CHAPTER 3

IMPERATIVES OF SECURING EQUITABLE ACCESS TO HEALTHCARE SERVICES FOR PERSONS WITH DISABILITIES IN NIGERIA

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Summary

The government of Nigeria, recognising the huge barriers facing persons with disabilities in their interaction with the healthcare system and daily living, passed the Discrimination Against Persons with Disabilities (Prohibition) Act 2018 (Disability Act) in January 2019 to address some of the factors that impede persons with disabilities in accessing health care. The Act provides for a right to free mental health services and unfettered access to adequate healthcare. It calls for equal access to the physical built environment through the provision and installation of special facilities in public buildings, including healthcare centres. Also highlighted in the Act is the need to provide special communication devices for individuals with visual, hearing or speech impairments. The Act further stipulates a five-year moratorium for compliance with its provisions regarding the alteration of the built environment to improve access of persons with disabilities to public infrastructure. However, three years after the passage of the Act at the national level and in some states in Nigeria, persons with disabilities in Nigeria still encounter a range of barriers in their attempt to access healthcare, and there is every indication that the moratorium is not effectively being utilised. Accordingly, this paper evaluates the impact of the Act in mitigating or eliminating barriers to equitable access to healthcare facilities and services for persons with disabilities in Nigeria. The paper argues that the passage of the Act has had a mixed impact on the equitable enjoyment of the right to accessible healthcare facilities and services for persons with disabilities in Nigeria and that both the national and state authorities are well on their way to miss the five-year moratorium on compliance. The paper recommends a few measures that Nigeria can implement to increase and entrench access to healthcare services and facilities for persons with disabilities.

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1 Introduction

This paper examines how the Discrimination Against Persons with Disabilities (Prohibition) Act 2018 (Disability Act) can shape equitable access to healthcare services for persons with disabilities in Nigeria. The passing of the Act is a significant step triggered by the ratification of the Convention on the Rights of Persons with Disabilities (CRPD)[1] and pressure from disability advocates and persons with disabilities in Nigeria.[2] Before the enactment of the Act, there existed incoherent disability legislation in nine states in Nigeria that have provisions on right to health for persons with disabilities.[3] Noteworthy is the fact that most of these state laws lack the principles underpinning the CRPD in relation to access to health for persons with disabilities. Consequently, the state laws would require substantial amendment and revision to bring them in line with the content of the CRPD. It was anticipated that the enactment of the Disability Act would engender the creation of effective measures for the full realisation of disability rights across all spheres in Nigeria, including equitable access to healthcare services. The peculiar circumstances existing in Nigeria and other African countries bring to the fore several challenges which impact accessible healthcare for persons with disabilities, including prohibitive costs, physical/structural barriers, lack of disability-specific services, lack of political will, prejudicial cultural and religious beliefs as well as weak enforcement of extant laws.

The Act, to some extent, mirrors most of the provisions of articles 9 and 25 of the CRPD on accessibility and the right to health, respectively, while creating a National Disability Commission (Disability Commission) on persons with disabilities with a governing council (the Council) to implement the Act.[4] In giving effect to the Act, the Nigerian government constituted the Disability Commission in 2020.[5] Ultimately, the main function of the Disability Commission is to contribute actively in confronting exclusionary policies and practices that keep persons with

1 UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution/adopted by the General Assembly, 24 January 2007, UN Doc A/RES/61/106 (2007), which came into force 2008, and was signed and ratified by Nigeria on 30 March 2007 and 24 September 2010 respectively.

2 A Ewang 'Nigeria passes Disability Rights Law: Offers hope of inclusion and improved access' *HRW* 25 January https://www.hrw.org/news/2019/01/25/nigeria-passes-disability-rights-law (accessed 27 May 2021).

3 Lagos State Special People's Law 2011; Plateau State Indigenes with Disabilities Rights and for Other Matters Ancillary thereto 2005; Kano State Persons with Disability Law 2017 (1439AH); Jigawa State Persons with Disabilities Law 2017; Bauchi State Persons with Disabilities Law 2015; Ogun State persons with Disabilities Law 2018; Ekiti State Rights of Persons with Disabilities Law, 2013.

4 Sections 31-38 of the Discrimination Against Persons with Disabilities (Prohibition) Act 2018 (Disability Act).

5 On 25 August 2020.

disabilities away from full participation.[6] To this end, it can be argued that the Disability Commission[7] has a mandate under the Act to enhance access to healthcare and other socio-economic rights of persons with disabilities contained in the 1999 Constitution of the Federal Republic of Nigeria and the Disability Act.

The Act has therefore been enthusiastically embraced in Nigeria, but so too has earlier disability legislation that has yet to show efficient administrative infrastructure and understanding of the meaning of disability.[8] Bearing in mind that healthcare is an item on the concurrent list that falls under the policy oversight and legislative control of both the state and federal government of Nigeria. The Act ultimately challenges state governments in Nigeria to domesticate the Act and ensure implementation in a manner that responds to the socio-cultural environment at the individual level and population level.

Hence, the inquiry that must be raised is whether the Act is being implemented and understood simultaneously with securing equitable access to healthcare services for persons with disabilities. This question is important as it provides an opportunity to appraise whether there is equity in the quality of healthcare provided to persons with disabilities as well as the extent to which health services in Nigeria meet the medical and rehabilitation needs of persons with disabilities. It also affords a platform to focus on surmounting barriers to equitable healthcare access for persons with disabilities. Equitable access is here conceived in terms of the ease with which persons with disabilities can seek and receive healthcare services when needed.[9] It further implies giving everyone a fair opportunity to attain their full health potential practically without discrimination. A substantive clarification of equitable access in health for persons with disabilities is articulated in the next section of this paper.

This article is divided into six parts including the introduction, which is the first part. The second part presents a conceptualisation of equitable access to healthcare for persons with disabilities in Nigeria. The third part

6 J Erunke 'National Disability Commission: I'm now fulfilled over take-off – Farouq' *Vanguard* 25 August 2020 https://www.vanguardngr.com/2020/08/national-disability-commission-im-now-fulfilled-over-take-off-farouq/ (accessed 31 May 2021).

7 Section 31 of the Disability Act.

8 For instance, before the enactment of the Disability Act, Nigeria had the Disability Decree of 1993. There has also been in existence different disability legislation in some states of Nigeria that on one hand, seek to protect the rights of persons with disabilities; but, on the other hand adopts the medical model approach to disability. The previous legislation has not been able to provide persons with disabilities in Nigeria the right to equality and non-discrimination. More so the Nigerian government has also been ambivalent in its approach to disability issues. See R Lang & L Upah 'Scooping study: Disability issues in Nigeria: Final report' (2008) 6-7 https://www.studylib.net/doc/13390397/scoping-study--disability-issues-in-nigeria-final-report (accessed 19 February 2021).

9 J Levesque et al 'Patient-centred access to health care: Conceptualising access at the interface of health systems and populations' (2013) 12 *International Journal of Equity in Health* 18.

provides an overview of persons with disabilities access to healthcare services before the passage of the Disability Act. The fourth part is an evaluation of progress relative to actualising health-specific provisions under the Act. Part 5 presents measures aimed towards operationalising equitable access to healthcare for persons with disabilities in Nigeria. The final part summarises the article.

2 Equitable access to healthcare for persons with disabilities as conceived

The Disability Act in section 21 makes provision for unfettered access to healthcare for persons with disabilities in Nigeria. Similarly, the obligation to ensure that all aspects of healthcare are accessible is systematically covered by sections 3 to 8 of the Disability Act. Together section 21 and sections 3 to 8 of the Disability Act make it clear that persons with disabilities have the right not only to accessible healthcare services, but also to equality and non-discrimination in relation to all aspects of the right to health as articulated under article 9 and 25 of the CRPD. This invariably reinforces the language and standards of general equality, non-discrimination, and access issues articulated by the Committee on Economic, Social and Cultural rights (The ICESR Committee) in General Comment 14. The ICESR Committee in an effort to give fundamental expression of the right to health in the context of human rights proceeds to discuss a range of interconnected components essential to the right to health which are accessibility, availability, acceptability and quality.[10]

According to the Committee on Economic, Social and Cultural Rights, accessibility implies that facilities, goods and services must be accessible to everyone without discrimination. Due regard was given by the Committee to issues of physical access, information access, communication access and attitudinal access as important dimensions of measuring access to healthcare in states. Related to the concept of accessibility is availability, which has to do with a sufficient number of functioning healthcare services, facilities and programmes to the public.[11] Acceptability refers to the need for health services to be respectful of professional ethics and sensitive to cultural disposition of those concerned,[12] while quality requires that health facilities, goods and services must be medically appropriate and of a good standard.[13]

10 See UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14: The Right to the Highest Attainable Standard of Health (Art 12 of the Covenant), 11 August 2000, UN Doc E/C.12/2000/4 (2000) https://www.refworld.org/docid/4538838d0.html (accessed 4 September 2020).
11 Paragraph 12(a) of General Comment 14.
12 Paragraph 12(c) of General Comment 14.
13 Paragraph 12(d) of General Comment 14.

The foregoing articulations of the ICESR Committee are compatible with the CRPD General Comment 2 on article 9 – accessibility.[14] Noteworthy is the fact that accessibility is one of the principles on which the CRPD is based.[15] The CRPD Committee has also addressed the issue of accessibility in its jurisprudence in the case of *Szilvia Nyusti, Péter Takács and Tamás Fazekas v Hungary*.[16] The CRPD Committee in its discussion of accessibility includes access to the physical environment, transportation, information and communication and other facilities and services open to the public. This means that without access to the foregoing interconnected elements, persons with disabilities would not have equal opportunities in access to adequate healthcare.[17] States therefore have a responsibility to provide accessibility and this principally relates to the idea of a universal design where the state foundationally makes provision for the diverse personal needs of everyone in the society, to the greatest extent and without need for specialised design. Against this backdrop, it is possible to argue that universal design is about operationalising accessibility from the start.

The term 'universal' in universal design denotes the importance of responding to the common good through 'universal programmes' or law in order to ensure the egalitarian distribution of basic public goods and services. It can be conceived as part of the roadmap to achieving standard access and equal participation in the enjoyment of adequate healthcare for everyone and not just persons with disabilities. This inevitably falls in line with the dictate of achieving equitable access to the right to health as an antithesis to the insensitivity to human differences. The universal design significance in relation to persons with disabilities lies in its appreciation that people having different impairments experience discrimination due to the manner in which accommodations are provided. The ethics of universal design regard this much as its starting point emphasises the importance of providing goods and services that align with the complexity of the human body in such a manner that anyone, irrespective of bodily impairment, is able to have access to designs within the social and healthcare environment.[18]

Nevertheless, the idea 'without the need for specialised design' usually included in defining what constitutes universal design has been regarded by some scholars as essentialising and ambivalent, because it seems to

14 CRPD Committee, General Comment 2 (2014): Article 9: Accessibility, 22 May 2014, UN Doc CRPD/C/GC/2 (2014) (advanced unedited version).
15 Article 3(f) of the CRPD.
16 Communication 1/2010, views adopted on 16 April 2013.
17 Article 9(1) of the CRPD.
18 Inspired from a reading of the 'Principles of universal design' compiled by the Centre for Universal Design (2011); R Imrie 'Designing inclusive environments and the significance of universal design' in J Swain et al (eds) *Disabling barriers, enabling environments* (2013) 287.

eliminate specialised interventions from universal design principles.[19] There is also the contention that the universal design disproportionately focuses on expert opinion as well as technological innovation rather than individual experiences.[20] Consequently concerns arise as to how universal design principles can respond to individual differences given the complexity of impairments and their interaction in the social environment.[21] Undeniably, the issues raised with respect to universal design as an equitable approach raise tensions. Yet, the phrase 'without the need for specialised design' ought not to be interpreted literally as suggesting an ouster of approaches that could accommodate and respond to a variety of impairments in order to make a wide range of access imaginable.[22]

The idea of universal design principle practically anticipates that equitable features of separate designs must come within the general design from the beginning, so as not to over emphasise individual impairments that are often amenable to segregated services or designs.[23] More so, much of the concerns raised can be ameliorated when evaluated within understandings of ethical and social provisions.[24] Universal design should be seen as a moral endeavour, especially in giving conscious attention to the needs of the people for whom the accommodations are intended. Securing equitable access to healthcare for persons with disabilities involves probing socio-political and cultural realities, and understanding that these realities must be traceable to historical and recent social structures. The fundamental basis for universal design is the promotion of equal opportunity and forestalling of discriminatory practices that tend to over emphasise personal impairment. These perspectives in essence demonstrate the need to apply moral reasoning to things we value for the different segment of individuals in the society. In this sense, it is argued that the universal design must pursue a flexible and broad approach in its formation in line with an objective moral theory.

19 P Welch 'What is universal design?' in P Welch (ed) *Strategies for teaching design* (1995) 1; R Mace *Universal design: Housing for the lifespan of all people* (1988); R Duncan 'Universal design for the 21st Century: Irish & International Perspectives' in *Conference proceedings of the National Disability Authority's in Universal Design for the 21st century: Irish and international perspectives* (2007) http://www.universaldesign.ie/what-is-Universal-Design/Confernce-proceedings/Universal-Design-for-the-21st-Century-Irish-International-Perspective/ Universal-Design/html (accessed 3 March 2016).

20 J Tibias 'Universal design: Is it really about design' (2003) 9 *Information Technology and Disabilities Journal* 5.

21 On this, see R Imrie 'Perspectives in rehabilitation: Universalism, universal design and equitable access to the built environment' (2012) 34 *Disability & Rehabilitation* 873; WF Preiser 'Paradigm for the 21st century: The challenge of implementing universal design' in T Vavik (ed) *Inclusive buildings, products and services: Challenges in universal design* (2009) 28; G Pullin *Design meets disability* (2009) 11.

22 Paragraph 8 of General Comment 2.

23 See Duncan (n 19); IK Zola 'Toward the necessary universalising of a disability policy' (2005) 83 *The Milbank Quarterly* 1.

24 Derived from a reading of A Mclean et al 'Designing as a moral enterprise: Technology Research for Independent Living researchers' in *Conference proceedings Universal Design for the 21st century: Irish and international perspectives* (n 19).

A flexible and broad approach demands making available in a progressive sense options of use in order to accommodate wider access, adapting same to the user and facilitating the user's potential capacity.[25] In order to achieve transformation, societies must work out answers to human problems. States must be able to bring their values into actuality by determining impediments and mutually work towards removing them. This means dealing with stakeholders' interests and power, issues of non-discrimination, as well as committing to a national plan of action towards achieving physical, information, communication and economic access in healthcare for persons with disabilities in Nigeria. Respect for dignity, non-discrimination, inclusion, participation and accessibility are to be the basis for any implementation measures under the Disability Act. Lawton suggests that individual needs inspire the making of needed provisions.[26] This is synonymous with the idea of introducing flexibility and dynamism with regard to the provision of reasonable accommodations.[27]

We are mindful that the act of creating a universal design can aid in minimising the inconvenience of impairment, but may not entirely equalise opportunities for persons with disabilities. Indeed, as argued by Shakespeare, even if society removed barriers, people would be impacted by their impairments to varying extents.[28] Pragmatically, when considering a universal design, modifications and alterations to existing structures in accordance with individual need is required for purposes of achieving substantive equality and equal opportunity. Accommodating individual differences is the key to eliminating discrimination against persons with disabilities and a denial of accommodations amounts to disability discrimination.[29] Reasonable accommodation seeks to achieve equitable justice for an individual in a manner that non-discrimination is assured, taking the dignity, autonomy and choices of the individual into consideration. For example, a person with an uncommon impairment might request for accommodation that falls outside the universal design.

Since the focus of reasonable accommodation is on the individual, alterations to remove barriers must be modified according to the individual need. This may necessitate that changes be made in respect of existing practices, the physical environment or the provision of additional support for individuals who require them. Hence, it may be argued that the provision of reasonable accommodation is a means of ensuring accessibility for a person with a disability in a particular situation. In the

25 N D'Souza 'Is universal design a critical theory?' in S Keates et al (eds) *Designing a more inclusive world* (2004) 3.

26 P Lawton 'Designing by degree: Assessing and incorporating individual accessibility needs' in WF Preiser & E Ostroff (eds) *Universal design handbook* (2001) 7.

27 D'Souza (n 25) 5.

28 T Shakespeare *Disability rights and wrongs revisited* (2013).

29 A Lawson 'The United Nations Convention on the Rights of Persons with Disabilities: New era or false dawn?' (2006-2007) 34 *Syracuse Journal of International Law & Commerce* 563; Committee on the Rights of Persons with Disabilities, General Comment 6 on equality and non-discrimination, 26 April 2018, UN Doc CRPD/C/GC/6 (2018).

end, the decision to provide reasonable accommodation is often dependent on whether it is 'reasonable' and 'whether it imposes a disproportionate or undue burden' on the state concerned. The CRPD Committee in its General Comment 6 on equality and non-discrimination explains the reasonableness of an accommodation with reference to its relevance, appropriateness and effectiveness for the person with a disability.[30] The CRPD Committee emphasises that the term 'reasonable' is not to be construed as an exemption clause or modifier of the duty to provide accommodations. Likewise, disproportionate or undue burden is to be understood as expressing the idea that the duty to provide reasonable accommodation is bound by a possible excessive or unjustifiable burden on the state concerned.[31] Moreover, this requires an assessment of the proportional relationship between the means employed and the enjoyment of the right concerned.

Other potential factors to be considered on a case-by-case basis include available resources, overall assets and size of the accommodating party, the effect of the modification on the institution or the enterprise, third-party benefits, negative impacts on other persons and reasonable health and safety requirements.[32] Usually, the removal of barriers that have an impact on the enjoyment of human rights concerned, feasibility of accommodation as well as relevancy of accommodation are important elements regarding implementation. Nigeria must therefore take positive action to reduce structural disadvantages by providing necessary services and giving appropriate support towards securing equitable access to healthcare services for persons with disabilities. This draws attention to consideration of things that are good, advocates for the realisation of the good and expects people to play a part in them.

3 Overview of persons with disabilities access to healthcare services before the Act

Prior to the enactment of the Disability Act, only general laws protected persons with disabilities' right to health under concepts such as 'everyone' or 'all'. The 1999 Nigerian Constitution of the Federal Republic of Nigeria as amended (Nigerian Constitution)[33] prohibits discrimination against persons generally. Chapter Two of the Constitution enjoins the state to direct its policy towards ensuring that all persons have equality of rights and opportunities before the law and directs the state to ensure that there are adequate medical and health facilities for all persons.[34] However, this

30 Paragraph 25 of General Comment 6.
31 As above.
32 Paragraph 26 of General Comment 6.
33 Sections 16 and 17 of the 1999 Nigerian Constitution of the Federal Republic of Nigeria as amended (Nigerian Constitution).
34 Section 17(3)(d) of the Nigerian Constitution.

broad provision has often been taken as unenforceable in any court of law in Nigeria by virtue of section 6(6)(c) of the Constitution.[35] This has been interpreted to mean that the right to health shall not by any means be the subject of litigation in any court of law in Nigeria, as noted in *Attorney General of Borno v Rev Joshua Adamu.*[36] This argument was also put forward in the case of *Registered Trustees of the Socio-Economic Rights and Accountability Project (SERAP) v Federal Republic of Nigeria and Universal Basic Education Commission.*[37] Thus, it becomes difficult to demand commitment with ease or navigate the implementation of progressive disability health policies and practices.

Despite the existence of some state disability laws[38] that provide for free healthcare for persons with disabilities and the existence of several health sector policies at the national and subnational level,[39] people with disabilities remain largely discriminated against and systemically excluded. In principle, though the state laws and national health sector policies appear to advance the provision of services to persons with disabilities, these laws/policies entrenched the notion of mere support to persons with disabilities. Arguably, the Nigerian government at the time may seem to have been committed to a rights-based policy for disability programmes because of international treaties it had signed.[40] However, a casual observation shows that most stakeholders in government lack political commitment and do not have a clear understanding of the ramifications of providing a rights-based agenda to disability inclusion in the health sector. Government institutions and most Nigerians still have what is essentially a medical understanding of disability, thus, making a comprehensive articulation and implementation of policies and services on the social model values of disability an appropriate objective.

35 The Nigerian Constitution provides in sec 6(6)(c) that 'judicial powers vested in accordance with the foregoing provisions of this section…shall not, except as otherwise provided by this Constitution, extend to any issue or question as to whether any act or omission by any authority or person or as to whether any law or any judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in Chapter Two of this Constitution'.

36 (1996) 1 NWLR (Pt 427) 68.

37 ECW/CCJ/APP/08/08.

38 n 3 above.

39 National Policy on Sexual and Reproductive Health for Nigerian Women and Girls with Disabilities; National Health Promotion Policy; National Health Promotion Policy; National Strategic Plan for Health Promotion.

40 These treaties include the UN General Assembly, Universal Declaration of Human Rights, 10 December 1948, 217 A (III); UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol 993, p 3; UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol 999, p 171; UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution/ adopted by the General Assembly, 24 January 2007, UN Doc A/RES/61/106 (2007); Organization of African Unity (OAU), African Charter on Human and Peoples' Rights (Banjul Charter), 27 June 1981, CAB/LEG/67/3 rev 5, 21 ILM 58 (1982); Organization of African Unity (OAU), African Charter on the Rights and Welfare of the Child, 11 July 1990, CAB/LEG/24.9/49 (1990).

Some medical decisions made by the Nigerian government and within the national space seem to convey the perception that the lives of persons with disabilities are not as valuable as those of persons without disabilities. To illustrate, children with disabilities have been used for clinical drug trials and interventions that would otherwise be considered improper if carried out on children without disabilities as was done in Kano in relation to the Pfizer-sponsored clinical trial of trovafloxcin.[41] Most persons with disabilities do not have access to healthcare services provided by teaching hospitals, orthopaedic hospitals and other specialist hospitals in Nigeria because they are yet to be included in the National Health Insurance Scheme (NHIS).[42] Some persons with disabilities who manage to get to the public or private hospitals grapple with negative attitudes of health workers and unsuitability of hospital facilities and installations. Persons with disabilities among the internally displaced Boko Haram insurgency survivors camped at Dalori in Borno State, lack access to appropriate healthcare facilities.[43] Medical rehabilitation therapy was not made available to the internally displaced persons in Dalori and referrals to psychological and social services were never made or provided at the camp.[44]

In relation to the foregoing exclusion, pertinent observations have been made by some persons with disabilities. Firstly, it has been observed that health administrators lack requisite awareness, capacity and necessary facilities as well as infrastructure to effectively provide disability-inclusive healthcare services in most states.[45] Secondly, there is absence of a policy framework that will ensure persons with disabilities are able to access the efforts made by some state governments in healthcare. Furthermore, a situational analysis of access to sexual and reproductive health services by women and girls with disabilities in Nigeria that was initiated by the Disability Rights Advocacy Centre (DRAC), revealed the plight of women with disabilities in accessing health services in Nigeria.[46] The survey indicated that women and girls with disabilities experience many challenges in accessing healthcare at various points of contact in the healthcare process. The challenges as stated include: inaccessible public

41 I Mohammed *Academics, epidemics, politics: An eventful career in public health* (2007) 10.

42 Y Osibanjo 'NHIS: Osinbajo says FG working to accommodate PWDs' *The Sun* 9 December 2021 https://www.sunnewsonline.com/nhis-osinbajo-says-fg-working-to-accommodate-pwds/ (accessed 9 December 2021).

43 FB Grema et al 'Camping condition and casual status of insurgency survivors living with disability in Internally Displaced Persons Camp in North Eastern Nigeria: A case series' (2017) 3 *Bayero University Journal of Evidence-Based Physiotherapy* 28 at 29.

44 Fatimah (n 43) 28.

45 Telephonic interview with Dr Adebukola Adebayo, board member of Lagos State Office of Disability Affairs and Ejiro Okotie of the Nigerian Association of the Blind on 10 October 2020.

46 Disability Rights Advocacy Centre 'A situation analysis on access to sexual and reproductive health services by women and girls with disabilities in Nigeria' May 2020 https://web.facebook.com/DRACNigeria/photos/women-and-girls-with-disabilities-wgwd-experience-many-difficulties-in-accessing/2978651835516968/?_rdc=1&_rdr (accessed 27 May 2021).

transport, lack of accessible facilities and equipment, absence of accessible communication facilities, poverty, negative attitude of healthcare personnel, and very few skilled medical providers. These concerns are not new but they have certainly not been realised in Nigeria and these gaps coalesce to deny persons with disabilities access to basic health services.

From the foregoing, denying persons with disabilities access to the physical environment, transportation, information and communication, and services open to the general public should be viewed in the context of discrimination. Before the passing of the Act, government policy statements on health were ambivalent, while efforts to establish practical laws including healthcare access for persons with disabilities were not followed through.[47] Nigeria's national health policies and strategies do not usually integrate issues of disability or prioritise accommodations for persons with disabilities. Often, mention is only made regarding persons with disabilities as target groups. What is required is the modification of existing services to suit persons with disabilities and to present information concerning health services in a readable and comprehensible format in accordance with reasonable accommodation. For instance, the 2006 National Health Insurance Scheme (NHIS), the National Strategic Health Development Plan, and the National Strategic Plan on HIV/AIDS never articulated substantive content and substantial interventions for addressing the health needs of persons with disabilities.[48]

Before the inauguration of the Disability Commission, the Ministry of Women and Social Affairs was the lead government department concerned with the responsibility of disability welfare programmes and provision of medical equipment including prosthetics and orthotics for persons with disabilities. Participatory observation and verifiable research inform that the Ministry is largely underfunded and staffed by individuals with little or no normative understanding of disability issues.[49] The processes and procedures for obtaining medical assistance were far too complicated that most persons with disabilities never really benefited in practice.[50] The problem is even more pronounced for persons with disabilities who because of their location and condition of disability miss out on medical treatment that can become life threatening without assistance from the Ministry. Persons with severe disabilities often do not survive due to lack of access to basic primary healthcare facilities that are

47 In the past, various attempts have been made to initiate bills at the Nigerian National Assembly in order to secure the rights of persons with disabilities in the country, see Joseph Onyekwere 'Persons with disabilities bill and the burden of presidential assent' *The Guardian* 9 March 2015 https://www.guardian.ng/features/law/persons-with-disabilities-bill-and-the-burden-of-presidential-assent/ (accessed 27 May 2021).

48 Lang & Upah (n 8) .

49 As above.

50 R Lang & A Murangira 'Barriers to the inclusion of disabled people in disability policy-making in seven African countries' in J Kumpuvuori & M Scheinin (eds) *The United Nations Convention on the Rights of Persons with Disabilities: Multidisciplinary perspectives* (2009) 159.

not readily available in the rural areas and some parts of the urban settings.[51] In locations where some interventions are considered, they are usually haphazard, one-off and palliative with no meaningful result, no checks and balances and no sustainability plan.

The Act was therefore expected to provide a policy direction to government, civil society organisations (CSOs), organised private sector and development partners on how to secure a rights-based approach to disability, including ensuring that persons with disabilities have unfettered access to adequate healthcare.[52] Under the Act, safeguarding free and equitable medical healthcare services for persons with disabilities in public hospitals is anticipated.[53] Leveraging on the Act to ensure that health issues of persons with disabilities are fully mainstreamed into the national health and social welfare programme is anticipated. Persons with disabilities have health needs like other people but require individualised support. Unfortunately, the implementation of these provisions remains largely anticipatory as three years within the five-year moratorium under the Act has now passed with little seen to have been done and mostly by private organisations. With regard to sections 8 and 21 of the Act on access to adequate healthcare, Nigeria undertook to take effective and appropriate measures to facilitate the full enjoyment of the right of persons with disabilities to accessible healthcare.

The Disability Commission though under the Act evidently has authority and powers that are wide-ranging. These include the right to sue or sanction in appropriate cases for the violation of the provisions of the Act, as well as receiving complaints of persons with disabilities on the violation of their rights. It also involves among others the responsibility of managing and superintending over the affairs of the Commission; establishing and promoting rehabilitation centres for the development of persons with disabilities; and collaborating with the public and private sectors and civil society to ensure that peculiar interests of persons with disabilities are taken into consideration in every government policy, programme and activity.[54] Indeed, the Nigerian government can co-operate with the Disability Commission as partners in implementing policies and programmes, assessment and monitoring, including information collection and dissemination for the effective delivery of accessible healthcare. However, persons with disabilities in Nigeria are wary, yet hopeful in contemplating how successful the inaugurated

51 World Health Organisation 'Disability and health' 24 November 2021 https://www.who.int/news-room/fact-sheet/detail/disability-and%20health (accessed 31 October 2022) ; Rick Hoel 'Lack of accessibility can create long term effects on people with disabilities' 18 December 2020 https://www.accessibility.com/blog/lack-of-accessibility-can-create-long-term-impact-on-people-with-disabilities (accessed 31 October 2022).

52 Section 21(1) of the Disability Act.

53 Section 21(2) of the Disability Act.

54 Sections 37-39 of the Disability Act.

commission will be, in view of the lack of firm intention on the part of government to carry through a policy that is not immediately in their interest.[55] In Nigeria, a large portion of public office and governance is founded on assistance and favouritism and the basis for provision of social economic needs of persons with disabilities is often viewed from the medical model of disability perspective.[56]

It is one thing to sign and ratify the CRPD, as well as enact a national disability Act, and another to advance administrative infrastructure and commitment for the effective implementation of the Act. In the absence of a directing framework, persons with disabilities in Nigeria will continue to experience discrimination in conditions and resources that promote and facilitate a healthy life. The Nigerian government is responsible for the quality and equal opportunity of its health systems because health for all is also affected by other human rights, for instance, right to life, adequate standard of living etc. Thus a cross-sector collaboration is critical for public sector reform and transformation. Experts working within the disability sector must work with government institutions in order to influence the deep-seated welfare and charity approach to disability issues.

4 Evaluating progress on actualising health specific provisions under the Act and one or two state laws

Disability rights groups, and community and faith-based organisations passed the Disability Rights Act in Nigeria in 2019 after decades of advocacy. Two years since the passage of this instrument at the national level, it is important to evaluate the level of progress made towards actualising the ideals enunciated therein. This part will enumerate progress and the lack of same. Progress towards achieving these rights as provided under the Act and state versions appear slow.[57] It is thought that the establishment of a Disability Commission under the Act would have assisted to ensure access to mainstream public services by all persons with disabilities in Nigeria.

The Federal Government of Nigeria, having enacted the national Disability Act, imposes positive obligations on the various state governments to adopt and pass same. The Act can be seen as a first step

55 CJ Eleweke 'A review of the challenges of achieving the goals in the African Plan of Action for people with disabilities in Nigeria' (2012) 28 *Disability and Society* 313.

56 The Ministry's approach to disability is based on the charity/welfare model of disability where demand for assistive devices is often met by massaging the ego of the official in charge of distributing these devices, see Lang & Upah (n 8) 8.

57 GU Bassey 'COVID-19 and its impact on at-risk individuals: Embracing a disability inclusive response' *The Guardian* 28 July 2020 https://guardian.ng/features/law/covid-19-and-its-impact-on-at-risk-individuals-embracing-a-disability-inclusive-response/ (accessed 27 May 2021).

towards the fulfilment of Nigeria's legal obligations under the CRPD. As stated elsewhere in this paper, some states in Nigeria including – Kano, Bauchi, Plateau, Kwara, Kogi, Ekiti, Lagos, Ondo, and Anambra – have also enacted state level disability laws. This arguably signifies a moral/ legal challenge on other state governments who are yet to enact laws for the protection of persons with disabilities in their jurisdiction. The main misgiving regarding the various state laws on disability however is that the provisions under the state's legislation and implementation are largely influenced by the medical model approach to disability.[58] The respective state legislation also remains applicable within the particular states and represents a mere arrangement of stipulations within the states.[59] Indeed the respective state legislation is not directed at the full development of human potential and strengthening of respect for human rights and dignity of all persons with disabilities in Nigeria.[60]

This research found that the Nigeria National Health Insurance Scheme[61] has a Physically Challenged Persons' Social Health Insurance Programme.[62] However, the major challenge is that many persons with disabilities are unaware of this programme. Secondly, the programme is only for a section of persons living with disabilities (in this instance, persons with physical disabilities). The scheme did not contemplate persons with sensory, intellectual and cognitive impairments. This principally resonates with matters regarding disability funding, inclusion and budget priorities. The people who articulated the NHIS operational guidelines might not have set out to discriminate; they simply forgot that persons with disability are a heterogeneous group that should be accommodated in the scheme of things.

The Act will be used to evaluate progress towards accessible healthcare facilities and services for persons with disabilities in Nigeria using a range of interrelated components essential to the right to health of persons with disabilities normatively. These components will evolve around issues of accessibility to facilities and services, availability of adaptive systems, quality and acceptability of services.

4.1 Unfettered access to healthcare facilities and services

The Act in sections 3 to 8 provides for a positive right to equal access to physical structures and environment for persons with disabilities in Nigeria. Sections 3 to 8 of the Act specifically cover the obligation to ensure that all aspects of healthcare are accessible and could be regarded as

58 NC Umeh 'Realising access to inclusive education for hearing-impaired learners in Nigerian Primary Schools' PhD thesis, University of Pretoria, 2017 at 97 & 98.
59 As above.
60 As above.
61 National Health Insurance Scheme (NHIS) Operational Guidelines (2012) 11-48.
62 As above.

applicable to the entire Act. This is based on the understanding that the sections address the general topics of access, requiring the government to take adequate measures to ensure that persons with disabilities have access on an equal basis to the physical environment, transportation, information and communication and other facilities and services provided to the public. Section 5 specifically provides for the duty on government to provide special facilities to ensure that the right to equal access is operationalised. In addition, the Schedule to the Act provides a list of necessary health facilities.[63]

Issues surrounding the access of persons with disabilities to the built environment, services and virtual spaces remain an important part of the Act. This provision of the Act is supported by the Committee on Economic, Social and Cultural Rights General Comment 14, which highlights that persons with disabilities have the right to accessible healthcare services, including the right to equality and non-discrimination in relation to all aspects of the right to health.[64] Drawing from General Comment 14, physical accessibility under the Act implies that health facilities, goods and services are situated within safe and easy to reach environments. It also entails the provision of medical services, potable water and sanitation within safe physical reach. Another inherent part of unfettered access to the right to healthcare is the ability of persons with disabilities to seek, receive and impart information relating to health issues in readable formats.

In Nigeria, persons with disabilities experience several barriers in hospitals that prevent them from accessing quality healthcare and actualising their full potential. Most of the facilities and accommodations listed in the Schedule to the Act are non-existent in most hospitals in Nigeria. This constitutes a denial of reasonable accommodation because states are required to ensure that persons with disabilities receive the support they need.[65] It has been reported that persons with disabilities face many challenges including transportation issues, lack of assistive technologies and non-adapted means of communication.[66] The reports also indicate that discriminatory service delivery and stigmatisation were

63 The First Schedule to the Discrimination Against Persons with Disability (Prohibition) Act 2018 lists necessary facilities for persons with disabilities inclusive access to healthcare to include but not limited to the following: wheelchairs; clear floors or ground space on wheel chair; wheel chair passage and turning space; crutches; guide canes; hearing aids; curb ramps; ramps; handrails; grab bars; stain-shopping stairs; elevators or lifts; windows; entrance doors; drinking fountains and water coolers; toilet facilities; door protective and re-opening devices; manoeuvring entrances at doors; parking spaces and passenger loading zones; accessible routes including walk ways; halls; sides and spaces; alarms including audible, visual and auxiliary alarms.

64 General Comment 14.

65 Inspired from a reading of art 5 of the CRPD.

66 World Bank 'Disability inclusion in Nigeria: A rapid assessment' (22 July 2020) https://www.elibrary.worldbank.org/doi/abs/10.1596/34073 (accessed 8 November 2021).

more prominent against persons with disabilities while accessing medical services in Nigeria.[67]

According to Pulrang, environments rendered inaccessible due to lack of adaptation to disability needs increase discrimination against persons with disabilities.[68] Choosing to ignore the need to provide accommodations in required spaces whether physical, cognitive or mental is tantamount to taking actions to exclude services to persons living with disabilities.[69] Pulrang while acknowledging that the actualisation of accessibility does not completely remove all barriers, restates that most issues of exclusion experienced by persons living with disabilities is underpinned by issues related to lack of accessibility. Door widths, counter heights, text readability and absence of proper signage often present daunting challenges for persons with disabilities in their attempt to participate in health programmes or access services.[70]

Inaccessibility of health facilities and services is a challenge for persons with disabilities in Nigeria in terms of both physical accessibility and other everyday matters like accessible communication and trained disability health providers. Even where the Act provides for accessible services and facilities, persons with disabilities often experience difficulties.

4.2 Availability of adaptive systems

Another critical issue in Nigeria is the unavailability of adequate healthcare without discrimination for persons with disabilities as provided under the Act. Transportation systems that are safe and responsive to the needs of persons with disabilities is an important facet of the capacity of persons with disabilities to enjoy the right to health. Where transport systems, whether municipal or rural, are not adaptive it directly impacts on the enjoyment of health rights by persons with disabilities. Ipingbemi observes that the Nigerian transport infrastructure is unfair to persons with disabilities.[71]

Another challenge to healthcare availability for persons with disabilities concerns admittance to documentation under the National Health Insurance Scheme (NHIS). Documentation and financial contribution are required in order to facilitate easy access to healthcare

67 World Bank *World report on disability: Main report* (2011) https://www.documents.worldbank.org/en/publication/documentsreports/documentdetail/665131468331271288/main-report (accessed 4 September 2020).

68 A Pulrang '7 Core arguments of Disability rights' *Forbes* 22 April 2021 https://www.forbes.com/sites/andrewpulrang/2021/04/22/7-core-arguments-of-disability-rights/?sh=5943b4aa5471 (accessed 31 October 2022).

69 As above.

70 As above.

71 O Ipingbemi 'Mobility challenges and transport safety of people with disabilities in Ibadan Nigeria' (2015) 18 *African Journal of Psychological study of Social Sciences* 23.

services for all Nigerian citizens,[72] and the Nigerian Government is yet to modify the National Health Insurance Scheme in order to accommodate the needs of persons with disabilities.[73] This is discriminatory as it prevents persons with disabilities the opportunity to access health services on an equal basis with others as provided under the Act. Indeed, lack of documentation often prevents many Nigerians from easily accessing healthcare services. Many people require assistance in obtaining documentation and for persons with disabilities, adverse socio-economic outcomes and discrimination often result in denial to provide documentation. Persons with disabilities may never have had such documentation in the first place due to poor education, stigma, low levels or lack of employment and high poverty. Most persons with disabilities are not employed, so may not seek healthcare in healthcare facilities because they lack funds. This has appreciably affected the ability of persons with disabilities to make successful claims for health services under the Act.

Ayub and Rasaki highlight that misperceptions about mental health conditions, including the misunderstanding that they are caused by evil or supernatural forces, often prompt parents or relatives to take persons with mental health issues to religious or healing places instead of hospitals.[74] Health practitioners usually fail to attend to patients with mental health conditions, maltreat them and subject the families of the patients to financial exploitation.[75] Also related to this is the fact that patients in wheelchairs are troubled when they are forced or conditioned to look up repeatedly while discussing with health professionals who are standing or not ready to sit or bend down. These include the absence of Braille and sign language interpreters as well as healthcare support facilities and professionals who are trained to cater for persons with disabilities.[76] Of particular significance, in this regard, is the unavailability of healthcare processes that are tailored to the specific needs of persons with disabilities as required under the Act.

4.3 Quality and acceptability of services

Where persons with disabilities are made uncomfortable with the level and quality of services available at hospitals it becomes impossible for them to enjoy the right to medical care and the right to live as everyone else in their immediate community.[77] The requirement under section 6 of the Act, for public buildings, structures and automobiles to be made accessible

72 NHIS Operational Guidelines (2012) 11-48.
73 Osibanjo (n 42).
74 AA Olalekan & RA Jimoh 'Barriers to accessing healthcare services by patients with disabilities in Nigerian hospitals' (2021) 4 *Gasua International Journal of Management and Social Sciences, Federal University, Gasua* 280.
75 As above.
76 As above.
77 Sections 3 and 4 of the Disabilities Act.

presupposes a universal design.[78] A study of 257 public buildings in Nigeria revealed that 80 per cent of the buildings observed had only stairs for both persons with disabilities and persons without disabilities.[79] This implies that persons living with disabilities in Nigeria continue to suffer exclusion in their attempt to use healthcare and ancillary services. This will in turn negatively affect their health. A study on the connection between the built environment and the health of persons living with disabilities reveals that related markers such as poor roadway situations, uniform land use, traffic, and surrounding hazards are suggestive of higher reported maladies, functional constraints, inertia, and social exclusion.[80]

Ojo acknowledged that patients with disabilities feel segregated when treated as people in need of charity.[81] This feeling of exclusion aligns with obvious lack of access to the basic needs of life, public infrastructure, healthcare delivery, education and employment. The absence of these basic needs and amenities prevent persons with disabilities from leaving as full citizens and living a productive life.

Perry asserts that patients with sensory and cognitive disabilities experience disrespect in hospitals when they complain of any health challenge.[82] Their impairment makes it impossible for them to discuss health issues with doctors and other healthcare professionals and several hospitals in Nigeria lack the facilities to ensure equal treatment of patients. The attitudes of healthcare providers are key factors to the general well-being of patients with disabilities. Where attitudes are negative, it will impact negatively on the health of the patients with disabilities.[83] Indeed poor attitudes of healthcare providers will deter adequate healthcare requirements under section 21 of the Act.

5 Towards operationalising equitable access to healthcare for persons with disabilities in Nigeria

In the first place, sections 3 to 8 read together with section 21 of the Act require Nigeria to put in place a framework on the implementation of

78 K Hanifen 'Living with disabilities in Nigeria' 18 July 2019 https://borgenproject.org/disabilities-in-nigeria/ (accessed 27 May 2021).

79 A Soyingbe et al 'A study of facilities for physically disabled people in public buildings in Nigeria' Proceedings of the 4th International Research Symposium (SCRI) in conjunction with the International Built and Human Environment Research, University of Salford, 26-27 March 2007, 251-264.

80 AL Boticcello et al 'Disability and the built environment: An investigation of community and neighbourhood land uses and participation for physically impaired adults' (2014) 24 *Annals of Epidemiology* 545.

81 J Ojo 'What Nigerians with disabilities want' *The Punch* (Nigeria) 20 December 2017 at 2.

82 RF Antonak & H Livneh 'Measurement of attitudes towards persons with disabilities' (2000) 22 *Disability and Rehabilitation* 211.

83 J Sanchez 'Perceived accessibility versus actual physical accessibility of healthcare facilities' (2000) 2 *Rehabilitation Nursing* 6.

unfettered access to adequate healthcare without discrimination based on disability. The framework should be structured in partnership with the Disability Commission and disability organisations in such a way as to include persons with disabilities high support needs. Nigeria, a country with about 27 million of its population[84] with varying degrees of disabilities, must rise to the occasion and provide a modicum of facilities and funded programmes to enable persons with disabilities to achieve their full potential in life. In order to secure a path to sustainable access to health for persons with disabilities the following must progressively be put in place by the government going forward.

(1) The right to unfettered access to healthcare needs to be construed and observed in a manner that recognises the place of 'reasonable accommodations'[85] with regard to housing, education, hospital visits, public facilities of all variations amongst others. This is to enable persons with disabilities to enjoy the right to adequate healthcare on an equal basis with others. Applying the principle of reasonable accommodations will ensure that these rights are operationalised in a manner that impacts the life of a person with disability directly. This can take the form of ensuring that modifications and health information is presented in an accessible manner for the benefit of persons with disabilities.[86]

(2) Successive administrations must work through inclusive communities[87] to provide both by way of legislation, policy and programme reform that anticipates the needs of persons with disabilities during public health and other emergencies. This is an existing gap found to be severely lacking in the Act and the national strategic response roll out of the federal and subnational COVID-19 Taskforces. More specifically economic stimulus packages /palliatives were handled in a manner that inadvertently excluded persons with disabilities.[88]

84 Jethro Ibileke '27.3 million Nigerians living with disability' *TheNews* (Nigeria) 3 December 2018 https://www.thenewsnigeria.com.ng/2018/12/03/27-3-million-nigerians-living-with-disabilities/ (accessed 27 May 2021).

85 Reasonable accommodation principles are applied generally to the workplace and post-secondary facilities and processes. However, basic principles of reasonable accommodation can be extrapolated to all parts of the life of the person with a disability to enable them to participate fully in the society like everyone. Reasonable accommodation may include, but is not limited to, making existing facilities used by employees readily accessible to and usable by persons with disabilities; job restructuring, modifying work schedules, reassignment to a vacant position; acquiring or modifying equipment or devices, modifying examinations, training materials, or policies, and providing qualified readers or interpreters. For further discussion on the concept of reasonable accommodation, see LV Martel 'Reasonable accommodation: The new concept from an inclusive constitutional perspective' (2011) 8 *SUR International Journal on Human Rights* 85. See also NC Umeh 'Progress towards inclusive primary education in selected West African Countries' (2018) 6 *African Disability Rights Yearbook* 264.

86 R Muhammad 'Life in Times of COVID-19 – Persons with Disabilities' *The Guardian* (Lagos) 5 November 2020 https://guardian.ng/features/life-in-times-of-covid-19-persons-with-disabilities/ (accessed 27 May 2021).

87 Section 25 of the Disability Act.

88 T Oyetunde 'What next for PWDs as government excludes them from COVID-19 intervention programme' *Sahara Reporters* 23 October 2020 http://saharareporters.com/2020/10/23/what-next-persons with disabilities-government-excludes-them-covid-19-intervention-programme (accessed 28 May 2021).

(3) Deliberate attempts must be made to generate disaggregated data and research towards accountability for existing programmes and factors limiting efficiency and impact on the actualisation of persons with disabilities right to access to healthcare. The size of the population living with disabilities, and the prevalence of inequality associated with disability in the Nigerian health sector are important signs of the magnitude of the challenge for inclusive policy and governance. Lack of data on access to healthcare for persons with disabilities in Nigeria in relation to inclusive budgeting should be understood in the context of a country that has yet to develop data that are more precise. Nigeria needs a comprehensive database not just for disability identification and services/programmes but also for every other programme implementation and management.

(4) Steps must be taken to incorporate social workers in the provision of services to persons with disabilities in Nigeria. Interventions are generally initiated to strengthen human functioning and to enhance the effectiveness of societal structures that provide resources and opportunities for clients and users of services, including people with disabilities. Social workers facilitate the access of individuals in a given society to resources and opportunities available to meet their needs including persons with disabilities. Social work in Nigeria is mostly relegated to few private organisations.[89] Consequently, persons with disabilities who use public healthcare facilities are not aware of beneficial service resources and opportunities in the few instances where these opportunities exist, thereby limiting their access to these resources.

Although the above recommendations are presented under separate paragraphs, they are cross-cutting.

6 Conclusion

More than two years since the national legislation on disability rights was passed, Nigeria is not on track to meet its commitments under its national and subnational laws. Commitments ranging from access to medical healthcare and associated facilities, with a five-year moratorium for attainment have yet to be considered or implemented in any substantial degree. If decisive steps, particularly regarding funding mechanisms, are not taken towards putting in place adaptations and modifications to actualise these rights, Nigeria certainly will not achieve adequate or equitable access to healthcare for persons with disabilities. Advocacy for the achievement of the right of access to healthcare will have to continue even now that there is an enabling Act. This will influence the Disability Commission established under the Act to gain traction and push Nigeria across the line of commitment and actualisation of obligations enshrined in the Disability Act. States should be seen to perform their legal

89 S Amadasun 'Social work services for persons with disabilities in Nigeria: A qualitative enquiry' (2020) 6 *International Journal of Social Science Perspectives* 59.

obligations in good faith. Ultimately, legal obligations under the Act must become transformative and 'translated into reality' for the intended beneficiaries.