1 The National Health Policy 2016: A Missed Opportunity for Advancing the Human Right to Sanitation for Nigerians?

by **Pedi Obani**

Introduction

Universal health coverage requires a broad focus not only on health-care settings and professionals but on related rights, infrastructure and services – such as sanitation – that can affect public health outcomes directly or indirectly. The synergy between universal health coverage and the human right to sanitation cuts across the public health promotion, disease prevention, and curative and rehabilitation dimensions of health services. For instance, public health promotion services can be an effective means of spreading information about the human right to sanitation and institutionalising mechanisms for access to information about sanitation services, remedies and accountability. Similarly, disease prevention can be strengthened through universal access to safe, accessible, acceptable, affordable and adequate sanitation services, including the safe collection, treatment and disposal of wastewater and health-care waste; curative services can be more effective when people within the healthcare setting are protected from disease vectors like mosquitoes and provided with safe access to sanitation and drinking-water facilities; rehabilitative and palliative services are enhanced when people who are either treating or managing various kinds of ailment or disability have access to basic necessities tailored to meet special needs they may have.

The National Health Policy 2016 indicates that Nigeria is currently far from the mark in attaining universal health coverage in terms of public health promotion, disease prevention, and curative and rehabilitation services. Although the country has recorded progress in some of its health indicators (such as under-five and infant mortality rates) and was among the countries that successfully contained the Ebola virus disease during the international health emergency in 2014, other health indicators such as maternal health suggest it is making slow progress. In this regard, Nigeria has a high prevalence of communicable diseases. These account for about 66 per cent of total morbidity, a situation exacerbated by poor sanitation and hygiene practices (Federal Ministry of Health, 2016). To put it differently, sanitation and hygiene services are pivotal for universal health coverage in Nigeria, and the focus this paper is on the prospects that the current Policy holds for advancing the human right to sanitation.

The Policy is the third national health policy for Nigeria, with the first two such policies having been introduced in 1988 and 2004, respectively. Formulated in order to promote universal health coverage for accelerated socio-economic development, the Policy comes at an especially opportune time, given that it follows in the wake of a global commitment to achieving the Sustainable Development Goals (SDG) by 2030. The SDGs include goals regarding health as well as water and sanitation, which underlines the growing recognition of sanitation as an independent right critical for the realisation of numerous other related social, economic and cultural human rights, among them the right to health.

In the sections below, I first highlight the institutional barriers to realising the human right to sanitation. Next, I analyse the coverage of sanitation within the Policy Objectives and Orientations in Chapter 4 of the Policy, showing how it falls short of promoting universal access to sanitation; this serve as a precursor to the concluding thoughts presented in the final section.

Institutional barriers to realising the human right to sanitation

Despite the increasing momentum that the human right to sanitation has gathered in recent years, the level of access to sanitation in Nigeria remains deplorable. About 30 per cent of households use improved toilets, 25 per cent of them use shared toilet facilities, 45 per cent use unimproved toilet facilities, and 29 per cent resort to open defecation (Federal Ministry of Health, 2016). Access to sewerage management and other waste management services is also limited (Federal Ministry of Health, 2016). The poor status of sanitation coverage is the result of a number of institutional barriers, which include an emphasis on individual responsibility; fragmented leadership from state departments and agencies; inequitable allocation of resources for sanitation; and the non-justiciability of socio-economic rights.

First, sanitation is viewed in the main as the responsibility primarily of households and individuals. To this end, national sanitation policies over the years have emphasised the need for community, including individual, ownership and management of on-site sanitation (Federal Ministry of Water Resources, 2000; 2004). However, the absence of technical and financial support for the very poor and other vulnerable groups that may not be able to afford the cost of sanitation, coupled with inadequate regulation to ensure compliance with safety standards for facilities as specified in the legal framework, means that individuals and communities cannot be expected to deliver the human right to sanitation.

This negates the character of sanitation as a public good, one that requires universal access in order to minimise negative externalities from non-users (Mader, 2012). In addition, sanitation is a merit good which requires the intervention of the state to counter inherent tendencies for preference distortion that may hamper private investments in safe sanitation options and instead make unsafe practices like open defecation more attractive in some contexts (Mader, 2012).

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Secondly, fragmented leadership or responsibility for sanitation compounds the sanitation problem (Federal Ministry of Water Resources, 2000). The National Sanitation Task Group and State Sanitation Task Groups are made up of the key stakeholders working in the sanitation sector at the national and state levels, respectively, but there is a lack of clarity about their roles and poor delivery of sanitation services is still a problem, particularly in the urban centres.

Urban sanitation is especially problematic because the responsibility for the delivery of sanitation services in urban areas is divided among a variety of departments and ministries dealing with, inter alia, the environment, health, water resources, agriculture, education, women's affairs and social development, yet with minimal coordination of their respective sanitation policies and programmes. At the same time, communities and individuals provide their own sanitation services within their homes and in public places under their control (business centres, for instance), with little regulation of technical and safety standards. This often creates public health risks as a result of unsafe practices such as the disposal of raw sewage in water bodies.

Thirdly, the predominant approach that public health authorities take to sanitation programming and intervention is one aimed at transforming the latent demand for sanitation services into a strong demand for services which is both visible and backed by the willingness to pay. However, the approach is limited in its effectiveness owing to the underlying motivations of the public and the disincentives that prevent people from accessing sanitation.

Sanitation is a basic necessity for human survival and environmental sustainability, but the demand for sanitation services may appear to be latent, where

(a) sanitation services are designed within a technocratic paradigm rather than being tailored to address the pre-existing needs of vulnerable and marginalised groups who are excluded from the sanitation governance process;

(b) taboos result in the exclusion of minorities from demanding or accessing sanitation services, or in other ways encourage unsanitary practices;

(c) insecurity of tenure hampers the willingness of households and individuals to make the necessary capital investment in sanitation infrastructure;

(d) poverty constrains the ability to afford the cost of sanitation infrastructure or connection and maintenance fees; or

(e) local environmental conditions affect the viability of certain pre-designed sanitation technologies.

With regard to the public, there is evidence that the motivations for using sanitation services are often more closely linked to dignity, physical security, privacy, convenience and affordability than an overriding concern for health benefits (Joshi et al., 2011; Seraj, 2008).

These factors may likewise affect the extent to which people are willing to pay for sanitation services. Hence, sanitation interventions ought to respond to the motivations and needs of the public in order to be effective in triggering demand and willingness to pay.

Nonetheless, even so there may still be poor people who cannot afford the cost of basic sanitation services and therefore require financial assistance if universal coverage is to be ensured.

Fourth, the limited public resources allocated for the expansion of sanitation services are often expended on formal settlements to the exclusion of informal ones. The available resources for regulation and enforcement are also concentrated within formal settlements and do not benefit the poorest and most vulnerable populations that are kept invisible outside the city. This occurs, for instance, when formal settlements are prioritised over informal settlements for the delivery of state-subsidised waste management services, with the result that the latter are excluded from the service network. Ironically, formal settlements are often inhabited by residents who are relatively more affluent, can probably afford at least the cost of basic sanitation services and therefore are already enjoying a higher level of sanitation coverage than people in informal settlements. Hence, policies that subsidise sanitation services in formal settlements to the exclusion of informal ones inadvertently exacerbate the inequities in access to sanitation and thereby pose a risk to public health outcomes for society as a whole.

Such policies also fuel distrust between the state and residents of informal settlements, with the latter being further sanctioned by the state for, inter alia, their poor sanitary practices. Conversely, public health promotion programmes disseminated in local languages and public places like markets and motor parks are capable of reaching large audiences and improving relational inclusion.

Fifth, socio-economic rights are stricto sensu not justiciable in Nigeria, except where they are legislated upon (Fagbohun, 2010; Popoola, 2010). Nonetheless, Nigeria voted in favour of the United Nations General Assembly (UNGA) Resolution A/64/292 of 3 August 2010, on the human right to water and sanitation. The Resolution is indeed one of the main international law instruments that heralded the evolution of the human right to sanitation as an independent right; the latter's emerging status in international law is supported by opinio juris and various practices among states in Nigeria, including the integration of human rights principles in the formulation of the SDG sanitation goal and targets. Furthermore, the human right to sanitation is critical to the realisation of fundamental rights contained in the country's 1999 Constitution, among them the right to life, as well as the human and peoples' rights in the African Charter on Human and Peoples Rights (the Charter). The Charter rights have been domesticated in Nigeria through the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1983.

Thus, the human right to sanitation imposes obligations on the Nigerian government to ensure that public utilities and non-state actors involved in the delivery of sanitation services respect, protect and fulfil the right. This duty is not diminished by the lack of express recognition of the human right to sanitation under the 1999 Constitution.

Coverage of sanitation in the National Health Policy

The Policy contains a combined water and sanitation goal under the section on health-related problems and issues. The goal, which is to 'reduce the disease burden resulting from unsafe drinking water and poor sanitation', is linked furthermore to the objective of promoting 'universal access to safe drinking water and acceptable sanitation' (Federal Ministry of Health, 2016). The four policy orientations or initiatives regarding water and

and sanitation are to

(a) promote the provision of adequate and safe water and appropriate sanitary facilities in urban and rural areas through multi-sectoral collaboration, public-private partnerships and effective community engagement';

(b) develop and implement quality standards for safe potable drinking water';

(c) develop and implement National Framework for Water Quality Monitoring and Surveillance strategies'; and

(d) promote awareness on the risks linked with consumption of unwholesome water' (Federal Ministry of Health, 2016).

There are arguments both for and against the linking of water and sanitation in the engineering, development and human rights fields (Ellis and Feris, 2014). However, looking at the Policy and the Nigerian context, there appears to be a stronger case for de-linking water and sanitation, and for at least two reasons.

To start with, combining the water and sanitation goal in the Policy already increases the likelihood that sanitation will be side-lined and more focus placed on water. This is already evident from the four policy orientations or initiatives, which tilt towards ensuring universal access to safe drinking water without creating much room for developing strong initiatives for acceptable sanitation. It is also not clear whether the policy orientation or initiative to promote 'appropriate sanitary facilities' pertains to the actual provision of sanitation infrastructure such as toilets, sewerage treatment plants, and hand-washing facilities, or to maintaining sanitation and hygiene levels in health facilities, for instance. Secondly, the combination of the water and sanitation goal is influenced by a predominantly technocratic approach and ignores the fact that the motivations for sanitation are much broader than those to do with concerns about water quality: this is one of the institutional barriers to universal access to sanitation. Conversely, there are dry sanitation systems which may also pose a contamination risk to land and environmental resources other than water quality per se.

The Policy's goal, objective, and orientations or initiatives do not adequately reflect the content of the human right to sanitation, which includes safety, accessibility, acceptability and affordability. Although the formal recognition of a human right is no magic wand for addressing a myriad of human development challenges, the content of the human right to sanitation offers inadequate framework for addressing the institutional barriers to universal access to sanitation. The human rights approach imposes a tripartite obligation on the state as the primary duty-bearer to respect, protect and fulfil the right to sanitation both within its jurisdiction and externally, for instance through developmental assistance to poorer states.

Hence, the state retains the duty to support individuals to access safe, accessible, acceptable and affordable sanitation services, either through direct provision or by creating an enabling environment for third parties to deliver the services. The human rights approach ensures top-down accountability in favour of the rights-holders: this requires clearly defined roles and responsibilities for all stakeholders involved in the delivery of sanitation services.

The human rights approach also imposes a duty on states to ensure that the maximum available resources are allocated to sanitation and that there is no discrimination or retrogression in the process: this enhances the equitable allocation of resources for sanitation.

Finally, there are judicial and non-judicial human rights enforcement mechanisms which empower people living without access to sanitation to demand coverage as a right rather than as a mere act of benevolence from the state.

Conclusion

Although the inclusion of a sanitation goal in the National Health Policy 2016 is laudable and indicative of the recognition of the importance of sanitation for universal access to health in Nigeria, the Policy's potential is hampered by a limited conceptualisation of sanitation as a component of water quality. The sanitation goal, and the related objectives and policy orientations or initiatives, also fail to reflect the content of the human right to sanitation.

Admittedly, given that the Policy is a health policy, it cannot be expected to address all aspects of sanitation governance. Nonetheless, the need to de-link water and sanitation has already been recognised by scholars as well as United Nations organs such as the General Assembly, which passed a resolution towards the end of 2015 recognising sanitation as an independent right (Feria and Ellis, 2015; Obani and Gupta, 2016).

Moreover, the human rights norm has become a part of global custom, as reflected in the SDGs, for instance. Hence, any modern policy initiative dealing with sanitation can indeed be expected to reflect the core content of the human right to sanitation as a minimum; inasmuch as it fails to do so, the Policy represents a missed opportunity for advancing the human right to sanitation for Nigerians and, in the process, benefiting universal health coverage.

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INTERVIEW

2 The United Nations Independent Expert on the Rights of Persons with Albinism with **Ms Ikponwosa Ero**

Ikponwosa Ero (Nigeria) was designated in June 2015 by the UN Human Rights Council as the first UN Independent Expert on the enjoyment of human rights by persons with albinism. Inspired by her experiences as a person with albinism, Ms. Ero has spent the last seven years fulfilling her mandate.
As international advocacy and legal officer of Under the Same Sun, an NGO with a focus on albinism, she has participated in multiple activities and panels at the UN in Geneva and New York. She has extensive experience in research, policy development and advocacy in the field of albinism. She is the author of numerous papers and articles on the issue, including ones examining the categorisation of persons with albinism in the international human rights system.

Can you briefly tell us about your mandate as the Independent Expert on the enjoyment of human rights by persons with albinism?

My mandate was created nearly three years ago by the Human Rights Council of the United Nations. It was created in response to increasing reports of attacks and other grave human rights violations against persons with albinism. The attacks are linked to witchcraft beliefs and practices, which propagate the absurd and erroneous notion that the body parts of persons with albinism can generate wealth and good luck when used in rituals, potions and amulets. Nearly all reports of attacks have come from sub-Saharan Africa. Globally, there are challenges over and above the attacks, including reports of infanticide, abandonment and discrimination in the areas of socio-economic rights, such as being denied jobs or places at school.

As with all other thematic mandates, I have general duties, such as reporting to the UN Human Rights Council and to the General Assembly, and visiting countries for fact-finding and first-hand assessment of the situation. My main focus in this mandate is to end the attacks against persons with albinism and to tackle their root causes. Consequently, I spend a lot of effort on the region of sub-Saharan Africa, where violations against person with albinism are severe. In so doing, I meticulously search for good practices and also seek out partners to replicate these good practices at the local level and national levels.

I also prioritise research. Since this issue [albinism] has been neglected for centuries and its members have suffered and continue to endure great violations, it is highly important to gather the facts to feed them into ongoing intervention. This means I engage in frequent dialogue with persons with albinism, academic researchers and other stakeholders. I am now working on building an international research collaborative on the issue. The collaborative will look into all relevant legal frameworks, but will also include the difficult questions surrounding harmful practices emerging from belief systems that pervade sub-Saharan Africa.

What is albinism?

The condition of albinism is non-contagious, genetically inherited and affects people regardless of race, ethnicity or gender. It results from a significant deficit in the production of melanin and is characterised by the partial or complete absence of pigment in any or all of the skin, hair and eyes.

Persons with albinism therefore often appear pale in comparison to members of their family and their communities.

Today, it is estimated that in Europe and North America the frequency is 1 in 17,000 to 1 in 20,000 births. In sub-Saharan Africa, the reported frequency ranges from 1 in 5,000 to 1 in 15,000, with prevalence rates of 1 in 1,000 for selected populations. A higher frequency has been reported in certain parts of the Pacific (1 in 700) and among some indigenous peoples in North and South America (1 in 70 to 1 in 125). While the condition is global, the impact of the condition on human rights, and its perception by others, including its effect on social inclusion, varies from region to region.

There are different types of albinism. The most well-known type is oculocutaneous albinism, which affects the skin, hair and eyes. Within this type are subtypes that may reflect varying degrees of melanin deficiency in an individual. Lack of melanin in the eyes results in high sensitivity to bright light and significant visual impairment, with the level of severity varying from one person to another. This visual impairment often cannot be completely corrected. In addition, one of the most serious health implications of albinism is vulnerability to skin cancer, which remains a life-threatening condition for most persons with albinism in certain regions. All violations of civil and political rights relating to albinism reported to date have been linked to its oculocutaneous form, which is also the most visible type of albinism.

Since your appointment as the Independent Expert on the enjoyment of human rights by persons with albinism, what would you consider to be the major challenges facing persons with albinism worldwide, particularly in Africa?

The overarching challenge faced by persons with albinism is long-term neglect of the issue, resulting in the absence of their voice in the public sphere. Also, a significant number of persons with albinism globally are not aware of the laws that protect them and continue to linger in various forms of suffering and neglect. Efforts need to be made to build their capacity (particularly that of civil society leaders and advocates) on the norms and standards of human rights and also on the human rights approach.

The second overarching challenge is a lack of understanding of the condition and consequently a failure to apply a robust legal framework to their experiences.