

IS THERE A RIGHT TO HEALTH IN GHANA? THE CASE OF GHANA'S 1992 CONSTITUTION

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ABSTRACT

The nuances and ramifications of the right to health are sufficiently large and varied, just as are its rendition in constitutional and statutory provisions. It is sometimes difficult, at the legal level, to ascertain whether a legal right is intended by a provision or is a mere use of 'rights language'. This ambiguity is visible in a number of provisions in Ghana's 1992 Constitution and legislation. However, there are few scholarly studies on the right to health in Ghana. This article seeks to explore the nuances of the concept of the 'right to health' in international human rights law to ascertain whether Ghana's 1992 Constitution and legislation provide for the 'right to health'. This paper further discusses some policy issues on health.

Keywords: Health, Rights, Law, Sustainable development, Concept

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Introduction

Health and the health of those we care about is a matter of daily concern. Regardless of our socio-economic circumstances and background, health is our most basic and essential asset for improving the 'human condition'. Bad health, on the other hand, can prevent us from carrying on our 'everyday life' or from participating fully in the activities of our community. In the same context, we are willing to make many sacrifices if only that would guarantee us and our families a longer and healthier life. In short, when we talk about improving the human condition and being sufficiently 'human', health is often what we have in mind. As is often said in Ghana, 'health is wealth'.

The right to health is a fundamental part of our human rights and of our understanding of a life in dignity. The right to the enjoyment of the highest attainable standard of physical and mental health, to give the right its full meaning, is not new. Internationally, it was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The preamble further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

In 1948 the Universal Declaration of Human Rights (UDHR) also referred to health as part of the right to an adequate standard of living in article 25. The right to health was further recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCRs).

From then onwards, other international human rights legal instruments have recognized or referred to the right to health or to elements of it, such as the *right to medical care*. The right to health is relevant to all States as almost every State has ratified at least one international human rights treaty recognizing the right to health. In addition, States have committed themselves to protecting this right through international declarations, domestic legislation and policies, and at international conferences. In the case of Ghana, it has ratified almost all international conventions, treaties and protocols related to the right to health.

Given the importance of health as a development variable, one cannot realize the United Nations 'right to development'² outside the right to health. And most of the discourse

² United Nations General Assembly. (2011). *Declaration on the Right to Development*. <http://www.un.org/documents/ga/res/41/a41r128.htm>. Also see Ellen Bortei-Doku Aryeetey, Raymond A. Atuguba &

on the right to development always invariably allude to the right to health. For instance, Ghana sees health as a tool for development and requires multi-faceted interventions such as health product development, marketing, standard and quality control on one hand and interaction of human behavioural factors such as healthy lifestyle, healthy environment and accessible quality healthcare service on the other hand³.

Ghana's current health policy is said to derive inspiration from the Directive Principles of State Policy (DPSP) of its 1992 Constitution, which among others requires the state to ensure the realization of the right to good healthcare for people living in Ghana irrespective of their colour, race, geographical location, religion and political affiliation. And all political actors are enjoined to be guided by the tenets of this policy and provide the needed leadership and support for its implementation.

The policy is also said to be inspired by the overall national medium-term policy development framework developed by the National Development Planning Commission (NDPC), as well as the Coordinated Programme of Economic and Social Development Policies (2017-2024). Development is broadly defined in Ghana as a "measure of progressive change in the lives of the Ghanaian population as a result of public and private strategies, investment and interventions put in place over the period of 2000 and 2015"⁴.

The relationship between health and development is often captured in the discourse through the Gross domestic product (GDP) and human development index in Ghana to measure development. Although the use of GDP as a measure of development is popular, it often fails to capture inequalities and differences in social deprivation in the population. Consequently, Human development index (HDI)⁵ is preferred as a broader approach to understanding developmental issues. The index includes most basic human capabilities such as long life, being knowledgeable, and enjoying a decent standard of living (UNDP, 1999) and good health.

Ghana's health policy also recognizes several global, regional and sub-regional compacts and policy frameworks, which include: the United Nations Sustainable Development Goals (SDGs) on the theme, "Transforming our World: the 2030 Agenda for Sustainable Development", the International Health Regulations (IHR 2005), the Astana Declaration

Benjamin Kunbuor (2004) *The Right to Development Report: Ghana Country Study*. Legal Resources Centre: Accra, Part Two, discussion on the right.

³ University of Ghana (2019), *The State of the Nation's Health*, School of Public Health: Legon, Accra. p. 143

⁴ Ibid.

⁵ *Human Development Index: A composite index measuring average achievement in three basic dimensions of human development—a long and healthy life, knowledge and a decent standard of living.*

on Primary Health Care (PHC), the African Union (AU) Vision 2063: "The Africa We Want", the ECOWAS Vision 2020, the African Health Strategy (2016-2030) and the Africa Health Transformation Agenda (2015-2020).

The nuances and ramifications of the right to health are sufficiently large and varied, just as are its rendition in constitutional and statutory provisions. It is sometimes difficult, at the legal level, to ascertain whether a legal right is intended by a provision or is a mere use of 'rights language'. This ambiguity is visible in a number of provisions in Ghana's 1992 Constitution and legislation. However, there are few studies on the right to health in Ghana, which I will allude to in a subsequent section of this article⁶. This article intends to engage a number of the themes raised in those studies in some detail and to discuss some subsequent policy issues on health since those publications.

This article also seeks to explore the nuances of the concept of the 'right to health' in international human rights law to ascertain whether Ghana's 1992 Constitution and legislation, provides for the 'right to health'. This need arises from the wording of the relevant articles in the Constitution and other legislation; as well as, the clustered nature of Ghana's human rights legal architecture. Three clusters are discernible in Ghana's Constitution as relevant to the right to health: enumerated human rights provision in chapter 5, unenumerated rights provisions in article 33 (5), and scattered provisions in chapter 6 as Directive Principles of State Policy (DPSP).

In addition, Ghana's Public Health Act, 2012 (Act 851), provides for a 'Patient's Charter of Rights' in its Sixth Schedule. These 'rights' provision in Act 851 is far from clear and what is intended by it. Apart from the obscurity of the detailed rights of the patient, in terms of its location in a public health legislation, it is not clear as to whether it is intended to provide for a right to health. It is therefore not surprising that legal scholarly interests have not been attracted by it.

The need for such a discussion is more compelling for a number of reasons. First, the courts are often unpredictable as to the extent of a recognition of a constitutional or legislative provision as human right- particularly economic, social and cultural rights. Second, the decisions of the Supreme Court remain inconclusive as to whether the

⁶ See Ellen Bortei-Doku Aryeetey, Raymond A. Atuguba and Benjamin Kunbuor (2004) *The Right to Development Report: Ghana Country Study*, Legal Resource Centre: Accra, Ghana, Part Two; and Atuguba, R. A. (2013) "The Right to Health in Ghana: Healthcare, Human Rights, and Politics", in Zuniga, J.M, Marks, S.P. & Gostin, L.O. eds. *Human Right to Health*, at <https://oxforduniversitypressscholarship.com/view/10.1093>.

DPSP are justiciable and for that matter the rights therein. And third, the extent of the rights anticipated by article 33 (5) of the Constitution. These issues get more complicated due to some philosophical and conceptual challenges on human rights discourse generally and the right to health in particular.

The article will provide a conceptual background to a number of these philosophical and conceptual challenges as well as the nature of the right to health as understood in international human rights law, in its historical context. In addition, it will introduce the African perspective on the right to health, informed by the Africa Human Rights Charter, given that Ghana is a state party to that charter. It will posit the problematic of Ghana's human rights clusters in its Constitution, with a focus on a number of provisions; which span from chapter five on fundamental human rights and freedoms to chapter six on the DPSP and other legislation. It would draw some conclusions and make some recommendations for legal reform.

Philosophical and Conceptual Issues

Philosophical challenges

First, though the current thinking on human rights is relatively new, the idea is closely related to an older notion of 'natural right'. John Locke (1632-1704), an influential advocate of the concept, sought to refute the feudal notion that human beings were *subjects* and not *citizens*. And therefore, any rights enjoyed by individuals are granted by their superiors, who received their privileged positions from a sovereign, appointed by God to rule by divine right. Nothing that the sovereign did, from the view of feudalism, could be understood as a violation of the rights of his subjects. Locke sought to prove the truth of the reverse, that human beings have *natural rights* that even the sovereign must respect. And that sovereign powers were granted only through a *social contract* with the people, and if the sovereign went beyond the limits of the natural rights of the people, rebellion could be justified. In Locke's version of the social contract,⁷ persons have natural pre-existing social rights to life, liberty, and property, but a central authority, brought about through a *social contract*, is eventually necessary to better protect those rights. The power of the authority is limited to that which is necessary to guarantee the equal fundamental rights of all, and revolt against it is justified if it fails in that basic purpose. Locke's political philosophy directly influenced the American Declaration of Independence.

⁷ Locke, J. (1988) *Two Treatise of Government*, Peter Laslett ed. Cambridge University Press: Cambridge.

However, this natural right doctrine suffered a number of set-backs and criticisms. Jeremy Bentham, a notorious critic of the doctrine, commenting on the *French Declaration of the Rights of Man and of Citizen* (1789), argued that 'natural rights is simple nonsense [...] natural and imprescriptible [inalienable] rights is [...] nonsense on stilts'. His argument was that 'rights are the child of law' and so a natural right- a right *a priori* to the law- was a nonsensical idea, strictly speaking, self-contradictory'. Bentham's foundational basis of human rights to say the least is worrying as its ghost surfaces on the moral foundations of human rights and the framework for interpretation, where there is consensus on the existence of a human right⁸.

A different line of criticism to rights-based arguments are also traceable to Hegel, Marx and communitarians and feminist human right praxis⁹. Marx was of the view that society (including culture and law) is 'merely 'superstructural' elements- reflecting the economic base of society, the class struggle within that society, and the interests of the ruling or dominant class¹⁰. A more common criticism is that human rights are an extension of values appropriate to some cultures of the world but not all. In particular, it is sometimes said that the doctrine of human rights is a western notion and there is something suspect or imperialistic, in attempting to apply it to the entire world as a whole¹¹.

Communitarians, led by Sandel¹² are of the view that liberal views of justice and rights treat people as essentially *atomistic* bearers of rights and argue that such a view of rights does not reflect real life at any level. To him, we come to the world as part of a family,¹³ community, ethnic or religious group, which is an essential part of our identity. In this context, Justice, rights and ethics should centre on or take account of our connections and responsibilities as members of our communities and citizens of a country. Another communitarian, Walzer, is of the view that notions of justice and rights arise *within* a community, a tradition, and particular set of circumstances. He disagrees with the general notion of justice, rights and morality seen as universally right for all

⁸ See Jacques Maritain (1951), *Man and the State*, Chicago: University of Chicago Press

⁹ See Karl Marx (1975) "On the Jewish Question", 1843, in *Karl Marx Early Writings*, Hammersworth: Penguin.

¹⁰ See Pashukanis, E. B. (1978) *The General Theory of Law and Marxism*, (3rd edn.) Transaction Publishers: London.

¹¹ See American Anthropological Association (1947), "The Executive Statement on Human Rights", in *American Anthropologist*, 49. Also see Sen, A. (...) *Asian Values and Human Rights*

¹² Sandel, M.J. (1984) 'Morality and the Liberal Ideal', in *The New Republic*. Cambridge University Press: Cambridge.

¹³ The importance of family as the basic unit of society that ought to be protected by law has been acknowledged by the African Charter on Human Rights that is addressed in a subsequent section of this paper.

people and for all times. For him critical debate about justice occurs within *thicker* culturally based moralities.¹⁴

The above arguments, though having some philosophical grounding, are sometimes uncomfortable as they gnaw away the foundations of human rights, the arguments for believing in them, our common humanity and dignity, and indeed on our basic needs.

Conceptual challenges

The discourse on the right to health as is the case of other economic, social and cultural rights, require an exercise in cautious idealism. The claim of a right to health raises a host of further questions. Is there really a 'right to health'? What does it actually mean? What does it call for in practice? Even if we have the right answers to these conceptual questions one is still daunted with a number of practical issues such as: providing essential medical care, keeping people free diseases, providing nutrition, clean water, sanitation, and descent working and housing conditions; when we begin to think of the cost and who is going to pay it.

There is also an underlying assumption that the right to health is not a right to be 'healthy', as no one can have that right. Contingencies of biological make-up and the reality of life make us all vulnerable to illness. Also, the right to health is not merely a right to 'medical care', as it is one of many determinants of health. The right seems to stand in-between the 'right to medical care' and the right to be 'healthy'. The Philosopher Henry Shue clarifies the idea of a human right as giving protection against a series of what he terms 'standard threats'. The human right to health therefore, gives individuals protection against 'standard threats to health'¹⁵. These 'standard threats' have been captured in *General Comment 14*, as the threats against which everyone should be guaranteed protection. The document outlines a series of obligations on governments as 'interrelated and essential elements', which include: availability, accessibility, acceptability, and quality.

In the particular context of the right to health, a new danger is lurking in the background, with the proliferation of human rights advocacy groups such as Amnesty International, Human Rights Watch and many others, which has introduced a 'political sociology' of human rights and in particular rights of 'advocacy and empowerment'. Though important in defending human rights, nevertheless, have the effect of disempowering disadvantaged groups. Some human rights activists tend to be privileged people from

¹⁴ See Walzer, M. (1994), *Thick and Thin: Moral Argument Home and Abroad*, University of Notre Dame Press: Notre Dame. 2–11.

¹⁵ Shue, H. (1996) *Basic Rights*, 2nd edn. Princeton: Princeton University Press, p. 131.

the developed world acting on behalf of others, who are passive beneficiaries of their energies. A recent, and important argument by William Easterly is that the practice of advocacy for the human right to health has done more harm than good. And that pressing for the right to health leads to distorted health priority-setting, diverting resources, effectively to those who shout loudest, to the detriment of general health promotion¹⁶.

It has also been argued that socioeconomic rights, including the right to health, are positive rights that require substantial resources to ensure their implementation. According to Fuller, the adjudication of socioeconomic rights is likely to raise 'polycentric problems'. He describes polycentric problems as "situation[is] of interacting points of influence 'which, when possibly relevant to adjudication, normally, although not invariably', involve many affected parties and a somewhat fluid state of affairs."¹⁷

In addition, it has been argued that courts are not competent to adjudicate on socioeconomic rights since these rights often give rise to raising and spending of resources, a duty belonging to the legislature. In other words, adjudicating on socioeconomic rights will undermine the doctrine of separation of powers- the political question doctrine. A contrary view is that the implementation of *civil* and *political* rights is not less expensive than socio-economic rights. For instance, the right to a fair hearing requires equipping the police system, building courts and recruiting competent judicial officers to dispense justice. All of this requires a substantial amount of resources. It is also the case that in implementing the right to vote, a large electoral machinery is often put in place with a huge human resource and financial outlay.

According to Wolff, our problem is not that there are no foundations for human rights, but that there are too many of them. The challenge is, which of them is the 'correct' account of the foundations? We are unlikely to find a conclusive universally convincing single argument or account¹⁸. However, and for what is true, there is much greater agreement on the broad list of human rights than there is on their conceptual foundations, since the UDHRs in 1948. There is also a remarkable convergence of human rights doctrines- term it human rights jurisprudence. This provides a basis for us to 'do human rights' and continue to debate its foundations.

¹⁶ William Easterly (2006) *The White Man's Burden*, Oxford: Oxford University Press,

¹⁷ Fuller L. (1978) 'The Forms and Limits of Adjudication', 92 *Harvard Law Review* 353-409.

¹⁸ Wolff, J. (2012), *supra*.

Convergence of the Essential Features of the Right to Health

The right to health is an 'inclusive right; and frequently associated with access to health care and the building of health infrastructure. This might be true, but the right to health extends further. It includes a wide range of factors that can help us lead a healthy life. The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the extent of realization of the International Covenant on Economic, Social and Cultural Rights,¹⁹ calls these the "underlying determinants of health". They include:

- Safe drinking water and adequate sanitation;
- Safe food;
- Adequate nutrition and housing;
- Healthy working and environmental conditions;
- Health-related education and information;
- Gender equality.

There is also broad consensus that the right to health contains *freedoms*, which include the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilization²⁰, and to be free from torture and other cruel, inhuman or degrading treatment or punishment.

It is also a shared view, even if that view is contested in terms of its content, that the right to health contains *entitlements* which include:

- The right to a system of health protection, which provides equality of opportunity for everyone to enjoy the highest attainable level of health;
- The right to prevention, treatment and control of diseases;
- Access to essential medicines;
- Maternal, child and reproductive health;
- Equal and timely access to basic health services;
- The provision of health-related education and information;
- Participation of the population in all health-related decision-making;

Following from Shue's schema, functioning public health and health-care facilities, goods and services must be:

- *available* in sufficient quantity within a State.

¹⁹ The Covenant was adopted by the United Nations General Assembly in its resolution 2200A (XXI) of 16 December 1966. It entered into force in 1976 and by 1 December 2007 had been ratified by 157 States.

²⁰ Most of these freedoms on the right to health are contained in 'Patient's Charters' of WHO Member States.

- *accessible* physically (in safe reach for all sections of the population, including children, adolescents, older persons, persons with disabilities and other vulnerable groups) as well as financially and on the basis of non-discrimination. *Accessibility* also implies the right to seek, receive and impart health-related information in an accessible format (for all, including persons with disabilities), but does not impair the right to have personal health data treated confidentially. The facilities, goods and services should also respect medical ethics, and be gender-sensitive and culturally appropriate. In other words, they should be medically and culturally *acceptable*.
- Finally, they must be scientifically and medically appropriate and of *good quality*. This requires, in particular, trained health professionals, scientifically approved and unexpired drugs and hospital equipment, adequate sanitation and safe drinking water²¹.

Divergence Views about the Right to Health

There is a common misconception of the right to health, that the State has to guarantee the good health of the citizen. However, good health is influenced by several factors that are outside the direct control of States, such as an individual's biological make-up and socio-economic conditions. Rather, the right to health refers to the right to the enjoyment of a variety of goods, facilities, services and conditions necessary for its realization. This is why it is more accurate to describe it as the right to the *highest attainable standard* of physical and mental health, rather than an unconditional right to be healthy.

The right to health is not also only a *programmatic goal* to be attained in the long term. The fact that the right to health is considered a tangible programmatic goal does not mean that no immediate obligations on States arise from it. In fact, States must make every possible effort, within available resources, to realize the right to health and to take steps in that direction without delay. Notwithstanding resource constraints, some obligations have an immediate effect, such as:

- the undertaking to guarantee the right to health in a non-discriminatory manner,
- to develop specific legislation and plans of action, or other similar steps towards the full realization of this right, as is the case with any other human right.

²¹ Shue, H. (1996), *supra*.

- States also have to ensure a minimum level of access to the essential material components of the right to health, such as the provision of essential drugs and maternal and child health services²².

In addition, a country's difficult financial situation does not absolve it from having to take action to realize the right to health. It is often argued that States that cannot afford it are not obliged to take steps to realize this right or may delay their obligations indefinitely. When considering the level of implementation of this right in a particular State, the availability of resources at that time and the development context are taken into account. Nonetheless, no State can justify a failure to respect its obligations because of a lack of resources. States must guarantee the right to health to the maximum of their available resources, even if these are tight. While steps may depend on the specific context, all States must move towards meeting their obligations to respect, protect and fulfil²³.

The right to health and other human rights

Human rights are said to be *interdependent, indivisible and interrelated*.²⁴ This means that violating the right to health may often impair the enjoyment of other human rights, such as the rights to education or work, and vice versa. The importance given to the "underlying determinants of health", that is, the factors and conditions which protect and promote the right to health beyond health services, goods and facilities, shows that the right to health is dependent on, and contributes to, the realization of many other human rights.

These other rights include the rights to food, to water, to an adequate standard of living, to adequate housing, to freedom from discrimination, to privacy, to access to information, to participation, and the right to benefit from scientific progress and its applications. It is also not difficult to see interdependence of rights in the context of poverty. For people living in poverty, their health may be the only asset on which they can draw for the exercise of other economic and social rights, such as the right to work or the right to education.

²² See UN, OHCHR, "The Right to Health: Fact Sheet No. 31, pp. 23-25. Office of the United Nations High Commissioner for Human Rights, at <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

²³ See Committee on Economic, Social and Cultural Rights, general comment N° 3 (1990) on the nature of States parties' obligations and general comment N° 14, paras. 38-42.

²⁴ See Vienna Declaration and Programme of Action (A/CONF.157/23), adopted by the World Conference on Human Rights, held in Vienna, 14-25 June 1993.

The Right to Health and International Human Rights Law

The right to the highest attainable standard of health is a human right recognized in international human rights law. The International Covenant on Economic, Social and Cultural Rights, considered as the central instrument of protection for the right to health, recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." It is important to note that the Covenant gives both mental health, which has often been neglected, and physical health equal consideration.

International Covenant on Economic, Social and Cultural Rights

This Covenant in article 12 provides that:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Subsequent international and regional human rights instruments address the right to health in various ways. Some of which are of general application while others address the human rights of specific groups, such as women or children, which Ghana has ratified. Examples include:

- The 1965 International Convention of All Forms of Racial Discrimination- article 5 (e) (iv)-and the Optional Protocol to the Convention- ratified in 2012.
- The 1966 International Covenant on Economic, Social and Cultural Rights- article 12- ratified in 2000, but not the Optional Protocol.
- The Convention on the Elimination of All Forms of Discrimination against Women- article 11 (1) (f), 12 and 14 (2) (b)- ratified in 1986 and Optional Protocol in 2011.
- The 1989 Convention on the Rights of the Child- article 24- ratified in 1990.

- The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families- article 28, 43 (e) and 45 (c)- ratified in 2000.
- The Convention on Rights of Persons with Disabilities- article 25- ratified in 2012 and Optional Protocol, also in 2012.

Ghana has also ratified the African (Banjul) Charter on Human and Peoples' Rights; the Protocol to the African Charter on Human and Peoples' Rights of Women in Africa in 2007, and the Children's Charter in 1989 among many others.

In addition, the treaty bodies that monitor the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child have adopted general comments or general recommendations on the right to health and health-related issues. These provide an authoritative and detailed interpretation of the provisions found in the treaties.²⁵

Numerous conferences and declarations, such as the International Conference on Primary Health Care (resulting in the Declaration of Alma-Ata²⁶), the United Nations Millennium Declaration and Millennium Development Goals, (now Sustainable Development Goals)²⁷ and the Declaration of Commitment on HIV/AIDS,²⁸ have also helped clarify various aspects of public health relevant to the right to health and have reaffirmed commitments to its realization. The Alma-Ata Declaration, for instance, affirms the crucial role of primary health care, which addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly. It stresses that access to primary health care is key to attaining a level of health that will permit all individuals to lead a socially and economically productive life, and to contribute to the realization of the highest attainable standard of health.

The right to health is also recognized in several regional instruments, such as the African Charter on Human and Peoples' Rights (1981), the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, known as the *Protocol of San Salvador* (1988), and the European Social Charter 1961, revised in 1996. The American Convention on Human Rights (1969) and the European

²⁵ For more details on these treaty bodies, see Fact Sheet N° 30.

²⁶ Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978.

²⁷ See <http://www.un.org/millenniumgoals/>.

²⁸ General Assembly resolution S-26/2 of 27 July 2001.

Convention for the Promotion of Human Rights and Fundamental Freedoms (1950) contain provisions related to health, such as the right to life, the prohibition on torture and other cruel, inhuman and degrading treatment, and the right to family and private life.

In addition, the right to health or the right to health care is recognized in at least 115 national constitutions. At least, some constitutions set out duties in relation to health, such as the duty on the State to develop health services or to allocate a specific budget to them. For example, the 1996 Constitution of South Africa provides for health care, food, water and social security in article 27 (1), which provides that:

- 27 (1) Everyone has the right to have access to
 - (a) health-care services, including reproductive health care;
 - (b) sufficient food and water; [...]
- (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
- (3) No one may be refused emergency medical treatment.

Obligations on States towards the Right to Health

States have the primary obligation to protect and promote human rights. Human rights obligations are defined and guaranteed by international customary law²⁹ and international human rights treaties, creating binding obligations on the States that have ratified them to give effect to these rights.

General obligations

The International Convention on Economic, Social and Cultural Rights in article 2 provides that:

- (1) Each State Party to the present Covenant undertakes to *take steps*, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving *progressively the full realization* of rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures (emphasis mine).

²⁹ International Customary law is evidence of a general practice of States accepted as law and followed out of a sense of legal obligation.

- (2) The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised *without discrimination* of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (emphasis mine).

Progressive realization

Through their ratification of human rights treaties, States parties are required to give effect to these rights within their jurisdictions. More specifically, article 2 (1) of the International Covenant on Economic, Social and Cultural Rights underlines that States have the obligation to *progressively* achieve the full realization of the rights under the Covenant. This is an implicit recognition that States have resource constraints and that it necessarily takes time to implement the treaty provisions. Consequently, some components of the rights protected under the Covenant, including the right to health, are deemed *subject to progressive realization*.

Not all aspects of the rights under the Covenant can or may be realized immediately, but at a minimum States must show that they are making every possible effort, within available resources, to better protect and promote all rights under the Covenant. Available resources refer to those existing within a State as well as those available from the international community through international cooperation and assistance, as outlined in article 2 (1) of the Covenant.

The role of international assistance and cooperation is reflected in other instruments as well, such as the Charter of the United Nations, the Universal Declaration of Human Rights and the Convention on the Rights of the Child.³⁰ It is not a substitute for domestic obligations, but it comes into play in particular if a State is unable to give effect to economic, social and cultural rights on its own, and requires assistance from other States to do so. International cooperation is particularly incumbent upon those States that are in a position to assist others in this regard. States should thus have an active programme of international assistance and cooperation and provide economic and technical assistance to enable other States to meet their obligations in relation to the right to health.³¹

³⁰ Charter of the United Nations, Arts. 1 (3), 55 and 56; Universal Declaration of Human Rights, arts. 22 and 28; and Convention on the Rights of the Child, arts. 4 and 24.

³¹ Committee on Economic, Social and Cultural Rights, general comment N° 3 (1990) on the nature of States parties' obligations and general comment N° 14, paras. 38–42.

While the concept of progressive realization applies to all rights under the Covenant, some obligations are *of immediate effect*, in particular, the undertaking to guarantee that all rights are exercised on the basis of *non-discrimination* and the obligation to *take steps* towards the realization of the rights, including the right to health, which should be concrete, deliberate and targeted. In this regard, retrogressive measures are not permissible, unless a State can demonstrate that it has made every effort to use all resources at its disposal to meet its obligations³².

Taking steps to realize the right to health

Taking steps to realize the right to health requires a variety of measures. As the most feasible measures to implement the right to health will vary from State to State, international treaties do not offer set prescriptions. The International Covenant on Economic, Social and Cultural Rights in article 2 (1) simply states that the full realization of the rights contained in the treaty must be achieved through "all appropriate means, including particularly the adoption of legislative measures"³³.

The Committee on Economic, Social and Cultural Rights has underlined that States should, at a minimum, adopt a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy. Setting indicators and benchmarks will be decisive in the formulation and implementation of such a strategy. Indeed, the right to health being subject to progressive realization, what is expected of a State will vary over time. Therefore, a State needs a device to monitor and measure these variable dimensions of the right to health. Indicators, especially when disaggregated, provide useful information on how the right to health is realized in a particular country. The Office of the High Commissioner for Human Rights (OHCHR) has been developing a conceptual and methodological framework for such indicators³⁴.

Core minimum obligation

The Committee on Economic, Social and Cultural Rights has also stressed that States have a *core minimum obligation* to ensure the satisfaction of minimum essential levels of each of the rights under the Covenant. While these essential levels are, to some extent, resource-dependent, they should be given priority by the State in its efforts to

³² Ibid.

³³ Ibid.

³⁴ See UN- OHCHR, <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>, supra.

realize the rights under the Covenant. With respect to the right to health, the Committee has underlined that States must ensure:

- The right of access to health facilities, goods and services *on a non-discriminatory basis*, especially for vulnerable or marginalized groups;
- Access to the *minimum essential food* which is nutritionally adequate and safe;
- Access to shelter, housing and sanitation and adequate supply of safe drinking water;
- The provision of *essential drugs*;
- *Equitable distribution* of all health facilities, goods and services³⁵.

State obligations fall into three categories, namely the obligations to *respect, protect* and *fulfil*.

The obligation to respect

The obligation to respect requires States to refrain from interfering directly or indirectly with the right to health. For example, States should refrain from denying or limiting access to health-care services; from marketing unsafe drugs; from imposing discriminatory practices relating to women's health status and needs; from limiting access to contraceptives and other means of maintaining sexual and reproductive health; from withholding, censoring or misrepresenting health information; and from infringing on the right to privacy (such as of persons living with HIV/AIDS). In addition, the Committee on Economic, Social and Cultural Rights underlined in its general comment No. 14 that States parties have to respect the enjoyment of the right to health in other countries³⁶.

The obligation to protect

The obligation to protect requires States to prevent third parties from interfering with the right to health. States should adopt legislation or other measures to ensure that private actors conform with human rights standards when providing health care or other services (such as regulating the composition of food products); control the marketing of medical equipment and medicines by private actors; ensure that privatization does not constitute a threat to the availability, accessibility, acceptability and quality of

³⁵ Ibid.

³⁶ Ibid.

health-care facilities, goods and services; protect individuals from acts by third parties that may be harmful to their right to health. For instance, prevent women from undergoing harmful traditional practices or third parties from coercing them to do so by, enacting laws that specifically prohibit female genital mutilation; ensure that third parties do not limit people's access to health-related information and services, including environmental health; and ensure that health professionals provide care to persons with disabilities with their free and informed consent³⁷.

In its general comment No. 14, the Committee on Economic, Social and Cultural Rights also stressed that States parties should prevent third parties from violating the right to health in other countries. It further noted that, when negotiating international or multilateral agreements, States parties should take steps to ensure that these instruments do not have an adverse impact on the right to health.

The obligation to fulfil

The obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health. States must, for instance, adopt a national health policy or a national health plan covering the public and private sectors; ensure the provision of health care, including immunization programmes against infectious diseases and services designed to minimize and prevent further disabilities; ensure equal access for all to the underlying determinants of health, such as safe and nutritious food, sanitation and clean water; ensure that public health infrastructures provide for sexual and reproductive services and that doctors and other medical staff are sufficient and properly trained; and provide information and counselling on health-related issues, such as HIV/AIDS, domestic violence or the abuse of alcohol, drugs and other harmful substances. Effective and integrated health systems, encompassing health care and the underlying determinants of health, are also key to ensuring the right to the highest attainable standard of health³⁸.

Perspectives of the African Charter on the Right to Health

The African Commission on Human and Peoples' Rights has handed down a number of important and landmark decisions relating to the socio-economic rights guaranteed in the Charter. The African Charter remains one of the few regional human rights instruments that guarantee both civil and political rights and socio-economic rights as enforceable rights. In addition, the African Charter remarkably contains provisions

³⁷ Ibid.

³⁸ Ibid.

safeguarding people's rights, which is a rare feat when compared with other regional human rights instruments.³⁹

Under the African human rights system, the first attempt to guarantee the right to health is found in Article 16 of the African Charter. Article 16 of the Charter provides as follows:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

From this provision it is clear that slight differences exist in the language used when compared with that of Article 12 of the ICESCR. First, while the provision of the ICESCR is addressed to states (duty-bearers), the first part of Article 16 of the African Charter focuses on 'every individual' (right-holders). In essence, while it would seem that the ICESCR is more concerned with holding states parties to the treaty accountable, Article 16 of the Charter would seem to lay emphasis on the real enjoyment of rights by individuals. For the purposes of monitoring human rights, these two approaches are relevant. However, since states are the subject of international law, it is assumed that the focus on individuals does not in any way diminish the obligations imposed on states parties to the African Charter. Indeed, the language of the second part of Article 16 supports this submission. As would be discussed later, the approach of the Commission has been to hold states rather than individuals responsible for human rights violations arising from Article 16.

Secondly, the specific reference to medical attention for those who are sick would seem to suggest more attention to clinical rather than preventive medical services. This provision is not as detailed as Article 12 (2) of the ICESCR and makes no reference to underlying determinants of health, such as, healthy environment, water and sanitation and prevention, treatment and control of epidemic. More importantly, Article 16 of the African Charter fails to address issues, such as, maternal and infant mortality, access to contraception and HIV/AIDS.

³⁹ For a detailed discussion about the African Commission and the African human rights system see Viljoen, F. (2012) *International Human Rights Law, Africa* Oxford: Oxford University Press.

It should be noted that Article 14 of the African Women's Protocol contains one of the most comprehensive provisions on the right to health and sexual and reproductive health under international human rights law. Article 14 provides as follows:

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:
 - (a) the right to control their fertility;
 - (b) the right to decide whether to have children, the number of children and the spacing of children;
 - (c) the right to choose any method of contraception;
 - (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
 - (e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices; f) the right to have family planning education.

Also, Article 14 for the first time explicitly guarantees a woman's right to sexual and reproductive health, including the right to decide about her fertility, access to contraception services and the right to abortion on certain grounds. Unsafe abortion remains a great threat to the lives of many women in Africa. It is estimated that unsafe abortions constitute 13% of all maternal deaths.⁴⁰ Discussions on abortion at international, regional and national levels have always generated controversies. Even during the Beijing Platform of Action an attempt to recognise abortion as a human rights issue for women failed due to strong opposition by religious "fundamentalists".⁴¹

Challenges to the Realization of the Right to health in Africa

Africa is faced with different health challenges ranging from the devastating effects of the HIV/AIDS pandemic (and now the COVID-19 pandemic⁴²), high maternal mortality, and deaths resulting from tuberculosis, to repeated cases of malaria. In present times, Africans remain the greatest burden-bearer of sexual and reproductive ill health. While

⁴⁰ WHO, *The World Health Report 2005 – Make Every Mother and Child Count* (2005).

⁴¹ See Grossman, A. *et al* (2005) *Beijing Betrayed*, New York: Women's Environment and Development Organization.

⁴² The COVID-19 Pandemic is still ravaging African Countries and its relative impact as against other regions will be premature to assess. However, the lack of appropriate health technology to address it in Africa, points to the fact that its effect will not be different from other global pandemics the region has experienced.

the region accounts for about 15% of the world's population, it is home to about 70% of the total number of people living with HIV worldwide. According to UNAIDS, about 23 million out of the 34 million people living with HIV worldwide are from Africa.⁴³

Moreover, the region accounted for about 70% (1.2 million) of the 1.7 million AIDS-related deaths in 2011. Worse still, a recent report by Save the Children indicates that ten of the worst places for a woman to give birth in the world are in Africa.⁴⁴ The maternal mortality rates in some countries, such as, Chad and Somalia, are about 1,000 deaths to 100,000 live births.⁴⁵ Indeed, the odds of a woman dying during pregnancy or childbirth in Africa are 1 in 39 compared to 1 in 3,600 in a country such as Malta. In recent times, maternal death in the region has been exacerbated by the prevalence of HIV/AIDS. The maternal mortality situation in the region is so appalling that many of the countries in the region did not meet the Millennium Development Goals 5 target of reducing maternal deaths from 1990 rates by 75% by 2015⁴⁶.

Furthermore, notwithstanding concerted efforts to address its menace, malaria remains a threat to lives in the region and deaths resulting from tuberculosis continue to increase by leaps and bounds.

Several factors militate against the realisation of the right to health in Africa. These include lack of political will, weak health care systems, non-justiciability of the right to health at the national level, corruption, and a dearth of health care personnel. This article will consider the challenges of non-justiciability of the right to health and discrimination in the provision of health services in Ghana's context. This does not in any way suggest that the other challenges are not important⁴⁷.

As indicated earlier, Ghana has ratified almost all the international instruments, which relate to the right to health, but to a lesser extent the Optional Protocols. However, it lacks behind in its reporting obligations; the last of some reports dating back to 2001. Be as it may, these international human rights instruments have become part of international customary law, which are part of the laws of Ghana. In *High Court (Commercial Division), Accra; Ex Parte Attorney-General (NML Capital Ltd & Republic of Argentina Interested Parties)*, Date-Bah (JSC, as he then was) of the Supreme Court held that, 'customary international law was part of the municipal law of Ghana

⁴³ UNAIDS (2012) *AIDS Epidemic Report* UNAIDS: Geneva.

⁴⁴ Save the Children (2012), *State of the World's Mothers Report*, Save the Children: London.

⁴⁵ WHO, UNICEF and UNFPA, (2010) *Trends in Maternal Mortality: 1990 to 2010*, at 14-32.

⁴⁶ Ibid.

⁴⁷ Ibid.

incorporated by the weight of common law case law'⁴⁸. The judgment goes further to say that:

[...] However, treaties, even when the particular treaty had been ratified by Parliament, will not alter municipal law until they were incorporated into Ghanaian law by appropriate legislation. That position of the law was usually referred to as reflecting the *dualism school of thought*, as distinct from the *monist* approach followed by other states (original emphasis).

The latter statement of the law may seem to suggest that the international treaties, which relate to the right to health ratified by Ghana, need to be incorporated by legislation before they are recognised as law in Ghana. However, the earlier statement of the law by Date-Bah and in the light of article 11 of the 1992 Constitution, in my view is the right legal position. Article 11 (2) provides:

[...]

(2) The *common law* of Ghana shall comprise the rules of law generally known as the *common law*, the rules generally known as the doctrines of equity and the rules of customary law including those determined by the Superior Court of Judicature (emphasis mine).

In addition, the combined effect of article 11 (4) and (5), make the common law part of 'existing law' (written or unwritten), which are part of the laws of Ghana and are not 'affected' by the coming into force of the Constitution.

Further, article 40 (c) of the Constitution provides that 'in its dealings with other nations, the Government shall promote respect for *international law, treaty obligations* and the settlement of international disputes by peaceful means' (emphasis mine).

In a subsequent section of this article, I would outline Ghana's domestic law regime on the right to health, aside customary international law. But before that, I will outline some salient features on the state of health in Ghana.

⁴⁸ [2013 – 2014] 2 SCGLR 990 at p.993, holding 1.

The General Context of Health in Ghana

A research report on 'The State of the Nation's Health' in 2018⁴⁹, conducted by the University of Ghana, School of Public health, gives one an idea of the state of health in Ghana and its underlying determinants in the following findings:

- There is no systematic programme in place to address the increasing burden of non-communicable diseases.
- The provision of emergency services (both clinical and public health emergencies) is inadequate and sub-standard. With increasing rate of Road Traffic Accidents (RTAs) and Non-communicable Diseases (NCDs), for clinical care and globalization with its associated exposure to diseases of pandemic potential, for public health. These areas have to be addressed as quickly as possible.
- Adolescent health and health for the elderly and other marginalized groups need focused attention.
- There is the need to establish systems for emergency clinical care and public health emergencies, including addressing inappropriate staff attitude, through preparedness and response to planning and execution of plans.
- Treat Non-communicable Diseases (NCD) as national emergency and addressed appropriately⁵⁰.

The report concludes that:

[...] life expectancy soars alongside increasing trends in GDP growth averaging 3.9% per annum over the last 15 years. In addition, a general increase in standard of living and alongside declining poverty trend (from 28.8 to 24.2) and malnutrition and other social and environmental health and development indicators were observed. [...] we established strong correlations between performance of health and development indicators over the study period. Correlation estimates show strong positive correlation between economic development (GDP and GDP per capita) and health indicators such as life expectancy, health expenditure, access to quality water, and good sanitation⁵¹.

Also, the revised Ghana's Health Policy Framework adopted in 2020⁵², observes that the health and well-being of the Ghanaian population has improved in the last three

⁴⁹ University of Ghana (2018) *State of the Nation's Health Report*, University of Ghana School of Public Health, Legon, Accra.

⁵⁰ Ibid, p. 143.

⁵¹ Ibid, p. 152.

⁵² Ministry of Health- Ghana (2020) *National Health Policy: Ensuring Healthy Lives for All*. Revised Edn. MOH: Accra.

decades. In 1990, Ghanaians on average, when born, lived up to 57 years (life expectancy), out of every 1,000 women who were delivered 6 died (maternal mortality), of all babies born 9% died before age 1 (infant mortality) and 12% died before age 5 (under 5 mortality). By 2017, Ghanaians on average, when born, lived up to 64 years (life expectancy), out of every 1,000 women who were delivered 3 died (maternal mortality), of all babies born 4% died before age 1 (infant mortality) and 5% died before age 5 (under 5 mortality), (GSS⁵³). As stated in the policy, this improvement has been slow and far from the desired Global targets. The changes, however as observed, represent an average improvement of 50% as against the desired improvement of 75% in the above indicators (MDG, 2015).

The policy notes further that, Ghana has not achieved the desired level of health because it has not adequately addressed, in a comprehensive manner, all the key determinants of health. Historically, the major health problems affecting Ghanaians have been primarily communicable, maternal, perinatal and nutritional diseases. Ghana is now acknowledged as having a more complex burden of diseases. This is evident across different age, gender, location, and socio-economic status groups in the country. For children, communicable diseases remain the major health conditions affecting them, with malaria prevailing. Maternal and neonatal health conditions remain a challenge, especially in rural areas and amongst poor women. NCDs such as hypertension, strokes, cancers, diabetes, eye disorders, oral health conditions; those of genetic origin such as sickle cell; injuries, substance/medicine abuse and related conditions are increasing in prevalence.

The guiding principles of the policy include the recognition that:

- Public policies and resulting actions of different sectors impact on health and population well-being. This policy shall ensure that all sector policies and actions support the achievement and maintenance of a healthy population.
- Partnerships with non-state actors (CSOs, industry, development partners, FBOs) in all its forms towards delivering appropriate health and wellness interventions for the population.
- Implementation of Government policies and intervention is at the local government level. To this end, the implementation of the National Health Policy will focus on improved collaboration with, and increased ownership and commitment of the local government sector and sub-structures to ensure no one is left behind in the attainment of good health.

⁵³ Ibid, pp. 14 and 15.

- The disease burden and its impact on segments of the population is influenced by the national demographics, geographical distribution and the socio-economic status of the population. Interventions and resources required to meet these needs of the population where they are will necessarily be different. These needs shall be addressed in an equitable and not an equal manner.
- The primary responsibility for the health of the population lies in the population itself. The policy shall empower the population to participate in the design, planning and the execution interventions that improve their health status and receive feedback from respective duty bearers for their actions⁵⁴.

This policy objectives include to:

- strengthen the healthcare delivery system to be resilient;
- encourage the adoption of healthy lifestyles;
- improve the physical environment;
- improve the socio-economic status of the population; and
- ensure sustainable financing for health.

These objectives are to collectively ensure that there will be improved alignment, complementarity and synergies within and across all public sector ministries as well as with other stakeholders, towards achieving the national health goal, of promoting, restoring and maintaining 'good health for all people living in Ghana'.

Ghana's health vision is to create a healthy population for development. This is supported by the sector mission of 'work towards the achievement of healthy lives for all people living in Ghana through an enabling policy framework that recognizes, empowers and brings together, in a coordinated manner, all stake-holders'. These vision and mission statements were carved with the aim of having a healthy and productive Ghanaian population to facilitate the achievement of the Millennium Development Goals (MDGs), now referred to as Sustainable Development Goals (SDGs) as well as human development and economic growth over the past 15 years.

The underlining mechanisms for achieving the MDGs (SDGs) in conjunction with the vision, mission and goals of the Ministry of Health in Ghana are:

- Delivery of health services;
- Policy formulation and policy implementation;
- Quality and regulatory services;
- Financing and infrastructure; and

⁵⁴ Ibid, p. 19.

- Research and training. Health is thus not only emphasized as central to development but also presents a unique set of opportunities for improving the health sector of Ghana.

Ghana's Human Rights Legal Architecture on the Right to Health

Studies on the right to health in Ghana are far between. Perhaps, the lack of legal scholarly interest in the right in Ghana is due to the fact that the right as provided in the 1992 Constitution is ambivalent. Therefore, the discourse on the right to health has not been well articulated in detail.

I was privileged to be part of a team, which worked on a 'Country Study of the Right to Development'; in which an entire chapter was devoted to the right to health⁵⁵. The study raised a number of challenges that the realization of the right to health often encounter. Of particular significance is the attitude of the Ghanaian courts of law. The report noted a 'trepidation of the courts to declare clear constitutional and statutory right to socio-economic rights for fear of stultifying themselves and/or overwhelming and displeasing the executive branch with legal obligations it cannot fulfill'⁵⁶.

On the right to health, the study noted that cases litigated and being litigated by the Legal Resource Centre (LRC):

[...] the attitude, disposition, mannerisms, facial expressions, cold handshakes and responses to the greetings of the LRC lawyers, and other ordinarily inconsequential things related to the judge who sat on the cases and the government lawyers that were the real and true, albeit unwritten, unproven, and quite improvable ruling of the case⁵⁷.

And Related to the above, the study also underscored the neglect of the courts to adopt innovative ways of expounding upon the jurisprudence of rights and entitlements in the face of resource constraints.

Atuguba has elsewhere taken up the issue of the right to health in Ghana in the context of general 'healthcare, human rights and politics'⁵⁸. The study concludes that in legal systems where social and economic rights are not well articulated, the right to health can be read through the civil and political right to life. It notes that in the African Charter on Human and People's Rights (1979), introduced by the formerly named Organization of African Unity (now the African Union), and other legal frameworks that articulate

⁵⁵ Ellen Bortei-Doku Aryeetey, et al (2004), *supra*, p. 110.

⁵⁶ *Ibid.*

⁵⁷ *Ibid.*

⁵⁸ Atuguba, R. A. (2013), *supra*,

social and economic rights, the challenge is how those rights should be defined and enforced in a way that requires States to have both the requisite rule of law framework necessary for transparent enforcement and also the programmatic development agenda that ensures the progressive realization of those rights. However, it is worth recognising that the African Human Rights Commission over the past few years have been addressing Atuguba's concern. In a number of landmark decisions, it is beginning to develop a progressive jurisprudence on economic, social and cultural rights generally, and the right to health in particular in the African Charter on Human and Peoples' Rights. I will refer to some of them shortly.

Atuguba's study rightly concludes further that, the right to health is clearly interrelated with other rights: poor social conditions, such as poverty; inadequate housing and nutrition; and lack of education as significant obstacles to the realization of the right to health and the right to life. He recommends that the realization of the rights to life, to physical integrity, and to privacy is also important for the maintenance of people's health and for the realization of the right to health. The interdependence and indivisibility of economic, social, and cultural rights and civil and political rights becomes visible in this regard and constitutes additional fodder for the struggle for economic and social rights, such as the right to health⁵⁹.

In the context of Ghana, this study is of the view that the Ghanaian Constitution can be interpreted to enforce a right to health, though it is not expressly included. At the very least, the Constitution imposes a duty on the government to take and report on steps for the realization of the right to health of Ghanaians⁶⁰.

The closest one gets to provisions that relate to the right to health in Ghana's legal architecture, as indicated earlier, are a cluster of human rights and human rights related provisions in its 1992 Constitution and the Sixth Schedule to the Public Health Act, 2012 (Act 851). I will next outline them briefly and thematically.

The Principle of Non-discrimination and the Right to Health

Article 17, provides:

- (1) All persons shall be equal before the law.
- (2) A person shall *not be discriminated against* on grounds of *gender*, race, colour, ethnic origin, religion, creed or social or economic status.

⁵⁹ Ibid.

⁶⁰ Ibid, p. 110.

- (3) For the purposes of this article, "discriminate" means to give different treatment to different persons attributable only or mainly to their respective descriptions by race, place of origin, political opinions, colour, *gender*, occupation, religion or creed, whereby persons of one description are subjected to disabilities or restrictions to which persons of another description are not made subject or are granted privileges or advantages which are not granted to persons of another description (emphasis mine).

The provision on non-discrimination is based on a number of descriptions such as: race, place of origin, political opinions, colour, gender, occupation, religion or creed. These descriptions relate to disabilities or restrictions and privileges and advantages, which persons of one description are subjected to or granted and persons of another description are not subject to or granted. However, article 17 (4) provides for a number of exceptions under which Parliament should not be prevented from passing laws that are reasonably necessary to provide for:

- implementing policies and programmes aimed at redressing social, economic and educational imbalance in society;
- matters relating to adoption, marriage divorce, burial, devolution of property on death or other matters of personal law;
- imposition of restrictions on acquisition of land by non-citizens or on political and economic activities of such a person and for other matters related to such a person; or
- making different provision for different communities having regard to their special circumstances if it is not inconsistent with the spirit of the Constitution.

In *Ghana Commercial Bank v Commission for Human Rights and Administrative Justice*,⁶¹ it was held that different treatment given to the complainant for a lesser breach of the appellant's rules constituted the essence of discrimination in article 17 of the 1992 Constitution and that the action of the appellants in termination of the complainant's appointment was in contravention of the said article 17. The brief facts of this case are that the respondent, who was a staff of the appellant bank, was dismissed by the bank for granting a loan without approval. He petitioned Commission on Human Rights and Administrative Justice Commission on Human Rights and Administrative Justice (CHRAJ) established under the 1992 Constitution. In the petition the petitioner raised

⁶¹ [2003–2004] SCGLR 91.

the issue that his right under article 17 of the Constitution was violated because other staff who granted higher loans without approval were not punished.

However, in clarifying the ambit of the right, the Supreme Court of Ghana, in *Nartey v Gat*⁶² held that the fact that article 17(1) provides for equality before the law should not be read in isolation. And that the provision meant freedom from 'unlawful discrimination' and that not all discrimination was 'unlawful'. Date-Bah JSC (as he then was) observed that 'equals must be treated equally, while treatment of persons not equal must be different [. . .] the law must operate equally on all persons similarly situated'.⁶³ This was a case in which the plaintiff, a lawyer by profession sued to recover his legal fees. On appeal the issue was raised that under section 30(1) of the Legal Profession Act,⁶⁴ a lawyer cannot sue to recover fees unless a written demand for same was made and one month has elapsed, which the plaintiff failed to do. The plaintiff contended that the Act was discriminatory under article 17 of the Constitution.

In the context of the right to health, Date-Bah's view needs to be put in its proper context, since the Ghanaian society is highly 'differentiated and stratified'. Therefore, the determination as to when people are 'similarly or unsimilarly situated' can be problematic and needs to be determined on a case by case basis. It is also the same in determining the criteria to use in characterising people as 'equal or not equal'. However, his use of the distinction 'lawful and unlawful' discrimination provides the context, which is consistent with article 17 (4). That is to say, the basis for 'discrimination' should be based on law; just as the exceptions in the article indicate the circumstances for such discrimination a legislation may provide for. Date-Bah's view should not be taken to mean a 'blank sheet' on which discrimination can be scripted outside the law.

In the context of the right to health, the exceptions in article 17 (4), read together with other relevant provisions of the Constitution, register the 'underlying determinants of health'; which can be realised by an 'affirmative action' legislation that are lawfully discriminatory. For instance, discrimination, is often linked to the marginalization of specific population groups and is generally at the root of fundamental structural inequalities in society. This, in turn, may make these groups more vulnerable to poverty and ill health. Not surprising, traditionally discriminated and marginalized groups often bear a disproportionate share of health problems. Studies have shown that, in some societies, ethnic minority groups and indigenous peoples enjoy fewer health services, receive less health information and are less likely to have adequate housing and safe

⁶² [2010] SCGLR 745.

⁶³ Ibid. 749.

⁶⁴ Act 32 of 1960 (Act 32).

drinking water, and their children have a higher mortality rate and suffer more severe malnutrition than the general population⁶⁵.

Also, the impact of discrimination is compounded when an individual suffers double or multiple discrimination, such as discrimination based on sex and race or national origin or age. For example, in many rural and deprived communities in Ghana, in traditional settings, women receive fewer health and reproductive services and information, and are more vulnerable to physical and sexual violence than the general population⁶⁶.

Disparities in development in Ghana are historical and at a number of levels. There is a disparity in development between the North and South of Ghana, urban and rural, and across gender relations. These disparities have effects on the 'underlying determinants of health' and for that matter the right to health.

The UNDP Ghana's Human Development Report (2007), highlighted spatial patterns of inequality and the potentially mutually reinforcing nature of social, economic and environmental factors as underpinning social exclusion in Ghana:

From the point of view of interregional differences and the intra-regional disparities, spatial differences are important drivers of social exclusion in Ghana. Indeed, the importance of geographical disparities in understanding social exclusion is partly captured in what are described as *spatial poverty traps focusing on physical remoteness and isolation* [...] Historically the *North/South divide* in the supply of goods and services coupled with a harsh economic environment has positioned Northern Ghana to be more prone to experiences of exclusion. Uneven *distribution of basic infrastructure* as well as remoteness from centres of trade work together to isolate some parts of the country [...] The bulk of investment in industry and manufacturing in Ghana continues to be

⁶⁵ See UNDP, (2007) *Human Development Report, 2007: Towards A More Inclusive Society*, UNDP Ghana, Combent Impressions: Accra, p. 4; Ghana Statistical Service (2013), "2010 Population & Housing Census: National Analytical Report", Ghana Statistical Service: Accra; UNDP, (2018) *Northern Ghana Human Development Report 2018: Bridging the Poverty Gap and Fostering Socio-economic Transformation and Empowerment to Contribute to Human Development for All*, Yamens Press Ltd: Accra, chapter 1; Konadu-Agyemang, K. (2000): "The Best of Times and the Worst of Times: Structural Adjustment Programs and Uneven Development in Africa: The case of Ghana", in *Professional Geographer*, 52(3), 469-483; Phebih-Agyekum, C.K. (2006), "Ghana's Gaping Gorge: The North/South Divide", at <http://www.ghanaweb.com/GhanaHomePage/features/artikel.php?ID=112310>; and Akologo, S.Z. & van Klinken, R. (2008), "Ghana: Why the North Matters", Pambazuka News 2008-06-17, Issue 381. <http://pambazuka.org/en/category/comment/48821>

⁶⁶ Ibid.

directed at the 3 major Southern cities of Accra-Tema Metropolis, Kumasi and Takoradi⁶⁷.

Statistical evidence suggests that the proportion of the population below the national poverty line in 2006 was 12% in the Greater Accra Region (in Southern Ghana); while the corresponding proportion in Upper West Region (in Northern Ghana) was as high as 88%. In 2010, the Upper East Region recorded the highest maternal mortality ratio of 802 per 100,000 live births, compared to 355 per 100,000 live births recorded by Greater Accra region. In the same year, all the three regions in Northern Ghana recorded a literacy rate of less than 50% while the Greater Accra, Ashanti and Eastern Regions recorded literacy rates of 81-89% (GSS 2013)⁶⁸.

At the level of gender disparity, Ghana's health sector gender policy acknowledges that:

Women's higher levels of poverty, lower literacy levels and ignorance as compared to men affect them adversely. In addition, negative sociocultural practices such as food taboos, non-involvement in decision-making regarding their health and that of their families also tends to compound this situation. The above factors cause women to delay in seeking health care and in turn results in high maternal mortality⁶⁹.

Legislation based on article 17 (4) can be used to address the above social disparities and that is the context into which Date-Bah's principle in the *Nartey Case* should be posited.

In addition:

- In most Ghanaian cultures, decisions on where and when to seek health care is primarily the preserve of men. This notwithstanding clients, (in particular women) often do not have enough information to empower them decide on treatment options.
- Biological differences and the socio-cultural environment of men and women have bearing on their presentation and the expression of diseases. Malaria, Tuberculosis (TB) and HIV/AIDS and all other communicable diseases are critical diseases, which have exemplary gender dimensions. Therefore, in coming out with disease control interventions, the socio-cultural conditions, roles and relationships between men and women should be analyzed.

⁶⁷ Ibid, p. 4.

⁶⁸ Ibid.

⁶⁹ Ministry of Health- Ghana (2009) *Health Sector Gender Policy*, MOH: Accra, p. 11.

- HIV/AIDS is one of the serious public health challenges in Ghana today with huge gender implications. The current national prevalence rate is estimated to be 2.7%) as compared to 3.1% in 2003. The pandemic is taking its toll more on women than men with serious gender dimensions to the disease as a result of women's anatomical, socio-cultural and economic vulnerability to the disease⁷⁰.

Non-discrimination and equality are fundamental human rights principles and critical components of the right to health. The International Covenant on Economic, Social and Cultural Rights in article 2 (2) and the Convention on the Rights of the Child in article 2 (1)), identify the following non-exhaustive grounds of discrimination: *race, colour, sex, language, religion, political or other opinion, national or social origin, property, disability, birth or other status*. According to the Committee on Economic, Social and Cultural Rights, "other status" may include health status such as HIV/AIDS or sexual orientation.

States have an obligation to prohibit and eliminate discrimination on all grounds and ensure equality to all in relation to access to health care and the underlying determinants of health. The International Convention on the Elimination of All Forms of Racial Discrimination in article 5 also stresses that States must prohibit and eliminate racial discrimination and guarantee the right of everyone to public health and medical care.

Non-discrimination and equality further imply that States must recognize and provide for the differences and specific needs of groups that generally face particular health challenges, such as higher mortality rates or vulnerability to specific diseases. The obligation to ensure non-discrimination requires specific health standards to be applied to particular population groups, such as women, children or persons with disabilities. Positive measures of protection are particularly necessary when certain groups of persons have continuously been discriminated against in the practice of States parties or by private actors.

Along the same lines, the Committee on Economic, Social and Cultural Rights has made it clear that there is no justification for the lack of protection of vulnerable members of society from health-related discrimination, be it in law or in fact. So even if times are hard, vulnerable members of society must be protected, for instance through the adoption of relatively low-cost targeted programmes.⁷¹

The Right to Work under Safe and Healthy Conditions

⁷⁰ Ibid, pp. 10-12.

⁷¹ General comment N° 14, para. 18.

Article 24 (1) provides:

- (1) Every person has the right to work under satisfactory, *safe and healthy conditions*, and shall receive equal pay for equal work without distinction of any kind (emphasis mine). [...]

The rendition of this right begs the question. One must first have a right to work before the consideration of the conditions under which a 'right bearer' works. In Ghana's context, with a high level of unemployment, might it not be the case that a person is left with no choice than to work under unsafe and unhealthy conditions? According to Plecher, in 2019, the unemployment rate in Ghana was at approximately 4.33 percent of the total labour force⁷². Ghana's unemployment rate is above the worldwide unemployment rate, and compared to other Sub-Saharan African countries and other regions, Ghana has a relatively average rate of unemployment⁷³. Though this statistic seems low, in real social terms, it means millions of people are out there without a livelihood and would 'agree' to work in unsafe and unhealthy conditions.

As indicated earlier, the right to health involves 'entitlements' such as health protection, prevention, treatment, medication, access to health facilities and participation in decision-making in health-related decisions. The global template on the right to health recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." And the African regional template on the right is that:

[...]

3. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
4. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. [...]

Given that the right to health is not explicit in Ghana's Constitution, it is important to explore the jurisprudence of international and regional human rights bodies (particularly the African Human Rights Commission) and other jurisdictions, which have interpreted

⁷² The unemployment rate is the percentage of a country's labour force that are without jobs but are available to work and actively seeking employment.

⁷³Plecher, H. (2020) "Ghana: Unemployment rate from 1999 to 2019", in *Statista*, at <https://www.statista.com/statistics/808481/unemployment/rate>

human rights provisions creatively to uphold the interdependence, indivisibility and inseparability of human rights norms to uphold the right to health.

For instance, the Committee on ESCR in General Comment 14 has noted that the enjoyment of the right to health is dependent on other rights, such as, the rights to life, privacy, dignity, and nondiscrimination.⁷⁴ Similarly, the Human Rights Committee in its General Comment 6 has observed that the right to life guaranteed in Article 6 of the ICCPR should not be construed narrowly but should be given a broad interpretation to include medical services and maternal health.⁷⁵ Leary, has noted that any discussion in relation to the right to health must take into account the fundamental principles of human rights, such as dignity, non-discrimination, participation and justice, since they are relevant to issues of health care and health status.⁷⁶

The first case the African Commission dealt with relating to the right to health is the celebrated case of *Social Economic Rights Action Centre and another v Nigeria*⁷⁷. The Commission held that the right to enjoy the best attainable state of physical and mental health enunciated in Article 16 (1) of the African Charter and the right to a general satisfactory environment favourable to development obligate governments to desist from directly threatening the health and environment of their citizens.

Affirming the indivisibility approach, the Commission observes that:

Internationally accepted ideas of the various obligations engendered by human rights indicate that all rights-both civil and political rights and social and economic-generate at least four levels of duties for a State that undertakes to adhere to a rights regime, namely the duty to respect, protect, promote, and fulfil these rights. These obligations universally apply to all rights and entail a combination of negative and positive duties. As a human rights instrument, the African Charter is not alien to these concepts and the order in which they are dealt with here is chosen as a matter of convenience and in no way should it imply the priority accorded to them.⁷⁸

In another case involving Nigeria, the Commission has held that failure of the Nigerian government to provide medical attention for a prisoner in its custody constitutes a

⁷⁴ The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment 14 para 12.

⁷⁵ The Right to Life UN GAOR Human Rights Committee 37th session Supp No 40.

⁷⁶ Leary V "The right to health in international human rights law" (1994)1(1) *Health and Human Rights* 27

⁷⁷ (2001) AHRLR 60 (ACHPR 2001).

⁷⁸ *Ibid*, para. 44.

violation of the rights to health and life guaranteed under the Charter.⁷⁹ The Commission explains further as follows:

The responsibility of the government is heightened in cases where an individual is in its custody and therefore someone whose integrity and well-being is completely dependent on the actions of the authorities. The state has a direct responsibility in this case. Despite requests for hospital treatment made by a qualified prison doctor, these were denied to Ken Saro Wiwa, causing his health to suffer to the point his life was endangered ... This is a violation of article 16.⁸⁰

Also, in *Purohit and others v The Gambia*, the Commission has explained that the right to health includes access to health facilities, goods and services on a non-discriminatory basis and that denial of medical attention to people suffering from mental disability will violate the non-discrimination provision of the African Charter.⁸¹ It further reasoned that the right to health includes “the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind”.⁸² According to Ebenezer Durojaye, this is no doubt a purposive interpretation of the right to health, which coincides with recent developments in international human rights law⁸³.

Some decisions of the European Court of Human Rights have tended to support this position. For instance, in *Tavares v France*,⁸⁴ the European Commission was asked to consider whether pregnancy related death would amount to a violation of the right to life guaranteed under the European Convention of Human Rights. The Commission noted that the right to life does not only impose a negative obligation on states but also a positive obligation to prevent the loss of lives. It further explained that no evidence of negligence was found and that France could have been liable for the loss of pregnancy if negligence had been established.

Also, in *D v United Kingdom*⁸⁵ the European Court of Human Rights held that a forcible deportation of a person living with HIV to another country where access to health care services could not be guaranteed amounted to inhuman, degrading treatment and a

⁷⁹ *International Pen and Others (On behalf of Ken Saro Wiwa) v Nigeria* (2000) AHLR 212 (ACHPR 1998).

⁸⁰ *Ibid*, para 5.

⁸¹ (2003) AHRLR 96 (ACHPR 2003).

⁸² *Purohit and others v The Gambia* para 80

⁸³ Durojaye, E. (2013) The Approaches of the African Commission to the Right to Health under the African Charter, in *Law, Democracy and Development*, Vol. 17, pp. 393-418.

⁸⁴ *Tavares v France* App. No. 16593/90 Euro. Comm. HR.

⁸⁵ 24 EHRR 423 (European Court of Human Rights).

violation of the right to dignity as guaranteed in Article 3 of the European Convention. Furthermore, in *Geurra v Italy*⁸⁶ the European Court has found that a state has a positive obligation under Article 8 on the right to family life to protect peoples' homes from smells and nuisance from a waste treatment plant, toxic emissions emanating from a chemical factory, environmental pollution from a steel plant, and noise from bars and nightclubs which made it impossible for local residents to sleep in their homes.

The Right to Special Care during and After Child Birth

- (1) Special care shall be accorded to *mothers during a reasonable period before and after childbirth*, and during those periods, working mothers shall be accorded paid leave.
- (2) *Facilities* shall be provided for the care of children below school-going age *to enable women*, who have the traditional care for children, realise their full potential.
- (3) *Women* shall be *guaranteed equal rights* to training and promotion without any impediments from any person (emphasis mine).

Though maternal, child and reproductive health are important elements in the right to health, it has to be noted that Article 14 of the African Women's Protocol contains one of the most comprehensive provisions on the right to health and sexual and reproductive health under international human rights law. Article 14 provides as follows:

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:
 - (a) the right to control their fertility;
 - (b) the right to decide whether to have children, the number of children and the spacing of children;
 - (c) the right to choose any method of contraception;
 - (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
 - (e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally

⁸⁶ (1998) EHRR 357.

recognised standards and best practices; f) the right to have family planning education.

More importantly and in language similar to that of General Comment 14, the African Women's Protocol enjoins states in Article 14 (2) to:

- (a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
- (b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
- (c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

Ghana's gender approach to the right to health in the Constitution, to say the least, is half-hearted as it has not taken cognizance of its obligations under the African human rights Charter, related conventions and protocols discussed earlier. Gender seems to come into the equation only during pregnancy and after child birth. The right of women to decide, whether to be pregnant and when are not considered; just as their right of choice to particular contraceptives and planning their families.

However, Ghana's *Health Sector Gender Policy*⁸⁷ observes that, whilst health needs of both men and women are crucial, gender issues are real and permeate every facet of health promotion and delivery. It is a complex consideration in health choices and needs to be understood and mainstreamed to ensure that the health needs of both men and women are met as well as the roles and responsibilities of men and women working with the health system are equitably considered. Gender equality is important for the achievement of sustainable management and development of the health sector because it ensures that both men and women are in a position to contribute effectively to health delivery and to demand for equitable health services, by recognising gender as one of the factors influencing roles, responsibilities, status and influence in society⁸⁸.

It notes further that, Society prescribes to women and men different roles and responsibilities within different social contexts. There are also differences in the

⁸⁷ Ministry of Health- Ghana (2007) *Health Sector Gender Policy*, Ministry of Health: Accra, Ghana.

⁸⁸ *Ibid*, p. 1.

opportunities and resources available to women and men, and in their ability to make decisions and exercise their human rights, including those related to protecting health and seeking care in case of ill health. Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health risk, and in differential access to and utilization of health information, care and services.

The Policy catalogues a number of gender health issues, which require urgent attention, some of which include:

- Women's higher levels of poverty, lower literacy levels and ignorance as compared to men affect them adversely. In addition, negative sociocultural practices such as food taboos, non-involvement in decision-making regarding their health and that of their families also tends to compound this situation. These factors cause women to delay in seeking health care and in turn results in high maternal mortality;
- Respect for clients/patients is usually more skewed towards men than women. The negative staff attitudes of some service providers, which are due to inadequate and poor conditions of service has been found to adversely affect the quality of care;
- Health care providers are often not alert to their professional ethical responsibility enjoining them to accord full respect at all times and in all circumstances to persons they attend to irrespective of sex, sexual orientation, religion, educational level, socio-economic position among others;
- In most Ghanaian cultures, decisions on where and when to seek health care is primarily the preserve of men. This notwithstanding clients, (in particular women) often do not have enough information to empower them decide on treatment options;
- HIV/AIDS is one of the serious public health challenges in Ghana today with huge gender implications. The current national prevalence rate is estimated to be 2.7% as compared to 3.1% in 2003. The pandemic is taking its toll more on women than men with serious gender dimensions to the disease as a result of women's anatomical, socio-cultural and economic vulnerability to the disease. As of 2003 it was estimated that for every man infected with HIV/AIDS two women are infected. Mother to child transmission (MTCT) is the second major means of transmissions, accounting for 15% of new transmission. It was estimated that the prevalence rate among pregnant women was 3.1% in 2006.

- Available health service information indicates that psychiatric illnesses affecting both men and women are on the increase and that the causative factors are different for the sexes. Whereas in men this increase is predominately due to pathological reasons, that in women is closely related to marital and other social factors. Depression, the most prevalent psychiatric condition is higher among women than in men.
- In Ghana, sexual and reproductive health relates critically to the role of men and women in exposing themselves and others to unhealthy or poor sexual behaviour; family planning particularly access to and acceptability of contraception; women's risk to abortion; high maternal deaths and general lack of knowledge about reproductive health options and opportunities⁸⁹.

Right of another Person to Give Consent for Medical Treatment

Article 30 of Ghana's Constitution, described in the side note as 'rights of the sick' and contained in chapter 5 of the Constitution, provides:

30. A person who by reason of *sickness* or any other cause is unable to give his consent shall not be deprived by any other person of *medical treatment*, education or any other social or economic benefit by reason only of religious or other beliefs (emphasis mine).

The rendition of this provision also falls short of a right to health as known in international human rights law. In the main, it provides only a right during 'sickness' and further limited to only situations of obtaining consent from other persons for medical treatment. It fails to address issues of health protection and prevention and the 'underlying determinants of health'. It takes only an activist or progressive judge in Ghana to uphold this provision as one of a right to health as properly understood. Some decisions of the courts in Ghana give credence to this view

For instance, in *Issah Iddi Abass & 10 Ors v. Accra Metropolitan Assembly & Anor*⁹⁰, the court was dismissive of the argument by the 'evictees' that article 33 (5) of the Constitution, which contained 'unenumerated rights' were justiciable rights. Justice Yaw Apau, as Atupare (2013) observes⁹¹, was of the view that the plaintiffs relied on articles 12 (1), 23 and 33, which simply provided for judicial mechanisms for enforcing

⁸⁹ Ibid, chapter Two.

⁹⁰ [2008-2009] 1 GLR 245.

⁹¹ See Atupare, A. P. (2013) *Constitutional Justice in Africa: An Examination of Constitutional Positivism, Fundamental Law and Rights in Ghana and Nigeria*, Lexis Nexis: Durban, pp. 11-14.

rights and not rights properly so-called. His main concern was the fact that the plaintiffs were 'squatters' and did not have any legal interest in the land'; and that the 'eviction of trespassers from the land did not amount to an infringement on their rights as human beings- since it is wrong to achieve rights through lawlessness'⁹². Still, the evictions did not take place as there was resistance from the plaintiffs⁹³.

Unenumerated Rights

Further, article 33 (5) provides that:

The rights, duties, declarations and guarantees relating to the fundamental human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned which are considered to be inherent in a democracy and intended to secure the freedom and dignity

The Supreme Court in *NPP v. AG (CIBA Case)*⁹⁴, alluded to the constitutional significance in article 33 (5) of Ghana's Constitution and was inclined to read in rights if an issue meets the threshold of the article. However, the failure in the *Abass Case* mentioned above, to be guided by the inclination of the Supreme Court in the *CIBA Case*, suggests that unenumerated rights in article 33 (5) are unlikely to be upheld by the courts in Ghana. As observed by Atupare, 'a judge steeped in the general traditions of constitutional positivism would have limited use for such a position'. As is the case in the *Abass Case*, Justice Apau ignored the relevance of the article in that, though acknowledging it formed part of human rights provision in the Constitution. The basis for his conclusion seems to be that, a right cannot be asserted in breach of the- as trespassers. However, my own research on the eviction of these 'squatters' in Fadama, popularly referred to as 'Sodom and Gomorrah' have lived in the area for over twenty years and therefore acquired a 'prescriptive right' under the Land title registration Act, existing at the time. They could therefore not be properly described as trespassers in law⁹⁵.

The argument being made is that if article 33 (5) is given a 'purposive approach' to interpretation, the courts can uphold the right to health based on Ghana's Constitution. The article qualifies the possible types of unenumerated rights anticipated by it- those

⁹² Ibid, p. 15.

⁹³ See *Parcitypatory* (2019), "Voices from Accra: Introducing Old Fadama", at <https://parcitypatory.org/2017/12/21>.

⁹⁴ [1997-99] 378.

⁹⁵ See Atupare, P.A. (2013) "Fundamental Law, Human Rights and Directive Principles Jurisprudence in Ghana and Nigeria: *Constitutional Justice in Africa*, Durban: LexisNexis, for a more detailed discussion on this issue.

'inherent in a democracy' and 'secure freedom and dignity of man'. Article 33 (5), taken together with article 36 (2) (e), which provides that, 'the recognition that the most secure democracy is the one that assures the basic necessities of life for its people as a fundamental duty; underscores the point'. Based on the doctrine of the 'underlying determinants of the right to health'; such a right is 'inherent in a democracy, just as it provides the needed 'freedom and dignity of man'.

As indicated earlier, article 12 (2) of the ICESCR recognises the importance of the underlying determinants of health to the enjoyment of the right to health. Similar to Article 12 of the ICESCR, Article 24 (c) of the CRC provides that the right to health includes access to *nutritious food, clean drinking water, and environmental sanitation*. The Committee on ESCR in its General Comment 14 has explained that the right to health is an inclusive right limited not only to timely and appropriate health care but including underlying determinants of health, such as, safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health related education and information.⁹⁶ More importantly, as mentioned earlier, the Committee has noted that the minimum core obligations of states in relation to this right to include ensuring access to sanitation, potable and safe water, primary health care services, food and essential medicines.⁹⁷

Furthermore, the Committee has explained that patterns of health and ill health are shaped by discrimination, poverty, and exclusion, and that both biological and sociocultural factors play a significant role in influencing health.⁹⁸ Also, the former Special Rapporteur on the right to health, Paul Hunt, has made the link between underlying determinants of health and the enjoyment of the right to health.⁹⁹ In another report he has observed that an effective and integrated health system, encompassing health care and the underlying determinants of health, is central to the enjoyment of the right to health.¹⁰⁰

⁹⁶ The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment 14 para 43.

⁹⁷ Ibid.

⁹⁸ Ibid, paras 18 & 20.

⁹⁹ Hunt P (UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health) "The right of everyone to the enjoyment of the highest attainable standard of physical and mental health" UN Doc. No. A/62/214 (2007) paras 45-49.

¹⁰⁰ Hunt P (UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health), "Promotion and protection of all human rights, civil, political, economic, social and cultural rights" UN Doc. No. A/HRC/7/11 (2008) para 15; *Free Legal Assistance Group and Others v Zaire* (2000) AHRLR 74 (ACHPR 1995); and Millennium Development Goals Report (2011).

Human rights provisions in chapter five of the Constitution are expressly stated to be justiciable. Under article 33, a person can bring an action in the High Court to seek redress for the enforcement of his right. Article 33 (1) and (2) provides:

- (1) Where a person alleges that a provision of this Constitution on the fundamental human rights and freedoms has been, or is being or is likely to be contravened in relation to him, then, without prejudice to any other action that is lawfully available, that person *may apply to the High Court* for redress (emphasis mine).
- (2) The High Court may, under clause (1) of this article, issue such directions or orders or writs including writs or orders in the nature of *habeas corpus, certiorari, mandamus, prohibition, and quo warranto* as it may consider appropriate for the purposes of enforcing or securing the enforcement of any of the provisions on the fundamental human rights and freedoms to the protection of which the person concerned is entitled (original emphasis).

There are also a cluster of provisions in the DPSP, which relate to economic, social and cultural rights worth taking note of, notwithstanding the debate as to whether such rights are justiciable or not.

Article 34 provides:

- (1) The Directive Principles of State Policy contained in this Chapter shall guide all citizens, Parliament, the President, the Judiciary, the Council of State, the Cabinet, political parties and other bodies and persons in applying or interpreting this Constitution or any other law and in taking and implementing any policy decisions, for the establishment of a just and free society.
- (2) The President shall report to Parliament at least once a year all the steps taken to ensure the realization of the policy objectives contained in this Chapter and, in particular, the realization of basic human rights, a healthy economy, the right to work, the right to good health care and the right to education.

Directive Principles of State Policy, Justiciability and the Right to Health

Article 37 on the DPSP also provides:

[...]

(b) the protection and promotion of all other basic human rights and freedoms, including *the rights of the disabled, the aged, children and other vulnerable groups* in development processes.

(3) In the discharge of the obligations stated in clause (2) of this article, the State shall be *guided by international human rights instruments* which recognize and apply particular categories of basic human rights to development processes (emphasis mine).

[...]

The issue of the DPSP and their justiciability have come up time and again in the Ghanaian courts. In *The Ghana Lotto Operators Association and Others v National Lotteries Authority*¹⁰¹ where their Lordships were of the view that 'save where democratic mandate dictates, or flagrant legislation rear their ugly heads, or the Economic, Social and Cultural Rights rebut the presumption of unenforceability then the DPSP will apply'. The matter for determination in the *Lotto* case was the interpretation of article 36(2)(b) of the 1992 Constitution on the ambit of 'enabling environment' contained therein; did it include having a pronounced role?

Article 36(2)(b) states:

The State shall in particular, take all necessary steps to establish a sound and healthy economy whose underlying principles include –

[. . .]

(b) affording ample opportunity for individual initiative and creativity in economic activities and fostering an enabling environment for a *pronounced role* of the private sector in the economy [my emphasis].

The view of Bamford-Addo JSC (as she then was), was to the effect that the DPSP only become enforceable if they can be conjoined with other enforceable provisions in the Constitution, for instance, provisions in Chapter 5 of the Constitution on fundamental human rights and freedoms.

However, an earlier case had held that the DPSP are justiciable. In *New Patriotic Party v Attorney General*,¹⁰² Adade JSC (as he then was) expressed the majority view in the following words:

¹⁰¹ [2007–2008] 2 SCGLR 1088.

¹⁰² [1993–1994] 2 GLR 35 SC.

I am aware that this idea of the alleged non-justiciability of the directive principles is peddled very widely, but I have not found it convincingly substantiated anywhere. I have the uncomfortable feeling that this may be one of those cases where a falsehood, given sufficient currency, manages to pass for the truth [. . .] I do not subscribe to the view that chapter 6 of the Constitution, 1992 is not justiciable. First, the Constitution, 1992 as a whole is a justiciable document. If any part of it is to be non-justiciable, the Constitution, 1992 must say so. I have not seen anything in chapter 6 of the Constitution, 1992 generally which tells me chapter 6 is not justiciable.¹⁰³

Durojaye is of the view that, while almost all the member states (with the exception of South Sudan) of the African Union have ratified the African Charter, very few countries (including South Africa and Kenya) have explicitly recognised the right to health as legally enforceable in their national constitutions. This is particularly true for many African countries that are former colonies of Great Britain. Thus, in countries, such as, Ghana, Nigeria and Zambia, provisions relating to socio-economic rights are classified as mere directive principles of governmental policy. For instance, under the 1999 Constitution of Nigeria, provisions relating to socio-economic rights are found in Chapter II captioned "Directive Principles of Government's Policies" which are not justiciable.¹⁰⁴ Though Durojaye's view might be right in relation to the right to health and to some other African common law jurisdictions, particularly Nigeria where DPSP are expressly said to be non-justiciable, the same cannot be said of Ghana. Certainly, one cannot find the 'right to health' expressly in Ghana's Constitution, however, based on the decision of its Supreme Court in *New Patriotic Party v Attorney General*,¹⁰⁵ (referred to above), the right to health can be upheld by the courts. Indeed, Ghana's Constitution is silent on the justiciability of the DPSP.

The classification of socio-economic rights including the right to health, as directive principles is often hinged on the argument of some scholars who claim that these rights are not amenable to judicial interpretation. Moreover, it has been argued that socioeconomic rights, including the right to health, are positive rights that require substantial resources to ensure their implementation. According to Fuller, the adjudication of socioeconomic rights is likely to raise polycentric problems. He describes polycentric problems as "situation[is] of interacting points of influence 'which, when

¹⁰³ Ibid. 65–66.

¹⁰⁴ See for instance, s 6 (6) of the Constitution.

¹⁰⁵ [1993–1994] 2 GLR 35 SC.

possibly relevant to adjudication, normally, although not invariably', involve many affected parties and a somewhat fluid state of affairs."¹⁰⁶

Furthermore, it has been argued that courts are not competent to adjudicate on socioeconomic rights since these rights often give rise to raising and spending of resources, a duty belonging to the legislature. In other words, adjudicating on socioeconomic rights will undermine the doctrine of separation of powers. An opposing view is that the implementation of civil and political rights is not less expensive than socioeconomic rights. For instance, the right to a fair hearing requires equipping the police system, building courts and recruiting competent judicial officers to dispense justice. All of this requires a substantial amount of resources.

It is also argued that preventing the courts from scrutinising the actions of the executive or legislature may lead to abuse of powers and undermine the doctrine of checks and balances.¹⁰⁷ The South African Constitutional Court in *Minister of Health Others v Treatment Action Campaign and Others* emphasises this point when it notes that courts have an important role to play in ensuring the realisation of the socioeconomic rights guaranteed under the South African Constitution¹⁰⁸.

From the above underlying determinants of health, taken together with Ghana's socio-economic development policies over the years, there ought not to be any debate as to whether there is a right to health in Ghana or not. However, the courts of law's approach to law in Ghana is steeped in legal positivism and 'black-lettered law'. In addition, Ghana's courts of law hardly take into consideration, these socio-economic contexts in interpreting constitutional provisions; preferring to consider them as 'political questions' to be addressed by the executive and legislative arms of government¹⁰⁹. Therefore, in the absence of an express provision of a right to health, the courts are unlikely to uphold the right health.

The above notwithstanding and taking the totality of Ghana's human rights legal architecture and its health policies, one 'ought' to draw the conclusion that there 'is' the right to health in Ghana. However, the realization of this right is premised on a number of considerations:

- The courts of law, in adopting, its 'purposive approach' to interpretation should take into consideration the tenets of international human rights law. And in particular, be guided by the decisions of the African Human Rights Commission's jurisprudence on the African Human Rights Charter.

¹⁰⁶ Fuller L. (1978) 'The Forms and Limits of Adjudication', 92 *Harvard Law Review* 353-409.

¹⁰⁷ See An-Na'im' A. (2004) "To Affirm the Full human Rights Standing of Economic, Social & Cultural rights", in Ghai Y & Cottrell J (eds) *Economic, Social and Cultural Rights in Practice: The Role of Judges in Implementing Economic, Social and Cultural Rights* (2004) at 7.

¹⁰⁸ BCLR 1169 [CC].

¹⁰⁹ See *J.H. Mensah v. AG* [1997-98] 1 GLR 227; *Ghana Bar Association v. AG* [1995-96] 1GLR 598; *NPP v. AG (31 Dec Case)* [1993-94] 2GLR 35.

- The health policies, which address the underlying determinants of health are not legal text that are binding on the courts and which they should enforce.
- Ghana has ratified most of the international human rights instruments and related instruments on the right to health and must live-up to her obligations therein.

The 'Patients Charter of Rights in Public Health Act, 2012 (851)

Ghana's Public Health Act of 2012, provides in section 167 that:

The principles contained in the Sixth Schedule shall apply to all persons who relate to patients or clients.

The said principles are contained in a 'Patient's Charter' made up of a number of rights of a patient. The Charter requires collaboration between health workers, patients, clients and society; as the attainment of optimal health care is dependent on team work. Therefore, Health facilities are to provide for and *respect the rights and responsibilities* of patients, clients, families, health workers and other health care providers. They are enjoined by the charter 'be sensitive to the patient's socio-cultural and religious backgrounds, age, gender and any other differences as well as the needs of patients with disabilities'. In addition, the Health Service expects health care institutions to 'adopt the Patient's Charter to ensure that Service personnel as well as patients, clients and their families understand their rights and responsibilities'¹¹⁰.

The Charter is made to protect the rights of the patient in the Health Service and addresses:

- (a) the right of the individual to an easily accessible, equitable and comprehensive health care of the highest quality within the resources of the country;
- (b) respect for the patient as an individual with a right of choice in respect of health care plans;
- (c) the right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability; and
- (d) the responsibility of the patient or client for personal and communal health through preventive, promotive and simple curative strategies¹¹¹.

There are fourteen specific rights of a patient enumerated under the schedule. Included in these rights is 'the right to quality basic health care irrespective of the patient's geographical location'. Other rights include the right to: information on a patient's health condition, information on alternative treatment, confidentiality and privacy during treatment, information on exemption facilities, the right to a second medical opinion if the patient desires, among others.

There are, however, a number of legal questions that arise as regards the enforceability of the 'Patient's Charter' of the rights enshrined in it. First, there is no provision in Act 851 as to the

¹¹⁰ See sixth Schedule to the Public Health Act, 2012 (Act 851).

¹¹¹ Ibid.

legal consequences of failure to comply with the obligations therein. Section 174 (1) of the Act only says the 'Act binds the Republic'. It is not clear what the import of this provision is. Does it create legal obligations between the state and the citizen or between the state and other states or international health organisations?

Second, is the anomaly of embedding, as it were, rights of a patient in a clinical setting in the public health legal regime. It is more the case where public health rights can also be considered as 'group rights' that can asserted by groups based on sex, gender, religion or geographical location; while health rights in a clinical setting are those of individual patients'.

Third, there is no reference in these 'charter rights' to either Ghana's Constitution or any existing human rights legislation. It is doubtful if the courts of law will recognise these 'rights' as rights so properly called.

Some Recommendations

It is recommended that necessary steps should be taken to implement the recommendations of the Constitutional Review Commission in the following areas:

- that the Affirmative Action Act should deal with all types of discrimination against vulnerable groups and minorities.
- that the Constitution be amended to guarantee specifically the right to food for all Ghanaians.
- that Article 30 of the Constitution on "Rights of the Sick" be titled "The Right to Health" and should guarantee the right of every Ghanaian to the highest attainable standard of health, including access to healthcare services without barriers.
- a thorough Mental Health Bill to make it more progressive and for its immediate passage into Law.
- that:
 - (a) The present heading of Article 27 of the 1992 Constitution "Women's Rights" be changed to "Gender Rights.
 - (b) Article 27(2) of the 1992 Constitution should be amended to provide as follows:
 - Facilities shall be provided for the care of children below school-going age *at the work place* to facilitate care by parents.
- that the right to a clean and healthy environment be specifically provided for in the Constitution¹¹².

¹¹² See Republic of Ghana (2011) *Report of the Constitution Review Commission: From Political to Developmental Constitution*, Constitutional Review Commission: Accra.

In addition, Judges, particularly of the human rights courts, should be given continuous legal training on the 'law-in context' methodological approaches to the interpretation of human rights texts. Such training should include equipping them with the tools such as the ambit of international human rights instruments on economic, social and cultural rights and its jurisprudence; with a focus on article 33 (5) of Ghana's 1992 Constitution.

The wording of article 30 of 1992 Constitution should further be amplified to reflect current legal developments on the right to health; by capturing the essential features of the underlying determinants of health.

Conclusion

This article has raised a number of conceptual issues on human rights generally and the right to health in particular. In that context, it outlined essential features of the right to health and its relationship with other human rights to underscore the interdependence, inseparability, interconnection, and inter-penetrability of human rights norms. It has also outlined in brief form the international human rights legal regime in international human rights instruments, with a focus on the Africa Human Rights Charter and its jurisprudence developed by its Commission on human rights. It has teased out a number of State Party obligations arising therefrom.

In addition, it has raised a number of policy issues in the context of the state of health in Ghana and how they relate to the realization of the right to health. The legal architecture on the right to health in Ghana's 1992 Constitution have been outlined and discussed thematically. It answers the question raised as to whether there is a 'right to health' in Ghana in the affirmative; subject to a number of caveats. It further makes a number of recommendations for legal reform to make the right more explicit.