

Financial Access to Reproductive Technologies: Options and Issues for Reproductive Rights in Nigeria*

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1.0. Introduction

The advances in reproductive technologies¹ have opened up new frontiers in medically assisted human reproduction as they have been used to assist many to achieve conception and parenthood. Reproductive technologies are relevant to the Nigerian society where infertility is a major problem.² A lot of infertility problems in Nigeria rare due to severe causes³ which cannot be solved by conventional treatment.⁴ Therefore that these technologies will impact on Nigeria and other nations in Africa is not in doubt.⁵

Access to medical treatment for infertility is one of the injustices obtainable in the field of reproductive medicine. Due to many factors, including financial incapacity, some people have far easier access to treatment than others. Financial access is an issue because funds are insufficient and scarce and have to be allocated between competing equally important claims.⁶

Our point of concern, as Okonofua and Obi rightly observed, is the extent to which African countries should imbibe the new technologies and the priority they should accord to its development as part of their public health policies.⁷ According to them while many babies have been born through ART in the private sector of African countries, the procedure is not cost effective in these countries. It has been argued that high technology treatment of infertility would be a heavy burden on the public health sector in a developing economy, and would limit resources for addressing other pressing health problems.⁸ The opposing argument is that high technology treatment should be provided as a public health effort to provide comprehensive care and allow low- income countries to match recent advances in knowledge in developed countries⁹. This would be based on the recognition of a right and correlative duty in the citizen and government respectively. It is our position that the issues are interwoven and it would require an understanding of the theoretical basis of the new reproductive technologies as a means of achieving procreation. The objective of this paper is therefore to examine the underlining legal construction of the new reproductive technologies and the basis of public sector intervention in such. With special reference to the Nigerian legal system, the paper examines whether public sector finance of ART can be a duty imposed on government, and if so based on what parameters.

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¹ This embraces the use of technology to achieve reproduction.

² According to the World Health Organization sixty to eighty million people experience infertility around the world and most of those people live in developing countries. See World Health Organization, *Infertility: A Tabulation of Available Data on Prevalence of Primary and Secondary Infertility* (Geneva, WHO, 1991).

³ Bilateral tubal occlusion, severe oligospermia and premature ovarian failure are examples of these severe causes. In a report on seven hundred and eighty couples who attended the reproductive health clinic of the Women's Health and Action Research Centre in Lagos in 2002, more than half were accessed to have severe causes of infertility for which conventional methods of infertility treatment would have little effectiveness.

⁴ Conventional methods of treatment consists of the surgical repair of blocked fallopian tubes, induction of ovulation, and donor insemination.

⁵ F. Okonofua, "New Reproductive Technologies and Infertility Treatment in Africa" *African Journal of Reproductive Health*. Vol. 7 No. 1 2003 p.7.

⁶ Other constraints to access are based on moral, social or religious grounds like age, marital status and mental capacity.

⁷ F. E. Okonofua, & H. Obi, "Specialized Versus Conventional Treatment of Infertility in Africa: Time for a Pragmatic Approach" *African Journal of Reproductive Health* 2009 13 (1): pp. 9 – 11.

⁸ Okonofua, "New reproductive Technologies" *supra* note 5at p. 10.

⁹ F. Okonofua, "The Case against New Reproductive Technologies in Developing Countries." *British Journal of Obstetrics and Gynecology* 1997; 104:970.

1. 1 The Significance of the Issue

Robertson posits that it is a valid interpretation to suggest that denial of ART is an infraction of procreative choice and equates to denial of basic personal respect and dignity because individuals that experience infertility often experience guilt, low self esteem, disappointment, depression, increased rate of relationship conflict and sexual dysfunction.¹⁰ The Warnock Report¹¹ in England acknowledged the stress faced by those who are childless because of the importance that society places on the family unit as a valued institution.¹² For an African in particular, infertility presents even greater challenges for it affects the entire private, family and social relations and determines status within these parameters.¹³ It is not in doubt that infertility is prevalent in Nigeria. Nigerian gynecologists have reported that 60 to 70 per cent of their consultations in tertiary institutions are infertility cases.¹⁴ Research also indicates that a greater percentage of those who experience infertility are in the poor sector. From available studies, there is a high rate of primary and secondary infertility in Nigeria in fact indicating that up to thirty per cent of couples may fall in this category.¹⁵ However, the treatment options are situated in the private sector with very few people able to afford it.

The medical treatment of infertility is definitely enormous and is in fact regarded as a multimillion pound industry worldwide.¹⁶ The question that necessarily arises is how treatment should be provided. Should it be left in the private sector, where it is presently located with its attendant exorbitant costs or is it feasible for public provision to be made in order to make it accessible to the generality of those affected? Okonofua argues¹⁷ that reports from private clinics indicate that high tech reproductive technologies are feasible in Nigeria and African countries if located in the private sector.¹⁸ Private clinics which depend on full cost recovery are not subsidized. Full cost recovery would not be feasible if treatment were done in a public hospital, which as presently conceived in most African countries, often include substantial subsidies and subventions from government. Without subventions from government, the programme is not likely to be sustainable in the public sector. Therefore Okonofua concluded that new reproductive technologies for the treatment of infertility in Africa is best left in the domain of the private sector rather than been incorporated into public health sector policy. Consequently, the cost of treatment will remain high and this makes it inaccessible to the generality of those affected.

In a country like Nigeria, this is particularly distressing as majority of the populace may not be able to afford the medical costs. Infertility treatment is not available under medical scheme or insurance coverage in Nigeria. As a result ART is simply unavailable or inaccessible to a vast majority of people in Nigeria. Private sector health service is generally a reserve of the few elite and with regards to infertility

¹⁰ J. A. Robertson, *Children of Choice: Freedom and the New Reproductive Technologies* (Princeton NJ: Princeton University Press, 1994).

¹¹ Report of Committee of Enquiry into Human Fertilization and Embryology in the United Kingdom.

¹² M. M. Peterson, "Assisted Reproductive Technologies and Equity of Access Issues" *J Med. Ethics* 2005 31

¹³ F. Okonofua *et al*, "The Social Meaning of Infertility in South West Nigeria" *Health Transition Review* vol. 7 No 2 (Oct. 1997) pp. 205- 220.

¹⁴ U. Megafu, "Surgical causes and Management of Infertility in Nigeria" *International Surgery* 73. 3. 144-148.

¹⁵ O. O. Adetoro & O. W. Ebonyi, "The Prevalence of Infertility in South West Nigerian Community" *African Journal of Medicine and Medical Sciences* 20, 1: 23- 27.

¹⁶ L. A. Rinehart, "Infertility: the Market, the Law and the Impact" (1994) 35 *Jurimetrics J.* pp. 77-106.

¹⁷ Okonofua & Obi, "Specialized Versus Conventional Treatment" *supra* note 7.

¹⁸ Okonofua, "New Reproductive Technologies" *supra* note 5 p. 8. He based his argument on the report on infertility in Nigeria by R. A. Ajayi *et al*, "Live Births after Intra Cycloplasmic Sperm Injection in the Management of Oligospermia and Azoospermia in Nigeria" *African Journal of Reproductive Health* 2003;(7); 12-16.

treatment; the astronomical costs are simply unimaginable. Economic and social status therefore impacts infertility. This poor /rich dichotomy is discriminatory.

The issues raised are therefore many: why should ART be provided and who should provide it. Should it be left to the private or the public sector? Should there be governmental regulation? Is not being able to have a child a medical problem (infertility) or is it an unfulfilled personal desire (involuntary childlessness). Is treatment of infertility a basic right and should be subsidized by government and health insurers. What legal theories underline this field? The answers to these would determine the policy direction to take in any country, including Nigeria.

There are different governmental approaches to the regulation and funding of infertility. For example in Britain, the government makes infertility services available under its National Health Service although the priority given to it is minimal. The result is that the few wealthy ones who can afford private treatment eventually resort to this. Interestingly, despite the fact that China is highly in favour of family planning due to its large population, it recognizes that family planning is a two-sided coin. China has therefore set up IVF and AID clinics to help infertile couples.¹⁹ In the United States, the federal government does not mandate the coverage of infertility treatment by insurance. The various states have different approaches. In some, occupational health insurance covers treatment for infertility. Nigeria has so far left the regulation and finance of infertility to the private sector. Insurance does not cover it and most people have to resort to self help in terms of funding or seek other trado- religious solutions to infertility and consequential childlessness.²⁰ The issue relating to regulation and treatment of infertility impacts on the reproductive rights of citizens and any decisions taken must adequately consider the implications on such rights.

1.2 The Nature of Reproductive Rights

According to the World Health Organization, reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number and timing of their children, and to have the information and means to do so: and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.⁷ Reproductive rights include, *inter alia*, the right to access reproductive health care and the right to education and access in order to make free and informed reproductive choices.

Realizing that the recognized legally binding human rights instruments do not make specific mention of sexual and reproductive rights, the Cairo Programme²¹ of Action explains that reproductive rights embrace certain human rights that are already recognized in international human right documents, and other United Nations consensus documents.²² Thereby a linkage to existing binding human rights instruments is created in the interpretation of these rights. The Programme of Action states that governments have the responsibility to meet individual's reproductive needs, rather than demographic targets.

This Programme of Action also provides the first definition of reproductive health to wit: reproductive health is a state of complete physical, mental and social well- being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and

¹⁹ G. Douglas, *Law, Fertility and Reproduction* (London: Sweet& Maxwell, 1991).

²⁰ F. E. Okonofua *et al*, "The Social Meaning of Infertility" *supra* note 13.

²¹ The twenty year non binding Cairo Programme of Action was adopted in 1994 at the international Conference on Population and Development. (ICPD) in Cairo.

²² These include the right to health, right to freedom from discrimination, right to privacy and right not to be subjected to torture or ill- treatment.

processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods for the regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.²³ Therefore the issue of access to reproductive technology is significant to reproductive rights.

1.3 Forms of Reproductive Technologies

Reproductive technology encompasses all current and anticipated uses of technology in human and animal reproduction. According to Akande, the term assisted reproductive technology²⁴ [ART] can be defined as all treatments that include medical and scientific manipulation of human gametes and embryos in order to produce a term pregnancy. ART is the use of reproductive technology to treat infertility. There are a wide range of assisted reproductive technologies in existence which include the following: Intrauterine insemination. (This is the oldest and least invasive method. The sperm of the man is ejaculated into a container, subjected to laboratory preparation procedures, and inserted through the vagina into a woman's uterus); In Vitro Fertilization (IVF); There are many variants of this but the general procedure involves both sperm and ova being retrieved from the human body, (either a husband and wife or egg and sperm donors), placed together in petri dishes under laboratory conditions to be fertilized and then transferred in the early embryonic stage²⁵ to the woman's uterus, with the hope that implantation and pregnancy will occur; and intracytoplasmic sperm injection (ICSI). (It is the most recent of the technological methods. This is an IVF variant that involves the micromanipulation techniques in which one spermatozoon is injected directly into an oocyte under laboratory conditions, in the hope of improving fertilization outcomes, in particular where there is male- female factor infertility. In extreme cases of male infertility where sperm is not present in the ejaculate, microsurgical epidermal sperm aspiration (MESA) and testicular sperm extraction (TESE) provide means of invasive sperm removal from the testicles for the ICSI procedure to be done.²⁶

2.0 Theoretical Foundations of Reproductive Technology in Law

The question whether the treatment of infertility by use of high technology reproduction with implications on access is governed by principally by two legal principles -the principles of reproductive liberty and reproductive autonomy.

2.1 The Concept of Reproductive (Procreative) Liberty

Robertson defines procreative liberty as the widely accepted fundamental individual right to either have or avoid having children. It entails reproductive freedom as a negative personal right meaning that 'a person violates no moral duty in making a reproductive choice and other persons have a duty not to interfere with that choice.'²⁷ Therefore, the ideal of procreative liberty cannot be realized unless women qualify or have access to all available treatments for infertility.²⁸ The concept of

²³ See also the non binding declaration and platform of action in the 1995 Fourth World Conference on Women in Beijing.

²⁴ It is also called artificial reproductive technology.

²⁵ It is popularly called embryo transfer.

²⁶ For feminists criticisms of the use of ART see Cook *et al* Reproductive Health and Human Rights (Oxford, Oxford University Press, 2003).

²⁷ Robertson, *supra* note 10.

²⁸ *Ibid.*

reproductive autonomy is sometimes used interchangeably with procreative liberty although it has been argued that they are different. While autonomy is a positive right, liberty is negative. Berlin defines liberty in the ordinary sense as a negative right to freedom, in that one is entitled to be free in certain areas from the interference of others.²⁹ The concept of reproductive liberty is a tool of restraining the state from interference in people's reproductive choices.³⁰ It does not give rights to treatment and it places no duty in third parties to provide the resources necessary to exercise that choice, in spite of plausible moral arguments for government assistance.³¹ Reproductive liberty would therefore be the basis of challenging the medical gate keeping of would be parents seeking to access ART.

2. 2. *Reproductive Autonomy*

Autonomy requires a consideration of the scope of freedom people have to pursue their desire and the extent of regulation, medical or legal, permissible. It represents the positive side of reproductive liberty. It is not freedom 'from' but freedom 'to.'³² This positive right to freedom is "autonomy" in the sense that one is entitled to recognition of one's capacity, as a human being, to exercise choice in the shaping of one's life. In the context of reproductive and sexual health, autonomy means the right of a woman to make decisions concerning her fertility and sexuality free of coercion and violence. It also means the recognition that women seeking treatment in areas of fertility and sexuality are individuals with separate legal personality from their sexual partners and must be allowed to make independent decisions based on her own needs.³³

Beauchamp defined autonomy as freedom from external constraint and the presence of critical mental capacities such as understanding, intending and voluntary decision making capacity.³⁴ Shalev posited that autonomy is intimately and intrinsically connected with many fundamental rights such as liberty, dignity, privacy, security of the person and bodily integrity.³⁵ He contends also that the right to autonomy in making health decisions in general, and sexual and reproductive decisions in particular derives from the fundamental human right to liberty. Reproductive autonomy shares all the ideas of reproductive liberty but goes further to request the state to assist couples who need treatment or help to have a child. Under this concept, infertility may be seen as analogous to a serious disease, for which a form of social security must exist. The state is under a positive duty to provide treatment for those suffering from infertility. Herring however cautions that even in its strongest manifestation, the right to reproductive autonomy is not a right to a child but a right of access to facilities so that one can try and have a child.³⁶

²⁹ I. Berlin, "Two Concepts of Liberty" in *Four Essays on Liberty* (Oxford: Oxford University Press, 1969).

³⁰ The state would be wrong to for example prevent a woman from reproducing on the ground that she would be a bad mother. Also denying a couple access to IVF on grounds of being inadequate, or to prevent abortion by a woman would be wrong.

³¹ J. A. Robertson, *Children of Choice*, *supra* note 10.

³² C. Shalev, "Rights to Sexual and Reproductive Health- the ICPD and the Convention on the Elimination of all forms of Discrimination against Women." <http://www.un.org/womenwatch/daw/csw/shalev.htm> accessed 11/16/10.

³³ *Ibid.*

³⁴ J. A. Beauchamp, "Ethical Theory and Bioethics" in Beauchamp T. L. & L. Walters eds. *Contemporary Issues in Bioethics* 5th ed. (Belmont, CA: Wards worth, 1999) p. 1-32.

³⁵ *ibid* p. 6.

³⁶ See also B. Steinbock, "Rethinking the Right to Reproduce" *Harvard Centre for Population and Development Studies Working Paper Series*. No. 98.05. April 1998 p. 1 at http://www.globalhealth.harvard.edu/hcpds/wpweb/reproright_9805.html (accessed 15th Dec., 2011).

Financial access denial is the fact of the inability of those unable to afford infertility treatment to get such treatment. This financial access constraint cuts across the globe but in different strata. In jurisdictions that make treatment a public health issue and ensure that it is subsidized or where treatment is covered by insurance policies, more people, across the socio- economic strata, are able to access treatment. Such access is uninhibited and poses no challenge. On the other hand, where treatment is essentially a private health concern, as it so happens in most African nations, Nigeria inclusive, treatment is very costly and this curtails the access to treatment of many equally situated people with the condition of infertility.

For example in the United States, infertility is not regarded as a medical condition by most health insurance companies. Its treatment is not reimbursable. It has in fact been compared with cosmetic surgery and seen as frivolous. Some states in the United States of America have however mandated private insurance companies to offer or cover infertility treatment. The implication then is that in the U.S and all over the world there is unequal access to treatment. The cost of infertility treatment, especially with the new reproductive technologies is very high.

3.1 Arguments against Financial Access in Africa/ Nigeria

According to Okoro and Obi, 'Africa is burdened by a large number of conditions- maternal mortality, STIs, HIV/AIDs, and malaria- that are more deadly, and for which allocation of resources will benefit a greater number of people.'³⁷ They therefore posit that 'with limited health resources available in Africa, the primary and secondary prevention of infertility would be more cost- effective as they would benefit a larger number of people.'³⁸ Consequently, they argued that 'efforts should be concentrated on the prevention of infertility while improving facilities and structures for the conventional treatment of infertility.'³⁹ Therefore, the best public health policy is one that seeks to prevent the problems that lead to infertility rather than a policy based on treatment of individual cases with expensive new reproductive technology procedures.

While it is agreed that prevention is a key component of the structure in Africa, it is also important to realize that high technology treatment is an equally twin component, as prevention cannot address the needs of people with core infertility which are not based on identifiable causes. This view is captured by Akande's argument that prevention though paramount, ignores the plight of infertile couples, including those with non infectious causes of infertility.⁴⁰ Infertility services in developing countries span the spectrum from prevention to treatment. Akande⁴¹ has suggested that in an effort to make much needed ARTs to developing countries accessible and affordable, developing countries should look to public- private partnerships (PPP). These partnerships can bring technical expertise, research, equipment and supplies to low resource settings. At the same time, PPP can offer services at lower costs that are more realistic in developing countries. He concluded that cooperative public and private partnership have the potential to make infertility care affordable and to make access more just. To Akande, evidence supports that there is a compelling need for infertility treatment beyond prevention. In many instance ART are the couple's last hope or the only means to achieve.

Another argument against the development of ART technology is that of overpopulation. This argument is that for a country grappling with overpopulation, there is no need to prioritize infertility

³⁷ *supra* note 7 at p. 10.

³⁸ *Ibid.*

³⁹ *Ibid.*

⁴⁰ E. O. Akande, "Affordable Assisted Reproductive Technologies in Developing Countries: Pros and Cons" *Oxford Journals ESHRE Monographs* vol. 2008.issue 1 pp. 12-14. Available at <http://eshremonographs.oxfordjournals.org> (accessed 7th April, 2012).

⁴¹ *Ibid.*

management for the overpopulation poses a demographic problem for the country and for the global community. However this argument is flawed as it works against the reproductive health rights of the couple, the right to reproduce in exercise of their autonomy. As Akande rightly observed, the same argument might hold true to stop investing in any form of medical technology to save lives.

3. 2 Arguments in Favour of Access

Within existing international and domestic legal system we can find the basis to justify government duty to fund and subsidize the treatment of infertility to make it accessible to those in need of it thereby situating infertility in the public sector. The framework of rights include state responsibility to observe reproductive rights- These rights are entrenched already in legally binding human rights to wit-, the right to be free from discrimination, the right to reproduce, the right to the benefit of scientific progress and the right to health care .

3.2.1 State Responsibility for Reproductive Rights

State responsibility for reproductive rights demands that government owes a duty to the citizen to protect their reproductive rights in that child bearing is about the physical and welfare of the citizen, of parent and of children. It is a reproductive right of a woman to bear a child and elect the number and spacing of her children and must be protected by the state. Articulating this viewpoint Cook *et al state*:

The rights under the International Covenant on Economic, social and Cultural Rights (the economic Covenant) to the benefits of scientific progress support resort to new reproductive technologies. The general right to found a family, recognized in many national constitutions and in many of the leading human rights conventions supports medical assistance to prevent and to overcome effects of infertility, whether or not scientific technology is applied. The right to private and family life may show that enactment of intrusive legislation to prohibit or monitor MAR on moral grounds is a human right violation. Reinforcing these human rights of resort to MAR is the right to the highest attainable standard of health. Health has physical, mental and social dimensions, and infertility among those who want to have children diminishes their mental and social wellbeing, and may have physical health repercussions. The objection that many techniques of MAR do not cure medical infertility is correct, but they may overcome involuntary childlessness, and so serve human rights to health services.⁴²

Therefore everyone has the right to the enjoyment of the highest standard of physical and mental health. Universal access to treatment for infertility is therefore a state obligation which it must promote on the basis of equality, of all persons in the same category. Access must be promoted with respect to reproductive health care, which includes family planning and sexual health. Reproductive health care programmes should provide the widest range of services without any form of coercion . All couples and individuals have the right freely and responsibly to determine the number and spacing of their children and to have information and education and means to do so.⁴³

3.2.2 Right of Freedom from Discrimination

Couples seeking recourse to medically assisted reproduction are unable to conceive in the course of nature, may claim a reproductive health disability and the human right not to suffer

⁴² Cook et al supra note 26.

⁴³ Principle 8, Cairo Programme of Action.

discrimination on that basis. They are therefore entitled to be provided with access to reproductive technology to enable them reproduce as freely as those who are capable of natural conception. The limits of this argument is that it would mean lack of access to state funding, since couples who conceive in the ordinary course of nature may receive state funded services in gestation and delivery but not for the purposes of conception. Since no state funding supports natural conception, states may accordingly decline funding of ART, since this would not deny women in infertile relationships services that are available to women in fertile relationships. Judicial responses to these are instructive. In *Cameron v Nova Scotia (Attorney General)*⁴⁴ the Nova Scotia Court of Appeal held that the non- funding of an expensive method of medically assisted reproduction is discriminatory on grounds of reproductive disability, but legally defensible under publicly funded health care in view of its high cost and limited record of success. While interpreting Article 12 of the European Convention on Human Rights which relates to the right to marry and found a family, the English Court of Appeal in *R v Secretary of State ex p Mellor*⁴⁵ held that the article did not give an absolute right to assisted reproductive services or impose obligations on the state to provide them. Access to assisted reproductive services should be regarded as a benefit offered by the state.

Recognition that non-funding of ART and the consequential denial of access to the poor infertile couples does not discriminate against them will lead to the conclusion that human rights of access to ART are only negative rights. A person may claim unimpaired access to ART they can afford, but cannot require the state to provide them with access to services, which, like cosmetic medicine, fall into the category of luxury medicine.⁴⁶ In the Canadian case of *Cameron v Nova Scotia (Attorney –General)*⁴⁷ the Court of Appeal in Canada held that non – funding of I.V.F. and I.C.S.I methods of assisted reproduction is discriminatory against the applicants on the grounds of reproductive disability. It conceptualized involuntary childlessness as a form of disability by stating that:

The government has failed to ameliorate the position of the infertile compared with the fertile people. They are unequally treated because they are denied a medically recommended treatment appropriate for them. The fertile on the other hand have no restrictions on access to Medicare for pre-natal treatments and treatment relating to childbirth.⁴⁸

Interpreting the right to marry and found a family under article 12 of the European Convention⁴⁹ it appears that it is doubtful if the convention can assist an infertile person, married or single, to demand a positive obligation on the part of a state to provide infertility treatment in order to create a family unit.⁵⁰ Madden made this conclusion that;

...the ECHR provide for the right to marry and found a family, it is improbable that these instruments could be used in an individual case to establish a legal right to reproduce. Although political and social pressure may be brought to bear on governments, both nationally and internationally, to introduce and legislate for reproductive technologies in order to promote the

⁴⁴ (1999) 177 DLR (4th).

⁴⁵ [2000] 3. FCR. 148.

⁴⁶ See Cook *et al supra* note 26 p. 312.

⁴⁷ (1999) 177DLR (4TH) 611 (N.S.C.A.).

⁴⁸ *ibid* paragraph 172.

⁴⁹ Also available in other human rights instruments.

⁵⁰ A. Liu, *Artificial Reproduction and Reproductive Rights* (Aldeshot: Dartmouth, 1991) p. 30.

reproductive health of their citizens, it is doubtful that a positive right to reproduce may be gleaned from international instruments for the protection of human rights.⁵¹

3.3.3 Right to Reproduce

There are divergent views on the existence and content of any right to reproduce. The question that is germane to this discourse is whether there is a right to reproduce and is there a correlative duty on the state to enable individuals to reproduce by the provision of treatment to those who may be unable to reproduce without medical assistance. Is such a right negative or positive? What is the practical effect of such a distinction? According to Madden these questions remain to be answered squarely by judicial decisions.

Herring⁵² posits that a claim to a positive right to procreate would be difficult to support, not least because natural procreation involves two people thereby construing the right to reproduce as a right to coital and non coital conception. It cannot be suggested that the state should be obliged to provide partners for anyone who wishes to produce a child. He argues that although, Article 12 of the European Convention on the right to marry and found a family,⁵³ Article 17 of the International Covenant on Civil and Political rights and Article 25(2) of the Universal Declaration of Human Rights might suggest a positive right to procreate on a literal reading, the notion has been rejected. In *R V Secretary of State for the Home Office, ex p Mellor*⁵⁴ the English Court of Appeal held that a married prisoner had no right under article 12 to have access to artificial insemination services to enable his wife to have a child. Such services were a privilege, which no one could claim as of right. In interpreting the right to procreate, Herring maintains the following arguments or possibilities.

On the one hand, the argument that there is the right not to have one's natural ability to procreate removed. The court in *Briody v St Helens and Knowsley HA*⁵⁵ considered the right to reproduce in this wise. The plaintiff was unable to have children due to the negligence of a health authority. She brought an action for damages in order to enable her to enter into a surrogacy contract in California, to enable a surrogate to carry her egg after fertilization with her partner's sperm. Although the action failed on grounds of its motivation for financial rewards in having a child, the court foresaw the possibility of an award in similar situation to enable a woman rendered infertile to have a child. In other words the court was ready to hold that her right to reproduce had been violated. In *Re D (A Minor)(Wardship: Sterilization)*⁵⁶ the court held that the sterilization of an 11 year old mentally handicapped girl cannot be legally justified, describing the procedure as one which involved the deprivation of basic human right, namely, the right of a woman to reproduce. It has been argued that this presumably means she would lose the chance of bearing a child. In *Re Eve*,⁵⁷ the Supreme Court of Canada held that a mentally handicapped woman should not be sterilized for non-therapeutic reasons tating that giving birth is a great privilege. In *Re F (Mental Patient Sterilisation)*,⁵⁸ Lord Brandon was of the view that one of the fundamental rights of a woman, is the right to bear children. Therefore it can be surmised that judicial

⁵¹ D. Madden, "Reproductive Rights and Assisted Conception" in *Human Rights: An Agenda for the 21st Century*. A. Hegarty & S. Leonard ed. (London: Cavendish Publishers, 1999) p. 217 at 224.

⁵² J. Herring, *Medical Law* (Oxford: Oxford University Press, 2006) p. 359.

⁵³ European Convention on Human Rights, 1950.

⁵⁴ [2003] FCRM 148.

⁵⁵ [200] 2 FCR 13

⁵⁶ [1976] Fam. 185, 193E.

⁵⁷ (1986) 31 D.L.R. (4th) 1, 5.

⁵⁸ [1990] 2 A.C.1.

precedence appears to favour construing the right to reproduce, if it exists at all, as a right simply to bear a child. It is a simple biological right.

A second possibility is that the right to reproduce involves a social security aspect- the right to rear children. Madden⁵⁹ contends that the issue of whether there is a right to reproduce may depend on whether it is simply a biological right, or whether it encompasses the right to rear a child. He concludes that in most cases the right to reproduce would involve both aspects of parenting, although this will not always be the case.⁶⁰ In *Baby M case*,⁶¹ these two aspects were seen as separate issues. The New Jersey Supreme Court stated:

The right to procreate very simply is the right to have natural children, whether through sexual intercourse or artificial insemination. It is no more than that...the custody, care, companionship, and nurturing that follow birth are not parts of the rights to procreation.

By this, the court divided and held divisible biological and social aspects of parenting. In the United States the case law is indicative of a constitutional right in both married and single to resist state interference with coital reproduction, unless the state can show that great harm would be done from the reproduction in question. Douglas suggests that the right to reproduce cannot be restricted to the right to bear a child, first because, men cannot have such a right, so their right must consist of something else, and secondly, because pregnancy and childbirth are not generally regarded as the most important aspects of being a mother (or parent). He argued further that it is the interest to fulfill the social role of parent that really needs protection. This wish to be a parent, to reproduce oneself implies that one wishes to take part in the upbringing of one's offspring. To him, there seems to be little justification for upholding a right simply to pass on one's genes if one has no intention of fulfilling the role of a parent, once the child is born. This is the premise that Douglas used to justify the sterilization of a severely mentally handicapped woman who would never be able to fulfill the role of a parent. The natural conclusion of this argument is that since the right to reproduce is a right to social parenting, state is obligated to make available the resources to achieve this even by ART.

Another conceptualization of the right to reproduce was made by Steinbock. He identified two possibilities. First, that if "reproduction" is conceptualized in accordance with Robertson's definition as the transfer of genetic material to offspring, then the right to reproduce will be understood as the right to transmit one's genetic material to offspring. Steinbock however argues that this is the wrong approach. He proposes that procreation is not transmitting one's genes, but rather is having offspring to rear. The right to reproduce protects the interests individuals have in founding families, and where this interpretation is accepted then where there is no intention or ability to rear, there is no right to reproduce, or at best a limited right.⁶²

Scott puts it thus;

The right to procreate is the right to produce one's own children to rear. The right presumes and indeed requires an intention as well as an ability to assume the role of parent....To be sure ...components of the reproductive process might have independent value for the individual. For example, a man might wish to donate a sperm to perpetuate his lineage even though the children conceived will remain unknown to him. A woman

⁵⁹ *supra* note 51 at p. 222.

⁶⁰ For example in a situation where woman conceives and gives birth to a child without ever having the intention to raise it, as in a surrogacy.

⁶¹ 109 NJ 396; 537 3d 1227 (1988).

⁶² Scott, "Sterilization of Mentally Retarded Persons" *Duke Law Journal* 806.

might want to act as surrogate mother because she finds pregnancy and childbirth to be meaningful and satisfying experiences. But neither of these desires, legitimate though they may be, implicates a fundamental right....It is the objective of rearing the child- of establishing a family- that elevates the right to procreate to a lofty status.⁶³

Steinbock argues that the European convention, which provides for the “right to marry and found a family” already, assumes a rearing component in the right to reproduce because “founding family encapsulates a rearing responsibility. Consequently, where there is no possibility of becoming a rearing parent the right to reproduce is meaningless, and in some cases works against the best interests of the individual whose right it is supposed to be.”⁶⁴

In the context of this discourse the right to reproduce can only mean a right not to have one’s reproductive ability wrongfully removed, the right to have equal access to treatment by technology already available to others and the right to fulfill the social role of parenting. The right to reproduce cannot be the basis of demanding that new technology be invented to meet their basic needs but it can be used to demand prevention of conditions causing infertility.

3.3.4 Right to Benefit of Scientific Progress and Right to Health Care

The Economic Covenant in Article 15(10) (b) recognizes the right of everyone to enjoy the benefits of scientific progress and its applications. The protocol on the right of women in Africa in Article 14(2) provides that ‘states parties shall take appropriate measures to provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; (b) establish and strengthen pre- natal, delivery and post- natal health and nutritional services for women during pregnancy and while breastfeeding. Every person shall have the right to enjoy the highest attainable standard of physical and mental health under Article 16(1) of the African Charter which also states in Article 16(2) that state Parties to the charter shall take the necessary measures to protect the health of their people and to ensure they receive medical attention when they are sick. Despite these laudable provisions, their scope remains uncertain but they may eventually form the basis of a legal right to claim funding of treatment by the government. The right to health care is a component of the right to life and the right to conditions necessarily positively impacting life.

4.0. Financial Access: Options and Issues for Reproductive Rights in Nigeria

Nigeria’s economy, been a developing economy, has not provided the economic power to the large population that it commands. In fact there appears to be no middle class as the divide is now between the very rich and the very poor. With the exorbitant rate of ART treatment, the reality is that legal basis for governmental assistance is in existence and must be articulated. This is more so when it is realized that there is generally poor infrastructural facilities, poor health care delivery system, even for conventional and more pressing illnesses and diseases. The position of this paper is that there are sufficient grounds to justify the provision of financial access to treatment of infertility in Nigeria’s legal framework. The government can seize the initiative of the constitutional provisions, the national health policy, the national health insurance scheme and socio- economic and cultural rights implications to develop a public sector ART framework that subsidizes access to treatment and gives equal rights to the rich and the poor suffering from infertility to get treated. These issues are discussed below.

4.1. Constitutional Initiatives

⁶³ *ibid.*

⁶⁴ For example the cases where the courts prevented the sterilization of severely mentally handicapped girls are seen to have resulted from a failure to appreciate a rearing component in right to reproduce.

With the realization that reproductive rights include the right of access to appropriate health services that will afford them the best chance of having a healthy baby, there are views that the constitution of Nigeria is a foundation of the right to claim governmental funding in public sector regulation and treatment. Yussuf expressed the view that sections 14 (2) (b) and 17 (3) of the Constitution of the Federal Republic of Nigeria might prove useful to impose a duty on the government to provide for the welfare of the people. Section 14(2) b provides that the welfare of the people shall be the primary purpose of government. Section 17(3) provides that the State shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons; provision is made for public assistance in deserving cases or other conditions of need; and the evolution and promotion of family life is encouraged.⁶⁵ According to Yussuf, these provisions can form the basis of a claim against the Nigerian government in order to make them accountable to provide reasonable access to infertility treatments in the country.

4.2 National Health Insurance Scheme

The objectives of the Nigerian National Health Insurance Scheme Act 1999 give the basis of public sector intervention in high technology treatment of infertility. Section 5 of the Act states that the scheme shall ensure that every Nigerian has access to good health care services; protect families from the financial hardship of huge medical bills; limit the rise in the cost of health care services; ensure equitable distribution of health care costs among different ethnic groups; maintain high standard of health care delivery services; ensure adequate distribution of health facilities within the federation; ensure equitable patronage of all levels of health care and ensure the availability of funds to the health sector for improved services;

4.3 The National Health Policy of Nigeria

The Nigerian government in 1998 adopted the National Health Policy and Strategy to achieve health for all Nigerians.⁶⁶ The policy should be a starting point in addressing the socio-cultural causes of infertility. The goal of the policy is to enable all Nigerians to achieve socially and economically productive lives. It seeks to distribute and disseminate fairly, health information and facilities. The government may use this policy as a basis to achieve a measure of welfare for the people seeking to have children by the use of conventional treatment and reproductive technology. A policy frame work provides direction and motivates action on stated objectives. The political power must be brought to bear realising the importance of child bearing to the average Nigerian. Child bearing is not merely a personal desire but a socio- cultural imperative.

4.4 Socio- Economic/ Cultural Rights Implications

Akande argues rightly in our view, that the idea that infertility is not a health care priority is based on the fallacious assumption that it does not have devastating material and life threatening consequences. He argues that indeed, with regard to developing countries, the consequences of infertility are so severe that they should assume an even higher priority in developing countries than it does in developed countries. The social definition of infertility impedes the right to family life, affects marital stability and erodes status in the family and in the society.

⁶⁵ Section 17 (30) (d) (g) (h) Constitution of the Federal Republic of Nigeria 1999.

⁶⁶ See, Centre for Reproductive Rights, "Laws and Policies Affecting Women's Reproductive Lives", *Women's Reproductive Lives in Nigeria: A Shadow Report* (June 1998), p .1, available at <http://www.cril.org/pdf/SRNigeria98.pgf> (accessed 6th Nov., 2011).

5. Conclusion

The adoption of the principle that men and women of full age, without any limitation due to race, nationality or religion have the right to marry and found a family and that 'the family is the fundamental group unit of society and is entitled to protection by society and the state' in Article 16 of the Universal Declaration of Human Rights, signified the wide acceptance that the family unit is central to human existence and dignity. Infertility is pervasive globally but in Africa, Nigeria inclusive, it has a social connotation that is fundamental to reproductive health and rights. Therefore it appears that the question of its medical status, as to whether it is a disease or not, is insignificant. What is important is that due to its social connotation, the need to access the reproductive technologies becomes imperative. Consequently the social, emotional, physical and economic consequences that infertile couples- and in particular women- face justifies investing in treatment options in developing countries.⁶⁷ Infertility affects mental health, an indices of reproductive health protection in law. Some cases of infertility can only be treated by ART. As infertility results in social suffering, low cost solutions are inevitable. Income is one of the factors which correlate with the use of infertility service.

It is an established fact that the treatment of infertility is costly and is not within the reach of the average citizen in most countries. Most treatments are handled in the private sphere with full cost recovery feasibility. This has ensured that the service remains outside the reach of the average person in need of the service. With respect to Nigeria, research has shown a high level of infertility. Therefore this paper adopts the position that since it is agreed that infertility is pervasive in Nigeria, is a public health issue, exposes the sufferers to injustice and discrimination socially and is an infringement of reproductive rights when access is not available, then it beholds government to use law and policy to give succor to this large segment of the society. The constitutional and human rights regime existing now are sufficiently developed to form the justification for the financing of reproductive technology in Nigeria and other developing countries.

⁶⁷ A. S. Daar, and Z. Merali, "Infertility and Social Suffering: the Case of ART in Developing Countries" in E. Vayena *et al* (eds.), *Current Practices and Controversies in Assisted Reproduction: Report of a WHO Meeting*, 2002.