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

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Abstract: This article interrogates financial access to Assisted Reproductive Technologies and suggests the need for treatment to be subsidized. Research shows that six to eight million people experience infertility globally with greater concentration in developing countries like Nigeria. The work discusses the theoretical foundation of access to ART: it weighs the two opposing positions on the public funding and access to ART. It finds that socio-cultural consequences of infertility make it an issue of mental health with implications on reproductive rights: reproductive rights embrace some human rights already recognized such as the right to health, the right to freedom from discrimination, the right to privacy and the right not to be subjected to inhuman treatment. Therefore, State responsibility for reproductive rights under the international human rights regime sufficiently imposes a duty to improve financial access to ART through subsidization of costs. Furthermore, it argues that in Nigeria, the Constitutional framework, the National Policy on Health and the National Health Insurance Scheme *inter alia* justify government funding. The work concludes that reproductive rights commitment of governments demands the elimination/reduction of the constraint of financial access to ART.

Keywords: funding; infertility; Nigeria; reproductive autonomy; right

1. Introduction

Many people have achieved conception and parenthood through Assisted Reproductive Technologies (ART)[2]. However, one of the constraints of ART is financial access: this is the ability of people to finance the cost of their treatment. (Other issues from ART relate to moral, religious or social concerns). Financial constraints results in unequal access to treatment of infertility. This constitutes one of the injustices obtainable in the field of reproductive medicine. Governmental funding of treatment is an issue because funds are insufficient and scarce and have to be allocated between competing equally important claims.

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[2] It is also called Artificial Reproductive Technology.

There are two opposing views regarding the possibility of government funding in Africa: first, that ART procedure is not cost effective in African countries. The fear is that in a developing economy, the costs of ART would be a heavy burden on the public health sector. Government funding would limit resources for addressing other pressing health problems (Okonofua, 2003, p. 7). The contrary argument is that public funding of ART should be a public health effort to provide comprehensive care and allow low-income countries to match recent advances in knowledge in developed countries. This is based on the recognition of a right and correlative duty in the citizen and government respectively. Therefore the concern for African countries is the extent government should fund ART and the priority they should accord to its development as part of their public health policies (Okonofua, 2003, pp. 9-11). This work examines legal foundations of ART and the template for funding. Focusing on Nigeria, it examines whether a duty to fund ART may be imposed on government, and if so, delineates the parameters.

1.1. Infertility in Context

The Warnock Report[1] 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. In Africa, infertility presents even greater socio-cultural challenges (Okonofua & all, 1997, pp. 205- 220). It is not in doubt that infertility is prevalent in Nigeria. Nigerian gynecologists have reported that 60 to 70 per cent of consultations in tertiary institutions are infertility cases. (Megafu, pp. 144-148) Research further 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. (Adetoro & Ebonyi, pp. 23- 27) A lot of infertility problems in Nigeria are due to severe causes (for example bilateral tubal occlusion, severe oligopermia and premature ovarian failure) which cannot be solved by conventional treatment. (Such as surgical repair of blocked tubes, induction of ovulation and donor insemination). Therefore ART impacts on Nigeria and other nations in Africa are not in doubt.

Unfortunately, the treatment options are situated in the private sector with very few people able to afford it. The treatment of infertility is a multimillion pound industry

[1] Report of Committee of Enquiry into Human Fertilization and Embryology in the United Kingdom.

worldwide. What should be the platform for funding- private provision and personal funding as it is presently with its attendant exorbitant costs or public provision with resultant wider coverage? Okonofua argues that reports from private clinics indicate that high tech reproductive technologies are feasible in Nigeria and African countries if located in the private sector.[1] However, 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, some have concluded that funding ART in Africa is best left in the domain of the private sector rather than been incorporated into public health sector policy.

In Nigeria, this private funding excludes a large percentage from access to ART as most people cannot afford the costs. Infertility treatment is not available under medical scheme or insurance coverage in Nigeria. Generally, private sector health service is generally a reserve of the few elite upper class.. Economic and social status therefore impacts infertility. This poor /rich dichotomy is discriminatory.

2. Assisted Reproductive Technology

Reproductive Technology encompasses all current and anticipated uses of technology in human and animal reproduction. According to Akande, Assisted Reproductive Technology can be defined as all treatments that include medical and scientific manipulation of human gamates 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 stage (embryo transfer) to the woman's uterus, with the hope that implantation and

[1] Okonofua, F. New Reproductive Technologies, *supra* not**e** 2, p. 8.

pregnancy will occur; and intracytoplasmic sperm injection (ICSI). 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.

3. 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. Reproductive rights also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. 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 Programme of Action[1] explains that reproductive rights embrace certain human rights that are already recognized in international human right documents, and other United Nations consensus documents: right to health, right to freedom from discrimination, right to privacy and right not to be subjected to torture or ill-treatment. 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. It 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 processes. Reproductive health

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

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.

The question of funding of ART raises the issues of whether inability to have a child is a medical problem (infertility) or is an unfulfilled personal desire (involuntary childlessness). Is treatment of infertility a basic right which 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. 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. Two legal principles -the principles of reproductive liberty and reproductive autonomy come into the equation.

3.1. 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" (Robertson, 1994). Contextually, procreative liberty is infringed unless women qualify or have access to all available treatments for infertility. Robertson posits 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. The concept of 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 (Berlin, 1969). The concept of reproductive liberty is a tool

of restraining the State from interference in people's reproductive choices (For example, denying a woman right to reproduce because she will be a bad mother). 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.

3. 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.'[1] 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 their own needs.[2]

Beauchamp defined autonomy as freedom from external constraint and the presence of critical mental capacities such as understanding and voluntary decision making capacity (Beauchamp, 1999, pp. 1-32). 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.[3] 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

[1] Shalev, C. *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 05/16/13.
[2] *Ibid.*
[3] *Ibid*, p. 6.

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.

4. Financial Access to ART

The inability of those in need of ART to finance the costs of their treatment results in lack of access to 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. However, where treatment is essentially a private health concern, as it so happens in most African nations, treatment is very costly and this curtails the access to treatment of many equally situated people with the condition of infertility.

Different countries approach funding of infertility differently: the British 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: Despite China's promotion 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 (Douglas, 1991): at Federal level, the United States does not mandate the coverage of infertility treatment by insurance. At state levels, different approaches exist. Some have mandated private insurance companies to offer or cover infertility treatment. In fact some allow occupational health insurance to cover treatment for infertility. In others 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. 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 trado-religious solutions to infertility and consequential childlessness.[1] Consequently, worldwide, there is unequal access to treatment.

[1] Okonofua, F. O. *et al*. "The Social Meaning of Infertility" *supra* note 12.

4.1. The Challenges of Public Funding of ART in Africa/ Nigeria

According to Okonofua 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"[1]. They 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". Consequently, "efforts should be concentrated on the prevention of infertility while improving facilities and structures for the conventional treatment of infertility". [2] 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.

Granted 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 (Akande, 2008, pp. 12-14). Infertility services in developing countries span the spectrum from prevention to treatment. Akande 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 challenge to public funding of ART is overpopulation. Some argue that for a country grappling with overpopulation, there is no need to prioritize infertility 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

[1] *supra* note 3 at p. 10.
[2] *Ibid.*

their autonomy. As Akande rightly observed, the same argument might hold true to stop investing in any form of medical technology to save lives.

4.2. Foundations of Public Funding of ART

At international and domestic levels there are strong legal justifications of governmental duty to fund and subsidize the treatment of infertility thereby promoting access to treatment in the public sector. The existing human rights regime entrench state responsibility to observe reproductive rights: 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 can accommodate reproductive rights.

4.2.1 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 (Cook & all, 2003).

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.[1]

4.2.2. Freedom from Discrimination

Couples who are unable to conceive in the course of nature and are seeking recourse to ART may claim a reproductive health disability and the human right not to suffer 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)*[2] 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*[3] 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

[1] Cairo Programme of Action, principle 8.
[2] (1999) 177 DLR (4th).
[3] [2000] 3. FCR. 148.

them with access to services, which, like cosmetic medicine, fall into the category of luxury medicine.[1] In the Canadian case of *Cameron* v *Nova Scotia (Attorney – General)*[2] 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 conceived 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.[3]

There are suggestions that it is doubtful if article 12 of the European Convention (also available in other human rights instrument) can be interpreted to 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 (Liu, 1991, p. 30). According to Madden:

[T]he 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 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 (Madden, 1999), pp. 217-224).

4.2.3. 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

[1] See Cook *et al supra* note 21 p. 312.
[2] (1999) 177 DLR (4th) 611 (N.S.C.A.).
[3] *ibid* paragraph 172.

practical effect of such a distinction? According to Madden these questions remain to be answered squarely by judicial decisions.

Herring (Herring, 2006, p. 359) 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, 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* [1] 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*[2]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)*[3] 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 loose the chance of bearing a child. In *Re Eve*[4] the Supreme Court of Canada held that a mentally handicapped woman should not be sterilized for non-therapeutic

[1] [2003] FCRM 148.
[2] [200] 2 FCR 13
[3] [1976] Fam. 185, 193E.
[4] (1986) 31 D.L.R. (4th) 1, 5.

reasons stating that giving birth is a great privilege. In *Re F (Mental Patient Sterilisation)*[1] 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 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 aspect- the right to rear children. Madden[2] 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. In *Baby M case*, [3] 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

[1] [1990] 2 A.C.1.
[2] *supra* note 29 at p. 222.
[3] 109 NJ 396; 537 3d 1227 (1988).

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 who examined two possibilities: first, that if "reproduction" is conceptualized 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. He contends that this is the wrong approach. He proposes that procreation is not transmitting one's genes, but rather is having offspring to rear. 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. The right is meaningless without a rearing component. Therefore the right to reproduce protects the interests individuals have in founding families, in which case, in the absence of ability or intention to rear, there is no right to reproduce, or at best a limited right (Scott, p. Duke). Scott argues:

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 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.[1]

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.

[1] *ibid*.

4.2.4. 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 Rights 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 positively impacting life.

5. 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. Especially because generally the infrastructural facilities and the health care delivery system are poor and inefficient, even for conventional and more pressing illnesses and diseases. We posit 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 therefore addressed subsequently.

5.1. Constitutional Initiatives

Understanding 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.[1] 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.

5.2. 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.

5.3. The National Health Policy of Nigeria

In 1998, the Nigerian Government adopted the National Health Policy and Strategy to achieve health for all Nigerians.[2] We suggest that the Policy should be a starting

[1] Constitution of the Federal Republic of Nigeria, 1999, section 17 (3)(d) (g) (h).
[2]Centre for Reproductive Rights (1998). 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 10th May, 2013).

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 muscle may be brought to bear realizing the importance of child bearing to the average Nigerian. Child bearing is not merely a personal desire but a socio-cultural imperative.

5.4. Socio- Economic/ Cultural Rights Implications

Akande argues rightly in our view, that the idea that infertility is not a health care priority in Nigeria 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.

6. Conclusion

Infertility is pervasive globally but in Africa it has a socio-cultural connotation that is adverse to the attainment of reproductive health and rights: infertility affects mental health, an aspect of reproductive rights recognized in law. Consequently the social, emotional, physical and economic consequences that infertile couples- and in particular women- face justifies investing in treatment options in developing countries (Daar & Merali, 2002). 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 socio-cultural connotation, the need to access the reproductive technologies becomes imperative. Some cases of infertility can only be treated by ART. As infertility infringes reproductive rights, 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. This work argues that infertility is pervasive in Nigeria, is a public health issue, has adverse socio-cultural implications -exposes the sufferers to injustice and discrimination socially- and is an infringement of reproductive rights when access is not available. Government should use law and policy to give succor to this large segment of the society. The constitutional and human rights regime existing now are sufficient justification for this: therefore within the Constitution of Nigeria, the National Health Insurance Scheme, the National Health Policy and other imperatives there is a strong basis for public/government funding of ART in Nigeria. Similar arguments exist for other developing countries.

7. References

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