio-economic conditions bear on the availability or accessibility of health care to the various population groups in Nigeria. The figure above substantiates the claim by statistically indicating how socio-economic factors determine the health status of these population groups. For instance, it indicates a higher proportion of child mortality in rural areas than in urban, and also shows that the mortality rate of the lowest income group is more than twice that of the highest income group. In practical terms, this would suggest that a child born to the highest income group has more than twice the chances of accessing quality health care than one born to the lowest income group.

One major determinant of access to basic health care is the availability or ease by which children can get essential vaccinations, which serve to buffer the vulnerability to deadly diseases. As shown in figure 2.3.7 below, only about one-quarter of children across the country receive all basic vaccinations, and approximately one-quarter with no vaccinations; the remaining half of the relevant child population receive only a few of the required vaccines.

Figure 2.3.7 Percentage of Children Aged 12-23 Months with Specific Vaccinations¹⁴ (NPC & ICF International, 2014, p. 159)



Note: Based on vaccination cards and mother's reports

NDHS 2013

The limited access to basic vaccines could be attributed to socio-economic conditions across population groups, or the lack of capacity of the health care system to make them available to all, or to both. To give an example, public hospitals in Abuja¹⁵ have only some of the basic vaccines required within the first 24 months of birth, all of which, if available, would be free of charge; private hospitals on the other hand, provide all the vaccines but at a cost of approximately N107,000 (£400) (Eseke, 2012, p.48-49). Considering that over half of Nigeria's population lives below the poverty line of \$US1 per day, the cost of getting vaccinated in private hospitals is beyond the means of most. One woman's narrative of her experience with raising five children attests to this concern: "private hospitals charge so much for immunisation, but in the Wuse General Hospital where the immunisation is free, we only get a few of the required vaccinations; we cannot afford to pay for the rest in the private health centres..." (Eseke, 2012, p.49).

¹⁴ BCG – Bacille-Calmette-Guerin vaccine against tuberculosis; DPT – Diphtheria, Pertussis and Tetanus vaccine;

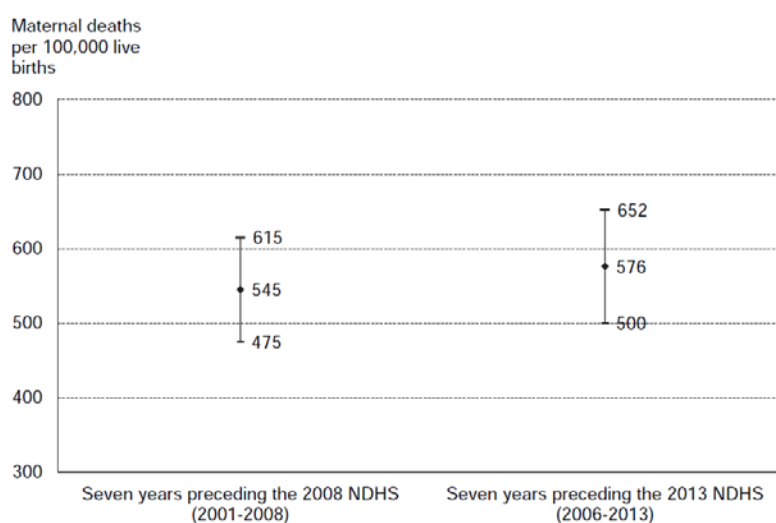
¹⁵ Abuja is Nigeria's administrative capital.

In line with the above, Babalola (2011, p.278) notes that the most common reasons for partial or non-uptake or incomplete immunization in Northern Nigeria include inadequate supplies in public health facilities, ignorance about the required dosages of vaccines and their specific benefits, and beliefs that having a few doses of the vaccines may be sufficient. Other studies show that geographical location, ethnicity and socio-economic factors variously affect the rate of vaccination uptake among different population groups (see Fatiregun & Okoro, 2012; Antai, 2009, 2011; Babalola & Lawan, 2009; and Singh, Haney & Olorunsaiye, 2013).

2.3.1.2 *Maternal Mortality*

Closely linked to child health and mortality is maternal mortality, which consolidates the observations made above. Worldwide, the 10 countries with the highest maternal mortality ratios are in Africa, and an estimated 14% of maternal deaths globally occur in Nigeria (UN Africa ctd in NPC & ICF International, 2014, p.273). 1 in 30 women in Nigeria will have a death related to pregnancy or childbirth, as an average of 567 deaths occur in every 100,000 live births, and 32% of all deaths among women aged 15-49 are maternity related (see figure 2.3.8 below).

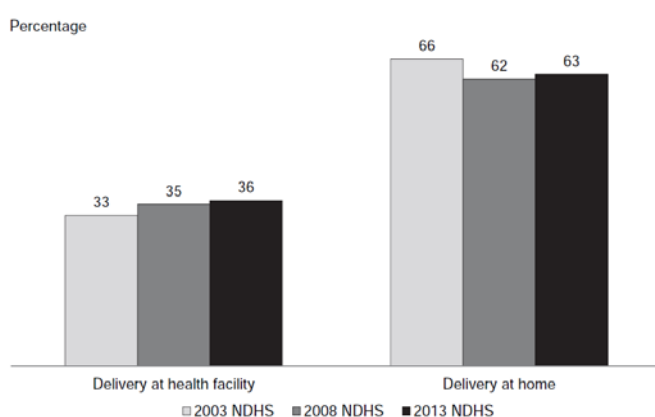
Figure 2.3.8 Maternal Mortality Ratios, Nigeria, 2001-2013 (NPC & ICF International, 2014, p. 278)



As with child mortality, major causes of these high rates have been attributed to the absence of health facilities within the reach of families, and where such facilities are available, they may be ill-equipped; the well-equipped childbirth facilities are expensive and many cannot afford them (GlobalOne, 2015). These factors reflect the fact that a large proportion of deliveries are not attended by skilled personnel (ibid). The distance of health facilities from most residences and inadequate transportation add to the already difficult situation (NPC & ICF International, 2013, p.20-21).

In the United States, the maternal mortality rate stands at 28 for every 100,000 live births (WHO, 2014a), reflecting a significant disparity with that of Nigeria. Hence, one can conclude that pregnancy or childbirth services are not as good, available, affordable or accessible in Nigeria, compared to the United States. For example, among the basic services required, essential immunization coverage for Nigerian children is way below 50%, general antenatal care coverage is less than 60%, and birth attended by skilled personnel stands at 38% (also see figures 2.3.7, 2.3.8 & 2.3.9). In the United States, the figures are around 92%, 97% and 99%, respectively (WHO, 2014a). The higher rate of births attended by skilled personnel in the United States suggests significantly better access to health care services than may be available in Nigeria.

Figure 2.3.9 Trends in place of delivery in Nigeria (NPC & ICF International, 2014, p. 137)



From the above, it is obvious that vulnerable population groups in Nigeria have limited access to basic health care services, and that their condition is worsened by

their socio-economic circumstances. Questions of justice will focus on the extent to which required services should be provided across the population. This will also require equalising access between the rural and urban populations.

2.3.2 Prevalent Health Conditions

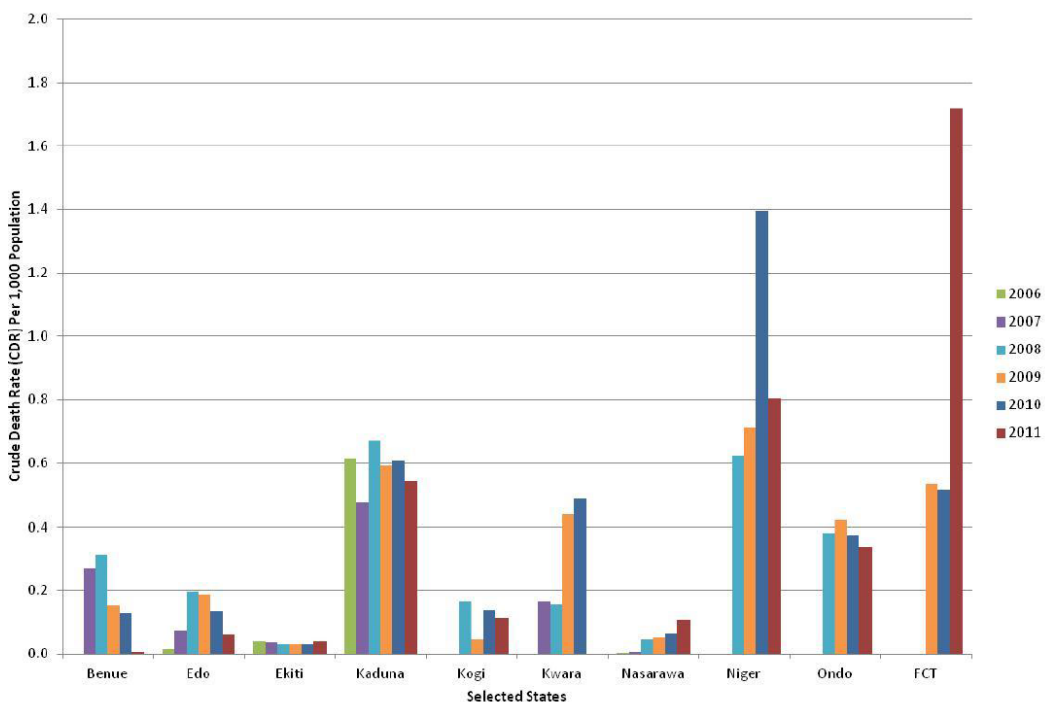
The prevailing disease conditions in Nigeria also determine the population's health, as well as the kind of demands on the system. The major diseases include malaria, typhoid fever, tuberculosis, hepatitis, HIV/AIDS and dengue fever (Indexmundi Online, 2015; WHO, 2014b, p.138; WHO, 2014a, p.98-99) – with Ebola being a recent addition (WHO, 2015a). The Centres for Disease Control and Prevention, CDC, have listed the following infectious diseases with their corresponding proportions among the ten leading causes of death in Nigeria: malaria, 20%; lower respiratory infections, 19%; HIV/ADS, 9%; diarrheal diseases, 5%; and tuberculosis, 2% (2013). The World Health Statistics 2014 estimates the number of cases as follows: malaria, 2,087,068; tuberculosis, 92,818; measles, 6,447; meningitis, 871; and cholera, 597 (WHO, 2014a). These figures point to malaria¹⁶ as one of the major health risks:

Malaria is endemic throughout Nigeria... [and] currently accounts for nearly 110 million clinically diagnosed cases per year, 60% of outpatient visits, and 30% hospitalisations. An estimated 300,000 children die of malaria each year. It is also believed to contribute up to 11 percent of maternal mortality, 25% infant mortality, and 30% under-five mortality... about 132 billion Naira [approximately US\$880 million] is lost to malaria annually in the form of treatment costs, prevention, and loss of work time (NPC & ICF Macro, 2009, p.187).

Figure 2.4.1 below shows the distribution of deaths caused by malaria across the country, with the corresponding risk of infection in different regions.

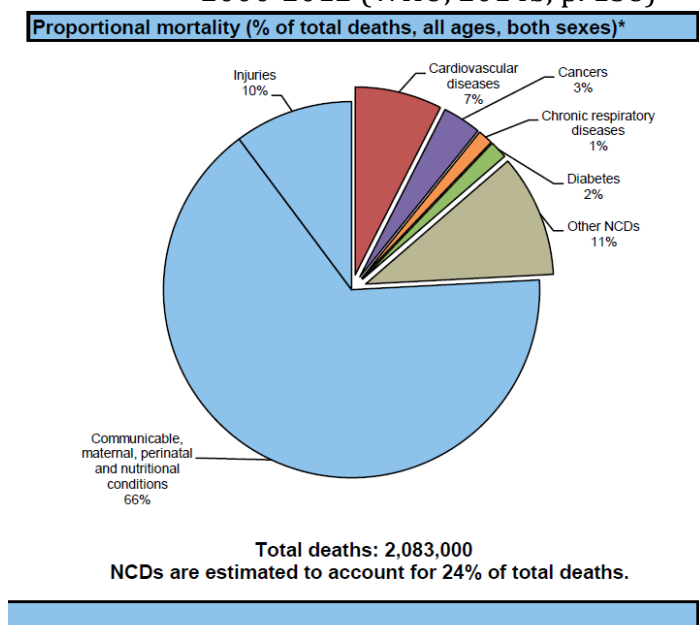
¹⁶ "Malaria is an infectious blood disease caused by a parasite that is transmitted from one human to another by the bite of an infected anopheles mosquito. Malaria symptoms, which often appear about 9 to 14 days after the infectious mosquito bite, include fever, headache, vomiting and other flu-like symptoms. If drugs are not available or the parasites are resistant to them, the infection can lead to coma, life-threatening anaemia, and death." (NBS, 2012, p.7)

Figure 2.4.1 Crude Death Rate per 1,000 Population of selected States, Nigeria, 2006-2011 (NBS, 2012b, p.8)



In comparison, non-communicable or non-infectious diseases are estimated to account for only 24% of the total number of deaths in Nigeria, as seen in figure 2.4.2 below:

Figure 2.4.2 Premature Mortality due to Non-Communicable Diseases, Nigeria, 2000-2012 (WHO, 2014b, p. 138)



Accordingly, infectious diseases account for the most urgent health conditions in Nigeria.

The causes and effects of the listed major infectious diseases are linked to environmental and living conditions. For instance, while malaria is caused by mosquito bites, poor and open drainages or pools of stagnant water could harbour mosquitoes, leading to greater rates of infection and death. Tuberculosis and cholera are mainly transmitted through poor sanitary conditions that are often evident in Nigeria (see NPC & ICF International, 2013, p.13-14). The burden of disease in Nigeria thus also includes poverty and development related features.

In the United States infectious diseases have a relatively insignificant effect on the population's health, accounting for less than 6% of total fatalities (see figure 2.4.4 below). The leading causes of death in 2013 with the corresponding figures include: heart diseases, 611,105; cancer, 584,881; chronic lower respiratory diseases, 149,205; stroke, 128,978; Alzheimer's disease, 84,767; and diabetes mellitus, 75,578 (Heron, 2013; CDC, 2015). The percentage distributions of these and other diseases are shown in figures 2.4.3 & 2.4.3 below.

Figure 2.4.3 Percentage distribution of the 10 leading causes of death, by sex, USA: 2010 (Heron, 2013, p. 9)

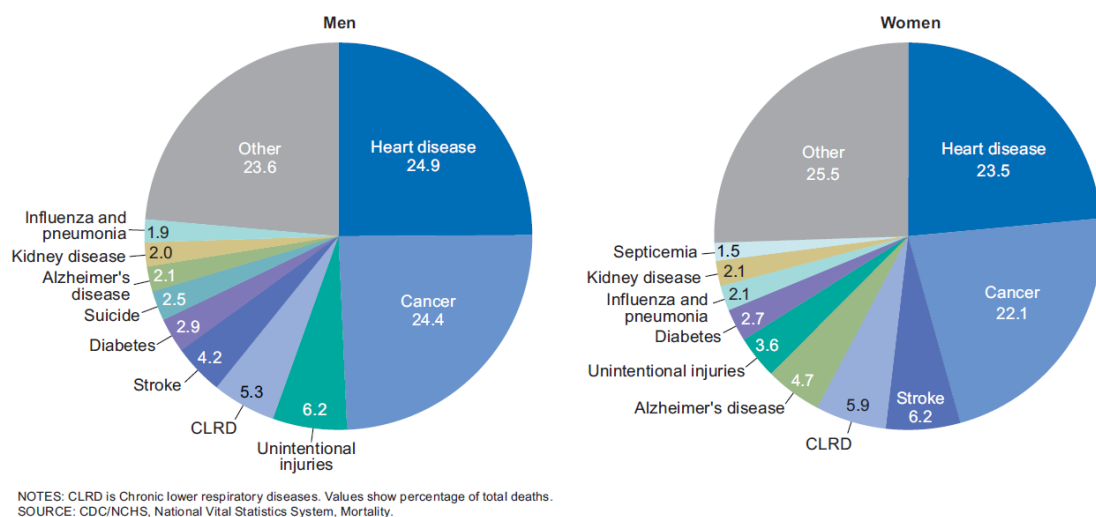
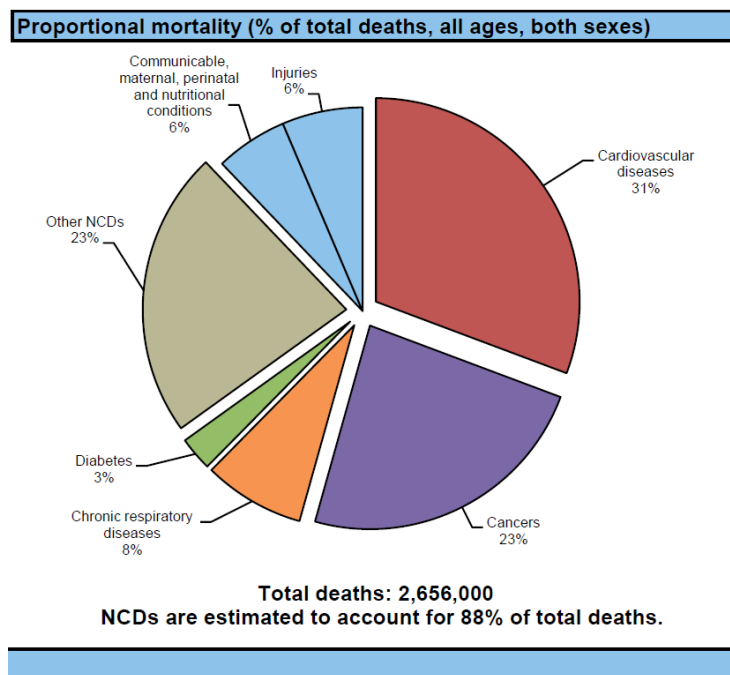


Figure 2.4.4 Premature Mortality due to Non-Communicable Diseases, USA, 2000-2012 (WHO, 2014a, p. 199)



It is evident that heart diseases and cancer constitute the highest disease burden or health risk in the United States; and non-communicable diseases account for approximately 88% of deaths, as compared to 23% in Nigeria. And while six of the ten leading causes of deaths in Nigeria are communicable diseases, all ten in the United States are non-communicable diseases. Communicable diseases have a spiral impact, in the sense that one infected person puts the immediate community at risk; whereas non-communicable diseases are specific to infected/affected individuals and the immediate community may only share the effects by proxy.

The relevant approach to health care in Nigeria will be one that addresses the impact of the diseases on communities, while also taking into account the infected persons; those in United States could be more individual-focused, or on a case-by-case basis, or to groups of such individuals with the diseases. Health care in both countries will require strategies that effectively address the conditions accounting for the greater proportions of deaths, equally saving greater numbers of the population. However, Nigeria will need to focus on the health of whole communities, without compromising the health of individual persons within these communities. A

relevant ethical approach will therefore hinge on a communitarian approach, which will require greater commitment from the health care system.

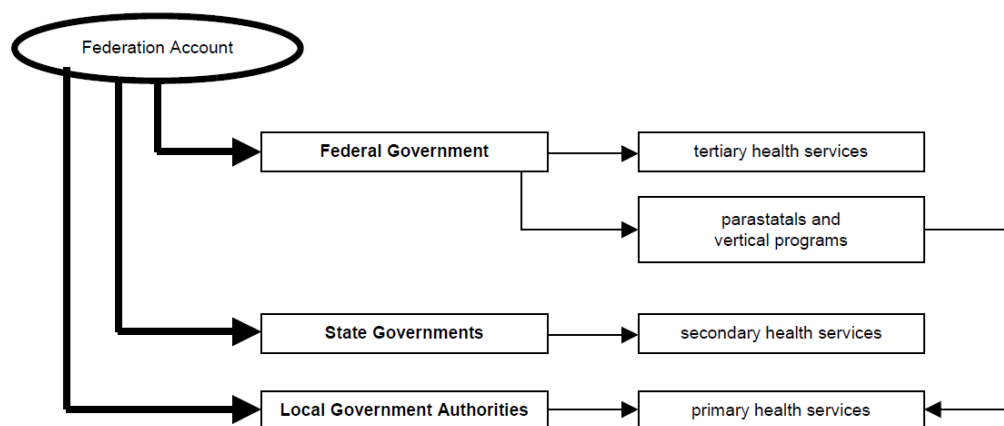
2.4.0 Health Care Resources

Despite Nigeria's high burden of disease, committing a proportionate amount of resources will count towards improving the population's health. Two kinds of resources will play a key role in paving the way towards just distribution of health care, namely, financial and human resources. These not only indicate the system's capacity to manage the burden of care, but will also be useful in determining the appropriate framework of just health care.

2.4.1 Financial Resources for Health

Nigeria's health care system is largely funded through the National Health Account with a large proportion of finance coming from the federal or central government, as shown in figure 2.4.5 below.

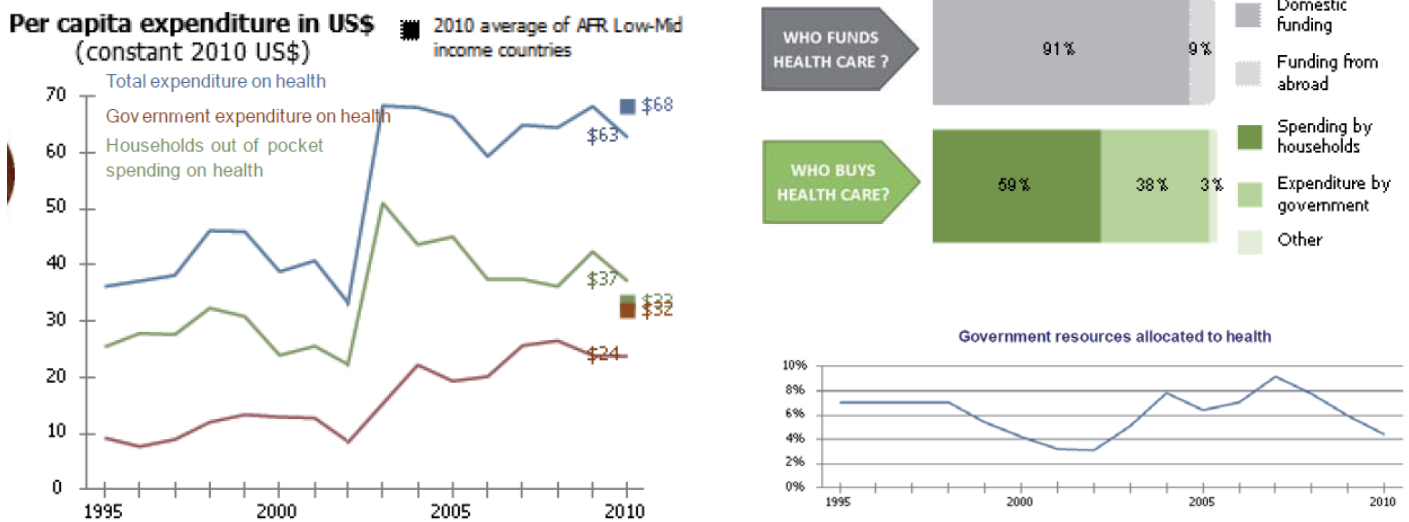
Figure 2.4.5 Government funding flows to the health system, Nigeria (Gilbert et. al., 2009, p.6)



Although the structure of Nigeria's health system suggests that health care is the responsibility of the three levels of government (as seen in section 2.2.1.3), in practice it is jointly financed through tax revenues, out-of-pocket payments, donor

funding, and health insurance (Oлакunde, 2012). The government’s total spending is estimated at 38% of the total annual expenditure on health care, with household spending accounting for 59% as shown in figure 2.4.6 below. In terms of the government’s total expenditure, health care only accounts for approximately 6.7%, which is way below the 15% global benchmark (WHO, 2014a, p.146 -147).

Figure 2.4.6 Health System Financing, Nigeria, 2010 (WHO, 2012a, p. 47)



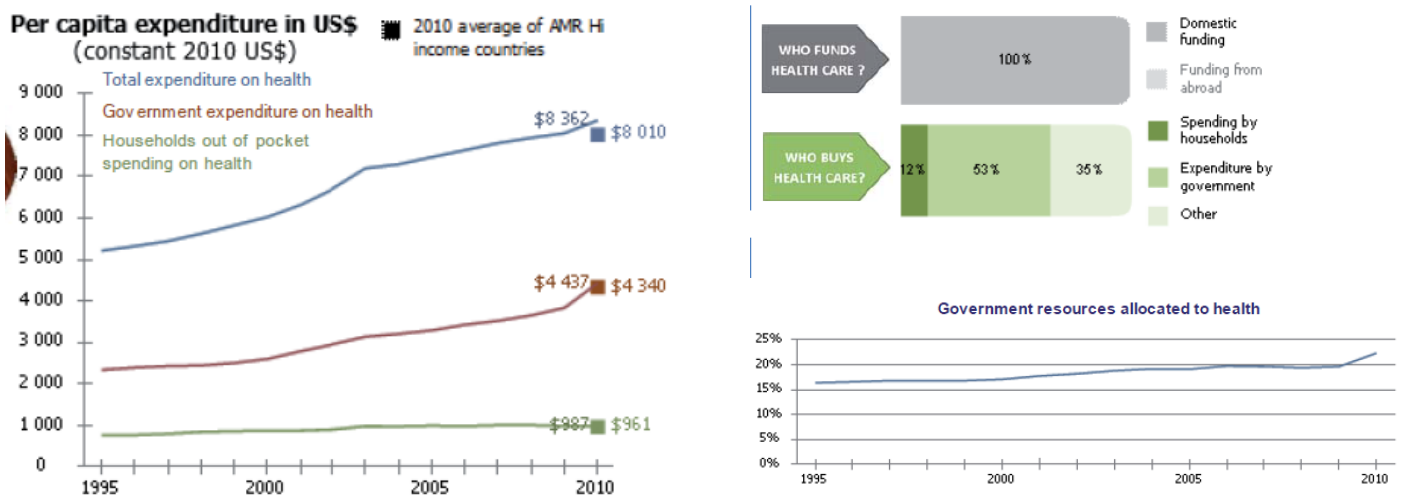
Considering the varying weightings of expenditure on health care, two implications follow:

- a) the greater financial burden of health care in the country is borne by families or individuals, despite the fact that a majority of the population is said to live in poverty; and
- b) there is no sufficient public financial investment in health given the low percentage of the government’s annual budget committed to health care.

This has further implications in determining the relevant approach to just health care or the specific ethical framework; as shown in one study, persistent high out-of-pocket spending is related to low frequency of visits to health care facilities, especially among rural populations or poor families (Riman & Akpan, 2012).

Compared to the United States (see figure 2.4.7), one sees that there is considerably higher out-of-pocket spending in Nigeria, constituting a greater financial burden. Also, the total financial resources committed to health care in Nigeria may not suffice to improve the population’s health status. The United States has the highest total spending on health per person per year in the world, estimated at US\$8,467, as against US\$85 for Nigeria; and health care constitutes 20.3% of the government’s total annual expenditure, which is significantly higher than Nigeria’s (WHO, 2014a, p.141-152). While household spending on health is estimated at 12% of total health expenditure, the government contributes 53% (WHO, 2012a, p.94). Given the similar contribution of government towards health care in both Nigeria and the United States, similar ethical strategies may apply to both contexts; to demand more contributions, for instance.

Figure 2.4.7 Health System Financing, USA, 2010 (WHO, 2012a, p.94)



The major health conditions in the United States, like heart diseases and cancer, are considerably expensive to treat, and may justify the high expenditure on health. Also the United States' income per capita is much higher than Nigeria's (as shown in 2.2.3.3); hence there may be a relative balance in terms of the financial resources committed to health care. The point is that the financial burden of health care on families is way higher than the average household income rate in Nigeria. Thus, considerations of justice in health care will be different for Nigeria than in the United States.

2.4.2 Human Resources for Health

Related to financial resources for health is human resources since low financial investment in health care would likely result in fewer trained personnel than would be required for the system to cover the entire population. In terms of total numbers of health personnel, Nigeria ranks among the highest in Africa, comparable only to South Africa and Egypt (Africa Health Workforce Observatory, AHWO, 2008, p.10). The total number of physicians is estimated at 55,376, nurses at 224,943, and pharmacists at 18,682 (WHO, 2012, p.126-127). While these figures may look impressive, the density to population ratios are not: physicians, 4:10,000; nurses 16:10,000; and pharmacists, 1:10,000 (WHO, 2014a, p.134-135). This means, for instance, that for the 2 million malaria cases reported, there were about 820 physicians available.

Although the ratios are higher than Africa's average (see WHO, 2014a, p.138), the impact for health care improvement are insignificant. Also, the health workforce is not evenly distributed across the country; urban residents have access to nearly three times more doctors and two times more nurses and midwives than rural residents (AHWO, 2008, p.10; FMOH, 2010, p.38). This means that some population groups have considerably less access to health care services or information. A relevant ethical approach will establish a framework for the distribution of health personnel according to needs across the board.

In comparison to the United States, Nigeria's health workforce is significantly low, both in real numbers and as a population ratio. For instance, there are an estimated 749,566 physicians and 2,927,000 nurses in the United States (WHO, 2012, p.128), both of which are approximately thirteen times the relevant figures in Nigeria. Since the United States' population is only about twice that of Nigeria, on the average, an American resident will have approximately six times more access to health personnel than a Nigerian resident. While Nigeria mostly relies on locally trained personnel, an estimated 10,000 Nigerian trained doctors are currently employed in the US (Business Day, 2014). An estimated 350 medical practitioners leave the country annually, and 77% of black doctors in the United States are Nigerians (Aina, 2011; Ameh, 2012). The United States is known to offer employment opportunities to foreign trained medical personnel in order to boost its health workforce capacity.

The health workforce disparity between Nigeria and the United States and the circumstances surrounding the capacities to increase the ratios, suggest that different measures may be required to address the situation. Accordingly, the ethical framework for the retention and distribution of health care practitioners in the two countries will be considerably different. Since Nigeria is unable to import medical personnel like the United States, a relevant ethical approach may refer to the communitarian attribute of sharing, to guide or ensure equity in the urban and rural distribution. The governance of the health care system may be required to adopt a communitarian ethical framework in its structure, if the retention strategies are to be effective.

2.5.0 Governance of the Health Care System

In order to ensure an ethically just approach, the social context and health status of the population must be matched by an appropriate governance of the health care systems. The natural conditions, socio-cultural environment, population distribution and socio-economic situations are a factor of prevailing health conditions, which determine the kind of services that the population seeks, and the nature and extent of resources to be committed to health care. These require an institutional structure within which to be

coordinated, to ensure balance between health care demands against the resources available. It should also ensure that the relevant social, cultural and economic conditions are effectively mediated in health care. Governance in health care thus plays an overarching role in determining how or whether considered frameworks for the just distribution of services or resources is attainable. Three aspects of governance will be considered: organisation of the health sector, structure of the referral system, and the state and mode of health service delivery. These constitute an essential channel towards establishing just health care reforms.

2.5.1 Public and Private Health Sectors

A health system operates within the framework of the relevant health care sectors. In Nigeria, the health care system is coordinated between the public and private sectors. The public sector comprises of three level of governance namely, primary, secondary and tertiary levels, which follow the three tiers of government (see sections 2.2.1.3 & 2.3.3.1). The tertiary level has overall responsibility for national health policies and for the delivery of advanced care services (World Bank, 2005, p.45-46). It provides policy guidance and technical support for the entire health system, monitors and evaluates the implementation of policies, and manages the national health information system (ibid). The secondary level is responsible for planning and coordinating the intermediary level of the health care system, and implementing public health programmes; and the primary level manages basic health care service delivery (ADF, 2002, p.4).

The structure set out above suggest a decentralised form of governance for the health care system, following the federal structure of the country's political organisation. The tertiary level forms the highest institution of governance, and is the point at which policies are determined; the primary level constitutes the base for effecting these policies; and the secondary level constitutes a mediating ground between policy formulation at the top and its practice in basic health care at the bottom. Ethically speaking, the three-layer-structure provides a suitable channel for effective distribution of health care across the board. In principle, the design of the system captures varying health care demands of the population at various points of need or access. The vision of

Nigeria's health care system thus points towards effective health service delivery across the country.

The three-tier public health care system also incorporates a vibrant private health care sector. Private-for-profit and faith-based facilities and traditional care are said to provide approximately 80% of health care services in the country, serving not only the urban wealthy, but also the rural poor populations (Kombe et. al., 2009, p.11). The high demand for private health care services has been variously attributed to the decline in the quality of services and capacity of the public sector (see 2009; Barnes, Chandani & Feeley, 2008; WHO, 2014c). And while the private sector makes an appreciable contribution to the system, it is not well regulated and supported, as policy guidelines are weak (Gilbert et. al., 2009, p.12-15). The large coverage of the private sector is not synonymous with high quality care; assessments have shown that while a number of the private health facilities are among the best in the country, several others fall below the basic quality standards (Barnes, Chandani & Feeley, 2008, p.16-17). For instance, within the Lagos area alone, about 184 private health care facilities were closed down between 2007 and 2008 for violating quality standards, with approximately 60% of them marked as substandard (IRIN News, 2008).

The large subscription to private care may be viewed in terms of the low level of trust that the population has in the public sector, given the poor quality of services it provides. Surely, the population would not opt for expensive treatments in private facilities if these were provided in public facilities at cheaper rates. The available public facilities cannot meet the population's health care demands; hence, the recourse to private health services. The implication is that a majority of the population cannot afford the cost of private health care. Given that over 60% of the population is considered poor, and only one-third of total health care expenditure is publicly funded, there are imminent question of justice. Of importance will be the overwhelming financial burden on the larger proportion of the population below the poverty line. And for those who can afford private care, how do we justify the high out-of-pocket spending for health? Since governance for the health system is well set up and the levels of accountability are well designated, these

questions are beyond simple structural arrangements; a substantive ethical framework may be required to address the situation.

2.5.2 Referrals in the Health Care System

The structure of governance in health care bears on its mode of operation: it determines how services are distributed, and the extent to which various population groups can access them. The three-level system in Nigeria is structured to facilitate adequate referrals in health care across the country. A referral system ensures that health practitioners transfer the responsibility of care to a higher or more specialized colleague or facility, where the former has limited capacity (Akande, 2004, p.130). Despite the promising referral structure in place, following from the health system's structural organisation, surveys show otherwise in achieving effective referral practice. According to a World Bank report, while many facilities refer patients to higher or relevant services, poor communication between the various facilities makes the process ineffective (2010, p.12-17). This limitation in referral practice is demonstrated in the manner the population often seeks health care, whereby most people choose which health facility to attend, regardless of their condition. In a study of a tertiary health facility, Akande (2004) found that less than one-tenth of patients seeking health care were referred from other lower or less specialist facilities; most of the patients referred themselves, claiming that the primary health care facilities have inadequate equipment and/or personnel.

One or all of three issues could be implied from Akande's finding:

- a) patients are mostly not referred by lower level or less specialised facilities to relevant others
- b) people are ill-informed about the relevant points for which to seek health care; and
- c) they no longer trust the basic public health care providers, perhaps due to previous experiences, and simply prefer to seek services where they anticipate good quality.

These implications are reflected in a study that explores the awareness and perception of referrals in Nigeria (Abodunrin, Akande & Osagbemi, 2010), which found there is poor knowledge among the population about the referral system and how it works.

Inadequacies in referrals practice and lack of its awareness suggests a limited capacity in service delivery across the health care system. For instance, the large proportion of self-referral to higher health facilities could lead to the influx of patients requiring basic health care, where services may be aimed at more complex or emergency conditions hence reducing the quality of care for other patients needing the relevant medical attention. Conversely, in rural areas where access to advanced or specialist health facilities are limited, primary facilities may be burdened by patients with overwhelming health conditions, thereby diverting medical attention from other patients with basic health conditions.

The limitations in the referral system suggest that basic health care services may be oversubscribed, especially in rural settings, while higher level or specialist facilities or services in urban settings may be underutilised. In other words, primary health care facilities may be overburdened with treating complex cases that should be assigned to higher levels; and higher level facilities may be overwhelmed by patients with basic health problems, which are disproportionate to the available expertise. For instance, Idris (2011) expresses concern about the persistent situation whereby e.g. consultant cardiologists who should be harnessed to treat patients with complex heart conditions are burdened with attending to malaria cases, which general practitioners and other community health care workers have adequate training to deal with. This constitutes a reciprocal burden syndrome that is helpful neither to the population nor the system.

The question remains that of balancing the available resources, so that patients can get the required medical attention that the relevant facilities can provide. While the burden of disease in the country and the limited capacity of the health care system may explain this gap, the ethical implications may not be pardonable. A relevant ethical approach will not only ensure that patients get the required quality of care, but also create effective

working conditions for practitioners, as well as reducing undue waste of resources to which the relevant population groups have no access.

2.5.3 Health Service Delivery

The present health status of Nigeria's population is reflected in the kind of health care services available or accessible to them. Whereas the health indicators explored in 2.3 suggest poor health conditions for a large proportion of the population, the nature and distribution of resources and the governance of the health care system point to a lack of adequate capacity to contain the high burden of care. Without intending to discredit the varied efforts in recent times to revive the health care system, it may be realistic to note that the health status of the population is yet to witness a significant change. WHO's statement about Nigeria's health care in 2008 may still apply: "despite several attempts at reform over the past 30 years, Nigeria still lacks a clear and coordinated approach to primary health care" (Reid, 2008, p.663).

Although a significant number of health care projects and initiatives have been proposed, established, or accomplished, a comprehensive search for positive reports about the health system's performance in terms of service delivery has not been encouraging. For example, the *National Strategic Health Development Plan 2010-2015, NSHDP* (FMoH, 2010, p.33) notes that public health care facilities are characterised by weak and decaying infrastructure and fragmented service delivery. Specifically, it points to: the incapacity of health facilities to provide emergency obstetric care; the state of disrepair in most primary health care centres; and tertiary health facilities functioning at less than optimal capacities in providing specialist care (ibid). A World Bank report expresses concern about the state of primary health care (PHC) facilities, noting for instance that most of them lack basic utilities like running water, sanitized toilets, and sterilised equipment (World Bank, 2010, p.13-14). The WHO Country Cooperation Strategy 2008-2013 report notes that major challenges to effective delivery of health care services in Nigeria include: "inadequate decentralization of services... weak referral linkages... dilapidated health infrastructure... [and] weak institutional capacity..." (WHO, 2009b, p.4).

Of significance is the Nigeria Health System Assessment report, which points to governance as the key problem:

Fostering collaboration and partnership and maintaining consistent standards and quality across the board has been particularly difficult... governance of the system is weak overall. It is hobbled by structural and institutional weakness, coupled with capacity gaps that limit responsiveness of services and undermine the voice of citizens and the accountability of providers and policymakers. While policies and systems continued to be developed... nationwide implementation and stakeholder buy-in... lags behind... public participation and confidence in the health system appears to be low... substantive reform is required to rebuild trust between users, providers and policymakers. (Kombe et. al., 2009, p. 12).

Without discounting the relevant progress made in Nigeria's health care over the past decade, the unfavourable reports indicate urgent concerns about the quality of care that the population gets. The health care system has a well-established structure, which if appropriately guided would meet the varied health care problems facing the population. Simply developing various health policies and/or allocating larger financial resources to health care, as has become the recent drive towards reform, may not be sufficient: for as Daniels (2006, p.23) notes, justice obliges us to pursue fairness in the distribution of health care, but policies need the guidance of ethics to determine what this obligation means. The questions raised by the several nagging reports have ethical underpinnings that need to be addressed if the envisioned reforms are to be successful. A specific ethical framework will be required to guide the policy, infrastructural, and financial reforms that are currently being attempted in Nigeria. Ethical dynamics should inform the reform process in a manner that engages the population at their varying points of need, while ensuring that service providers and policy makers can be called to account.

Although the improvement of Nigeria's health care sector and unfavourable health indicators is slow, one can recognise some progress in the system. For instance, Nigeria was certified free of indigenous transmission of Guinea Worm in 2013, and has recorded significantly low incidents of polio, with only two cases being reported nationwide as at

the first quarter of 2014 (WHO, 2014). The apparent success is said to be “tempered by the continuing challenges presented by communicable diseases” (WHO, 2014, p. 1). In the face of the Ebola crisis in parts of West Africa, Nigeria was the first country to be declared Ebola-free by the World Health Organization (see section 1.5.3). Most recently, the country was taken off the list of countries where the polio virus disease is endemic, upon marking a polio-free year (Kelland, 2015b).

2.6.0 Towards Just Health Care in Nigeria

The present state of the population’s health, and the persisting low living standards in Nigeria mean that expectations towards the health care system are considerably low. The socio-cultural context, the nature and distribution of the disease burden, and the quality of and/or access to health care across the country, all point towards a kind of reform that must account for the various demands of the population, while holding service providers and policy makers responsible towards meeting them effectively. For as the WHO (2014) has noted, there are great disparities in health status across states and geopolitical zones in the country; and the aetiology of the major diseases is linked to socioeconomic status, education, and gender inequality, as well as poor access to water, sanitation and hygiene.

The health status of Nigeria’s population and the current state of health care discussed thus far, present two identifiable considerations of inequity: urban-rural and rich-poor disparities. For instance, the effects of socio-economic conditions described in section 2.2.3 variously show how the population’s access to health and relevant services are influenced by wealth status or location. Hence, a just health care reform in Nigeria will require a focus on equalising urban-rural and rich-poor disparities, which have been shown to determine the population’s health. The relevant ethical approach will consider a proportionate distribution of health services, granting relevant access to facilities as may be needed. The point will be to:

- a) address prevailing disparities in the population’s health and relevant access to health care; and

- b) restore public confidence in the system, whereby both public and private care providers, as well as policy makers, can be called to account by the population.

In order to clarify the content of just health care requiring attention in Nigeria, I will describe the nature of urban-rural and rich-poor disparities in the following sections. It should help us to understand the function of justice in Nigeria's health care, and the kind of outcomes we should expect from a just health care reform.

2.6.1 Urban-Rural Disparity

As seen in 2.2.3.3, living standards are mostly higher among urban populations as compared to those in rural areas. One implication is that people living in urban settings are potentially less exposed to certain strains of communicable diseases. This is variously shown by the health indicators (see NPC & ICF International, 2014), and established in the Ebola case in West Africa, whereby the outbreaks in Liberia, Sierra-Leone and Guinea have been mostly concentrated in rural settings or poorer settlements. Also, better access to education among the urban population means that they are on average better informed about the prevailing health situation, the relevant precautions and the available health care services than their rural counterparts (see figures in section 2.3.1.1).. Finally, the higher concentration of health facilities and personnel in urban areas means that the average urban resident has relatively better access to health care as compared to a rural resident.

Hence, the urban population in Nigeria has a relative health care advantage over the rural population. This may not be taken to mean that the urban population has access to good or quality health care services. Rather, the point emphasises the significant disparity in access to the available health care services and resources between these two population groups. The disparity has varying implications for both the rural and urban populations' perceptions about the health system, and determines the kind of health care they seek or their utilisation of the available services. For instance, in one study, Okeke & Okeibunor (2010) observed a difference in health-seeking for childhood malaria treatment between rural and urban areas in Nigeria. They noted that health-seeking for malaria treatment differs significantly between rural and urban areas, with a majority of urban women,

64.7%, seeking treatment in private or public health care facilities, while most rural mothers, 62%, resort to self-treatment with over-the-counter drugs. This they attribute to the higher concentration of health facilities in urban settings, making it difficult for people in the rural areas to reach them (Okeke & Okeibunor, 2010).

The rural predicament is worsened by the disproportionate ratio of health personnel, as health workers prefer to work in urban settings due to better economic and career benefits (see Ebuechi & Campbell, 2011). Additionally, the strong traditional structures and cultural environments in rural areas sometimes become limiting factors to how frequently people in these settings seek health care. For as Iyun & Oke (2000) have observed, cultural factors influence the rate at which people in rural communities seek treatment for infectious diseases such as childhood diarrhoea. Also, the lower health care seeking attitude in rural areas means that in some instances, available health services may be underutilised. For instance, Onwujekwe et. al. (2010) observed that whereas urban dwellers tend to use private health care facilities and specialist hospitals, rural dwellers go to patent medicine dealers and pharmacies in search of cheaper treatments. Hence, while treatments for complex disease conditions may not be available in rural areas, even the available basic services may be undersubscribed because pharmacies are used instead.

For an effective health care reform, therefore, specific attention to urban-rural disparities would be required. This does not suggest meeting all the health care burdens of rural populations, but meeting them in view of the resources available to the system, and in comparable measures to those of the urban populations. A fundamental feature of such reform processes will be a specific ethical framework against which policies and relevant implementation strategies will balance the available resources against the varying needs of both rural and urban populations. An ethical reform will not only aim to eliminate the relative health care advantage enjoyed by the urban population over the rural, but also ensure significant access to the available resources and services across the board.

2.6.2 Rich-Poor Disparity

Further to the urban-rural differential, socio-economic factors also influence the rate at which health care is sought among various groups. For example, the child mortality rate by socio-economic consideration (see figure in 2.3.1.1) shows that the rates in the lower wealth groups are about twice those of the upper wealth brackets. This disparity suggests that, among both rural and urban populations, wealthier persons are mostly better-off in accessing needed health care, than the less wealthy or poor. Social class thus becomes commensurate to one's health status or the kind of health care that one can get, as shown in the figure below.

Figure 2.6.1 Socio-economic disparities in health outcomes and basic service utilization, Nigeria, 2003 (NDHS 2003 cited in World Bank, 2010, p.8)

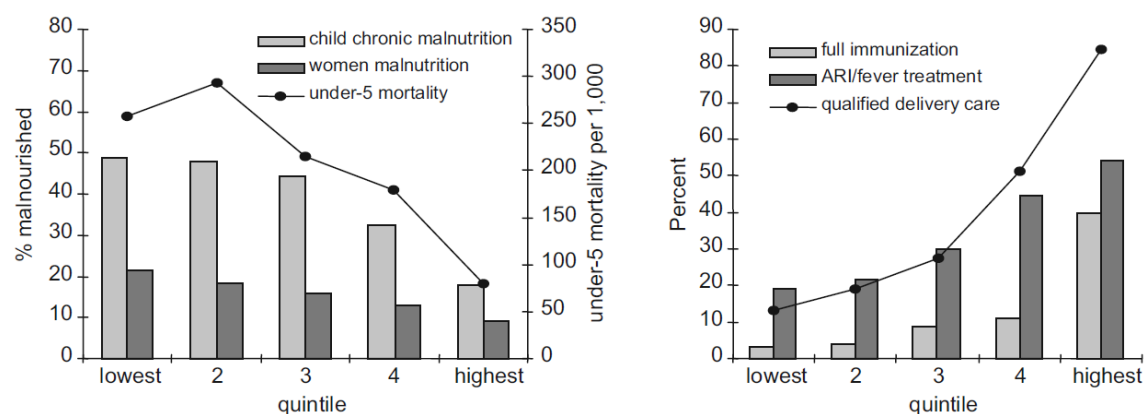
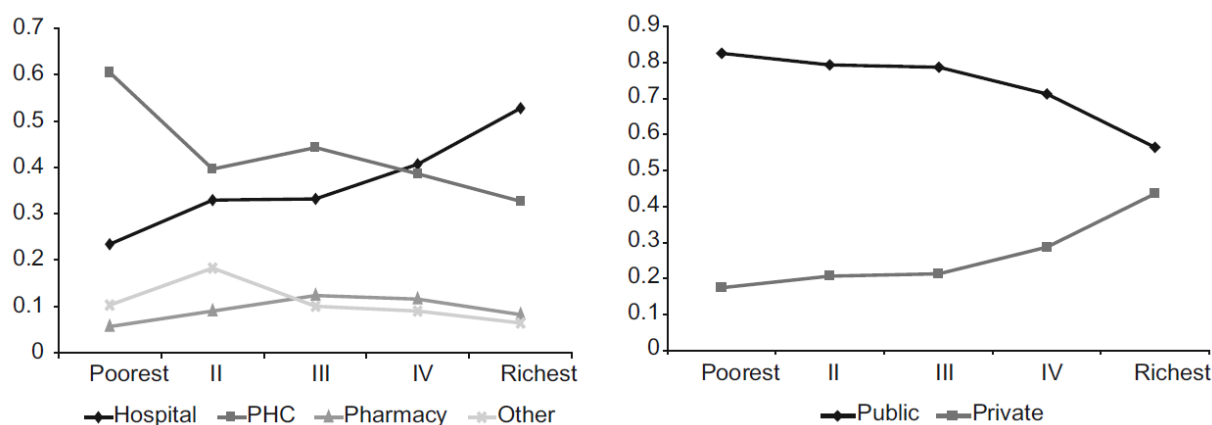


Figure 2.6.2 Utilization of outpatient care across population consumption quintiles and types of provider or type of provider ownership (World Bank, 2010, p.9)



While these figures reflect somewhat old data, the NDHS 2013 clearly indicates that the relative disparity in health status among the various socio-economic groups in Nigeria has not seen any significant change in the past decade (NPC & ICF International, 2014). The first figure indicates that the health conditions of higher wealth groups are better than those of lower income groups, and that access to basic health care is relatively easier for the higher income groups. In the second figure, one sees that the poorest groups mostly attend primary health care (PHC) facilities for much of their health problems, while the richest groups mostly use hospitals. These represent the nature of the rich-poor disparity in the health care system, and reflect the current situation. Whereas the poorest groups are worse-off in terms of health outcomes, they have the least access to needed services. Also, the best health care is mostly provided in hospitals or private health facilities, which the richer population groups have better access to.

In addition to the NDHS 2013 report, recent studies have also variously shown that not much has changed regarding the rich-poor disparity in Nigeria's health care. For instance, Onwujekwe et. al. (2010a) observed that poorer income groups are more likely to seek care from lower level service providers, like pharmacies, medicine stores or traditional healers, while higher income groups mostly seek care in hospitals or specialist health centres. They insist that since all income groups equally sought privately paid care, there is a higher financial burden on the poorest groups (ibid). The high financial burden for the poorer population has a further effect of making them seek less expensive health services, in consequence of which they get poor quality of health care; quality services then become a property of the wealthier population. Onwujekwe & Uzochukwu (2005) and Amaghionyeodiwe (2008) substantiate this view in their studies, variously showing that low spending on health care among the lower income groups in effect leads to less health care coverage than that which the higher income groups get.

Given that a higher proportion of health care is provided by the private, for-profit, sector, and that a higher proportion of the population is considered to be poor, only a small fraction of Nigeria's population may be said to have reasonable access to the kind of health care they need. As in the urban-rural disparity, effective health care reform must

consider the impact of wealth disparity among social groups and establish the grounds for fairness in the distribution of health care across the board. A substantive nature of such reform will constitute an ethical approach or framework by which considerations of fairness will be determined.

2.7 Conclusion: Priorities for Just Health Care Reform

In steaming towards improving the population's health through effective services, several policies, operational guidelines and strategic plans have been developed over the past years. Among these, the National Health Insurance Scheme, NHIS, Decree No 35 (National Assembly, 1999) established the responsibilities of the system towards the population, ensuring efficient and quality services that are accessible to all. In complementing the NHIS Decree, a revised National Health Policy (FMoH, 2005) developed a framework against which a reformed health system would be established, covering areas like: national health system and management, health care resources, health interventions, and partnership for health development. It mapped out legislative strategies for a national health system, which have subsequently been passed into law through the National Health Bill 2014 (Godwin et. al., 2014).

Of overarching importance is the National Strategic Health Development Plan, NSHDP, 2010-2015, which aligns national health policies, development programs and initiatives with international agreements such as: Millennium Development Goals, Ouagadougou Declaration, Paris Declaration on Aid Effectiveness, and Accra Agenda for Action (FMoH, 2010; WHO, 2014). A concurrent NSHDP Framework (FMoH, 2009) identifies eight priority areas of reform in health care, which include a focus on: leadership and governance to create a sustainable environment for quality health care; health service delivery to revitalise equitable health care; and financing to ensure funds are available and accessible towards affordable and efficient health care. Of specific interest is the focus on community participation and ownership, which aims to enhance inclusion of community members in managing their own health care (ibid).

These policies and reform strategies, while constituting a novel approach, lack a substantive theoretical or conceptual framework against which to establish just/ethical reform in the health care system. Perhaps this deficiency may explain why they have yet to engender significant improvements in the health status of the population. In light of the envisaged reforms, health policies and strategic action plans require an ethical framework, not only to guide the planning and implantation processes, but also to determine their moral underpinning and the extent to which the affected population would endorse them. An ethical approach to the reform process will ensure that significant attributes of justice are embedded in the very process of formulating policies and the strategic action plans. This will mean that the demands of the population are effectively considered by policy makers and that health service providers are obliged to abide by their responsibility for care. In effect, nationwide implementation will be appropriately supported by the majority of the population and service providers will be compelled to uphold specific guidelines or regulations.

An ethical reform in Nigeria will revive the lost trust between service users, providers and policy makers, and restore public confidence in the health care system. In order to be effective, the approach will require a framework of justice that is inclusive of the significant stakeholders in health care, namely, services users, providers and policy makers. Daniels (2008; 1985) offers an established ethical framework for just health care reforms which has already made significant contributions to the United States' health care system. Having been adopted by the World Health Organisation in the popular 3-by-5 programme for the treatment of HIV/AIDS patients (WHO, 2004), the ethical approach has been further developed into *benchmarks of fairness* for health care reforms in the United States, and reformulated for adaptation in low and middle-income countries (Daniels et. al., 2005; Daniels et. al., 2000; Daniels, Light & Caplan, 1996). Daniels' approach may offer a useful ethical pathway for a substantive health care reform in Nigeria. It is worth exploring his ethical approach, to determine how applicable or adaptable it may be towards health care reform in Nigeria. The next chapter sets out to undertake this task.

Chapter Three: The Just Health Care Theory

3.1.0 Introduction

As I described in the previous chapter, the structural arrangement of Nigeria's health care is shown to be well-ordered; yet certain factors, including poor infrastructure and governance, and financial inadequacies impede efficiency in the system. The existing disparities in health status between the rich and poor and urban and rural population groups, low standards of health service delivery, and limited capacity for governance raise questions of justice. Also, the limited availability of some essential health services even for person who can afford the financial burden raises hard questions. For instance, what explanation can we provide for the extra cost incurred by those who have to travel abroad in search of medical services that could be made available in the country? These questions need substantive moral explanation that the population can consider to be just or fair in view of their health and wellbeing. The explanations must seek to address not only the concerns of the less advantaged population groups, but also of the extra financial burdens on the economically advantaged groups.

In terms of justice, Nigeria's health care system has yet to meet the basic demands of the population and falls short of the public's confidence. Beyond the poor infrastructure and governance, there is no existing protocol by which the population can hold policy makers or health service providers to account. There is also no adequate public engagement in policy decision processes or in the planning of health interventions. These factors imply that the relevant population's voice is often not represented in decisions about their own health care, and that they are not accorded the appropriate right of appeal over decisions or plans they may consider unfavourable. An ethical strategy stands to provide the appropriate guide towards all-inclusive decisions and planning in Nigeria's health care.

However, the relevant ethical framework requires a theory of just health care against which to articulate various health care claims, and the corresponding obligations, and to determine the appropriate pathway towards meeting the population's demands equitably. Daniels' (2008) ethical approach offers the most comprehensive theory of just

health care in current literature through which the issues raised in Nigeria's context could be interpreted or evaluated. It provides an ethical tool that could guide equitable distribution of health care resources and services to the population. This chapter will outline Norman Daniels' ethical approach in view of its relevance to the questions raised and determine its applicability towards just health care reforms in Nigeria. It will draw from the three case studies outlined in chapter one to not only clarify complex concepts, but also to indicate the specific relevance for an African context of health care. Being the most sophisticated distributive theory of justice for health care, Daniels' ethical approach is more than worthy of a closer consideration for Nigeria's case.

3.1.1 Why Daniels?

While not discounting the significant contributions of other scholars, especially as evident in the volumes of work by Thomas Pogge (see Pogge, 2008; Hollis & Pogge, 2008; Pogge & Cabrera, 2012; Pogge, 2005; Pogge, 2001) towards effective and equitable delivery of health care in Africa, Norman Daniels' ethical approach is considered here for three reasons.

Firstly, he unveils a dimension of social justice by which questions of fairness in or equity in access to health care should be considered. Considering that the traditional approach to justice in bioethics has been limited to clinical practice and research, he extends the question to the broader context of health care, including the varying social factors and policy implications: "a broader bioethics agenda would take up unresolved questions about the distribution of health and the development of fair policies that affect health distribution" (Daniels, 2006, pp.22). In Nigeria, where quality health care has become more like a form of luxury available to a privileged few, approaches to justice in bioethics must go beyond typical clinical settings and health research to address relevant questions arising in population health, especially those occurring in public health interventions.

Secondly, the ethical approach substantiates an established distributive theory of justice, as articulated by John Rawls, within a framework of health care. Rawls' theory of "justice as fairness" (see 1999, 2001) is widely recognised as the leading theory of distributive justice from the 20th century. While describing the nature of just social arrangements and

how social goods may be distributed fairly, the theory overlooked the essential place of health and health care. Daniels makes a significant contribution to Rawls' theory by extending it to health care: "...my extension of [the theory] to health... provides one plausible justificatory framework... that includes health... and for having obligation of justice to protect... health" (Daniels, 2008, p.47). Thus, the ethical approach matches concerns about inequality in the broader context of health care with an established conceptualisation of distributive justice.

Finally, the ethical framework, while originally formulated towards just health care reforms in the United States, has been further developed for adaptation in low and middle income countries, and initial attempts have already been made in parts of East Africa to test it in real health care situations. The generic framework developed in Daniels et. al. (2000) for benchmarking fairness in health care reforms in low and middle-income countries was followed by an evidence-based trial in some countries, including Cameroun and Zambia (Daniels et. al., 2005). The trials concluded that the generic benchmarks are an effective tool for policy development and implementation in African health systems (ibid). The WHO's "3 by 5 program" for scaling up anti-retroviral treatment in Tanzania was also established against a background of Daniels' ethical approach (see WHO, 2003; Daniels, 2008, pp.274-290). Initial efforts have been made by African researchers to apply the prescriptions of the ethical framework – *accountability for reasonableness* - to health policy development in Tanzania and Uganda (see Maluka, 2011; Maluka et. al., 2010; Byskov et. al., 2009). The results of these attempts appear to be favourable¹⁷.

In light of these considerations, Daniels' (2008) ethical framework shows great potential to address the ethical questions surrounding the distribution of health care in Nigeria. The approach promises to inform substantive reform for the health care system that will not only ensure better access to health care, but also legitimise the process by which policy decisions are made and strategic intervention plans implemented. It also promises

¹⁷ Details will be discussed in chapter five

to impose obligations on health service providers to guarantee relevant access, while at the same time granting users the capacity to demand the available services and be able to hold policy makers accountable. Although the original ethical approach does not offer specific solutions for Nigeria's health care system, it does offer important insights towards the required ethical reform.

3.2.0 Conceptual Foundations of Just Health Care

As noted previously (3.1.1), Daniels' ethical approach to just health care is informed by and defended through the underpinnings of Rawls' theory of justice as fairness. According to Rawls (1999):

Justice is the first virtue of social institutions, as truth is of systems of thought. A theory however elegant and economical must be rejected or revised if it is untrue; likewise laws and institutions no matter how efficient and well-arranged must be reformed or abolished if they are unjust. (p. 3)

In view of this assertion, the search for an effective ethical framework for just health care reform in Nigeria will not only rely on the popularity of an existing theory, but also on the specific benefits it envisages for the system. The relevant ethical approach should not only engender substantive reforms in the laws guiding health service delivery in the country, but also address the socio-cultural context within which health care takes place.

Furthermore, discussions about social equity and justice in Nigeria, while considering illness and health as a major concern, must factor in health care reform since, as Sen (2002, p.659) affirms, health equity is a central feature of all just social arrangements. The stride towards social justice in Nigeria will consider the health care system as an essential feature towards attaining a just society. A theory of just health care will play a central role in determining which equity considerations are made in the distribution of social welfare services. We cannot boast of achieving an effective welfare system in Nigeria if inequalities in access to health care persist.

Therefore, an effective health care reform in Nigeria must consider the role of justice in determining what aspects are given priority in view of the population's health. The quest for just health care reform requires a substantive theory and an established ethical framework, such as that provided in Daniels' (2008). Daniels' ethical approach to just health care has three conceptual phases, which he explores in the form of "three focal questions". The focal questions constitute the framework against which ethical issues in health care are understood, evaluated and addressed. In establishing the theoretical foundations of the focal questions, Daniels appeals to Rawls' theory of *justice as fairness* (ibid). This section will outline the three focal questions and show how Daniels' substantiates them against the background of *justice as fairness*.

3.2.1 Framework of Just Health Care

According to Daniels (2008), the three focal questions against which an ethical reform in health care should be established and evaluated are:

- a) Is health of special moral importance?
- b) When are health inequalities unjust?
- c) How can we meet health needs fairly under resource constraints?

An appropriate response to these questions, he insists, will constitute a theoretical framework of just health care and further offer practical ethical guidance to policy (Daniels, 2008, p.12). The first focal question should show whether health is morally important in ways that justify why societies should distribute health care more equally than other social goods¹⁸; the second should account for the many socially controllable factors, besides access to health care, that affect levels of population health and degrees

¹⁸ Rawls (2001, p.58-59) distinguishes five kinds of social goods, namely: basic rights and liberties, including freedom of thought and liberty of conscience; freedom of movement and free choice of occupation against a backdrop of diverse opportunities; powers and prerogatives of office and positions of authority and responsibility; income and wealth, understood as all-purpose means; and the social bases of self-respect, understood as those aspects of basic institutions required for citizens to have a sense of personal worth.

of health inequity; and the third should stipulate a fair process for making rationing decisions in distributing health care resources (Daniels 2001, p.2).

In view of just health care, the response to the focal questions will provide a conceptual basis for pursuing justice through health care, identify evidence of health inequalities that raise questions of justice, and offer a practical pathway towards just health care reforms. Hence, the ethical framework will need to examine the broader institutional settings and policies that mediate a population's health, and will: clarify when a health inequality is unjust, what counts as a reasonable rate of progress towards reducing health inequality, and test these in the context of actual policy choices (Daniels, 2001, p.23,26). More importantly, it should develop a general account of fair process by which policy formulation and implementation processes could be presented as fair and legitimate(*ibid*). Achieving these priorities will not only imply effective reforms, but also a just health care system.

The rationale for the focal-questions approach is that they help to prompt us regarding the obligations we have for each other to ensure justice in and through health care:

If we can explain why societies should give special moral importance to meeting health needs, then we may be able to characterize the basis of our obligation to protect health. If we can explain when health inequalities are unjust, then we will have a better idea of what factors affecting population health and its distribution we are obliged to modify through policy. If we know how to make fair and legitimate priority setting decisions about meeting health needs under resource constraints, then we can guide our actions toward more just outcomes under non-ideal conditions. (Daniels, 2008, p.16)

While different social settings may have varied challenges, the essence of health care remains the same across the board: mainly, that of ensuring good health for the population. For example, while the contextual differences between Nigeria and the United States (as described in chapter two) implies that issues of justice in health care will vary, the questions are fundamentally the same. The conceptual framework of just health care

addresses questions of inequalities broadly construed, transcending socio-cultural backgrounds.

Hence, considerations of just health care will abstract from the substantive issues of fairness across contextual boundaries and point towards a relevant pathway for ethical reforms. Against this background, Daniels (2008) relies on a specific definition of health, as normal functioning. Where this conception of health is defended against an “opportunity thesis”¹⁹, the ethical approach can provide a tenable explanation towards the universal obligation to protect health, provide health care, and ensure equitable access to health care services and resources.

3.2.1.1 *Health as Normal Functioning*

The conception of health underlying the focal questions is that of an individual’s ability to function normally, as is typical of the human species (Daniels, 2008, pp.36-42; Daniels, 1985, pp.26-32). Assuming we understand health as the absence of pathology, whereby pathology refers to any deviation from the natural functional organisation of a typical member of the human species, one may be said to have normal functioning if they are in good health (ibid). For instance, if a typical human being should be capable of walking long distances or talking for great lengths, then one could be said to be functioning normally if he/she were able to do so.

There are other views about the meaning of health and illness, such as the existential view, whereby psychological and social factors are accepted as influencing the susceptibility to disease (Burr, 2003, pp.36-40). In the existential view, illness is understood as: “...global representations that influence individuals’ perceptions of their place within the world” (Richer & Ezer, 2000, p.1112); or cosmic, abstract representations that have a pervasive impact on many facets of human experience (ibid), especially in regard to health and wellbeing (Whitehead, 2003). This view of health

¹⁹ Opportunity thesis is explained in a later section.

centres on humanistic values, attitudes, and beliefs that guide individuals in daily life (Mickley, Soeken & Belcher, 1992), and emanate from individuals' personal coexistence and connectedness with themselves and their environment (Smucker, 1998). It is a state whereby individuals know what they do and why, who they are, and where they belong (Blaikie & Kelson 1979).

In spite of differing views, Daniels (2008) insists on the biological model that attributes causal relations to typical biological goals, such as reproduction, as defining health and illness. The rationale for the biological model is mainly that it considers health or departure from it, against a background of natural conditions (Daniels, 2008, p.38). This makes for a value-free judgement in determining who is healthy or ill, making it a more objective approach, especially where equity in the distribution of health care resources is concerned.

3.2.1.2 *Opportunity*

Beyond its objective nature, the understanding of health as normal functioning has a specific connection to *opportunity*, which constitutes a central thesis in the distributive theory of justice. According to Daniels, there is a functional relationship between preserving normal function (i.e. health) and the kind of opportunities that would be open to an individual in any given society (2008, pp.42-46). While the variety of opportunities open to individuals to pursue may depend on key economic and cultural features, and socialisation and/or historical developments of their particular societies, their physiological functionality (beyond talents and skills) is significant in determining the kind of opportunities that they can actually pursue (ibid):

Impairment of normal functioning through disease and disability restricts an individual's opportunity relative to that portion of the normal range his skills and talents would have made available to him were he healthy... disease and disability shrinks his share from what is fair. (Daniels, 1985, pp.33-34)

And hence:

Individuals' fair shares of that societal normal opportunity range are the plans of life it would be reasonable for them to choose were they not ill or disabled and were their skills and talents suitably protected... (Daniels, 2001, p.3)

The kind of opportunities open to persons resident in Nigeria may not compare to those in the United States. There are obvious differences between these countries, such as in technological advancement, relative distribution of wealth, and developmental conditions. While it may be reasonable for someone in the United States to pursue a career in astronomy for which funding could be provided, such career aspiration may not be feasible in Nigeria in the current historical space. Yet, in both contexts, individuals can enjoy relative benefits in pursuing their life plans, within the given range, only to the extent that their physiological conditions allow. Given the conception of health as normal functioning, the "opportunity thesis" becomes essential in formulating a comprehensive ethical approach for health care reform.

The functional relationship between health and opportunity is defended through a coherent theory of distributive justice, as articulated in "Justice as Fairness" (Rawls, 2001). Specifically, the theory's emphasis on *fair equality of opportunity* (ibid) is consistent with the relationship between health and opportunity. As Daniels (2008, p.56) shows, the "opportunity thesis" defends the moral obligation to provide health care for all. The rationale for drawing on a principle of justice, Daniels (1985, p. 39) states, is that simply showing a causal link between health and opportunity does not oblige society to protect individuals' health or to provide necessary health care. However, if we are able to show that justice requires society to protect the opportunity of individuals, then there will equally be a causal justification for obliging society to provide health care for all (ibid).

3.2.2 The Fair Equality of Opportunity (FEO) Principle

The idea of *fair equality of opportunity (FEO)* is central in the Rawlsian theorisation of justice as fairness. According to Rawls (1999, pp.10-15), *justice as fairness* is concerned with principles that free and rational persons in a society, each of whom are concerned

to advance their own interests, would accept in an initial position of equality²⁰ as stipulating their basic terms of agreement. For example, suppose that in the ARV (antiretroviral medicines) case, the South African government and policy makers had considered all other stakeholders affected by the Anti-ARV policy as equal partners, then the decision making process may have taken a different course from the start. As equal partners, also concerned for their own benefit, the other stakeholders, including the people living with HIV/AIDS and those responsible for their care, would not have accepted the rationale for taking ARVs off the list of health services provided in public health centres. The policy decision would have emerged from a decision that all concerned parties endorsed; the process would have been fair, and the outcome acceptable.

In order to attain justice under the FEO principles, Rawls argues, we must assume that certain social conditions have already been fulfilled (2001, p.8-26). *Justice as fairness* is presupposed under ideal conditions, where society is understood as a fair system of cooperation, to the extent that such society is well-ordered, and its members are willing to limit their personal benefit in a harmonious association to everyone's advantage (ibid). Under these conditions, basic equality in agreeing to or choosing a way of proceeding, such as could have been the case in the ARV scenario, would be just and legitimate.

Two key principles underscore the Rawlsian conception of justice as fairness, mainly that:

²⁰ The original position implies a situation whereby agreement is made on the basis that none of the parties involved has any kind of advantage over the others, so that principles as initially agreed upon would regulate further arrangements amongst them, specifying the kinds of cooperation to be entered into:

...we are to imagine that those who engage in social cooperation choose together, in one joint act, the principles which are to assign basic rights and duties and to determine the division of social benefits. Men are to decide in advance how they are to regulate their claims against one another and what is to be the foundation of their society. ...a group of persons must decide once and for all what is to count among them as just and unjust... It seems reasonable to suppose that the parties in the original position are equal... all have the same rights in the procedure for choosing principles; each can make proposals, submit reasons for their acceptance, and so on (Rawls 1999, p. 10-11,17).

- a) each person has the same indefensible claim to a fully adequate scheme of equal basic liberties, which is compatible with the same scheme of liberty for all; and
- b) social and economic inequalities are to satisfy two conditions: first they are to be attached to offices and positions open to all under conditions of *fair equality of opportunity*; and second, they are to be to the greatest benefit of the least-advantaged members of society. (Rawls, 2001, p. 42-43).

Just health care appeals to the FEO principle, in view of its potential to defend the obligation for universal coverage. For instance, it grants a fair advantage to those who are economically, socially or circumstantially less advantaged in the distribution of health care resources (Daniels, 2008, pp.51-58). It also considers individuals' disadvantages in attaining their life plans, e.g. career goals, which they would have been able to pursue were they in good health conditions (ibid). In other words, allowing greater access to health care or other relevant resources to those who are worse off would reduce their relative social disadvantage and offer them a chance to pursue their desired life opportunities. For example, in some countries, like the United Kingdom, persons with disabilities are allowed to attend job interviews with supporting persons, as a means to reduce their relative competitive disadvantage against other applicants without any apparent disabilities. For "fair equality of opportunity... require[s] not merely that public offices and social positions be open in the formal sense, but that all should have a fair chance to attain them" (Rawls 2001, p. 43). Hence, both applicants with and without disabilities are given fair chances at getting the advertised job. Persons with disabilities will not be offered jobs on account of compassion, but on relative merit; and those without disabilities do not gain undue advantage for being more physically or mentally able.

The rationale is that people with the same level of natural talents or skills, and who are equally willing to utilise them, should be given the same prospects of achievement regardless of their social position, class, race or gender: "in all parts of society there are to be roughly the same prospects of culture and achievement for those similarly

motivated and endowed (Rawls, 2001, p. 44). Extending this rationale to health care has two implications:

- a) access to health care may not be determined by one's social categorisation or economic advantage, and
- b) society may not allow one's health condition to limit his or her ability to pursue life opportunities relative to the said healthy person in that society.

Hence, like the consideration given to disabled persons at job interviews, fairness in the distribution of health care will ensure that relative disadvantages do not unduly limit access to some categories of persons, especially given that health care is an institutional agent of social justice. For instance, in systems where health care is paid for from out of pocket, those without the financial capacities will be given other relevant privileges, so that they can also equally enjoy the benefits of the available resources and services.

3.2.3 Extending Opportunity Thesis to Health Care

The overwhelming desire for individuals to protect their own health and the central place of health care in most societies, suggest a moral obligation to make health services available to all. However, in real life situations, where varying demands about specific health care services cannot be met, there will be questions about fairness or equity in access. Effective solutions will not necessarily be in black-and-white, as there is a grey area as well. For example, it may not be prudent to divert half of the public resources for health to rural areas in Nigeria, having established that they are worse off. Other factors that make the urban population healthier will also be taken into account. For it may be that the urban population makes more financial commitment towards health care; and hence giving their share of services to the rural population will be equally unjust. The ethical dilemma in dealing with such "grey" situations is what Daniels (2008) aims to address in extending the FEO principle to health care.

The requirements of FEO suggest that in practice, a theory of justice should oblige us to protect opportunity for all, so that everyone has a fair chance of attaining their feasible life plans or goals. If we proceed from the intuition that since health is linked to

opportunity, therefore we are obliged to provide health care for all, the danger is that society will be required to meet all health demands. Yet, the reality is that resources are limited, and some kind of rationing may be necessary for equitable distribution. Hence, rather than dwell on the mere causal connection between health and opportunity, Daniels (2008) appeals to the underlying intuition behind the FEO principle in explaining the grounds for just health care:

The intuition behind fair equality of opportunity is to restore the fair opportunity range for individuals to what they would have if social arrangements were more just and less unequal. A similar intuition underlies our practice in protecting opportunity against ill-health. The impairment of normal functioning... restricts individuals' opportunity relative to the normal range that their skills and talents would have made available to them were they healthy. Maintaining normal functioning by meeting health needs... lets them enjoy that portion of the opportunity range to which their skills and talents would give them access, assuming these too are not impaired by special social disadvantage. (Daniels, 2008, p. 44-45)

Against this background, Daniels (1985, p.45) insists that the most promising strategy will be to extend Rawls' theory to include health care among the social goods to be distributed equitably. Since good health is essential in guaranteeing individuals' opportunities, the intuition for wanting to guarantee health care is the same as that for opportunity (ibid). Hence, if we are obliged to protect opportunity for individuals, we are equally obliged to protect their health by making health care accessible (ibid). Extending Rawls' theory to health care will evade such naïve claims as ones insisting that everyone gets whatever health care they want. It will however, ensure that all who need health care, e.g. available lifesaving treatments, are given the relevant services. Yet individuals will not be given more than their fair shares in terms of the health care resources available to a health care system.

Extending the opportunity thesis to health care, as Daniels's does, not only presents the "opportunity thesis" as a theoretical basis for an ethical framework of just health care,

but also provides a practical frame of reference for Rawls' theory. Sachs (2012, p.323) notes that the principle of fair equality of opportunity, as proposed by Rawls, does not say anything at all until certain variables are filled in, including: identifying which opportunities are to be distributed equally, be it welfare, jobs or something else; and specifying the time at which such distribution should be equal – whether all the time, intermittently or just once (ibid, p.326). Also, Sen (2002, p.660) has noted that equality, being an abstract idea, does not have much cutting power unless a specification of what is to be equalised has been made. Ascribing the FEO principle to health care grounds it in practice, and helps to ensure that Rawls' theory of justice can effectively influence practical policy processes, like decision making in health interventions.

The opportunity thesis provides a plausible justificatory framework for the obligation of justice to protect the opportunity of individuals through health care (Daniels, 2008, p.47). It constitutes a conceptual background for providing a coherent response to the three focal questions, which form the framework of just health care. Thus, the “opportunity thesis” provides a defensible moral ground for prioritizing health care among other social goods, as well as giving special considerations to disadvantaged persons or groups in the distribution of health care resources and services.

3.3.0 The Three Focal Questions

Varied questions of justice arise in the distribution of and access to health care. The three focal questions provide a comprehensive ethical framework against which to address these questions. This is important, especially where the focus of health care improvement has been mostly towards boosting financial capacity and infrastructural development. The ethical framework, as established through the focal questions, provides an explanation about how the finance or infrastructure for health care can be distributed equitably. Specifically, the *benchmarks of fairness* provide practical guidelines for evaluating the relevant policies guiding such equitable distribution.

In view of the focal questions, the ethical framework for just health system reforms is established against three factors: the causal relationship between health and

opportunity; the fact that due to societal structures some persons are more disadvantaged in accessing health care than others; and what society must do to meet the obligation of justice in providing health care for all. Hence, the first question establishes a moral imperative, the second describes the nature of the practical situation to be considered, while the third explores an ethical pathway towards an effective solution. The opportunity thesis runs through the ethical framework, constituting both the conceptual frame of reference and the summative principle of just health care.

This section echoes what has already been discussed in the previous one. However, while they both explore the three focal questions, there is a subtle, yet significant difference. Section 3.2 mainly considered how Daniels substantiates Rawls' theory of justice with the content of health, and also how the theory should inform a relevant ethical approach to justice in health care. Section 3.3 has considered how the focal questions are articulated into an ethical framework, and the evolution of "justice as fairness" into a practical policy tool in health care. Specifically, section 3.2 described what the focal questions are, while section 3.3 has provided an explanation for how they constitute an effective tool towards just practices in health care.

3.3.1 The First Focal Question

The theoretical basis of just health care derives from the first question: is health, and hence health care, of any special moral importance? (Daniels, 2008, pp.29-78). This provides a moral basis without which it is untenable to make a case for justice in the distribution of or access to health care. According to Daniels (1985, p.17), if most societies believe that health care should be distributed more equally than other social goods, there must be an explanation for this special preference or urgency attributed to it:

- a) Is there any function or effect of health care that explains the importance we attach to it?
- b) Can we explain our belief that some kinds of health care are more important than others, and does this show the relationship between health care and other social goods that are subject matters of theories of distributive justice?

If these questions are suitably addressed, then we can have the moral confidence to make justifiable claims for meeting the varied demands for certain kinds of health care, while postponing others.

The moral basis for the specialness of health care is established against the causal link between health and opportunity. Hence, the opportunity thesis is central in understanding why health care should get priority over other social goods in most societies. According to Daniels:

The central importance, for the purposes of justice, of preventing and treating disease and disability with effective health care services... derives from the way in which protecting normal functioning contributes to protecting opportunity. Specifically, by keeping people close to normal functioning, health care preserves for people the ability to participate in the political, social, and economic life of their society. (Daniels, 2001, p. 3).

Since health contributes to the range of opportunities open to us, providing health care will not only restore individuals' normal functioning, but also sustain or enhance their fair share of the normal opportunity range (Daniels, 2008, p.77). It will allow individuals to be able to choose certain goals or life plans that their talents and skills avail them of. The loss of functioning associated with disease and disability reduces the range of opportunity open to us compared to what it would be were we healthy or fully functional (Daniels, 2008, p.27). By keeping people functioning normally, we protect their range of opportunities; hence, if we have a social obligation to protect opportunity in this way, then we have a general framework for thinking about justice and health (ibid).

In view of the ARV case, one sees that the physical abilities of patients for whom the ARV treatment was sought were variously impaired due to the impact of the disease. Their ability to participate in the economic, social and political life of their communities was severed. This in turn constituted a burden to their families; for beyond reducing their productive capacities, several families were burdened with the care of HIV/AIDS patients, which the ARV could help to alleviate. Since ARV drugs have proven to be effective in

improving the conditions of HIV/AIDS patients in neighbouring countries by sustaining their opportunity range, the South African health care system was obliged to make them available. Insistence on the provision of ARV treatments, against other proposed alternatives, shows that the population considered the health care of HIV/AIDS patients as specially important. This constituted the moral ground against which they could oblige the government to provide the ARV drugs. The opportunity thesis may have been instrumental in establishing the claims for a pro-ARV treatment policy. It guaranteed HIV/AIDS patients a fair chance of enjoying the benefits of the available health care resources, and thus to attain a larger opportunity range.

The logic of the specialness of health care is thus: if society is obliged to protect opportunity for individuals, and health care is essential in protecting or sustaining such opportunities, then society is obliged to protect the health of individuals by guaranteeing effective access to health care²¹. The health care of the HIV/AIDS patients is important because of the special role their well-being and flourishing plays not only in their individual lives, but also in enhancing the lives of their families and immediate communities. In short, health care would enhance the opportunities both of the individual patients and the affected families or communities.

Given the centrality of the opportunity thesis to the specialness of health care, the claims of other views of health (e.g. the existential view) can make its conceptual basis untenable. It is difficult to defend the specialness of health care in situations where the lack of “normal functioning” has clearly not impeded opportunity. This is exemplified in the case of famous achievers, like Stevie Wonder or Stephen Hawking²². Also, in social

²¹ Daniels (2008, p.29) would endorse this line of the argument.

²² At an early age, Hawking showed a passion for science and the sky. At age 21, while studying cosmology at the University of Cambridge, he was diagnosed with Amyotrophic Lateral Sclerosis. Despite his debilitating illness, he has done ground-breaking work in physics and cosmology, and his several books have helped to make science accessible to everyone. (<http://www.biography.com/people/stephen-hawking-9331710#synopsis>)

Born blind...singer, songwriter and multi-instrumentalist Stevie Wonder made his recording debut at age 12. He recorded his first hit single in 1963. Over the next decade, Wonder recorded several hit songs, including

contexts where health and illness are understood in other terms than “normal functioning”, like in the African holistic view²³, the opportunity thesis may not provide a tenable moral imperative to provide health care for all.

Despite these limitations, I shall take it as given that health is special and that we are morally obliged to provide health care for all. The next challenge is that of distinguishing between real health care situations where we can establish whether or not injustice has been done or suffered. Only then can we know what situations to address, or which are more urgent than others, ethically speaking. The second focal question addresses this challenge.

3.3.2 The Second Focal Question

The second question of just health care asks: “when are health inequalities unjust?” (See Daniels, 2008, pp.79-102). Simply establishing the moral imperative for providing health care may not suffice to address the more complex issues of access to health care or the provision of specific services, as exemplified in the ARV case. While the first question establishes a conceptual or moral basis, the reality of health care is such that we must distinguish which situations have defensible claims of justice. We must know when provisions in health care, or their absence, would count as just or unjust. Only then will the specialness of health care become meaningful in practical situations.

The central thesis of the second question is thus: health inequalities are unjust when they result from an unfair distribution of the varied social factors affecting the distribution of health care and health outcomes of a population (Daniels, 2008, p.27). Simply knowing

"Living in the City," "Boogie on a Reggae Woman" and "Isn't She Lovely." His fertile period came to an end in 1979. Wonder's 1980s hits include "I Just Called to Say I Love You" and "Ebony and Ivory." He was inducted into the Rock and Roll Hall of Fame in 1989. (<http://www.biography.com/people/stevie-wonder-9536078#synopsis>)

²³ Details of the African holistic view of health are provided in chapter five.

that protecting health protects opportunity, Daniels affirms, does not tell us anything about when inequalities in health are unjust, either generally or across social groups:

The importance of the second focal question rests on understanding the many socially controllable factors that affect health inequalities.... [since] health is produced not just by having access to medical prevention and treatment but also, to a measurable extent, by the cumulative experience of social conditions across the life course (p.21,79).

I have shown in the previous chapter (2.3) how basic health care, like children's vaccination, and antenatal care, are more accessible to persons in the upper wealth quantiles or in urban areas in Nigeria. This difference in access creates health disparities between the population groups: the nature of access appears to be proportionate to the health status of each population group considered. Given this fact, will improving access to health care facilities be sufficient to improve the health status of the worse off groups? Yes, of course; but only intuitively.

There is a wider scope to the problem, beyond improving health care infrastructure; hence, the importance of the second focal question. It asks whether bridging the inequality in access to basic health care is sufficient for what just health care requires (2008, p.21). Answering this question will help us to understand the breadth of what justice requires us to do to protect population health and its fair distribution (ibid). Just health care considers not only the distribution of services but also the various social factors that make some population groups more disadvantaged than others in regard to health status: "an account of justice should help us to determine which inequalities are unjust and which are tolerable" (Daniels, Kennedy & Kawachi, 1999, p.216).

The rationale for considering other social factors derives from the observation that there is a significant connection between health inequalities and relative incomes of individuals or groups (Daniels, Kennedy & Kawachi 1999). Cross-national evidence shows that the total wealth of a country is not directly proportional to the overall health conditions of its population (ibid, p.218-220). For example, the relative wealth of the United States far

exceeds that of Cuba; yet both countries present equivalent health status. They show evidence that the health status of individuals gets better in proportion to their incremental rise on the socio-economic ladder (ibid, p.220-221). This is affirmed in Nigeria's case, where under-five mortality rates are shown to better with every rise in the five wealth quintiles considered (see 2.3.1). The link between social inequality and health inequality is thus established:

Some of these occur at the societal level, where income inequality creates a pattern for the distribution of social goods, such as public education, thereby affecting access to life opportunities – which are, in turn, strong determinants of health. (Daniels, Kennedy & Kawachi, 1999, p.233).

A just health care system should not only aim to guarantee better access to health services, but should also considerably address relevant social, economic, cultural, and political factors that affect health and the distribution of health care. An appropriate ethical approach will look beyond traditional health care. It will include equal basic liberties, robustly equal opportunities, a fair distribution of resources, and support for our self-respect among the considerations for attaining equity in health care and health outcomes (Daniels, 2001, p.6). When this has been accomplished, any further inequalities that remain, and which bear on access to health care or health outcomes, would count as acceptable, fair or just (2008, p.23).

As in the first focal question, the conceptual justifications are founded against a background of the opportunity thesis. An approach to justice in health care will require, for instance, equalising the socio-economic factors that limit the life opportunities of individuals or population groups, and/or the relevant opportunities to access available health care. Also, the lack of good education for some individuals or population groups will affect their career opportunities, which may in turn worsen their health status. Where quality health care is paid for from out-of-pocket, such as in Nigeria, this will lead to a spiral effect: poor education = poor income = poor health status = poor health care = poor opportunities = poor education. Just health care approaches thus require the mitigation of all these allied features, to ensure equitable health care for the population.

While health care is specially important because of its impact on opportunity, justice also requires other socio-economic inequalities to be mitigated to ensure fair health outcomes for all population groups. Achieving such fairness requires practical guidelines to direct health care systems in the distribution of resources and services that bear on health. It should provide an ethical framework that population health policies and health care intervention strategies can be mirrored on. The inquiry into the practical approach leads to the third question.

3.3.3 The Third Focal Question

The distribution of health care raises complex ethical questions that policies must address to ensure effective service delivery. Theories and moral justifications, as considered above, often have valid criticisms that point to other alternative explanations. The theses of the first and second focal questions have been critiqued against other justifiable moral claims. For instance, Sen (2002, p.660) does not ascribe moral importance to health care for its impact on opportunity, rather because health is among the most important conditions of human life, and constitutes a significant aspect of human capabilities that we have reason to value. The connection to capabilities makes health care essential to any consideration of justice in distribution of social goods (ibid). Hence for Sen, the specialness of health hinges on capability rather than opportunity.

Despite the wide criticism, there appears to be a common view that health and health care are special. What is important then is to provide practical tools towards equalising health outcomes in society. The third focal question thus asks: “when are limits to health care fair?” It sets out to design a “fair deliberative process” that should inform relevant policy decisions and implementation plans (see Daniels, 2001, pp.9-13; 2008, pp.103-139). This promises to transcend moral disagreements, and rather look to a practical way forward. As Daniels & Sabin (1997) have shown, the moral controversy over distribution of health care is more complex. One such difficulty is illustrated in the *best outcomes* versus *fair chances* controversy. The best outcome approach affirms the maximisation of benefits, where, say, a particularly scarce drug will be given only to those patients in whom it will be most effective (see Daniels, 2008, p.107). On the other hand, fair chance

will argue that all affected patients should be given equal chances to take the drugs, as even limited benefits to the worse off cases can alleviate further suffering (ibid).

The Ebola case exemplifies the moral disagreement as above. At the peak of the crisis and with limited trial drugs available, there was a difficulty in deciding who gets priority: health workers in the frontline considered most at risk, or people in affected communities where the risk of infection was high and unpredictable (see Rid and Emmauel, 2014; Arie, 2014). Giving the vaccines to health workers appears to suggest that maximum benefits will be gained from the limited drugs available. It meant that more personnel could be committed toward stopping the spread of the virus, which is one effective strategy of eliminating the disease. Yet, a fair chance approach will also recommend that everyone within the high risk areas should be equally considered. The third focal question, aims to resolve such moral disagreements by providing practical guidelines: for “even if there are principled solutions that philosophical investigations may eventually uncover, there is considerable disagreement now about how to solve these problems” (Daniels & Sabin, 1997, p.322).

In the light of such challenges in the distribution of health care, Daniels (2008, p.25ff) provides an account of “fair process” by which we accept certain outcomes as just, since we cannot agree in principle:

Reasonable people, who have diverse moral and religious views about many matters, disagree morally about what constitutes a fair allocation of resources to meet competing health needs.... We should expect and respect such diversity in views about rationing health care. Nevertheless, we must arrive at acceptable social policies despite our disagreement. (Daniels, 2001, p. 9)

Through a framework of four conditions the fair process promises a robust form of public accountability that will appeal both to principles and to process, in a coherent form (2008, p.177). The four conditions constitute the ethical framework of “accountability for reasonableness”. This should guide the distribution of health care in ways considered just or fair by all stakeholders, despite their competing interests.

3.4.0 Accountability for Reasonableness and the Four Conditions

The accountability for reasonableness (AFR) approach is established against a background of the four conditions: publicity of rationales, a search for relevant reasons, opportunity for revising decisions, and assuring implementation (Daniels, 2008, pp.118ff – see figure 3.1 below). It emerges against a background of other popular approaches to fair process, including:

- a) the *market accountability* approach, which claims that there is nothing unfair or illegitimate about the limits we face in making informed purchases of health care or health insurance
- b) The *majority rule* approach, representing the widely acclaimed democratic process. It legitimises the will of the majority to inform limits setting in the distribution of health care; and
- c) The *cost-value methodology*, which uses a cost analysis of best health outcomes to determine what gets priority, and what limits would be fair. (see Daniels, 2008, pp. 110-117)

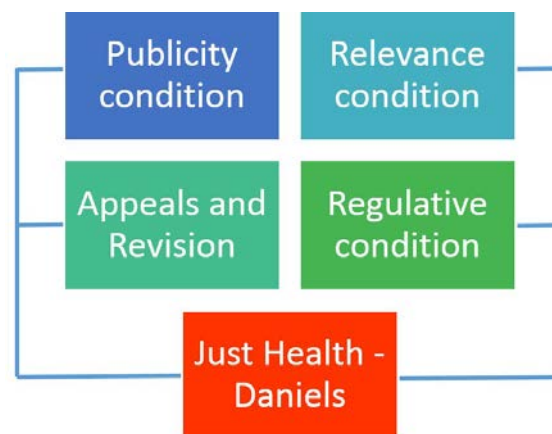
As a common limitation, these three approaches do not emphasise the importance of the rationales for setting limits in health care, which should persuade other stakeholders who may not favour the decisions to accept them as fair (see Daniels, 2008). In view of the ARV case, the cost-value methodology appears to have informed the initial anti-ARV treatment policy, given that financial reasons were also cited by the government. Assuming the financial reasons were justifiable, the government did not explain the rationale or the financial implications for the population's health. The unexplained or unjustifiable rationale, perhaps, informed the public rejection of the policy.

The AFR approach proposes to legitimise limits set in health care service provision through a fair deliberative process:

...the idea that the reasons or rationales for important limit-setting decisions should be publicly available... [and] must be ones that fair-minded people²⁴ can agree are relevant for appropriate patient care under resource constraints (Daniels, 2008, p. 117).

The framework of the fair process hinges on the four conditions: the publicity condition requires transparency about the reasons for a decision; the relevance condition specifies acceptable reasons; and appeal/revision and regulative conditions provide a mechanism (see Daniels & Gruskin, 2008, p.1575-1576). The fair deliberative process is a rational mechanism that helps all parties involved or affected to understand the justification for whether or not a specific health service will be provided. It ensures that policy decisions made are acceptable to all, at least in principle. Consider the controversy in the ARV case study, for instance, where the campaign may have initiated a deliberative process which compelled the government to revise the anti-ARV policy. Although the roll-out program for ARV treatment may not have covered every demand, as desired, the revised policy was acceptable and fair.

Figure 3.1: Daniels' *Just Health* framework



²⁴ "Fair-minded people" refers to those who seek to cooperate with others on terms that they can justify to each other: "indeed fair-minded people accept rules of the game – or sometimes seek rule changes – that promote the game's essential skills and the excitement their use produces" (Daniels 2008, p.117).

3.4.1 Publicity Condition

The publicity condition requires that the rationale for decisions guiding the distribution of health care resource or services be made publicly available, making them accessible to those who may wish to raise objections or suggest other considerations (Daniels & Sabin, 1997, pp.325-329). Beyond enhancing transparency, publicity will over time demonstrate coherence or consistency in relevant health care decisions (Daniels, 2008, p.120). It will also show the system's commitment to an even-handed appeal to reason and principles in the policy process (ibid). In the ARV case, for instance, the rationale for excluding the drugs from the list of free treatments was not presented for public evaluation and input before the policy was implemented. Policy makers wrongly presumed public acceptability of the rationales guiding their decision – as we see in the ensuing protest.

Similarly, the public protest against the Ebola vaccine trials in Ghana (see case study III) suggests that the approval process may not have been publicly communicated. Although the vaccine is scientifically proven to be safe, fears about its safety implies either one or both of two questions: the population was not duly informed, or participating communities did not effectively contribute to the process. In short, the process overlooked the publicity condition. The protest reveals the wide communication gap between policy makers and the affected population in the decision making process. If Ghanaians understand the rationale behind wanting to use them for the early trial phase, they may compromise their fears for greater health benefits. The publicity process has potentials to improve the fairness of decision processes both formally and substantively, and will over time lead people to better understand the moral commitments of the institutions making these decisions (Daniels, 2008, p.122):

Only by being explicit about reasons can health plans or public agencies demonstrate that the solutions they adopt for coverage under resource constraints reflect reasons and principles that everyone affected by those decisions should take seriously (Daniels, 2008, p.122).

As seen in the South African and Ghanaian controversies, minimal transparency or inadequate involvement of the population in policy decisions has consequences for legitimacy. Without such legitimacy or public endorsement, health care policies or intervention plans will be ineffective. Therefore, the affected population's interest must be considered, as well as inform the decisions or plans made. Only then will the process and outcome be legitimate and just.

3.4.2 The Relevance Condition

The relevance condition requires that the reasoning guiding decisions in health care should be explainable to everyone. It ensures that two kinds of explanation are made publicly accessible:

... the rationales for coverage decisions should aim to provide a) a *reasonable construal* of b) how the organisation or public agency seeks to provide *value for money* in meeting the varied health needs of a defined population under reasonable resource constraints... A construal of goal will be reasonable only if it appeals to... values and principles that are accepted as relevant by the people. (Daniels & Sabin, 1997, p.329).

Furthermore:

... not just any kind of moral reason, compelling as it might be to the decision maker or the patient, will be seen as appropriate or relevant to those affected by the decision... [They] must be the types... that patients can recognise as relevant and appropriate for the purpose of justifying decisions (Daniels 2008, p.125).

In terms of reasonable construal, the ARV case presents a situation where the kind of reasoning was not explainable to all. For instance, the government's supposed scientific explanation of HIV/AIDS did not match other widely acceptable explanations. Hence, the alternatives they proposed were considered inappropriate. In other words, the reasons provided were not considered relevant by the affected population. Suppose the government had proposed another effective therapy as an alternative, then the rationale

may have been reasonable and acceptable. The fact that patients and those providing care could not fit their experiences with the alternatives offered meant that the decision had no reasonable construal. The rationales must involve a publicly accessible method of reasoning, transcending personal convictions such as those deriving from specific religious views that may not be accessible to non-believers, or belief about certain unproven remedies (Daniels, 2008, p.125),).

The second constraint to the kind of relevant explanation involves a cost-value analysis:

How should we view the claim that a treatment or regulation providing protection against health risk will not be provided because it costs too much? ...when one treatment or regulation to protect against risks provides comparable benefits at lower cost, cost-effectiveness is widely seen as a relevant and acceptable reason” (Daniels, 2008, p. 127).

One reason referred to by the South African government was the cost of a comprehensive roll-out program for an ARV drug based treatment plan, which it could not afford. The anti-ARV policy thus sought to provide a value-for-money rationale in meeting the wider health care demands of the population. However, the rationale was not tenable in the light of new evidence, as a High Court judge shows:

My analysis shows that the total cost to the health sector of Mother-to-Child Transmission (MTCT) programs (i.e. the costs of voluntary counselling and testing, the costs of anti-retroviral regimen and the costs of treating all children born HIV+ despite the MTCT programme) is less than the costs of treating all children born HIV+ in the absence of a MTCT programme... saving children from HIV infection by implementing a MTCT programme will save the state more money... (Cited in Overy, 2011, p.3)

In view of the reasonable construal of rationale and cost-value analysis, one sees a lack of moral commitment to the population’s health on the part of policy makers. While not meeting public acceptability, the rationales provided also raised questions about

commitment to the population's welfare. If the policy process met the relevance condition from the start, the decision would have been acceptable.

3.4.3 Appeals and Revision Condition

Where a decision has already been made, say, about limiting a particular health service, there may be concerns about how this may affect the population. How will their reactions or objections be addressed, and what provisions should be made? Specifically: "there must be mechanisms for challenge and dispute and, more broadly, opportunities for revision and improvement of policies in the light of new evidence or arguments" (Gruskin & Daniels, 2008, 1576). The appeals and revision condition thus set out to provide a procedure by which such decision may be disputed, and the objections considered. It plays three distinctive roles in both private and publicly administered health care:

- a) offering citizens a form of due process by which to attempt to revise adverse effects of decisions;
- b) giving those who are affected the opportunity to present their views towards improved decisions; and
- c) educating society about the need for setting limits in health care through fair resource allocation decisions. (Daniels, 2008, p.131-132)

The polio controversy in Nigeria, the ARV dispute in South Africa, and most recently, the Ebola protest in Ghana represent appeals and revision situations in the health care decision process. The polio boycott represents an appeal against the process leading to a mass polio vaccination campaign. It impelled changes in the vaccine delivery process, as adjustments made later were informed by the affected population's views. The protest against the anti-ARV policy led to a revision of the decision, as special ARV treatment centres were established across the country. Finally, in Ghana, the public protest led to the suspension of the phase I Ebola trial. These variously show how the appeals and revision condition legitimises the decision making process, making the outcomes more acceptable.

Although I have referred to the appeals and revision condition in all three case studies, such mechanisms do not exist in Nigeria's health care systems, or in South Africa and Ghana. The events leading to the protests and their explicit nature are evidence of the absence of established procedures for public inclusion in health care decision making. If the decision processes in all three cases were publicly accessible from the start, and rationales for the interventions or limits were appropriately communicated, value disagreements would have been resolved before the decisions were taken. Also, if relevant grievance channels were established, the decisions would have been appealed and/or revised without necessarily resorting to public protests. Hence, the health care systems in question need to establish standard procedures for regulating the decision making process. This will seek input from the affected population regarding policy decisions and intervention plans.

3.4.4 The Regulative Condition

In order to ensure the effectiveness of the first three conditions, some regulative procedures may be required. The process will require clarifying the rationales behind health care decisions. It will also ensure significant involvement of all stakeholders in the process, thereby facilitating accountability. The regulative condition thus sets up voluntary, public or legal strategies to ensure that the publicity, relevance and appeals conditions are met (Daniels 2008, p.133):

Our analysis of how to solve the legitimacy and fairness problems is neutral between public or voluntary private enforcement of the conditions we outline. Either would suffice to establish the kind of accountability that is necessary where fundamental issues of fairness are involved, provided that the process meets the four conditions. (Daniels & Sabin, 1997, p.343).

As the ARV case shows, there is no established regulative process for policy decisions in South Africa. Hence, the campaign employed existing legal frameworks to impel a revised policy: "everyone has the right to have access to... health care services, including reproductive health care" (Constitution of SA, 2006, cited in Heywood 2009, p.21). Also, a comprehensive regulatory strategy for inclusion in the health policy process is yet to be

established in Nigeria. As seen in the polio case, an ad-hoc health committee had to be set up to negotiate terms with the affected communities. The most recent improvement in this regard is the Emergency Polio Eradication Plan, which considers issues linked to cultural or religious convictions as effectively relevant to the legitimate intervention plans (National PHC Development Agency, 2013).

The relevant ethical approach for just health care in Nigeria, with the potential to benefit other African countries like Ghana and South Africa, has much to gain from the framework of AFR. As I have shown in the three cases, lack of public inclusion in the policy decision process and implementation plan is a major concern for justice. Ethically just inclusion has a further benefit of giving the population a sense of ownership of decisions made about their health and wellbeing.

3.5.0 Just Health Care in Practice

The three focal questions and the four conditions of AFR constitute the conceptual framework for just health care approaches. Health care reforms however, will require practical guidelines in order to be effective. The “benchmarks of fairness” for health care reform provide realistic guidelines; they have been applied in the WHO’s “3 by 5” program for scaling up HIV treatment and care. While the former provides an ethical tool towards just reforms, the latter shows evidence of its effectiveness.

3.5.1 The Benchmarks of Fairness

The benchmarks, originally designed for health care reform in the United States, constitute a practical ethical tool for designing and evaluating health policies. They “...translate central ideas about justice and health into an evidence-based approach for improving health policy” (Daniels, 2008, p.243), and specify what should be done to ensure equity in the distribution of health care resources and services. The original formulation of the benchmarks identifies ten guidelines that should ensure just reforms, as summarised below (see Daniels, Light & Caplan, 1996):

- i. *universal access by coverage and participation*, where health care insurance will include everyone in considering limits to the array of benefits;
- ii. *universal access in minimizing nonfinancial barriers*, which ensure that appropriate resources, sufficient education, and training of personnel facilitate service usage and provide adequate information to users;
- iii. *comprehensive and uniform benefits*, to ensure equitable access to an appropriate set of health care services;
- iv. *equitable financing by community-rated contributions*, to ensure that the burden of health care is shared proportionately across the board;
- v. *equitable financing by ability to pay*, to ensure that those in the lower socio-economic ladder are equally covered;
- vi. *value for money by clinical efficacy*, addressing the need to ensure that the utilization of health care services produces value for money;
- vii. *financial efficiency*, to minimise layers of bureaucracy and cost shifting, maximise value in contracts, and prevent fraud and abuse;
- viii. *public accountability*, to ensure a fair democratic process in the formulation of policies;
- ix. *comparability*, to ensure that health care spending is adequately weighed against others, like education and security; and
- x. *degree of consumer choice*, to ensure that service users can have informed choice about basic health care, specialist services, alternative care, and/or kinds of medical procedures.

These guidelines were specifically designed for health care reform in the United States and made significant impact. The scope of the guidelines was however limited the United States' context; hence, a further consideration was required to make it applicable in other contexts around the world. Against this background, the benchmarks were adapted for use in middle and low income countries through the "generic benchmarks", which were later backed by evidence from a number of countries (see Daniels et. al., 2005; 2000). It is hoped that this development will shape just health reform within the relevant countries, rather than simply relying on guidelines imposed by the international

community, through agencies like the World Bank and the International Monetary Fund (IMF) (Daniels, 2008, p.243-245).

The generic benchmarks set out nine guideline to ensure equity, efficiency and accountability in health care reforms, as summarised below (see Daniels et. al., 2000):

- i. *intersectoral public health*: to evaluate the extent to which the population benefits from reductions in a comprehensive set of health risks as a result of the reform;
- ii. *financial barriers to equitable access*: to account for the large informal, non-taxable sector, and to establish strategies that provide health care coverage for this sub-population;
- iii. *nonfinancial barriers to access*: to establish strategies that address poor distribution of drugs, supplies, and facilities and personnel; and curb gender and cultural barriers, and social discrimination;
- iv. *comprehensiveness benefits and tiering*: to identify comparable health care demands across cultural, socio-economic and gender groups;
- v. *equitable financing*: to identify implications of the various forms of payments for health care services, and to proffer strategies for an integrated system;
- vi. *Efficacy, efficiency, and quality improvement*: to evaluate the usage of resources, where community-based delivery and evidence-based practice are prioritised as measures of quality improvement;
- vii. *Administrative efficiency*: to identify effective management strategies that minimise or enhance cost of purchase, cost shifting, abuse, fraud and inappropriate incentives;
- viii. *Democratic accountability and empowerment*: to account for fairness in health resource allocation through publicly accessible decision-making processes; and
- ix. *Patient and provider autonomy*: to enhance users' choice of health service providers, especially in the light of their varied cultural or social considerations.

These guidelines should provide a comprehensive framework for evaluating health policies and assessing the viability of health intervention plans in middle and low income countries like Nigeria. The first five benchmarks aim to ensure equity in the reform

process; vi and vii point towards efficiency of both the process and outcomes; and viii and ix ensure accountability in the health care system (Daniels, 2008, 246).

In order to ensure that the generic benchmarks are effective for the target countries, an evidence-based trial was conducted in a number of countries, which included two African countries (see Daniels et. al., 2005). The strategy involved adapting the generic benchmarks and criteria to specific health policies by each team. Despite cultural and social historical differences among the countries considered, the trial shows that teams in the collaborating sites were able to agree on a generic matrix that included the nine benchmarks. The cross country comparison suggests a positive impact of the benchmarks on the health systems considered. Specifically, "...it builds capacity to understand the process of monitoring and evaluating reform" (Daniels et. al., 2005, p.538).

3.5.2 WHO 3 by 5 Program

The WHO "3 by 5" initiative to treat three million HIV/AIDS patient by 2005 adopted the generic benchmarks in seeking ethical guidance towards equitable access (UNAIDS & WHO, 2005). This shows further evidence of the success of the benchmarks in low and middle-income countries. Specifically, the "3 by 5" program aimed to scale-up ARVs and other HIV-related treatments against three key ethical guidelines: firm reference for public discussion, a process that is fair to all, and results that are ethically sound (ibid, p.7). According to Daniels (2005), the need for fair process in the "3 by 5" program was essential for patient selection, given the lack of a specific principled approach. The ethical ideals of fair process were illustrated in four key aspects considered in the scale up program (see Daniels, 2005):

- a) cost-recovery for drugs and services: despite reasonable disagreements about what principles should guide the funding, the final decision hinged on reasons that all can agree on to provide free ARV treatments;
- b) medical eligibility criteria: against the WHO's recommendation to consider best outcomes in the distribution of scarce medical resource, the program extended the benefit to even the most sick patients;

- c) siting of treatment facilities: in view of the principle of fairness, the program attempted to balance the distribution of treatment facilities to cover a wide proportion of the population, as well as reach those most in need; and
- d) priority to special groups: the ethical framework provided practical guidelines in balancing priority concerns between health workers who are most at risk and the sickest patients, and similar value disagreements.

Considerations of fairness were observed in the decision making process, given that several value disagreements were mitigated by through the “fair deliberative process”. The process allowed room for counter cases to be raised, and allowed initial decisions to be revised in the light of further evidence (Daniels, 2005).

Like the generic benchmarks, the “3 by 5” program also gave specific attention to some African countries, which were among the most affected by the HIV epidemic. However, the account of fair process in both the generic benchmarks and the “3 by 5” program did not give specific consideration to the socio-ethical contexts of the African countries included. For example, the socio-moral conception of what a special group is, or who should be given priority in the ARV treatment course, may differ between countries, say, the United Kingdom and Nigeria. Given the nature of family networks and dependencies in Nigeria, priority consideration would be made to persons with larger dependent family members, for instance. Yet such a consideration may not be relevant in the UK. The “3 by 5” program seems to overlook such varied ethical considerations in adopting a blanket approach. Despite this oversight, I will take it that generic benchmarks and the “3 by 5” program have significant benefits for health improvement and health care reforms in countries like Nigeria. Questions remain whether such intervention processes or reforms will not be even more effective where specific socio-ethical contexts of health care are considered.

3.6.0 Question on Method

Daniels’ ethical framework is presented as a practical tool to guide policy towards just designs and reforms in health care across the board. Hence, one would expect the

underlying methodological approach to match varying modes of moral evaluations wherever it is adopted. It is only appropriate to establish what this methodological underpinning is, and how it matches other forms of ethical analysis:

Our beliefs about the acceptable design of health systems should also have a bearing on what we think is just... health care... we should look to such “reflective equilibrium” between different levels of moral belief and practice as a source of justification in the ethics of health policy... (Daniels, 2008, p.243).

Nigeria’s socio-cultural context presents moral attributes and processes of ethical analysis that vary from those outlined in Daniels’ account. If an ethical framework is to be adopted, the methodological framework may require specific adjustments.

In designing the ethical framework of just health care, recourse is made to a philosophical method of investigation, reflective equilibrium, to establish coherence. It is important to consider how this approach will fit in an African socio-ethical context, like Nigeria. For example, the reasons for boycotting the polio vaccination programme in Nigeria have religious bases, and lacked substantive justification – in terms that process equilibrium will endorse. Also, the public protest against the Ebola vaccine trial in Ghana lacks a similar kind of evidence. The reasoning behind the three focal questions of just health care and the four conditions of AFR will refer to the justifications in both cases as incoherent. To see how this work in Daniels’ argument, I will briefly explain this philosophical method of investigation.

3.6.1 Reflective Equilibrium

The idea of reflective equilibrium is traceable to John Rawls, who applied it in his “Theory of Justice” (Rawls, 1999). However, much of the conceptual methodology was later developed by other scholars like Norman Daniels.

...reflective equilibrium consists in working back and forth among our considered judgements²⁵ (some say our “intuitions”) about particular instances or cases, the principles or rules that we believe govern them, and the theoretical consideration that we believe bear on accepting these considered judgements, principles, or rules, revising any of these elements wherever necessary in order to achieve an acceptable coherence among them. The method succeeds and we achieve reflective equilibrium when we arrive at an acceptable coherence among these beliefs. An acceptable coherence requires that our beliefs not only be consistent with each other, but that some of these beliefs provide support or provide a best explanation for others. (Daniels, 2011, p. 1-2).

As may be observed, the three focal questions are not only coherent, but also provide logical support for each other. For instance, we are able to establish that some health inequalities are unjust in view of how they limit opportunities of the affected individuals or population groups. Opportunity is highlighted by the state of wellbeing that health care seeks to preserve. The coherence in the first two questions leads to a third, which offers a pathway for just practices in health policy and interventions. In short, the first focal question establishes the imperative for pursuing justice in health care; the second reveals the complexity of pursuing justice in the practice of health care; while the third offers a third level analysis and outlines effective guidelines. Together, they respond to the questions – why, when, and how – of policy and interventions in health care.

Reflective equilibrium is a modest approach which thrives on the convergence of ideal and non-ideal approaches in bioethics (Arras, 2010). An ideal approach like *principlism* presents a top-down model of ethical analysis, where moral judgements are reached through normative precepts that cover such judgements, and proceed from theory to application (Beauchamp & Childress, 2009, p.99ff). The idea is that particular cases are

²⁵ “Considered judgements are those given when conditions are favourable to the exercise of our powers of reason and sense of justice: that is, under conditions where we seem to have the ability, the opportunity, and the desire to make a sound judgement; or at least we have no apparent interest in not doing so, the more familiar temptations being absent.” (Rawls, 2001, p.29)

treated by applying general ethical principles. In other words justified judgements about particular cases are deduced from already established and acceptable ethical principles or moral norms. On the other hand, the *case-based reasoning* method represents a non-ideal approach that derives from particular cases to make general judgements, using comparative case analysis (DeGrazia & Beauchamp 2001, p.39). It claims that justifiable moral judgements in health care can only be made if we have an intimate understanding of similar situations. This is an inductive process that derives general norms from particular case experiences in health care, and in time becomes a guiding principle for practice.

In bridging these two approaches, reflective equilibrium aims to harmonize obvious or subtle disparities among them, especially in how they influence health care decisions. For example, in terms of principlism, a patient's autonomy²⁶ is breached if the person's consent is not sought prior to a medical procedure; case-based reasoning will consider whether there were similar cases where such a procedure was undertaken without prior consent, and whether it was acceptable. However, reflective equilibrium will allow for an on-going re-evaluation of the situation and the circumstances around which the decision was made. Reflective equilibrium is holistic insofar as it emphasises the importance of disparate elements and fits them together in a satisfactory manner, finding justification through the coherence of all these elements (Arras, 2010). It appears to be a non-discriminatory approach that gives value considerations to all competing factors in determining what is right, good or just – such as in health policy or intervention processes - as these concern varying sets of beliefs and interests.

3.6.2 Reflective Equilibrium in African Ethical Contexts

Although reflective equilibrium is a widely recognised method of philosophical analysis, the success of an ethical framework designed against it will be determined by the relevant

²⁶ Respect for patient's autonomy implies acknowledging their rights to hold views, make choices and take actions about their health care, based on their personal values and beliefs; it goes beyond merely respectful attitude to involve respectful action. (Beauchamp and Childress, 2009, p.103)

socio-ethical environment. In most African social contexts, there may be fundamental value disagreements about the specific policy guidelines which are informed by reflective equilibrium. For example, the *palaver process*²⁷ underlies essential modes of discovering and justifying ethical norms in African contexts (Bujo, 2001). A relevant ethical approach should be consistent with this line of thought; for arguments about morality and reason cannot be successfully justified in detachment from actual ways of life and the social meanings embodied in the African communitarian world view (Coetzee, 2003, p.276):

We cannot, for example, understand Akan²⁸ beliefs about human rights without seeing how their conception is linked to their understanding of the relationship between the ontology of the human person and a system of entitlements... Nor... can we understand Akan belief about justice without first seeing their understanding of the relationship between practical reason and the social meaning of consensus. It is only within a system of agreements, making possible agreed actions without agreed notions, that rational questioning in moral and political traditions take place. (Coetzee, 2003, p.276).

Likewise, it may be untenable to consider applying Daniels' ethical framework to the Nigerian context without considering local ethical implications of health care. Fundamental problems may follow from an approach to health policy or intervention that overlooks the local modes of moral reasoning embedded in the local context and the relevant causal relationship between health care and justice.

3.7 Conclusion: Beyond the Opportunity Thesis

The idea of health as normal functioning with its link to opportunity constitutes a central thesis in Norman Daniels' account of just health care. That our health status bears on the opportunities available to us and that society has an obligation to protect these

²⁷ Detailed explanation of the *palaver process* is provided in chapter four.

²⁸ Akan is a dominant ethnic group in Ghana.

opportunities, makes health care worth protecting. The centrality of health care to opportunity emphasises the need for equity in its distribution. A fair procedure will ensure access to needed services or resources. Daniels' ethical approach provides a rationale for fairly distributing health care and designs a realistic framework to ensure fair process. Thus, the ethical framework of just health care offers guidelines towards just reforms and fair process in health care systems around the world:

Our characterization of a fair process must be general enough to apply in both developed and developing countries and in health systems with public, private, and mixed organizational forms, though, of course, details will have to fit the institutional context. (Daniels, 2008, p. 103-104).

The underlying opportunity thesis provides a defensible moral ground that impels a fair process in designing health policies and strategizing intervention plans, universally. However, the appeal to universal applicability appears to be too generic: it overlooks socio-ethical variance in regions around the world, especially where local modes of ethical evaluation may be fundamentally different from that sustained in "*Just Health*" (see Daniels, 2008). For instance, in social contexts that prioritise individual liberty, such as the United States, it is morally defensible to base the distribution of health care against individuals' right claims or considerations of individual opportunity. Yet in Nigeria, where a communitarian world view informs ethical evaluations, the welfare of communities may be prioritised in terms that include individuals.

Without discounting the significance of Daniels' generic approach, my contention is that local socio-ethical contexts should be considered in adopting the ethical framework. Rather than simply import the approach to Nigeria's health care system, for instance, considerations will be given to specific social and cultural conditions which were not anticipated in the original formulation. Hence, just health care will take the shape of the socio-ethical context, wherever it is adopted.

Insisting on universalising one ethical model for just health care reforms across the board tends to perpetuate the dominance of one moral worldview against several others in

different parts of the world. Such an approach may simply extend the current trend in bioethical theories, where specific societies' ideals are taken as universal principles, thereby minimising the significance of the varied social, cultural, and contextual factors, like social relationships and interactions, that shape moral precepts, attitudes and behaviour (Fox & Swazey, 2010, p.278). This:

...disparages the social and cultural differences that exist within and between societies, negates the importance of recognising and respecting *otherness* and the many ways of being in the world, and rather ironically mask what is particularist about bioethical thought by attributing universalism to some of the Western and specifically American culture patterns with which it is imprinted. (Fox & Swazey, 2010, p.278).

Nevertheless, the ethical approach as founded against the opportunity thesis should not be abandoned for an entirely new or opposing framework, in designing just health care reforms in Nigeria. If we insist on a strictly African ethical approach, without recourse to some universal principles in the current framework, we may forego some features that effective reforms will require in Nigeria. The ethical strategy then is to pursue an even-handed approach that accounts for the varied social and cultural conditions, as well as universal phenomena:

There can be no culturally and psychologically perspective ethics without taking account of the diversity of moral lives, but there can be no ethics at all without universals, allowing a means of trying to stand aside from particulars to make meaningful ethical assessments. (Callahan, 2000, p. 38).

A viable pathway towards just health care in Nigeria must consider both the African modes of moral explanations and relevant universal dynamics. Hence, without discounting the relevant universalist perspective, like the opportunity thesis, it will consider the specific ethical dynamics embedded in the Nigerian moral worldview and local approaches to justice. This may require substantiating the focal question and the resulting benchmarks with African moral values and ethical principles, especially those

that constitute the social meaning of consensus in health care. In order to understand how this will work in practice, the next chapter will explore the African moral world view and conception of justice. It will outline the essential moral attributes and basic principles of justice. The relevant approach for Nigeria will adapt these ethical attributes and principles of justice into the framework of just health care.

Chapter Four: African Moral Thought and Concept of Justice

4.1.0 Introduction

Norman Daniels' account of just health care (henceforth to be referred to as "ND Account") provides a useful tool towards effective reforms, and should be considered for Nigeria. However, questions arise regarding the conception of justice, as founded on the opportunity thesis, against which this ethical framework is established. The specifics in Nigeria's socio-ethical context of health care means that appeals to justice may not be defended against the ideals of individual liberty, as highlighted in the opportunity thesis. The Nigerian socio-cultural context emphasises community as opposed to individuality, and would favour the ideals of welfare rather than those of opportunity. Hence, an approach defended against the opportunity thesis may not be tenable towards developing just health care in Nigeria's context. We must look to one that is informed by the African moral world view, and which can be defended against the relevant conception(s) of justice.

In order to determine a viable ethical approach and its foundations, this chapter provides a comprehensive analysis of African moral thought from which it abstracts four fundamental attributes. Against this background, I consider specific African approaches to justice, from which I abstract three principles. Informed by the African moral worldview, African justice as it will be presented below should more appropriately shape the relevant ethical approach to just health care for Nigeria.

4.2.0 Four Pillars of African Moral Thought

The African communitarian worldview presents four key attributes worth exploring, namely: Ubuntu, notion of personhood, vitality, and the palaver or dialogic process²⁹ -

²⁹ For the rest of the thesis, the term "dialogic process" will be used to represent the African mode of deliberation; and "dialogue process" will mostly refer to Norman Daniels' description of the "fair deliberative process".

henceforth to be referred to as “the four pillars”. The four pillars also constitute the foundation for African moral thought from which ethical values and norms emerge. Where the ethical dynamics of African justice need to be established, recourse must be made to the four pillars as foundational. Co-extensively, the relevant ethical approach towards just health care in Nigeria will also need to hinge on the four pillars. It becomes imperative to understand the underlying features of African morality, as encapsulated in the four pillars, in order for a specific African approach to just health care to make sense.

Thus, rather than attempting to provide an explanation for the concept of African justice head-on, I will proceed by first presenting the background moral attributes of the African communitarian worldview. While providing the conceptual framework for African justice, exploring the four pillars will also clarify the subtle differences between Norman Daniels’ presentation of justice and the corresponding understanding in an African socio-ethical context. Although each of the four pillars addresses specific aspects of the African moral worldview, they work in harmony to constitute a specific African moral thought or ethic. Accordingly, Ubuntu describes the specifications of the socio-ethical context; the notion of personhood forms the background for creating or assigning meaning; vitality provides the conceptual framework; and the palaver or dialogic process provides the framework for realising the first three pillars in practice.

4.2.1 Ubuntu as Socio-ethical Context

Like every existential reality or societal feature, morality and ethics require a social space within which to be grounded, and against which they are abstracted. African justice, as will be described later in this chapter, also requires a socio-ethical space against which to be conceptualised and actualised. The moral environment ensures that the ideals of justice are realisable not only in principle, but also in the experiences of the relevant population. Ubuntu provides the social and moral space for conceptualising and actualising the Africa-specific approach to justice in health care.

Ubuntu represents the African understanding of communitarianism. Although the concept has been variously explored, the central thesis remains that “a person is a person through other persons” (Munyaka & Motlhabi, 2009). Simply put, this means that the

existence of an individual – his/her livelihood, activities, achievements, and burdens – is predicated on those of other individuals, who together share a common social space. Social relationships and interdependencies between persons are central features, so that individual self-understanding is embedded within a shared life with others. Mbiti (1990) articulates this embeddedness:

Only in terms of other people does the individual become conscious of his being, his own duties, his privileges and responsibilities towards himself and towards other people... What happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can only say, "I am because we are; and since we are, therefore I am". (p. 108 – 109).

Specifically, the process of self-understanding through others involves a person in various social and moral duties and commitments, plunging the individual into a moral universe that focuses on the wellbeing of others (Munyaka & Motlhabi, 2009). The socio-ethical milieu for this relational self-understanding is situated within the African communitarian structure, where values characterising the imperative for social relationships and interdependencies are emphasised (see Gyekye, 1996, p.35ff).

Thus, Ubuntu constitutes the socio-ethical space that sustains the kind of harmony envisioned in African cultural communities at various levels and in different circumstances. Community here does not necessarily refer to a physically locatable group of people who live together and share things in common, as is often found in rural African settings. A "cultural community" (Gyekye 1997, p. 44), refers to a group of people who have shared values and practices, where the natural sociability of the human being is recognised, and a sense of community is acknowledged as relevant to total well-being and full realization of the human potential. In view of the cultural community, the idea of Ubuntu:

...places emphasis on the activity and success of the wider society, not necessarily to the detriment of the individual, but rather to the well-being of every individual

member of society... [It] appreciates and espouses values that in African cultures are seen as essential to a human society of which membership is considered natural. (Gyekye, 1997, p. 36).

Nussbaum (2003) describes the idea of Ubuntu as:

...the capacity in African culture to express compassion, reciprocity, dignity, harmony and humanity in the interests of building and maintaining community with justice and mutual caring... [It] speaks of our interconnectedness, our common humanity and the responsibility to each other that flows from our deeply felt connection. (p. 2).

Therefore, against the contextual background of Ubuntu, where vital social interactions constitute the cultural community, an approach to justice in health care will require variously sharing the burden of ill health across the relevant community or society. For instance, the health care system will not create conditions whereby individual patients are left to pursue the course of their recovery alone. In keeping to such principles, the moral commitment of the health care system will be consistent with the people's mode of shared meaning, the aim of which is strengthening interconnectedness with others in balanced relationships – which good health enhances. Considering the Ebola case, for example, the relevant intervention will not only focus on providing care for sick persons or stopping the spread of the virus; it will also seek ways to restore the full capacities of the affected communities (economically, developmentally, and otherwise), against which the people's social life is sustained. Against this background ethically tenable health care reforms will be informed by the goal of harmony in the lives of individuals for whom health care is sought, as well as the communities in which they belong.

4.2.2 Personhood and the Assignment of Meanings

Once we are clear about the context of our analysis, the next logical step is to ask how meanings are created or construed in such contexts. Understanding the contexts alone only tells us what things are, but does not say why they are that way. We need to understand the dynamics of meaning in the understood context in order to appropriately

apply relevant values and principles to complex realities like health care. In health care, patients or persons affected are often in the best position to determine whether a medical procedure or intervention has worked for them or not. Likewise, in an African communitarian context, affected individuals and/or their communities would best determine what the kind of health care they get means to them. They stand at the vantage point of meaning that effectively determines what outcomes of a health care or intervention decision may count as just or fair. Thus, the relevant decision making process in an African context of health care needs to be guided by the pattern of meaning underlying the African moral worldview.

The notion of personhood is central to the assignment and construal of meanings in African moral thought. For while the African moral worldview emphasises harmony between three worlds – natural environment, human beings and the supernatural world – the human person is understood to be the focal point (see Tangwa, 2010, p.9-28; Mbiti, 1990, p. 74ff; Gyekye, 1996, p. 35ff). Therefore, justice in an African context of health care should be meaningful in the light of the notion of personhood.

4.2.2.1 *Dimensions of Personhood*

In light of the communitarian structure as shaped by Ubuntu, the individual person is viewed as always caught up in a web of process, which mainly involves a) building up social relationships, and b) developing one's moral character. Among the Akan of Ghana, as with many other African cultures, moral judgements or evaluations of individuals are made in reference to their character; how they have developed it over time or its inherent progressive development (Gyekye, 2010). One may be judged as being a "bad person" in view of his/or her bad character; and on this basis be considered as "not a person" (ibid). Similarly, Tangwa (2000) refers to the world view of the Nso tribe in Cameroon, where personhood represents the ascription of moral worth in an interconnected universe, as opposed to the freestanding singularity of the Western individual. To be considered not-a-person, as Gyekye notes above, does not literally mean that the individual does not exist. Rather it emphasises that the ascription of personhood is always a moral statement; and to be referred to as not a person is an inherent reference to the lack of moral worth.

In Nigeria for instance, one frequently hears the *Pidgin English* expression, “*you no be person sef*” – which simply translates as, you are not a person - mostly used when someone has been badly offended by another. The statement expresses the offended person’s withdrawal of moral worth from the offender. It is an indication that no reasonable social relationship can be built with such a person. Thus, the quality of an individual’s character is weighed against his/her web of social relationships, and the requirements may vary depending on their status within their various communities. For instance, the quality of character expected from the eldest child in a family may differ from that expected from the youngest:

It is a matter of common knowledge that when one speaks of the family in an African context one is referring, not to the nuclear family consisting merely of husband, wife, and children, but to the extended family, which comprises a large number of blood relatives who trace their descent from a common ancestor and who are held together by a sense of obligation to one another. (Gyekye, 1996, p.75).

Personhood in African moral thought is a fluid process, not predetermined by a fixed set of criteria. The dynamism of the notion of personhood is expressed in two ways, as noted above. Firstly, in developing moral character, one needs to sustain the social relationships by which s/he is bound to others. The network of relationships is first established through kinship, situating the individual in a web of the wider family setting. Whereas not everyone in a given community may be related through kinship, the existing network of relationships has wider societal implications. For instance, it is common practice in Nigeria for a person to refer to his wife’s parents or relatives as family; also, one’s siblings would refer to his/her spouse’s family as family, to whom they have certain obligations. The activity (e.g. marriage) of one individual is capable of reshaping the entire web of relationships, and vice versa. Every individual is constantly involved in making and reshaping the nature of these social relationships, and a person’s life evolves with every change in the communitarian structure. The self-understanding of the individual person is thus construed in these terms:

I only become fully human to the extent that I am included in relationship with others. So I must see myself as a process of becoming a person. It is not just that I change and grow. I am being built up, constructed. (Shutte, 2009, p.92).

Secondly, the process of becoming a person has moral implications, given the consideration of character or virtue against which personhood is granted: it “implies that the pursuit or practice of moral virtue is intrinsic to the conception of person held in African thought” (Gyekye, 1997, p. 50). Tangwa (2000) adds that the African notion of personhood is appropriately understood in terms of the ascription of moral worth; and applying to the human being in all its possible conditions, it differs from the Western perception defined in term of self-consciousness, rationality, freedom and self-determination. Therefore, it can be said that “a person is his character, or more definitively she is her practice-in-relationship as a result of her character” (Mkhize, 2008, p.39). In view of the moral dimension, personhood is not simply given to an individual for being a physically existing entity; rather, it is developed through consistent and conscious effort or practice in relationship with others-in-community (Menkiti, 1984); as if to re-echo Aristotle’s claim:

Moral virtue, like the arts, is acquired by repetition of the corresponding acts... none of the moral virtues arise in us by nature; for nothing that exists by nature can form a habit contrary to its nature (Brown ed., 2009, p.23).

Thus, personhood “...is the process of becoming an ethical human being... by which balance or the orderedness of being is affirmed” (Mkhize, 2008, p.35), which an individual constantly seeks and attempts to sustain. A person, in African moral thought, never *is*, but is always *becoming*. Being a person is not a static experience, but a continuum; and one’s self-understanding as person is always a moral statement.

4.2.2.2 Personhood and Meaning in Health Care

The fluid notion of personhood by which meaning is assigned to other existential realities, has some implications for health care. Specifically, it will require that the decision making

process accounts for the kind of continuum underlying the web of social relationships and character development in the context of health care. For example, we cannot simply embark on a mass polio vaccination or a large scale Ebola vaccine trial without considering how the decision is consistent with the self-understanding of the persons involved, by which moral legitimacy is granted to the process; or how such decisions are informed by the social process of personhood, which involves the communities around the individual persons involved. Against this background, decision making will require particular health care policies or interventions to be equally fluid and in continuum, so that they are effectively shaped by the relevant population's mode of meaning. This will in effect require wider acceptability of policy implementation strategies or the planned intervention, among the affected population or groups.

The common knowledge that vaccines improve health against infectious disease is logical enough to persuade communities to accept polio vaccines, for instance. However, it does not constitute a sufficient ground for a conclusive decision about a universal vaccination or trial program. The decision making process about such campaigns needs to be legitimised against the population's modes of moral evaluation. Hence, the effectiveness of such programs lies not simply in the verifiable facts about the vaccines, but also in the moral implications for the affected communities. The polio boycott in Nigeria and the public protest over the Ebola vaccine trial in Ghana provide evidence of how local meanings determine the effectiveness or success of health policies or programs. The modes of meaning or self-understanding amongst the population bear on their understanding of health, the kind of health care they would expect to receive, and the extent to which they may consider the entire process just or legitimate.

4.2.3 Vitality as Conceptual Frame of Reference

The notion of *person as a continuum*, whether in terms of social relationships or moral character, suggests the presence of inherent vital connections underlying the African communitarian moral worldview. The kind of obligations towards family members to which one is bound has implications beyond mere social interaction; it is deeply seated in one's self-understanding. Also, the understanding of health and health care in terms of

harmony with other existential features³⁰ reflects the vital links in our shared interaction as humans, as well as with other features in our environment. For example, obesity, acute malnutrition or anorexia, being food related health conditions, are essentially a factor of disharmony in one's relationship with food. In the case of obesity, there is an excessive flow of life or energy from the natural environment into the individual, in view of over-indulgence in food; the reverse being the case with acute malnutrition or anorexia. Maintaining a balance or harmony in our relationship with food (or the relevant flow of energy), as well as with other physical and existential features of our environment is thus required to maintain a healthy life. Hence:

Within the African outlook, human beings tend to be more humble and more cautious, more mistrustful and unsure of human knowledge and capabilities, more conciliatory and respectful of other people, plants, animals, inanimate things, as well as sundry invisible/intangible forces, more timorous with wantonly tampering with nature, in short, more disposed towards an attitude of *live and let live*. (Tangwa, 2010, p.57).

In the African communitarian worldview, vitality refers to the creative life force within the cosmos, which initiates and sustains interaction among the various elements of the natural, social and existential components. The individual person is thus presented as a living "force" existing not by itself, but in ontological relationship with other living beings and inanimate forces around him/her; and there is a constant flow of this force or energy between individual persons and other elements within the cosmos (see Tangwa, 1996; Tempels, 1952, Chap. 5). The *force thesis* recognises two realms of existence, the visible and invisible, both of which are independent realities, yet are inherently linked to form a "community of interacting forces" (Imafidon, 2014, p.38-42). The vital interaction of forces means that the human person's life force can be strengthened or weakened, and

³⁰ The African view of health and illness is explored in greater detail in chapter five (see section 5.2.2).

one would need to take the necessary action to avoid diminution of vitality (Tempels, 1952, p.99-103). This:

...reality or nature is a continuum and a harmonious composite of various elements and forces. Human beings are a harmonious part of this composite reality, which is fundamentally, a set of mobile life forces. Natural forces and reality are interlocking forces. Reality always seeks to maintain an equilibrium among the network of elements and life forces... there is no conceptual... gap between the human self, community, the dead, spiritual or metaphysical entities and the phenomenal world. They are interrelated, they interact... (Ikuenobe (2006, p. 63-64).

Therefore, the conceptual frame of reference in African communitarian settings is situated within the continuum of interaction among the various natural, social and existential features of the community. The individual person, community, and unfolding life events are all understood against this background. As will be shown in chapter five, health in African terms is also conceptualised against the background of the harmony of forces; between the individual person and other forces within the environment. Consider a situation where people in a given country or city fall sick because of environmental pollution. Notwithstanding the empirical explanation of their condition, one fact remains: their ill-health is a physical manifestation of the deep-seated wrongness or disharmony in the environmental structure. There is an inordinate interaction between the life force of the human community and that of the environment. In order to restore health and well-being to the affected community, we must restore the balance to the environmental structure, which in turn ensures a proportionate interaction of forces between the human and environmental communities. And to achieve this, the human community needs to enter into a form of dialogue with the existential community (the environment in this case). This perhaps explains the underlying motivation or rationale for the global “green” campaign. Hence, a relevant approach to just health care should not overlook this vital interconnectedness, especially in decision making for policies or interventions.

In health care decision making, a just process will consider as significant the kind of harmony sought through proportionate interaction within the human community, as well as with the existential communities. Against this background, the goal of health care will be to restore not only the physical condition of persons, but also the balance of their vitality within their social network and with those of other interacting forces. Therefore, in regard to health policy decisions or intervention strategies, we do not dwell simply on the conditions of individual persons (i.e. in isolation), but always in relation to those of others with whom they share vital relationships, as well as the surrounding physical, socio-economic, and existential environments.

4.2.4 Palaver as Essence of Dialogic Process

The interactive socio-ethical context, the fluid nature of personhood and the web of forces, against which health is conceptualised (see section 5.2.2), together influence attitudes towards and determine the kind of or extent to which health care services may be sought. They further determine the effectiveness of relevant policies or interventions in the face of desperate health conditions, such as those posed by infectious diseases in communities. The fluid nature of health care contexts, whether in general clinical practice or in the face of public health emergencies, may require an ethical approach that is equally fluid or consistent with any given context, to inform effective reforms, policies or interventions. The mode of decision making, as described in the African *Palaver Process*, against which ethical norms are established, presents a potential to inform health care decision making in ways that are acceptable to the relevant population.

4.2.4.1 *The Palaver Process*

In its common usage, “palaver” often refers to a prolonged or tedious fuss or discussion that may be unnecessarily lengthy. However, in African understanding, it refers to a kind of improvised conference between two sides that is often employed in addressing important issues within the family or community. In the African understanding, palaver represents a kind of dialogic process by which decisions about important issues affecting the community are made: it is “...by no means superfluous talk or useless negotiation, but the efficient institutionalisation of communicative action” (Bujo, 2009, p.122). The

palaver process is observable in various forms in contemporary African settings, even in urban places. For instance, in Nigeria, “community meeting”, “village meeting” or “town’s meeting” are common terms used to refer to such dialogic processes, depending on where they take place. In small villages, such meetings could involve the whole community in the dialogic process; and in bigger towns or urban settings, they may involve suburbs or other group identities with shared cultural or other interests. Whatever form it takes, the palaver or dialogic process has one aim: to represent the common mind of the group, especially in the face of a shared problem or in aiming to take a common course of action.

In South Africa, *Indaba* is the Zulu term for the dialogic or palaver process; it simply translates as a gathering for purposeful discussion, which describes the traditional meeting for discussing important matters affecting the community:

Underlying such discussion is the conviction that the community has a common mind, a common heart. The purpose of discussion is to discover that common mind... in relation to the specific issue being discussed... the goal of *indaba* is consensus. A mere majority vote on the issue is not enough. Discussion must continue until unanimity is achieved, a really common mind and heart. This is the only adequate sign that the truth of the matter has been discovered... [The unanimity] builds up the community... intensifying the spirit of solidarity of its members. (Shutte, 2009, p. 95).

In practise, *indaba* was employed in the process leading to, as well as the actual process of the Truth and Reconciliation Commission (TRC) in post-apartheid South Africa. The dialogic process was also employed in the Gacaca Courts’ proceedings in Rwanda, in a bid to not simply punish persons accused of having taken part in the 1994 genocide, but also to restore a harmonious Rwandan society³¹.

³¹ Further detail about the TRC and Gacaca are discussed later in this chapter (see section 4.3.4).

Nigeria held a Sovereign National Conference in 2014, which brought together around 500 representatives (including elder statesmen, serving and retired civil servants, traditional rulers, religious leaders, various social groups and unions, among others) from different parts of the country to an open-ended dialogue about the varied problems facing the nation (OpenMind Foundation, 2015). It sought to discuss the problems from the varied perspectives of different ethnic, religious, social and civil groups in the country and to offer recommendations that will help in constitutional reforms (ibid). The initiative can be said to draw from the traditional “supra-familial palaver” (see below) in attempting to address issues of national concern. The point is that, like in both the TRC and the Gacaca Courts, a form of palaver or dialogic process consistent with African communitarian values was adopted to provide some guidance to policy, as well to the constitutional government. And like the traditional “village meeting”, it took the form of an open-ended process, leaving issues to be discussed, as well as relevant recommendations, to emerge from the process. The palaver process is thus a recognised and acceptable mode of decision making, not only in traditional settings, but also for addressing important issues in contemporary African contexts.

According to Bujo (2001, p.45), the *palaver process* is the mode of discovering and justifying ethical norms in African ethics, through an ongoing discourse among members of the community at various levels. The palaver process involves a back-and-forth conversation at various levels of the community, beginning with the household (small family) to the supra-familial or community level, and through this, both domestic and community norms are founded, elaborated and reinforced (see Bujo, 2001, p.46-54). At the family level, the process shapes family values, as is evident in the resolution of a variety of issues affecting families, such as in the sharing of inherited properties, and appointment or removal of responsibilities in certain areas. This contributes towards the family’s moral growth in many respects and gives it a vital dynamism. The supra-familial or administrative palaver addresses issues involving different families or affecting the wider community/society:

Apart from those immediately concerned, the participants in this palaver meeting are the members of the village or regional council of elders, who are delegated by the various communities to be counsellors... All who can make valuable contributions to the resolution of the problem are admitted to this meeting too and have the right to join in the consultation. (Bujo, 2001, p. 51).

The engaging conversation at community level yields ethical norms that shape the society's moral worldview, and which the people would accept as a favoured mode of moral judgements or ethical evaluations. The mode of proceedings in the supra-familial palaver can be seen in the TRC, and Gacaca Courts, as well as in Nigeria's Sovereign National Conference. The open-endedness of the palaver process thus provides a platform for actualising the conceptual dynamics of communitarian harmony in decision making for health care.

4.2.4.2 *The Palaver Process versus Simple Deliberative Process*

The palaver process appears to be like the approach described in *discourse ethics*, which is largely credited to Juergen Habermas (see Habermas, Lenhardt & Nicholse, 1990; Bujo 2001, p.54-63); yet it remains distinct from it. On one hand, discourse ethics emphasises logical conclusions from ensuing arguments, allowing only persons capable of a certain level of logical reasoning to participate. Palaver process, on the other, allows a broader range of participants, "...since it speaks not only of *every subject who is capable of speech and action*, but simply of *everyone*" (Bujo, 2001, p. 55). The palaver process proceeds not by means of logical argumentation, but of dialogue; the mode of argumentation is not aimed at logically consistent conclusions, but is undertaken for the sake of communicative action through varied communal interaction (ibid). To explain the dynamics of the palaver or dialogic process more simply, a reference to Nussbaum's description of her experience may suffice:

I recall being the only white person working in an NGO in Zimbabwe in the late 1980s. Matanga, a colleague, and I disagreed about an issue and after discussing it for an hour or two, I said, "Matanga, can't we agree to disagree?" He said, "No *sisi*

(sister) Barbs, we have to sit and talk until we agree.” I have never forgotten this conversation, since it illustrates a value base that stresses cooperation, the desire for reconciliation and communication in the interest not only of harmony but a shared understanding. (Nussbaum, 2003, p. 5).

Matanga’s point, which Nussbaum appears to miss, is that discourse in an African moral sphere has a specific methodological process, which should culminate in a harmonious consensus between the parties involved. Although the process may appear to be unnecessarily long and tedious, and without specific criteria for reaching an agreement, a sense of unanimity is sought through it. Attainment of that point of equilibrium or harmony signals the end of the process; precisely the point Nussbaum missed when she opted for a more logical or Habermasian approach of “agree to disagree”. From this view, therefore, moral consensus is not simply knowing or understanding the other’s viewpoints logically, but also essentially sharing in them. The essence of the palaver process is a kind of consensus that derives from a shared meaning with or among relevant parties, so that all may accept outcomes or ensuing decisions, not always for their own sake, but also for those of others.

4.2.4.3 *Palaver Process and Health Care*

In health care decision making (especially towards policy formulation and health care interventions), the dialogic process will constitute a kind of deliberation that takes seriously not only the views of policy makers or major health providers, like pharmaceutical corporations, but also those of the “common people” who are at the receiving end of health care. This implies that in making important decisions about health care the common people will have equal bargaining powers to other stakeholders involved in the process. The common people (as compared to the policy makers or other significant stakeholders) may lack coherent knowledge about the wider implications of the situation and what decisions may have “universal” benefits; yet they provide valuable insights into their own specific context. Their views, however inconsistent, will constitute an important consideration not only for their personal wellbeing, but also for the successful implementation of health care policies or interventions.

Consider the public protest against the Ebola vaccine trial in Ghana, which also instigated a wide reaction from people across the globe. Many people expressed disappointment, through social media, about Ghanaians' lack of moral will towards resolving an African health crisis. The process leading to the vaccine trial had sufficient scientific evidence, and was endorsed by the ethical proceedings of the WHO amidst sound scholarly guidance (Sayburn, 2014; Rid & Emmanuel, 2014; Kass, 2014; WHO, 2014c). For instance, the WHO panel of ethicists insist that ethical considerations must guide the use of experimental Ebola vaccines and treatments, where efficacy and safety has not been established (Sayburn, 2014). Such considerations include: "transparency about all aspects of care, informed consent, freedom of choice, confidentiality, respect for persons, preservation of dignity and involvement of the community" (Sayburn, 2014). In view of the Ghanaian case, the ethical guidelines against which the process was initiated concentrated on the overwhelming scientific evidence about the efficacy of the drugs, without giving appropriate consideration to specific objections that may arise from the local populations (see below). Hence, the decision to initiate the trial process in Ghana, while observing internationally set ethical guidelines, overlooked the local ethical considerations of the population regarding the implications for their communities.

There is no rationale that the Ghanaian population, especially the earmarked communities, should accept the outcomes of a decision making process about a medical intervention that involves them, to which they have made no significant contribution – in a similar sense that the pharmaceutical corporation responsible for administering the trial drugs have. Although the Ebola epidemic specifically affected African countries, it is a global crisis, given that the virus has a high tendency to migrate across continental boundaries. The Ghanaian protest was motivated by a moral imperative towards the welfare of the concerned communities. This was consolidated by the underlying suspicion that they were being used as international guinea-pigs, and the fact that no Ebola case had been declared in the country (see Aljazeera, 2015). For instance, the Ebola vaccine trial in Guinea (one of the affected countries) has been criticised for not protecting participants against side effects of the drugs, and also potentially exposing them to infection at Ebola holding centres (Shuchman, 2015). If the decision to undertake

the vaccine trial in Ghana had adopted a form of dialogic process that engaged the local communities' modes of ethical analysis and moral judgements, the trials may well have been accepted by the population.

Therefore, in order for health care decisions to be considered ethically just and acceptable to the relevant community or population group, it must resonate with their mode of moral judgement and ethical analysis. In this case, the decision making needs to adhere to the dialogic process, as informed by the African moral framework. Only in this form will ensuing policies, interventions or other plans become acceptable as just or fair to the population or communities they are meant to serve.

4.3.0 African Conceptions of Justice

The mode of meaning or analysis underlying the agitations against the various health care decisions described above, is entrenched in a specific African understanding of justice: it requires the involvement of the relevant communities in equal capacities as other major stakeholders through the decision making process. Such a process will entail engaging in a form of open-ended discourse with the communities or population groups; open-ended in the sense that the process itself is informed by the people's view about the situation (ethical and otherwise), and what they wish for or how they hope to benefit from it. The palaver or dialogic³² process should lead to a point where all parties have sufficient appreciation of the situation and the potential effect of the policy or intervention being considered. At this point the palaver process reaches equilibrium, and a just conclusion has been attained. The underlying process and equilibrium reached constitute a litmus-test for determining what should count as just or fair in the decision making process, and which health care policies or interventions should be ethically acceptable to local communities or relevant population groups.

³² Henceforth, I will use the terms "palaver" and "dialogic" interchangeably.

4.3.1 Socio-Cultural Backgrounds of Justice

Since Africa is geographically vast and culturally diverse, describing an African conception of justice would raise questions about endorsement across the board. In order to address this concern, a brief exploration of the notion of justice as variously understood in three different parts of the continent – West, East, and Southern Africa – will be helpful. These may still not fully represent the variety of socio-ethical understandings of justice across the continent. While the first and second examples are drawn specifically from West and East Africa, the third example cuts through Central and Southern Africa. However, we can abstract common features that satisfactorily represent an African conception of justice. Harmonising these three notions will present a coherent outlook of what justice should mean within an African socio-ethical framework. This conceptual outlook will be substantiated with examples of how the African account of justice has been used to resolve local problems in various countries. The nature of coherence among these justice processes will sustain the claim for an African conception of justice in this chapter. The three considerations will define an African paradigm or model of justice that may represent a notion traceable in practice across the Sub-Saharan Africa region.

My analysis here presents an African outlook of restorative justice, which is often considered a viable alternative to punitive justice (Daly, 2002); yet, my aim in this thesis is to provide an African account of distributive justice for health care, against the standard framework already provided by Norman Daniels. There will be questions about the feasibility of integrating or converting a restorative approach with/into a distributive account of justice for an African context of health care. In light of the African moral framework, punitive or restorative accounts of justice are simply two different representations of the same thing; they are both practical applications of the same concept or set of ideals. Hence, the exploration herein looks to the abstract content of justice in the African ethical milieu, from which restorative, punitive or distributive applications are derived. My aim is thus to investigate the ethical basis of an African model of justice, extract the basic principles, and determine the underlying methodology. These should guide the formulation of a distributive theory and a relevant methodology

that will shape an ethical approach towards just health care in Nigeria. I will now turn to the notion of justice as variously expressed in different socio-cultural settings within the sub-continent.

4.3.2 Justice in Igbo Culture

Among the Igbo people of Nigeria, justice has traditionally been conceived in terms of “*akankwumoto*”, which literally means the hand that keeps straight, and denotes an uprightness of conduct (Oraegbunam, 2010, p.56-57). This implies a straightforward, upright, honest, predictable and impartial life; it reflects the Igbo understanding of a just act as one that is not crooked, but performed as it should, unequivocally. The notion derives from the traditional process involved in the division of land among kinsmen³³, where a person considered to be the most straightforward and honest is chosen to share the land equally or in accordance with the laid out rules; and has subsequently evolved to mean conformity with the ideals of a right/good action or attitude (Oraegbunam, 2010, p.57-59).

According to Otakpo (2009, p.29), the Igbo notion of justice is founded against a background of “*Omenani*”, which represents a cluster concept that embraces morality, laws, customs and traditions, and basic conceptions about nature, society and life. *Omenani* refers to “...that which is done in the land”, and constitutes the means by which the community ensures conformity with the right order of things. The Igbo notion of justice thus constitutes a virtue of righteousness, not only of individuals in their interaction with others, but also in addressing the community’s concerns. Since *omenani* constitutes a binding principle towards communal obligations, justice so construed is viewed in practice as the web of the Igbo society – in accordance with the proverb, “when the nose is affected, the eyes weep” (Otakpo, 2009, p.38). The proverb, which shows the literal connection of the eyes to the nose, indicates the essential link between all members of the same community, which is sustained through just or good acts. Accordingly, the

³³ Kinsmen refers to a group of persons belonging to the same kinship (see explanation of kinship in section 2.2.2).

absence of *omenani* will imply a disruption of the communitarian network and truncate the essential relationships that sustain the Igbo community.

In view of the uprightness constituting Igbo justice, *truth* is emphasised as a primordial commitment in sustaining a just community or determining a just procedure; as expressed by the proverb, “*eziokwu bun du... truth is life*” (Otakpo, 2009, p.50). Since justice is the web sustaining the communitarian structure, and truth is fundamental to justice, truth becomes the lifeline for just persons, community or procedure, which in turn sustains balance in essential relationships. The place of truth in the Igbo conception of justice makes *oath-taking* important, as it helps to maintain a balance in what the community can accept, by establishing the truth that leads to justice (Otakpo, 2009; Oraegbunam, 2010). It serves as a reminder that one’s conduct affects the life of the community, and that truth must be sustained for justice to be guaranteed.

In light of the four pillars, one sees that the ontology of the Igbo notion of justice is informed by the moral dimension of personhood (see section 5.2.2.1), where character is a notable feature. For instance, one who is considered to be of bad character will not be endorsed or given the privilege to share the land; his/her character implies an inherent incapacity to execute justice in the distribution process. The consideration of character means that one who is given such responsibility is trusted to be considerate of the well-being of others. Such a person is believed to have a self-understanding of a shared life with others in the community – resonating with the primordial feature of Ubuntu.

The just person thus follows a set of procedures endorsed by the community or family (as the case may be) in adjudicating the piece of land entrusted to him/her. Where there is disagreement about the shares, a redistribution may be considered. Therefore, justice also observes the kind of open-endedness described in the dialogic process. For the person is also aware that the *sharing* responsibility further defines or affirms their existence in relations to other members of the community. The Igbo concept of justice has a distributive principle or effect, which is transferable to other expressions of justice.

4.3.3 Justice in Gikuyu Traditional Morality

Across the geographical landscape from the west to the east of Africa, the Gikuyu in Kenya have a notion of justice that is similar in many respects to the Igbo conception. However, unlike the Igbo notion which derives from a distributive principle, the Gikuyu concept proceeds from the astuteness or quality of the moral character. The idea of justice for the Gikuyu culture derives from the term “*kihooto*”, which literally means “to defeat” or “to convince morally” (Kinoti, 2010, p.128). The art of defeating or convincing is a process whereby a person continuously persuades others about objections raised regarding their character, until no further objection can be raised – or equilibrium is reached in the process (ibid). The criticism of a person’s moral character may not be specific only to the Gikuyu, as claims could also be made for similar kinds of persuasions among other cultures across the world. However, the peculiar aspect of the Gikuyu is that personal character is used as the reference point for conceptualising justice. For instance, *Kihooto* specifically refers to a person’s sense of right and wrong, reasonableness or fairness in reference to the community in which he/she belongs:

...the ideas concern community life and the rights, privileges and responsibilities of the individuals who constitute that community... [and] the forces believed to be at work in the community... People demonstrate justice by subscribing to those attitudes and modes of conduct that are... reasonable ways of achieving prosperity, social harmony, goodwill and peace. (Kinoti, 2010, p.130).

Therefore, *Kihoto*, justice refers to “*the reasonable order of things*” as determined by the community and continually endorsed by its members (ibid, 138). And since “justice” is the closest English equivalent of *kihooto*, the Gikuyu’s definition of justice will simply be: action, attitude, mode or way of being that accords with the reasonable order of things. The notion of *the reasonable order of things* reflects the continuum of equilibrium or balance in the Gikuyu community, and is consistent with the vitality attribute of African moral thought. For instance, if one takes another’s share of family inheritance, the action, being outside of the *reasonable order of things*, will disrupt the balance in that family’s web of relationship. The further consequence will be a disruption of the community’s

harmonious existence. The African moral attribute of vitality is thus effective in the Gikuyu notion of justice. This is in some way similar to the Igbo conception, where righteous conduct, according to the stipulated norms, customs and tradition, is emphasised.

Three key features of the Gikuyu understanding of justice include truth (*ma*), defeat (*hoota*), and uprightness (*uthingu*), all of which have the underlying outcome or expectation of *contentment* and/or *restoration* (Kinoti, 2010, p.128-164). *Ma* refers to proof or truthfulness, as opposed to any kind of falsehood, such as lies, hypocrisy and deception; it is employed in dispute resolution or in the light of a questionable action or character (ibid). The emphasis on truth calls for trustworthiness among individuals within the community: “the moral quality of trustworthiness is therefore essential in enabling justice...” (Kinoti, 2010, p.136). This is similar to the moral character attributable to the just person in Igbo culture, as described above, who could be trusted with the responsibility of sharing property.

In terms of *hoota*, the Gikuyu describe justice as the weapon by which one defeats a critic in morally convincing others about the nature of the situation (Kinoti, 2010, p.137). This understanding of justice is appealed to especially in resolving conflict between two parties, and requires other moral qualities like wisdom, honesty and patience. Finally, as *uthingu*, justice refers to the state of uprightness of a person or the community’s process of judgement; it speaks of the sense of moral maturity that is required among individuals in order to sustain harmonious relationships within the community (Kinoti, 2010, p.144).

Contentment constitutes an essential background against which the justice process is attained among the Gikuyu; it is also an expected outcome. Upright or just persons are said to be content with their state/status in life, making contentment a valued state of mind that contributes to the course of justice within the community (Kinoti, 2010, p.145-147). Where the distribution of goods is concerned, justice will be considered to be served if the process and/or the outcome leads to a sense of contentment for affected individuals as well as the community, even if they are not entirely favourable.

Finally, restoration is the end for which justice is sought, in the Gikuyu understanding:

Justice functions to promote peace, unity and goodwill in the local community. Punishment and reward are part of justice. But forgiveness and atonement are also part of *kihooto* (reasonable order of things). Justice allows for forgiveness even when punishment is deserved... [It is] therefore reasonable that forgiveness and reconciliation should be available... Nevertheless, the Gikuyu [do] not believe in forgiveness '*just like that*', that is, without some cost to the offender... The reasonable order of things appears to have been that the individual should not suffer from evil that was not confessed. (Kinoti, 2010, p. 161-162)

The phrase, "just like that", is also a common expression in Nigeria which often means that a wrong action requires some kind of atonement, or rewards or honour should be given to one who is deserving. To cite an example: you cannot become a chief just like that; i.e. you must earn the title by merit, or according the required customary stipulations. That brings us to the second aspect, about confessing evil. Customarily, even among many cultures in Nigeria, confession is an important first step toward the adjudication of justice. Where a confession is made, the course of justice proceeds with the restoration process; i.e. to begin the re-integration of the offender into the community. For example, following the situation where one takes another's share of family inheritance, there are prescribed processes of atonement by which he/she seeks to be restored to the family. Restoring the family relationship does justice to both the offender and the offended person: to the offender, by restoring his/her place within the family; and to the latter by securing their privileges within the family. Hence, restoration is an essential aim of the justice process.

Truth, defeat, uprightness, contentment and restoration variously emerge through different processes within the community. The process is affirmed once balance is attained. The Gikuyu notion of justice is thus encapsulated in the continuum of process, and justice is served once there is equilibrium in the process. Underlying these principles is the life force of the community that needs to be kept in harmony, which ensures that everyone enjoys their rights and privileges as members. Unlike the Igbo notion, where

moral personhood is emphasised, the Gikuyu conception appeals more to the African moral attributes of vital force and harmony.

4.3.4 Ubuntu Justice

Justice in the light of Ubuntu follows the truth-contentment-restoration pattern. The ideals of Ubuntu, as described earlier, are traceable among the Bantu cultures spread across central, east and southern African regions (see Kamwangamalu, 1999, p.25).), the Ubuntu understanding of justice envisions balance and harmony as central; it demands a restoration of the desired state of the community's existence by reversing the dehumanizing consequences of an unjust act (Ramose, 2001). Since such reversal may not always be practicable, given the irreversibility of the effects of some acts, Ubuntu justice does not insist on an actual or absolute reversal of a situation, which may result in reverse injustice with further harmful consequences to the community. A story is told of a woman whose uncle had participated in the killing of her husband and children for being of another tribe, in the Rwandan genocide. During the post-genocide reconciliatory justice process, she invited him to her home for a meal, after he had publicly confessed his involvement and pleaded for forgiveness. For the woman, retributive justice, i.e. killing the man, would not do her justice – she had seen enough deaths in her family, and he was the only family she had left. Justice for her meant a restoration of her emotional state of grief, as enhanced by the uncle's public confession. It also meant the restoration of a lost harmony in the essential relationship within her family, of which the "guilty" man remains an important part.

As in the Gikuyu notion, the man was not forgiven "just like that"; he had to perform some acts of reparation as prescribed by the community as well as the tribunal. The Ubuntu notion of justice demands that restitution and reparations are due to affected persons, their families, or the community that may have been affected by an unjust act or proceeding (Ramose, 2001). A significant aspect of this event is that Ubuntu justice was served not only in restoring the woman's emotional harmony disrupted by grief, but also in absolving her uncle from the weight of guilt that may have caused disharmony in his life, and re-integrating him into the community. Ubuntu justice is thus a reciprocal

process that involves not only individuals, but also their wider network of relationships within the community, constantly seeking to maintain balance or equilibrium within the social framework. Against this background, Tutu (1999) affirms:

...the central concern is not retribution or punishment but, in the spirit of Ubuntu, the healing of breaches, the redressing of imbalances, the restoration of broken relationships. This kind of justice seeks to rehabilitate both the victim and the perpetrator, who should be given the opportunity to be reintegrated into the community he or she has injured by his or her offence... [It] sees the offence as something that has happened to people and whose consequence is a rupture of relationships... justice, restorative justice, is being served when efforts are being made to work for healing, for forgiveness and for reconciliation. (p. 51-52).

Thus, Ubuntu justice refers to the continuous process of maintaining harmony or equilibrium in a community or society. It is highlighted by establishing the truth of a situation, the contentment of the parties involved, and the restoration of individuals and communities through reparation, forgiveness, and reconciliation. The place of truth, contentment and restoration in the Ubuntu notion of justice is affirmed where equilibrium has been attained in the process. In view of the African moral framework, therefore, Ubuntu justices emphasises the attribute of essential relationships within the community as the foundation and aim of justice. Since the aim of Ubuntu justice is the restoration of harmonious relationships, the African dialogic process becomes central to achieving justice.

4.3.5 African Justice in Practice

In practice, the underlying framework of the three notions of justice considered above have found expression in two historical proceedings within the African continent, namely: the TRC in South Africa, and Gacaca Courts in Rwanda. During the two proceedings, victims variously recounted their experiences, and perpetrators acknowledged, corrected or recounted the extent of their involvements. The processes continued until some equilibrium was attained in the dialogic process; and the balance of truth, contentment and restoration was key in determining how and/or when

equilibrium was attained in the justice process. The TRC and Gacaca Courts were meant to effectively resolve raging conflict within the countries' social frameworks, and hence may not be considered to effectively address issues of distributive justice, which is the focus of just health care. Notwithstanding their specific nature however, they clarify how the identified principles of African justice operate in practice, and reveal the underlying methodological approach. Having proved the practicability of African justice, both processes are relevant to a distributive theory that will inform an African ethical approach to just health care.

The TRC was set up during South Africa's post-apartheid era, as a dual process: to bring about justice to the victims of apartheid, and to restore harmony to South African society, through a back-and-forth conversation between victims and perpetrators in the presence of other community members (Tutu, 1999, p.32-60). It steered a middle path between an uncompromising insistence on prosecution and the acceptance of amnesty, and aimed to restore moral equilibrium to South Africa's amnesty process (van Zyl, 1999, p.648). The TRC's main objectives were:

To establish as complete a picture as possible of the causes, nature and extent of gross violations of human right... the fate and whereabouts of victims... [And] to assist in restoring the dignity of victims by affording them the opportunity to testify about the violation of their rights or death of their loved ones. (van Zyl, 1999, p. 654).

Accordingly, the proceedings of the TRC primarily aimed to establish the truth of the situation, and to restore dignity to victims and wholeness to the South African community. It:

"...emphasized reconciliation between perpetrators and victims, built ideally on a perpetrator's repentance and a victim's forgiveness. Ultimately, it was hoped, the South African nation as a whole would likewise become reconciled." (Graybill & Lanegran, 2004, p. 6).

The Gacaca Courts in Rwanda followed a similar process to the TRC to address the atrocities committed during the 1994 genocide, and ultimately to restore the divided Rwandan society. The aim of the Gacaca tribunals was both daunting and inspiring: “Punish *genocidaires*, release the innocent, provide reparations, establish the truth, promote reconciliation between the Hutu and the Tutsi, and heal a nation torn apart by genocide and civil war in 1994” (Rettig, 2008, p. 26). Gacaca, which translates as “justice on the grass” (ibid, p.30), is a traditional form of justice that emphasises reparations and community restoration. It is a traditional Rwandan method for settling disputes over property or inheritance, and minor offences between neighbours (Graybill & Lanegran, 2004; Reyntjens, 1990).

The Gacaca Courts, however, assumed a more complex form in handling the cases of individuals’ involvement in the genocide on a much wider scale, with three levels: cell, sector and appeal (see Rettig, 2008). These formed an organised network of approximately 11,000 community courts across Rwanda (Graybill & Lanegran, 2004). Yet the ultimate purpose remained the same as the traditional understanding and expectations: “...to arrive at the truth through community dialogue” (Rettig, 2008, p.32). Key elements of the process included: some reward to those who confessed their crimes, by halving their prison sentences; apology, as an important ingredient to promote reconciliation; and reparation to victims through a contribution to a compensation fund or community service, as a cornerstone of the process (Graybill & Lanegran, 2004, p.9). Thus, the Gacaca Courts may be said to have followed the reasonable order of things – in the Rwandan socio-cultural setting – to establish and adjudicate a kind of justice that restores society, as well as the individuals within it.

In both the TRC and Gacaca Courts, resolutions were reached through a communitarian process of consensus about: established grievances by victims, corresponding confirmation and reparation by perpetrators, and acceptance of the protocols involved. The resolutions reached in both cases evoked a sense of justice for affected individuals or communities, in terms variously described in all three conceptions of justice above. Ultimately, justice sought to restore harmony in essential relationships between

individuals, among families, and within communities across both countries. The culmination of what became acceptable as just to victims, perpetrators, and whole communities was the deep sense of equilibrium attained through the processes.

There are many objections to the proceedings of the TRC and Gacaca, and wider political implications of the kind of justice they served (see McEvoy & Eriksson, 2006; Waldorf, 2006). For instance, Waldorf (2006) argues that the Gacaca Courts' proceedings fall short of the re-integrative shaming they profess, and that over time, the process has become less participatory and more coercive (p.422-423). His claim is based on the idea that forgiveness must remain a choice by individuals, with the inextricable power to choose not to do so. Without intending to dismiss such objections, it suffices to note that the processes were built on the indispensable attributes of African justice, which seek restoration through truth and reconciliation; with an underlying feature of contentment. The TRC and Gacaca Courts thus point towards three fundamental principles – truth, contentment and restoration – and the underlying continuum of *process equilibrium*³⁴ as essential for an African paradigm of justice.

The dynamics of the TRC and Gacaca are variously reflected in the three African notions of justice explored above. For instance, the Igbo, Gikuyu and Ubuntu conceptions all emphasise truth and communal harmony as essential attributes of justice. These attributes have also been shown to constitute the moral basis for the TRC and Gacaca approaches to justice. Both the TRC and Gacaca show how the nation, as community, assumed their responsibilities towards establishing the true nature of a situation and to restore harmony among its communities. The communities in turn assumed reciprocal responsibilities to restore harmonious relationships between families and individuals, and to reintegrate individuals. There have also been expressions of reciprocal responsibilities on the part of individuals in view of their vital connection to their respective communities and the nation; hence the wide participation in the TRC and

³⁴ Process Equilibrium will be discussed in detail in chapter five.

Gacaca processes. As Tutu (1999, p.52) has noted, justice is served when such effort is made to harmonise communities through healing, forgiveness and reconciliation.

4.4.0 The African paradigm of Justice and Health Care

From the three notions of justice considered above, three features variously emerge against a background of process equilibrium, constituting an African paradigm of justice: truth, contentment, and restoration. They represent the basic principles of African justice, where reference is made to:

- a) established *truth* about the nature of a situation, and disruption caused to individuals and/or community;
- b) *contentment* of affected parties about the proceedings and resolutions reached or decisions made; and
- c) efforts made towards *restoring* the harmonious state of relationships between individuals and within communities.

The African justice paradigm is thus a continuum of process, where the truth sought should lead to a desirable fulfilment (i.e. contentment about the state of affairs or outcomes). The process should bring about restoration, in the form of: re-establishing broken relationships resulting from unjust acts or proceedings within the community; or reinstating individuals' state of wholeness that may have been disrupted due to some deprivations that may have resulted from injustice done. According to Elechi, Moris and Schauer (2010):

The goal of justice as a practical matter in Africa is the restoration of relationships, peace and harmony within the community... The quality and efficacy of African justice [processes] is measured through the wellbeing of victims, the community, offenders, and the system's capacity in restoring social equilibrium following a conflict... [It] is also an opportunity for the socialisation of community members and the relearning of important... values and principles of restraint, respect, and responsibility. (p.74).

Contrary to Waldorf's objection above, the justice process essentially involves a willing participation of all concerned persons, or the community, and all parties have the opportunity to present the situation in the presence of everyone else, in seeking to arrive at the truth (Elechi, Moris & Schauer, 2010). While the empowerment and vindication of those affected is central, all voices are recognised and respected in the process and decisions are reached through a consensus (ibid). A reasonable sense of contentment about the established truth and the resolution reached ensures adherence to the decision reached about the issue being addressed. The restoration process is thereby initiated.

The continuum of process, consisting of truth, contentment and restoration, peaks where a sense of harmony or coherence is attained between these principles. This signals that justice has been served. Going back to our example of one taking another's share of inheritance, the justice process will attempt to establish the claim against customary rules or norms. The review process and outcome will be such that they represent the desirable state of the situation, as prescribed by the community's ethical guidelines. The anticipated end is not simply the return of the property to the deserved person, but ultimately the restoration of the essential (family or other) relationship between the parties.

In view of the three principles, African justice does not emphasise winner or loser in the process; rather, it insists on a harmonious end. The process mainly aims to restore ruptured relationships within the community. That point, where truth has been established, contentment attained, and restoration is imminent, marks an equilibrium in the process, and affirms that justice is being served. Hence, the dialogic process of justice employs truth as the foundational principle, contentment as mediating principle, and restoration as the summative principle.

The foregoing presents evidence that the African paradigm of justice does not emphasise right claims to individual equality or other social goods. Yet it affirms respect for the individual's place, needs and privileges, and the corresponding community's responsibility towards meeting them. This does not presuppose that the rights of individuals are not recognised within the African communitarian moral framework; only

that it is not considered the greatest good. “Social harmony is for us the *summum bonum* – the greatest good” (Tutu, 1999, p.35). Hence, there is an unrelenting preoccupation with human welfare, as society thrives on relationships that promote social welfare, solidarity, and harmony in the human community (Gyekye, 1996, p.57) – all of which harmoniously constitute the preoccupation of African justice. A more specific explanation of the inheritance example above may clarify this point.

Among most ethnic groups in Nigeria, when a person is considered too young to assume claims of rightfully inherited property, it is common practice for older relatives to assume such positions on their behalf until they have come of age. Within this time-frame it is considered just or fair for the care-takers to make decisions regarding the use of the property, as long as it ties to the benefit of the former. However, the time comes when everything is expected to be handed over; and laying claim to any part of the property becomes morally and customarily unacceptable. Maintaining equilibrium is important in this regard, and is ensured through a continuous process of palaver within the family, community or a relevant social group. The dialogic process is concluded once it has been reasonably determined – in view of the customary procedures – that a point of equilibrium has been attained; that is, when the rightful owner of the inherited property, the care-taker and the wider family or community are reasonably content with, or can accommodate resolutions or decisions about, the hand-over terms. The dialogic process thus reaches equilibrium, and we can postulate justice at this point.

Therefore, the idea of justice in African socio-ethical contexts, like Nigeria, would emphasise protection of the individual’s welfare which the family, community or group has a responsibility to sustain; and vice versa – in a continuum of process, and always weighing the points of equilibrium. Individuals’ and communities’ welfare, and the corresponding responsibilities, are central to the African conception of justice. A similar understanding would apply to an African distributive theory for *just health care*. Here, the underlying approach will be to maintain balance between individuals’ needs and the community’s welfare against the corresponding responsibilities in providing health care.

4.4.1 Principles of African Justice in Health Care

Against a background of the African justice paradigm, where the goal of justice is the restoration of harmony, just health care in Nigeria will not focus only on individual needs or right claims. A just approach will always look towards balancing health care benefits for individuals against those of the relevant families or communities. For within the communitarian moral framework, the needs or conditions of individuals are always tied to or affect those of others within their network of relationships (see Gyekye, 1996, p.35-51). For example, when in poor health an individual always requires the participation of family or other relatives in seeking the means to restore well-being (e.g. in taking the person to the hospital, or helping to execute some already planned activities). Likewise, where the family is affected, individual persons are expected to share in the burdens, according to their abilities or capacities. In considering the health care of individual persons, recourse is made to their essential relationships (be it family, relatives or other significant groups, who assume responsibility for the care of the ill person).

Since African justice emphasises a reciprocal responsibility towards harmonious co-existence (as above), the relevant approach to just health care must seek to sustain the wellbeing of individuals in view of the welfare of others (family or community) around them. Just health care will always seek equilibrium in the process of weighing individual needs against the community's welfare. The three principles of African justice – truth, contentment and restoration – thus become significant for what just health care should mean, as well as informing effective practice in providing health care for all.

4.4.2 The principle of truth

The principle of truth constitutes the basic framework against which African justice is established. In describing the nature of the relevant situation, it helps the adjudicating community to understand the broader perspective and reach decisions that also consider wider implications. For example, the proceedings of the TRC and Gacaca Courts all began with narrative processes, where individuals recounted their experiences and others (e.g. accused persons) have the opportunity to affirm or correct the narratives (see Tutu, 1999, p.93ff; and Rettig, 2008). Whereas some individuals who are versed with the moral

standards and ethical norms of the community preside over the truth process, the whole community (as represented by those present) determines its legitimacy. Specifically, in the Gacaca Courts:

A preliminary phase... known as information gathering, establishes a basic record of what happened... by speaking with the community... On the day of the trial the *Inyangamugayo* (president) calls the accused before the community... the *lyangamugayo* questions the accused one by one for accuracy and completeness of the confessions or... to discern the facts (of the allegation). The *Inyangamugayo* then invites the community to give testimony or question the accused... Once the testimony has been gathered (and read out)... the *Inyangamugayo* deliberate in private and announce a verdict. (Rettig, 2008, p. 31-32).

What would count as truth is not simply the logical description of the situation, for instance, but also the subjective interpretations by the affected persons, which may include emotional cost, for instance. The initial dialogue thus constitutes a process by which the community first attempts to reach a point of equilibrium in the various narratives being provided by the affected individuals. Once the initial dialogic process has been exhausted, the adjudicating community has a broader understanding of the situation, and is in a better position to adjudicate justice.

In view of a distributive theory for health care, the principle of truth will aim to establish the nature of a health situation being considered. Unlike in the ND Account, where only the practical or objective distributive effects are considered relevant, considerations of truth here also involve the subjective experiences of individuals or communities that are linked to the health condition in question. Consider the polio boycott case, for instance. The truth of the health situation was first established against objective/scientific considerations, against which the mass immunization campaign was decided. The affected communities' subjective experiences about health care were not considered – hence the boycott. The boycott brings to bear the non-inclusion of affected communities' relevant experiences in determining the effects of the disease and how the campaign would enhance their welfare. The situation is synonymous with a conflict between two

regimes of truth, resulting in non-compliance in several communities. While the non-compliance has been widely condemned, I will emphasise the suppression of the communities' experiences, which are equally important for their considered welfare.

In light of the African justice paradigm, the proceedings of mass immunisation or other relevant health care interventions will begin with a broader consideration of not only objective or scientific truths, but also of the relevant population's subjective experiences. The two dimensions work together to present a true picture of the impact or implications of the situation for affected communities. The truth principle thus helps to establish a comprehensive outlook on the health problem being addressed, which will include: empirical evidence about (say, a particular disease –and one may think about the Ebola case), and relevant experiences of the population relating to the disease or condition. Active involvement of affected communities in relevant health policy or intervention decisions thus become paramount; not only in helping them to understand the objective nature of the problem, but also in drawing from their relevant interpretations of the situation. Both are equally important; no intervention or policy can be effective if either of the truth perspectives is overlooked.

4.4.3 The Principle of Contentment

Once the dialogic process has established the comprehensive nature of the health care problem, only then can we move to the next consideration of justice. As a mediating principle of justice, contentment constitutes the background against which relevant considerations or decisions are evaluated to determine if equilibrium has been achieved. For instance, in both the TRC and Gacaca Courts, the various narratives of individuals' experiences or personal testimonies of involvement were weighed against basic appreciations by the relevant others, as well as the presiding communities. Contentment does not only imply a simple commitment (say, of a guilty party to confess to a grievance) on one hand, and appreciation (say, of the confessed grievance) on the other. Rather, in recognising the vital connection of all affected persons towards communal harmony, contentment implies a joint effort to make certain compromises, or a disposition to accept some terms in view of the explained situation.

Hence, the listening community acted as *mediator cum moderator* in the dialogic process, until unanimity was attained. For in the view of the African justice paradigm, "...justice required a particularised procedure of public acknowledgement to restore human and civic dignity, and to exact some measure of accountability from the perpetrators" (Du Toit, 2000, p. 134). One important point to note is that the justice process allows not only particular individuals, but also the relevant communities an opportunity to endorse intermittent explanations regarding the issues being considered. Hence, the comprehensive nature of the situation (as informed by the truth principle) only becomes legitimate once it has been endorsed by the relevant community – as reasonably representing their minds, general interests and welfare. The periodic endorsement affirms the principles of contentment in what may be considered a just procedure. While not every individual may indicate specific affirmation, the unanimity attained in the endorsement process indicates that the community affirms the outcome, and the principle of contentment is thereby observed.

Specifically, in health care affirming the principle of contentment requires that the rational or objective truth (e.g. scientific evidence, and the obvious effects of a particular disease) are acceptable to the affected population, against their considered experiences. This will mean they are content (say, with an intervention protocol, which they understand as also meeting their welfare needs) beyond the specified empirical outcomes. Consider the decision for the Phase I Ebola vaccine trial in Ghana. The public protest or rejection does not imply the people's ignorance about the potential benefits of the vaccine. Rather, it suggests that the process relied mostly on the empirical evidence or truth about the intervention; it attempted to avoid the intermediate principle of contentment in reaching a decision, relying only on the facts about the vaccine's efficacy. Overlooking the subjective dimension of the situation (i.e. the affected communities' experiences and concerns about the vaccine trial) meant that they were not content with the decision, and hence would not endorse it. Simply stating the potential benefits of the vaccine or the goodwill of the Ghanaian Ministry of Health for the population's health was thus not sufficient.

The communitarian context of health care requires an effective policy or intervention plan to weave through the legitimate process, of which contentment by relevant communities is part. Established truths about the health care situation, aims of the policy, and potential benefits will require endorsement by relevant communities. Beyond the immediate situation, the process should be informed by the wider concerns, needs and overall welfare of the relevant communities. Therefore, the dialogic process in health care decision making requires recognising the mediating principle of contentment. Here, not only policy makers, but also affected communities, will endorse the outcomes – before the implementation process is initiated. Hence, just health care will be informed by the kind of equilibrium guiding the African explanation of justice.

4.4.4 The principle of Restoration

While the established truth about a situation requires endorsement in view of contentment, procedures may not count as just until they are vetted to culminate in restoring a desirable state of being in the community. Restoration thus constitutes a summative principle of justice. In the proceedings of the TRC and Gacaca Courts, endorsement of established truths was not the final criterion against which decisions were made; considerations were made in view of restoring harmony to the affected persons, as well as the whole community. In light of the African justice paradigm, what counts as a just procedure or decision is not that which identifies and annihilates the problem or its cause, but more that which restores broken relationships or the life of the community.

As would be seen through the Gacaca Courts' proceedings, what has now become widely acclaimed as just procedure subsists in the *end*, which was essentially a re-establishing of harmonious relationships among Rwandan families and communities. The summative principle of restoration in Rwanda steered wide participation: many persons who were initially reluctant later came forward, having understood the ultimate aim to be reintegration into the community, and restoring harmony to the communal structure. While not presupposing that every individual or community in the country was happy with the entire process (see Brouneus, 2010 & 2008; Le Mon, 2007; Corey & Joireman,

2004), it suffices to state that the proceedings and outcomes were, on the whole, acceptable as just (see Clark, 2007; Wierzynska, 2004; Uvin & Mironko, 2003), in view of the three principles of the African justice paradigm.

In considering the relevant African approach to just health care, the decision making process would not presume to conclude only on the basis of established facts or acceptability by affected persons (such as in the form of informed consent for the Ebola vaccine trial). The process will need to establish the summative benefits of the intervention or policy beyond, say, a targeted disease condition. The relevant policy or intervention plan must establish strategies to restore health and wellbeing to individuals, and harmony to communities in sustaining their welfare. For instance, the effort to stop the spread of the Ebola in West Africa, and to provide care for affected persons are appreciable. Yet a just intervention procedure will be one that not only focuses on eradicating the disease, but also includes a comprehensive plan to restore the lives of the affected communities to normality. Hence, while sponsoring research for the innovative medicines, it will also address the background conditions that encouraged the spread of the disease, as well re-empowering communities that were devastated by the disease or condition.

Thus, the ultimate aim of the African justice paradigm is restoration. At the same time, restoration is the summative outcome that the considered harmony aims to re-establish within communities. Against this background, a just approach to health care will demonstrate that the potential outcomes of interventions or policy (beyond restoring healthy states) will restore harmonious wellbeing both for individuals and their relevant communities. For instance, considering that polio causes physical disabilities to individuals, which invariably affects the lives of the communities to which they belong, a just campaign against polio must look beyond the physical effects to the overall welfare of the affected communities.

Accordingly, a just approach to health care in Nigeria will have effective outcomes where it can establish that restoring the population's welfare – not simply the health of individuals – is its main aim. A policy that targets the health care of particular groups or

individuals, without recourse to their relevant communities' welfare, may undermine its own legitimacy. The effective approach should learn from one health worker's experience in Uganda. The Aljazeera documentary, "*The End is in Sight*" (2014), shows how the health worker with his team established the process of eradicating river blindness among communities in the White Nile Valley in Uganda. The team's initial efforts were marred by mistrust among communities. However, they were able to demonstrate to the communities that the intervention brought with it the promise, not only of health to individuals, but also of opportunities for functional and harmonious communities. This allayed the people's fears, they embraced the intervention plan, and normality was restored to their communities. Policies or interventions that aim to address the health care of people who need the most attention will succeed, in the light of African justice, if they have as a priority the restoration of communities' welfare.

4.5.0 African Justice and the Ethic of Responsibility

Whereas the foregoing presents the three principles of African justice and their distributive significance for health care, it also establishes the place of the dialogic process and emphasises equilibrium in just procedures. In the background of African justice is the communitarian ethic of responsibility, which provides the theoretical frame of reference. The framework of African justice is sustained by an account of responsibility, which in the context of health care will entail involving affected persons and communities as well as policy makers and health service providers in decision making. Through the truth principle, we see that individual persons in the Gacaca Courts, for instance, are obligated in view of their responsibility towards the community to relate the event as it happened. Contentment is essential in regard to the functionality of the relevant individual within the community, rather than of personal or selfish motives. And in view of restoration, precedence is set towards a joint responsibility for the community's welfare. An ethic of responsibility is, thus, fundamental to the conception and practice of justice in African communitarian settings.

4.5.1 African Ethic of Responsibility

The African paradigm of justice, as enjoined in the TRC and Gacaca Courts' proceedings, is founded on an ethic of responsibility both emphasise a preoccupation with the community or society's welfare, rather than just of individuals. The understanding, in view of Ubuntu and the notion of personhood, is that whatever affects individual persons also affects their relevant communities. The dialogic process seeks harmony in the deliberations, which ultimately aims to restore various family and communities' relationships which were severed by regimes of injustice – i.e. apartheid and genocide. Hence, the resolutions reached, rather than condemning persons found wanting, aspire toward re-instating the fundamental responsibility that they owe to their communities.

Against a backdrop of responsibility:

The social morality of the African society enjoins its members to seek the good of the society as a whole, for in doing so they not only seek their own good but also build a firm basis for their own lasting happiness. Hence, the highest good... is the welfare of the whole community. (Gyekye, 1996, p. 62).

The restoration of individuals' dignity and communal harmony are central to the justice process, as enjoined by the three principles. African justice is thus defined not by the right claims that individuals can make, for which equivalent compensation must be made. Rather, it is a process by which the community assumes its responsibility towards restoring lost dignity to affected individuals, in realistic terms, but always with the community's overall welfare in view.

The African ethic of responsibility “does not give short-shrifts to rights as such; yet, it does not give obsessional or blinkered emphasis on rights” (Gyekye, 2010, p.16). Hence, while the community as a whole may shoulder the responsibility for ensuring the place of individual persons, the latter are required to acknowledge their responsibilities in revealing the truth (as with the TRC and Gacaca) or accepting harm done and undertaking the necessary atonement. The re-instated harmony in communal relationships, against which both individuals and the community thrive, is thus a concerted effort towards

various assigned responsibilities. It is easy to think that individuals' rights are in crass contrast to the kind of responsibility enjoined in the African moral sphere, given the emphasis on communitarian welfare. However,:

In a social situation that... stresses the importance of social relationships... insistence on rights (some rights) may not always be necessary or appropriate... The communitarian ethic acknowledges the importance of individual rights, but it does not do so to the detriment of responsibilities that individual members have or ought to have toward the community or other members of the community. Concerned, as it is, with the common good or the communal welfare, the communitarian moral theory considers responsibility as an important principle of morality ...responsibility [being] a caring attitude or conduct that one feels one ought to adopt with respect to the well-being of another person or other persons. (Gyekye, 1997, p.66).

Within the African ethical framework, rights are interwoven with responsibilities, so that claiming certain rights does not relieve one of the relevant responsibilities, either to one's self or to his/her network of relationships. Justice not only consists in granting individuals' right claims, but always in balancing them against essential responsibilities, as variously owed.

Against this background, African justice does not eliminate the benefits that are due to individuals or personal desires that individuals may wish to pursue. Individuals may lay claims to their entitlements, but must always be conscious of their responsibilities to other persons in their web of relationships (i.e. family, community, social group or others). For instance, among most cultural groups in Nigeria, male or older children in the family are entitled to larger shares of property inheritance. Yet the inheritance comes with a corresponding share of responsibility towards the family's burdens, which may include taking care of: the widowed mother/wife, the financial, educational, and other needs of younger/dependent siblings, among others. Younger or dependent siblings, who get lesser shares of the inheritance, are relieved of the responsibilities by which the older

siblings are obligated. Specifically, older siblings are considered to have unequivocal responsibility towards their younger siblings:

A story is told of a family, where the parents had gone out, leaving their four children at home, aged between five and fourteen. The three younger siblings fell asleep, and a while later, the oldest child (boy) got bored and decided to join in. Not long afterwards, the parents returned home. Upon finding everyone asleep, they woke the oldest child up with the stroke of a whip, cautioning: “must you sleep because everyone else is sleeping; don’t you know that you’re supposed to watch over your younger siblings while they sleep?”

The waking stroke is a strong reminder to the older child of his responsibility towards the others. Of course he also has a right to sleep; yet, given the situation, such a right claim is weighed against the corresponding responsibility to care for the younger siblings, and the latter takes precedence. In this scenario, caring for others represents the welfare of the family, the older child’s basic network of relationship, which he is obliged to sustain. The right to sleep is recognised, but is considered secondary to the responsibility expected towards sustaining the family.

In regard to family inheritance, of which the oldest child gets the larger share, this is by implication inheriting a larger share of the deceased’s responsibilities to the family (see above). It is possible, and has happened in some instances, that older siblings take everything and ignore their obligations to the family. In such cases, elders of the extended family hold that person to account, and may impose relevant sanctions as enjoined by the community’s principles. Here, “the family palaver”, as described in Bujo (2001, p. 48-51), plays a significant role, and emphasis is placed on the joint effort to ensure the wellbeing of everyone within the family:

The success that must accrue to a shared or cooperative living depends very much on each member of the community demonstrating a high degree of moral responsiveness and sensitivity to the needs and well-being of other members. This

should manifest in each member's pursuit of his responsibilities. (Gyekye, 1997, p. 67).

Also, priority for communal welfare does not imply a neglect of individuals' welfare. As may be seen in the story above, the interpretation is that the welfare of the older child also largely depends on that of the other three sibling. For as the Akan proverbs affirm: "the reason two deer walk together is that one has to take the mote from the other's eye; [and] because the tortoise has no clan, he has already made his casket" (Gyekye, 1996, p.45). Individuals are essential parts of the community, and the welfare of the community always also seeks the welfare of its individual members:

...the responsibility an individual has toward the community and its members does not – should not – enjoin her to give over her whole life, as it were, to others and be oblivious of her personal well-being. What the communitarian ethic enjoins, then, is dual responsibility... the successful pursuit [of which] requires that, through the development of her capacities and through her own exertions and striving... the individual should herself attain some appropriate status... (Gyekye, 1997, p. 70).

The inclusiveness underlying the ethic of responsibility means that dependency is a favoured feature in the pursuit of justice. It will be considered morally reprehensible, for instance, for one to live an economically superfluous life, while his family (siblings or other relatives) live in abject poverty. Justice thus requires one to balance his or her well-being against those of others with whom he/she shares essential relationships. As may be seen with the outcomes of the TRC and Gacaca Courts, rather than insisting on sentencing "guilty" persons, emphasis was placed on the essential interdependencies of both accuser and accused, in order for a harmonious progress to be restored within the two countries. The aspiration was towards reconciliation, which is the groundwork for restoration. It may be overstating the case to insist that the social and economic conditions of both South Africa and Rwanda have been restored to desired states, following the TRC and Gacaca proceedings. Yet, it may suffice to note that these have

provided the groundwork for social stability, which variably offer citizens the opportunity to pursue their career goals or other life plans.

4.5.2 African Ethic of Responsibility in Health Care

The implication for a just health care approach is that responsibility for the welfare of the community, rather than only of affected individuals, becomes central to policy or intervention plans. It is a just approach to consider the opportunities of individual persons through strategic health plans, like the mass polio immunisation campaign in Nigeria. However, the communitarian context of health care means that affected communities are likely to become unreceptive to such proceedings which focus only on the needs of individuals or isolated groups, without recourse to comprehensive social welfare. Considering that the communities most affected by the polio epidemic were situated in the North-Western region, which enjoys the least access to public health care services in Nigeria (see Yahya, 2007; Renne, 2006); the trend over time became synonymous with the system's disregard for the population's welfare. It should have been foreseeable that the sudden mass provision of free drugs for a select category of the population would raise suspicion about the motive – which, given the people's experience of health care, would not have been towards their welfare.

Part of the suspicion surrounding the polio campaign undoubtedly stems from a perfectly understandable failure on the part of local people to understand why such disproportionate resources are being devoted to them. (Yahya, 2007, p.201)

Perhaps the people wondered: we cannot get free health care *just like that!* The resulting boycott was thus only waiting to happen.

Although the claims for the boycott could not be substantiated with empirical evidence, the administering pharmaceutical company, Pfizer, had earlier been responsible for an illicit drug trial that killed many people in the region (Yahya, 2007, p.190). The health care system's inaction against Pfizer on behalf of the affected communities initiated a lack of confidence regarding communities' welfare; it became a further motivation for rejecting the polio vaccines, which were disproportionately available, as compared to

other basic health services (see Yahya, 2007). The basic question of just health care for the affected communities was mostly tied to the system's failed responsibility in providing comprehensive primary health care in the first place. The latter is what the communities needed for their considered welfare; not a one-off campaign with an over-abundance of one among many essential drugs for children. The system's *prerogative for responsibility*³⁵ towards communal welfare thus becomes significant in determining what just health care service delivery would mean for the population.

The starting point for a just policy or intervention plans in Nigeria will require the system to establish a responsibility towards the welfare of beneficiary communities or groups. As seen in the polio case, simply publishing the medical benefits of the vaccination campaign was not sufficient to grant it legitimacy among the local population, thereby making the intervention plan ineffective. Establishing responsibility towards communities' welfare, rather than the rights of individuals to access the polio vaccines, constituted the ground against which the campaign eventually succeeded (see Yahya, 2007, p.187-193).

In order to establish legitimacy for the polio eradication plan or other similar health care schemes, relevant ethical approaches must include strategies that give substantial attention to the welfare of underserved communities. Nigeria may have learnt some ethical lessons from the polio boycott experience. Having identified non-compliance among local communities as a major challenge to polio eradication, the *Nigeria Polio Eradication Emergency Plan* strengthened its communication and advocacy strategies:

The program intensified social and community mobilization activities, providing opportunities for community leaders to engage in the response and become advocates for the program's success... [It] also supported the establishment of health camps to provide primary care services during SIAs (supplementary immunisation activities) to address unmet health care needs particularly in

³⁵ Detailed explanation is provided in chapter five (see section 5.5.1).

communities where non-compliance is high. The engagement of polio survivors... was also a game changer... Religious leaders have been mapped according to sects in the high risk areas... to further enhance support within communities... Some... enlisted the support of... local physicians who advocate for the program... The program also developed pro-polio CDs... to address anti-polio sentiments and counter anti-polio messages... ((National PHC Development Agency, 2014), p. 14-15).

While these community engagement strategies are laudable, just health care would require, as a matter of prerogative for responsibility towards welfare, more than temporary or one-off comprehensive health service provision. The health camps set up in communities during SIAs (supplementary immunisation activities) presume to address other health care issues beyond polio. The provision of other health services alongside the polio vaccine will attract uptake in many communities. However, the big question remains: what happens after the polio campaign? Will the communities go back to the “norm” of the absence of the short-lived services? Soon the population will wake up to the understanding that the underlying interest was only the eradication of polio – perhaps to gain international recognition about the success of the campaign. In the wake of another health plan, this strategy may not work, as it would have become obvious that it is a bait to attract people.

An ethical strategy with the potential for continuous success in the polio eradication program, as well as other relevant health plans, will need to show sustainable commitment towards a responsibility for population health and welfare, beyond intermittent interventions. Following this ethical pathway will help affected communities to perceive themselves as central to any proposed health policy or plan. This perception will be informed by a sustained commitment to addressing basic health issues affecting these communities, including making primary health care services available and accessible to all. Therefore, the ultimate success of a policy or strategic plan will depend on the extent to which it can establish as central the welfare of the population or communities in which the affected persons or groups are situated. Nigeria’s health care

system would have met its prerogative for responsibility towards health and welfare, where the services provided are considered just and acceptable to the relevant communities.

4.5.3 African Justice, Ethic of Responsibility, and Just Health Care

The three principles underlying African justice, as construed against an ethic of responsibility, will substantiate a distributive theory for health care. Such a theory promises to be effective towards just or responsible policy development in Nigeria's health system. Since the goal of health care remains the restoration not only of the individual's physiological state, but also the welfare of the relevant network of relationships, just health care will require emphasising a *prerogative for responsibility* towards the population's welfare. Accordingly, the principles of truth, contentment and restoration, constituting the ethical foundation for just health care, will guide policy development and inform relevant implementation strategies:

- a) truth will involve transparency on the side of policy makers and major stakeholders, like pharmaceutical companies;
- b) health plans will be considered legitimate to the extent that the relevant population groups are content with the specifications and endorse them; and
- c) to be effective or considered just, such policies or health plans will ultimately show promise of restoring to a desirable state not only the health of individuals, but also the health status of the population, as befitting their considered welfare.

The relevant approach to just health care will not only emphasise fair equality of opportunity for individuals to access available services; it will also ensure that the advantage has an effect beyond individuals to address the relevant community's welfare. The community advantage may involve, for instance, increasing its productive capacity through the good health of individual members – it will eliminate incidents of malnutrition.

Just health care will be seen in terms of the essential relationships binding individuals, which also impose obligations, commitments and responsibilities that individuals owe to

each other and to the community, and which the community owes to individuals. Gyekye (1997) explains this relationship:

Responsibilities to the community as a whole or to some members of the community would not derive from a social contract between individuals... The responsibilities will derive from the communitarian ethos and its imperatives... The justification derives from our understanding of what social and solidaristic life requires... Also, the common good of shared relationships... requires that each individual should work for the good of all. The ethical values of compassion, solidarity, reciprocity, cooperation, interdependence, and social well-being... primarily impose responsibilities on the individual with respect to the community and its members... Responsibilities, like rights, must therefore be taken seriously. (p. 67)

Therefore, just health policies or strategic health plans will look to a wider frame of welfare for target communities, without overlooking the benefits accruing to affected individuals within them. Insistence on right claims and mutual advantages, as proposed by the ND account of just health care will have limitations for communitarian contexts, like Nigeria. Likewise, insisting on strict adherence to communitarian welfare may undermine the health care benefits of affected individuals. An effective approach to just health care for Nigeria may require a middle or harmonious pathway between the opportunity thesis and the responsibility thesis. It should emphasise the welfare of affected communities, for instance, without trumping the right of individuals to equal access in health care.

The relevant African ethical framework will emphasise a *prerogative for responsibility*, against a background of *process equilibrium*; yet, without dismissing specific relevance of the *accountability for reasonableness* approach. On this reading, just health care reform processes will account for the system's responsibility towards the care not only of individuals, but also of the welfare of their communities. Consider what this approach to just health care will mean for public health emergencies, like in the polio or Ebola cases:

the effective and just policy or intervention will be one that looks to the welfare of the communities, beyond only curing affected persons or eradicating the disease.

4.6. Conclusion

Given the emphasis on dialogic process in African justice, the relevant approach to just health care should be established against a similar background. If the ideals of process prove to be effective in the moral, as well as economic and social spheres, they should equally inform a distributive theory for health care in an African context. Ideals of process are already reflected in African traditional practices of medicine, and initial attempts have been made to frame them into bioethical guidelines for clinical and health research settings (see Tangwa, 2010; Metz, 2010). The boundaries remain to be pushed towards just approaches in population health.

The African dialogic process requires a specific theorising in population health, especially toward just distribution of resources and effective interventions. Among considered factors in health care harmony will constitute the substance of the relevant ethical framework, since health is understood in holistic terms (see chapter five). Also, the ethical approach will seek harmony between health care and other practical or existential features, like social, cultural, economic, environmental, political, and spiritual dimensions of human wellbeing. A distributive theory for health care will therefore require health policy or strategic plans to be consistent with the essential communitarian process underlying all of these features. Since social consensus in African contexts is attained through an open-ended process of evaluating deeply held values, *process equilibrium*, through which harmony is sought, should constitute the methodological framework of what an African approach to just health care will be.

Chapter Five: Process Equilibrium and Just Health Care

5.1 Introduction

Norman Daniels' account (ND Account) of just health care is established against a methodological background of reflective equilibrium and defended by a conceptual framework of the opportunity thesis. Daniels appeals to widely acclaimed processes of philosophical investigation, from which he provides an approach to just health care that can be used in different parts of the world. Daniels presents the ND account as a suitable tool for designing, assessing or evaluating the grounds for fairness in health policy development and intervention plans in a variety of settings. An evidence-based exercise undertaken in some low and middle income countries has shown that the generic benchmarks of the ND Account are adaptable to local conditions in seeking ethical reforms for varying health care systems (Daniels et. al., 2005, p.358). As a result, one can assume that the ND account has the capacity to reach across cultural boundaries, but that background justifications and local inputs for local ethical solutions can be provided for specific health care reforms in different settings (see Daniels et. al., 2000 & 2005). Hence, the ND account of just health care is presented as a flexible method of evaluation, which also provides ethical guidelines towards health policy development and system reforms.

In light of the above, a question arises: why insist on a specific African ethical approach when the ND Account already provides a practical tool with a substantive theoretical background? In response to this question, I would like to note that the ND Account hinges on the Western analytic tradition in mainly employing the method of *reflective equilibrium*, as shown in chapter three (see section 3.6). By contrast, my exploration of the African justice paradigm in chapter four revealed a method that emphasises process equilibrium, which differs from the Western analytic tradition. As Tangwa (2002) would affirm, the analytical approach employed by the like of Daniels is overly empirical, statistical and business-like, and tends to overlook other non-Western Knowledge systems, such as those underlying the African justice paradigm:

It is a question whether all problems that face us... can be solved by a purely analytical method where the baseline approach is to try to reduce complex systems to constituent parts, and where treatment of the parts of necessity implies salvage for the whole. This... analyticity may, from some perspectives, appear like the epitome of rationality, but it ignores other perspectives and other aspects of being alive and being human. The analytic paradigm of knowledge... is not the only one. There are other types of human knowledge... much better developed and more prominent in non-Western cultures. The point is: globalisation should not be allowed to fix analytic knowledge as the sole paradigm of knowledge because there are aspects of reality and human life and existence with which that paradigm... cannot adequately deal with. (Tangwa, 2002, p.227-228).

Furthermore, Hountondji (1997) insists that an African methodological perspective is important, as the knowledge components can make significant contributions towards addressing Africa-specific problems. Hence, principles from African thought should be foundational to research methods for relevant issues within African socio-cultural contexts.

Therefore, it becomes imperative that we explore a relevant African methodological approach in the search for an African ethical framework of just health care. The African account of just health care, beyond considering the African paradigm of justice, will require an appropriate centrality of African methods of ethical analysis and moral judgement. The specific African approach will provide the frame of reference against which just health care reforms in Nigeria are to be considered. If the ND Account of just health care is imported as a whole into Nigeria's context, policy makers may have challenges applying it, and may have to rely on personal experiences or common sense judgement to align it with local ethical considerations. There is a need for a systematic theorisation of local ethical dynamics if we consider just health care reforms in contexts like Nigeria, with different knowledge systems from those emphasised in the ND Account.

As shown in chapter four, the dialogic process underpins the African justice paradigm, and the attainment of harmony or equilibrium is important in determining what counts

as just or fair outcomes. Against this background, in this chapter I will explore the methodological approach of *process equilibrium*, which will inform the African account of just health care. Having established the methodological dimension, I will present the relevant African ethical framework, as relevant for health care reforms in Nigeria.

The above approach will be further justified by first looking at challenges encountered in East Africa, where the ND Account was applied to health care reforms.

5.2.1 Application of the ND Account in African Contexts

The ND Account, as exemplified in the *Accountability for Reasonableness (AFR)* approach, supported a project to determine its specific relevance for health policy development and implementation in Tanzania, in 2006 (see Maluka, 2011; Maluka et. al., 2010 & 2010a). The five year project, Response to Accountable Priority Setting for Trust in Health Systems (REACT), aimed to determine the applicability and impact of the ethical framework of AFR in a low income country in Africa, with cultural traditions and resource limitations which differed from those in the original context of the United States. The project's strategy involved describing existing policy practices in health care and attempting to supplement them with the four conditions of AFR, in order to enhance effectiveness in the design and implementation processes (Maluka, 2011, p.4). Evidence from the project showed that the ND Account had wide appeal for both policy makers and the population, in view of three considerations:

- a) multiple stakeholder involvement to ensure that relevant values of affected communities are considered;
- b) informing the population about the rationale behind set priorities to create greater transparency, and enable communities to know how health care resources are allocated; and
- c) a mechanism for appeal to enable communities to express their dissatisfaction about certain decisions taken. (Maluka, 2011, p.7; Maluka et. al., 2010a)

However, some limitations were observed in the attempt to adapt the ethical framework to typical policy processes against the background of local conditions. Among these, Maluka (2011, p.9-10) notes the need:

- a) for greater engagements of affected communities in the decision making process than the framework presently suggests;
- b) to recognise underlying power asymmetries between affected communities and policy makers; and
- c) to recognise the nature of the local context's socio-cultural traditions.

Substantiating these limitations, Mshana et. al. (2007, p.3-4) also observed that:

- a) the ethical approach was considered by local communities to be too technical and complicated;
- b) many potential stakeholders may not have had the knowledge, skills or experience to effectively contribute to the process, which made some participants feel intimidated; and
- c) the analytical description of relevant reasons was complex and difficult for policy makers to communicate to the relevant population .

Overall, Maluka et. al. (2011) affirm that there is an inadequate understanding of the process and its mechanism for influencing legitimacy and fairness in the local Tanzanian context, as reflected in health service management processes and outcomes. They conclude that:

support from researchers in providing a broader and more detailed analysis of health system elements, and the socio-cultural context, could lead to better prediction of effects of the innovation and pinpoint stakeholders' concerns, thereby illuminating areas that require special attention to promote sustainability. (Maluka et. al., 2011, p.15).

The limitations outlined above have sequential correlations, all of which suggest an attempt to simply fit the ethical framework into the Tanzanian health care context. The

analytical strategies of the ND Account were imported wholly, and recourse was not made to the local ethical dynamics. In light of the first set of limitations, a relevant mode of meaning (or knowledge system) that effectively engages the affected communities needs to be determined: it must be one that the local population can relate to within their socio-ethical frame of reference. The second set presents the challenge of adopting a power structure that is unknown in the local process of decision making. Hence, the relevant approach must recognise local processes in determining how decisions are to be made for health care. This will help the local population to more easily identify with their roles as stakeholders, and actively participate in the decision making process. The third set of limitations presents the socio-cultural challenges to the ND Account. They show that cultural perceptions bear on health care, and that local cultural conditions must be accounted for in designing the relevant ethical approach. The fact that the ND Account was too technical or complex may not mean that the policy makers were simply unintelligible; rather the knowledge system against which the framework is built is different from the knowledge system that prevails within the local Tanzanian context. Therefore, a viable ethical framework should be informed by the local knowledge system, in order to ensure effective communication among all stakeholders in the decision making process.

The limitations of the ND Account in the Tanzanian context partly rest on the conceptual framework or the underlying methodology, which does not correlate with the specific African socio-ethical framework. My analysis is that one major set-back for the REACT project was the failure to adapt the ethical guidelines in view of the local knowledge system and method of ethical analysis. There is a need to substantiate the ethical guidelines of the ND Account with specific African ethical content, as well as to situate it against the background of the African dialogic process, which is a particular method of ethical analysis.

Considering the established challenge of the ND Account in the Tanzanian setting and its potential applicability toward health care reform in Nigeria, two levels of limitation are notable. Firstly, there is a conceptual problem, as noted in the difficulty in communicating

the relevant reasons. Secondly, the nature of health care problems in Tanzania (which are not particularly different from Nigeria or most of Sub-Saharan Africa – see WHO, 2014a) are notably different from those of the ND Account’s original context. I will attempt to articulate these two limitations below in order to further establish the need for a specific African approach.

5.2.2 Conceptual Limitations

In chapter three (see section 3.7), I outlined the conceptual conflict that may arise in attempting to make the theorisation of the ND Account universally defensible. While I focused there on the theoretical foundation, I will here consider how the meaning of health that the ND Account relies on creates a further conceptual limitation in considering the approach for an African context.

The physiological understanding of health, as described in chapter three, informs the ND Account of just health care. Daniels prefers the empirical description because it makes it easier to determine who is ill or well, identify instances of exclusion from health care, and to affirm when just outcomes are being realised (2008, p.36-46). For instance, we can easily tell which regions in Nigeria have more malnourished children, and tailor relevant health care and other related services to them. The specifically empirical consideration of the ND Account differs from the African holistic view of health. African societies uphold a dual-approach to health and illness, where both natural and existential conditions are recognised as causal links; harmony with oneself, community and the metaphysical world is a key determinant of good health (Omonzejele, 2008):

The African conception of health is all-embracing... health is not just about the proper functioning of bodily organs. Good health... consists of mental, physical, and emotional stability for oneself, family members, and community. This integrated view of health is based on the African unitary view of reality. (Omonzejele, 2008, p.120).

...health does not simply mean the absence of disease; it incorporates balance and harmony between the individual and his or her social surroundings, including

harmony with the self. Disease results from the breakdown in relatedness, including disharmony between the individual and the rest of the universe. (Mkhize, 2008, p.39).

Bujo (2001) further substantiates the holistic view in affirming that in an African understanding, ill health always has a community dimension, especially regarding interpersonal relationships:

It [ill health] is always a sign that something is wrong in the community... and this means that the re-establishing of the broken interpersonal relationship cannot be a matter for doctor and patient alone: it demands the participation of the entire community... The doctor who is giving treatment, the patient, and the others involved... form a communicative community, which endeavours to achieve the physical and psychological healing... (p. 46-47).

Given this understanding of health, African traditional healing approaches are undertaken within a framework of dialogic process, where the healer mediates between the physical condition and the varied causal forces (see Tangwa, 2010. P.49ff; Manda, 2008; Mbiti, 1990, p.162ff;). The dialogic process often begins between the doctor and patient, and may eventually involve other family or community members, in order for a healing relationship to be established (Bujo, 2001, p.46). The healing process is thus essentially a communal process, so that patients' conditions also involve others with whom they share essential social relationships: for "African communities... attempt to bear the illness in common..." (Bujo, 2001, p.47).

This holistic view of health still persists in the contemporary African context, and evidence is seen especially in the high subscription to traditional or spiritual healers in Nigeria. It is particularly prominent where Western medicine has been unable to provide satisfactory explanations for certain ailments (see Manda, 2008; Omonzejele, 2008). The persistence of the holistic view of health in contemporary times means that it also shapes the population's attitude towards seeking health care, and determines the effectiveness of policies and intervention plans. Hence, a relevant approach to just health care in such

contexts cannot be constrained by the physiological meaning of health. The natural, existential, social, emotional and physical dimensions of health must be accounted for, if a just health care approach expects to be effective in an African context.

5.2.3 Practical Limitations

Further to the prevailing holistic meaning of health in most African settings, the nature of prevailing health conditions are different from those presupposed in the framework of the ND Account. For instance, the kinds of health care situations that policy makers in the United States deal with are different from those Nigerian policy makers would normally face. Also, the socio-economic conditions around which health care situations must be addressed are different in the two contexts. Hence, while the ND Account of just health care may be viable for the United States context, it may face practical challenges in a Nigerian (or other African) context, as seen below.

5.2.3.1 Prevailing Health Conditions

As seen in section 2.3.2, the United States has a high prevalence of chronic conditions or non-communicable diseases. These disease conditions are isolative, in the sense that they are not transmissible to other persons. For instance, a person with a heart condition cannot infect other family members or friends. In this context, individual-focused health care, in terms of what they should get from the system, is justifiable or fair. Here, the distribution of health care services is morally defensible against the opportunity thesis, as outlined in chapter three.

However, the opportunity thesis may not offer a tenable justification in Nigeria's context, where the prevalence of communicable or infectious diseases is high. The infectious nature of the prevailing diseases means that the system is burdened by the urgency to provide patient care, as well as contain the spread of the diseases to family members or surrounding communities. In this context, an ethical approach that focuses on individuals in the distribution of health care will be too narrow in scope. An ethically realistic response to Polio in Nigeria, HIV/AIDS in South Africa, or the Ebola crisis in West Africa, for instance, will not only consist in successfully treating all ill persons. It must extend

towards restoring affected families' lives, and communities' sustainable capacities against re-occurrence or further spread. Thus, we must look to a social welfare approach, as sustained by a communitarian ethic of responsibility.

5.2.3.2 *Socio-Cultural Contexts and Economic Conditions*

Social, cultural and economic factors also largely determine the population's attitude towards seeking health care, and what they may perceive as fair with regard to the services they get (as shown in chapters two and three). The ethical underpinnings of a just approach to health care may differ in varying socio-economic/cultural contexts. Consider the United States, where society is a fusion of migrant cultures, with ideals of liberty entrenched in the social life, and emphasis placed on individual opportunity (see section 2.2.2). Citizens express certain right claims by which the system is obliged to meet their individual benefits through health care. In this context, an approach to just health care will be justifiable against the opportunity thesis.

However, in Nigeria's context, where family or community concerns are accorded priority and where health care resources are more constrained, a commitment to individual-focused care may not be ideal, ethically speaking. Here, the relevant account of just health care will prioritize communitarian considerations in policy intervention plans. While the boycott in the polio case may be dismissed as lacking coherent evidence, the allegation highlights an inherent communitarian concern. The vaccine's rejection does not presuppose a dismissal of its potential benefits. Rather, it reveals the underlying moral disagreement surrounding the approval process, which appeared not to fit with the population's moral considerations. The questions asked have implications for the communities' survival, as opposed to only those of individuals. A communitarian-welfare-focused approach thus becomes imperative for the kind of ethical explanations that the affected communities would endorse as fair or just.

5.2.4 *Need for an African Ethical Approach*

While the ND Account is innovative towards just and acceptable policy decisions and strategic plans, it remains contextually limited, given differences in ethical views bearing

on health care across the globe. For, whereas it may constitute a viable approach for the United States' context, it faces several challenges in Nigeria. This difference requires reformulating an account of just health care for Nigeria and Sub-Saharan Africa as a whole. The relevant approach to just health care will seek explanations from the African moral vision that shapes the socio-cultural contexts against which policies are formulated and strategic plans implemented.

As seen in chapter four, African ethical principles derive from the mode of process underlying the moral community. In communitarian settings, process constitutes a methodological framework for arriving at ethically acceptable decisions about important issues affecting the community. Specifically, the palaver or dialogic process constitutes the channel through which ethical norms emerge, and by which urgent problems affecting families or communities are resolved. Translating this into a relevant approach for decision making in health care will require abstracting from the same underlying principles. The outcome will be an African approach to just health care that is acceptable in principle and endorsed in communitarian contexts like that in Nigeria.

5.3.0 Process as African Principle of Thought

The idea of process is embedded and expressed in the African experience. I will take process here to mean a step-by-step approach to reaching a goal, or for accomplishing tasks, which may not necessarily require logical causation. While process is not specifically referred to in daily life, events unfolding in most African settings reflect the underlying ideals of process, as they shape the moral outlook. These are traceable in interactive activities, such as in market settings and interchange of greetings. More importantly, process underlies the African understanding of health and illness, and traditional modes of healing (see section 5.2.2). A distributive theory for just health care in an African context thus, needs to be guided by the methodological dynamics of the African process. I should like to state here that cultures across the world have varied kinds of processes which guide daily activities and moral life. My focus here, being the

African health care context, limits my description of process to that within the African context.

5.3.1 Process in African Communitarian Settings

In the African moral worldview, process underscores events and largely determines relevant outcomes in different spheres. Among these, cultural events, like marriages, child initiation rites or naming ceremonies, burial ceremonies and the daily interchange of greetings reflect inherent processes (similar to those described below). Process is also embedded in the socio-economic sphere, where agreement protocols are observable between parties involved, as essential in both principle and practice. This should not be taken to mean that other cultures in different parts of the world do not have relevant processes guiding such events – where they exist. My aim here is to present the particular African mode of process. To present a clearer picture of the role of process in contemporary African societies, I will show how process provides basic ethical guidelines in the economic and cultural spheres. Firstly, I will consider the market scene, to show the kind of process underlying the socio-economic sphere; then I will explore the greeting norm, as an exemplification of process in the cultural sphere.

5.3.1.1 *The Open Market Scene*

Socio-economic activities around the Sub-Saharan Africa region, as exemplified by buyer-seller interaction in “open markets”³⁶, reflect a kind of open-ended process that regulates business transactions and obliges stakeholders to trade fairly. Tangwa (2002) describes this:

In a typical African market, the prices of goods are never fixed... [notwithstanding] modern shops all over... where the prices... are fixed. But fixed prices... [remain] a borrowed practice... which... has not yet been fully accepted and integrated into

³⁶ Open Market is a term that refers to the kind of market settings one finds in African towns or villages, where prices are not regulated. Actual prices of goods are mostly decided in dialogue between buyers and sellers.

the culture and everyday practice. It is not... uncommon today to witness an African trying to beat down the fixed price of an article in a shop... the price quoted to a prospective buyer by any seller usually depends on who the former happens to be... [It] is always an invitation for an animated and lively dialogue in which both the buyer and seller reveal and learn information about each other and his/her particular situation... The... [situations] of both buyer and seller... are always a factor to be considered in reaching the final price.... (p.218-219).

This description of the Open Market setting represents a common scene found across Nigeria, and in many other African countries, like Cameroon, Niger, Benin, Togo, Ghana, Zimbabwe, DR Congo, Ethiopia, Kenya, Tanzania, and Uganda – to my personal knowledge. It is a common understanding in Nigerian markets that the *first price*³⁷ offered to the buyer is often around twice the actual price at which the seller expects to sell the commodity. The *first price* is often an invitation for the buyer to engage in the negotiation process. The buyer's reasonable attempts to beat down the price affirms his/her desire to buy the commodity, and also helps the seller to gauge what the *last price*³⁸ should be. The dialogue continues back and forth, often deviating into some other conversations, until both agree to a *last price*. Where the agreement is reached based on the buyer's offer, he/she would be obliged to pay for the goods. The buyer may not suddenly decide not to pay for the commodity, unless he/she has a significant reason. For buyers who unjustifiably decline payment, most sellers will decline future transactions with them.

Selling and buying engagements are not contemplated without the interactive process. A transaction may be regarded as incomplete without the inherent process of price negotiation. For instance, Tangwa (2002, p.180) relates his experience in Kumbo Town's market in Cameroon, where on being told the price, one buyer immediately paid the

³⁷ "First price" refers to the initial price quoted by the seller, which the buyer is expected to beat down by offering a lower price, according to his/her discretion.

³⁸ "Last price" refers to the minimum amount the seller is willing to let-off a commodity to a buyer.

quoted amount, took the item and left without attempting to negotiate. The seller ran after him, gave back the money and retrieved the item, pretending it was not for sale after all. The main reason was that the buyer's non-negotiation raised suspicion about the genuineness of the transaction. The resulting equilibrium – i.e. when both parties reach a mutually agreeable price – signals an end to the process, and the commodity is either purchased or held back. In the example above, the interruption of the process by the buyer invalidated the transaction. The negotiation process constitutes a form of mutual dialogue involving the wider social correlation of the commodity. For instance, when buying some children's medicines in a pharmacy store, the attendants may often engage the buyer in a brief conversation about the child's condition – and this is not seen as an invasion of privacy. The commodity is not only an object of business transaction, but also represents a form of social connection between the parties involved. Thus, buying and selling is also a form of social relationship; not simply the exchange of goods and services.

5.3.1.2 *The Exchange of Greetings*

The exchange of greetings, which also often precedes the market transactions, is a major cultural representation of process in various parts of the continent. Among most African cultures, the exchange of greetings constitutes an essential part of daily interactions. A specific kind of open-ended process guides the greeting procedure, and one is not expected to abruptly end it (see Falola, 2001, p.137ff; Akindele, 1990; Hooker, 2003, p.288-289). Among the Isoko people of Nigeria – which is where I come from – greetings are emphasised at all times of the day, even to strangers. One would be expected to greet another should they meet at various points of the day, for as many times as they meet. A standard greeting (say, in the morning) may take a few minutes. The length and details mostly depend on the nature of the relationship, and several inquiries are made about (for instance): how the night was spent, family wellbeing, children's health, wife or husband's state, business or work situation, or school conditions in the case of students, among others. This may sound like an invasion of privacy to a Westerner. A simple "hello" is not sufficient, one must inquire about the whole wellbeing of the other within

the brief (or seemingly long) greeting period. Typically, a younger person is expected to initiate the greeting process, and the older one must in turn engage the former.

This greeting process also applies to many other cultures in Sub-Saharan Africa. The formula is similar to that found among ethnic groups, like the Akan of Ghana, Shona in Zimbabwe, or Zulu in South Africa (see Mbiti, 1990; Gyekye, 1996; Hooker, 2003, p.288-289; Lessem & Nussbaum, 1996). The underlying process is also established in other cultural practices, like marriage, naming ceremonies and funerals, where greetings play an important role. In my experience, the greeting process among the Hausa in Nigeria and Shona in Zimbabwe are notable for their length, interphases and expressions. In both instances, one witnesses occasional pauses and deviations into other conversations, following which another greeting phase begins. The process ends when both parties have reached a satisfactory point, or a kind of equilibrium. While this point is not specified, a mutual satisfaction between the greeting parties indicates an end to the process.

Greetings go beyond simple pleasantries in African contexts. Both the greeting and buying/selling process may be viewed as ceremonial forms of interaction from a Western cultural perspective. I would like to state however, that they represent an essential aspect of social relationships within the communitarian framework, through which harmony is continuously re-established. Specifically, the greeting process constitutes a reference point of morality, so that one who has a habit of non-greeting is considered rude or lacking in moral character (see Gyekye, 2010, sec.3). Such a person would often be reprimanded by others. Like in the market interaction, a specific kind of process underlies the greeting course, and is understood by the parties involved. In both the market and greeting protocols, a form of dialogic process is observed, which continues until a sense of harmony or equilibrium is attained – signalling the end of the process. There is no logical determination of the point of equilibrium, yet both parties perceive it once it has been attained, and mutually conclude the process. Thus, a form of *process equilibrium*³⁹

³⁹ Detailed explanation is provided in section 5.5.

signals an end to the engagement, whether in the marketplace, daily greeting or other important interactive activities within communities or groups.

5.3.2 Process in African Philosophical Thought

Albeit implicitly, the form of *process equilibrium* observed in daily interactions in African socio-cultural contexts has also been adopted by African scholars in their modes of philosophical analysis of the African worldview. Among these, Asante (1991, p.171) refers to an “Afrocentric” method of analysis, where phenomena are viewed in light of the framework that rests on the centrality of the African notion of personhood⁴⁰, which is founded against a continuum of process. Also, Masolo (2009) shows the trend for a *narrativistic* approach in the field of African Philosophy, as opposed to the analytic or continental approaches in Western Philosophy, where analysis of “...thought involves an essential responsiveness to other reasons...” (Masolo, 2009, p.44). He notes that “plotting theoretical presentations through narratives is a well-known medium in oral cultures, and lies at the heart of African traditions” (Masolo, 2009, p.46). The narrative dialogue introduces a dimension to philosophical analysis whereby thinking is expressed as a kind of relational analysis or process. In short, he affirms that the narrative or relational process of analysis also constitutes an axiom that informs and directs Africans’ theoretical practices in the human and social sciences, and creates an alternative way for critiquing philosophical issues (Masolo, 2009, p.47-48).

A review of some major works in African philosophy attests to this narrativistic approach, especially in the analysis of African ethical thought. Notable among these are Gyekye (1997) and Mbiti (1990), who employ several African narrative experiences to establish the underlying philosophy. Specifically in forging the pathway for African Bioethics, Tangwa (2010) abstracts from various African narratives, against which he establishes the relevant African bioethical outlook. Interestingly, some Western scholars who have over time tapped into the African philosophical sphere have also (perhaps unknowingly) engaged in the narrative approach. For instance, Metz (2007) attempts to establish an

⁴⁰ The African notion of personhood is explained in section 4.4.2.

African moral theory by abstracting from various modes of process inherent in African socio-cultural contexts. He illustrates twelve African moral intuitions, against which he traces the theoretical foundations of African morality through Ubuntu. His attempt to establish an African conception of human dignity (Metz, 2012) also follows a similar pattern. Like Metz, Nussbaum (2003) has noted that “the hallmark of Ubuntu is about listening to and affirming others with the help of “processes” that create trust, fairness, shared understanding and dignity and harmony in relationships” (p.3).

As may be observed, the narrative approach is a broad area in African thought, and may be interesting to explore. However, the scope of this thesis does not allow room for an in-depth explanation. Hence, I refer to it here mainly for the purpose of illustration, to show the embeddedness of the African process in formal and/or academic settings.

The foregoing underscores the significance of process in African moral thought and ethical analysis. It is worth noting that the kind of process described for African contexts is distinct from the “deliberative process” that Daniels (2008) refers to, which may be akin to a relevant kind of process in the United States. Whereas Daniels describes a logical and fixed framework against which such deliberations must take place, the African idea of process is fluid in nature, mostly intangible; yet always leading to a point of harmony or equilibrium, against which ethical considerations or moral judgements are made. In short, the African idea of process is open-ended; and unlike Daniels’ “deliberative process”, it aims at “process equilibrium” without fixed parameters: “open-endedness is a general feature of African traditions, so there is in principle no difficulty with re-interpreting...” (Coetzee, 2003, p.277) the notion of process, and in determining the point of equilibrium.

5.4.0 Process Equilibrium

Process equilibrium is achieved when unanimity is reached through a palaver or dialogic process or *indaba* (see section 4.2.4). As a matter of caution, it is important to note that unanimity, as referred to in this thesis, does not refer to a situation where a decision reached represents the exact mind of everyone. Our differences as individuals mean that

at some point we may want something different from everyone else, and the situation is no different in Africa. The idea of unanimity is a kind of communitarian outcome, where (for instance) a decision made may not benefit me personally, but may be of great benefit to (say) some members of my family or close relatives, and others who share essential relationship with me. In the light of unanimity, I would be required to endorse such a decision, as the benefits are in the long run also tied to me, through my essential relationships with the direct beneficiaries.

In health care, unanimity will highlight the attainment of a harmonious decision, which is acceptable even to those who may not entirely agree with a resolution reached. As an ethical principle of thought or method of practice, process equilibrium needs to be understood in the light of African socio-ethical contexts, interpreted against the mode of shared meaning, viewed through the existential dynamics of harmony, and actualised through the practical dynamics of dialogic processes. These features are variously incorporated into the African moral framework, and underlie important decision making processes in African settings (see section 4.2). Against this background, the relevant ethical framework for just health care will not only account for the socio-cultural contexts, but also assume the shape of the moral outlook in which the African process plays an essential role. Thus, Process Equilibrium should underscore the African ethical approach to just health care. It is abstracted from the ethical underpinnings of the four pillars: solidarity, shared meaning, harmony and the dialogic process. In what follows, I will describe these four attributes in view of how they could become effective tools for just health care reforms.

5.4.1 Underpinnings of Solidarity

The African dialogic process, through which equilibrium is attained in practice, is underscored by the ideal of solidarity as entrenched in the Ubuntu moral vision. Since social relationships and interdependencies are central to the socio-ethical contexts of Ubuntu, solidarity becomes imperative, as opposed to a merely optional moral requirement. I shall distinguish between the act of solidarity and the conception of

solidarity, in order to clarify the dimension we should employ in determining a just approach to health care.

The term solidarity mostly refers to a kind of unity or agreement of feeling or action between individuals or groups, in responding to a common problem or interest or in taking a common course of action. This generic understanding of solidarity focuses on its active component, i.e. solidarity as is expressed in practice, which I will refer to as the act of solidarity. The notion of Ubuntu (see 4.4.1) also recognises the observable or active dimensions of solidarity as the hallmark of communitarian existence. However, in explaining the conception of solidarity, I will abstract from this active dimension, and refer to the *attribute of solidarity*. As opposed to the practical expressions of support between individuals or groups with shared interests, the attribute of solidarity looks to the conceptual dynamics from which such shared actions, interests or support are derived. Hence, whereas practical or active solidarity may refer to a common course of action, the attribute of solidarity will look to the imperative towards *otherness*, the essential consideration of others, as the effective determinant of process equilibrium.

In light of the attribute of solidarity, the African ethical approach to just health care needs to be substantiated by ideals that recognise the “other” as equally significant to the discourse. In health care, the relevant discourse or decision making process will be considered thus: *health care “is” because these “others” “are”; or they “are”, therefore there “is” health care*. Against this maxim, an ethically valid policy decision making process will recognise the inherent importance of all affected parties. It will not underestimate the values of particular individuals or groups on account of logical incoherence. For instance, where a decision is made about the Ebola vaccine trial, the participating communities’ view would be considered equally important to those of other major stakeholders (like public health experts and pharmaceutical companies); and not only at the implementation stage, but also in the planning process.

Where such inclusion is evident, the affected communities (or target groups) perceive the process to effectively recognise them. In return, they are more likely to cooperate with emerging plans that will ultimately see the success of the health policy or strategic plan.

Hence, while such communities may depend on policy makers to implement relevant health interventions, the latter need to equally rely on the former's input to ensure effective implementation. The underlying interdependencies are a factor of solidarity, and need to be reflected in health care decision making. Where the attribute of solidarity has been considered, the outcomes of policy or intervention plans will not only represent the needs and wellbeing of the affected communities, but will also fit with their mode of ethical justification.

Through solidarity, process equilibrium will require not only supporting a community affected by a health crisis, for instance, but also giving appropriate consideration to their essential place in the decision and planning process. Establishing or implementing the attribute of solidarity may be difficult in practice, as communities' modes of process will vary across different regions of the same country. I consider this a major challenge that policy makers should be aware of in the first instance. However, a further development of this strategy is beyond the scope of this thesis; hence, I will consider it in my further research.

5.4.2 Underpinnings of Shared Meaning

The attribute of solidarity, as described above, should be premised on the shared meanings of the relevant health care context. In African contexts, like Nigeria, the notion of personhood (see section 4.2.2) reflects that sense of shared meaning that should underscore the dialogic process for health care decisions. Process equilibrium will be attainable only where a shared meaning is apparent, as only against this background will consideration for "otherness" be mutually inclusive. Otherwise there may be some grievances, especially arising from the differences in interpretation. In planning the mass polio eradication program, for instance, considerations will not only be made about the health of children in isolation from others (i.e. families, caretakers or guardians) will also be considered as essential in the process, whether in actual participation or in the nature of the expected outcomes. This is because in that context, children are seen as an essential part and future of their families and communities. What is perceived as endangering them, thus poses a threat not only to the individual children, but also to wider family

circles and whole communities. In considering other factors beyond the target group, children, in this case, the immunization program will represent a kind of unanimity that accounts for the mode of shared meaning within the target communities.

Specifically, the decision making process will seek to identify with the relevant community's understanding of the disease or condition, without necessarily subscribing to it. It will consider the population's underlying perceptions and concerns about the situation, and look to decisions or plans that not only cure the disease, but also address the population's wider considerations. The example of the Ugandan health worker described earlier (see section 4.4.1.3) may clarify this point. Although his primary aim was to bring the generic drug for River Blindness to the affected communities, he had to consider the wider implications for the local communities – in terms of what the disease variously meant for those communities. For instance, the disease severed family relationships, as many couples were unable to have intimate sexual relationships. For these communities, River Blindness meant more than the disease itself. An effective health care plan required more than insisting on the curative effect of the medicine; and the health worker understood this. His intervention plan was thus acceptable and effective for these communities. Thus, a mode of shared meaning constituted an effective tool in designing the relevant health care plan.

Therefore, policy decisions or interventions plans have potential for success where recourse is made to shared meanings. Engaging with relevant communities' shared mode of meaning about a health care situation will ensure that decisions do not presume to be imposed on the targeted population group. Rather, the dialogue between all the considered reasons, especially in view of their modes of meaning, will enhance the acceptability, and hence the effectiveness of the policy or intervention plan. The African ethical framework for just health care will ensure equilibrium in the dialogue of meaning to ensure acceptable and effective policies.

5.4.3 Underpinnings of Harmony

The consideration of shared meaning is meant to establish harmony in the decision making process, as well as sustain harmony between a health plan or program and a

population's relevant concerns. Policy makers may decide on a health care plan that some communities may not consider important, as it may not address their particular concerns. For instance, embarking on wide polio vaccination in a community where children are generally malnourished does not effectively address the basic concern of that community for their children. In such an instance, one can consider the intervention plan, which is important nonetheless, to be in disharmony with the effective health care concerns of the relevant community. Hence, consideration for the essential place of affected communities in the decision making process should not be for procedural inclusiveness purposes only. The recognition of *otherness* is important in determining how or whether the considered health plan is appropriate in the affected population's view.

Recognition of the affected communities' considerations does not mean that the decisions or plans will be limited to their worldview. Rather, there should be an appropriate integration of perspectives (between policy makers, communities and other major stakeholders) in mapping out the plan. In the polio case, for instance, the revised strategy for administering the vaccines reflects an integration of shared meaning between policy makers and the affected communities. The success or benefits of the campaign thus constitute a shared outcome, derived from integrated or shared meaning. The revised strategy, being an outcome of shared meaning, reflects the attainment of harmony in the plan to eradicate polio in Northern Nigeria.

The envisioned harmony is informed by the vitality principle, as described previously (see sections 4.2.3 & 5.2.2), which sees inherent interconnectedness among the various elements that bear on health. Just as the African outlook recognises the inherent interaction among the composite realities of health, a similar form of interaction needs to underscore decision making in health care; i.e. health plans should not isolate and treat disease conditions only, they should also appropriately incorporate other related factors or concerns. Specifically, there should be an appropriate integration of the goals of policy and the broader needs or concerns of affected communities, beyond medical provisions. In deciding about a particular health care intervention (say, towards eradicating malaria), the health of individuals, as well as other relevant considerations for the population's

wellbeing should be accounted for. Hence, other factors, like the living or environmental conditions, will be considered alongside medical provision.

In the light of process equilibrium, harmony should constitute the basis for establishing health policy decisions or intervention plans. The point of harmony is to establish an appropriate balance between the wider societal benefit of a particular policy or plan and the specific benefits for the affected communities or population groups. It should not, for instance, appear to sacrifice the people's specific interests on the altar of national interests; but should be in harmonious interaction with them. Otherwise, boycotts, public protests or campaigns, and even extreme measures (as seen in the killing of Ebola health workers in Guinea) may recur. Health policy or plans should aim to sustain an overall balance in health care outcomes for communities. Attaining such a balance may require both policy makers and the relevant communities to make some concessions. Such a double compromise may be observed in the events following the polio boycott, whereby Nigeria's ministry of health was compelled to adjust its initial position and accept certain conditions initiated by the affected communities. The success of the campaign is attributable to the harmonious interaction of perspectives that now sees that country being declared polio free.

5.4.4 Underpinnings of the Dialogic Process

Solidarity, shared meaning and harmony represent the conceptual framework of Process Equilibrium; they require a practical dynamic in order to constitute an effective approach to health care. The African dialogic process offers this practical dimension: it will provide guidelines about the mode of engagement by which all-inclusive considerations are made, meaning shared, and harmony achieved in decision making for health care. Where double compromise needs to be made in a policy decision or plan, such as in the Polio or Ebola trial case, the dialogic process presents a useful guide by which the desired harmony will be attained.

Thus, the approach of Process Equilibrium needs the guidance of the dialogic process to determine whether a particular health care decision is ethically viable. In the Ebola case, the approval for the trial in Ghana can be said to have morally defensible grounds,

accounting for the health and wellbeing of the relevant communities, especially since Ghana's close location to the endemic countries presents obvious risks. As such, one can insist that it has "otherness" as an essential principle, thereby also meeting the requirement of solidarity in the decision. Also, given that no prior Ebola case has been recorded in Ghana, the decision appears to consider the population's health in a harmonious sense; considering the wider societal benefits that will accrue from the vaccine trial. The problem, however, stems from the practical dynamics guiding the decision process. The complaints leading to the protest show that there was no formal attempt to initiate a dialogic process with the proposed trial communities, by which the decision would also have been harmonious in practice. The decision for the trial was rejected not because the potential benefits are not recognisable to the people, but because the ethical explanation was considered flawed from the population's perspective.

A viable approach will be grounded in Process Equilibrium, which as a practical step will involve a dialogic process that accounts for the local modes of ethical analysis. The ethical process will entail appreciating the shared experiences of relevant communities or population groups, not necessarily for their logical coherence, for instance, but precisely for being meaningful experiences. It will require policy makers to engage in active discourse with communities or groups, outlining their priorities, yet remaining open to integrate the meanings against which the communities perceive the situation. Being in harmony with the people's modes of analysis, decisions reached or plans made will be appreciated, and will in turn constitute an important step toward successful policy implementation. The underlying dialogue in Process Equilibrium is significant towards making effective health policy decisions and/or intervention plans, given that these same populations are always at the receiving end of the outcomes. Considering the Polio case, the communities' previous experience became the basis for the vaccine's rejection. The initial decision process did not account for a shared meaning about the situation, since it did not initiate a dialogic process with the communities. The boycott was not based on an utter disregard for the welfare benefits of polio vaccines. Rather it emerged from relevant ethical concerns that engaging in a dialogic process would have solved.

Of course it will be difficult in practice to attain the kind of unanimity that is proposed through the dialogic process, especially given the obvious power imbalances between the participating stakeholders. It is worth noting that every policy procedure has its own practical challenges, and the dialogic process is not exempt from this. While I may not have fully developed a strategy toward effectively achieving the said unanimity, my investigation here has shown the need for a dialogic process in the policy process, in Nigeria's case. This is sufficient for the scope of this thesis, as the aim has been to establish the foundations for the framework, in the first instance. A more comprehensive framework that will tackle the unanimity-related challenges will be developed through further research. This will help to outline more specific strategies.

5.4.5 Process Equilibrium versus other Established Approaches

The dialogic approach of Process Equilibrium is at once an African principle of thought and a methodological proposition toward just health policy decisions or intervention plans. While remaining markedly different from other established methods of analysis in bioethics, like reflective equilibrium, it represents an established mode of moral reasoning and of ethical analysis in African communitarian contexts. Hence, it also constitutes an appropriate ethical method of analysis in view of just health care for Nigeria. As a practical ethical approach, process equilibrium comes close to one established method in health research: community engagement. However, the former remains substantively different from the latter. In what follows, I will consider Process Equilibrium against one conceptual approach (reflective equilibrium) and one practical approach (community engagement) in health care. This should show the subtle similarities, as well as establish the substantive differences that make Process Equilibrium a more ethically viable approach for the Nigerian setting.

5.4.5.1 *Process Equilibrium versus Reflective Equilibrium*

The features of process equilibrium appear to resemble those of reflective equilibrium, in the sense that there is a back and forth consideration of relevant experiences or reasons in either case. On one hand, process equilibrium involves a continuous discourse with the aim of arriving at a shared sense of meaning, in the light of an anticipated course

of action. It follows a pattern of aggregating the varied experiences of the participants or stakeholders in the process, and establishes grounds for harmony, marking the end of the process. Reflective equilibrium, on the other hand, involves an objective consideration of cases or events in the light of our varying beliefs about them. It aims to establish a point of coherence upon several considerations; coherence being the terminal point. The terminal points in the two approaches – harmony and coherence, respectively – may appear to be identical.

However, the substantive difference is that the harmony constituted by process equilibrium is marked by open-endedness; whereas the coherence subsisting in reflective equilibrium is sustained by a form of logical consistency. In the first instance, no prior restriction is set on the kinds of reasons or experiences to be considered in the process; in the second, however, only reasons or experiences that are logically or rationally consistent with the relevant issue would be considered. For instance, guided by reflective equilibrium, the “fair deliberative process” in the ND Account (see section 3.4) suggests that:

- a) the process must follow a logically consistent pattern; and
- b) participating stakeholders may need to understand the logical complexity of the issue and be able to provide reasons that are consistent with it.

This approach effectively isolates stakeholders who may have useful contributions to make, but who do not understand the broader issues, or are unable to present their views in a coherent manner in order to persuade other stakeholders. Or even if such people are included in the deliberative process, the kinds of reasons they present may not be considered relevant.

In contrast, the open-endedness of process equilibrium describes a horizontal pattern – as opposed to the vertical dynamic of reflective equilibrium – whereby the mode of deliberation is dialogic; reasons presented or experiences shared do not need to be logically persuasive. Considerations are given to reasons or explanations that may be useful or effective towards best outcomes, enhance harmony of the dialogic process, or

sustain the welfare of the relevant community. The dialogue continues in an open sequence, with variable guidelines, until a point of consensus is reached. The open-endedness means that in health care decision making, the deliberation should be inclusive of a broader range of stakeholders than would be granted by reflective equilibrium. For instance, the kind of dialogue following the polio boycott was less mindful of the logical inconsistency of reasons given by the communities, than of the consideration given to its significance for their overall welfare. Against the tide of logical consistency, conceding to the communities' demands was a significant step towards the polio eradication program, and an affirmation of the place of process equilibrium in health care decision making.

If we are to visualise the difference, process equilibrium will emerge as a spiral and circular, yet horizontal strategy; while reflective equilibrium will appear as a step-wise vertical process. And whereas harmony is attained through an open-ended sequence, coherence is reached through logical consistency in the hierarchy of reasons being considered. As a principle of thought, therefore, process equilibrium has a conceptual difference from reflective equilibrium.

5.4.5.2 *Process Equilibrium versus Community Engagement*

As a practical method of analysis, process equilibrium appears to be similar to the recently advanced approach of "community engagement" in health research, especially in low and middle income countries; yet it remains distinct from it. Community engagement:

...is a process of involving populations in a defined area in research; identifying priority interventions within a social context and the environmental problems, as well as implementing intended interventions in a culturally acceptable manner (Asante et. al., 2013, p. 1).

They note the need to involve people in communities, not only in the research process, but also in setting up the research agenda. Tindana et. al. (2007, p.1452) view the concept of engagement in research to extend beyond community participation, and includes

working collaboratively with relevant partners who share common goals and interests. The community's involvement could be in the form of direct collaboration with leaders or other 'research participants' in the communities, or through volunteers and research officers drawn from within the communities where the research is being conducted (Chantler et. al. 2013; Asante et. al., 2013).

Seven ethical principles of community engagement are set out by Emmanuel, Wendler & Grady (2000) to include: value, scientific validity, fair subject selection, favourable risk-benefit ratio, independent review, informed consent, and respect for subjects. These principles have been subsequently consolidated with corresponding benchmarks in Emmanuel et. al. (2004); and a twelve criteria framework has also been developed to guide the engagement process (see Lavery et. al., 2010).

The community engagement approach is widely accepted, and has been adopted for health research in African countries with some evidence of success. Among these, Geissler et. al. (2008) in evaluating a malaria vaccine trial (MVT) carried out in The Gambia show how social relations within the 'trial community' (staff, volunteers and the host community) enhanced the effectiveness of the research process; owing to the integrations of the ideals of kinship ethics, as practiced in the community. They note that:

...research ethics should be understood, not just as a quasi-legal frame but also as an open, searching movement, much in the same way that kinship is not merely a juridical institution and a prescriptive set of rules, but a network made through relational work. (Geissler et. al., 2008, p. 696).

They conclude that although the trial procedures as laid down in the consent form followed the strict formal ethical approach for health research, the actual research process took a different turn, for want of effectiveness of the entire process (Geissler et. al., 2008, p.701). The MVT process reflects the claims by Kotze et. al. (2013) that community conversations are an essential attribute of the engagement process.

Similarly, a major health research program in the Kilifi District of Kenya shows favourable evidence of the use of community engagement to facilitate effectiveness of the process. Marsh et al. (2008) trace the initiation of the research process in Kenya, where community engagement was adopted with the view to strengthen mutual understanding between communities and the research centre. They show that the strategy provided new and diverse opportunities for dialogue, interaction and partnership building. And while Kamuya et al. (2013) also claim that the Kenyan experience presents evidence of how community engagement contributes to meeting the ethical values of the local population, Chantler et al. (2013) have noted some ethical challenges, mainly:

- a) those relating to the requirement to negotiate implicit and explicit expectations in the cultural setting that place great importance on sharing and mutuality; and
- b) noting the need for further research about the problematic aspects of relational ethics, undue inducement, power relation and negotiating expectations.⁴¹

A common feature of the community engagement evaluations considered is that they are mostly inclined to the benchmarks prescribed in Emmanuel et al. (2004) and the framework developed in Lavery et al. (2010), which are generic for low and middle income countries. One major challenge is that cultural expectations vary across countries within these socio-economic spectra, and the generic ethical benchmarks and frameworks do not provide relevant theorisation for specific culturally-linked regions⁴². The approach of community engagement does not tell us when the process has been appropriately established or how this can be done ethically, in African socio-cultural contexts. For example, given the Ebola vaccine trial in Ghana, how can we tell when or whether the relevant communities have been appropriately engaged? Also how can we gauge or establish the moral expectations of the population, or determine when this has been adequately met? Community engagement lacks a substantive theory or conceptual

⁴¹ For further analysis of community engagement in other relevant areas of health care in Africa, see: Asante et al., 2013; Okello et al., 2013; O'Meara et al., 2011; Nakibinge et al., 2009; Simon, Mosavel & van Stade, 2007; Mosavel et al., 2005.

⁴² Chantler et al. (2013) have made reference to this ethical implication.

frame of reference that is akin to the African moral worldview, and which is capable of addressing these questions. In effect, this makes its application in the relevant health care settings more of a mechanistic or purely empirical approach, as Tangwa (2002) would suggest. It is precisely this kind of limitation that process equilibrium sets out to address.

In order to supplement for such conceptual limitations, relevant approaches for health care settings like Nigeria need a specific theorisation that is grounded in the socio-ethical context, understood in terms of the relevant mode of meaning, conceptualised against the relevant moral outlook, and actualised through the acceptable process of ethical evaluations. Whereas other approaches, like community engagement, provide useful tools for enhancing health care or research in African contexts, the theoretical and ethical foundations have substantive limitations due to the socio-cultural realities. Process equilibrium offers a theoretical framework that is ethically viable, as well as providing a practical approach that is founded on the specific African moral vision against which just health care should be considered. In edging towards just health care reforms in Nigeria, the relevant approaches being employed need to be supplemented by the robust ethical framework of Process Equilibrium.

5.5.0 Process Equilibrium in Practice

In health care, process equilibrium will represent a mode of open-ended, yet meaningful discourse among the various stakeholders about relevant reforms, especially as they affect the relevant communities. The dialogic process continues until a sense of balance is attained between the potential outcomes and the wider societal welfare, as well as among the various perspectives of the situation which are brought to the discourse. Equilibrium in the process helps to establish what health care outcomes are most desirable, and which outcomes policy makers and service providers, as well as services users will endorse. The aim is not simply to establish rational reasons or justifiable claims to health care, but to discover the common interests of all stakeholders in the situation under consideration. Where unanimity is attained (that is, the potential

outcome is acceptable to all), the decision making process can be said to have appropriately integrated the various perspectives presented.

Thus, conclusions reached, judgements made or actions taken will be viewed as just or fair not only by policy makers or health service providers, but also by the communities or population groups at the receiving end. The imperative to involve all stakeholders in the decision making process, and to ensure that all concerns presented are appropriately considered, is founded against the ethic of responsibility⁴³. It provides the theoretical frame of reference for both the decision making process and the anticipated outcomes. Against this background, all parties will be constrained by a *prerogative for responsibility*, whereby claims will not only be based on proven rights; considerations will be made for what it is reasonable to provide – i.e. “the reasonable order of things” (Kinoti, 2010, p.138). Also, health care plans will not be undertaken only in the light of coherent reasons or practical evidence. Rather, appropriate consideration will be given to the population’s welfare concerns, however insignificant or inconsistent they may appear to be. Prerogative for Responsibility, thus, becomes the ethical imperative in the practice of just policy or strategic plans for effective health care. It is the manifestation of Reflective Equilibrium in the actual decision-making process.

5.5.1 The Prerogative for Responsibility (PFR) Account

The ethical framework that emerges from the ND Account – *Accountability for Reasonableness (AFR)* – focuses on the benefits or fair advantages of individual persons in regard to the available health care services and/or resources. While the outright appeal to right claims may not constitute an appropriate starting point for the inquiry into just health care, they are an acceptable theory of justice or a particular theory of just health care: for “such a theory would tell us which kind of right claims are legitimate” (Daniels, 2008, p.15). The AFR framework provides systematic rationales that guide key features

⁴³ As described in chapter four.

of the rights of individuals to health care, since it allows for a careful deliberation that highlights underlying value disagreements(Gruskin & Daniels, 2008, p.1575-6).

As noted earlier, imminent challenges abound for the AFR approach in communitarian contexts of health care, like Nigeria. For whereas AFR is substantiated against an *opportunity thesis* that legitimises right claims, communitarian settings appeal to a *welfare thesis* as the starting point for ethical analysis in health care. The emphasis on communal welfare derives from the African ethic of responsibility, and is built against the framework of Process Equilibrium. Hence, it becomes imperative to substitute (or at best, supplement) the *Accountability for Reasonableness (AFR)* framework with the *Prerogative for Responsibility (PFR)* approach towards just health care improvement in an African communitarian setting, like Nigeria. This will not necessarily discount specific benefits of the former in particular health care situations. The PFR approach will guide the dialogic process (i.e. African form of deliberative process in health care) in determining which decision or plans will count as just or fair, thereby ensuring the legitimacy of policy decisions or intervention plans.

Before proceeding to the content description of the African ethical framework – as envisioned by PFR – it may be appropriate to clarify the substantive difference between the two ethical approaches (i.e. AFR and PFR), and their varying implications for health care in a communitarian setting, like Nigeria.

5.5.2 Between Protecting Opportunity and Sustaining Welfare in Health Care

The AFR approach is informed by an understanding of health as normal functioning. It considers the health of individuals as having a causal link to the range of opportunities open to them, thereby making health care central in determining what opportunities individuals can pursue. Against the background of AFR, the imperative to make health care available to all lies in society's obligations to protect such opportunities for individuals. The imperative derives from a set of right claims against which individuals can oblige society to protect these opportunities (see section 3.2ff).

On the other hand, PFR appeals to the African holistic view of health, and seeks appropriate justification against a social or communitarian ethic, as opposed to an individualistic ethic. Against this background, the imperative to provide health care goes beyond right claims, to societal responsibility to provide such care. The imperative is emphasised in the African communitarian structure, where the natural sociality prescribes a social ethic that recognises the value of mutual help, goodwill and reciprocity. Communitarian values counteract the lack of human self-sufficiency in regard to talents and capacities, and help to realise the basic needs of individual persons (Gyekye, 2010, p.14). Likewise, the social morality places great emphasis on human welfare, and in turn also prescribes an ethic of duty or responsibility (Gyekye, 2010, p.16).

If we understand health in holistic terms, then our approach to health care ought also to embrace broader strategies; i.e. health care should also be holistic. The health of an individual bears on his/her network of relationships; hence, his or her health care becomes the responsibility of all who have a recognisable association. Whereas the individual person (i.e. the patient) may not have a specified right claim for the care being provided, the imperative towards welfare (of the patients, as tied to that of their web of relationships) accounts for such provision. Health care and its provision will be viewed from the perspective of social responsibility, as opposed to individual right claims. A welfare thesis thus substantiates the PFR approach. The imperative also requires individuals to demonstrate concern for the interests of others, in the light of solidarity and shared meaning, thereby achieving a sense of harmony in the wellbeing of the individual, as well as the relevant community.

In the PFR account, a moral defence for the specialness of health care would emphasise the impact on societal (community) welfare as the primordial source of obligation. The maxim is thus: health care is important not simply because of the impact of health on the opportunity of individual persons, but more so because of its significance for the societal/communal welfare. The welfare of the community, as seen in the Ebola case, is not separable from that of the individuals constituting it; hence the drive to stop the spread of the disease also meant that infected persons or suspected cases received the

best possible medical care available. The health condition of individual persons impacts on the welfare of others in their web of relationship. Thus, an ethical approach to just health care that hinges on opportunity may lose sight of the communitarian or welfare implications. The first principle of action is (should be) the health and welfare of the community. While the medical treatment provided has health and welfare benefits to infected individuals (e.g. in the Ebola case), the end serves the community's welfare. I will consider the broader justice implications of the Ebola case below.

5.5.3 The Argument for International Obligation

Beyond the imminent health risks, the effect of the Ebola crisis' on the welfare of affected communities and countries appealed to a global obligation to address the situation. There is a vast literature on global justice, which provides tenable explanations for why situations like the Ebola case, call for international action. However, my claim remains that a welfare approach will impel greater obligation than what appears to be the *enlightened self-interest* that underscores Western countries' involvement in the fight against Ebola.

According to Dwyer (2005), an adequate account of global health and justice must include three duties:

- a) not to harm, such as through unjust wars and environmental degradation;
- b) to reconstruct international arrangements, in terms of the relational equality between countries; and
- c) to assist other countries in ways that promote decent conditions within them, and not merely for the narrow interest of the assisting countries.

Affirming such duties, Benatar (1998, p.295) insists that we need a long term acknowledgement that the self-interest of wealthy or powerful nations can only be optimised through policies that foster all human well-being. A failure to recognise this would lead to greater poverty, deprivation, continuing conflict, escalating migration of asylum seekers from poor to rich countries, and the spread of new and recrudescing infectious diseases. This claim is perhaps evident in the recurring conflict in the Middle-

East, and North and Central African regions. The conflicts are widely acknowledged to have caused the recent mass migration of asylum seekers to Western Europe, which has now become an immigration crisis for receiving countries, especially Greece, Macedonia, Italy, France, Hungary, Austria, Germany and the United Kingdom. It is noteworthy that Germany has been widely recognised for its commendable effort in leading Europe towards implementing what true global justice requires. As at September 2015, approximately 450,000 asylum seekers have entered Germany, and up to a million are expected by the end of 2015 (BBC, 2015d). Perhaps Germany has acted on considerations of welfare, more than any other European country, in this case.

The Ebola crisis in West Africa represents one example of where the negligence of Dwyer's three duties can threaten global health. Singer (2014) notes that the disease became a global threat because it only affected poor countries. His claim is validated on the grounds that the world has known of the disease since 1976; yet, affluent countries with the capacity to develop cures or vaccines have disproportionately directed medical research towards less threatening diseases that affect their own citizens. Indeed the world stood and watched the initial phase of the Ebola crisis, and slow international responses and inadequate health systems have been widely blamed for the escalation of the disease (see Dale, 2014; Branswell, 2015; Tafirenyika, 2014; Regan, 2015). The fact that many people died while the world watched, and that it only took two infected Americans for the United States to acknowledge they have a potential Ebola therapy, only reaffirms Singer's claims. Kerridge & Gilbert (2014, p.2) have dubbed the initial global inaction "a moral failure", especially given that the eventual response was driven more by military imperatives than genuine concern for the affected communities. We can refer to this as enlightened self-interest on the part of the United States and allied Western countries.

Others would disagree with the global welfare imperatives discussed above. For instance, Sangiovanni (2007) argues that justice is a requirement of mutual reciprocity among citizens, which excludes foreigners, and Arneson (2005) says that co-nationals are bound together by a strong governmental coercion and support system, which does not apply to

foreigners. Yet the claim for a global imperative, especially as emphasised in the idea of negative duties, appears to imply the kind of approach that my African welfare thesis would endorse:

We may well have less reason to benefit from foreigners than to confer equivalent benefits on our compatriots. The priority for compatriots can thus help justify our conduct, our policies, and the global economic institutions we impose only insofar as we are not through their injustices harming the global poor... [The challenge hinges] on whether the global institutional order in its present design is unjust and our imposition of it a harm done to the global poor (Pogge, 2008, p.16).

The idea of negative duties imposes a global responsibility for some poverty related ill health, so that we are obliged to design any institutional order in a way that prioritizes the alleviation of those medical conditions to which it substantively contributes; and we ought to ensure that any institutional order we help impose avoids causing adverse medical conditions, and gives priority to alleviating any medical conditions it does cause (Pogge, 2002).

The Ebola case may well be a manifestation of the global institutional order. Liberia and Sierra Leone are still recovering from long term civil wars, which have been widely alleged to relate to the rich mineral resources (especially diamonds) that are in high demand in high income countries. The weakness of their health care systems, an obvious effect of civil war, has also been largely blamed for the escalation of the disease. Following Pogge's argument, if the West has institutionalised the system that ripped these two countries' stability apart, then it has an obligation to protect their welfare. The slow response from Western countries perhaps indicates that they did not share Pogge's view, and many may see their involvement as charity – or a supererogatory act. I would argue further that the African communitarian welfare thesis, if taken seriously and recognised globally, would have engendered more urgent support in the time of Ebola. For many recent events, like the Ebola crisis and wars in the Middle-East, have proved our inherent interconnectedness as a global community, in much the same sense as in African kinship. If anything, the Ebola crisis serves as a stark reminder to affluent countries about this fact

– on the basis of which they should also be obliged to take seriously the development of medicines for diseases that may not have initial benefits for their own citizens, but which they have the capacity to progress.

Thus, *Prerogative for Responsibility* (PFR) becomes the prior principle in addressing health care issues that affect population groups or communities, even outside of one's own country. In the light of PFR, one can claim that governments of the Ebola affected countries were obliged to provide medical treatment to infected individuals primarily on grounds of responsibility towards the welfare of the affected communities or the nation-as-community. If this claim is extended to the global community, affluent countries will be equally obliged to provide medical and humanitarian assistance, primarily for the welfare of the affected countries; not as matter of self-interest. Thus, although we consider the health and wellbeing of infected individuals in the fight against Ebola, a successful intervention will be one that can guarantee the (present and future) health and wellbeing of the affected communities or nations. The moral obligation therein lies not on the claims that individuals or community have against their governments or the global community. Rather governments' *Prerogative for Responsibility* in light of their citizens' welfare engenders such imperative.

5.6.0 The Harmonised Ethical Framework of Just Health Care

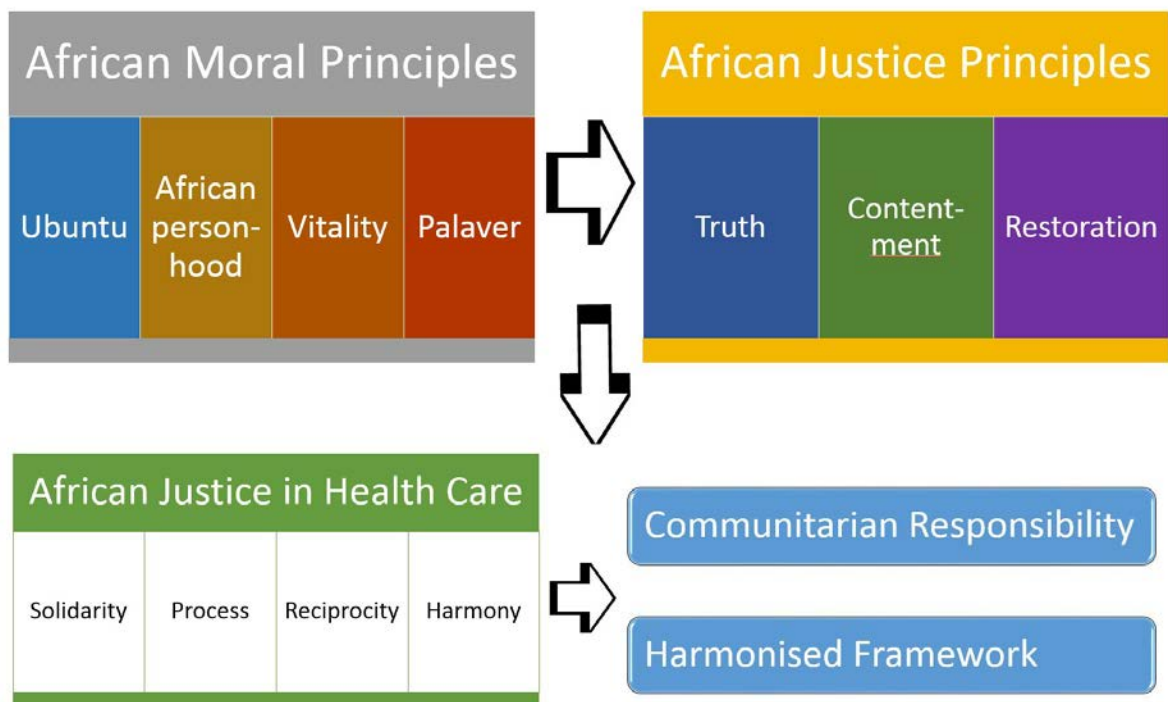
In order for the *Prerogative for Responsibility* (PFR) account to be relevant or effective in actual policy situations, we need a feasible framework for implementing it in institutional settings. As pure principle, PFR remains a conceptual ideal that at best informs a moral action with regards to policy formulation. Translating the moral ideals into an ethical tool will entail mapping out specific guidelines that policy processes or intervention plans will need to meet, if they are to count as just or fair. I have shown earlier that the African ideals of justice are underpinned by four basic attributes which derive from the communitarian ethic of responsibility, and are established through process equilibrium. In keeping with communitarian moral dynamics, the PFR account of just health care will need the guidance of the underlying attributes in designing a set of ethical tools towards just

reforms. Against a background of the four pillars of African moral thought, four corresponding attributes will emerge as practical tools against which to consider just policies: solidarity, process, reciprocity and harmony. These attributes will be specifically relevant to the kind of deliberative processes that should guide just health care reforms in African communitarian settings like Nigeria.

It may be observed that the framework follows a similar pattern as the *Accountability for Reasonableness (AFR)* framework, which specifies four conditions for fair process in health care policy and practice. The point to note is that the PFR account does not propose to disregard or eliminate the AFR framework. Rather, it is a supplementary approach toward just health care in communitarian contexts, given the fundamental limitations of AFR in principle and practice. Hence, the four attributes of PFR will be considered with the four conditions of AFR: the solidarity attribute with the publicity condition; process with relevance; reciprocity with revision/appeal; and the attribute of harmony with the regulative condition. Incorporating the four attributes into the framework of just health care ensures that the local considerations of justice are acknowledged, and policies or intervention plans are legitimised against this background. Thus, I propose a harmonised ethical framework towards just health care reforms in African contexts.

The four conditions of AFR are established against a background of *reflective equilibrium*; yet PFR has *process equilibrium* as its underlying strategy. This presupposes a kind of incongruity in the proposed harmonised framework. The novelty of the harmonised approach hinges on the fact that the institutional frameworks of African health care systems are essentially Western; yet they are situated within socio-cultural contexts that are inherently communitarian. As such, we will need an ethical tool that specifically addresses these communitarian contexts, but also accounts for the Westernized institutional framework. The harmonised ethical framework, AFR+PFR (as shown in figure 5.1 below), will thus provide viable tools toward just health care improvement initiatives in settings like Nigeria.

Figure 5.1: *Harmonised Framework of Just Health Care*



5.6.1 Attribute of Solidarity

Solidarity through Ubuntu entails a process of self-understanding through others, where individuals' personal and social responsibilities and commitments are always informed by the wellbeing of the community around them. In search of an ethical tool, I will not appeal to the literal consideration of solidarity in the policy process; rather, I will refer to the conceptual frame of reference to provide relevant ethical guidelines. For instance, we should not perceive solidarity in health care to mean a policy consideration that will bring people into mutual collaboration. Applying the attribute of solidarity to the decision making process means that health policies are informed by or understood against a background of the social realities in the relevant population. The policy process or ensuing decision will account for (or be in solidarity with) the affected communities' practical health experience, as well as their relevant interpretations of the condition or situation. In effect, the population in accepting a health policy, would have understood its specific relevance in light of their own considerations of health and well-being.

The benefit of the solidarity consideration lies in its capacity to aggregate endorsement from the local population, whose health care is the subject of the decision-making process. Achieving such endorsement means that the process is ethically viable, thereby legitimising the policy or intervention plan. If we incorporate solidarity into the decision making process, it will allow for vital participation by affected communities in ways that will eliminate the limitations noted in section 5.2.1. It will recognise their socio-cultural contexts and engage with the relevant values that define their social and/or existential realities.

With regard to the polio case, incorporating solidarity will entail giving due consideration to the communities' perceptions about the situation, so that decisions or intervention plans address their particular concerns, while at the same time bringing to bear the aims of the vaccination program. Just health care will be attained through:

- a) acknowledging the truth of the situation, i.e. in considering both objective and subjective perspectives;
- b) significant contentment of all stakeholders regarding the decisions made; and
- c) establishing the recognisable benefits or restorations that will ensue from the outcomes.

Incorporating the attribute of solidarity will enhance greater acceptability of a proposed policy or intervention plan (the vaccination program, in this instance), which has benefits for the local population, as well as the health care system as a whole.

5.6.1.1 *Attribute of Solidarity and the Publicity Condition*

On the grounds of the publicity condition, Daniels (2008) affirms:

Where possible, stakeholders affected by decisions should have input in determining which reasons count as relevant. In the case of many decisions made by public agencies, this feature of fair process is not only feasible but is required as part of the administrative process... we take the perspective of those affected

by a decision, including those whose health care needs are not met when priority is given to the needs of others. (Daniels, 2008, p.128)

This presents a basis for community participation in health care decision making regarding issues that affect them. On this reading, the publicity condition appears to be sufficient even in a communitarian setting. However, such participation is not considered a necessary requirement:

...consumer participation is not generally either a necessary or a sufficient condition for establishing legitimacy. Even without consumer participation, it is possible to achieve accountability for reasonableness and thus legitimacy, and even with consumer participation, a process not aimed at accountability for reasonableness will not achieve legitimacy. (Daniels, 2008, p. 129).

The publicity condition views community participation as an optional requirement for the decision making process. Yet, as shown in chapter three, community participation is essential for the African moral outlook, and in legitimising just proceedings. Hence, in health care contexts like Nigeria community participation will constitute an essential aspect of the process. The solidarity attribute provides an appropriate explanation for this inclusion. Where important decisions are being made about health care that affect particular communities, for instance, it will not be sufficient only to provide them with relevant information about the process or the proposed decision. Their participation will be considered essential to the process, allowing their local experiences and values to appropriately inform the process and the decisions reached. This will in effect yield effective outcomes or plans that the affected population is willing to endorse and cooperate with.

The need for the solidarity attribute has been variously outlined in noting the limitations of the AFR approach. Among these, Maluka (2011) shows that “...without greater opportunities for engagement of affected communities, it is uncertain how the... process can enhance legitimacy... [Hence] stakeholders affected by the decisions should have an input in determining how priorities are ranked” (Maluka, 2011, p.9). The relevant

approach, he insists, should “...broaden the involvement of stakeholders from the demand side, making sure also that representatives of vulnerable groups are present and heard” (Maluka, 2011, p9); and Daniels (2011) has acknowledged these constraints. Rather than insist on broader publicity, as suggested above, the solidarity attribute emphasises a hard line for community participation, and considers as essential the social and cultural values and perspectives of relevant communities or groups.

Thus, the publicity condition needs supplementing by the solidarity attribute to ensure the legitimacy of the decision making process and the effectiveness of the outcomes. The polio case provides a good example of where an intervention plan’s legitimacy was not recognised despite meeting the publicity condition. Although there was wide publicity about the mass vaccination campaign, the decision making process did not appropriately engage the population’s views and concerns, hence, the boycott. If supplemented by the solidarity attribute, the process would be impelled to engage varying perceptions about the situation, and to address specific concerns raised by affected population groups. Coincidentally, the boycott compelled policy makers to engage with local perceptions, which was key to legitimising the process, and the effectiveness of the campaign. Supplementing the publicity tool with the solidarity attribute makes it sensitive to the communitarian context.

It is important to note that *solidarity* has been previously suggested for inclusion as a fifth condition of *accountability for reasonableness (AFR)*. Hasman and Holm (2005) argue that policy or health plans should not be constrained to *due process*, and that all stakeholders should be able to decide what counts as relevant in different contexts. They cite the Northern European context, where *solidarity* has played a significant role in public discourse, making way for solidarity based reasons. However, this suggestion is different from the solidarity attribute being considered here. The former considers solidarity in terms of outcomes of the decision process, i.e. potentially strengthening social bonds. The solidarity attribute, however, appeals to the conceptual framework which necessitates inclusion (of local communities and their values, views and perceptions) alongside publicity.

5.6.2 Attribute of Process

The need for the solidarity consideration in decision making hinges on the modes of meaning in African communitarian contexts. As noted in chapter four, the understanding of personhood in terms of process shapes meaning and is central to local deliberative processes. Since the understanding of person as process indicates the vital connections inherent in the communitarian structure, decision-making in health care should also reflect this interconnectedness in both the process and outcomes. Reasons presented should be considered relevant against the relevant pattern of meaning, which in African settings has a specified communitarian process.

Bringing the attribute of process to bear in policy making will entail aligning the dialogue with the local modes of deliberation and the underlying ascriptions of meaning. Hence, reasons that count as relevant to the dialogue will not only be those that are considered to be rational or are endorsed by the policy makers, but also those that are subjective to the local contexts. For example, insisting on scientific evidence regarding the effectiveness of the vaccines, in the polio case, without recourse to the local meaning of the campaign, dismisses valuable input from the affected communities, and also makes the intervention potentially ineffective.

Scientific evidence has an empirical mode of meaning, which is from the type enmeshed in the communitarian process. While the empirical approach may provide explanations about the effectiveness of the vaccines, which means people should be obliged to accept it for their children, the dialogue should be open enough to acknowledge what this means in the local context's considerations of justice. Insistence on scientific evidence will entail ensuring that every child gets a dose of the vaccine; yet incorporating local meaning (i.e. that these children have inherent connection with the rest of the communities, in view of which the intervention should be inclusive in its restoration approach) will consider other related health problems or benefits for the whole community. The campaign will not be isolative of a category of persons, but inclusive of all the relevant inter-relationships in the intervention plan. This will see the policy's wide acceptability against the local considerations of justice.

5.6.2.1 *Attribute of Process and the Relevance Condition*

The place of local *process* needs to be sustained in decision making for health care; yet the relevance condition only accommodates reasons that patients (or other affected persons) can rationally consider as appropriate to their health care needs. Accordingly, decision making in health care relies on reasons that are rationally justifiable to policy makers and to the relevant communities. For instance, the decision regarding ARVs was not considered rationally justifiable by HIV/AIDS patients, and others who were variously affected by the disease – despite the supposed scientific claims which were appealed to; the policy was implemented, nonetheless. Similarly, the relevance condition would acknowledge the decision for the mass polio campaign, given its rational basis; yet it does not accommodate the kinds of explanations underlying the boycott, as they were mostly faith based. Two problems can be noted in relation to the rational-reason-only approach:

- a) it tends to give policy makers the power to determine the decision and effect the plans, whether or not affected communities agree with them – as observed in the South African case; and
- b) what is meaningful to the affected communities may not be considered relevant, notwithstanding its importance to them, as noted in the Nigerian polio case.

Where either of these problems occur, the decision making process may not be considered legitimate, and policies or plans will not be effective; yet the relevance condition would have been met. The attribute of process provides a useful tool for mediating such a situation, whereby relevant resolutions will also consider the local modes of meaning by recognising what the population considers to be important.

However, the AFR framework insists that the rationales must appeal to reason, evidence, and principles that fair-minded people can accept (see Gruskin & Daniels, 2008). The relevance condition emphasises objective reasons against subjective ones. The fact that some reasons are subjective does not make them unimportant or meaningless within

given contexts. Hence, reliance on the hard grounds of rational consistency can sometime jeopardise the legitimacy of the policy process, as may be seen in the polio case. In order for the insistence on objective reasons to make sense, Friedman insists, “...there needs to be an identifiable divide between a group of beliefs, exemplified by religious faith, that are illegitimate grounds for public deliberation on one hand, and acceptable non-empirical beliefs on the other” (Friedman, 2008, p. 108-109). For even comprehensive ethical theories, like Kantianism, utilitarianism or libertarianism, are not usually accepted by everyone as morally persuasive grounds for the purpose of allocating resources in health care, in a similar way to some faith-based reasoning:

...there is no clear and non-controversial way to draw the line demarcating the “bad” (non-public) religious reasons from good (public) philosophical ones... [and] many stakeholders in policy deliberations who do not share in the assumptions from the realm of political philosophy that underlie the *relevance condition*, are very likely to find Daniels’ ...reason for drawing the line unconvincing...” (Friedman, 2008, p. 109).

Indeed, the kind of explanations underlying the polio vaccine boycott were mostly faith-based reasons. Yet they should not be dismissed simply for being what they are: there is a sense in which they are important to the decision making process, as well as to the effectiveness of the implementation plan. Whatever the basis for the grievance, the (subjective) reasons are important, both to the policy process and the wellbeing of the affected communities. Rather than import the criteria of relevance into the African approach to just health care wholesale, the attribute of *process* should supplement decision making. This will align reasons to a pattern of acceptable explanations in African socio-ethical contexts of health care. Health care decision making should incorporate an integrated narrative between the relevance condition and the attribute of process, in a similar way that person and community (in the African socio-ethical milieu) are in both simultaneous and interactive process.

Through process, the harmonised framework of just health care will consider the common mind of the community, and stakeholders or variously affected groups.

Explanations for what gets priority will be informed by the considerations of the affected communities. Whatever their reasons, legitimacy should hinge on what the affected communities consider to be important or meaningful to their wellbeing. For in African socio-ethical contexts:

...thinking is a relational process that takes place meaningfully only in a communal context ...not only is reasoning a response to (other) reasons, it is also the act by which we commit ourselves to norms, or, more precisely to specific norms among others. (Masolo, 2009, p. 47).

Against a background of process, health care decision making will assume a communitarian dimension of ethical reasoning. Deliberation will not only be based on what is rationally justifiable, but also on explanations that affected communities or population groups consider to be acceptable, in view of their wellbeing.

5.6.3 Attribute of Reciprocity

Since the African conception of health and illness hinges on restoring balance in a person, and within communities, a just approach to health care needs also to account for such balance in order to be sustainable. The implication of *balance* is that health care should not only aim at the physical functioning of individual persons, but should also consider their overall wellbeing and that of their web of relationships, i.e. families or communities. It is a matter of common experience in Nigeria, as in many African countries, that family members are (or must be) actively involved in the care of an ill member, providing financial coverage or physical presence, as may be required. Against this background, a just approach to health care will be expected to alleviate (or reciprocate in some ways) the burden of care on families, while also treating the physical conditions of individual patients. Hence, integrating the attribute of reciprocity into the relevant ethical framework of just health care becomes paramount.

Considering the South African ARV case, the agitation for the drugs by entire communities had reciprocal implications. Providing ARV treatment would alleviate not only the physical conditions of HIV/AIDS patients, but also the burden of care on their families, as

well as improving the productive capacities of their communities. Hence the protest was not only about the wellbeing of individual patients, but also the reciprocal welfare or benefits of their families and communities. A just system will aim to restore balance by providing the kind of care that has reciprocal benefits (or restorative effects) to their web of relationships. Restoring balance thus becomes an essential aspect of just health care, as restoration is the summative principle of African justice.

Considering the Ebola case, where not only individual patients, but also their respective families and communities were affected, there are two senses in which the situation had reciprocal causation and effect, requiring relevant actions with reciprocal effects. Firstly, although the causal agent of the disease is known to be the Ebola virus, the crisis was also widely blamed on poor health system management and inadequate health care facilities. The Ebola crisis thus has a reciprocal causation: the virus caused the disease in the first instance; but the poor health systems, especially in Liberia, Guinea and Sierra Leone, provided ripe conditions for the spread of the disease. In such a situation, a just approach to health care will take reciprocal action in fighting the disease. It will explore cures or vaccines that will save patients' lives, as well as strengthening health systems to deal with similar emergencies, thereby enhancing the welfare of whole communities.

Secondly, the disease condition, while physically affecting individuals, also reduced the productive capacities of the affected communities. Quarantines were imposed on whole communities where the risks were particularly high. Although individual patients suffered the physical effects, whole families and communities were not spared the emotional, social and economic effects, as well as the burden of care for children who had been orphaned by the disease. Against a background of African justice, determining the true nature of Ebola will consider all the above, and more. A just intervention will entail broadening the scope beyond medical provisions, and priority will also be given to the health and welfare of the affected families and communities. To cite an example, such an approach will provide curative drugs or vaccines for patients and others at risk, and equally take appropriate measures to restore the broken social and economic fabric of

the affected communities. It will also guarantee social security for children and elderly persons whose parents, guardians or carers have been killed by the disease.

Incorporating the attribute of reciprocity will ensure that decisions or outcomes of health policies or plans do not only target single or physical aspects of health conditions, but also address the correlating social, economic, cultural and existential dimensions. A holistic restoration of the individual person's health will entail addressing all these aspects, which at the same time ensure a restoration of the relevant family or community's welfare. Thus, the health care of an individual patient will have a reciprocating effect on those around them, who inevitably become involved in his/her condition. The obligation derives from the summative principle of African justice, restoration, and is accounted for by integrating the attribute of reciprocity into health care decision making processes.

5.6.3.1 *Reciprocity and the Revision/Appeal Condition*

As shown in chapter three, the revision and appeal condition of AFR ensures that there are mechanisms for disputing the decisions or relevant outcomes, which may lead to some revisions. However, the context of the appeal and the content of the revision remain to be determined for different socio-ethical settings and these may be different for different contexts. For instance, what constitutes an acceptable appeal or revision to a policy decision in the United Kingdom may be different to what may be acceptable to Nigeria's population, given the socio-cultural differences. Context is important in considering what appeals are relevant, and also determines the content of the corresponding revision.

In view of an African communitarian context of health care, relevant appeals and revisions should incorporate elements of reciprocity (as discussed above). Demands that envision reciprocal restorative effects (as seen in the three case studies) should be considered relevant in the appeal/revision process. Hence, the harmonised framework of just health care will supplement the revision/appeal condition with the attribute of reciprocity.

To see how this may be effected in practice, I will relate it to the Ebola case. Consider where some individual persons or communities may have reason to believe that they were being unduly quarantined. The appeal may not be granted in view of the harmonised framework, as it does not consider a reciprocal restorative benefits or welfare of the wider community. The mechanism for appeal and revision may allow the grievances to be presented, yet, the attribute of reciprocity provides the context for evaluating them, and determines the content of a possible revision. Through the harmonised framework, appeals will be allowed where recourse is made to provisions or outcomes that have reverse benefits for the community's welfare, where the health care of individuals is involved and vice versa.

Therefore, in view of the harmonised framework, and given Nigeria's specific health care context, supplementing the appeal/revision condition with the attribute of reciprocity will help policy makers to better understand the reverse implications of their own roles for the health and welfare of individuals and for communities. If we bring the attribute of reciprocity to bear in the appeal/revision process, then we have both a viable context for consideration, and some effective content to anticipate.

5. 6.4 Attribute of Harmony

Holistic restoration is of the utmost consideration in African understandings of the healing process, and hence of health care; it is at the same time the summative principle of African justice. If harmony has been described as the greatest good in African moral thought⁴⁴, then summative restoration in health care must be considered in the light of harmony. The harmonised framework of just health care thus incorporates harmony as an essential feature. There are two levels on which we can consider the attribute of harmony as an effective tool towards just health care. For this thesis, I will consider the second outlook of harmony as the relevant tool for just health care. The first level considers the literal outlook, where health care will aim at harmonious relationships by making resources and services available and accessible to all. For instance, allowing some

⁴⁴ See Tutu, 1999, p.35, and Gyekye, 1996, p.55-71.

persons access to relevant treatment while denying it to others, can cause apathy within a given population group or community. This, however, remains a basic consideration.

The second and more systematic outlook of harmony abstracts from the literal dynamics above. It requires policy decisions or intervention plans to resonate with other aspects of the affected population's wellbeing, in more realistic terms. In the polio case, for instance, a disproportional amount of resources were committed to the campaign, as compared to other aspects of the people's health care or welfare. This disproportionality consolidated the suspicion that led to the boycott. The suspicion was also strengthened by the fact that the affected region has the worst health care outcomes and has some of the worst health indicators, compared to other regions in Nigeria⁴⁵. The intervention plan was thus not in harmony with other important aspects of the population's health and wellbeing. Where is the harmony in administering three doses of the polio vaccine to a malnourished child, one may ask? The unprecedented generosity of the polio campaign was in disharmony with the average health care resources or services available or accessible to the population. It was reasonable then that they should boycott it.

The harmonised framework thus emphasises harmony as a guiding principle in evaluating policy decisions and determining the effective outcomes of intervention plans. Just health care will consider harmony between the policy makers' considerations and the population's particular concerns. It will also maintain an appropriate balance between the anticipated outcomes of health policy plans and the population's considered welfare. Of course the term *harmony* in Standard English does not present it as a tool that we can employ towards decision making in health care. This is comparable to saying that the *Dogon-Yaro Tree* is after all just a tree; until we discover that its bark, root and leaves actually constitute medicine for curing malaria. Just like we extract the malaria medicine from the *Dogon-Yaro Tree*, I have here extracted an ethical tool for health care decision making from the supposedly plain term, *harmony*. Thus, harmony becomes an effective tool in the decision making process for health care, given the harmonised framework.

⁴⁵ See section 2.3.

Harmony between the health outcomes of policy decisions or intervention plans will ensure their acceptability among the population at the receiving end. It is imperative then that in regulating health policies, we are able to account for their effective harmony.

5.6.4.1 *Harmony and the Regulative Condition*

The *fair deliberative process* that underscores AFR appears to reflect harmony, since it involves a broad range of stakeholders at various levels in the policy process. Fairness in decision making is determined by the extent to which publicity, considerations of relevance, and conditions of appeal/revision are regulated. The regulative condition presumably ensures a kind of harmony among the first three conditions, or in their application as tools to design a just policy or strategic plan.

However, the kind of regulation specified hinges on public or legal procedures. It does not specify content beyond a procedural framework. The fixed procedure may be presented with significant challenges where the socio-cultural/ethical context of health care is fluid. By itself, the regulative condition does not tell us when, how or to what extent socio-ethical dynamics should inform the decision making process. Yet implementing the latter unavoidably requires engaging the former. It does not tell us how to engage the moral outlook of the affected communities or population groups in the polio or Ebola cases, for instance. The public or legal procedures it outlines risk becoming circular protocols, where intervention decisions require revision, in the light of these cases. Where there is an appeal, regulations may require the provisions of the law to decide if the outlined regulations have been met; and only on this condition will a revision be considered. We are thus restrained by the law circle.

In the light of the harmonised framework, the regulative conditions need to be supplemented by the attribute of harmony, if we envision effective and just health care reforms. Harmony, in the more systematic outlook described above, provides both context and content against which to consider the procedural regulations proposed by AFR. Thus, just health care will consider the outcomes of health policies or plans in terms

of measurable benefits, which at the same time resonate with the considered welfare of the affected population.

5.7 Conclusion

The harmonised framework of just health care emerges against the background of process equilibrium and is informed by the summative principle of African justice; restoration. Through the four attributes, the harmonised approach ensures that just health care accounts for the differences in context and the modes of ethical evaluation in different population groups. As I have noted earlier, recognising these differences will enhance the acceptability of relevant policies or strategic plans. Acceptability here implies legitimacy: where health care decisions are not acceptable to targeted population groups or communities, they are likely to be ineffective, as we have seen in the polio, the ARV and the Ebola cases.

While health care takes place within given socio-cultural contexts, the institutional setting is paramount. For instance, the socio-cultural context of Nigeria's health care is communitarian; yet health care is delivered in an overarching institutional setting. Nigeria's health care system, as with most in Africa, is structured according to the Western system, which represents the international standard of practice; yet it is situated within a strongly communitarian context. Considerations for just health care in Nigeria will not overlook international standards of care by focusing only on the particular communitarian setting. The AFR framework provides the tools for meeting international requirements but misses out on important aspects of the communitarian context. Therefore, given the dual dimension of health care in Nigeria (i.e. Western health care system in an African socio-ethical context), the harmonised framework becomes paramount for integrating the conditions of AFR with the attributes of PFR. Insisting on the former will overlook the peculiarity of Nigeria's communitarian context; likewise, focusing only on the latter ignores the reality of the institutional setting. In order to appropriately address the dual dimensions of health care for an effective and just outcome, the harmonised framework provides the more adequate ethical tool.

The simple formula for the harmonised framework of just health care (HFJHC) is thus:

$$\text{AFR} + \text{PFR} = \text{HFJHC}$$

In order to determine how this formula may be effective in practice, I will provide an analysis of an established health policy in Nigeria against the harmonised ethical framework. This will offer a first-hand indication of how the framework could be used to evaluate or review existing policies or strategic plans, as well as to inform the decision making process for new ones.

Chapter Six: An Ethical Review of Nigeria's National Health Insurance Scheme (NHIS)

6.1 Introduction

Thus far, I have described the health care situation in Nigeria and considered reviewing it against Norman Daniels' account of just health care – using the *Accountability for Reasonableness (AFR)* framework. Having noted the limitations of the framework, I have shown that a viable approach will need to account for the specific socio-cultural context, as well as the institutional setting of health care in Nigeria. Following this consideration, I have explored the African moral outlook and conceptions of justice, in search of appropriate underpinnings for the relevant ethical framework. My investigation has revealed three principles of African justice and specific moral outlook which should inform the relevant ethical approach towards just health care in Nigeria. The African moral outlook consists of four basic attributes, namely: Ubuntu, which constitutes the socio-ethical context; notion of personhood, which guides the assignment of meaning; vitality, which provides the conceptual framework; and the dialogic process, which guides the formulation and application of moral values in real life. The three principles of African justice include: truth, contentment and restoration. A further exploration of the three principles reveals an underlying methodological approach of *process equilibrium*, which differs from that underlying the ND Account of just health care. Against this background, I have developed a harmonised ethical framework that could inform just health care reforms in African countries.

Since the thesis seeks a viable approach towards just health care reforms in Nigeria, it is important to see how the harmonised framework can work in real policy situations. There are several policy documents and strategic plans in Nigeria, which have been designed to improve the health care system. Some of the major schemes include: the Revised National Health Policy (FMoH, 2005), the National Health Insurance Scheme, NHIS (2012), the National Strategic Health Development Plan, NSHDP, 2010-2015 (FMoH, 2010), and the National Health Bill 2014 (The Senate, 2014). For the purposes of

this thesis, I will review the NHIS as an example of how my developed framework could work. I focus on the NHIS for two reasons. Firstly, it has been in existence for over a decade and its strategies have been variously tested or challenged; and ten years provides sufficient time to make a relevant evaluation in view of substantive changes to the strategies employed previously. Secondly, of the five initiatives mentioned above, the NHIS has a more direct effect on the population, as everyone will need to seek health care at some point where some form of payment may be required.

In principle, the policy initiative, strategies and plans above show the immense effort being committed towards health care reforms in Nigeria. In practice however, the health care situation in Nigeria has not made notable progress in the past decade. One can link the ineffectiveness of the health care system to repeated failures in the implementation of existing policies, or the lack of political will to enforce specified recommendations. My proposition remains that the health care system needs ethical guidance in its policy development, as well as in the implementation process. The harmonised framework of just health care, as developed in this thesis, may offer a viable ethical tool towards developing just policies, and acceptable and effective implementation plans in Nigeria.

In this chapter, I will provide an ethical review of the National Health Insurance Scheme (NHIS). The implementation process has been variously assessed over the past decade, and the operational guidelines similarly revised to address issues not previously considered. Whereas many of the previous reviews have focused on socio-economic limitations, I will show that there are ethical limitations that remain to be addressed. In what follows, I will evaluate the conceptual background and the various programs of the NHIS in the light of the four African ethical attributes and the three principles of African justice. These should outline the relevant ethical limitations (that may be context-specific), and provide some guidance for future reviews. I will also show how the harmonised framework of just health care, as developed in this thesis, can provide ethical guidelines in the anticipated review.

6.2 Background of the NHIS

Following several decades of demands by the Nigerian population to achieve comprehensive health care coverage (see Awosika, 2005), the NHIS was instituted by decree in 1999:

There is hereby established a scheme to be known as the National Health Insurance Scheme for the purpose of providing health insurance, which shall entitle insured persons and their dependants the benefits of prescribed good quality and cost effective health services as set out in this Decree. (National Assembly, 1999, Sec. 1.1).

This opening statement suggests that some consideration of justice underlies the NHIS initiative towards providing quality health care to the population. However, this appears to be more on a generic level, as the guaranteed access is only considered for “insured persons and their dependants”. Yet, as shown in chapter two, the majority poor, employed or retired population may be unable to buy insurance; hence, denied health care. The just health care consideration here appears to be founded on a theory of individual rights; i.e. everyone who buys insurance, will accordingly be provided with all the stated benefits.

The first major limitation of the NHIS decree is that it is framed out-of-context. It assumes a rights approach to just health care which is inconsistent with the strongly communitarian context. Nigeria’s socio-ethical context is grounded in the basic principles of Ubuntu, where social interconnectedness is emphasised. Individuals are inherently linked to other individuals; and families, communities, and various population groups are also similarly linked. If quality health care becomes restricted to only those (individuals, families or population groups) who can buy insurance, the problem that the NHIS attempts to resolve will remain largely unsolved.

It is common practice in Nigeria that families (extended family) provide holistic care to sick members, including contributing towards the cost of treatment. If a person (with his household) is insured, but has a sick uncle or grandparent who is uninsured and lacks

financial resources, the former has some obligation to contribute financially towards the treatment of the latter. For instance, my grandmother (God rest her soul) died after being bed-ridden for over three years; she suffered from total paralysis. She had no insurance and no savings, yet required constant medical attention. This meant that my mother (her daughter) and we (her grandchildren) had the responsibility to take care of her, as well as cover the whole cost of treatment. Whether or not we were insured would not matter, as we would all still have to pay from out-of-pocket for her care. The point here is that providing quality care for those who are insured, and leaving out the uninsured in this communitarian setting does not alleviate the cost of health care to families, as the decree seems to suggest. In the light of Nigeria's communitarian context and the ideals of vital interconnectedness which shape it, the NHIS overlooks a major ethical concern, thereby setting it up for failure from the start. The underlying principle of the NHIS is inconsistent with basic African ethical attributes. As such, its capacity to deliver just access to health care for the population has serious limitations.

The NHIS' vision describes its commitment to secure universal coverage and access to adequate and affordable health care, in order to improve the health status of all Nigerians. Its mission is to: "...facilitate fair-financing of health care cost through pooling... [in order] to provide financial risk protections and cost-burden sharing for people..." (NHIS, 2012, p.xviii). The outlined objectives of the NHIS show that the principle of fairness underscores its *modus operandi*:

- i. ensuring that every Nigerian has access to good health care services;
- ii. protecting families from the financial hardship of huge medical bills;
- iii. limiting the rise in the cost of health care services;
- iv. ensuring equitable distribution of health care costs among different income groups;
- v. maintaining high standard of health care delivery services within the Scheme;
- vi. ensuring efficiency in health care services;
- vii. improving and harness private sector participation in the provision of health care services;

- viii. ensuring adequate distribution of health facilities within the Federation;
- ix. ensuring equitable patronage of all levels of health care; and
- x. ensuring the availability of funds to the health sector for improved services. (NHIS, 2012, p.xiii)

On a general scale, these objectives present the NHIS as an ethically informed scheme. For instance, the authors (policy makers) promise fair access to various health care services for all population groups. If this principle were met by the structural framework of the NHIS (see below), then the Nigerian population could not want for more in health care. On paper it looks as though everything is already in place; an ethical approach to national health care coverage. So why would one need a new ethical framework? When asking this question, one also has to ask: if the NHIS is established against the principle of fairness, why is access to basic health care services still a major problem a decade after the implementation process began? Could the principle of fairness have informed the initiative, but failed to steer the operational guidelines? Addressing these questions requires the guidance of an appropriate theory of justice, and a specific framework that provides relevant ethical guidelines in the policy process. The question of context remains paramount.

Thus, a theory of just health care will clarify the ethical foundations of such a policy, establish the moral basis for its legitimacy, guide the stipulation of entitlements to beneficiaries, and determine the obligation of the health care system towards ensuring equitable access. Such a theory, while acknowledging general principles of justice, will need to address the specific socio-ethical context of health care in determining the legitimacy of the NHIS guidelines. Therefore, I will review the NHIS' Operational Guidelines against the background of the four attributes of African ethics, as well as the three principles of African justice. This will help to show whether the NHIS in practice addresses the moral requirements of the contexts in which it is situated, or is simply founded against general principles that may be viable elsewhere. In order to establish the ethical limitations of the NHIS, I shall now turn to its structural framework. Here I will consider the various programs through which the NHIS operates.

6.3.0 Structural Framework of the NHIS

The NHIS operates through two major programs, namely: formal sector programs (FSHIP) and informal sector programs (NHIS, 2012). It also includes as a third category, the vulnerable groups program. These programs are further divided into sub-programs, to provide specifically for various population groups. Except for the vulnerable groups program, all others are entered into through earning-related or direct financial contributions (see NHIS, 2012).

As shown above, the NHIS promises equitable access to health care for all population groups. I will take this to include both employed and unemployed persons, as well as those with or without the relevant income. One could contend reasonably that poor households or unemployed persons should not fall into the general vulnerability grouping. Given the high poverty rate in Nigeria, as sustained by the high unemployment rate, this would mean that half the population were included in the 'vulnerable' group. This would lead to a loss of meaning of the term vulnerability, i.e. requiring special protection due to special circumstances (e.g. refugees, the disabled, and children). Given that earnings or direct financial contributions are necessary for all programs, other than the vulnerable groups program, NHIS benefits for elderly or retired persons are also limited. One sees therefore that the background structure of the NHIS already creates equity gaps, which negate its vision and objectives.

This outlook can be defended against more general ethical theories, including that of individual rights. Where there are obvious constraints on health care resources, relevant justifications can be provided for insisting on the required payments toward health insurance; i.e. paying some amounts will boost the financial capacity of the system to provide the necessary care, and those who make relevant contributions should get priority. There are further counter-rights arguments, which will propose covering those who cannot pay. But that can lead to an endless circle of arguments and counter arguments, whereas health care is urgent for many and the policy process needs to be undertaken soon. The African justice approach will save us the time.

The summative principle of African justice would emphasise a restorative approach, where the aim of health care (despite limited resources) will be the holistic welfare, not only of individuals and their households, but of the whole population. Therefore, the principle of restoration would not advocate covering individuals, families or groups who can afford insurance, and leaving out those who cannot afford it. A holistic restoration of the population's health would require putting strategies in place that will avert the kind of scenario described above. The restoration of an individual or household is not complete without a similar restoration for the wider family or groups with which they are inherently connected. To see these ethical limitations in a broader perspective, I will begin by focusing on the NHIS' formal sector programs.

6.3.1 Formal Sector Social Health Insurance Program (FSHIP)

The formal sector program covers public service employees; organised private sector employees, i.e. organisations employing ten or more persons; armed forces, police and other uniformed services; as well as students of tertiary institutions, i.e. colleges, polytechnics and universities (NHIS, 2012). Public service and organised private sector employees' contributions to the scheme are earnings-related:

For the public (federal) sector program, the employer pays 3.25% while the employee pays 1.75%, representing 5% of the employee's consolidated salary. For the private sector program and other tiers of government, the employer pays 10% while the employee pays 5%, representing 15% of the employee's basic salary. (NHIS, 2012, p.6).

For uniformed services, such as the armed forces, the earnings-related contributions equal 5% of participants' basic salaries. The scheme covers participants, their spouses and up to four children under 18 years old (NHIS, 2012, p.8). It includes, but is not limited to: basic health care services, like maternity care; advanced medical care, consultation with specialist personnel; and emergency care (NHIS, 2012, p.8-15).

One sees an unexplained disparity in the contribution rates required for the different categories in the formal sector program. Why, for instance, are federal government

employees (working for the highest level of government) required to contribute only 1.7% of their earnings, while other employees (working for the lower tiers of government, and the private sector) pay 5%? Also, no explanation is provided for the lower contribution of the federal government, at 3.25%, as opposed to the 10% from other employers. These are obvious questions that can arise from a more basic or general ethical review. The ND Account will also not miss this obvious limitation in contemplating just health care. For instance, it will ask: how can one explain these differentials in regard to justice or fairness, or the equity that the NHIS promises? The lack of justifiable rationales will raise further questions in regard to the four conditions of AFR. Specifically, there is neither public explanation for the differences, nor relevant reasons provided for the decision. This makes the current structure of the NHIS difficult to appeal against, in view of relevant revisions which would need to be made.

However, the African ethical attributes and principles of justice will take a different approach (especially when considered together with the other guidelines – outlined below). The inherent social interconnectedness means that others (with less ability or capacity) benefit appropriately from the provisions of more able or capable members. And the summative principle of restoration means that the latter are not whole without the relevant restoration to the former (in principle, as well as in practice). Hence, there may be a sense by which the disparity above is justifiable: i.e. say, public service employees contribute directly to the good of the national community, and hence should contribute less towards health insurance; and that private employees will complement that deficiency by paying more. However, this will only count where the latter earn higher wages, for instance. More importantly, the whole argument will only work (from an African justice perspective) if these contributions go towards providing health care for the whole population, which as will be shown below (see 6.3.2), is not currently the case.

Secondly, the Nigerian communitarian socio-ethical context means that one's dependants are not limited to wife and children only. The FSHIP considers 'dependant' to only include spouses and biological children: "eligible cover... refers to a maximum of four biological children of the principal under the age of 18 years" (see NHIS, 2012, pp.7-8). However,

the real context presents many households which include extended family members (e.g. children of other relatives, for instance, whose educational needs are being taken care of by the host family/household). Accordingly, the whole health and wellbeing of the host family can only be accounted for where the non-biological child living with them is also covered. Suppose such a family has only four members (husband, wife and two biological children – not counting the extended family). Even if they are covered under the FSHIP, there will be a further liability to buy additional insurance to cover the third non-biological child for whom they have the obligation of care. The FSHIP's guidelines thus ignore the relevant socio-ethical context, which means that it does not consider some important context-specific issues in health care.

One can already see a problem arising from the summative requirement of African justice for the NHIS. That relevant explanations are not provided regarding the payment differentials raises questions about the truth quality of the guidelines – truth being the fundamental principle of African justice. Also, the insistence on only spouses and biological children as dependants denies the true socio-cultural reality of the Nigeria's health care context. As seen in chapter four, African justice can harmoniously incorporate differences, where the explanations are acceptable and contentment is widely acknowledged. But this only happens if the truth process has been undertaken. The question is whether this has been the case for the FSHIP. Let us see if this is accounted for in the tertiary students program.

6.3.1.1 *Tertiary Institutions Social Health Insurance Program (TISHIP)*

Another important sub-category of the formal sector program is the program which covers students of tertiary institutions. It is paid for from funds pooled through students' contributions (NHIS, 2012, p.17-22). The contributions replace medical fees charged by institutions, are compulsory for all students, and institutions are currently required to charge a minimum of N1600 (less than £10) per session. The coverage entitlements are similar to those of other sub-categories in the formal sector scheme, except that no provision is made for dependants. The aim of the students' program is to ensure that they

have access to good health care services and to boost the quality of health care facilities in tertiary institutions (NHIS, 2012, p.18).

On the one hand, the minimum contribution benchmark for the TISHIP appears to relieve students from the excessive medical charges that some institutions may demand. However, this appears to ignore the fact that tertiary students come from different socio-economic backgrounds; and that some adult full-time students may have dependants (wife, children, and other extended family members). The problem is that a blanket payment requirement will have an unequal effect on different groups of students. For instance, adult students who are not employed in the formal sector, may have to pay for their own insurance, as well as those of their family members – assuming the spouse is also not employed in the formal sector. Considering the principles of contentment and restoration, this undermines the TISHIP's capacity to protect students and families from financial hardship due to medical cost – which it promises.

One may argue on grounds of fairness that the amount is meagre, and if pooled together will benefit poorer students even more. However, Tables 6.3.1, 6.3.2 and 6.3.3 below present recent statistics of the financial costs of education per student in Nigeria, against various backgrounds. The data show that the wealthiest families can invest more than four times the amounts that the poorest families can afford towards paying for education. Given the similarities in financial capacity by socio-economic background in the data for primary and secondary schools, one can infer a similar trend for higher education (for which no reliable statistics were available). Also tables 6.3.3 and 6.3.4 show that on average, Nigerian households cover over 90% of educational costs themselves. Direct funding from the government and other sources cover the remaining 10% or less. The relevant percentage for higher institutions will be similar, given the similarities between those of primary and secondary schools.

Given these data, poorer families with a similar number of members in tertiary institutions will incur a greater financial burden than richer ones. The supposed meagre amount can (in cumulative sums) increase financial hardship for poorer families. For instance, families who are not eligible for cover under the formal sector program as

above, and whose earnings are considerably lower, will make a comparatively greater financial commitment toward the overall cost of education. The compulsory students' contribution is thus an added burden to the already constrained financial resources of many families (as shown in chapter two). The communitarian nature of Nigerian society means that a child is not only educated for the interests of the (nuclear) family, but always in view of the larger family's welfare. Increased financial burden means that many students may not be able to enrol in or complete tertiary education, thereby affecting the welfare of their wider families.

Table 6.3.1 Per-Student Household Expenditures on Secondary Schooling for Students, 2009-2010 (NPC & RTI International, 2011, p.107)

Average annual per-student household expenditure (in Nigerian Naira) on secondary schooling in the 2009-2010 school year, by background		
Background Characteristics	Mean total expenditures (Nigerian Naira)	Number of primary school pupils
Sex		
Males	17,799.8	5,723
Females	19,162.9	5,177
Residence		
Urban	23,244.3	4,912
Rural	14,511.3	5,988
Region		
North Central	14,466.2	1,538
North East	6,775.4	838
North West	10,655.5	1,567
South East	23,151.7	1,713
South South	22,900.8	2,246
South West	21,741.5	2,999
Economic status quintile*		
Lowest	7,562.9	501
Second	8,044.5	1,117
Middle	10,430.4	1,514
Fourth	13,378.3	1,810
Highest	28,681.9	2,121
Total	18,447.5	10,900

*Statistics based on imputed data

Table 6.3.2 Per-Pupil Household Expenditure on Primary Schooling for Pupils 2009-2010 (NPC & RTI International, 2011, p.100)

Average annual per-pupil household expenditure (in Nigerian Naira) on primary schooling in the 2009-2010 school year, by background characteristics,		
Background Characteristics	Mean total expenditures (Nigerian Naira)	Number of primary school pupils
Sex		
Males	7,618.5	16,033
Females	7,776.4	13,723
Residence		
Urban	13,831.7	9,866
Rural	4,631.7	19,889
Region		
North Central	5,559.6	5,076
North East	1,974.9	3,760
North West	2,961.5	6,960
South East	9,657.9	3,555
South South	12,036.1	4,775
South West	14,253.6	5,629
School type*		
Government	3,660.1	21,893
Non Government	19,316.8	7,588
Economic status quintile*		
Lowest	1,944.3	3,781
Second	2,634.4	5,329
Middle	3,887.7	5,378
Fourth	6,718.4	4,354
Highest	20,214.6	3,515
Total	7,691.2	29,755

*Statistics based on imputed data

Table 6.3.3 Sources of Support for the Monetary Cost of Secondary Schooling 2009-2010 (NPC & RTI International, 2011, p.112)

Background Characteristics	Sources of support						One or more sources of support	Number of children
	One or both parents/ household	Child himself/ herself	Extended family	Scholarship	Borrowing	Gift from non-relative		
Sex								
Male	97.3	5.5	10.5	0.7	9.0	2.6	98.7	5,723
Female	97.2	2.6	11.7	0.6	8.6	2.3	98.6	5,177
Residence								
Urban	97.3	3.0	11.0	0.5	6.0	2.3	98.4	4,912
Rural	97.2	5.1	11.2	0.7	11.1	2.6	98.9	5,988
Region								
North Central	98.0	4.4	7.9	0.2	5.5	2.3	99.6	1,538
North East	86.9	15.8	13.6	0.8	6.8	3.1	91.7	838
North West	95.3	6.8	7.0	2.1	3.0	2.2	96.9	1,567
South East	98.0	3.0	20.4	0.6	15.2	2.0	98.9	1,713
South South	98.6	1.2	11.6	0.3	14.1	3.3	99.8	2,246
South West	99.4	2.3	8.5	0.3	6.6	2.1	100.0	2,999
Economic status quintile*								
Lowest	92.9	10.7	10.1	1.4	8.3	3.3	96.2	501
Second	95.1	11.2	10.4	1.3	9.9	3.1	97.2	1,117
Middle	97.0	5.6	10.7	0.9	9.4	1.9	98.5	1,514
Fourth	96.4	2.8	10.7	0.4	7.7	1.8	98.4	1,810
Highest	97.7	1.6	8.6	0.5	4.2	1.7	98.6	2,121
Total	97.3	4.1	11.1	0.6	8.8	2.4	98.6	10,900

*Statistics based on imputed data

Table 6.3.4 Sources of Support for the Monetary Cost of Primary Schooling 2009-2010 (NPC & RTI International, 2011, p.105)

Background Characteristics	Sources of support						One or more sources of support	Number of children
	One or both parents/ household	Child himself/ herself	Extended family	Scholarship	Borrowing	Gift from non-relative		
Sex								
Male	96.9	1.4	8.0	1.3	6.5	1.5	98.2	16,033
Female	96.9	0.7	8.7	1.4	5.9	1.6	98.1	13,723
Residence								
Urban	96.6	0.9	9.5	0.6	4.8	1.7	97.7	9,866
Rural	97.1	1.1	7.7	1.7	6.9	1.5	98.4	19,889
Region								
North Central	98.6	1.5	5.9	0.1	4.0	1.5	99.6	5,076
North East	87.9	2.9	9.2	0.3	5.2	1.8	91.5	3,760
North West	97.1	1.1	3.8	5.0	2.5	1.3	98.2	6,960
South East	97.4	0.5	18.8	0.4	9.9	1.5	98.3	3,555
South South	98.8	0.2	7.9	0.2	12.9	1.7	99.8	4,775
South West	99.3	0.5	9.4	0.1	5.6	1.7	99.8	5,629
Economic status quintile*								
Lowest	94.5	1.9	6.2	3.3	4.0	1.3	96.9	3,781
Second	96.5	1.5	5.5	2.5	6.1	1.2	97.8	5,329
Middle	96.2	1.5	9.3	1.1	5.3	1.4	97.6	5,378
Fourth	97.4	0.6	7.4	0.8	5.7	1.6	98.4	4,354
Highest	97.4	0.2	6.7	0.6	3.0	1.4	98.1	3,515
Total	96.9	1.1	8.3	1.3	6.2	1.6	98.2	29,755

*Statistics based on imputed data

Since the welfare of extended families is tied to the progress of those in tertiary education, a just approach to insurance coverage for tertiary students must consider easing payment requirements, as this has a reciprocal effect on their families' welfare. Where this is missing, the outcome would have missed out on the summative aim of African justice, holistic restoration, which is tied to the welfare of extended relationships. Yet again, the NHIS overlooks the specific socio-ethical context of health care in Nigeria.

6.3.2 The Informal Sector Programs

While my consideration above seems to suggest outright disregard for the communitarian nature of Nigeria's setting, the informal sector programs appear to show that my analysis may be overstating the case. The informal sector programs cover all the other population groups which do not meet the criteria described under the FSHIP. It features two main sub-programs: community-based, and voluntary contributions programs.

6.3.2.1 Community Based Social Health Insurance Program (CBSHIP)

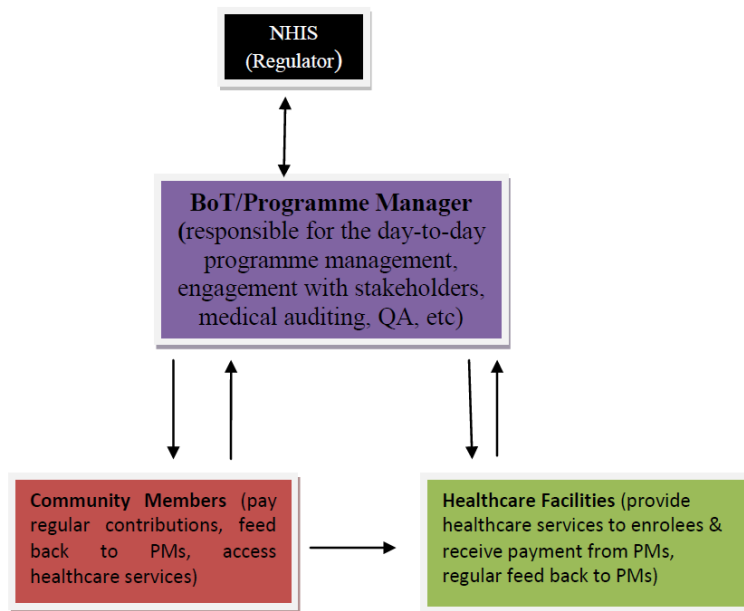
The community based program covers:

...a cohesive group of households/individuals or occupation based groups, formed on the basis of the ethic of mutual aid and the collective pooling of health risks, in which members take part in its management (NHIS, 2012, p.28).

Membership of the CBSHIP is voluntary and open to all, and considers either individual persons or family as the unit of registration within a given community or occupation group. However, it requires at least 50% of communities or occupation group members or a minimum of 1000 individual members to be willing to participate (i.e. make financial commitment) before the program can be established (NHIS, 2012).

This aspect of the CBSHIP appears to consider the attributes of *solidarity* and *process*. For instance, the CBSHIP management model recognises the cultural heterogeneity of Nigeria, and leaves specific guidelines to community discretion, providing only a basic structure (NHIS, 2012, p.29), as below:

Figure 6.4.1 CBSHIP Management Model (NHIS, 2012, p.29)



The management model allows the beneficiaries or communities to provide direct input to the management of the program:

...the community elected Board of Trustees (BoT) acts as the program managers (PMs) carrying out day-to-day... engagement with all other stakeholders... Existing community structures and organisations, such as village, community development committees... provide the platform for easy program take-off. (NHIS, 2012, p.29).

The CBSHIP looks to present the potential to meet just health care in view of the communitarian ethical and justice considerations. But there are two notable problems. Firstly, it remains the least developed part of the NHIS, as participation is much lower than that which obtains in formal sector programs. The lapse is attributed to the financial commitment required from community members, which most persons or families are not willing to pay. For instance, one study shows that less than 40% of respondents were willing to pay for CBSHIP membership for themselves or other household members, and the figure is less than 7% in rural areas (Onwujekwe, et. al., 2010). People willing to pay

in rural communities only considered contributing monthly premiums of N250 (£1) on average, and around N350 (£1.40) in urban communities.

Secondly, there are questions arising on grounds of African ethical values and principles of justice. Some major underlying principles of the communitarian context include solidarity and mutual interdependencies, which the CBSHIP appears to have already addressed – both of which are established through the dialogic process. The problem arises where the financial stipulations are compulsory and the size of membership is fixed. This already jeopardises the open-ended dialogic process that should guide CBSHIP. The point is not that limits should not be set for the CBSHIP. Rather, such limits should be set in relevant consultation with the communities. Otherwise, the whole process becomes an imposition of policy makers' specific expectations or considerations, which many communities may reject. The rejection will be a result of the understanding that elements of the community's dialogic process are not reflected in the imposed requirements.

In regard to mutual solidarity and interdependencies, the African understanding does not limit these to a nuclear application; i.e. only within communities. It involves individuals at the micro-level, and community interdependencies at the macro-level; i.e. one community may depend on another for what it lacks. Against this background, rural communities, for instance, appreciate their economic dependence on urban structures. The implication for the NHIS is that rural communities will expect that form of solidarity or interdependency to be reflected in the CBSHIP. For instance, they may know that public service employees get support from the government towards coverage, yet they get none. This would infer a deflection of solidarity, as the rural communities are aware that public service employees, most of whom are located in urban settings, enjoy better living conditions than they do. If they are supported toward health coverage, solidarity will imply making some kind of support available to rural communities. This lack of solidarity will amount to the consideration by rural communities that they are unjustly treated in regard to NHIS coverage. It provides some explanation for why even the few who are

aware of the CBSHIP are only willing to pay significantly less than the relevant benchmark.

6.3.2.2 Voluntary Contributors Social Health Insurance Program (VCSHIP)

Unlike the CBSHIP, the voluntary contributors program does not limit participation to specific communities or groups, as enrolment is on an individual basis. The VCSHIP is open to all citizens who are not covered under the other programs but who may wish to take up health insurance. Specifically, it covers interested individuals, families, employees of establishments with less than ten staff, self-employed persons, political office holders, retirees and persons of other nationalities, as well as dependants who are ineligible under the FSHIP (NHIS, 2012, p.23). The rationale is to provide all citizens with the opportunity to equally access health care, as stated in the motivation for the program: “to cater for those Nigerians who are yearning daily for opportunity to benefit from quality, affordable and cost reducing health care services...” (NHIS, 2012, p.23). Contributions for the voluntary program are wholly self-funded, and currently stand at the rate of N15,000 (approximately £60) per annum per insured person, and is subject to review. The coverage entitlements are similar to those of the FSHIP, except that no dependents are included as enrolment is on an individual basis. This is in contrast to the coverage under the FSHIP, where spouses and up to four children are included.

The enrolment fees appear to be low, especially compared to the cost of health care services or medicines around the world. From this outlook, it is easy to conclude that the VCSHIP is consistent with a relevant approach to just health care. However, the official minimum wage in Nigeria currently stands at N18,000 (£72) per month, as approved by law in the National Minimum Wage Act (National Assembly, 2011). Yet many employed persons still earn less than this amount (Nwogu, 2015). Given these figures, the more basic ethical question is how many persons who are not employed in the formal sector can afford this payment for themselves and their dependants. Suppose one earns a minimum wage and does not qualify for the FSHIP, he/she will need to enrol for the VCSHIP. Where this person has an unemployed spouse (as is common in Nigeria) and four

children, the burden of buying health insurance will lie solely on the working spouse. The total cost of health insurance for the household will be N90,000 per annum. Given total annual earnings of N216,000, about half of the family's income will go towards buying health insurance. This amount is certainly unaffordable for such families, and many households would therefore give up the option of health insurance for other more immediate needs.

Additionally, if one takes a clue from the data that shows the working age population without employment to be 45% (see section 2.2.3.3), it will mean that a larger proportion of this population group cannot afford health insurance for themselves. In light of the ND Account, one can say that the individuals in this population have their future opportunities in the balance, as they are not guaranteed health care in the event of a medical emergency. The African approach to just health care will consider the ND Account's view to be narrow. The vital social interconnectedness, which obliges solidarity and endorses interdependencies, means that the 45% unemployed will mostly rely on the other 65% employed (within that population group) for their health care cost if/when the need arises.

The communitarian structure means that in real conditions, many of the unemployed get some financial support from the employed towards the cost of health care (especially where there are family relationships). In the long run, the 65% employed (assuming they are formal sector employees, and are insured) will have their financial resources affected by the non-coverage of the 45%. In order to ease the financial hardship from huge medical fees for families, as one NHIS objective emphasises, the framework of the VCSHIP must also account for this proportion of the unemployed population. Such provision will help to ensure that the employed population is able to take care of their other needs with the same funds that they would otherwise be obliged to commit towards the health care of other family members or relatives.

Therefore, if the VCSHIP is to be successful, the guidelines will need to recognise the vital social interconnectedness of Nigerian society and address it accordingly. As we have seen from the four ethical attributes, participation in others' problems is not optional, where

there is an inherent relationship. Solidarity, and hence participation, is a moral obligation. Financially capable persons are obligated to contribute towards the medical cost of ill, non-insured family members or relatives. The NHIS which presumes to care for the health and wellbeing of the population must assume a similar obligation towards solidarity and participation in the health care coverage of the unemployed and unemployable population groups. This would involve making special considerations for: children between 6 and 18 years old, who may not be qualified for coverage under the current guidelines; the working age population without employment; and elderly persons or retirees. Lumping these population groups together under the current VCSHIP guidelines is inconsistent with the key African ethical values and principles of justice.

Given the communitarian framework underlying health care in Nigeria, the relevant approach may consider setting up a kind of solidarity fund that will be drawn from the earnings of those with comparably high income. What is pooled can then be used to provide the required coverage for the three population groups mentioned above. This does not presuppose a complete non-payment framework, as money will have to be drawn from somewhere. This is where the dialogic process becomes important. The relevant communitarian deliberations will help to establish the acceptable limitations in terms of how much will be pooled, and from whom. Of course there are other needs that also deserve consideration for these groups. However, since health is acceptable as the most basic of these needs, there is a communitarian obligation to ensure that those members who lack the basic capacity to afford the seemingly low financial contribution towards health insurance are also provided for. This will work not only for the good of these individual persons; the ultimate aim is the welfare of the whole (national) community or population, given the nature of the communitarian framework and the relevant moral obligations.

6.3.3 Vulnerable Group Social Health Insurance Program (VGSHIP)

As if in response to the questions raised above, the vulnerable group program appears to meet the relevant solidarity consideration for this group. Programs under this scheme are “...designed to provide health care services to persons who due to their physical

status cannot engage in any meaningful economic activity” (NHIS, 2012, p. 33). These include: persons with physical or mental disabilities; prison inmates; children under five years old; refugees, victims of human trafficking, internally displaced persons, and immigrants; and pregnant women and orphans. One is eligible for the program only by qualifying as vulnerable (NHIS, 2012, p.35). Hence, unlike the formal and informal sector programs, the VGSHIP does not require any form of financial commitment. Contributions are provided by all three levels of government and other agencies, and the entitlements are the same as those of the formal sector program (ibid).

The conditions of the VGSHIP are ethically plausible, and can be defended against any modern justice philosophy, as well as the human rights framework. For instance, the ND Account would explain that providing coverage for the vulnerable population will enhance their already limited range of opportunities in pursuing their life plans. There is, however, a special sense in which the African ethical framework will consider this consideration plausible. The communitarian framework as founded on the vitality principle emphasises the inherent interconnectedness between individuals and among communities. The vulnerable population, especially children, elderly persons and people with disabilities are considered a special part this chain. Hence, in traditional African settings, for instance, anyone so defined was not the sole responsibility of the immediate families; other extended family members, relatives and persons within the neighbourhood also participated in their care (Mbiti, 1990, p.107ff). It is still a common practice, even in contemporary urban settings, for neighbours or family friends to feel obliged to caution children or young persons when they behave inappropriately. The point is that taking care of this population group is by reciprocation taking care of the community’s welfare – or even of oneself, as the case may be. Hence, caring for the vulnerable is not impelled by a principle of fairness, opportunity or rights; the focus is the whole welfare of the community, which includes both the vulnerable persons and their carers.

Thus, the obligation of solidarity and vital participation constitute the grounds for the moral obligation, the end of which is communal welfare. There is a sense in which the

VGSHIP demonstrates *solidarity* with the vulnerable population in providing unequivocal coverage. And in guaranteeing their health care it offers them the chance to vitally participate in the lives of their families and communities. Although the VGSHIP does not indicate the above as its grounding principle, doing so may help to make it more effective, especially in pooling the funds from the intended agencies. This can even help to broaden the contributory network to include willing individuals who have more financial resources at their disposal.

Against this background, and deriving from the African ethical dimension of just health care, I would propose a *Communitarian Solidarity Health Care Fund*, which will constitute funds pooled from those who have disposable wealth, and donor agencies, as well as individuals who would wish to contribute. The aim of the fund will be to provide coverage for vulnerable groups, as well as the unemployable or long-term unemployed persons who can easily pass as vulnerable. The fundamental principle will be that of community or population welfare; contributing to the fund will entail the welfare not only of the beneficiaries, but also that of the contributors – in the light of the principle of reciprocity. Reciprocity here does not refer to a kind of favour that beneficiaries would be expected to return to the donors. Rather, it refers to the associated welfare benefits that the donors will stand to gain in enhancing the welfare of the beneficiaries. Hence, what one gives towards the fund also enhances one's own welfare, in the long run, through the harmonious workings of the community/society.

Whereas the NHIS fundamentally aims to ensure access to health care for Nigerians, and to reduce the financial burden of health care on families, considerations from an African perspective of just health care show that it is not informed by the local context's ethical dynamics. Its operational guidelines appear to be justified against some rights theory, which is not consistent with the communitarian socio-ethical context. A noteworthy reform of the NHIS needs to be guided by the relevant ethical values and principles of justice that underlie the Nigerian social structure. I would suggest that in its current form, the NHIS guideline may be more acceptable in a socio-ethical context that is rights oriented – in the United Kingdom, for instance. The conceptual frameworks are informed

by ideals of individual rights, and do not account for the communitarian structure or the local considerations of justice. The relevant ethical approach towards a more context specific reform is provided by the harmonised framework of just health care, as developed in this thesis.

In spite of these limitations (noted above), it may be that the implementation of the NHIS might reveal a more positive impact. Therefore, before making any conclusive ethical claims, it will be worth exploring the implementation process and outcomes of the NHIS since its establishment.

6.4 Ethical Evaluation of the NHIS' Performance

The implementation process of the NHIS began in 2005 with the partial rollout of the formal sector programs (Joint Learning Network, 2015). It was consolidated by the Revised National Health Policy (FMoH, 2004, Sec. 5.17), which obliged all tiers of government to review their allocations for health care resources in order to give priority to under-served groups and areas. The revised policy reviewed the underlying principle of the NHIS to include: equity, availability, acceptability, accessibility, affordability, efficient use of resources, community participation, and sustainability (FMoH, 2004, Sec. 5.17). The immediate problem with this statement is that the grounds are not substantiated; the policy does not indicate the relevant ethical guidelines or justifications by which it will defend these principles, or against which relevant demands for the NHIS benefits can be made. This function was left to be undertaken by the NHIS Operational Guidelines discussed in 6.3 above; the specifications were motivated by the policy's directives.

A decade later, only around 5 million people, or 3% of the Nigerian population, are enrolled in the NHIS (Dutta & Hongoro, 2013, p.1). This means that approximately 165 million Nigerians are not covered and are thus ineligible to benefit from the NHIS package. Studies have shown that a large proportion of the 3% enrolled are employees in the formal sector (Chubike, 2013; Akinwale, Shonuga & Olusanya, 2014). By inference, the population not covered by health insurance will be mostly persons or households

within the 27% unemployed population group, or the 69% of the population living below the poverty line⁴⁶. It is also likely that small scale business owners (a major form of employment for many Nigerians) are among the 97% uninsured persons.

Given these figures, one can conclude that the foundational objectives of the NHIS have not been achieved. With 97% non-enrolment, one might argue that the system effectively does not exist for the population, let alone achieve just health care. One may wish to attribute this failure to the design or implementation of the scheme. I would argue, however, that a greater part of the challenge lies in the ethical values informing the NHIS Operational Guidelines, as well as the implementation process. I have already shown the limitations in the light of the local context's ethical framework. In what follows, I will investigate the implementation process in light of the three principles of African justice, to see how the African ethical framework can better inform the NHIS in practice.

Awareness of the NHIS and its Benefits

Despite being in existence for over fifteen years, public awareness about the NHIS remains very limited. Surveys conducted show that public knowledge about the NHIS is narrow (Olugbenga-Bello & Adebimpe, 2010; Chubike, 2013). The wide lack of awareness shows that there has been little to no public participation in the processes leading to the establishment of the NHIS. If the population was involved in such an important process, they would not suddenly forget that it exists. African justice requires substantive participation. Where this is lacking, the legitimacy of an ensuing decision risks being rejected among local communities. One can see this salient rejection in the attitude of the rural population toward the CBSHIP. They were not involved in the process, they do not know it, and hence, they do not recognise its legitimacy. The hesitation derives from a non-recognition of the *truth principle* – the foundational principle of African justice – in NHIS proceedings. This provides some explanation for the larger failure of the CBSHIP. One cannot speak of holistic restoration, which is the goal of

⁴⁶ Details have been provided in chapter two.

African justice, where such participation is lacking. If restoration is the summative principle of justice, then considering the massive non-participation, just health care through the NHIS remains far-fetched.

As the mediating principle of African justice, *contentment* plays a vital role in legitimising decisions made or specific plans that affect the population's wellbeing. The rate of contentment with the NHIS will determine its legitimacy from the population's perspective. Of course, the NHIS is legitimised by constitutional endorsements. However, it still needs the public's endorsement in order to be legitimate in practice – in a similar way that a dictatorial regime's laws may be legitimate within the law of the country adopted by the regime, yet rejected by the relevant population.

Since only a fraction of the population is enrolled in the NHIS, one cannot generalise their contentment level to the much larger unenrolled population. Much of the existing literature presents good rates of satisfaction among beneficiaries of the NHIS (see Obikeze et. al., 2013; Akande, Salaudeen & Babatunde, 2014; Mohammad, Sambo & Dong, 2011; Iloh et. al., 2013). One common limitation of these surveys however, is that they mostly focus on narrow population groups. For instance, Akande, Salaudeen & Babatunde's (2014) survey was conducted in the staff clinic of a University Teaching Hospital. One would expect persons using this facility to be among the first beneficiaries of the NHIS, given that they will be mostly health care personnel or other persons close to them. We cannot extend this claim to, say, users of a health clinic in a remote community. Also, if only 3% of the population currently benefit from the NHIS, and only a proportion of these people are content with the services, the discontentment rate is likely to escalate once we include the larger unenrolled population. Thus, in the light of the unaccounted population, and what this means for the mediating principle of contentment, the NHIS has yet to meet the basic requirement of just health care for Nigerians.

NHIS Access in the Informal Sector

The CBSHIP, as previously discussed, also covers small business owners or artisans, aiming to create community-like groups for efficiency. Subscription amongst this population group is no different from what is shown in rural communities. Akinwale, Shonuga & Olusanya, (2014) show that artisans⁴⁷ are generally uninformed about the NHIS, and those who have some knowledge raise concerns about the financial requirement. They observe that while self-financing for health care remains the norm for persons in this population group, most are either indifferent to or displeased with NHIS programs– as some respondents affirm:

Of course! Why not. We are surviving already. With NHIS or without NHIS life must go on. Government just introduced NHIS in less than 10 years. Have we not been surviving before, and does the government really mean well for the people?

...What have I benefited from the government since the day I was born? I am close to 50 years now and I cannot see the impact of government in my life... I pay for everything I need... (Akinwale, Shonuga & Olusanya, 2014, p. 16).

These reactions represent the position of most persons in the informal sector about the NHIS generally (see Agba, Ushie & Osuchukwu, 2010; Christina, et. al., 2014; Onyedibe, Goyit & Nnadi, 2012; Sanusi & Awe, 2009). The above persons do not see how the NHIS can contribute meaningfully to their lives, yet the ultimate aim of the NHIS should be the holistic restoration of the population's health and wellbeing. If the people for whom the scheme is meant do not recognise its legitimacy, we cannot talk about the restorative focus of the NHIS, which African justice would oblige it towards.

⁴⁷ Artisans here refer to small-scale business owners, including: barbers, blacksmiths, designers, drivers, hairdressers, painters, plumbers, tailors, and photographers, among others.

6.5 Achieving Just Health Care through the NHIS

Thus far, one can see that despite the well-meaning intent of the NHIS as described in its main objectives, both the operational guidelines and implementation process have been marred by inadequacies that raise ethical concerns. This is especially problematic when considered in the light of basic African ethical values and principles of justice. For instance, the approximately 5 million Nigerians enrolled in the scheme gain plausible health care benefits from the NHIS, while the entitlements for the remaining 165 million still hangs in the balance. The communitarian ethical framework does not endorse a situation whereby only a few gain from a scheme that is designed to benefit the whole community. It also does not endorse a scheme that is designed to benefit only a few members, unless the other members unanimously choose not to participate. And in the latter case, it will mean that such a scheme is considered illegitimate. Against this background, one can say that the NHIS lacks legitimacy among the local population.

In order to promote enrolment through media publicity, one often sees what appears to present the NHIS as a generous offer from the government (policy makers) to the population, as the report below shows:

Yemi had never really been able to afford hospital treatment... Already a mother, she was pregnant and jobless when her husband died... luckily, she resides... in one of the states benefitting from the NHIS... her local government was chosen for the pilot project. This was the saving grace for Yemi...

Kelechi, a 20 year old orphan... became pregnant in the process of making ends meet. A Good Samaritan who turned out to be a nurse... got her to enrol on the free NHIS/MDGs project...

Ali Egba... a government employee suddenly passed out in front of his house... an enrollee under the scheme. He was... rushed to the hospital where he presented his card and was treated free of charge.

This and many more, health watchers say, justifies the reason for the NHIS to function effectively. (Obinna, 2012)

One finds many such reports in the media about how citizens have benefitted from the NHIS, as well small health projects that some state or local governments have undertaken. However, what these reports do not tell us is how many such people actually benefit from the health care system, and what proportion of the population these constitute. At best, one can describe such reports as presenting the NHIS as a charitable course towards the health and wellbeing of the population, especially the vulnerable. This kind of perception reflects a sense of distance between the population and the health care system. It means that the population is not involved (especially) in the planning processes of the NHIS. In the communitarian structure, developments made without due consultations with communities often come across as some generous favours from well-meaning persons. The local population does not consider itself to be a part of the project. From what I have described so far, the NHIS appears to take this form among local communities, most of whom would not consider themselves to be a part of the program. Hence, individual persons or groups mostly do not understand their legitimate claims or benefits.

The perception noted above indicates that the imperatives of the NHIS are not adequately understood. Without the appropriate understanding, the population cannot hold policy makers and health service providers to account, in view of their entitlements. Therefore, the challenge remains for the NHIS to integrate the harmonised ethical framework within its structure. Metiboba (2011) has shown that one of the NHIS' major challenges is the non-involvement of the population in the critical stages of planning, decision-making, and implementation. He proffers "beneficiary or citizen participation" as a way of inclusion in the NHIS (Metiboba, 2011, p. 54). In order for such inclusions to be effective and just, they could be informed by the harmonised ethical framework developed in this thesis.

Establishing a *Communitarian Solidarity Health Care Fund* can enhance such participation, where not only members of local/village communities contribute to the fund, but also governmental and non-governmental agencies and well-off persons around the states. The solidarity dimension of the fund will serve as a guarantee to local

communities that they are an essential part of the project. Hence, they will be willing to fully participate in the scheme. Such an approach will not only make the NHIS successful among local communities or groups, but also help the population to realise that they have legitimate claims to adequate health care from the system.

6.6.0 NHIS and the Harmonised Ethical Framework

The challenges surrounding its implementation, especially the extent to which it guarantees health care access to under-served population groups, leaves much to be desired in terms of justice from the NHIS. Given that Nigeria's context of health care remains strongly communitarian, simply publicizing the NHIS programs may not suffice to grant it legitimacy. As shown by some reactions of people who fall under the informal sector programs, the NHIS' Operational Guidelines are not acceptable to many. Hence, the publicity dimension needs to integrate the element of solidarity. Through this integration, communities and groups will be involved in developing the requirement and benefits of enrolment, for instance. This will also ensure that the system gives equitable priority to the health care of the under-served population or communities, as well as economically well off groups. Thus, the NHIS needs to be informed by the harmonised ethical framework. In what follows, I will provide a basic demonstration of how the harmonised framework can inform a more just reform in the NHIS.

6.6.1 Attribute of Solidarity & Publicity Condition (AS+PC) in the NHIS

As with many other policy processes in Nigeria, there was no wide public participation in developing NHIS programs. This is re-iterated by the massive non-awareness among the population ten years after the implementation process began. As well as not being part of the planning process, the population still has a minimal say about their place in the NHIS, as information about the proceedings are not available. For instance, one can find relevant information about the enrolment process and benefit package on the NHIS official website (<http://www.nhis.gov.ng/>); yet no information is provided about the rationale for the stated enrolment amounts, for instance. If the population was not appropriately involved in setting up the NHIS programs, and they are not provided with

all the information with the relevant explanations, one would not expect them to suddenly become eager about participating in the programs. For in the first instance, they were not part of the scheme's design process; and if the implementation appears to be simply an imposition of what was designed without their endorsement, then participation becomes even more difficult. A distance has already been established between the NHIS and the population it aims to serve.

Bridging this gap will entail integrating elements of solidarity into the scheme. Solidarity is an essential requirement of the African communitarian ethic; it is not optional or supererogatory, as some ethical theories would present it. The requirement for solidarity is defended by the four basic attributes of the African moral outlook discussed in chapter four. If a person is a person through other persons, then there is a sense in which we are all in a vital relationship with one another; one can only define him/herself in relation to the other. Consequently, solidarity cannot but be an essential requirement in this kind of setting, which one finds in Nigeria. Against this background, solidarity will require that the health care needs of all citizens be accounted for regardless of their socio-economic conditions. The NHIS so far lacks the basic requirement of communitarian solidarity. Establishing the *Communitarian Solidarity Health Care Fund* will thus provide the first reasonable step towards achieving greater participation in the NHIS.

The inclusion, through the solidarity approach, will have effective benefits for the underserved communities or population groups by giving them:

- a) negotiating power from the onset of the NHIS, as well as the power to hold policy makers and service providers accountable in regard to the specified claims; and
- b) a sense of ownership of the NHIS, and the assurance that the system shares in (or is in solidarity with) their health care concerns.

Without demonstrating solidarity in these or similar forms, the publicity about the NHIS will mean little or nothing to most people, thereby undermining its legitimacy. For instance, many people do not see a reason for the personal contribution that makes one eligible for the NHIS programs (see Odeyemi, 2014; Akinwale, Shonuga & Olusanya, 2014;

Onwujekwe et. al. 2009). This view may appear naïve, yet it presents the reality of the situation. Even if it is naïve thinking, the problem remains that participation in NHIS programs is extremely low, since only 3% of the population is enrolled. If substantive community participation was not considered in the initial process, any future review process must take it seriously. Participation remains the most significant means to demonstrate to communities or population groups that the scheme is in solidarity with their health care and wellbeing.

Thus, the NHIS needs to integrate publicity with solidarity in order to meet the requirements of the harmonised framework of just health. This will make it legitimate and acceptable to the population. There will be some difficulty in determining the process of integrating solidarity or making participation an essential part of the process. We can rely on the attribute of process to achieve this.

6.6.2 Attribute of Process & the Relevance Condition (AP+RC) in the NHIS

Given the consideration of solidarity, the NHIS will need to relax its present mechanistic method and incorporate an approach that is recognisable to the population it serves. The current outlook of the NHIS' programs appears to show that it has relied on relevant empirical justifications (such as statistical data that many people do not get health care because the medical bills may be too costly), and then proceeded to establish an advanced form of payment method through health insurance. However, such empirical explanations are by themselves insufficient as they cannot explain the communitarian structure for instance, and what the relevant approach to providing health care to identified communities can be.

In regard to the relevance condition proposed in the ND Account, the empirical approach described above would suffice. However, the African communitarian process has some requirements that are substantively different from those the relevance condition considers appropriate. We must go beyond emphasising the empirical relevance (or Relevance Condition, RC) to include the relevant communitarian process, in designing NHIS programs. One can claim that in both principle and practice, the current design and implementation process of the NHIS constitutes an established framework that has been

effective in another health care system, perhaps in Western Countries. Local adaptations or processes have not been incorporated into the scheme's formulation and implementation.

In order to make it effective under local conditions, local processes must be adopted. One such adaptation can be done by establishing a dialogic process in setting up the *Communitarian Solidarity Health Care Fund*. Policy makers should not just sit in the Ministry of Health to set up the framework of the fund; they must include the considerations of the local population for whom the fund is being established. The dialogic process entails a justifiable participation by the relevant communities or population groups. The aim of the dialogic process is not simply to know the wishes of the local population and then set up the fund according to what they demand. Rather, it will be an exchange of ideas, expert advice, and local situation experience, in a bid to determine what will best serve the health and welfare of the community or population group.

In light of the Attribute of Process (AP), the CBSHIP, for instance, will not have its stipulations (i.e. requirements and benefits) dictated by policy makers. Rather, basic guidelines will be provided against which small communities or relevant population groups can determine or negotiate their specific insurance terms. This means that NHIS planning and implementation processes will integrate local meanings and procedures. Where the local forms of dialogic processes have been considered, the population's actual needs can be appropriately integrated into the NHIS. This may appear difficult or almost impossible in the real context of health care.

However, we cannot remove health care from the actual ways of life of the people, otherwise strategies developed towards health improvement will just not work. If what is currently being attempted does not work, policy makers are obliged to adopt a new approach, which may be unprecedented. We have already seen in chapter one that Cuba's unprecedented and seemingly impossible approach has worked – the main reason being the focus on the local population's way of life, and patterning health care delivery through it. The recommendation for incorporating a dialogic process may be unprecedented in

health care, but remains an established method in of decision making in daily life across Nigeria, and in much of the African continent. The NHIS thus has an imperative to consider the local processes in order to make its programs more acceptable to the population. This will ensure wider participation in the scheme.

6.6.3 Attribute of Reciprocity & Appeal/Revision Condition (AR+ARC) in the NHIS

The idea of vitality (see “force thesis” in section 4.2.3) suggests that the relevant approach will consider the reciprocal effect of health care services within the relevant population group. Within the communitarian structure, there is an obligation to take care of ill persons, as well as all elderly persons, especially within family circles – which includes providing for their health care. This means that if one is sick, not only himself or his/her spouse is responsible for their care – including paying medical bills where the need might arise. In the light of vital reciprocity, the ill health of one person becomes an illness for everyone around the person. Therefore, in considering a reform of the NHIS, accounting for local conditions will involve integrating elements of reciprocation into its framework. For instance, the formal sector program’s coverage should not exclude non-biological children who are being cared for by enrolled families from its dependants’ clause. Also, considerations should be made to include elderly persons into the coverage framework for the persons who have direct responsibility to provide care for their grandparents, for instance.

It is worth mentioning here that in Singapore, persons are obligated under the law to provide care for their elderly parents (see Attorney-General’s Chamber, 1996), which is different from the kind of elderly care provided in countries like New Zealand or the United Kingdom. The point is that Singapore’s strategy is built on their local values, and I would want to believe that the United Kingdom’s approach is also built on British values. Thus, if the NHIS is to be successful in Nigeria, it must similarly reflect Nigerian values, among which vital reciprocity is essential. The reciprocity dimension of the NHIS will complement the *Communitarian Solidarity Health Care Fund* to ensure wider coverage of local communities, and lighter burdens of health care costs on families and persons who take care of others within communities.

Accordingly, in considering the appeals/revision condition (ARC) proposed in the ND Account, the NHIS should not be constrained by the kinds of reasons (logically sound or effective counter evidence) that ARC would endorse. Rather, the NHIS should consider ARC against the background of reciprocal dynamics underlying health care in the local context. Revisions to the NHIS will be more effective if considered against this reciprocal-restorative background. Colombia's "*solidarity contribution*" fund which targets economically disadvantaged persons or groups can be considered potentially relevant to the NHIS. It pools financial resources from financially well-off groups to consolidate the insurance of the poorer population (Dutta & Hongoro, 2013, p.6). Similar approaches also exist in most European countries. However, the mainstay for the NHIS will be the emphasis on strategies that also have reciprocal-restorative effects on families who assume responsibility for the care of sick members, elderly and young persons.

6.6.4 Attribute of Harmony & Regulative Condition (AH+ReC) in the NHIS

The underlying idea of the reciprocity approach is to create a harmonious approach to health care, as well as a harmonious health care system. A solidarity approach in the NHIS will, beyond supplementing publicity, also accord with the local processes. Its inclusion will strengthen participation in NHIS programs. Adopting the local processes and modes of meaning will help to balance the power differentials in the future revisions of NHIS Operational Guidelines. Consequently, the benefits of the NHIS will not be constrained to the consideration of each individual person's health, but will give broader consideration to the health and wellbeing of the population as a whole.

If informed by the attribute of harmony, the NHIS' Operational Guideline will not be individual-focused, as it presently is. The communitarian structure means that one's health and wellbeing is always in harmony with those of other around them. Essential considerations will thus be made on how benefits will accrue to individuals not only as single entities, but in light of their vital relationships. The formal sector programs attempt to include this consideration, but limiting the dependant clause to only spouse and biological children betrays the harmonious social framework within which health care takes place. A harmonious approach to the NHIS will entail integrating elements of the

holistic understanding of health, and also address the local understand that the health care of one person is also a reciprocal care to those with whom they share vital relationships.

Thus, in designing the operational guidelines or regulations for the NHIS, considerations will be made for the harmonious effects on the relevant population groups. As stated above, a specific example will factor in persons who would generally be cared for by others, under the latter's benefits. If one is covered, for instance, one's retired father who would rely on him/her in the event of a significant ill-health should be covered under them. Likewise if one has taken responsibility for the care of a deceased brother's (or sister's) children, there should be relevant coverage for these children under the enrolled carer/guardian. The NHIS will need to demonstrate a commitment to the holistic welfare of families, communities or population groups; rather than of isolated individuals, as the current structure seems to suggest. This will require two basic strategies:

- a) creating a balance between the coverage of individual persons who fall within the formalised categories, while making supplementary provisions for those who may have more family dependants than biological children (e.g. children of deceased relatives and elderly relatives); and
- b) making specific provisions for economically disadvantaged groups, such as unemployed or underemployed persons, rural populations, and small-scale business owners (like market-women).

Achieving such a harmonised approach will mean the NHIS is consistent with the socio-cultural realities of the local population. This may appear to be similar to the stipulation of the World Health Report 2010 (WHO, 2010) which paves a pathway towards universal coverage in health care for all countries. And one may wonder if Nigeria can provide the harmonised coverage suggested, especially considering its population size and inadequate distribution of the available wealth and resource benefits. The harmonised approach to just health care that I urge the NHIS to adopt is unprecedented. Cuba was able to use a small fraction of the United Kingdom's per capita health care expenditure to achieve similar health outcomes (and better in some areas) for its population - the United

Kingdom has tried to learn from Cuba's approach (Boseley, 2000). Cuba's health outcomes compare well with those of the United States, Norway, Sweden and Canada (Coyne, 2014; teleSUR, 2014; Stone, 2014). It is known to have large number of doctors deployed in parts of South America and Africa in leading the way towards the population's health improvement with its unique model (Fitz, 2012; Huish, 2008; Campion & Morrissey, 2013; Chan, 2009). As mentioned earlier, Cuba used a locally developed approach to achieve this goal. If Cuba's health care has thrived under the unknown approach (unknown to the rest of the world), the harmonised approached proposed for Nigeria can/may in the future become an attractive model to even high income countries.

6.7 Conclusion

The NHIS presents a useful strategy towards realising equitable access to health care for Nigeria's population. It recognises that some population groups do not have their health care needs met, and attempts to guarantee access to the available resources and services. Through its main objectives, the NHIS promises to meet the basic requirements of just health care: to establish a process by which the whole population will attain sustainable health and wellbeing, through adequate and equitable access to health care. However, the NHIS' current structural challenges limit its capacity to guarantee access to health care for underserved communities or population groups. Its distributive strategy does not present a substantive framework for justice in regards to health care access across population groups. That only 3% of Nigeria's population is presently covered by health insurance leaves much to be desired for just health care.

In view of these limitations, I have provided the harmonised ethical framework of just health care as an effective tool. In adopting this harmonised approach, revisions to the NHIS Operational Guidelines will see more just provisions of health care, consistent with the local conditions (including social, cultural and economic features). Such an approach will be acceptable to the local population as legitimate; which means that they would have been actively involved in the various processes to a greater or lesser extent.

Incorporating the features of the harmonised approach will encourage greater participation in NHIS programs. The health improvement that the NHIS seeks for the population is achievable through the harmonised framework. It is important to note that the provisions of the harmonised framework presented towards revising the NHIS guidelines are not conclusive. More work still needs to be done to determine specific outlines of the required strategies that the harmonised framework will endorse, which will also be effective in practice.

Chapter Seven: Just Health Care in an African Frame

1.1 Introduction

The person with a disease condition is always in the best position to explain the nature of his or her health problem to the physician, assuming the former can reasonably engage in a conversation. This is exemplified in the difficulty that parents encounter in trying to explain their children's health conditions to a physician. Similarly, an African ethical approach is better placed to explain the relevant issues of justice in African health care than an ethical approach which is situated in another context. This is not to say that African health care has nothing to benefit from the contributions of other systems. Otherwise, it would be synonymous with saying that just because a child cannot speak for him/herself, the parents' description of the child's health condition cannot be helpful. Historical facts and contemporary experience regarding health care in and around Africa have shown that health care systems across the continent have greatly profited from the adoption of Western medicine and health care delivery strategies. However, the approaches to health care practice are mostly Western developments, with little or no adaptations to local knowledge or strategies. For instance, if a medical procedure or public health strategy has worked in the United Kingdom, the same approach would be transmitted and applied in Nigerian health care – the reason being that it worked in the United Kingdom.

While there is a wide subscription to traditional medicine among Nigeria's population, little has been done towards developing traditional therapies and approaches in the light of standards equivalent to or appropriately integrated with the imported approaches (see Awodele et. al., 2012; Awodele et. al., 2011; Tamuno, 2011; Fakeye, Tijani & Adebisi, 2007; Elujoba, Odeleye & Ogunyemi, 2005; Izugbara, Etukudoh & Brown, 2005). China is known to have appropriately integrated Western medicine with traditional approaches in advancing health care (see Chaturvedi et. al. eds., 2014; Nie, 2011; Unschuld, 1985). A similar undertaking could be useful in order to achieve better outcomes for population health in Nigeria.

One could venture that the Western health care system is effective and successful in Western contexts mostly because it originates from and is applied within the same context. The foundations of health care systems are thus shaped by the same contexts in which they are applied. The health care approaches understand the contexts, and vice versa; there is a shared sense of meaning between health care and the relevant context. However, the reality of contemporary African health care systems is that they are founded on Western frames. It is obvious that some benefits have been gained from using Western medicines in Africa. However, the more obvious disparity in health status between African and Western populations shows that over-reliance on Western approaches has not been as effective for African countries as they are in their original Western contexts. This appears to reflect the old saying that: *the disciple is not greater than his master, but everyone whose learning is complete will be like his master.*

If African health care systems are to be as successful as those in Western countries, which they emulate, it is important that they are also shaped by particular African contexts. As I have noted in chapter one, good health care strategies may not always be effective simply for being “good strategies” elsewhere; and local approaches have the potential to be more effective in the local contexts, as Cuba has shown with its innovative health care strategy. In attempting to solve Africa’s health care problems, one can learn from what has worked elsewhere in the world, but should focus on what works for the African context.

The point is that a health care approach developed from outside or out-of-context cannot understand the situation as well as, or even better than, one which emerges from within the local context. Notwithstanding the success rate of a health care approach in its original context, it needs to be appropriately informed by the new situation, in order to be effective in the latter’s context. I will illustrate this with an example of a friend’s experience:

An old friend told of his experience with his little daughter’s health, when she once developed a swelling on the cheek. They were referred from one hospital to another, and had several laboratory tests done. Diagnosis was made, yet all the

drugs prescribed were ineffective. Frustrated by the situation, he complained to one of his uncles about it. The uncle thought about the explanation of the condition, and suggested a local herb, which was found all around the area where they lived, to be squeezed and rubbed on the neck. That herb was the long-sought solution.

The fact that a seemingly minor condition evaded treatment may not be the result of a physician's lack of skills. However, I will consider it to be a case of inadequate understanding of local health conditions, which the relevant medical training may not have incorporated. Where local approaches that better understand the health context are overlooked, the situation can be likened to the application of an innovative medicine to a misdiagnosed condition; such as prioritising the distribution of useful Ebola vaccines in a malaria endemic community. The case is not different with the ethical approaches to just health care.

1.2 The Thesis

The motivation for this PhD thesis derives from the need to integrate local approaches into efforts to achieve more just and effective health improvements for Africa's populations. While acknowledging that the standard or internationally recognised approaches being deployed are useful, I have tried to show that they may not be sufficient for the desired health outcomes. Hence, I have argued that current reform strategies in African health care systems need to be informed by local ethical approaches in order to make them more just and effective for the local contexts of health care. My claim rests on the fact that despite the adoption of relevant and effective externally developed strategies (especially coming from Western countries) health care service delivery and the populations' health status in much of Africa does not compare well with those of Western countries, where similar strategies have been deployed.

My analysis is that if these strategies work for Western health systems, but not for African contexts, then we must also seek local approaches that can better explain and address the situation. Consequently, although the Norman Daniels (ND) Account has offered a useful

ethical framework for just health care reform, I have considered it more appropriate to integrate this with a relevant African ethical framework. The rationale for the integrated approach is that the ND Account hinges on a liberal Western ethical theory, which does not fit well with the African communitarian context of health care. If one insists on applying the ND Account to the African context, specific socio-ethical challenges will appear, as the attempts in East Africa have shown (see section 5.2.1).

Therefore, the appropriate starting point is to consider adapting the ND Account against the background of specific African ethical values and principles of justice, where this is possible. As a way forward, I have developed the *harmonised framework*, which captures African ethical values, conceptions of justice, and the underlying ethical method of *process equilibrium*, as the more appropriate approach to just health care in African contexts. The harmonised framework is an integration of the four attributes *Prerogative for Responsibility* (PFR) account with the four conditions of *Accountability for Reasonableness* (AFR) framework. Specifically, the harmonised framework combines the attribute of solidarity with the publicity condition; attribute of process with relevance condition; attribute of reciprocity with the appeals/revision condition; and attribute of harmony with the regulative condition. Thus, the harmonised framework considers the useful elements of the ND Account, but incorporates them into an African moral framework, which makes the emerging approach more appropriate to local health care conditions.

In developing the African approach or harmonised framework, I first explored the broad literature in African bioethics, to see how this may have attempted to address the ethical dimension of justice in access to health care or health promotion in parts of the continent, or as a whole. Large parts of the field of African bioethics are still in their infancy, when compared to the broad literature and applications in North America, Europe or Australasia. Hence, much of what one finds in the African bioethics literature appears to be attempts to apply Western bioethical concepts (which mostly define the international bioethics standards) – with a few exceptions (see section 1.4). While the main focus in African bioethics remains health research ethics, there is very little in the literature about just/ethical approaches to population health. This focus has been partly motivated by the

rampant scandals in medical research or trials in Africa over the past decades, and African scholars may have focused on that aspect due to its urgency. However, my argument has been that just access to basic health care is paramount, and without addressing this, other ethical issues become even more complicated. Hence, I considered it important to focus on a relevant ethical framework for just health care (access or promotion) as a crucial starting point.

Africa is vast, both geographically and culturally; hence, considering a relevant framework for such a massive continent would be ambitious. Hence, at the first level, I reduced my focus to Sub-Saharan Africa, given that the countries share much in common – in terms of cultural dynamics, social orientation, health status, situation of health care services, and economic conditions. At the second level, I narrowed the consideration to one country, Nigeria, as a case example, in order to avoid excessive generalisation of “African” issues. Hence, in attempting to describe the current health care situation, I focused my discussion specifically on Nigeria’s health care. A comparison with the United States helped to clarify the situation through a global lens, and to capture its urgency in terms of what justice requires for better access to health care. Against this background, I have tried to show the need to establish a relevant framework of just health care, which will provide ethical guidance to the current strategies being employed towards improving population health in Nigeria.

I have identified the ND Account of just health care as worth considering, since it provides ethical tools that have been tried and tested in various health systems, both in high and low income settings (see chapter three). The ND Account presents a coherent ethical framework, *Accountability for Reasonableness (AFR)*, which can guide decision making processes in health care towards more just and effective outcomes. It also provides nine generic ethical benchmarks that should be considered when evaluating the fairness of health policies or reform strategies in middle and low income settings. Given the health care situation in Nigeria (here exemplifying the African situation), the ND Account was found to present a useful tool towards more just and effective improvements. However, the ethical foundations of the ND Account hinge on “justice as fairness”, which is a liberal

Western theory that emphasises individual opportunity as the basic determinant of justice. This theory is substantively opposed to African ethical values, which provide the context for health care in Africa. The problem arises then, that simply adopting the ND Account in an African health care context will require an imposition of Western ethical values in widely communitarian settings, which is likely to be counterproductive.

While not dismissing the relevance of the ND Account, it becomes imperative to establish an African account that will appropriately consider specific values and principles that are relevant to the context. Accordingly, I explored the African moral outlook in order to abstract the relevant ethical values underlying the social context. I identified four key attributes of the African moral framework (see section 4.2). Against these attributes, and reviewing relevant justice proceedings in some parts of Africa, I have established African justice against three main principles: truth, contentment and restoration.

A further investigation of the African ethical attributes and principles of justice revealed a particular African ethical methodology: *process equilibrium*. Together, these three features constitute the foundation for an African theory, on which the relevant approach to just health care must hinge. In chapter six, I have attempted to establish the foundational framework for an African approach to just health care, which integrates these three features; hence the *harmonised framework*. If applied within African contexts of health care, the harmonised framework may yield better outcomes than the ND Account. For it is an African approach to just health care developed against African moral values, principles of justice, and modes of ethical evaluation.

Much of the work is theoretical, yet the aim has been to develop a practical tool for policy decision making and implementation of strategic plans. Therefore, I considered an initial application of the harmonised framework to an existing health improvement initiative in Nigeria. I undertook an ethical review of the National Health Insurance Scheme (NHIS), against a background of the relevant African ethical values. Through this, I have attempted to show the ethical gaps in the scheme which an African outlook of justice would not endorse. Having outlined the relevant limitations, I went on to provide an

initial analysis of how the NHIS could be shaped by the harmonised framework I suggested, towards achieving more just and effective health outcomes for the population.

1.3 Local Approaches to Just Health Care: Analogy of the Tortoise

Thus, I have developed a specific African approach, the harmonised framework, towards just improvements of population health in African settings. I consider the ethical framework as “African” on two grounds. Firstly, it has been developed in my capacity as an African scholar, specifically to address questions of just access in African health care. Secondly, it is consistent with the *principle of origination*⁴⁸, in that its substantive origin is grounded in African moral values and principles of justice. My approach does not attempt to undermine existing approaches, but rather to review them in light of their specific relevance to the African health care situation, as exemplified in Nigeria.

My exploration of an African approach to just health care can be explained by the analogy of a popular Nigerian tale about the tortoise– I recently learnt from my Ghanaian friend that a similar tale also exists in his local setting. As a preface, I would like to state that the tortoise is popular in African folklore for his shrewdness, which in most cases reveals his greed or self-centeredness. Part of the practical reason for the stereotype is that the tortoise is often found alone, unlike other animals who always walk in pairs or groups. For instance, there is an Akan proverb that says: “Because the tortoise has no clan, he has already bought himself a coffin”. This simply means that the tortoise is aware that since no one will be there to bury him when he dies, he will have to prepare for his own funeral. Now my story:

A long time ago, there was a big festival in the sky and all animals were invited to the celebration. Tortoise heard about the festival and wanted to attend, but foresaw a problem: he could not take himself to the sky. He decided to associate with the community of birds long before the event, and became like one of them.

⁴⁸ An idea which I have recently been developing with a colleague, Frank A. Abumere.

On the day of the festival, after everyone got ready for the event, tortoise explained his predicament to the birds – he could not fly like everyone else. Of course being one of them already, the birds gave a feather each to Tortoise without question. Tortoise gathered enough feathers to make wings strong enough to fly him to the sky.

As they all flew to the sky, they told each other stories and laughed. Each one mentioned the nicknames by which they wished to be addressed at the festival. Tortoise nicknamed himself *All-of-You*: “I am All-of-You” he noted. At the festival all guests were entertained according to groups: food and drinks were served to groups – not to individuals. When the first set of drinks were brought to the Birds’ community, Tortoise purposely asked the attendant: “Whose drinks are these?” The attendant responded: “They are for all of you!” Then Tortoise turned to the birds and said: “Did you hear the attendant? She said the drinks are for *All-of-You* – she called my name; yours might be served soon”. The same thing happened when snacks were served. And when the main food was being served, Tortoise repeated the same trick.

Tortoise had his fill at the festival: he ate and drank and got drunk, throwing food and drink away. In all of this, he never considered offering anything to the birds – even when they begged him – who went hungry and thirsty all day. Then came the end of the event and time to return to earth. The birds were obviously displeased by Tortoise’s individual focused “All-of-You” attitude, and they all took their feathers back from him. They flew back to earth, leaving him behind. Tortoise had considered this reaction in advance, and already had an idea: “I only needed feathers to get up here; it is easy to come down to earth from here. I have a strong shell on my back, so I will just jump down backwards – my landing should be smooth”. Tortoise jumped and crash-landed on the ground. His back-shell crashed into pieces. He was rushed to the local medicine man who helped to put the pieces back together. Generations have gone by, and the Tortoise family still bears the scars of that single act on their back.

There are two ways by which we can interpret the tale of the tortoise in regard to the just health care approaches considered in this thesis. One can view it from the perspective of justice, as well as from the consideration of over-reliance on one imported approach towards local development.

In the first instance, the story relates that justice in the African context is not a matter only for or about the individual; it always bears a community dimension. Justice is not only a matter of the rights or the opportunity of individuals, but always has considerations of communal welfare. One can say that the Tortoise appropriately used a rights theory to his own advantage; or at least that Tortoise subscribed to a rights theory by which his claims were legitimised. For instance, where a parcel full of treasure is sent to a shared house, and addressed to an individual, he/she has the right to keep all the treasure to him/herself; other occupants have no legitimate claim to any part of the treasure. However, Tortoise's rights theory was applied in the wrong context – one where communitarian welfare was prioritised. In associating with the Bird community Tortoise became one of them, and was better placed to enjoy the benefits, which included securing wings to fly to the sky. Having become part of the community, Tortoise would enjoy the privilege of benefiting from its features. Hence, Tortoise used a double-standard approach, subscribing to either one or another, wherever he had a chance to benefit.

However, as a community, the birds were concerned for the welfare of all. Hence, they sustained the privilege of responsibility for others, and contributed their feathers to Tortoise. The problem is that while Tortoise enjoyed the privilege of communal responsibility, he unscrupulously maintained his ideal of individual rights, against which he could justify taking all the food and drinks meant for *All-of-You*. He disregarded his reciprocal responsibility towards welfare for the community. As a result, he might have had a right claim to the food and drinks, in virtue of his new name, but not to the feathers. While Tortoise's attitude can be considered as pure egoism or greed, one might also defend his actions against a rights theory – which he in fact employed. However, from the two sides of the story, the privilege of communal responsibility and consideration for

communal welfare should have trumped individual opportunity considerations or right claims, but they did not.

In the second instance, one can consider the story in the light of the ND Account and African health care. The AFR framework is considered by some to be a viable approach for just reforms in low and middle income countries, despite being originally developed for a high income country. This is evident in the generic benchmark developed from the framework for use in low and middle income countries (see Daniels et. al., 2000 & 2005); as well as in the attempts to apply it in East Africa (see Maluka, 2011; Maluka et. al., 2010a; Maluk et. al., 2011; Kapiri, Norheim & Martin, 2009). These applications appear to present AFR as a meta-framework that could over-ride other similar or relevant local approaches. When this happens, the following may occur: wherever the AFR has been considered towards health care improvement, any remarkable achievement will be attributed to it. This may be a biased outcome, as other relevant local approaches might have created the recognised improvement. In this case, the ND Account assumes the nickname, “All-of-You”, so that every remarkable achievement is attributed to it. In order to recognise the significance of local approaches, we may have to change the nickname to “One-of-You”. This will present the AFR framework as one among other equivalent approaches whose combined effect can lead to better health outcomes for the population.

It is in virtue of this harmonised effect that I have proposed the *harmonised framework* as a viable approach towards better health care in Nigeria. Considering that Nigeria’s health care system is modelled on Western/international standards, it becomes important that the particular applications of these standards are adapted to the local knowledge. Although the ND Account is presented as a universal approach to just health care, the particularity of the African socio-cultural contexts makes it necessary to incorporate local ethical methods. The harmonised framework developed in this thesis may offer a foundational consideration for incorporating local knowledge towards effective and just health outcomes for the population.

I have attempted to avoid the *All-of-You* factor in regard to the applicability of the harmonised framework to the whole of Africa by limiting the initial explanation to

Nigeria. Nigeria is just a *One-of-You* in Africa. Even if the harmonised approach works in Nigeria, it cannot tell the whole of the African story. However, it might show its potential viability in other African contexts of health care, given the substantive similarities in socio-ethical structures. Thus, like the method of process equilibrium or dialogic process, the harmonised framework remains an open-ended approach recognising the subtle differences in the various socio-cultural contexts underlying African health care systems. This open-endedness provides the opportunity to appropriately incorporate local meanings or processes into health care decision making; and hence, avoids the danger of overstating the “African”.

1.4 The Harmonised Framework and Health Care in Africa

African countries are often in the spotlight when problems in global health are considered. The recurrent questions are mostly those of inequity in access to basic health care service and medical resources, as compared to high income countries. There are also always questions of inequity within African health care systems, where the poorer, rural and vulnerable population groups are more disadvantaged. The search for the right formula for health care reforms has been a challenging one for most African countries. They have had to rely on strategies developed by Western countries, through international agencies, like the WHO, the World Bank and the IMF, which do not always consider specific local knowledge.

The ethical dimension of health care reforms is a new frontier in the global effort towards universal health care coverage, in all countries. The tried and tested approaches remain limited, and health care systems in most low and middle income countries have had to rely on the strategies that have worked for high income countries. One must comment on the innovative works of scholars like Norman Daniels and Thomas Pogge for pushing the frontiers towards specific ethical strategies that might work for low and middle income countries. Underlying their endeavours is the motivation towards improving the health and welfare of the populations in these countries. Their approaches are unique in the sense that they are radically opposed to those previously offered through International

Agencies, which have often carried with them some forms of enlightened self-interest of the donor high income countries. Also worthy of commendation are the various attempts in Tanzania and the WHO's 3-by-5 initiative in attempting to adapt the ND Account to policy making and the implementation process in African contexts of health care.

However, despite the notable efforts above, much remains to be done in mapping out the specific ethical strategy towards a more just and effective improvement in population health for most African health systems. Until this research project, not much work has focused on developing a relevant ethical tool for just health care reforms using African approaches. My exploration of an African approach to just health care is thus novel, as it is informative about the underlying dynamics of health care in African settings. It addresses aspects of population health care that are particular to African settings, which externally developed approaches would easily miss. For instance, rather than simply adapt the AFR framework to the health policy process in Nigeria, as Maluka et. al. (2011) have done in Tanzania, I have considered the relevant African ethical values and principles of justice that bear on population health. These have effectively informed the emerging harmonised ethical framework.

Whereas the harmonised framework has been developed in the light of Nigeria's context of health care, the larger vision remains African health systems as a whole. It may appear ambitious to claim that an ethical approach developed for Nigeria will apply across the Sub-Saharan African region; for despite the similarities in the socio-cultural dynamics and nature of prevailing diseases, there are subtle differences that may require some alterations in applying what works for Nigeria in other African countries. I would like to reiterate, however, that the approach developed in this thesis mainly provides a foundational framework for just health care in Africa. It does not promise outright to address the problems of justice arising in population health across the continent. Rather, it provides the appropriate ethical platform for relevant attempts at just health care improvements for the different populations with shared socio-cultural backgrounds, economic conditions, and nature of prevailing diseases. Therefore, my approach partly remains that of motivating further research engagement about the specific content or

design of the harmonised framework for the various African health systems, as well as for varying policies that address specific health care challenges. This thesis thus constitutes an invitation to other African scholars to engage in the relevant research that will specify the contents of the harmonised framework for their particular context of health care, or address specific policies for the more pertinent health care issues within their countries.

1.5 The Harmonised Framework and Specific Policy Reforms

Having developed the harmonised approach in chapter five, I have considered its initial application against an existing health care initiative in Nigeria, in chapter six. Although the thesis mainly offers a foundational framework, it is noteworthy that it also considers the applicability of the approach in the real context of health care. For the ultimate goal of ethical theorisation and development of such tools is to enhance effective and just health service delivery to the population. Just as further research is needed to specify the contents of the harmonised approach for other African countries, a similar step will also need to be taken to make specifications for policies that focus on particular aspects of population health. What I have outlined in chapter six is only an initial consideration of what the particular ethical strategy should be like. Outlining the specific ethical guidelines or a template for the formulation and implementation of health insurance schemes will need further work. Beyond health insurance, areas needing urgent attention in regard to just policies include, but are not limited to: mental health care, child health and elderly care, as well as pharmaceuticals and the distribution of medicines.

Mental health care is one aspect of population health that currently lacks both financial and policy commitment in most African countries (see Spooner, 2014; Daar et. al., 2014; WHO, 2011c). Where policies exist, the implementation strategies are mostly weak, and the policy processes often leave out the relevant population groups (see Omar et. al., 2010; Burns, 2011). This means that people with mental illness or disabilities are more disadvantaged than others without any such problems, especially regarding the kind of health care that is available and accessible to them. Also, there are social, cultural and

economic factors that limit the health care benefits of persons with mental illness or disability. While faced with the difficulty of accessing needed services, they are further limited by the existing social stigma in many communities (Amuyunu-Nyamongo, 2013). This means that affected persons often do not seek help from the few services available (Chambers, 2010). Hence, in addition to infrastructural inadequacies, the population group with mental health problems also suffers from various social disadvantages. These factors raise questions of just health care for the relevant population group. Beyond simply including mental health more prominently in national health budgets or formulating relevant policies, the underlying questions of inequity need to be addressed. Further research will be needed, in light of the harmonised framework that will provide explanations to these questions, as well as providing a viable strategy towards more just policies and effective resource distribution.

As seen in chapter two, child health remains a major concern for population health in Nigeria, and many other African countries. There is already an ongoing campaign towards improving child health around the continent. For instance, as has been shown in chapter two, one of the major health concerns in Nigeria, as also seen in existing literature and health initiatives, presents child and maternal care as paramount. This suggests that some effort is being made towards improving this aspect of health care. On the other hand, health care for elderly persons appears to be missing from the discourse and improvement initiatives. It would suffice to note that elderly care receives little or no attention in Nigeria's health care system. As I have shown in chapter six, the NHIS makes no specific provision for children over six years old or senior citizens. These population groups will widely be considered vulnerable, as they are within the economically non-active population group. Justice requires that certain health care provisions be made for these population groups. Specifying the relevant ethical template towards just considerations for the health and wellbeing of these population groups has clearly been beyond the scope of this thesis. Hence, I will take this as an initial proposal for future research.

Finally, access to medicines remains one of the major health care problems in Nigeria. As Pogge (2008) and Hollis & Pogge (2008) have shown, it is a major problem in all poor countries around the world, and most African countries fall within this group. Hence, even where disease conditions are known, many people cannot afford the cost of the available medicines. In Nigeria, most people resort to buying sub-standard drugs as an alternative, or end up buying counterfeit drugs in the search for cheaper ones – the distribution of counterfeit drugs is still being fiercely combatted in Nigeria (Ross, 2013). Also many may turn to traditional healers. In present day Nigeria, many self-acclaimed traditional healers actually lack the required apprenticeship to qualify as a healer. Given the high demand for traditional medicines, quack traditional healers and medicines are now as commonplace in Nigeria as sub-standard or counterfeit Western medicines in the market. In addition, some Nigerian pharmaceutical companies have been found wanting for distribution of sub-standard or harmful drugs. One example is the case of “MY Pikin”, a child teething medicine that killed many children in 2008 (ThisDayLive, 2012). The harmful effect of the drug was traced to the company’s lack of proper adherence to procedure in manufacturing the drug.

It is important to note that victims of counterfeit medicines or fake traditional healers and herbal mixtures are often those who are driven by the high cost of medicines to seek cheaper alternatives. Part of the explanation for the inefficiency of the pharmaceutical companies above may be profit related, as they may also want to make cheaper medicines to attract consumers. The situation of pharmaceutical companies and the distribution of medicine in Nigeria raise concerns of justice that a relevant ethical framework would need to resolve. Presently, the ethical dimension of this problem remains unexplored for Nigeria. Hence, the area presents great potential for research. As part of future initiatives to establish a more effective and just system for the distribution of medicines in Nigeria and parts of Africa, some consideration may be given to the account of just health care developed in this thesis.

1.6 Process Equilibrium and African Bioethics

Further to presenting an African approach to just policy development for African health care, the thesis also introduced a new methodological approach for African bioethics. Specifically, I have developed the method of *process equilibrium* and offered it as relevant for ethical considerations in health care and health research in African settings. Process equilibrium abstracts from the African mode of moral reasoning, by which ethical norms and values are formed, to determine the nature of ethical problems in health care or health research, and to offer relevant ethical solutions. Given its context-specific approach, *process equilibrium* can inform other bioethical approaches, like informed consent in health care or health research, for better outcomes in African settings. Patients always come into the clinic bearing their moral worldviews, and health research is undertaken within socio-cultural contexts that endorse these moral dimensions. Effective ethical considerations should be able to account for these features. Integrating the method of *process equilibrium* may help bring these to bear in African bioethics.

Through *process equilibrium*, ethical considerations, like patient autonomy and informed consent, which are informed by theories of individual liberty, will consider the value of communitarian welfare when applied in African contexts. As I have mentioned earlier, research ethics remains the most developed aspect of African bioethics, which has addressed several dimensions of the ethical problems arising in medical research within African contexts. There are still several challenges that international guidelines have tried to address. While my work has not focused on the subject of research ethics, given its broader consideration of health care, the African ethical approaches it has explored may be useful to future revisions of global ethics guidelines. However, this remains a further area of exploration that relates to this thesis.

1.7 The Challenges

The current health care situation in Nigeria requires relevant reforms at the levels of policy formulation, implementation of plans, infrastructural development, as well as resource distribution strategies. Several empirical strategies are already being deployed

towards reforming the health care system, but these have not been complemented by desirable outcomes. According to the analysis in this thesis, a viable ethical framework is needed to bolster the current reform strategies. Policy makers can consider the harmonised framework as a foundational tool in seeking the relevant ethical guidelines towards more just and effective reforms. Considering the challenges encountered by the application of the ND Account in some African contexts, like Tanzania, an Africa-specific approach has the potential to better address the varying justice questions for the population's health. Where the African account captures foundational local ethical considerations, it can inform relevant reforms even in other parts of the continent. Situating the harmonised framework within the policy process could help policy makers to better consider the relevant issues and address them in ways that are appropriate to the local context.

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Appendix I

Nairaland Forum

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PLEASE HELP: Mother Of 2-year-old Boy, Maureen Omoraka Need Your Help by [valencia25\(m\)](#):
6:45pm On Nov 03, 2014

Ten months ago, Maureen Omoraka was a very pregnant mother - one who was looking forward to seeing her newborn baby. She and her husband, Robert, and their two year son were waiting expectantly for a successful delivery. But that turned into their worst nightmare. An unbelievable case of criminal negligence from the medical staff, resulted in Maureen not only losing her baby but battling for her life. For months, Maureen bleed profusely. Her loving husband and other well-meaning Nigerians donated blood and purchased blood to save her life. Yet as I write today, Maureen is still in critical condition. The doctors later discovered that she had also suffered a rupture to her bladder due to complications from birth, and further determined that her most precious gift of womanhood was damaged.

Maureen had her womb removed.

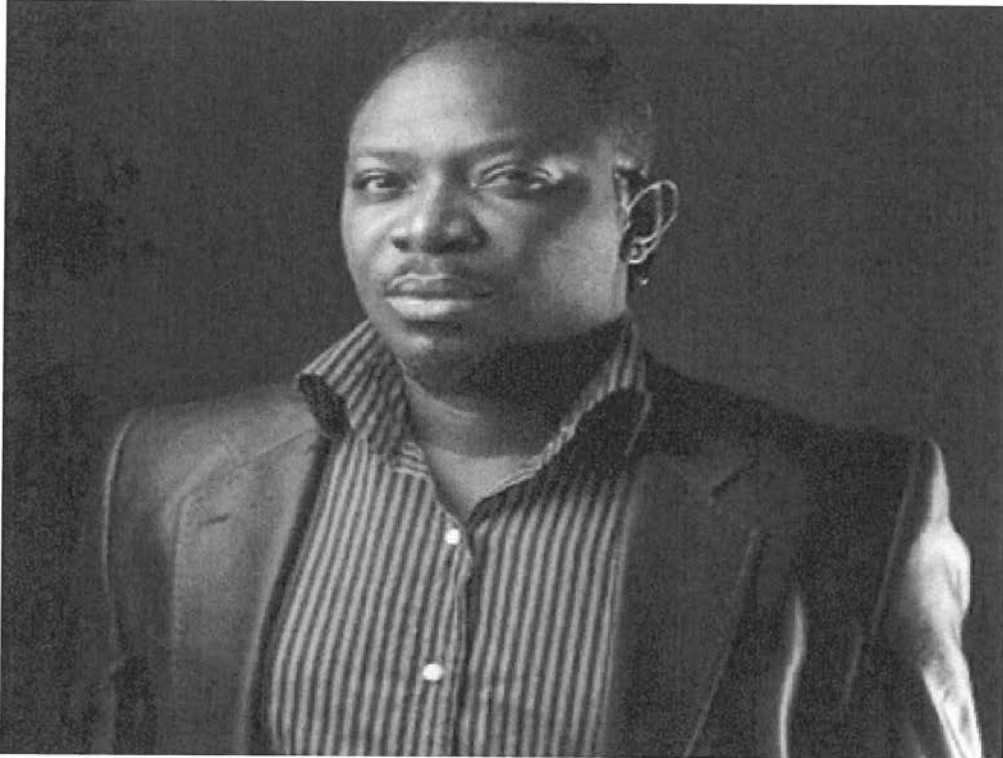
January 2014 was supposed to be a memorable and happy period for the expectant mother, her husband and their family. Instead on November 28th 2014, Maureen will be going for her final surgery to correct her bladder (November 18th is her birthday). Maureen will be receiving a life-saving surgery to suture her ruptured bladder. The medical expenses for her care and treatment is more than 1 million Naira (~\$10,000). Her family has already spent over 2.2 million Naira (~\$20,000) sourced from their savings and well-meaning Nigerians. Maureen and her family needs your help to save her and bring her home.

Robert Omoraka, a childhood friend of my partner, told me of the very sad and unfortunate incident that led to this calamity. Maureen's complications started while she went to the



Help... Let's save
Maureen Omoraka

Your little contribution will
will save this life...
Thank you.



Top producer OJB needs N16m for Kidney transplant

Posted by: Aisha Jolaosho in Entertainment, News Update June 21, 2013

Top producer- cum singer, Babatunde Jezreel Okungbowa a.k.a. OJB Jezreel, who is currently bed-ridden in a Lagos hospital needs about 16 million naira (\$100, 000) for a kidney transplant.

The Surulere- based producer, who is widely regarded as the creative force behind hits of notable artistes like multi-award winner, 2face Idibia, rap sensation, Ruggedman, Nomoreloss and Raskie is currently battling with the life threatening ailment and needs financial and moral support to stay alive.

Public spirited individuals can make donations to his UBA account - **BABATUNDE OKUNGBOWA (Account number: 1015075120).**

Print Friendly



Adeyiminu: Fights for his life

Seeking a Stitch in Time

A retired maintenance engineer is diagnosed with renal failure and seeks public assistance to raise N6.5 million for a kidney transplant

By **OLUSEGUN ADEOSUN**

After a meritorious 15-year service as a maintenance engineer at C&C Towers, Victoria Island, Lagos, Isaac Adeyiminu retired in 2009, hoping to enjoy the rest of his life in comfort. But his hope was dashed two years later when he was diagnosed with a chronic renal failure at the St Nicholas Hospital, Lagos. Since 2011, relations have been wheeling Adeyiminu from his residence at 260, Murtala Muhammed Way, Yaba, to the hospital two times a week for dialysis.

To sustain his life, Adeyiminu coughs up N70,000 weekly, estimated at N3.36 million per annum, to battle the ailment. But the weekly dialysis does not seem to be bringing the desired result, as doctors now recommend a speedy arrangement for kidney transplant. "Doctors told me it has got to a stage that I cannot continue with dialysis because of the adverse effects, that I must do a kidney transplant as soon as possible," the Ondo-born patient told

the magazine in pains. The crux of the matter is Adeyiminu needs a total of N6.5 million for the life-saving surgery.

In a letter dated July 27, 2012, Eburn Bamgboye, a consultant nephrologist at St Nicholas Hospital, affirms that Adeyiminu is a known patient with "chronic kidney disease, secondary hypertensive nephrosclerosis and he has been counselled on the long term management options and advised that a live donor renal transplant confers the best possible 'quality of life' in established end stage kidney disease."

Bamgboye stated that renal transplant will require the deposit of N5 million. This, he said, covers "the cost of all pre-transplant investigation in recipient and one donor, including cross match sent to the United Kingdom and renal angiogram in the donor; cost of donor nephrectomy and actual transplant surgery; post operative admission of the donor recipient." The nephrologist added that N1.5 million will also be needed for the first year for the recipient to remain

on regular immunosuppressive to prevent rejection of the graft. "Even though not to be deposited, the unit will seek reassurance that it will access these funds (1.5 million) over the period," Bamgboye said.

He assured that the renal transplant will be arranged as soon as a "suitable donor is identified, preliminary investigations concluded and the necessary deposit has been made." Having exhausted his savings and that of his wife on dialysis, Adeyiminu has no hope of raising such an amount as huge as N6.5 million except through public-spirited Nigerians. He said his former employers gave him N200,000 at the initial stage of the illness for dialysis, and letters written to solicit help from Babatunde Fashola, the Lagos State governor, and Olusegun Mimiko of Ondo State have not elicited any favourable response yet.

Currently, Adeyiminu has found a kidney donor, but he lacks funds for the surgery and the longer the surgery is delayed, the more his pains persist. His left hand on which an artery was joined to a vein for dialysis is almost dead. "It is traumatic," he said. Consequently, Adeyiminu is appealing to Nigerians for assistance, by sending donations to Isaac Adeyiminu, First Bank account number: 2012530290. "I will be eternally grateful to such people. I have exhausted my savings. I now live on friends and relatives," he explained. ■

PRIORITY

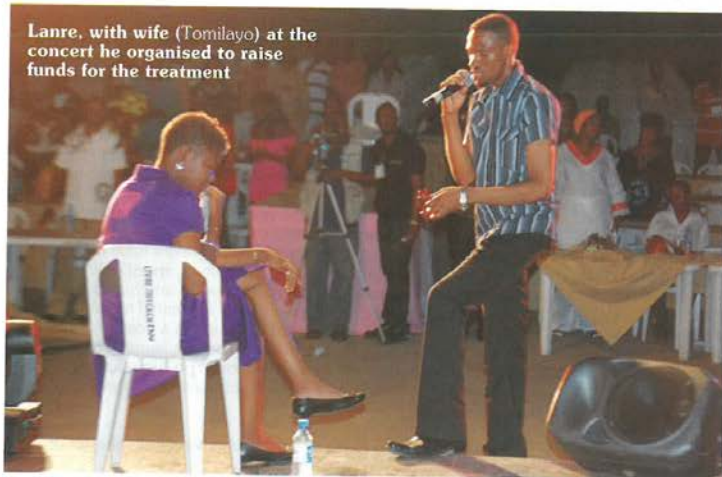


A dialysis patient

Lagos, has said that more than five per cent of the adult population have some form of kidney damage. Experts have also warned that it could also be a very costly disease even after surgery.

Indeed, for Tomilayo Fakeye, a kidney transplant patient, the cost of a kidney transplant is more than the N6 million attached to the surgery. A year after she was diagnosed of kidney failure at the Lagos State University Teaching Hospital, LASUTH, Ikeja, the cost of treating kidney failure has taken a huge toll on the family purse.

At a point, desperation set in. Lanre, her musician husband, organised a concert to raise funds for a kidney transplant. But the proceeds from that venture barely covered the necessary weekly dialysis to keep his wife alive. Dialysis cost N25,000 per session and she required three in a week.



Lanre, with wife (Tomilayo) at the concert he organised to raise funds for the treatment

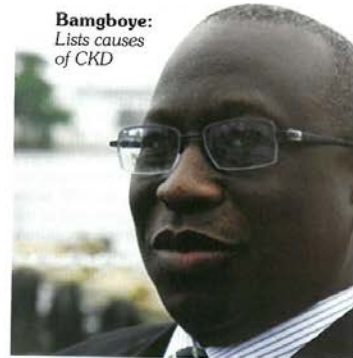
Providence later smiled on Fakeye when the Lagos State government decided to sponsor her treatment. Last week, Fakeye and her husband, who donated one of his kidneys, were discharged from the St. Nicholas Hospital. Grateful to all who came to her aid, Fakeye said, "I am, indeed, grateful to everybody that extended their love to me and my family. The experience has been challenging over the last one year but I thank God that I was able to come out alive and stronger and a better person."

But this is just one leg of the journey. After the transplant, the family would still have to spend money on maintaining the new kidney. This much was not lost on Lanre who while thanking the Lagos State government and Ayodele Adewole, chairman, Amuwo-Odofin, who donated N1 million, called for more assistance for the family. He disclosed that the family now spend N17,000 weekly on Iron Sucrose and Epopen, two of her drugs.

Joseph Iniovosa, a 15-year-old student had a similar challenge when he tasted the bitter pill of kidney failure in 2008. After his diagnosis, his mother could not pay for dialysis, let alone foot the bill of a transplant. But she never gave up. Her cries for help later attracted Foluke Mobereola, president of Nathan Kidney Foundation, a non-governmental organisation, which sponsored the transplant at St. Nicholas Hospital. With his transplant, Iniovosa becomes the first paediatric kidney transplant patient in Nigeria.

But not many are that lucky. And this is why nephrologists are calling on Nigerians

Bamgboye:
Lists causes of CKD



to imbibe a more positive lifestyle to prevent the disease. Toyin Amira, consultant nephrologist, Lagos University Teaching Hospital, LUTH, Idi-Araba, says it is important for people, especially those who are hypertensive to go for kidney check once a month. Amira said it is alarming that many Nigerians are hypertensive without knowing it. As far as she is concerned, lifestyle modification is necessary for every Nigerian. "It is important for people who are obese to lose weight. Also, those who are already diagnosed with hypertension, which is a major predisposing factor should reduce their alcohol intake and refrain from smoking because such lifestyle will only trigger off kidney failure," she said.

As far as Bamgboye is concerned, common causes of CKD include inflammatory diseases of the kidney, infections, obstruction in the urinary tract and inherited disorders like polycystic kidney disease. He said the first consequence of undetected CKD is the risk of developing progressive loss of kidney function leading to kidney failure and the need for dialysis treatment or a kidney transplant, which is very expensive.

According to him, it also leads to premature death of those within their productive age even as he said individuals who appear to be healthy who are then found to have CKD have an increased risk of dying prematurely from coronary disease, cerebrovascular disease, peripheral artery disease and heart failure regardless of whether they ever develop kidney failure.

He, however, noted that most forms of kidney disease are treatable and its progression can often be curtailed particularly if detected early, adding that early detection and treatment can often keep chronic kidney disease from getting worse, and can prevent the need for dialysis or transplant.

Please Help Save Oke's Legs And Life (WARNING: GRAPHIC CONTENT.....) - Health - Nairaland

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[Please Help Save Oke's Legs And Life \(WARNING: GRAPHIC CONTENT.....\)](#) by [uppa\(m\)](#): 9:11pm On Mar 18, 2012

Please help save Oke's legs and life[
Oke

His name is Okeoghene John Igwhiwoto, an ex-student of Federal Government College. He's a diabetic mellitus type 1 and 2 patient and has been bedridden for the past six years, after losing all the toes on both feet, due to injuries he sustained many years ago. Sadly, this has prevented him from completing his university education (he dropped out from OAU). At the moment, his life is at stake and he is in need of surgery urgently.

He was supposed to have the surgery in January 2012, but he has not been able to, because of his inability to raise funds. Oke needs 5million Naira for treatment in India...and needs your help. He can be reached through the phone number, 08063255842. Banke details - Igwhiwoto Okeoghene John (0012913007 - GTB). Igwhiwoto Okeoghene John (2054468076 - UBA).

Continue to see what happened to his feet. Warning: Graphic content...

NOTE: The leg is not this big. click [Here](#) to see other pics

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BREAKING NEWS

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Baby Rachael needs N2.5m to stay alive

on August 05, 2011 / in Just Human 7:52 pm / Comments

BY EBUN SESSOU

When baby Rachael was born some six months ago at Sacred Heart Hospital, popularly called Lantoro Abeokuta, Ogun State, the joy of having a new baby was palpable. Both the mother and father were happy for having another child.

Just a month after, the story changed. Baby Rachael wasn't developing. She doesn't feel comfortable. She is always weak and she doesn't play at all. She vomits and rejects food at random. She doesn't even tolerate breast milk. And her condition keeps deteriorating by the day.

Unfortunately, her parents did not know what was wrong with her until, it was discovered that she has a hole in the heart. The ailment she has been battling for months without improvement.

When Saturday Vanguard visited her in Abeokuta where the parents live, her living condition was enough to prove the adverse effect the ailment has caused this child. Accordingly, the mother's condition is nothing to write home about.



Rachael

Speaking with her father, Mr. Ayoola Oludotun, a public servant who said the problem persists and right now, the baby is at the point of death. According to him, "We noticed that her weight was lesser than normal when she was born. She was about 2.41 kg. So it aroused our curiosity to want to know what was wrong with her. After a month, we discovered that her breathing was faster and higher than normal, so we took her to Federal Medical

www.vanguardngr.com/2011/08/baby-rachael-needs-n2-5m-to-stay-alive/

1/4

Vanguard



BREAKING NEWS

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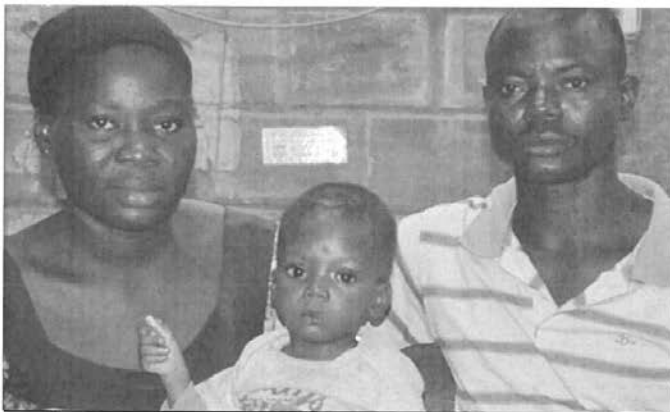
Hole in the heart: Ayoola Israel needs N2m to survive

on September 21, 2012 / in Just Human 7:30 pm / Comments

By Ishola Balogun

It was difficult consoling Mr. and Mrs. Toriola Akin as they narrated the condition of their only son Ayoola Israel who is said to have a hole in his heart and require not less than N2million for a surgery in India urgently.

Both parents who stormed Vanguard premises few days ago cried for help from well meaning Nigerians to save the life of their only son.



(http://www.vanguardngr.com/?attachment_id=314776)

Mr. and Mrs. Toriola Akin and the little Ayoola Israel

According to Mr. and Mrs. Toriola, the 15-month old baby was recently discovered to have a hole in his heart after several diagnoses following persistent illness and intermittent respiratory disorder which affected his growth.

Mrs. Toriola, a tailor, otherwise known as fashion designer in Ejigbo who could not hold back tears narrated how it started. "We began to suspect that something is wrong with him when he was three months. We went to the hospital at Isolo and we began to run series of tests."

Later, I was again referred to LUTH, I saw Dr. Okoromah, he prescribed some tests like Echo, ECG and others. I

Appendix II

9/9/2015

Ogun medical workers protest colleague's death after hospital refused treatment - Premium Times Nigeria

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Ogun medical workers protest colleague's death after hospital refused treatment

May 12, 2015 Dimeji Kayode-Adedeji



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Angry ASUU members chase Kogi governor, Idris Wada, out of Lokoja General Hospital
November 14, 2013

Woman in coma after bus accident in Ogun
June 15, 2015

The death of a staff of the Ogun State Hospital, Ijebu-Ode, over his inability to pay N3, 500 before receiving treatment, has triggered a protest by his colleagues, who grounded services at the hospital for over five hours on Tuesday.

The incident occurred on Friday, when Olusegun Ososan was refused treatment in the hospital because he could not pay the mandatory N3, 500.

Authorities had insisted he must pay before service, a condition usually waived for staff members.

Mr. Ososan died after he was taken to another hospital where he sought help, his colleagues told PREMIUM TIMES.

In response, staff of the hospital, majority of them junior workers, staged a protest, resulting in the suspension of normal hospital services for hours.

The protesters carried placards with inscriptions such as "Staff are not slaves; Give us our rights"; "We don't want obnoxious decree", "Dr. Seyi Adegoya must go".

A colleague of the deceased, Oluwaseun Hameed, who spoke to journalists, said the deceased pleaded for prompt treatment but was not admitted because of financial constraint.

The deceased friends, Folashade Oropo and Olunmi Adegoya, expressed displeasure over the treatment, describing it as discriminatory against junior staff.

The hospital management met with the staff union.

The Chairman, Ijebu Zonal Area of the Medical and Health Workers Union, Oriade Bamidele, said the meeting resolved that the policy be reversed immediately, expressing sadness over the death of the member.

The leader of the Hospital Management team, Isaiah Aiyegoro, refused to comment, saying the matter was an internal affair.

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Beyond belief: the absence of regulation of medical practice in Nigeria

Unless effective and enforced regulation can be introduced, public confidence in health delivery in Nigeria will not be won. Shima Gyoh reports



The absence of regulation of medical practice in Nigeria has caused unimaginable degeneration in the delivery of healthcare at all levels. There are many ghastly stories of malpractice and anyone with sufficient ruthlessness can simply set up a business to practise as a professional in any field of his or her choice.

Abject poverty ensures they always have many patients and pervasive ignorance protects them from the consequences of their criminal activities.

The picture shows a baby delivered by caesarean section at a facility at Genyi, Yandev near Gboko on Friday 21 September 2012. Careful study of the picture shows a well-developed normal baby. The only problem is exenteration. The intestines are also well developed. There is evidence of trauma and subserosal bleeding in parts of the ileum. Despite the blood staining of the skin seen on the right side of the body, the general colour

of the baby suggests it was born alive and breathed, as all the visible blood seems to be well oxygenated. The inevitable conclusion is that the 'surgeon' must have accidentally cut open the baby's anterior abdominal wall during the stage of incising the uterus. Had this clumsy, careless, and extremely stupid accident happened in a proper environment for practising medicine, the baby would have been immediately transferred to a surgeon for proper care. This was not to be. The practitioner left this baby to die of his injuries rather than expose his incompetence.

The quack told the parents that the baby was a 'monster' without an abdomen. This brought fear to the parents, and some relatives are reputed to have taken to their heels. Powerful witchcraft by enemies was feared to have caused the tragedy. The credulity of the people around gave him the confidence to permit a photograph to be taken of the 'monster'. With no post-mortem done, the parents satisfied with the superstitious explanation, the quack is quite safe to continue his criminal activity. This is the tragedy of Nigeria.

Prof Shima Gyoh, Co-Editor, Africa Health (Nigeria)

- P.M. NEWS Nigeria - <http://pmnewsnigeria.com> -

Nigerian pregnant woman denied care because of \$150

Posted By [pmnews](#) On December 1, 2012 @ 5:59 pm In [Metro,National,News,Today's Headlines](#) | [Comments Disabled](#)

A pregnant Nigerian lady has died because doctors in Port Harcourt insisted the husband must pay N20,000, less than \$150, before she was treated. And her family members are still in shock about her death, such that they are not even thinking of burying her for now.

The 34 year old woman, Ijeoma Umumadumere, nee Ahamefule, was rushed in the morning of 25 November to Garrison Clinic in Port Harcourt, when she complained of a sudden stomach pain and headache, while cooking. Her husband rushed her to the clinic on Udom street in the oil rich city. It was between 9-10 a.m. And she was five-months pregnant.

But doctors and nurses would not attend to the pregnant woman because the husband only had N5,000 on him, instead of the N20,000 being demanded, as a precondition for treatment. Even the N5,000 the man had on him had been used to offset registration and other costs.

Her brother, based in Austria could not understand why doctors in a Nigerian hospital could have so callously and uncaringly treated the woman, pregnant with her first child. As he put it:

"Her husband begged the doctor and the nurses to attend to her since they had collected about N5, 000 he had in his pocket in the name of registration and other little things while he would go home and bring money. He had also told them that because of the nature of the emergency and the way his wife had been shouting while on the ground that his mind had only been pre-occupied with the thoughts of rushing her to any nearby hospital and had not thought of money or any other thing as he had even forgotten to put on shoes, but all his pleading and explanations to the doctor and the nurses had fallen onto deaf ears. With her pains increasing and death knocking and the doctor and the nurses refusing to understand, there was no way he could have left her there unattended, to go home and bring money. He took her and headed to another hospital, but unfortunately my sister did not make it as the damage had already been done before the doctors in that second hospital could do something reasonable to save her life."

"What a country, what a failure and what a loss! This is a sad story of the sorry state of the Nigerian health policy, how Nigerians are heartlessly and carelessly neglected because of money by doctors and nurses to die in hospitals, and how I lost my sister to a failed system,"wrote Uzoma Ahamefule, based in Austria.

Many hospitals in Nigeria, both private and public, are in the habit of asking for pre-payment from patients, even when the case is an emergency.

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Ijeoma umumadumere, nee Ahamefule: abandoned by doctors over money

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Samuel Oyoma, Lagos Man Dies After Hospital Refuses To Treat Him Over N5,000 Medical Bill

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It was a pathetic sight at Ejigbo, Lagos, Southwest Nigeria when a man, Samuel Oyoma died in his room after he was rejected by several hospitals because he could not afford to pay N5,000 deposit so that his illness could be treated.

His neighbours told P.M.NEWS that he fell ill and was taken to some hospitals where he was rejected because he could not afford the N5,000 the hospital demanded as deposit before he could be treated. He returned home dejected, P.M.NEWS gathered.

Samuel was found dead on his bed inside his room in the morning at the weekend at Chris Oladunni Street Ejigbo, Lagos.

Although neighbours did not suspect that Samuel might have committed suicide, he was found dead with some drugs beside him.

The late Samuel had sent his family home in Cross River State when he fell on bad times.

He had hoped to bring them back to Lagos when his finances improve. But he could not do so before he died.

According to one of his neighbours, Mrs. Helen Williams, Samuel took ill about three weeks ago. She said Samuel was battling to stay alive but nobody could lend him the N5,000 he needed for his treatment. Even his neighbours could not assist and they watched him die in pains.

Following his death, the police at Ejigbo Division arrested his landlord and some of his neighbours to explain what they knew about his death.

The landlord had gone to the station to report his death and inform the police that he did not know any of his relatives.