

# TUBERCULOSIS LEGAL ENVIRONMENT ASSESSMENT

**Nigeria**

Final Report July 2018

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This report is, in part, made possible by the support of the American People through the United States Agency for International Development (USAID).



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## OBJECTIVE, SCOPE AND APPROACH

### Objective

The objective of the Nigeria Tuberculosis (TB) Legal Environment Assessment (LEA) is to create an enabling legal environment for people with TB, TB survivors, their families and people at risk of the disease in Nigeria. This, in turn, will promote better individual health outcomes and TB program performance. To achieve this, the LEA examines the laws, policies and case law that constitute the legal and policy framework related to TB in Nigeria to identify those that support the fight against TB, those that hinder these efforts, and gaps in the framework where new law or policy is needed. The assessment leads to concrete recommendations, including reforms to existing law and policy, enactment of new law and policy, and capacity-building for key stakeholders and decision-makers.

### Scope

The scope of the LEA comprises assessment of the legal and policy framework related to TB at the international, regional and domestic levels. This framework includes international and regional treaties, the Constitution of Nigeria, judicial case law, and legislation, policies, regulations and guidelines at the federal and Lagos State levels on TB, health and related topics, including TB key populations. The LEA examines the framework as it exists on paper and its implementation and impact on people with TB, TB survivors, their families and people vulnerable to the disease. This impact is examined through an in-country assessment during which the TB LEA Task Team (members listed below) conducts in-depth interviews with a wide range of stakeholders, including people affected by TB and TB program coordinators, hosts stakeholder dialogues, and visits key sites, including DOTS centers. The in-country assessment is described in greater detail below, in the *TB Legal Environment Assessment Stages and Methodology* section

### Human Rights-Based Approach

The TB LEA is grounded in a human rights-based approach to TB prevention, testing, treatment and care. The approach provides the lens through which law and policy is assessed and the challenges faced by people affected by TB are understood. Implementation of a human rights-based, people-centered approach to TB prevention, testing, treatment and care in Nigeria is also an overarching goal of the TB LEA.

The WHO End TB Strategy establishes the “Protection and promotion of human rights, ethics and equity” as one of four key principles necessary for ending the global TB epidemic.<sup>1</sup> This principle, in turn, supports the three pillars of the strategy: (1) Integrated, people-centered TB care and prevention; (2) Bold policies and supportive systems; and (3) Intensified research and innovation. The WHO acknowledges that the Strategy’s success is entirely dependent on respect for the key principles and implementation of interventions outlined by the pillars at the country level.<sup>2</sup>

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<sup>1</sup> WHO, *The End TB Strategy: Global strategy and targets for tuberculosis prevention, care and control after 2015*, approved by the Sixty-seventh World Health Assembly May 2014, available at [http://www.who.int/tb/strategy/End\\_TB\\_Strategy.pdf?ua=1](http://www.who.int/tb/strategy/End_TB_Strategy.pdf?ua=1).

<sup>2</sup> WHO, *Brochure: The End TB Strategy*, p.7, WHO/HTM/TB/2015.19 (2015), available at [http://www.who.int/tb/End\\_TB\\_brochure.pdf?ua=1](http://www.who.int/tb/End_TB_brochure.pdf?ua=1).

A human rights-based approach to TB is grounded in international, regional and national law that establishes the rights to life, health, nondiscrimination, privacy, informed consent, information, liberty and security of person, participation, science, housing, food, water and sanitation, freedom of movement, and freedom from cruel, inhuman and degrading treatment. Only through the protection and promotion of these rights for all people affected by TB in Nigeria will fulfillment of the WHO End TB Strategy be possible in the country.

A human rights-based approach to TB supports and enhances traditional approaches to combatting the disease. It is founded on the recognition, protection and fulfillment of the rights of people with TB, TB survivors, their families and people vulnerable to the disease. The approach focuses on the socioeconomic drivers of the disease, including the stigmatization and discrimination of people affected by TB in, among other things, health care settings, employment, education and housing. It articulates the domestic, regional and international legal obligations of governments and non-state actors, among other things, to ensure good-quality testing and treatment for TB is available and accessible without discrimination. And it requires that people with TB, TB survivors and other affected individuals have access to effective remedies for human rights violations. The approach also aims to create an enabling legal environment for the research and development of new tools for preventing and treating TB, through application of the right to benefit from scientific progress.

At the core of a human rights-based approach to TB is the participatory, democratic principle “nothing about us without us.” This principle requires that people affected by TB in Nigeria be meaningfully engaged so they may participate in the formulation, implementation, monitoring and evaluation of all legislation, policies and regulations related to TB. Along with the closely related norm requiring a focus on vulnerable or marginalized groups, the principle demands that special attention be paid to the needs of TB key populations in all relevant decision-making and implementation processes. These include, among others, the rural and urban poor, prisoners, mobile populations, people living with HIV, miners, children, and people who use drugs.

Though much remains to be done in the fight against HIV, the human rights-based approach has contributed meaningfully to advances in the prevention and treatment of HIV around the world. The mobilization of affected communities in grassroots campaigns has spurred research and development of new medicines and lowered the prices of existing drugs. People living with HIV have claimed their rights to life, health, privacy, informed consent, information and participation, and won protections against discrimination, through litigation and advocacy based on international and constitutionally derived human rights. The human rights-based approach to TB is modeled on these successes and seeks to build upon and expand them in the fight against TB.

## Recommendations

The objective of the Nigeria TB Legal Environment Assessment recommendations is to support the fight against TB in Nigeria through creation of an enabling law and policy environment. To this end, the recommendations aim to:

- Respect, protect and fulfill the rights of people affected by TB, including to life, health, participation, privacy, nondiscrimination, liberty, information, and safe and healthy working conditions;
- Implement a people-centered approach to TB prevention, testing, treatment and care; and
- Strengthen the capacity of people with TB, TB survivors, lawyers and other key stakeholders and decision-makers through legislation, policy and regulation at the federal and state levels, with financial and technical support from donor and development partners.

The recommendations use the term “TB,” but they apply to both drug-susceptible TB and all forms of drug-resistant TB, unless explicitly stated otherwise.

## To Legislators and Policymakers

1. **Convene a Dialogue on TB in the National Assembly** in partnership with the Ministry of Health, Ministry of Justice and the National Human Rights Commission, during which legislators in the Senate and House of Representatives may receive input from key stakeholders in order to deliberate and consider legislative action on TB. Legislation action the National Assembly should consider includes: amendments to existing laws and consideration of TB-specific legislation, adopting a human rights-based, people-centered approach to TB prevention, testing, treatment and care, in accordance with the *National Health Policy, 2016* call “to revise, update and enact new health legislation as relevant.”<sup>3</sup>
  - A. The Dialogue on TB should involve the participation and meaningful contribution of all key stakeholders. These include: people affected by TB, including people with TB, TB survivors and their family members; representatives of TB key populations, including the rural and urban poor, prisoners, mobile populations, people living with HIV and miners; civil society and NGO groups working in TB; physicians and health care workers from the public and private sectors; policymakers from the federal and state governments; religious, tribal and other traditional leaders; medical and public health researchers working in TB; public and private sector employers and businesses; academics with expertise in human rights and constitutional law related to health; drug and medical equipment manufacturers; and regional and international TB experts.
  - B. The Dialogue on TB may be organized, coordinated and led by the HIV/AIDS, TB and Malaria Control Committee of the National Assembly, in coordination with the Ministry of Health, including the NTBLCP and state TB programs, the Ministry of Justice and the National Human Rights Commission.

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<sup>3</sup> Federal Ministry of Health, *National Health Policy 2016: Promoting the Health of Nigerians to Accelerate Socio-economic Development*, § 5.3 (Sept. 2016) [hereinafter *National Health Policy*], available at <https://wawang.org/wp-content/uploads/2017/03/National-Health-Policy-Final-version-2016-1.pdf>.

2. **Mandate and facilitate through legislation and policy the participation of people affected by TB, including people with TB and TB survivors—engaging TB community-based organizations and networks of affected people—in the formulation, implementation, monitoring and evaluation of all federal and state legislation, policies and regulations related to TB**, including the NTBLCP’s *National Strategic Plan for Tuberculosis Control*, the *Workers’ Manual*, the *National Guidelines for TB Infection Control*, and the *Guidelines for Clinical Management of TB and HIV/AIDS Related Conditions in Nigeria*, in accordance with Objective 7 of the *National Strategic Plan for Tuberculosis Control*, which aims to “[s]trengthen the collaboration with and capacity of community-based organizations and networks to support NTBLCP objectives and activities.”<sup>4</sup>
  - A. Establish explicit requirements in legislation and policy that people affected by TB, including people with TB and TB survivors, be members of decision-making bodies in the NTBLCP and state TB programs so they may contribute to the formulation, implementation, monitoring and evaluation of all federal and state TB policies, regulations and guidelines, including TB-related budget development and monitoring.
  - B. Establish explicit requirements in legislation and policy that people affected by TB, including people with TB and TB survivors, be meaningfully consulted during the drafting, implementation, monitoring and evaluation of all federal and state legislation, including TB-related budget development and monitoring, through engagement with the HIV/AIDS, TB and Malaria Control Committee of the National Assembly, relevant committees in state Houses of Assembly, and other existing or newly established legislative bodies or mechanisms.
  
3. **Prohibit all forms of discrimination against people affected by TB—both intentional and indirect, in the public and private sectors—in legislation and policy**, including people with TB infection, people with TB disease, TB survivors and members of TB key populations, in response to the *National Strategic Plan for Tuberculosis Control*’s acknowledgement that “[f]ear of stigma and discrimination” are Priority Contributing Factors to low TB case detection and low treatment success rates,<sup>5</sup> and in line with the protections provided to people living with HIV in the *HIV and AIDS (Anti-Discrimination) Act, 2014*.
  - A. Legislation and policy should prohibit intentional and indirect discrimination against people affected by TB in public and private employment, health care, education, housing, social services, immigration and all other settings, both for discrimination based on health status—i.e., TB infection and TB disease—and for membership in certain groups, such as the poor, prisoners, migrants, women, people who use drugs and people living with HIV.
  - B. Legislation and policy prohibiting discrimination against people affected by TB should establish mechanisms, or identify and authorize the use of existing mechanisms, by which people who have experienced or are threatened with discrimination may access the courts and other administrative bodies to file claims and access remedies, including restitution, financial compensation, reinstatement and protection against future discrimination.

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<sup>4</sup> NTBLCP, Department of Public Health and Federal Ministry of Health, *The National Strategic Plan for Tuberculosis Control: Towards Universal Access to Prevention, Diagnosis and Treatment, 2015-2020*, p. 9 (2014) [hereinafter National Strategic TB Plan], available at <https://www.medbox.org/ng-policies-hiv-tb/nigeria-the-national-strategic-plan-for-tuberculosis-control-2015-2020/preview?q=>.

<sup>5</sup> *Id.* at p 63.



- C. Legislation and policy prohibiting discrimination against people affected by TB should require courts to provide petitioners with the option to file a claim and participate in the trial anonymously, using a court-appointed pseudonym, if they choose.
- D. Legislation and policy prohibiting discrimination against people affected by TB should provide for and require accommodations for people with TB so they may obtain and retain employment, health care, education, housing, social services and immigration privileges, even while they are contagious, allowing them to take appropriate infection control measures, such as receiving home-based care without jeopardizing their employment, health care, education, housing or social services status.

**4. Develop and implement a human rights-based, people-centered policy for isolation and involuntary isolation of people with TB through federal legislation** to replace the *Quarantine Act, 1926* and to preempt all relevant state laws and policies as regards TB—in accordance with the *National Health Policy, 2016*'s call to revise and update the *Quarantine Act, 1926* and “enact new health legislation as relevant”<sup>6</sup>—to amend the *Prisons Act, 1972*, and to be promulgated with detailed guidelines for implementation in all relevant NTBLCP policies, including the *National Strategic Plan for Tuberculosis Control*, the *Workers’ Manual*, the *National Guidelines for TB Infection Control*, and the *Guidelines for Clinical Management of TB and HIV/AIDS Related Conditions in Nigeria*.

- A. The policy should be explicitly based on respect for the human rights to liberty and security of person, freedom of movement, freedom from arbitrary detention, and freedom of association as enshrined in the *Constitution of Nigeria*, the *African Charter on Human and People’s Rights* and the *International Covenant on Civil and Political Rights*.
- B. The policy should be based on chapter 15 of the WHO *Ethics Guidance for the Implementation of the End TB Strategy* on isolation and involuntary isolation, which establishes the specific circumstances, conditions and justifications for isolation and involuntary isolation:
  - i. Isolation should only be employed when a person with TB is contagious and there is a clear public health benefit to the community.
  - ii. Isolation should always be voluntary, except in exceptional and narrowly defined circumstances, and it should use the least restrictive means possible; e.g., if basic respiratory isolation measures are sufficient, then physical isolation is not necessary.
  - iii. Involuntary isolation should never be a routine component of TB prevention, testing, treatment and care. Involuntary isolation should be limited to exceptional circumstances when an individual:
    - a. Is known to be contagious, refuses effective treatment, and all reasonable measures to ensure adherence have been attempted and proven unsuccessful; OR
    - b. Is known to be contagious, has agreed to ambulatory treatment, but lacks the capacity to institute infection control in the home, and refuses inpatient care; OR
    - c. Is highly likely to be contagious (based on laboratory evidence) but refuses to undergo assessment of his/her infectious status, while every

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<sup>6</sup> *National Health Policy*, *supra* note 3, at § 5.3.

effort is made to work with the person to establish a treatment plan that meets his or her needs.

- iv. In addition, all of the following conditions must be met in order to justify involuntary isolation:
  - a. Isolation is necessary to prevent the spread of TB; AND
  - b. There is evidence that isolation is likely to be effective in the particular case; AND
  - c. The person with TB refuses to voluntarily remain in isolation or institute adequate infection control measures despite having been properly counseled about the benefits of treatment, the risks of refusing treatment, the meaning of being isolated, and the reasons for isolation; AND
  - d. The person with TB's refusal puts others at risk; AND
  - e. Community-based care has been considered and offered before involuntary isolation is contemplated; AND
  - f. All less restrictive measures have been attempted prior to forcing isolation; AND
  - g. All other rights and freedoms (such as basic civil liberties) besides that of movement are protected; AND
  - h. Due process rights are protected and the person with TB has the right to appeal the decision to involuntarily isolate him or her before an administrative, judicial or quasi-judicial body; AND
  - i. The person with TB has, at least, his or her basic needs met, including all necessary clinical and social support; AND
  - j. The isolation occurs in an appropriate medical setting, never in a prison cell or in a general prison population; AND
  - k. The isolation time is the minimum duration necessary to achieve its goals.
- C. Sections 25 and 26 of the *Nigeria Public Health (Quarantine, Isolation and Emergency Health Matters Procedures) Bill, 2014* (that failed to pass in the Senate) may serve as partial models for the new isolation and involuntary isolation legislation and policy.<sup>7</sup> These sections would have required:
  - i. Use of “the least restrictive means necessary to prevent the spread of a contagious ... disease to others ... [including] confinement to private homes”;<sup>8</sup>
  - ii. Provision of “adequate food, clothing, shelter, means of communication with those ... outside these settings, medication, and competent medical care” to isolated individuals;<sup>9</sup>
  - iii. The “immediate” release of isolated individuals when they pose “no substantial risk” of transmitting the disease;<sup>10</sup> and

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<sup>7</sup> Nigeria Public Health Establishment Bill, A Bill for an Act to Establish the Nigeria Public Health (Quarantine, Isolation and Emergency Health Matters Procedure) Act. To Provide for and Regulate the Imposition of Quarantine, Isolation and to Make Other Provisions for Preventing the Introduction into and Spread in Nigeria, and Regulate Steps for the Containment in Nigeria, and the Transmission from Nigeria, of Dangerous Infectious and Communicable Diseases, Organisms and Agents, SB. 210 (2013) [hereinafter Public Health Bill], available at <http://www.nassnig.org/document/download/652>.

<sup>8</sup> *Id.* at § 25.

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

- iv. The right to a hearing, to apply for an “order to show cause” for continued isolation to be heard within 48 hours, to remedies for “breach of conditions,” to state-appointed counsel at state expense, and to consolidate claims.<sup>11</sup>

- 5. Establish and fulfill the right of all people to access free, good-quality testing and treatment for TB, including second-line drugs, new TB drugs and diagnostics, preventive therapy and community-based treatment, in legislation and policy** at federal and state levels, in accordance with the *National Health Act, 2014*, which aims to “protect, promote and fulfil the rights of the people of Nigeria to have access to health care services,”<sup>12</sup> the *National Health Policy, 2016*, which establishes the “right to the highest attainable level of health as a fundamental right of every Nigerian, including access to ... affordable health care of highest quality,”<sup>13</sup> the *National Strategic Plan for Tuberculosis Control*, which calls for “universal access to high-quality, patient-centred TB [services]” and establishes the “right of all Nigerians to enjoy the highest level of health attainable,”<sup>14</sup> and in line with the *National Guidelines for HIV Prevention, Treatment and Care, 2016*, establishing that the right of people living with HIV to access “quality ... HIV prevention, treatment, care and support is a basic human right.”<sup>15</sup>
- A. Legislation and policy establishing the right to access free, good-quality TB testing and treatment should establish a TB Services Trust Fund to ensure adequate financing is available to procure and distribute: (1) TB drugs, including second-line and new drugs, free of charge to all people who need them; and (2) new TB diagnostic technologies, including GeneXpert MTB/RIF assay machines, modules and cartridges, and/or other advanced diagnostics, to all public TB clinics in the country.
  - B. Legislation and policy establishing the right to access free, good-quality TB testing and treatment should establish mechanisms by which people who lack access to free, good-quality TB testing and treatment may access the courts and other administrative bodies to file claims and access remedies, which include provision of TB diagnostics and treatment, and financial restitution or compensation for resultant harms. Petitioners should be able to file a claim anonymously, using a court-appointed pseudonym, if they choose.
  - C. If new TB drugs and diagnostics are under patent protection and thus too costly for the NTBLCP and state TB programs to make available to all people who need them, legislators and policymakers should consider utilization of section 13 of the *Patents and Designs Act, 1971*, which grants the Minister for Trade and Tourism authority to order compulsory licenses for “certain patented products and processes ... declared by the order to be of vital importance ... for public health.”<sup>16</sup>

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<sup>11</sup> *Id.* at § 26.

<sup>12</sup> National Health Act, An Act to Provide a Framework for the Regulation, Development and Management of a National Health System and Set Standards for Rendering Health Services in the Federation, and Other Matters Connected Therewith, Law No. 8, Cap. A139 (Oct. 27, 2014), available at [http://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/1189\\_\\_2014\\_Official-Gazette-of-the-National-Health-Act-\\_FGN\\_1272.pdf](http://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/1189__2014_Official-Gazette-of-the-National-Health-Act-_FGN_1272.pdf).

<sup>13</sup> *National Health Policy*, *supra* note 3, at § 3.4.1.

<sup>14</sup> *National Strategic TB Plan*, *supra* note 4, at pp. 6, 73.

<sup>15</sup> NASCP, Federal Ministry of Health, *National Guidelines for HIV Prevention, Treatment and Care*, (2016) [hereinafter National HIV Guidelines], available at <http://apps.who.int/medicinedocs/documents/s23252en/s23252en.pdf>.

<sup>16</sup> Patents and Designs Act, An Act to Make Comprehensive Provisions for the registration and Proprietorship of Patents and Designs in Nigeria and Other Matter Ancillary thereto, Cap. 344, L.F.N. 1990 (Dec. 1, 1971) [hereinafter Patents Act].

**6. Establish and protect the rights to privacy and confidentiality of people with TB and TB survivors in legislation and all relevant policies and regulations** at the federal and state level, including the NTBLCP's *National Strategic Plan for Tuberculosis Control*, the *Workers' Manual*, the *National Guidelines for TB Infection Control*, and the *Guidelines for Clinical Management of TB and HIV/AIDS Related Conditions in Nigeria*, in order to combat stigma and discrimination, promote health-seeking behavior and encourage treatment adherence, in accordance with *the National Health Act, 2014*, which establishes that “[a]ll information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential,”<sup>17</sup> and in line with the protections for privacy and confidentiality provided to people living with HIV by the *HIV and AIDS (Anti-Discrimination) Act, 2014*.

A. Legislation and policy protecting the rights to privacy and confidentiality of people with TB and TB survivors should be based on the principle that an individual has an absolute right to keep his health status private subject only to exception: (1) when he is contagious; (2) only for the duration of the period of contagion; and (3) only with respect to people at a real risk of exposure to infection.

B. Legislation and policy protecting the rights to privacy and confidentiality of people with TB and TB survivors should apply to all public and private employment, health care, education, housing, social services and all other settings, and should protect against intrusion of privacy and confidentiality through the collection and sharing of health data by physicians, health care workers, researchers, public health officials and policymakers, while allowing for narrow exceptions necessary to protect and promote individual and public health and for sharing based on an individual's informed consent.

C. Legislation and policy protecting the rights to privacy and confidentiality of people with TB and TB survivors should establish mechanisms by which people who have experienced unwarranted intrusions on their privacy and confidentiality may access the courts and other administrative bodies to file claims and access remedies, including restitution, financial compensation, and reinstatement related to harms, along with protection against future intrusions. Petitioners should be able to file a claim anonymously, using a court-appointed pseudonym, if they choose.

**7. Establish and fulfill the right to information for all people affected by TB, including people with TB, TB survivors and their family members, in legislation and policy**, including the NTBLCP's *National Strategic Plan for Tuberculosis Control*, the *Workers' Manual*, the *National Guidelines for TB Infection Control*, and the *Guidelines for Clinical Management of TB and HIV/AIDS Related Conditions in Nigeria*, in accordance with the *National Health Act, 2014*, which establishes that “[e]very health care provider shall give a user relevant information pertaining to his state of health and necessary treatment relating thereto including: ... the range of diagnostic procedures and treatment options generally available ...; the benefits, risks, costs and consequences ...; ... and the implications, risks, [and] obligations of [refusing health services],”<sup>18</sup> the *National Strategic Plan for Tuberculosis Control*, which calls for interventions to “[c]reate an informed public who know TB facts ... and what their rights and responsibilities are,”<sup>19</sup> and in line with the right to counseling provided to people living with HIV by the *National Guidelines for HIV Prevention, Treatment and Care, 2016*.

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<sup>17</sup> National Health Act, *supra* note 12, at § 26(1).

<sup>18</sup> National Health Act, *supra* note 12, at § 23(1).

<sup>19</sup> *National Strategic TB Plan*, *supra* note 4, at p. 7.

- A. The right to TB information should include a right to receive the following information from physicians, health care workers and relevant government authorities: information to promote treatment literacy, including the names, purpose and side effects of all prescribed TB drugs; information about the risks and benefits of all forms of treatment; the risks of treatment nonadherence; information about the nature of TB infection and TB disease; information about the nature and duration of the TB contagion; and information about preventive and infection control measures.
  - B. In order to facilitate realization of the right to TB information and to successfully impart the information described in 8(A), the NTBLCP and Ministry of Information, in coordination with people affected by TB, civil society and religious, tribal and other traditional leaders, should develop and implement a Strategic TB Communication Plan, targeting high TB burden areas and TB key populations across the country through use of social media, mobile phone applications, television and radio, and other forms of media communication.
- 8. Prohibit all forms of forced, involuntary or compulsory TB treatment and require informed consent for all treatment for TB in federal legislation and policy** to preempt all relevant state laws and policies, in line with the WHO *Ethics Guidance for the Implementation of the End TB Strategy*, in accordance with the *National Health Act, 2014*, which establishes a “user’s right to refuse health services,”<sup>20</sup> and in line with the protections for informed consent and provision of counseling provided to people living with HIV by the *HIV and AIDS (Anti-Discrimination) Act, 2014*.
- A. Legislation and policy requiring informed consent should describe the necessary information to be provided through counseling prior to seeking consent for TB treatment, including the risks and benefits of treatment, the risks of treatment nonadherence, cure rates of particular forms of treatment and side effects of all prescribed drugs.
- 9. Establish and protect the right to safe and healthy working conditions in legislation, policies and regulations at the federal and state level for people at high risk of contracting TB at the workplace, particularly health care workers and miners**, including through amendment of the *Labour Act, 1971* and the *Nigerian Minerals and Mining Act, 2007*.
- A. Legislation and policy protecting the right to safe and health working conditions should provide detailed instruction on the precautions necessary to prevent exposure to and transmission of TB among workers in particular industries, particularly health care workers and miners, such as appropriate preventive and infection control measures, including routine screening, provision of respirator masks, and information and trainings on appropriate preventive and infection control practices.
  - B. Legislation and policy protecting the right to safe and health working conditions should establish mechanisms by which people who have acquired TB at the workplace, particularly health care workers and miners, may access the courts and other administrative bodies to file claims and access remedies, including restitution, financial compensation, and reinstatement related to harms, as well as protection against future harms, including protection from termination and dismissal and provision of appropriate

<sup>20</sup> National Health Act, *supra* note 12, at § 23(1).

employment accommodations. Petitioners should be able to file a claim anonymously, using a court-appointed pseudonym, if they choose.

- 10. Prohibit over-the-counter sale of TB drugs without prescription in retail pharmacies and restrict prescription and dispensing rights of TB drugs** to accredited providers and facilities, including qualified private providers, in legislation and policy at the federal level, in combination with meaningful incentives for private provider participation and penalties for violations.
  - A. TB drugs included under the prohibition and restriction should include the principal medicines used in first- and second-line treatment of TB and MDR/RR-TB, as indicated by the NTBCLP and in line with WHO treatment guidelines. These should include isoniazid, rifampicin, pyrazinamide, ethambutol, ethionamide and cycloserine.
  - B. Simple, clear and easy-to-follow electronic accreditation and registration procedures should be developed, implemented and monitored in a coordinated manner by the NTBCLP, the National Agency for Food and Drug Administration and Control, the Federal Ministry of Health and the relevant state Ministry of Health, in cooperation with the Nigerian Medical Association and the Pharmaceutical Society of Nigeria, and through existing Public-Private Mix programs and other collaborations between the NTBCLP and private providers and facilities.
  - C. Meaningful incentive mechanisms should be developed and implemented to incentivize accreditation and registration of qualified private providers and facilities.
  - D. Enforcement capacity of relevant agencies and authorities should be strengthened through provision of adequate financial and human resources to ensure implementation of the prohibition of over-the-counter sale and restrictions on prescription and dispensing rights of the TB drugs listed above in 11(A).
  
- 11. Conduct a nation-wide survey of people affected by TB to identify the barriers they face in accessing and adhering to testing and treatment services for TB, including second-line drugs and preventive therapy**, in order to better understand and address delays in diagnosis, barriers to accessing treatment, and the reasons people interrupt or stop treatment.
  - A. The survey should be designed, conducted and evaluated by the NTBCLP, in close coordination with people affected by TB, including people with TB, TB survivors, TB community-based organizations and networks of affected people, as well as civil society and NGO groups working in TB.
  - B. The survey should be conducted on a voluntary, anonymous basis, requiring the informed consent of all survey participants, with strong privacy protections for participants' identities and all personally identifiable information.
  - C. The survey findings should be disseminated publicly, with full transparency— but without inclusion of participants' identities or any personally identifiable information— and the findings should be evaluated and integrated into the NTBCLP's *National Strategic Plan for Tuberculosis Control*, the *Workers' Manual*, the *National Guidelines for TB Infection Control*, and the *Guidelines for Clinical Management of TB and HIV/AIDS Related Conditions in Nigeria*.
  
- 12. Remove and replace all stigmatizing and discriminatory terms in all relevant federal and state legislation and policy implicating TB**, including the NTBCLP's *National Strategic Plan for Tuberculosis Control*, *Workers' Manual*, *National Guidelines for TB Infection Control*, and the *Guidelines for Clinical Management of TB and HIV/AIDS Related Conditions in Nigeria*, in response to the *National*

*Strategic Plan for Tuberculosis Control's* acknowledgement that “fear of stigma and discrimination” is a “major barrier to case-finding and [treatment adherence].”<sup>21</sup>

A. In line with the Stop TB Partnership’s language guide—*United to End TB: Every Word Counts, Suggested Language and Usage for Tuberculosis Communications*—remove and add the following replacement terms:

- i. Remove “TB suspect” and replace with “person to be evaluated for TB”;
- ii. Remove “defaulter” and replace with “person lost to follow-up”;
- iii. Remove “TB patient” and “TB case” and replace with “person with TB”; and
- iv. Remove “TB control” and replace with “TB prevention and care.”

**13. Repeal and rewrite all sections of the Lagos State *Public Health Law, 2015* on infectious diseases—sections 20 – 39, section 43 (as applied to sections 20 – 39) and section 69—in accordance with Recommendations 2 to 11** to promote a human-rights based, people-centered approach to prevention, testing, treatment and care for TB, HIV, AIDS and other infectious diseases.

A. Repeal of sections 20 – 39, section 43 (as applied to sections 20 – 39) and section 69 of the Lagos State *Public Health Law* should have the effect of rescinding Part 1 of the Lagos State *Public Health Regulations* on Infectious or Communicable Diseases, which were promulgated pursuant to section 43 of the *Public Health Law*. Part 1 of the Lagos State *Public Health Regulations* should be rewritten and re-promulgated in line with the revised *Public Health Law* in accordance with Recommendations 3 – 12.

**14. Provide dedicated funding and strengthen the NTBLCP’s and state TB programs’ capacity for technical training and sensitization of physicians and health care workers to eliminate stigmatizing and degrading treatment of people with TB in health care facilities** and all program activities, in response to the *National Strategic Plan for Tuberculosis Control's* acknowledgement that “people with TB have reported poor treatment by health care providers” and that the “behavior and attitude[s]” of health care workers are barriers to TB services.<sup>22</sup>

A. Training and sensitization should be designed and implemented in partnership with key stakeholders, including people affected by TB, civil society, the National Human Rights Commission, and national, regional and international technical experts, and should include training on how to implement a human rights-based, people-centered approach to TB prevention, testing, treatment and care of people with TB at the program and health facility levels, with specific instruction on appropriate infection control measures and guidelines for dignified, respectful treatment of people with TB and their families.

**15. Incentivize private health sector involvement in NTBLCP and state TB programs through legislation and policy** that expands upon and develops new TB Public-Private Mix programs with increased funding for private provider compensation, improved notification and data sharing networks, and other incentives, including participation of chemists and pharmacies, in accordance with the *National Health Act, 2014*, which directs the Minister of Health to “prescribe mechanisms to ensure a coordinated relationship between private and public health

<sup>21</sup> *National Strategic TB Plan, supra* note 4, at p. 64.

<sup>22</sup> *National Strategic TB Plan, supra* note 4, at pp. 73, 199.

establishments in the delivery of health services,”<sup>23</sup> and in response to the *National Strategic Plan for Tuberculosis Control*’s declaration that “[p]rivate sector engagement is extremely important . . . , as an estimated 60% of all health care is delivered by the private sector.”<sup>24</sup>

- A. Legislation and policy expanding and developing TB Public-Private Mix programs should allocate funding for increased compensation to private health care providers who provide free, good-quality TB testing and treatment services to ensure all incurred costs are compensated at a reasonable rate, including staff time, all TB testing equipment and materials, all drugs and other TB treatment incidentals.
- B. Legislation and policy expanding and developing TB Public-Private Mix programs should ensure effective, easy-to-use electronic notification and data sharing networks are established, with appropriate safeguards for privacy and confidentiality, to promote notification of TB disease and sharing of health data among private health care providers, the NTBLCP and state TB programs.
  - i. This should include a review of the operation and interaction of the Integrated Disease Surveillance and Response system, the Health Management Information System and the e-TB Manager system with the purpose of integrating and coordinating the three systems to promote increased notification of TB cases and private health care provider participation in the Public-Private Mix program.
- C. The following measures should also be considered for inclusion in legislation and policy expanding and developing TB Public-Private Mix programs:
  - i. Provision of tax breaks for participating private health care providers to incentivize participation in the programs;
  - ii. Permitting people to utilize insurance coverage provided through the National Health Insurance Scheme or state insurance schemes to obtain free, good-quality TB testing and treatment services in the private sector; and
  - iii. Provision of technical capacity-building support to participating private health care providers, both to ensure provision of appropriate, good-quality TB testing and treatment services and to incentivize participation in the programs.

**16. Provide dedicated funding and strengthen the NTBLCP’s and state TB programs’ capacity to improve and expand the TB Treatment Supporter program**, including development and implementation of effective training procedures for treatment supporters in line with a human rights-based, people-centered approach to TB, formulation and implementation of clear, efficient program guidelines, and promulgation of the guidelines and training procedures in relevant state TB program and NTBLCP policies, such as the *National Strategic Plan for Tuberculosis Control*, *Workers’ Manual*, *National Guidelines for TB Infection Control*, and the *Guidelines for Clinical Management of TB and HIV/AIDS Related Conditions in Nigeria*.

**17. Create a federal Inter-Ministerial TB Task Force to review all existing policies, regulations and guidelines related to TB across all relevant federal ministries to revise or promulgate new policies, regulations or guidelines in accordance with Recommendations 2 to 15** to promote a human rights-based, people-centered approach to TB prevention, testing, treatment and care, and to consider harmonization, where appropriate, of HIV and TB policies, regulations and guidelines.

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<sup>23</sup> National Health Act, *supra* note 12, at § 18(1).

<sup>24</sup> *National Strategic TB Plan*, *supra* note 4, at p. 41.



- A. The Inter-Ministerial TB Task Force should include high-ranking officials from the federal Ministries of Health, Justice, Finance, Labour and Productivity, Interior (including from the Nigerian Prisons Service and Nigerian Immigration Service), Mines and Steel Development, Education, Women’s Affairs, Information, Education and Youth Development and the National Human Rights Commission.
- B. The Inter-Ministerial TB Task Force should establish mechanisms to ensure the participation and meaningful contributions of all key stakeholders in its work. These include: people affected by TB, including people with TB, TB survivors and their family members; representatives of TB key populations, including the rural and urban poor, prisoners, mobile populations, people living with HIV and miners; civil society and NGO groups working in TB; physicians and health care workers from the public and private sectors; religious, tribal and other traditional leaders; medical and public health researchers working in TB; public and private sector employers and businesses; academics with expertise in human rights, constitutional and health law and policy; drug and medical equipment manufacturers; and regional and international TB experts.

## To Donors and Development Partners

**18. Support the mobilization, development and operation of new and existing community-based organizations and networks of people affected by TB**, including people with TB, TB survivors and their families, in accordance with objective 7 of the *National Strategic Plan for Tuberculosis Control*, which aims to “[s]trengthen the collaboration with and capacity of community-based organizations and networks to support NTBLC objectives and activities.”<sup>25</sup>

- A. Provide funding and technical support for the development of new community-based organizations and networks of people with TB, TB survivors and affected communities and for the continued development and operation of existing groups and networks.

**19. Strengthen the capacity of people affected by TB, including people with TB, TB survivors and their families, to use the courts, to advocate on their own behalf in front of decision-makers, and to participate meaningfully in legislative and policymaking processes**, including in the National Assembly and state Houses of Assembly and federal and state TB programs, to remove barriers to TB prevention, testing, treatment and care services, to prevent and remedy human rights violations, and to participate in law and policy review and formulation.

- A. Provide funding and technical support, utilizing existing networks of people with TB, TB survivors and people living with HIV, to train and educate affected individuals and communities on the scientific, medical and public health aspects of TB and MDR-TB, the human rights-based approach to TB prevention, testing, treatment and care, and the international, regional and domestic Nigeria legal and policy frameworks related to TB.

**20. Strengthen the capacity of lawyers to use the courts to protect the rights of and obtain effective remedies for people affected by TB**, including people with TB, TB survivors and their families, through litigation based on the *Constitution of Nigeria*, the *African Charter on Human and People’s Rights*, and relevant federal and state legislation outlined in the *Nigerian Domestic Law and Policy*, *Legislation* section of this report, in accordance with the *National Health Policy, 2016*,

<sup>25</sup> *National Strategic TB Plan*, *supra* note 4, at p. 9.

which calls on “Stakeholders in the health sector [to] advocate for a review of the Constitution ... to make health an enforceable right in Nigeria.”<sup>26</sup>

- A. Provide funding and technical support, utilizing existing legal networks and civil society organizations, to provide trainings for lawyers to strengthen their capacity to bring litigation in courts representing people with TB pursuant to the *Constitution of Nigeria*, the *African Charter on Human and People’s Rights* and relevant federal and state legislation, applying and expanding on case law involving HIV and the rights to life, health and nondiscrimination, and employing the *Fundamental Rights (Enforcement Procedure) Rules, 2009*.

**21. Strengthen the capacity of lawyers to use international and regional human rights bodies**, including the UN Committee on the Elimination of All Forms of Discrimination Against Women and the African Court and Commission on Human and People’s Rights, to protect the rights of and obtain effective remedies for people with TB and TB survivors.

- A. Provide funding and technical support, utilizing existing legal networks, to provide trainings for lawyers to strengthen their capacity to file petitions on behalf of people with TB and TB survivors in international and regional bodies pursuant, among others, to the *Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women* and the *African Charter on Human and People’s Rights*.

**22. Engage, sensitize and strengthen the capacity of the federal and state judiciary to adjudicate legal disputes involving TB** with an enhanced understanding of the scientific, medical and public health aspects of TB, and a human rights-based, people-centered approach to TB prevention, testing, treatment and care.

- A. Provide funding and technical support for sensitization and capacity-building activities for members of the federal and state judiciary in line with workshops conducted by Stop TB Partnership and partners in New Delhi, India and Nairobi, Kenya, convening diverse national, regional and international experts and stakeholders and featuring the participation of people with TB and TB survivors.<sup>27</sup>

**23. Engage, sensitize and strengthen the capacity of members of the National Assembly and state Houses of Assembly, as well as their legislative aides and staff, to legislate issues related to TB** with an enhanced understanding of the scientific, medical and public health aspects of TB, and a human rights-based, people-centered approach to TB prevention, testing, treatment and care.

- A. Provide funding and technical support for sensitization and capacity-building activities for members of the National Assembly and their legislative aides and staff, in partnership with the HIV/AIDS, TB and Malaria Control Committee of the National Assembly, including through engagement with people affected by TB and national, regional and international TB experts, and horizontal engagement with legislators in other countries.
- B. Provide funding and technical support for sensitization and capacity-building activities for members and committees of state Houses of Assembly and their legislative aides and

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<sup>26</sup> *National Health Policy*, *supra* note 3, at § 5.3.

<sup>27</sup> The Stop TB Partnership, University of Chicago Law School, University of Chicago Department of Medicine, Kenya Judicial Training Institute and Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) convened judicial workshops entitled TB, Human Rights and the Law in New Delhi, India in 2015 and Nairobi, Kenya in 2016. Information about the workshops is available upon request from the LEA Task Team.

staff, including through engagement with people affected by TB and national, regional and international TB experts.


- 24. Engage, sensitize and strengthen the capacity of policymakers, bureaucrats and implementers in the NTBLCP and federal Ministry of Health, as well as state TB programs and Ministries of Health**, to develop and implement policies and regulations with an enhanced understanding of the scientific, medical and public health aspects of TB, and a human rights-based, people-centered approach to TB prevention, testing, treatment and care.

  - A. Provide funding and technical support for sensitization and capacity-building activities for policymakers, bureaucrats and implementers in the NTBLCP and federal Ministry of Health, including through engagement with people affected by TB and national, regional and international TB experts.
  - B. Provide funding and technical support for sensitization and capacity-building activities for policymakers, bureaucrats and implementers in state TB programs and Ministries of Health, including through engagement with people affected by TB and national, regional and international TB experts.
  
- 25. Engage, sensitize and strengthen the capacity of policymakers, bureaucrats and implementers in key ministries, departments and programs at the federal and state levels**, including those overseeing prisons, labor, education, housing and immigration, to develop and implement policies and regulations with an enhanced understanding of the scientific, medical and public health aspects of TB, and a human rights-based, people-centered approach to TB prevention, testing, treatment and care.

  - A. Provide funding and technical support for sensitization and capacity-building activities for policymakers, bureaucrats and implementers in key ministries, departments and programs at the federal and state levels, including those overseeing prisons, labor, education, housing and immigration, including through engagement with people affected by TB and national, regional and international TB experts.
    - i. At the federal level, this includes the Ministries of Justice, Finance, Labour and Productivity, Interior (Nigerian Prisons Service), Mines and Steel Development, Education, Women’s Affairs, Information, Education and Youth Development and the National Human Rights Commission.
  
- 26. Engage and sensitize religious, tribal and other traditional leaders and institutions** to better understand the scientific, medical and public health aspects of TB, and a human rights-based, people-centered approach to TB prevention, testing, treatment and care.

  - A. Provide funding and technical support for sensitization activities for religious, tribal and other traditional leaders and institutions, including through engagement with people affected by TB and national, regional and international TB experts.
  
- 27. Engage, sensitize, raise awareness and strengthen the capacity of national and local media to report on TB** with an enhanced understanding of the scientific, medical and public health aspects of TB, and a human rights-based, people-centered approach to TB prevention, testing, treatment and care.

  - A. Provide funding and technical support for awareness-raising, sensitization and capacity-building activities for members of the national and local media, including through engagement with people affected by TB and national, regional and international TB



experts, in order to promote increased reporting on and more accurate coverage of issues related to TB in English, Hausa, Igbo, Yoruba, Urhobo, Ibibio, Edo, Fulfulde and Kanuri and other local languages.

## LEA TASK TEAM AND TECHNICAL EXPERT GROUP

The Nigeria TB Legal Environment Assessment was conducted and the Final Report was written by the LEA Task Team, with support from the Technical Expert Group. The LEA Task Team is comprised of four members:

**Brian Citro**, *Assistant Clinical Professor of Law, Northwestern Pritzker School of Law (USA)*

**Mayowa Joel**, *Executive Director, Communication for Development Centre (Nigeria)*

**Ryan Maher**, *JD, University of Chicago Law School (USA)*

**Shelbi Smith**, *JD, University of Chicago Law School (USA)*

The Technical Expert Group is comprised of five primary members:

**Colleen Daniels**, *Human Rights, Gender & TB/HIV Advisor, Stop TB Partnership (Switzerland)*

**Dr. Temitayo Odusote**, *Senior TB/HIV Advisor, USAID/Nigeria (Nigeria)*

**Jumoke Adebari**, *Chief Program Officer, National TB and Leprosy Control Program, Nigeria (Nigeria)*

**Barr. Rommy Mom**, *President, Lawyers Alert (Nigeria)*

**Barr. Kema Ufelle**, *Partner, Capitalfield Attorneys (Nigeria)*

## STAGES AND METHODOLOGY

The TB LEA was conducted in five main stages: (1) planning; (2) desk research; (3) in-country assessment; (4) evaluation and report writing; and (5) feedback and finalization. The stages and their methodologies are detailed below.

### Planning

The planning stage comprised a series of preparatory activities. These included recruiting the LEA Task Team and Technical Expert Group, identifying and contacting key stakeholders, and developing the in-country assessment schedule.

### Desk Research

The LEA Task Team conducted desk research and wrote a series of memos to identify and assess the legal and policy framework, epidemiological profile and programmatic aspects of the TB epidemic in Nigeria. The team conducted legal research to identify and assess Nigeria's domestic legal and policy framework related to TB through focused examination of constitutional law, case law, legislation and administrative policies and regulations. The team also examined international and regional human rights law to understand Nigeria's human rights obligations related to TB. The results of this research are discussed below in the Nigeria Legal and Policy Framework section.

The LEA Task Team also conducted desk research to ascertain and understand Nigeria's epidemiological TB profile, the key challenges faced in the prevention, testing, treatment and care of people with TB, and the programmatic aspects of the fight against TB in the country. In conducting

this research, the team utilized reports and resources from the Government of Nigeria, the World Health Organization (WHO) and civil society, as well as peer reviewed articles in medical and social science journals.

The Technical Expert Group reviewed the LEA Task Team's research and memos and provided detailed feedback. The team incorporated the Technical Expert Group's feedback into its research and memos and refined its legal and policy assessment accordingly.

The LEA Task Team then drafted a set of questionnaires for in-depth stakeholder interviews based on its identification and assessment of the Nigeria's TB legal and policy framework and epidemiological profile. The team developed questionnaires for the following types of stakeholders: physicians and health workers, people with TB and TB survivors, judges, lawyers, policymakers, legislators, and members of civil society and community-based organizations. The Technical Expert Group reviewed and provided input on the questionnaires; the LEA Task Team revised and refined the questions based on this input. The questionnaires are available in the In-Depth Stakeholder Interview Questionnaires in the Appendix.

## **In-Country Assessment**

After completing the desk research stage, the LEA Task Team, with support from the Technical Expert Group, conducted an in-country assessment using qualitative research methodologies in the form the site visits, in-depth interviews and stakeholder dialogues in Abuja and Lagos, Nigeria. The geographic scope of the assessment encompassed Lagos State and the Federal Capital Territory (FCT). Qualitative research comprises non-statistical, non-representative and exploratory methods, and commonly measures perceptions, beliefs, opinions, and behaviors of populations using in-depth interviews, group dialogues, mapping or observation. During the in-country assessment, the team engaged a variety of stakeholders, including people with TB, TB survivors, members of the National Assembly and state Houses of Assembly, federal and state government ministry officials, public and private physicians and health workers, medical researchers, members of civil society and community-based organizations, international organizations and development partners, and others. A full list of stakeholders is available in the In-country Assessment Schedule and Abuja and Lagos Stakeholder Dialogue Agendas and Lists of Participants in the Appendix.

## **In-Depth Stakeholder Interviews**

The LEA Task Team, with support from members of the Technical Expert Group, conducted a series of in-depth stakeholder interviews based on the questionnaires developed during the desk research stage. The interviews provided the team an opportunity to obtain information and perspectives directly from key stakeholders about the design, implementation and impact of the TB legal and policy framework and the TB epidemiological and programmatic profiles in the country. The team also aimed to develop ongoing relationships and promote ownership of the LEA process through these engagements. With permission from the stakeholders, the content of each interview was documented in a series of notes taken during the interview that were later refined for accuracy by the team. The in-depth interview notes were reviewed and considered when developing the key findings and recommendations in this report.

## Site Visits

The LEA Task Team and members of the Technical Expert Group conducted site visits in Abuja and Lagos, Nigeria to document first-hand the impact and implementation of the legal and policy framework and to engage key stakeholders, including people with TB, ministry officials, health workers, medical researchers and others. The team visited and observed the operations of research facilities, public and private health clinics, and government ministry offices. The team also conducted in-depth interviews with stakeholders during each site visit. The sites visited are included in the In-Country Assessment Schedule in the Appendix.

## Stakeholder Dialogues—Abuja and Lagos

The LEA Task Team, with support from the Technical Expert Group, organized and conducted Stakeholder Dialogues in Abuja and Lagos, Nigeria to cover Lagos State and the FCT. The dialogues comprised day-long meetings with presentations, panel discussions and robust group deliberation on the design, implementation and impact of the TB legal and policy framework, the key challenges faced by people with TB, and the key drivers of the disease in Nigeria. The dialogues facilitated constructive exchanges, and sharing of solutions and good practices between key stakeholders, including TB survivors, federal and state ministry policymakers, lawyers, members of civil society, and physicians and health workers. The dialogues also aimed promote ownership of the LEA process among diverse stakeholders to encourage their participation in the finalization and implementation of the LEA findings and recommendations. The Abuja and Lagos Stakeholder Dialogues Agendas and Lists of Participants are available in the Appendix.

## Evaluation and Report Writing

Following the in-country assessment, the LEA Task Team, with support from the Technical Working Group, evaluated the findings and drafted the LEA report. The evaluation process included a review of the initial desk research in light of information and perspectives obtained from the in-depth stakeholder interviews, site visits and Stakeholder Dialogues during the in-country assessment. The team then developed a series of recommendations based on its evaluation of the desk research and in-country findings.

## Feedback and Finalization

Upon completion of the draft LEA report, the LEA Task Team and Technical Expert Group shared the report with a group of core stakeholders to receive and integrate feedback. The report was then presented to a broader group of stakeholders during a national Validation Workshop in Lagos, Nigeria on 13 August 2018. The workshop provided an opportunity for all parties to engage in critical dialogue on the findings and recommendations; seek consensus on, finalize and prioritize the recommendations; and develop a mechanism for monitoring progress made in implementing the recommendations. The LEA report was revised in accordance with consensus reached during the Validation Workshop and a final version was submitted to the Government of Nigeria in September 2018.

# TB IN NIGERIA

## Epidemiological Profile and Program Highlights

Nigeria has the seventh largest TB burden in the world and the second largest in Africa.<sup>28</sup> It is one of 14 countries on all three of the WHO's TB high-burden country lists—the TB, multidrug-resistant TB (MDR-TB) and TB/HIV high-burden country lists.<sup>29</sup> The WHO estimated the total TB incidence in Nigeria in 2016 was 407,000 (219 per 100,000 people) and the combined HIV-negative and HIV-positive TB mortality was 154,000 (83 per 100,000 people).<sup>30</sup> Nigeria's national TB budget in 2017 was approximately 336 million USD, with 9% from domestic funds, 27% from international sources, and 64% unfunded.<sup>31</sup> As of 2015, 5,389 health facilities in the country provided TB treatment services (Directly Observed Treatment Short-course (DOTS) centers) and, as of 2014, 1,602 health facilities provided acid-fast bacilli (AFB) sputum smear microscopy testing services.<sup>32</sup> As of Quarter 3 2017, there were 443 GeneXpert MTB/RIF assay modules in Nigeria.<sup>33</sup>

The WHO estimated incidence of MDR-TB and rifampicin-resistant TB (RR-TB) in 2016 was 20,000 (11 per 100,000 people), with 25% of previously treated and 4.3% of new TB cases having MDR/RR-TB.<sup>34</sup> However, a 2017 systematic review and meta-analysis of data from published studies of rates of drug-resistant TB in different cohorts across various settings in Nigeria found higher levels of drug resistance.<sup>35</sup> The review found that 32% of new and 53% of previously treated cases had at least some form of drug resistance and 6% of new and 32% of previously treated cases had MDR-TB.<sup>36</sup> Interrupted treatment, nonstandard treatment in the private sector, and over-the-counter sale of TB medicines, among other factors, contribute to the development of drug resistance.

Nigeria achieved an 84% treatment success rate for registered new and relapse TB cases in 2015,<sup>37</sup> falling short of the WHO's 2015 global target of 90%.<sup>38</sup> The country achieved a 74% treatment success rate for MDR/RR-TB cases started on second-line treatment in 2014,<sup>39</sup> exceeding the WHO's 2015 global target of  $\geq 75\%$  treatment success among confirmed MDR-TB cases.<sup>40</sup> And, according to the National Tuberculosis and Leprosy Control Programme (NTBLCP), TB case

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<sup>28</sup> WHO, *Global Tuberculosis Report 2017*, p. 29, WHO/HTM/TB/2017.23 (2017) [hereinafter Global TB Report], available at [http://www.who.int/tb/publications/global\\_report/en/](http://www.who.int/tb/publications/global_report/en/).

<sup>29</sup> *Id.* at p. 17.

<sup>30</sup> *Id.* at p. 180.

<sup>31</sup> *Id.* at p. 180.

<sup>32</sup> *National Strategic TB Plan*, *supra* note 4.

<sup>33</sup> This includes all GeneXperts procured under concessional prices; it excludes modules purchased for use by for-profit entities. Information provided by Cepheid Inc. (the GeneXpert MTB/RIF module manufacturer) in an email to the Stop TB Partnership on November 15, 2017, on record with the LEA Task Team.

<sup>34</sup> *Global TB Report*, *supra* note 28, at p. 180.

<sup>35</sup> Cajetan Onyedum et al., *Prevalence of drug-resistant tuberculosis in Nigeria: A systematic review and meta-analysis*, 12 PLOS ONE 7 (2017), available at <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0180996>.

<sup>36</sup> *Id.* at p. 1.

<sup>37</sup> *Global TB Report*, *supra* note 28, at p. 180.

<sup>38</sup> WHO, *The Global Plan to Stop TB 2011–2015: Transforming the fight towards elimination of tuberculosis*, p. 12, WHO/HTM/STB/2010.2 (2010) [hereinafter Global TB Plan 2011–2015], available at [http://apps.who.int/iris/bitstream/10665/44437/1/9789241500340\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44437/1/9789241500340_eng.pdf).

<sup>39</sup> *Global TB Report*, *supra* note 28, at p. 180.

<sup>40</sup> *Global TB Plan 2011–2015*, *supra* note 38, at p. 40.



notifications to the program increased from 31,164 in 2002 to 100,401 in 2013.<sup>41</sup> However, TB treatment coverage (notified cases/estimated incidence) in Nigeria during 2016 was only 24%, meaning approximately 309,320 TB cases were not notified.<sup>42</sup> Ten countries accounted for 76% of the total estimated global gap between estimated incidence and reported cases in 2016, with Nigeria alone accounting for 8% of the global gap.<sup>43</sup> Nigeria was also one of five countries in 2015 that accounted for more than 60% of the gap between enrollments in MDR-TB treatment and the estimated number of new MDR/RR-TB cases.<sup>44</sup> In July 2017, the Ministry of Health introduced a new shorter treatment regimen for MDR-TB that will be available in the South West Zone TB reference laboratory at the University College Hospital in Ibadan, Oyo State.<sup>45</sup>

In 2012, Nigeria conducted its first national TB prevalence survey “aimed at determining the prevalence of bacteriologically-confirmed (sputum smear-positive and/or culture-positive) TB among the general population aged fifteen years and above.”<sup>46</sup> The 2012 survey found that prevalence rates of bacteriologically-positive TB among men were higher (751 per 100,000 men) than in females (359 per 100,000 women).<sup>47</sup> The survey also found that 75% of smear-positive cases detected had symptoms meeting national screening criteria and 88% had radiological findings consistent with active TB disease, but only 0.2% of all survey participants reported being on TB treatment at the time of the survey.<sup>48</sup> In 2013, among all Nigerian states, Lagos State had the second highest magnitude challenge in notifying TB cases—the state accounted for 5.9% of the national gap in TB case notification that year; the FCT accounted for 0.8% of the gap.<sup>49</sup>

To address the gap between notified cases and TB incidence, on February 2, 2017, the Minister of Health for Nigeria declared 2017 the year of “Accelerating TB Case Finding in Nigeria.”<sup>50</sup> The declaration aims to mobilize political commitment and resources from all levels of government and from strategic partners to implement TB case finding interventions.<sup>51</sup> On the same day, the Minister of Health also announced the launch of a plan to implement the “Accelerating TB Case Finding” initiative and the “End TB Strategy Operational Framework for Nigeria.”<sup>52</sup>

The most recent Epidemiologic Analysis of Tuberculosis in Nigeria published in May 2017 by the Federal Ministry of Health reports that, in 2016, 475,437 presumptive TB cases were tested (32,583 for drug resistance) of which 466,662 or 98.2% were bacteriologically examined, using either AFB

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<sup>41</sup> *National Strategic TB Plan*, *supra* note 4, at p. 1.

<sup>42</sup> *Global TB Report*, *supra* note 28, at p. 180.

<sup>43</sup> *Global TB Report*, *supra* note 28, at p. 1.

<sup>44</sup> WHO, *Global Tuberculosis Report 2016*, p. 54, WHO/HTM/TB/2016.13 (2016), available at <http://apps.who.int/medicinedocs/en/d/Js23098en/>.

<sup>45</sup> Federal Ministry of Health, *Nigeria Adopts WHO Guidelines On Tuberculosis*, at <http://www.health.gov.ng/index.php/78-featured/395-nigeria-adopts-who-guidelines-on-tuberculosis>; see also Sola Ogundipe, *FG adopts WHO guidelines for multidrug resistant TB*, *Vanguard* (July 6, 2017), at <https://www.vanguardngr.com/2017/07/fg-adopts-guidelines-multidrug-resistant-tb/> two pilot locations.

<sup>46</sup> NITBLCP and Federal Republic of Nigeria, *Report: First National TB Prevalence Survey 2012, Nigeria*, p. 4 (2012), available at [www.who.int/tb/publications/NigeriaReport\\_WEB\\_NEW.pdf](http://www.who.int/tb/publications/NigeriaReport_WEB_NEW.pdf).

<sup>47</sup> *Id.* at p. 55.

<sup>48</sup> *Id.* at pp. 12-13.

<sup>49</sup> *National Strategic TB Plan*, *supra* note 4, at p. 200.

<sup>50</sup> Stop TB Partnership, *Walking the talk: Nigeria Declares 2017 the Year of “Accelerating TB Case Finding”*, News and Events (2017), at [http://www.stoptb.org/news/stories/2017/ns17\\_007.asp](http://www.stoptb.org/news/stories/2017/ns17_007.asp).

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

smear microscopy or GeneXpert, the balance presumed to have been evaluated clinically.<sup>53</sup> The Analysis reports a ratio of 1 male to 6 females for each new smear-positive TB case in 2016.<sup>54</sup> It reports that the TB case notification rate for new and relapse TB cases of all forms was 52.6 per 100,000 people.<sup>55</sup> The Analysis also states that the total number of drug resistant-TB cases reported in 2016 was 1,251.<sup>56</sup> If this is accurate, as compared to the WHO's estimated incidence of MDR-TB and RR-TB in 2016—20,000 cases—it means only approximately 6.3% of drug resistant-TB cases were notified in 2016, leaving more than 18,700 cases unregistered.

## Lagos State

Lagos State accounts for 8.4% of Nigeria's TB burden and is responsible for about 11% of the registered TB cases in the country.<sup>57</sup> (The LEA Task Team has not been able to obtain Lagos State TB and MDR/RR-TB incidence and mortality data.)

The primary focus of the Lagos State TB Control Programme is to ensure people have access to TB services in all areas of the State. To this end, all 20 local government areas (LGAs) had at least one DOTS center by 2006.<sup>58</sup> Currently, all 57 LGA/local community development areas (LCDAs) are covered.<sup>59</sup> As of April 2017, there were 470 DOTS centers in the State—289 public and 181 private centers, constituting 89.2% of the 324 public health facilities and 5.9% of the 3,088 private health facilities, respectively.<sup>60</sup> The DOTS centers per person ratio in the State is 1 per 23,557 people, slightly less than the 1 per 25,000 people target set by the NTBLCP.<sup>61</sup> As of April 2017, Lagos State had 102 AFB microscopy service centers and 25 GeneXpert MTB/RIF assay diagnostic machines.<sup>62</sup> Each of the 20 LGAs in the State has at least one GeneXpert machine; Lagos mainland has 3 and Oshodi-Isolo and Eti-Osa LGAs have 2 each.<sup>63</sup>

The number of registered TB cases in Lagos State rose from 4,307 in 2003 to 8,976 in 2014.<sup>64</sup> In 2016, the State TB Control Program reported 8,757 TB cases, as compared to 4,117 notified by Disease Surveillance Officers, indicating a need for data reconciliation between these institutions.<sup>65</sup> The TB case cure rate in Lagos State increased from 64% in 2003 to 76% in 2014.<sup>66</sup> However, a 2012 study found very low rates of adherence to the national TB testing and treatment guidelines by both public and private DOTS providers in Lagos State: only 19% of people at public facilities, 25% at private not-for-profit facilities, and none at private for-profit facilities were treated in full

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<sup>53</sup> USAID, Challenge TB, KNCV and The Global Fund, *Epidemiologic Analysis of Tuberculosis in Nigeria*, submitted to the Federal Ministry of Health, NTBLCP, p. 25 (May 9, 2017).

<sup>54</sup> *Id.* at p. 35.

<sup>55</sup> *Id.* at p. 31.

<sup>56</sup> *Id.* at p. 39.

<sup>57</sup> Lagos State Government, Ministry of Health, *Tuberculosis Control Program*, at <https://health.lagosstate.gov.ng/tuberculosis-control-program/>.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *National Tuberculosis Epidemiological Review and Analysis of Lagos State*, p. 13 (Apr. 2017) [hereinafter Lagos TB Epidemiological Review].

<sup>61</sup> *Id.*

<sup>62</sup> *Id.* at p. 15.

<sup>63</sup> *Id.* at p. 17.

<sup>64</sup> Lagos State Government, *supra* note 57.

<sup>65</sup> *Lagos TB Epidemiological Review*, *supra* note 60, at p. 20.

<sup>66</sup> Lagos State Government, *supra* note 57.



adherence with national guidelines.<sup>67</sup> In 2016, the TB treatment success rate declined from 86% Quarter 1 to 80% in Quarter 4, below the 90% target for the state.<sup>68</sup>

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<sup>67</sup> Olusola Adejumo et al., *Are Tuberculosis Patients Managed According to the National Guidelines in Lagos State Nigeria?*, 7 Int'l. J. of Clinical Med. 16-24 (2016), available at [https://www.researchgate.net/publication/291391729\\_Are\\_Tuberculosis\\_Patients\\_Managed\\_According\\_to\\_the\\_National\\_Guidelines\\_in\\_Lagos\\_State\\_Nigeria](https://www.researchgate.net/publication/291391729_Are_Tuberculosis_Patients_Managed_According_to_the_National_Guidelines_in_Lagos_State_Nigeria).

<sup>68</sup> *Lagos TB Epidemiological Review*, *supra* note 60, at p. 25.

## IN-COUNTRY ASSESSMENT KEY FINDINGS

Notes from stakeholder interviews, dialogues and site visits are on record with the LEA Task Team and may be made available upon request, contingent upon stakeholders' consent.

### Programmatic Challenges

The LEA Task Team learned about several key challenges for the performance of TB programs at the national and state levels during stakeholder interviews, dialogues and site visits.

#### Barriers to TB Testing and Treatment Services

Lack of physical access to DOTS centers is a key barrier to TB testing and treatment in Nigeria. TB survivors, civil society members and TB physicians explained that public DOTS centers are often located too far from communities where people with TB live, especially at the Local Government Area (LGA) level. As a result, people with TB sometimes interrupt their treatment, rather than bear the cost and inconvenience of both transportation to the clinic and time away from their employment. This was confirmed by a Matron and Head Physician at a DOTS center in Abuja. The Matron cited distance from her clinic and the cost of transportation as key barriers faced by members of the community to accessing TB services and treatment adherence. She explained that her staff makes home visits and phone calls to reach people lost to follow-up. However, she noted that these activities are done on a voluntary basis—they are not required or provided for by policy—and her staff often bear the cost of the visits due to a lack of resources for these kind of follow-up activities. As a result, the Matron indicated that this kind of follow-up work is not sustainable or scalable at other DOTS centers without an increase in dedicated financial and human resources. In accordance with the Matron's description of the challenges faced by her community in Abuja, a TB survivor living with HIV in Lagos shared that she had considered stopping TB treatment many times because of the inconvenience of traveling to two separate clinics to obtain HIV and TB treatment, one of which was a great distance from her home.

TB survivors also explained that the lack of privacy involved in obtaining TB services is a barrier to effective testing and treatment, and a challenge for adherence. They noted that DOTS centers often have signs marking them as TB clinics, thus “outing” all people entering and leaving as people with TB or people being tested for TB. They asserted that this lack of privacy discourages some people from utilizing the clinics. Dr. Lovett Lawson, Chairman of Zankli Medical Centre in Abuja and Professor of Infectious Disease at Bingham University—an internationally renowned Nigerian TB physician and researcher—shared information revealing similar concerns. Dr. Lawson explained that, in his experience, wealthy people often do not seek TB care in the public sector because DOTS centers are often overcrowded and lack privacy. In addition, he stated that people seeking care at public clinics often experience long wait times for services and delays in obtaining test results. He added that people with TB are separated and isolated from other patients in public clinics and some have concerns about confidentiality of medical records. Dr. Lawson, however, was careful to note that in most cases health care workers in public DOTS centers are competent professionals, often working under difficult circumstances. The Program Coordinator of the Lagos State TB Control Program, Dr. Hussein Abdulrazak, also cited the perception of low quality treatment in the public

sector, including long waits and other hassles experienced prior to receiving treatment, such as stigmatizing behavior by health care workers, as key barriers to utilization of TB services.

Dr. Abdulrazak also highlighted the problem of TB drug stock-outs in Lagos State as a barrier to treatment. He noted that although TB drugs are generally available in public clinics, supplies fluctuate and the state program has experienced long delays—up to two years—in receiving drugs procured at the national level. He stated that second-line drugs used for MDR-TB treatment are more difficult to keep in supply, explaining that the two new drugs used to treat MDR-TB—bedaquiline and delamanid—are not available at all because they have not been registered for use in Nigeria.

TB survivors in Abuja and Lagos reported they paid out-of-pocket for some TB services. Most paid for testing services at the point of their initial diagnosis, including chest x-rays in public and private clinics and hospitals. They also stated that incidental costs, including for transportation to and from clinics, presented barriers to obtaining TB services and a challenge for treatment adherence.

### **TB Treatment Interruptions**

TB survivors, civil society members and TB physicians cited the lack of consistent and good-quality counseling for people diagnosed with TB as a key contributing factor to TB treatment interruptions. They explained that the lack of counseling means people with TB are not provided information about the benefits and risks of treatment, including those associated with stopping or interrupting treatment. A private TB physician noted that private providers are often too busy to properly counsel people with TB. He also stated that private providers lack resources to reach out to people lost to follow-up or to provide financial support for transportation to and from clinics and other incidental costs that often lead to treatment interruptions. A TB survivor in Abuja who acquired TB as a child explained that she stopped her treatment due to a lack of information about the risks of doing so. As a result, her TB became drug resistant. She noted that, while she and her family were well-informed about HIV and malaria, they lacked even basic information about TB. She further explained that she had undergone ineffective and harmful self-medication and traditional treatments prior to initiating and completing treatment for MDR-TB.

Lagos State TB Control Program Coordinator, Dr. Hussein Abdulrazak, explained that treatment interruptions in Lagos State often occur because members of mobile populations leave the state during their treatment to return home or to seek employment elsewhere. He explained that, in order to follow-up with these individuals, DOTS centers must expend scarce resources or the person with TB must take the initiative himself to inform the clinic he is leaving and to provide information about his destination. In many cases, neither occurs and the person's treatment is interrupted and he is lost to follow-up.

In order to improve TB treatment adherence, Dr. Abdulrazak called for a strengthening of the TB Treatment Supporter program. He explained that people with TB in Lagos State are provided the option of coming to the DOTS center daily to receive treatment or participating in the Treatment Supporter program. If the person chooses the program, an individual close in relationship and physical proximity to him is recruited to be trained as a Treatment Supporter. The Supporter is tasked, among other things, with ensuring the person takes his daily medication and communicating

by SMS or phone with the DOTS center. However, Dr. Abdulrazak cautioned that in order for the program to work effectively Treatment Supporters must be properly trained, which requires increased funding and capacity for DOTS centers in the state and across the country.

### **Over-the-Counter Sale of TB Drugs**

Lagos State TB Control Program Coordinator, Dr. Abdulrazak, and National Program Officer for TB at WHO Nigeria, Dr. Ayodele Awe, both indicated that TB drugs are available at private chemists and pharmacies throughout the country. They expressed concern about the lack of quality assurance for drugs obtained from private chemists and they asserted that over-the-counter sale of TB drugs contributes to inappropriate treatment and drug resistance. They therefore called for a prohibition on over-the-counter sale of drugs used to treat TB and restrictions on prescriptions and dispensing rights to ensure TB drugs are used appropriately.

### **Delays in TB Diagnosis**

During interviews and stakeholder dialogues, TB survivors attested that they experienced lengthy delays—more than one year in some cases—from the onset of symptoms to their diagnosis for TB. They cited several reasons for the delays. A crucial contributing factor was a lack of awareness among themselves, among chemists and among health care workers about TB symptoms and when to seek testing, like when a cough lasts for two or more weeks. Even when TB survivors had sought advice from a professional, their first point of contact was often a local chemist who prescribed cough medicines, but did not refer them to a DOTS center.

An interview with a person with MDR-TB in Abuja revealed that he experienced a six-month delay from the time he started coughing to his diagnosis. He first presented at a local chemist, was directed to a hospital when symptoms persisted, then finally, months later, attended a public clinic for TB diagnosis. A TB survivor in Lagos described a two-month delay in diagnosis, during which he experienced clear TB symptoms, but was provided cough syrups by a local chemist and treatment for typhoid and malaria at a private clinic. He explained that he felt better for a few days after treatment for typhoid, but quickly began losing weight and experiencing night sweats again. Finally, two weeks later, he went to a private hospital and paid for a chest x-ray that confirmed he had TB. He started treatment at the hospital and continued at a public DOTS center.

### **Public-Private Mix Program Challenges**

Several stakeholders discussed challenges to the success of Public-Private Mix (PPM) programs, meant to involve the private health sector in delivery of TB services. Dr. Lovett Lawson, Chairman of Zankli Medical Centre in Abuja, explained that his Centre treats people with TB irrespective of their financial status, but he offered several reasons why his Centre does not officially participate in the PPM program. He first mentioned concerns related to TB stigma, discussed in greater detail below, stating that some private providers fear participation in the PPM program will drive away their other patients. He next raised the issue of financial incentives. He explained that if his Centre was to participate in the program, it would only be provided drugs free of cost; all other costs associated with TB testing and treatment, including staff and other materials costs, would be borne by the Centre. He asserted that this model creates a financial disincentive, discouraging private

health care providers from joining the program. In addition, he complained about the poor quality and difficult-to-use notification and data sharing systems, by which private providers notify and share data with the NTBLCP. Dr. Lawson added that, as far as he is aware, many private providers lack even basic information about how to use the notification systems, as well as where to access such information. To address these challenges, Dr. Lawson called for greater resource allocation to the PPM program to improve notification systems, increase financial incentives for participation and expand training and capacity-building of private providers. He further stated that private providers in areas with a high incidence of TB should be prioritized for training and capacity-building.

Lagos State TB Control Program Coordinator, Dr. Abdulrazak and Lagos Mainland Hospital MDR-TB Treatment Centre Medical Director, Dr. Abimbola Bowale, expressed similar concerns about the PPM program. Like Dr. Lawson, they noted that some private providers believe stigma surrounding TB will drive away their other patients. They also emphasized that private providers fear losing money as a result of treating people with TB in the program. However, both men asserted that as more private clinics join the PPM program, competition among them, along with reputational benefits, may spur higher levels of participation in the private sector. To these points, they suggested that PPM program facilitators should highlight two benefits likely to accrue to private clinics that participate in the program. First, people with TB who receive good-quality treatment at a private clinic may refer others in their community to the provider and, second, they and their family may return to the clinic in the future to obtain other health services. However, Dr. Bowale stressed that private providers should not be permitted to charge user fees for TB services in order to incentivize their participation in the PPM program.

Staff of the United States Agency for International Development (USAID) Nigeria office of HIV/AIDS and TB shared concerns about the underutilization of existing notification systems by private TB service providers. They attributed the problem, in part, to the fragmentation and lack of coordination among parallel notification systems. USAID staff mentioned three separate systems used to notify TB cases: the Integrated Disease Surveillance and Response system; the Health Management Information System; and the e-TB Manager system. They suggested a review of the systems and determination of how best to integrate and coordinate them would promote increased notification of TB cases by private providers, strengthening the PPM program and improving case detection rates in the country.

## **Stigmatization and Discrimination of People with TB**

Stakeholder interviews and dialogues revealed that stigmatization and discrimination of people with TB is pervasive in Nigeria, with devastating impacts on people with TB, their families and the performance of TB programs.

### **Stigma and Discrimination in the Community**

People with TB experience severe stigma and discrimination in their communities and families. The Matron and Head Physician at a DOTS center in Abuja shared two stories highlighting this phenomenon. In one case, a person with TB living with HIV receiving treatment at her clinic was abandoned by his wife and two sons because of his illness. He subsequently stopped coming to the clinic for TB treatment. When clinic staff visited the man's home to check on him, they found him

alone and in a severely deteriorated state of health. They immediately took him to the hospital, but he died shortly thereafter. In another instance, the healthy children of a person with MDR-TB were not permitted to attend their local school, forcing the whole family to relocate.

During the Lagos Stakeholder Dialogue, TB survivors and community members shared stories of the impact of TB stigma and discrimination in their communities and families. In one case, a stakeholder's uncle—a prominent Nigerian neurosurgeon—died from TB without having informed his family or colleagues, due to self-stigma and shame associated with the disease and his failure to fully understand the gravity of his condition. In another case, a TB survivor and member of a community-based TB and HIV outreach group in Lagos, shared the story of a 23 year-old woman who had recently died from TB/HIV coinfection. She had been locked in a secret room in her family home, prohibited from leaving the room and denied appropriate treatment. She had delivered a child during this time and became emaciated to the point where she was unable to leave her bed. The woman was denied TB and HIV treatment, but she had undergone expensive and ineffective treatment by a traditional healer. The healer charged the woman's family the equivalent of more than 400 USD and was to collect approximately the same amount if the treatment was successful. The TB survivor asserted that the woman had died a painful and unnecessary death due to her family's deep fear of stigma associated with TB and HIV.

As noted above, Dr. Lawson of the Zankli Medical Centre in Abuja cited stigma surrounding people with TB as a key reason his Centre does not participate in the PPM program. He stated that some of his patients might be uncomfortable and decide to go elsewhere for care if his clinic provided free TB testing and treatment services on a large scale. Lagos State TB Control Program Coordinator, Dr. Abdulrazak, described an experience that conveyed the same fear of TB stigma. He shared the story of a public hospital in Lagos State that had refused to incorporate a DOTS center in its facility. Dr. Abdulrazak attributed the hospital's refusal to the stigma and a lack of awareness about TB.

### **Stigmatizing and Discriminatory Treatment in TB Health Facilities**

TB survivors and their family members consistently reported having been treated in a stigmatizing, disrespectful and discriminatory manner by health care workers, in both public and private clinics. Other stakeholders, while not having directly experienced such treatment, also spoke to the poor treatment people with TB receive from health care workers. A TB survivor in Abuja who acquired MDR-TB as a child reported having been “kept at arms-length” by a health worker at a public clinic when she presented with a cough. The experience was so unpleasant that she did not return to that clinic for follow-up. A TB survivor living with HIV in Lagos described stigmatizing treatment she experienced from TB health care workers, and noted she did not experience the same kind of treatment in HIV clinics. She reported that health care workers in the DOTS center she attended would not get close to her; they refused to be in the same room and would only communicate through a glass window. Another TB survivor in Lagos experienced what she described as “serious stigma” and a “lack of encouragement” from health care workers. She stated that health care workers would not even hand her TB drugs to her, refusing to be in the same room as people with TB. A third TB survivor in Lagos experienced similar treatment by health care workers at the private hospital he initially attended for testing and treatment. He said that health care workers there refused to be in the same room as people with TB and provided no support during treatment. Instead, he



described experiencing and witnessing intensely stigmatizing behavior that included health care workers yelling “Don’t infect me!” at people with TB.

Lagos State TB Control Program Coordinator, Dr. Abdulrazak, cited stigmatizing treatment of people with TB by health care workers as a leading barrier to TB care in Nigeria. He explained that health care workers are often undertrained and not fully informed about TB. As a result, they are fearful of people with TB, as well as people to be evaluated for TB. Lagos Mainland Hospital Medical Director, Dr. Bowale, also asserted that stigmatizing and discriminatory treatment of people with TB by health care workers is pervasive and a key challenge for TB programs in the country. Like Dr. Abdulrazak, he stated that better training of health care workers is necessary to eliminate stigmatizing treatment in health facilities.

### **Employment Discrimination against People with TB**

TB survivors who participated in stakeholder interviews and dialogues reported having been permanently dismissed or forced to leave their employment after being diagnosed with TB. TB survivors who lost employment included school teachers, as well as factory and construction workers. A TB survivor in Lagos explained that he lost his job as a school teacher after he was diagnosed with TB. Though the Principal of his school was sympathetic and offered him time off for treatment, the survivor’s position was filled without his knowledge shortly after he left. As a result, he was unable to return to the school to teach. A TB survivor in Abuja who participated in the Abuja Stakeholder Dialogue shared that she was dismissed from her employment as a public school teacher when she was diagnosed with TB. She has not since been able to return, even though she has been cured for some time. During the Lagos Stakeholder Dialogue, a community member told the story of a man who was fired from his factory job because he had TB, without concern for whether or not he was contagious. The man later died of the disease. In Abuja, a person with MDR-TB undergoing treatment at a public DOTS center explained that, while he does not believe he experienced discrimination, he nonetheless has not been able to return to work as a construction foreman, though he believes he is strong enough and has applied for work and is no longer contagious.

To address the pervasive discrimination against people with TB in employment, NTBLCP National Coordinator, Dr. Adebola Lawanson, Lagos State TB Control Program Coordinator, Dr. Abdulrazak, TB survivors, TB physicians and civil society members all expressed support for legislation prohibiting discrimination against people with TB, including in employment settings.

### **Low Public Awareness and Lack of Accurate Information about TB**

Low public awareness and a lack of accurate information about TB among the public, including health care workers and people affected by TB, was a recurring theme encountered during stakeholder interviews and dialogues. TB survivors, civil society members, physicians, federal legislators, TB researchers, and NTBLCP and state TB program officials all cited the lack of awareness and information about TB as a key driver of the epidemic in Nigeria. Hon. Emmanuel Ombugadu Davemetics, Chairman of the HIV/AIDS, TB and Malaria Control Committee of the National Assembly, emphasized that awareness about TB is very low even among members of the National Assembly. He noted that the problem is exacerbated by a lack of demand for legislative

action on TB from Assembly members' constituents, who are themselves under-informed about TB and the extent of the epidemic.

Incorrect beliefs and the lack of awareness about TB have deadly consequences. Lagos State TB Control Program Coordinator, Dr. Abdulrazak, shared the story of two sisters with TB in Lagos State who stopped treatment on the instruction of a religious leader in their community. The sisters never returned to receive treatment and later died in their community. In a similar case, a stakeholder during the Lagos Stakeholder Dialogue told the story of a woman with TB who died because her own religious views along with pressure from religious leaders in her community resulted in her stopping treatment.

A TB survivor living with HIV who serves as the Chief Executive Officer (CEO) of a TB and HIV community-based organization in Lagos reported that she was completely unaware and had not even heard about TB prior to being diagnosed. Although she was informed about HIV and aware of her positive status, she did not know about the risk of TB/HIV coinfection. As a result, even though she was experiencing clear symptoms of TB disease, she did not seek TB testing and was only diagnosed with TB after testing was ordered by her HIV treatment provider—two years after testing positive for HIV. The disparity between the availability of information and high level of awareness about HIV, as compared to TB, was highlighted by nearly everyone consulted during the in-country assessment. The TB survivor living with HIV emphasized the need to engage the media to promote increased coverage of TB in national and local news, as well as to disseminate accurate information about the disease. She asserted this was necessary in order to sensitize people and raise their awareness about TB and the challenges faced by people with TB in obtaining care.

The experiences of TB survivors, including the CEO in Lagos, highlight that the lack of awareness about TB, including its symptoms, contributes to long delays in diagnosis, which in turn drives spread of the disease. To this point, the Matron and Head Physician at a DOTS center in Abuja, cited a lack of knowledge and awareness about TB as the primary barrier people in her community face in accessing TB testing and treatment services. The Matron underlined this concern by noting that many people in her community incorrectly believe TB is a “death sentence.”

Another TB survivor in Lagos explained during an interview that her DOTS provider had not provided her any information about her TB treatment. She was not informed about the potential side-effects of the drugs she was taking or the fact that she was no longer contagious after having been on treatment for several weeks. Instead, she suffered side-effects without knowledge of why they were occurring and she mistakenly believed she was contagious during her entire treatment. At one point during her treatment, she experienced a reddish-orange discoloration of her urine. She was told by a health care worker she had acquired a sexually-transmitted infection (STI). In response, the health care worker provided her one month's worth of TB drugs and told her not to come back to the DOTS center until the STI was gone. The TB survivor later confirmed, through a paid consultation at a private health clinic, that she did not have an STI, but rather was experiencing a common side-effect of rifampicin. She also reported that her belief that she was contagious for many months when she was not had profound negative impacts on her family and professional life. She described one of the impacts as an intense self-stigmatization, resulting in, among other things, her physical separation from her husband and decision to sleep on the floor in her home during her entire period of her treatment.

## Lack of TB Community Mobilization

During stakeholder interviews and dialogues in Abuja and Lagos, TB survivors, civil society members and TB program facilitators noted the lack of community mobilization around TB and expressed concern that too few TB community-based organizations existed in Nigeria. This shortage was made evident during the dialogues by the fact that TB survivors who participated were not all members of organized community-based TB groups. Instead, most community members present were part of HIV organizations, conducting TB advocacy and activism through established HIV networks. TB survivors and civil society members called for more funding and technical support to increase mobilization and strengthen capacity of people affected TB to form community-based organizations and advocate at local, national, regional and international levels.

## Need for a Policy on Isolation and Involuntary Isolation of People with TB

NTBLCP National Coordinator, Dr. Lawanson, Lagos State TB Control Program Coordinator, Dr. Abdulrazak, and Lagos Mainland Hospital MDR-TB Treatment Centre Medical Director, Dr. Bowale, all expressed the urgent need for a clear policy on the isolation and involuntary isolation of people with TB that effectively balances the human rights of people with TB and protection of public health. These and other stakeholders described the confusion faced by health care workers regarding what measures are lawful and appropriate in situations where people with TB are contagious, refuse treatment and are unwilling or unable to take appropriate infection control measures.

Dr. Abdulrazak articulated the need for a policy that provides direction on: when it is appropriate to isolate someone against their will; how to affect the isolation; where the isolation should occur; and what rights and basic necessities should be provided to isolated individuals, such as food, the right to appeal the isolation, and rights to receive visitors and make phone calls. To this point, he noted with frustration the absence of law or policy at the federal or state levels granting him authority to consider isolation and treatment for the two sisters with TB in Lagos State, mentioned above, who stopped treatment on the instruction of a religious leader and died in their community.

Dr. Bowale also lamented the lack of clear guidance in Nigeria on what appropriate and lawful measures may be taken when a person with TB refuses treatment after extensive outreach. The lack of law and policy authorizing and establishing guidelines for isolation of people with TB is of particular concern to Dr. Bowale because the MDR-TB Treatment Centre he directs in the Lagos Mainland Hospital is the largest such center in the country. He noted instances where outreach to people with MDR-TB has failed and infectious individuals have remained in the community without treatment or implementation of proper infection control measures. In these cases, Dr. Bowale and his staff provide the person with information about the risks of discontinuing treatment and they voluntarily conduct outreach to family and community members. However, without recourse to a policy that provides guidance on what further measures are appropriate and lawful, they must eventually suspend these activities and leave the contagious person in the community without further support.

# TB LEGAL AND POLICY FRAMEWORK IN NIGERIA

## International and Regional law

Nigeria has signed and ratified all the major international human rights instruments.<sup>69</sup> These include: the International Covenant on Civil and Political Rights (ICCPR),<sup>70</sup> the International Covenant on Economic, Social and Cultural Rights (ICESCR),<sup>71</sup> the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD),<sup>72</sup> the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT),<sup>73</sup> the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW),<sup>74</sup> the Convention on the Rights of the Child (CRC),<sup>75</sup> the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICMW),<sup>76</sup> and the Convention on the Rights of Persons with Disabilities (CRPD).<sup>77</sup> Nigeria is also a State Party to the Convention relating to the Status of Refugees (Refugee Convention)<sup>78</sup> and has ratified the Optional Protocol to the ICESCR.<sup>79</sup> The ICESCR Optional Protocol allows individuals or groups to submit communications, under the jurisdiction of a State Party, to the Committee on Economic, Social and Cultural Rights with claims related to violations of rights in the treaty, including the right to health.<sup>80</sup>

At the regional level, Nigeria has ratified the African Charter on Human and Peoples Rights (African Charter).<sup>81</sup> Section 12(1) of the Constitution of the Federal Republic of Nigeria requires the National Assembly to enact a treaty into law in order for it to have the force of law in the country.<sup>82</sup> In 2004, the National Assembly enacted the African Charter on Human and Peoples Rights (Ratification and Enforcement) Act, making the African Charter part of Nigerian domestic law.<sup>83</sup> For those treaties that have not been enacted into domestic law, Nigeria nonetheless has legal obligations under international and regional law.

A comprehensive presentation of Nigeria's international and regional human rights obligations related to TB is outside the scope of this report. Instead, Table 1 below provides: (1) a snapshot of

<sup>69</sup> Office of the High Commissioner for Human Rights, *Status of Ratification Interactive Dashboard: Nigeria*, at <http://indicators.ohchr.org/> [hereinafter Ratification Dashboard].

<sup>70</sup> ICCPR, New York (United States of America), 16 Dec. 1966, in force 23 Mar. 1976.

<sup>71</sup> ICESCR, New York (United States of America), 16 Dec. 1966, in force 3 Jan. 1976.

<sup>72</sup> ICERD, New York (United States of America), 7 Mar. 1966, in force 4 Jan. 1969.

<sup>73</sup> CAT, New York (United States of America), 10 Dec. 1984, in force 26 Jun. 1987.

<sup>74</sup> CEDAW, New York (United States of America), 18 Dec. 1979, in force 3 Sept. 1981.

<sup>75</sup> CRC, New York (United States of America), 20 Nov. 1989, in force 2 Sept. 1990.

<sup>76</sup> ICMW, New York (United States of America), 18 Dec. 1990, in force 1 Jul. 2003.

<sup>77</sup> CRPD, New York (United States of America) 30 Mar. 2007, in force 3 May 2008.

<sup>78</sup> Refugee Convention, New York (United States of America), 14 Dec. 1950, in force 22 Apr. 1954; UN High Commissioner for Refugees, *States Parties to the 1951 Convention relating to the Status of Refugees and the 1967 Protocol*, available at <http://www.unhcr.org/en-us/protection/basic/3b73b0d63/states-parties-1951-convention-its-1967-protocol.html>.

<sup>79</sup> Ratification Dashboard, *supra* note 69.

<sup>80</sup> UN GA Resolution A/RES/63/117, of 10 Dec. 2008, on Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, Art. 2.

<sup>81</sup> African Charter, Nairobi (Kenya), 27 Jun. 1981, in force 21 Oct. 1986; African Commission on Human and Peoples' Rights, *State Reporting*, at [http://www.achpr.org/states/?s=ratification\\_achpr](http://www.achpr.org/states/?s=ratification_achpr).

<sup>82</sup> Constitution of the Federal Republic of Nigeria, 1999, Art. 12(1) [hereinafter Constitution of Nigeria], available at [http://publicofficialsfinancialdisclosure.worldbank.org/sites/fdl/files/assets/law-library-files/Nigeria\\_Constitution\\_1999\\_en.pdf](http://publicofficialsfinancialdisclosure.worldbank.org/sites/fdl/files/assets/law-library-files/Nigeria_Constitution_1999_en.pdf).

<sup>83</sup> African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap. A9, L.F.N. 2004, available at <http://www.lawyrd.ng/wp-content/uploads/2015/11/AFRICAN-CHARTER-ON-HUMAN-AND-PEOPLES-RIGHTS-Ratification-and-Enforcement-ACT-2004.pdf>.

key human rights and their sources (including the nonbinding, but foundational, Universal Declaration on Human Rights (UDHR));<sup>84</sup> (2) an example each rights’ health-related content; and (3) Nigeria’s corresponding obligations for its law and policy related to TB.

**Table 1: Key International and Regional Human Rights and Nigeria’s Obligations Related to TB**

HUMAN RIGHTS	HEALTH-RELATED CONTENT	OBLIGATIONS RELATED TO TB LAW AND POLICY
<p><b>Right to life</b></p> <p>Sources: UDHR, ICCPR, ICMW, African Charter</p>	<p>States must adopt positive measures to protect life, eliminate epidemics, and ensure access to medical care.<sup>85</sup></p>	<p>Nigeria must adopt measures in law and policy to protect the lives of people with TB, including ensuring the right to access to life-saving testing and treatment.</p>
<p><b>Right to health</b></p> <p>Sources: UDHR, ICESCR, ICERD, CRC, CEDAW, ICMW, CRPD, African Charter</p>	<p>States have a core obligation to provide essential medicines on the WHO Model List of Essential Medicines.<sup>86</sup></p>	<p>Section 6.2.4 of the 19th WHO Model List of Essential Medicines includes first- and second-line anti-tuberculosis drugs, including bedaquiline and delamanid. Nigeria must adopt laws and policies that ensure people with TB and drug-resistant TB are provided first- and second-line medicines.<sup>87</sup></p>
<p><b>Right to be free from discrimination</b></p> <p>Sources: UDHR, ICCPR, ICESCR, ICERD, CEDAW, ICMW, CRPD, African Charter</p>	<p>Prohibition of discrimination based on “other status” includes health status and includes direct and indirect discrimination in the public and private spheres.<sup>88</sup></p>	<p>Nigeria must protect people with TB in law and policy against all forms of discrimination in both the public and private spheres, including employment, education, housing, immigration and health care settings.</p>
<p><b>Right to be free from torture and other cruel, inhuman or degrading treatment or punishment</b></p> <p>Sources: UDHR, ICCPR, CAT, ICMW, African Charter</p>	<p>Failure to provide adequate medical care to prisoners and other people deprived of their liberty constitutes inhuman and degrading treatment.<sup>89</sup></p>	<p>Nigeria must adopt law and policy that ensures people with TB in prisons and other detention centers are provided good-quality testing and treatment services.</p>

<sup>84</sup> UN GA Res. A/RES/217(III), of 10 Dec. 1948, on UDHR [hereinafter Universal Declaration].

<sup>85</sup> Human Rights Council, General Comment No. 6: The Right to Life (Art. 6), Adopted at the Sixteenth Session of the Human Rights Committee (April 30, 1982); *Association X v. United Kingdom*, Application No. 7154/ 75, 14 Decisions and Reports 31 (1978), European Commission on Human Rights; A Human Rights Framework for Intellectual Property, Innovation and Access to Medicine, Joo-Young Lee (ed.) (Ashgate Publishing, Limited, 2015).

<sup>86</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), UN Doc. E/C.12/2000/4, ¶ 43(d) (Aug. 11, 2000).

<sup>87</sup> WHO, 19th WHO Model List of Essential Medicines (April 2015), available at [http://www.who.int/medicines/publications/essentialmedicines/EML2015\\_8-May-15.pdf](http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf).

<sup>88</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), UN Doc. E/C.12/GC/20, ¶¶ 10-11, 27, 33 (July 2, 2009).

<sup>89</sup> Interim report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/68/295, ¶ 50 (Aug. 9, 2013); *Vasnyukov v. Russia*, European Court of Human Rights, Application No. 2974/05 (2011).

<p><b>Right to privacy</b></p> <p>Source: UDHR, ICCPR, ICMW, CRPD, African Charter</p>	<p>Right to privacy includes the right to keep information related to health and health status private.<sup>90</sup></p>	<p>Nigeria must establish in law and policy the right of people with TB to keep their health status and other health-related information private and confidential, except from those to whom they pose a real risk of transmission and only for the duration of the risk.</p>
<p><b>Right to liberty and security of person</b></p> <p>Sources: UDHR, ICCPR, ICERD, ICMW, CRPD, African Charter</p>	<p>Any deprivation of liberty must be proportionate in light of the circumstances and necessary to protect against serious harm or prevent injury to others; it must be used only as a last resort, for the shortest period of time, and accompanied by adequate procedural and substantive safeguards established by law.<sup>91</sup></p>	<p>Nigeria must establish in law and policy clear protections against involuntary detention or isolation of people with TB, except for under exceptional circumstances, as a last resort, when a person is known to be or highly likely to be contagious but refuses treatment or testing and all reasonable measures to ensure adherence have been unsuccessful. In these cases, the least restrictive possible measure must be used; isolation must occur in an appropriate medical setting; and the individual must be provided treatment and basic necessities, as well as the right to appeal the isolation decision.<sup>92</sup></p>
<p><b>Right to participation (to take part in the conduct of public affairs)</b></p> <p>Sources: UDHR, ICCPR, ICERD, ICMW, CRPD, African Charter</p>	<p>Conduct of public affairs is a broad concept including legislative, executive and administrative powers, all aspects of formulation and implementation of policy at international, national and local levels, the means of which should be established by constitutions and other laws.<sup>93</sup></p>	<p>Nigeria must establish and facilitate through law and policy the right of people with TB and TB survivors to participate in the design, implementation, monitoring and evaluation of laws and policies implicating TB at the federal, state and local government area levels.</p>
<p><b>Right to asylum</b></p> <p>Sources: UDHR, African Charter, Refugee Convention</p>	<p>Everyone has the right to seek and enjoy asylum from persecution in other countries without discrimination.<sup>94</sup></p>	<p>Nigeria must establish in law and policy the right of people with TB to receive asylum without discrimination based on their health status and it must allow for asylum consideration based on a high risk of contracting TB in a person's home country, including when a person is likely to be detained in a prison with high rates of TB.</p>
<p><b>Right to adequate housing (right to shelter)</b></p>	<p>Housing must be accessible, affordable and habitable, providing adequate space and ventilation and</p>	<p>Nigeria must ensure through law and policy access to affordable housing with adequate ventilation, particularly for the</p>

<sup>90</sup> Office of the United Nations High Commissioner for Human Rights and Joint United Nations Program on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights*, UN Doc. HR/PUB/06/9, ¶¶ 119-122 (2006) (stating right to privacy includes “privacy of information” and “need to respect confidentiality of all information relating to a person’s HIV status”), available at [http://data.unaids.org/publications/irc-pub07/jc1252-internguidelines\\_en.pdf](http://data.unaids.org/publications/irc-pub07/jc1252-internguidelines_en.pdf); *ARE 855.179 AgR/RJ, Reporting Justice Luiz Fux*, Supreme Federal Court of Brazil (2015) (upholding lower court judgment that held newspaper violated constitutional right to privacy when it published individual’s image in a story about TB without consent).

<sup>91</sup> Human Rights Council, General Comment No. 35: Article 9 (Liberty and security of person), UN Doc. CCPR/C/GC/35, ¶ 19 (Dec. 16, 2014).

<sup>92</sup> See WHO, *Ethics Guidance on the Implementation of the End TB Strategy*, Ch. 15, WHO/HTM/TB/2017.07 (2017), available at <http://apps.who.int/iris/bitstream/10665/254820/1/9789241512114-eng.pdf?ua=1>.

<sup>93</sup> Human Rights Council, General Comment No. 25: The right to participate in public affairs, voting rights and the right of equal access to public service (Art. 25), UN Doc. CCPR/C/21/Rev.1/Add.7, ¶ 5 (Dec. 7, 1996).

<sup>94</sup> Universal Declaration, *supra* note 79, at art. 14; Refugee Convention, *supra* note 78, at art. 3.

Sources: UDHR, ICESCR, ICERD, CRC, CEDAW, ICMW, CRPD	protection from threats to health and disease vectors, especially for disadvantaged groups, such as people living with HIV and those with persistent medical problems. <sup>95</sup>	rural and urban poor, to prevent the transmission and spread of TB.
<b>Right to food</b>  Sources: UDHR, ICESCR, CRC, CRPD	States must ensure everyone under their jurisdiction can access minimum essential food that is sufficient, nutritious and safe, with priority consideration given to disadvantaged groups. <sup>96</sup>	Nigeria must adopt laws and policies to ensure people with TB have access to adequate, nutritious food during treatment, as under-nutrition and low body mass index are associated with poor treatment outcomes. <sup>97</sup>
<b>Right to education</b>  Sources: UDHR, ICESCR, ICERD, CRC, ICMW, CRPD	Education must be accessible to all, especially the most vulnerable groups, in law and fact, without discrimination, including for persons with disabilities, children of migrants, and other disadvantaged groups. <sup>98</sup>	Nigeria must protect children with TB in law and policy against all forms of discrimination at school and ensure they are allowed to attend normal classes, unless and only for as long as they pose a real risk of transmission to their classmates.

### THE NIGERIAN COURT SYSTEM (IN BRIEF)

The Supreme Court of Nigeria is the highest court in the country. It has original jurisdiction over matters of constitutional interpretation and any matter brought before it pursuant to an act of the National Assembly. The Supreme Court is also the court of final appeal for decisions of the Federal Court of Appeal on all civil and criminal matters.

The Court of Appeal has appellate jurisdiction over decisions of the Federal High Court and State High Courts for all civil and criminal matters. It also has appellate jurisdiction over decisions of specialized courts, including the Sharia Court of Appeal and the Customary Court of Appeal.

The Federal High Court has jurisdiction over civil and criminal matters at the federal level. The capital city, Abuja, also has its own High Court of the FCT, a Sharia Court of Appeal of the FCT, and a Customary Court of Appeal of the FCT.

Each state has a Magistrate's Court that is the court of first instance for certain kinds of criminal and civil cases. Each state also has a High Court. State High Courts have unlimited civil and criminal jurisdiction and also hears appeals from lower courts. Some states also have specialized courts, such as the state Sharia Court of Appeal and state Customary Court.

## Nigerian Domestic Law and Policy

Nigeria does not have TB-specific legislation. Instead, a complex domestic legal and policy framework governs the prevention, testing, treatment and care of TB and establishes legal rights for

<sup>95</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 4: The Right to Adequate Housing (Art. 11(1) of the Covenant), UN Doc. E/1992/23, ¶¶ 7, 8 (Dec. 13, 1991).

<sup>96</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 12: The Right to Adequate Food (Art. 11), UN Doc. E/C.12/1999/5, ¶¶ 13, 14 (May 12, 1999).

<sup>97</sup> See, e.g., Olivia Oxlade and Megan Murray, *Tuberculosis and Poverty: Why Are the Poor at Greater Risk in India?*, 7 PLOS ONE 11, e47533 (Nov. 2012).

<sup>98</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 13: The Right to Education (Art. 13), UN Doc. E/C.12/1999/10, ¶¶ 6, 16 (Dec. 8, 1999).

people with TB and those vulnerable to the disease. Along with Nigeria's international and regional human rights obligations, the country's domestic legal and policy framework comprises three main sources of law and policy: the Constitution and related jurisprudence (i.e., judicial opinions); legislation; and administrative policies and regulations.

## Constitutional Law and Jurisprudence

The Constitution of the Federal Republic of Nigeria is the supreme law of Nigeria.<sup>99</sup> It binds all persons and organs of the state at all levels of government. Legislation, policies and regulations enacted or promulgated at any level of government must conform with the Constitution. The rights established in the Constitution provide protections and entitlements for people with TB and create corresponding obligations for all levels of government in Nigeria.

Chapter IV of the Constitution enshrines a set of civil and political rights. They are fully justiciable, meaning people may bring claims of violations of these rights to court. The rights in Chapter IV relevant to people with TB include: right to life (section 33); right to dignity of the human person and to be free from torture and inhuman or degrading treatment (section 34); right to personal liberty (section 35); right to privacy (section 37); right to freedom of movement (section 41); and right to freedom from discrimination (section 42). The rights largely conform in text and character with the international human rights instruments protecting civil and political rights, including the UDHR and the ICCPR. Section 46 of the Constitution establishes the right to redress for violations or likely future violations of Chapter IV rights in the High Court of the state where the violation occurred or is likely to occur. State High Courts have original jurisdiction for this purpose. There is, however, concern among scholars about the level of derogation of Chapter IV rights permitted under section 45 of the Constitution.<sup>100</sup> Derogation of civil and political rights is permissible in the interest of public safety, public order, public morality or public health.<sup>101</sup> The threshold levels of urgency justifying derogation in the name of these interests are not defined. The public health and public order exceptions are especially of concern for people with TB.

Chapter II of the Constitution, titled Fundamental Objectives and Directive Principles of State Policy, establishes a set of economic and social rights. Section 6(6)(c), however, establishes that Chapter II rights are not justiciable, meaning judges may not hear claims related to these rights. The provisions set forth in Chapter II relevant to TB include:

- Section 16(2)(d), directing the state to ensure that “suitable and adequate shelter, suitable and adequate food, reasonable national minimum living wage, old age care and pensions, and unemployment, sick benefits and welfare of the disabled are provided for all citizens”;
- Section 17(2)(e), requiring “easy accessibility” to courts of law;
- Section 17(3)(b), requiring that “conditions of work are just and humane”;
- Section 17(3)(c), protecting the “health, safety and welfare of all persons in employment”;
- Section 17(3)(d), requiring that “there are adequate medical and health facilities for all persons”; and

<sup>99</sup> Constitution of Nigeria, *supra* note 82, at § 1.

<sup>100</sup> See, e.g., Jacob Abiodun Dada, *Human Rights under the Nigerian Constitution: Issues and Problems*, 2 Int'l. J. Human. & Soc. Sci. 12 (Special Issue, June 2012), available at [http://www.ijhssnet.com/journals/Vol\\_2\\_No\\_12\\_Special\\_Issue\\_June\\_2012/6.pdf](http://www.ijhssnet.com/journals/Vol_2_No_12_Special_Issue_June_2012/6.pdf).

<sup>101</sup> Constitution of Nigeria, *supra* note 82, at § 45(1)(a).



- Section 24, directing “every citizen” to “respect the dignity of other citizens and [their] rights.”

Section 13 strengthens Chapter II rights to some extent. It establishes “the duty and responsibility of all organs of government, and of all authorities and persons exercising legislative, executive or judicial powers, to conform to, observe and apply the provisions” of Chapter II of the Constitution.<sup>102</sup> In *Attorney General of Ondo State vs. Attorney General of the Federation and Others*, (2002) 9 NWLR (Pt. 772)222, the Supreme Court of Nigeria confirmed that Section 13 imposes a duty on federal, state and local government actors to “conform to, observe and apply” the rights in Chapter II. Section 13 and the Supreme Court’s interpretation of the section in *Attorney General of Ondo State* provide some leverage to hold government and government agents legally responsible for conforming to, observing, and applying the rights in Chapter II. This includes the right to health established through sections 16(2)(d), and 17(3)(c) and (d), discussed in detail below.

### **Right to Health**

In his article “Realization of Health Right in Nigeria: A Case for Judicial Activism,” Ajiboye Oyeniyi, Lecturer at College of Law, Afe Babalola University argues that the Constitution provides a right to health through the composite of sections 17, 33 (right to life) and 35 (right to personal liberty).<sup>103</sup> Oyeniyi urges that section 6, which supplies the judiciary with the power to hear cases, implies a judicial activist role for judges that includes the power to render the non-justiciable Chapter II rights justiciable. Oyeniyi’s argument is strengthened by the international canon, deriving from the UN Committee on Economic, Social and Cultural Rights’ General Comment No. 9, that domestic laws should be interpreted “as far as possible in a way which conforms to a State’s international legal obligations.”<sup>104</sup> Nigeria’s obligations under international and regional law include an obligation to respect, protect and fulfill the right to health in article 12 of the ICESCR and article 16 of the African Charter.

As noted above, the African Charter has been given the force of law in Nigeria by African Charter on Human and Peoples Rights (Ratification and Enforcement) Act. The Supreme Court of Nigeria, in *General Sani Abacha v. Chief Gani Fawehinmi*, 1 CHR 20 (2001), confirmed that the Act had made the African Charter part of Nigerian law. However, the Court explained that “in the likely event of a conflict between [Nigerian] Constitutional provisions and the provisions of the African Charter, the Nigerian Constitution will prevail as the superior Law.”<sup>105</sup> Because the right to health in the Nigerian Constitution is non-justiciable, this aspect of the ruling suggests the African Charter’s right to health may not be enforceable in the country. Subsequent case law, though, has rendered questionable the force of this preemption.

*Odafe and Others. v. Attorney General and Others*, FHC/PH/CS/680/2003 (2004), heard by the Federal High Court, was the first of two “leading cases’ for litigating health rights in Nigeria.”<sup>106</sup> In *Odafe*,

<sup>102</sup> Constitution of Nigeria, *supra* note 82, at § 13.

<sup>103</sup> Ajiboye Oyeniyi, *Realization of Health Right in Nigeria: A Case for Judicial Activism*, 14 Glob. J. Hum. Soc. Science 3, 23 (2014), available at <https://socialscienceresearch.org/index.php/GJHSS/article/download/1133/1075/>.

<sup>104</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 9: The domestic application of the Covenant, UN Doc. E/C.12/1998/24, ¶ 15 (3 Dec. 1998).

<sup>105</sup> *General Sani Abacha*, 1 CHR 20 (2001), ¶¶ F-G.

<sup>106</sup> See Ebenezer Durojaye, *Litigating the Right to Health in Africa: Challenges and Prospects*, pp. 150-153 (Routledge, 1st ed., 2016).

HIV-positive prisoners succeeded in their allegations that they were being provided inadequate medical care. The Court did not apply sections 16 and 17 of the Nigerian Constitution, but rather the right to health in article 16 of the African Charter, along with provisions of the Prison Act, in determining that plaintiffs' right to health had been violated. The Court stated that, since the African Charter "entrenched the socio-economic rights of a person," it was "enjoined to ensure the observation of these rights."<sup>107</sup> In Nigeria's second major case on the right to health, *Georgina Abamefulu v. Imperial Medical Centre and Dr. Alex Molokwu*, ID/1627/2000 (2012), a woman challenged the termination of her employment as a nurse as unlawful because it was based on her HIV-positive status. Her employer also subjected her to HIV testing without her consent and failed to provide her with pre-test and post-test counseling. The High Court of Lagos State held the defendants' actions constituted a "flagrant violation" of the right to health secured to the plaintiff under article 16 of the African Charter, as well as article 12 of the ICESCR.<sup>108</sup>

While these cases represent significant advancements for health rights in Nigeria, criticisms of the High Courts' approaches in the two cases nonetheless apply. First, in *Odafe*, the Court failed to address whether the right to be free from discrimination in section 42 of the Constitution prohibited discrimination against the prisoners based on their health or HIV status. Through its avoidance of the issue, the Court has not explicitly made plain that discrimination based on HIV status is actionable under section 42. One critic asserts that *Abamefulu* committed the same mistake in failing to address this question.<sup>109</sup> The same critic argues that the Court in *Abamefulu* failed to adequately respond to the gender dimension of the plaintiff's experience as an HIV-positive woman.<sup>110</sup> However, though courts have declined to clarify whether section 42 of the Constitution prohibits discrimination based on health or HIV status, the federal HIV and AIDS (Anti-Discrimination) Act, 2014, discussed in detail below, prohibits all forms of discrimination against people based on their HIV status.<sup>111</sup>

Lastly, it should also be noted that *Odafe* and *Abamefulu* did not ascend to the Supreme Court, so their holdings have not been affirmed at that level. Nor has the opportunity arisen for the Supreme Court to resolve the tension between these High Court decisions and its own holding in *General Sani Abachai*, discussed above.

### **Fundamental Rights (Enforcement Procedure) Rules**

The Fundamental Rights (Enforcement Procedure) Rules of 2009, promulgated by the Supreme Court of Nigeria, further secure a role for the African Charter in courts' interpretation and application of the Constitution of Nigeria. The Rules state: "The overriding objective of these Rules are as follows...The Constitution, especially Chapter IV, as well as the African Charter, shall be expansively and purposely interpreted and applied, with a view to advancing and realising the rights

<sup>107</sup> *Odafe*, FHC/PH/CS/680/2003 (2004), p. 37.

<sup>108</sup> *Abamefulu*, ID/1627/2000 (2012), p. 23.

<sup>109</sup> See Ebenezer Durojaye, *So Sweet so Sour: A commentary on the Nigerian High Court's Decision in Georgina Abamefulu v. Imperial Hospital & Another Relating to the Rights of Persons Living with HIV*, 13 Afr. Hum. Rts. Law J. 464-480 (2013), available at <https://repository.uwc.ac.za/bitstream/handle/10566/1366/DurojayeSoSweet2013.pdf?sequence=1&isAllowed=y>.

<sup>110</sup> Ebenezer Durojaye, *supra* note 106, at p. 153.

<sup>111</sup> HIV and AIDS (Anti-Discrimination) Act, An Act to Make Provision for the Prevention of HIV and AIDS-Based Discrimination and Protect the Fundamental Human Rights and Dignity of People Living with and Affected by HIV and AIDS and for Related Matters, (Nov. 27, 2014) [hereinafter HIV Law] available at [http://www.lawnigeria.com/LawsOftheFederation/HIV-and-AIDS-\(Anti-Discrimination\)-Act,-2014.html](http://www.lawnigeria.com/LawsOftheFederation/HIV-and-AIDS-(Anti-Discrimination)-Act,-2014.html).

and freedoms contained in them and affording the protections intended by them.”<sup>112</sup> In committing the Supreme Court to “expansively and purposely” interpreting and applying the African Charter, the Rules appear to confirm the promise of *Odafe* and *Abamefule*.<sup>113</sup>

### **Right to Life**

The Constitution of Nigeria enshrines the right to life in section 33. In *Kalu v. State*, (1998) 13 NWLR (Pt. 583)531, the Supreme Court held that the right to life is not absolute, but is instead qualified. As one commentator has noted, the right has not easily expanded into the health context but is instead generally confined to the “bare fact of having the right to be alive.”<sup>114</sup> However, by contrast, in *Gbemre v. Shell Petroleum Development Company and Others*, (2005) AHRLR 151 (NgHC 2005), the Federal High Court in the Benin Judicial Division held that the constitutional right to life, together with the right to dignity of the human person, guarantees the right to a “clean, poison-free, pollution-free healthy environment.”<sup>115</sup>

### **Locus Standi and Access to Justice**

Section 36 of the Constitution of Nigeria guarantees people “a fair hearing within a reasonable time by a court or other tribunal established by law and constituted in such manner as to secure its independence and impartiality.” The Supreme Court, however, established a strict interpretation of the *locus standi* requirement in *Attorney General of Kaduna State v. Hassan*, SC.149/1984, affirming that only those personally affected by a rights violation can bring suit. The Court explained the decision as a defense against impertinent involvement of those with only “remote, hypothetical or no interest” to sue.<sup>116</sup>

Contrary to this decision, the Fundamental Rights (Enforcement Procedure) Rules, discussed above, state:

“The Court shall encourage and welcome public interest litigations in the human rights field and no human rights case may be dismissed or struck out for want of *locus standi*. In particular, human rights activists, advocates, or groups as well as any non-governmental organisations, may institute human rights application [sic] on behalf of any potential applicant.”<sup>117</sup>

In 2013, the High Court of the FCT applied the Fundamental Rules and granted standing for Lawyers Alert (a human rights legal NGO) to file suit pursuant to the Rules on behalf of a group of female sex workers, claiming violations of their fundamental rights in the Constitution and African Charter.<sup>118</sup> The Court quoted the language cited here above from section 3 of the Rules and further

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<sup>112</sup> Chief Justice of the Supreme Court of Nigeria, Fundamental Rights (Enforcement Procedure) Rules, at § 3(a) (Dec. 1, 2009) [hereinafter Fundamental Rights Rules], available at <http://www.refworld.org/pdfid/54f97e064.pdf>.

<sup>113</sup> *Id.*

<sup>114</sup> Edoba Bright Omoregie and Daud Momodu, *Justifying the Right to Healthcare in Nigeria: Some Comparative Lessons*, 12 The Nigerian Juridical Rev. 13, 23 (2014).

<sup>115</sup> *Gbemre*, (2005) AHRLR 151 (NgHC 2005), ¶ 5.

<sup>116</sup> *Attorney General of Kaduna State*, SC.149/1984, pp. 524-525; see also *Adeyinka Abosede Badejo v. Federal Minister of Education*, [1996] 8 NWLR (Pt.464)15.

<sup>117</sup> Fundamental Rights Rules, *supra* note 112, at § 3(e).

<sup>118</sup> *Lawyers Alert v. Minister of the FCT and Others*, Suit No. FCT/HC/CV/3816/12, High Court of the FCT, Abuja Judicial Division (2013).

quoted from the same section, indicating that an “[a]ssociation acting in the interest of its members or other individuals or groups” may institute a lawsuit.<sup>119</sup>

It is unclear how the liberal *locus standi* requirement of the Fundamental Rules interacts with the strict standing requirement established in the Supreme Court’s case law. The latter likely restricts access to the courts, particularly for indigent or illiterate persons, while the former likely expands access, particularly in allowing advocates and non-governmental organizations (NGOs) to file human rights cases on behalf of individuals or groups.

Along with strict *locus standi* requirements, other impediments to justice through the courts exist in Nigeria. Delays in pending cases—often more than three or four years—caused by a variety of circumstances postpone the administration of justice and deter potential plaintiffs from approaching the courts in the first place.<sup>120</sup> Critics of the Nigerian court system also cite high costs of litigation, including high filing fees, and complex procedural rules in courts as barriers to justice in the country.<sup>121</sup>

## Legislation

As noted above, there is no federal legislation on TB in Nigeria—i.e., no TB-specific law. However, TB is directly addressed in some laws and others indirectly impact the prevention, testing, treatment and care of people with TB and those vulnerable to the disease. This assessment of the legislative framework prioritizes health-specific laws, then broadens to examine legislation affecting key populations, as defined in the Stop TB Partnership LEA Operational Guide.<sup>122</sup> Both federal and Lagos State laws are examined.

### Federal Health Legislation

#### National Health Act, 2014

The National Health Act, 2014 (NHA) is the primary health legislation in Nigeria.<sup>123</sup> The NHA does not address TB specifically, but it establishes a National Health System that aims, among other things, to establish “the rights and obligations of health care providers, health workers, health establishments and users; and protect, promote and fulfil the rights of the people of Nigeria to have access to health care services.”<sup>124</sup> The NHA also establishes a National Council on Health, chaired by the Minister of Health, that is “the highest policy making body in Nigeria on matters relating to

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<sup>119</sup> *Id.* at p. 5.

<sup>120</sup> See, e.g., Nlerum Okogbule, *Access to Justice and Human Rights Protection in Nigeria: Problems and Prospects*, 2 Int. J. on Hum. Rts. 3, 94-113 (2005).

<sup>121</sup> See *id.*; A.G. Shettima, “Socio-Economic Obstacles to the Realization of a Just Society: The Nigerian Experience,” in Y. Osinbajo et al. (eds.), *Human Rights, Democracy and Development in Nigeria* (Lagos: Legal Research and Resource Development Centre, 1999), pp. 100-104.

<sup>122</sup> Stop TB Partnership, *Legal Environment Assessment for Tuberculosis: An Operational Guide*, § I (3) (Jul. 2017), available at [http://www.stoptb.org/assets/documents/communities/StopTB\\_TB%20LEA%20DRAFT\\_FINAL\\_Sept%2027.pdf](http://www.stoptb.org/assets/documents/communities/StopTB_TB%20LEA%20DRAFT_FINAL_Sept%2027.pdf). TB key populations identified in the Guide include children, health care workers, miners, mobile populations, people living with HIV, people who use drugs, prisoners, rural poor and urban poor.

<sup>123</sup> National Health Act, *supra* note 12.

<sup>124</sup> National Health Act, *supra* note 12, at § 1(d-e).

health” with authority to “facilitate and promote the provision of health services for the management, prevention and control of communicable ... diseases.”<sup>125</sup>

Another key provision of the NHA secures “all Nigerians” an entitlement to the “basic minimum package of health services.”<sup>126</sup> The “basic minimum package” is defined as “the set of health services as may be prescribed from time to time by the Minister [of Health] after consultation with the National Council on Health.”<sup>127</sup> The NHA creates a fund called the Basic Health Care Provision Fund.<sup>128</sup> Fifty per cent of the fund is to be used for the provision of the “basic minimum package of health services to citizens, in eligible primary/or secondary health care facilities through the National Health Insurance Scheme” and 20% is to “provide essential drugs, vaccines and consumables for eligible primary health care facilities.”<sup>129</sup>

The NHA also establishes a right to confidentiality for health system users. It states that “[a]ll information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential.”<sup>130</sup> However, the right is subject to several exceptions, the most important of which allows for disclosure of such information if “non-disclosure ... represents a serious threat to public health.”<sup>131</sup> Relatedly, Part III on the Rights and Obligations of Users and Healthcare Personnel establishes a right to information and to refuse services:

“Every health care provider shall give a user relevant information pertaining to his state of health and necessary treatment relating thereto including: ... the range of diagnostic procedures and treatment options generally available ... the benefits, risks, costs and consequences ... [and] the user's right to refuse health services and [ ] the implications, risks, obligations of such refusal.”<sup>132</sup>

The same section directs health workers to “inform the user in a language that the user understands and in a manner which takes into account the user's level of literacy.”<sup>133</sup> The NHA does not mention informed consent, except in the context of participation in medical research and blood and tissue removal.<sup>134</sup>

In its introduction, the NHA obligates the Ministry of Health to “promote availability of good quality, safe and affordable essential drugs, medical commodities, hygienic food and water.”<sup>135</sup> The NHA operates to this end in concert with other legislation governing the quality, registration and commercial sale of drugs and other medical products. These include the National Agency for Food and Drug Administration and Control Act; the Food, Drugs and Related Products Act; and the Counterfeit and Fake Drugs and Unwholesome Processed Food (Miscellaneous Provision)

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<sup>125</sup> National Health Act, *supra* note 12, at §§ 4(1), 5(1)(h).

<sup>126</sup> National Health Act, *supra* note 12, at § 3(3).

<sup>127</sup> National Health Act, *supra* note 12, at § 64.

<sup>128</sup> National Health Act, *supra* note 12, at § 11.

<sup>129</sup> National Health Act, *supra* note 12, at § 11(3)(a-b).

<sup>130</sup> National Health Act, *supra* note 12, at § 26(1).

<sup>131</sup> National Health Act, *supra* note 12, at § 26(2)(c).

<sup>132</sup> National Health Act, *supra* note 12, at § 23(1).

<sup>133</sup> National Health Act, *supra* note 12, at § 23(2).

<sup>134</sup> National Health Act, *supra* note 12, at §§ 32, 48.

<sup>135</sup> National Health Act, *supra* note 12, at § 2(l).

(Amendment) Act.<sup>136</sup> Patents on pharmaceuticals, laboratory supplies and other medical products are regulated under Nigeria’s general intellectual property law, the Patents and Designs Act, 1971 (PDA).<sup>137</sup> The PDA grants the Minister for Trade and Tourism the authority to order compulsory licenses for “certain patented products and processes ... declared by the order to be of vital importance ... for public health.”<sup>138</sup>

The NHA also addresses the relationship between the public and private health sectors. The law states that the Minister of Health “shall prescribe mechanisms to ensure a coordinated relationship between private and public health establishments in the delivery of health services.”<sup>139</sup> It further indicates that the “Federal Ministry, any state ministry or any Local Government or any public health establishment may enter into an agreement with any private practitioner, private health establishment or non-governmental organization in order to achieve any objective of this Bill.”<sup>140</sup>

### **National Health Insurance Scheme Act, 1999**

The National Health Insurance Scheme Act, 1999 (NHISA) aims to “ensure that every Nigerian has access to good health care services,” to “limit the rise in cost of health care services” and to “improve and harness private sector participation in the provision of health care services.”<sup>141</sup> The National Health Insurance Scheme was launched on June 6, 2005, in accordance with the NHISA. As of mid-2012, the scheme only covered about 3% of the population, approximately five million people.<sup>142</sup> The scheme’s current coverage includes the formal sector (both public and organized private-sector firms employing 10 or more persons), the informal sector (urban self-employed and rural community user-groups) and several vulnerable groups (children under five, permanently disabled persons and prison inmates).<sup>143</sup>

### **National Primary Health Care Development Agency Act, 1992**

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<sup>136</sup> National Agency for Food and Drug Administration and Control Act, An Act to establish the National Agency for Food and Drug Administration and Control with the functions, among others, to regulate and control the importation, exportation, manufacture, advertisement, distribution, sale and use of food, drugs, cosmetics, medical devices, bottled water and chemicals, Cap. N1, 1993 No. 15, as amended by 1999 No. 19 (Oct. 1, 1992); Food, Drugs and Related Products (Registration, etc.) Act, An Act to regulate the manufacture, importation, exportation, advertisement, sale or distribution of processed food, drugs and related products and registration thereof, 993 No. 19 (Jan. 27, 1993); Counterfeit and Fake Drugs and Unwholesome Processed Food (Miscellaneous Provision) (Amendment) Act, An Act to provide for the prohibition of sale and distribution of counterfeit, adulterated, banned or fake, substandard or expired drug or unwholesome processed food; and of sale, etc., of drugs or poisons in certain premises or places, Cap. 34 (Nov. 3, 2016).

<sup>137</sup> Patents Act, *supra* note 16.

<sup>138</sup> Patents Act, *supra* note 16, at § 13.

<sup>139</sup> National Health Act, *supra* note 12, at § 18(1).

<sup>140</sup> National Health Act, *supra* note 12, at § 18(2).

<sup>141</sup> National Health Insurance Scheme Act, An Act to establish the National Health Insurance Scheme with the objectives of ensuring access to good health care services to every Nigerian and protecting Nigerian families from financial hardship of huge medical bills; and for matters connected therewith, § 5, Cap. N42, L.F.N. 2004 (May 10, 1999), available at [http://kyg.nigeriagovernance.org/Attachments/Organization/Act/33\\_Law\\_NATIONAL%20HEALTH%20INSURANCE%20SCH EME%20ACT.pdf](http://kyg.nigeriagovernance.org/Attachments/Organization/Act/33_Law_NATIONAL%20HEALTH%20INSURANCE%20SCH EME%20ACT.pdf).

<sup>142</sup> A. Dutta and C. Hongoro, *Scaling Up National Health Insurance in Nigeria: Learning from Case Studies of India, Colombia, and Thailand*, Health Policy Project and USAID (Mar. 2013), available at [https://www.healthpolicyproject.com/pubs/96\\_NigeriaInsuranceFinal.pdf](https://www.healthpolicyproject.com/pubs/96_NigeriaInsuranceFinal.pdf).

<sup>143</sup> Felicia Monye, *An Appraisal of the National Health Insurance Scheme of Nigeria*, 32 Commonwealth Law Bulletin 3, 415 (Sept. 2006), available at <http://www.tandfonline.com/doi/pdf/10.1080/03050710601074450>.

The National Primary Health Care Development Agency Act, 1992 creates an institution for the review and reification of health care policy.<sup>144</sup> The agency is tasked with providing support to the National Health Policy with, among other things, “the translation of policies into relevant and feasible strategies.”<sup>145</sup> The agency includes a Department of Disease Control and Immunization with a primary objective of ensuring “all children are vaccinated against preventable diseases ... [including] tuberculosis.”<sup>146</sup>

### **Quarantine Act, 1926**

The federal law prescribing rules for quarantine and isolation—the Quarantine Act, 1926—has been in place for almost a century.<sup>147</sup> The act provides the President with broad powers to act in the name of public health when “any dangerous infectious disease” has been identified.<sup>148</sup> The definition of the term “infectious disease” in the act, however, excludes TB, as does the term “quarantinable disease.”<sup>149</sup> As a result, the act does not appear to apply to people with TB, except for one substantive provision that mentions the disease. Section 17, entitled “Examination and removal of infected persons from ships,” grants port authority officers the authority to “detain ... for examination,” “require ... to be disinfected” or “prohibit ... from leaving the ship” people “suffering” from TB. The act does not provide any rights for people with infectious diseases subject to quarantine or isolation.

### **Nigeria Public Health (Quarantine, Isolation and Emergency Health Matters Procedures) Bill**

In 2014, during the Ebola outbreak in West Africa, the National Assembly considered repealing and replacing the Quarantine Act with the Nigeria Public Health (Quarantine, Isolation and Emergency Health Matters Procedures) Bill (PHB).<sup>150</sup> However, the bill failed in the Senate as the threat posed by Ebola receded. The objectives of the PHB included:

“(e) To grant state and local officials the authority to provide care, treatment, and vaccination to persons who are ill or who have been exposed to contagious disease, and to separate affected individuals from the population at large to interrupt disease transmission.

(f) To ensure that the needs of infected or exposed persons are properly addressed to the fullest extent possible, given the primary goal of controlling serious health threats.

(g) To provide Federal, State and local officials with the ability to prevent, detect, manage, and contain emergency health threats without unduly interfering with civil rights and liberties.”<sup>151</sup>

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<sup>144</sup> National Primary Health Care Development Agency Act, An Act to provide for the establishment of the National Primary Health Care Development Agency and for matters connected therewith, (June 26, 1992), available at [http://kyg.nigeriagovernance.org/Attachments/Organization/Act/38\\_Law\\_NATIONAL%20PRIMARY%20HEALTH%20CARE%20DEVELOPMENT%20AGENCY%20ACT.pdf](http://kyg.nigeriagovernance.org/Attachments/Organization/Act/38_Law_NATIONAL%20PRIMARY%20HEALTH%20CARE%20DEVELOPMENT%20AGENCY%20ACT.pdf).

<sup>145</sup> *Id.* at § 3.

<sup>146</sup> National Primary Health Care Development Agency, Department of Disease Control and Immunization, at <https://www.nphcda.org/department-of-disease-control-and-immunization/>.

<sup>147</sup> Quarantine Act, An Act to provide for and regulate the imposition of quarantine and to make other provisions for preventing the introduction into and spread in Nigeria, and the transmission from Nigeria, of dangerous infectious diseases, Cap. Q2, L.F.N. 2004 (May 27, 1926), available at <http://www.placng.org/new/laws/Q2.pdf>.

<sup>148</sup> *Id.* at § 4.

<sup>149</sup> *Id.* at § 2.

<sup>150</sup> Public Health Bill, *supra* note 7.

<sup>151</sup> Public Health Bill, *supra* note 7, at § 2.

The terms “tuberculosis” and “TB” did not appear in the PHA. However, the scope of the terms “contagious disease” and “infectious disease” in the PHB were broader than in the Quarantine Act and, by definition, would have included TB.<sup>152</sup> The PHB distinguished between isolation—for people infected with a contagious or possibly contagious disease—and quarantine—for people exposed to a contagious or possibly contagious disease who do not show symptoms.<sup>153</sup> Like the Quarantine Act, the PHB would have granted the President broad powers to make regulations to carry out the “purposes and provisions” of the bill.<sup>154</sup> The PHB would have required doctors and other health workers to report all cases of persons with health conditions “that may be potential causes of a public health emergency” to the Public Health Authority, including the “patient’s name, date of birth, sex, race, occupation, and current home and work addresses.”<sup>155</sup> However, the bill also provided that “[p]rotected health information . . . shall not be disclosed to others without individual written, specific informed consent,” with some exceptions, including for the person’s “immediate family members.”<sup>156</sup>

The PHB provisions that would have authorized and established conditions and procedures for the isolation and quarantine of people with TB and MDR-TB were in Part V, entitled Special Powers during a State of Public Health Emergency: Protection of Persons. The provisions therefore would only have applied during public health emergencies, officially declared in accordance with bill. The PHB defined the term “public health emergency” as “an occurrence or imminent threat of an illness or health condition that,” among other things:

- “Poses a high probability of any of the following harms:
- i. A large number of deaths in the affected population;
  - ii. A large number of serious or long-term disabilities in the affected population; or
  - iii. Widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.”<sup>157</sup>

Therefore, while TB and MDR-TB might meet these conditions, the PHB does not appear to have been intended to govern the isolation or quarantine of people with TB or MDR-TB in the normal course of prevention and treatment of the disease.

It is nonetheless valuable to examine the PHA’s provisions authorizing and establishing conditions and procedures for isolation and quarantine. The PHB would have allowed the Public Health Authority to isolate or quarantine “any person whose refusal of medical examination or testing results in uncertainty regarding whether he or she has been exposed to or is infected with a contagious or possibly contagious disease or otherwise poses a danger to public health.”<sup>158</sup> The bill also granted the Public Health Authority the power to compel both vaccination “as necessary to address the public health emergency” and treatment of “persons exposed to or infected with disease.”<sup>159</sup>

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<sup>152</sup> Public Health Bill, *supra* note 7, at § 3.

<sup>153</sup> Public Health Bill, *supra* note 7, at § 3.

<sup>154</sup> Public Health Bill, *supra* note 7, at § 4.

<sup>155</sup> Public Health Bill, *supra* note 7, at § 7.

<sup>156</sup> Public Health Bill, *supra* note 7, at § 28.

<sup>157</sup> Public Health Bill, *supra* note 7, at § 3.

<sup>158</sup> Public Health Bill, *supra* note 7, at § 23.

<sup>159</sup> Public Health Bill, *supra* note 7, at § 24.



However, the PHB stated that isolation and quarantine “must be by the least restrictive means necessary to prevent the spread of a contagious ... disease to others and may include ... confinement to private homes.”<sup>160</sup> The bill directed that the “needs” of isolated or quarantined persons must be addressed, including “providing adequate food, clothing, shelter, means of communication with those ... outside these settings, medication, and competent medical care.”<sup>161</sup> The bill also stated that isolated or quarantined persons “must be immediately released when they pose no substantial risk” of transmitting a contagious disease.<sup>162</sup> Finally, the PHB would have established a series of due process protections for persons isolated or quarantined. For persons isolated or quarantined “without notice,” the PHB would have required the Public Health Authority to produce a “written directive” with information about the circumstances provided to the affected person and to petition for a court order for continued isolation or quarantine within 10 days of issuing the written directive.<sup>163</sup> For persons isolated or quarantined “with notice,” the PHB would have required the Public Health Authority to file a petition in trial court, obtain a court order and provide 24 hours advance notice to the affected person prior to isolation or quarantine.<sup>164</sup> The bill provided affected persons the right to a hearing, to apply for an “order to show cause” for continued isolation or quarantine to be heard within 48 hours, to remedies for “breach of conditions,” to state-appointed counsel at state expense, and to consolidate claims.<sup>165</sup>

### **HIV and AIDS (Anti-Discrimination) Act, 2014**

Finally, the federal HIV and AIDS (Anti-Discrimination) Act, 2014 is remarkable for its recognition and protection of the rights of people living with HIV.<sup>166</sup> The law is discussed in detail below in the *Legislation Protecting Key Populations* section addressing people living with HIV. The rights of people with TB are not similarly recognized or protected by law at the federal level.

### **Lagos State Health Legislation**

#### **Health Sector Reform Law, 2006**

Lagos State also has a general health law entitled the Health Sector Reform Law, 2006 (HSRL).<sup>167</sup> The law establishes a state health system, comprising public and private providers, and sets out the “rights and duties of health care providers, health workers, health establishments and users.”<sup>168</sup> It charges the Lagos State Commissioner for Health with taking steps to “determine the policies and measures necessary to protect, promote, improve and maintain the health and wellbeing of the population.”<sup>169</sup> The HSRL also grants the Commissioner authority to “prescribe conditions subject

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<sup>160</sup> Public Health Bill, *supra* note 7, at § 25.

<sup>161</sup> Public Health Bill, *supra* note 7, at § 25.

<sup>162</sup> Public Health Bill, *supra* note 7, at § 25.

<sup>163</sup> Public Health Bill, *supra* note 7, at § 26.

<sup>164</sup> Public Health Bill, *supra* note 7, at § 26.

<sup>165</sup> Public Health Bill, *supra* note 7, at § 26.

<sup>166</sup> HIV Law, *supra* note 111.

<sup>167</sup> Health Sector Reform Law, Lagos State House of Assembly, Cap. H3, A Law to Make Provision for the Reform of Health Sector, State Hospitals Management Board, Primary Health Board and Traditional Medicine Board in Lagos State and for Connected Purposes (Jan. 16, 2006) [hereinafter Lagos Health Law].

<sup>168</sup> *Id.* at § 1.

<sup>169</sup> *Id.* at § 3(3).

to which categories of persons eligible for [ ] free health services at public health establishments as may be prescribed.”<sup>170</sup>

TB is only mentioned once in the HSRL, in Schedule 15 on the Medical Officer of Health. The section states that the Medical Officer of Health is the Administrative Head of the Primary Health Care Department and the Primary Health Care Coordinator for the Local Government.<sup>171</sup> The Officer is responsible for implementing state and federal health policies at the local government level and enforcing state and federal laws relating to health that apply at the local government level within the jurisdiction of the customary courts.<sup>172</sup> The Officer is also responsible for the “supervision, coordination and control of all the functions” of the Health and Disease Control Division, which includes the state TB and leprosy control programs.<sup>173</sup>

Like the NHA, the HSRL establishes a right to confidentiality for health system users. It states that “[a]ll information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential.”<sup>174</sup> However, also like the NHA, the right is subject to a public health exception, allowing disclosure of such information if “non-disclosure ... represents a serious threat to public health.”<sup>175</sup> Schedule 2, on the Rights and Duties of Users and Health Care Providers, establishes that every health care provider in the state must inform health system users about:

- “(a) the user’s health status except in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interest of the user;
- (b) the range of diagnostic procedures and treatment options generally available to the user, certainly within and possibly outside that facility;
- (c) the benefits, risks, costs and consequences generally associated with each option; and
- (d) the user’s right to refuse health services.”

Schedule 2 also establishes users’ right to informed consent subject to several caveats, the most important of which eliminates the requirement if “failure to treat the user, or group of people which includes the user, will result in a serious risk to public health.”<sup>176</sup> Informed consent is defined in the section as “consent for the provision of a specified health service given by a person with legal capacity to do so.”<sup>177</sup> Relatedly, the HSRL creates a duty for the Ministry of Health and all Hospital Governing Boards to “ensure that adequate and comprehensive information is disseminated on the health services for which they are responsible,” including “the types and availability of health services; ... operating schedules and time-tables of visits; procedures for access to the health services; ... and procedures for laying complaints.”<sup>178</sup>

## Health Scheme Law, 2015

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<sup>170</sup> *Id.* at § 4.

<sup>171</sup> *Id.* at Schedule 15.

<sup>172</sup> *Id.*

<sup>173</sup> *Id.* at Schedule 15(2).

<sup>174</sup> *Id.* at § 109

<sup>175</sup> *Id.* at § 109(2)(c).

<sup>176</sup> *Id.* at Schedule 2 § 3.

<sup>177</sup> *Id.* at Schedule 2 § 3(2).

<sup>178</sup> *Id.* at § 30.

Lagos State has implemented a health insurance program at the state-level through the Health Scheme Law, 2015.<sup>179</sup> The agency created by the law—the Lagos State Health Management Agency—is directed to “promote, regulate, supervise and ensure the effective administration of the Lagos State Health Scheme and Health Fund.”<sup>180</sup> The objective of the Scheme is, among other things, to ensure all residents of Lagos State have access to “affordable health care services” and financial protection from “huge medical bills.”<sup>181</sup> The Scheme is compulsory and applies to all residents of Lagos State who are not already covered by an existing health scheme.<sup>182</sup> The Scheme pools funds collected from employees, employers, individuals and families in Lagos state in the Lagos State Health Fund.<sup>183</sup> The Scheme includes three insurance plans, ranging from a basic plan providing a minimum set of services to a plan consisting of a variety of packages providing services in direct proportion to the level of contribution.<sup>184</sup> All Lagos residents who possess a registration agency card can obtain insurance under the law for use in more than 3,700 public and private health facilities in the state.<sup>185</sup> Registration in the scheme is free, but people who do not possess the paperwork needed to obtain a registration agency card may be unable to obtain coverage under the law.

### Public Health Law, 2015

The Lagos State Public Health Law, 2015 (PHL) grants enforcement and rule-making authority to state officials to address all aspects of public health in the state, including sanitation, food safety and infection diseases.<sup>186</sup> The law grants broad authority to the Commissioner for Health, medical officers, enforcement officers and private health facilities, while establishing stiff financial penalties and non-custodial sentences for private citizens, health care workers and health facilities that fail to abide by the law.

The PHL contains many troubling, overly broad provisions relating to infectious diseases that, if fully enforced, would violate the human rights of people with TB and their family members, as well as the rights of people living with HIV and AIDS. The term “infectious disease” in the PHL is defined to include TB, HIV and AIDS, among several other diseases, including the Ebola virus.<sup>187</sup> TB and HIV are treated the same as the Ebola virus under the law; no distinction is made between them regarding the mode of transmission, duration of the contagious period, or magnitude of the harm of infection.

The provisions highlighted here are among the most problematic in the PHL. As noted, if fully enforced as written, these provisions would result in violations of the human rights of people with TB, HIV or AIDS. The rights affected would include rights to due process of law, to informed

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<sup>179</sup> Lagos State Health Scheme Law, A Law to Provide for the Establishment of the Lagos State Health Management Agency and the Lagos State Health Scheme for Residents of Lagos State and Connected Purposes, Law No. 4 (May 25, 2015) [hereinafter Lagos Health Scheme Law].

<sup>180</sup> Lagos State Government, Ministry of Health, *Brief on the Lagos State Health Insurance Scheme* [hereinafter Lagos State Health Scheme Brief], at <http://health.lagosstate.gov.ng/2017/07/18/brief-on-the-lagos-state-health-insurance-scheme/>.

<sup>181</sup> Lagos Health Scheme Law, *supra* note 179, at § 20.

<sup>182</sup> Lagos Health Scheme Law, *supra* note 179, at § 6(3).

<sup>183</sup> *Lagos State Health Scheme Brief*, *supra* note 180.

<sup>184</sup> Lagos Health Scheme Law, *supra* note 179, at § 6(2).

<sup>185</sup> *Lagos State Health Scheme Brief*, *supra* note 180.

<sup>186</sup> Public Health Law, A Law to Provide for Public Health in Lagos and for Connected Purposes, Cap. P16, Vol. 9 (2015).

<sup>187</sup> *Id.* at § 69.

consent and freedom from nonconsensual treatment, to liberty and freedom from arbitrary detention, to privacy and confidentiality, to family life and to property. These provisions are also overly broad, unnecessary and counterproductive for the protection of public health. These draconian provisions are likely to discourage health seeking behavior among people with TB, HIV and AIDS and those at risk for the diseases because they are stigmatizing and excessively punitive. This, in turn, would promote spread of the diseases, lower case detection rates, decrease services utilization rates, and negatively impact treatment outcomes.

The PHL grants authority to state officials to apprehend people with TB, HIV or AIDS from public streets without any notice:

“Apprehension of persons on the streets suffering from infectious diseases: Every enforcement officer, police officer or any authorized officer may apprehend and take, any person suffering from any infectious disease whom the officer finds on any street, public place, shop or public transportation to a hospital.”<sup>188</sup>

The PHL allows compulsory treatment of people with TB, HIV or AIDS:

“Compulsory medical treatment: Any person certified after an examination and inquiry to have contracted an infectious or communicable disease may be compelled to receive any appropriate medical treatment necessary to prevent transmission of the disease to any other person.”<sup>189</sup>

The PHL criminalizes transmission of TB and HIV:

“Acts contributing to spread of disease: Any person who—(a) does any act or thing to the spread of the disease while suffering from an infectious or communicable disease or being in charge of a person suffering from such a disease; or (b) gives, lends, sells, transmits or exposes without previously disinfecting any article which has been exposed to infection, commits an offence and is liable on conviction to a fine of Five Hundred Thousand Naira [ ] or one (1) year imprisonment or both.”<sup>190</sup>

The PHL grants authority to medical officers of health to involuntarily remove “any person suffering or reasonably suspected to be suffering from an infectious disease” to be detained at a state hospital “or such other place provided by the State or by a Council until the persons can be safely discharged to the public.”<sup>191</sup> Section 24 of the PHL authorizes private health facilities to involuntarily detain “any person suffering or reasonably suspected to be suffering from an infectious or communicable disease” at the health facility pending removal by a state official.<sup>192</sup>

The PHL authorizes state (or possibly even non-state) officials to use any force necessary to remove and detain any person in contact with a person with TB, HIV or AIDS or a person thought to have TB, HIV or AIDS including, but not limited to, family members and people living in the same house:

“Isolation of contacts: A medical officer of health may order any person living in the same house compound or who has been in contact with any person suffering or suspected to be suffering from an infectious or communicable disease, to be isolated in such place as the Government may provide, until the person can be

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<sup>188</sup> *Id.* at § 31

<sup>189</sup> *Id.* at § 25.

<sup>190</sup> *Id.* at § 29.

<sup>191</sup> *Id.* at § 23.

<sup>192</sup> *Id.* at § 24.

safely discharged, and every person authorized by the medical officer of health to carry out such order may use such force as is necessary to compel obedience to such order.”<sup>193</sup>

The PHL also requires the “occupier or owner” of “any house, place of worship, school, shop or any other building” to give oral notice to a medical officer of health when a person in the building is “suspected of suffering from an infectious disease.”<sup>194</sup> If the “occupier or owner” of the building fails to do so, he is liable upon conviction for a fine of “One Million Naira [ ] or any non-custodial sentence,” and in the case of a “medical practitioner or health institution the penalty will be Two Million Naira ...”<sup>195</sup> The Commissioner for Health “may order the evacuation of the whole or part of” any place “[w]hensoever an infectious disease breaks out ...”<sup>196</sup> An enforcement officer “may cause to be placed any mark on or about” a premise in which “any case of infectious disease has occurred for the purpose of denoting the occurrence of such disease, and may keep the mark affixed for such time as necessary.”<sup>197</sup> An enforcement officer may also “obtain an order of court to destroy any building in which a case of infectious disease has occurred,” though the owner of the building is entitled to compensation.<sup>198</sup>

The PHL has implementing regulations, made under section 43 of the law, entitled Public Health Regulations.<sup>199</sup> Part 1 promulgates rules and regulations related to infectious or communicable diseases. Like the law, they contain problematic provisions. However, this LEA will not examine them in detail, because it is recommending repeal of sections 20 – 39, section 43 (as applied to sections 20 – 39 on infectious diseases) and section 69 of the PHL on infectious diseases (see Recommendation 13). This would have the effect of rescinding Part 1 of the Public Health Regulations.

Lagos State has also enacted a law on HIV, discussed in the next section, entitled the Protection of Persons Living with HIV and Affected by AIDS Law, 2007.<sup>200</sup> Among other things, the law establishes and protects the rights of people living with HIV. The rights of people with TB are not protected by law in Lagos State.

### *Legislation Protecting Key Populations*

#### **People Living with HIV**

Recent efforts at the federal and state levels have culminated in laws designed to protect people living with HIV. The federal HIV and AIDS (Anti-Discrimination) Act, 2014 prohibits all forms of discrimination against people based on their HIV status.<sup>201</sup> The law prohibits employers, individuals and organizations from denying health care to people living with HIV and from requiring HIV testing for employment or to obtain health services. The law also prohibits all public and private

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<sup>193</sup> *Id.* at § 26.

<sup>194</sup> *Id.* at § 20.

<sup>195</sup> *Id.*

<sup>196</sup> *Id.* at § 21.

<sup>197</sup> *Id.*

<sup>198</sup> *Id.* at §§ 35, 40.

<sup>199</sup> Public Health Regulations, Cap. P16, Vol.9 (2015).

<sup>200</sup> Protection of Persons Living with HIV and Affected by AIDS Law, A Law for the Protection of Persons Living with HIV and Affected by AIDS in Lagos State and for other Connected Matters, Cap. A209, Law No. 17 (2007) [hereinafter Lagos HIV Law].

<sup>201</sup> HIV Law, *supra* note 111.

entities, including individuals and non-governmental institutions, from requiring disclosure of a person's HIV status, in contexts ranging from employment to the provision of private services, before proceeding in the interaction.<sup>202</sup> The law protects the rights to privacy, confidentiality and informed consent. Section 13 establishes people with living HIV's "right to protection of data with respect to their health and medical records," subjecting violators of the provision to "a fine of not less than N500,000 for an individual and N1 million for an institution, or for a term [of imprisonment] not exceeding two years, or to both fine and imprisonment."<sup>203</sup> Section 9 states that "HIV testing ... shall be carried out with the informed and full consent of the person concerned, in accordance with national guidelines on confidentiality and counselling."<sup>204</sup>

Individuals who have experienced violations of the act and those who have knowledge of violations have the right to petition the Minister of Justice to conduct an inquiry into the allegations.<sup>205</sup> People may also file claims in court pursuant to the act. However, case law research and interviews with lawyers and community members indicate that no case has yet been heard and decided under the federal HIV and AIDS (Anti-Discrimination) Act, 2014.

Lagos State preceded the federal government with its Protection of Persons Living with HIV and Affected by AIDS Law, 2007 (Lagos HIV Law).<sup>206</sup> The law guarantees that people living with HIV "shall have access to medical care in the State, including ... life prolonging drugs, treatments, and therapies," as well as testing and voluntary counseling services.<sup>207</sup> To fulfill this guarantee, the Lagos HIV Law establishes an Anti-Retroviral Drugs Trust Fund to ensure procurement and distribution of HIV drugs free of charge to people living with HIV and affected by AIDS in the state.<sup>208</sup> The law prohibits all discrimination and stigmatization of any person living with HIV or affected by AIDS and creates a private right of action for the person to sue the party responsible in court.<sup>209</sup> Separate provisions explicitly prohibit discrimination against people living with HIV or affected by AIDS in housing, health care, education and public transportation.<sup>210</sup> The Lagos HIV Law protects the right to confidentiality of people living with HIV or affected by AIDS, requiring health workers who disclose their health status to be suspended or relieved of their duties.<sup>211</sup> The law also prohibits compulsory and mandatory HIV testing for employment.<sup>212</sup>

## Prisoners

The Prisons Act, 1972 contains a number of provisions intended to protect prisoner health.<sup>213</sup> A medical officer "may order any prisoner to be excused [from] labour or to perform light labour."<sup>214</sup> In the case of "serious illness," as determined by the medical officer, prisoners may be removed to a

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<sup>202</sup> HIV Law, *supra* note 111, at § 8.

<sup>203</sup> HIV Law, *supra* note 111, at § 1.

<sup>204</sup> HIV Law, *supra* note 111, at § 9.

<sup>205</sup> HIV Law, *supra* note 111, at § 24.

<sup>206</sup> Lagos HIV Law, *supra* note 200.

<sup>207</sup> Lagos HIV Law, *supra* note 200, at §§ 2-3.

<sup>208</sup> Lagos HIV Law, *supra* note 200, at § 4.

<sup>209</sup> Lagos HIV Law, *supra* note 200, at § 14.

<sup>210</sup> Lagos HIV Law, *supra* note 200, at §§ 10, 11.

<sup>211</sup> Lagos HIV Law, *supra* note 200, at § 18.

<sup>212</sup> Lagos HIV Law, *supra* note 200, at § 10.

<sup>213</sup> Prisons Act, An Act to make comprehensive provisions for the administration of prisons in Nigeria and other matters ancillary thereto, Cap. P29, L.F.N. 2004 (Apr. 10, 1972), available at <http://www.lawnigeria.com/LawsoftheFederation/PRISONS-ACT.html>.

<sup>214</sup> *Id.* at § 3.

hospital.<sup>215</sup> The medical superintendent decides when the prisoner's health no longer requires hospital treatment.<sup>216</sup> The law also establishes that prisoners undergoing medical treatment will not be released upon expiration of their sentence until they request discharge or the medical officer determines that discharge will not endanger the prisoner's health.<sup>217</sup>

#### The Prisons Act addresses TB in section 14:

“In the case of a prisoner who is suffering from pulmonary tuberculosis or leprosy not in itself serious enough to endanger his life under suitable conditions, but liable to endanger the health of other prison inmates, the medical officer shall inform the superintendent of the prison, in writing, who shall take, without unnecessary delay, measures to carry out the recommendations of the medical officer in order to maintain the health of prisoners. In the event of the medical officer recommending the transfer of a prisoner for reasons of health, the superintendent shall forward a detailed report of the case through the Director of Prisons to the Minister for his decision.”

Medical officers are responsible for giving “directions in writing for separating prisoners having infectious disease.”<sup>218</sup> The law provides no information about the specific circumstances justifying separation, the material conditions of the separation, or the standards and procedures governing the termination of the separation period. The medical officer also has authority to supervise and inspect the sanitary conditions of prison facilities, though no specific standards or procedures are built into the law.<sup>219</sup>

The Sheriffs and Civil Process Act, 1990 provides that a person imprisoned who has a “serious illness,” as certified by a medical officer, may be removed by court order to a government hospital for treatment.<sup>220</sup> The court determines whether the time spent in treatment counts toward the prisoner's sentence, though the default rule is that it will. The court also decides whether the government or a judgment creditor should bear the costs of the prisoner's treatment, over and above the costs covered by the “subsistence allowance” paid to prisoners.<sup>221</sup> Judgment creditors, in turn, can attach and sell the property of prisoner-debtors in satisfaction of unresolved accounts.<sup>222</sup>

### People who Use Drugs

Drug use is criminalized in Nigeria and incarceration is prioritized over treatment and rehabilitation for offenders. The National Drug Law Enforcement Agency Act, 1989 criminalizes drug use and creates an agency designed to enforce the laws against cultivation, sale, trafficking and use of drugs.<sup>223</sup> The act assigns a term of imprisonment for “not less than fifteen years but not exceeding

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<sup>215</sup> *Id.* at § 8.

<sup>216</sup> *Id.*

<sup>217</sup> *Id.* at § 9.

<sup>218</sup> *Id.* at § 121.

<sup>219</sup> *Id.* at § 124.

<sup>220</sup> Sheriffs and Civil Process Act, An Act to make provision for the appointment and duties of sheriffs, the enforcement of judgements and orders, and the service and execution of civil process of the Courts throughout Nigeria, § 79, Cap. 407, L.F.N. 1990 (June 1, 1945), available at

<http://www.nigerianlawguru.com/legislations/STATUTES/SHERIFFS%20AND%20CIVIL%20PROCESS%20ACT.pdf>.

<sup>221</sup> *Id.*

<sup>222</sup> *Id.* at § 80.

<sup>223</sup> National Drug Law Enforcement Agency Act, An Act to establish the National Drug Law Enforcement Agency to enforce laws against the cultivation, processing, sale, trafficking and use of hard drugs and to empower the Agency to investigate persons suspected

twenty-five years” for any person who “knowingly possesses or uses the drugs popularly known as cocaine, LSD, heroine or any other similar drugs by smoking, inhaling or [injecting]” them.<sup>224</sup> In addition to imprisonment—but not as a substitute—the law allows for the sentencing tribunal to “make an order requiring an offender to undergo measures such as treatment, education, aftercare, rehabilitation or social re-integration.”<sup>225</sup> Harm reduction services, however, such as needle exchange programs, supervised injection facilities, outreach services for those who inject drugs, or bleach distribution (including in prisons) are generally not available in the country.<sup>226</sup> According to the WHO, Nigeria does provide “specialized treatment services” for people living with HIV who have drug use disorders, but the services are not available to all who need them as a matter of statutory right.<sup>227</sup>

## Workers (Miners)

The Labour Act, 1971 contains a limited number of provisions securing workers’ rights related to health.<sup>228</sup> The law establishes that, subject to the Workmen's Compensation Act, workers are entitled to “wages up to twelve working days in any one calendar year” if they are absent due to a temporary illness.<sup>229</sup> If requested by the employer, the worker must consent to examination by a qualified medical practitioner to qualify for the wages. The law does not provide for workers who must miss more than twelve days of work due to illness and it does not expressly prohibit employment discrimination.

The Nigerian Minerals and Mining Act, 2007 states that the government shall provide “extension services” to “duly registered and performing Mining Co-operatives of small-scale and artisanal miners,” including “introduction of health and safety procedure in the mines, [and] provision of water and health facilities to large mining camps.”<sup>230</sup> Notably, the law makes no specific mention of lung disease or tuberculosis.

## Children

The Child’s Rights Act, 2003 establishes that the “best interest of the child shall be the primary consideration” in all actions taken by public and private individuals and institutions concerning a child.<sup>231</sup> The law also establishes children’s right to health, stating that “[e]very child is entitled to enjoy the best attainable state of physical, mental and spiritual health.”<sup>232</sup> The right creates an

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to have dealings in drugs and other related matters, Cap. N30 (Dec. 29, 1989), available at <http://www.lawnigeria.com/LawsoftheFederation/NATIONAL-DRUG-LAW-ENFORCEMENT-AGENCY-ACT.html>.

<sup>224</sup> *Id.* at § 10

<sup>225</sup> *Id.* at § 11(3).

<sup>226</sup> WHO, *Atlas of Substance Use Disorders: Resources for the Prevention and Treatment of Substance Use Disorders*, Country Profile: Nigeria, (2010), available at [http://www.who.int/substance\\_abuse/publications/atlas\\_report/profiles/nigeria.pdf](http://www.who.int/substance_abuse/publications/atlas_report/profiles/nigeria.pdf).

<sup>227</sup> *Id.* at p. 2.

<sup>228</sup> Labour Act, An Act to repeal and replace the Labour Code Act and consolidate the law relating to labour, Cap. 198, L.F.N. 1990 (Aug. 1, 1971), available at <http://www.nigeria-law.org/LabourAct.htm>.

<sup>229</sup> *Id.* at § 16.

<sup>230</sup> Nigerian Minerals and Mining Act, An Act to repeal the Minerals and Mining Act, No. 34 of 1999 and re-enact the Nigerian Minerals and Mining Act 2007 for the purposes of regulating all aspects of the exploration and exploitation of solid minerals in Nigeria; and for related purposes, § 91, Cap. 34, L.F.N. 1999 (Mar. 29, 2007), available at <http://www.lawnigeria.com/LawsoftheFederation/Nigerian-Minerals-and-Mining-Act.html>.

<sup>231</sup> Child Rights Act, An Act to Provide and Protect the Rights of a Nigerian Child; and Other Related Matters, § 1, Cap. A459 (July 31, 2003), available at <http://www.refworld.org/pdfid/5568201f4.pdf>.

<sup>232</sup> *Id.* at § 13.



obligation for “[e]very government in Nigeria” to, among other things, ensure provision of adequate nutrition and “necessary medical assistance and health care services to all children,” and to “combat disease and malnutrition within the framework of primary health care through the application of appropriate technology.”<sup>233</sup>

The Lagos State Child’s Rights Law, 2007 also establishes that “the best interest of the child shall be the primary consideration” in all actions taken by public and private individuals and institutions concerning a child.<sup>234</sup> The law also recognizes children’s right to health and creates corresponding obligations for every Local Government in Lagos State, using identical language to the federal Child’s Rights Act.<sup>235</sup>

## Women

Nigeria does not have legislation specifically designed to protect women’s health or to guarantee women access to health services. In 2006, the National Assembly considered the Abolition of Discrimination Against Women Bill based on the international Convention Against All Forms of Discrimination Against Women (CEDAW), which included a section on the right to health, but it was not enacted into law.<sup>236</sup> The federal Violence Against Persons (Prohibition) Act, 2015 and the Lagos State Prohibition Against Domestic Violence Law, 2007 aim to protect women from domestic violence and ensure access to related health services, but neither relate directly to TB.<sup>237</sup> In addition to the dearth of legislative protections for women, some existing laws perpetuate discrimination against women.<sup>238</sup> For example, the Labour Act, 1971 prohibits women from performing manual labor underground and, with some exceptions, from working at night in any public or private industrial or agricultural occupation.<sup>239</sup> The federal Police Act, 1943 also discriminates against women.<sup>240</sup> The law limits women’s employment to duties connected with women and children, requires women to receive permission to marry from the commissioner of police for the State Command in which she serves, prohibits women from “drilling under arms,” and requires the discharge from employment of unmarried women who become pregnant.<sup>241</sup>

## Migrants

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<sup>233</sup> *Id.*

<sup>234</sup> Child’s Rights Law, A Law to Enforce the Rights and Advance the Welfare of the Child, and to Amend and Consolidate all Legislations Relating to the Protection and Welfare of the Child in Lagos State and for Other Connected and Incidental Purposes, § 1, Law No. 11 (May 28, 2007), available at [http://dsrvrtlagos.org/pdf%20and%20doc/Child%27s%20Right%20Law%202007%20\(2\).pdf](http://dsrvrtlagos.org/pdf%20and%20doc/Child%27s%20Right%20Law%202007%20(2).pdf).

<sup>235</sup> *Id.* at § 12.

<sup>236</sup> Abolition of Discrimination Against Women, A Bill for An Act to Enact an Act for the Abolition of all Forms of Discrimination Against Women in Nigeria and Other Related Matters, Cap. 1759, S.B. 39, available at <http://www.nassnig.org/document/download/820>.

<sup>237</sup> Violence Against Persons (Prohibition) Act, An Act to eliminate violence in private and public life, prohibit all forms of violence against persons and to provide maximum protection and effective remedies for victims and punishment of offenders; and for related matters, (May 25, 2015), available <http://www.refworld.org/pdfid/556d5eb14.pdf>; Prohibition Against Domestic Violence Law, A Law to Provide Protection Against Domestic Violence and for Connected Purposes (May 18, 2007).

<sup>238</sup> For a discussion of laws in Nigeria that discriminate against women, see, e.g., Ekhaton, Eghosa Osa, *Women and the Law in Nigeria: A Reappraisal*, 16 J. of Int’l Women’s Studies 2 (2015).

<sup>239</sup> Labour Act, *supra* note 228, at §§ 56(1), 55(1).

<sup>240</sup> Police Act, An Act to make provision for the organisation, discipline, powers and duties of the police, the special constabulary and the traffic wardens, Cap. P19, 1967 No. 41 (Apr. 1, 1943), available at <http://www.placng.org/new/laws/P19.pdf>.

<sup>241</sup> *Id.* at §§ 121, 123, 124, 127.

The federal Immigration Act, 2015 does not directly address the right of migrants with infectious diseases to enter or reside in Nigeria.<sup>242</sup> The law prohibits entry of people “considered to be a risk to public health” and it grants broad authority to immigrations officers who may, upon the advice of a medical inspector, refuse entry into Nigeria of a non-citizen if “it is undesirable for medical reasons.”<sup>243</sup> The law does provide some protection for “smuggled migrants,” defined as a person brought illegally into the country by a smuggler for the smuggler’s financial or material benefit.<sup>244</sup> The law directs the Nigeria Immigration Service to ensure smuggled migrants are not subject to discriminatory treatment on account of, among other things, race, religion or other status and to ensure they have access to “adequate health and other social services” during their temporary residence in the country.<sup>245</sup>

The Immigration Act, 2015 has implementing regulations, but this assessment does not discuss them because they do not elaborate on the public health or medical provisions of the act, except to affirm the rights of smuggled migrants, as noted above, including to access adequate health care and social services.<sup>246</sup>

## Administrative Policies and Regulations

A spectrum of administrative policies and regulations in Nigeria implicate TB, both directly and indirectly. This assessment examines federal policies and regulations in the following areas: health, including policies and regulations on TB and HIV/AIDS; prisons; labor and employment.

### *Health Policies and Regulations*

The Federal Ministry of Health National Health Policy, 2016 (NHP) presents a vision of Universal Health Coverage for all Nigerians in the context of the legal framework of the National Health Act, 2014 “in tandem with the Sustainable Development Goals.”<sup>247</sup> The Overall Policy Goal of the NHP includes “to deliver quality effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians.”<sup>248</sup> Importantly, the NHP declares it will be guided by a set of Social Values and Guiding Principles, including:

- “A right to the highest attainable level of health as a fundamental right of every Nigerian, including access to timely, acceptable and affordable health care of highest quality and international best practice;
- Maintenance of professional ethics through observance of human dignity, human rights, confidentiality and cultural sensitivity; ...
- Gender equity and responsiveness, cultural sensitivity and social accountability ...; ...
- All health actors shall ensure the provision and use of health services that are gender-sensitive, evidence-based, responsive, pro-poor and sustainable ...; ...[and]
- Focus on the poor and the vulnerable in all health interventions.”<sup>249</sup>

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<sup>242</sup> Immigration Act 2015, An Act to Repeal the Immigration Act, Cap II, Laws of the Federation of Nigeria, 2004 and Enact the Immigration Act 2015; and for Related Matters, Act No. 8, Cap. A 179 (May 25, 2015), available at <http://www.lawnigeria.com/LawsoftheFederation/Immigration-Act,-2015.html>.

<sup>243</sup> *Id.* at §§ 18-19.

<sup>244</sup> *Id.* at § 116.

<sup>245</sup> *Id.* at § 98.

<sup>246</sup> Immigration Regulations, § 67, Cap. B369, S.I. No. 3 (Feb. 27, 2017).

<sup>247</sup> *National Health Policy*, *supra* note 3, at § 3.4.1.

<sup>248</sup> *National Health Policy*, *supra* note 3, at § 3.4.1.

<sup>249</sup> *National Health Policy*, *supra* note 3, at §§ 3.4.1-2.

The NHP indicates that communicable diseases, including TB, account for 66% of Nigeria’s total burden of morbidity.<sup>250</sup> It establishes a series of Policy Objectives and Orientations, including for Prevention and Control of Communicable Diseases, one of which commits:

“To achieve reduction in the [TB] prevalence rate and the [TB] mortality rate in Nigeria by ensuring universal access to high-quality, client-centred TB/Leprosy diagnosis and treatment services.”<sup>251</sup>

Another objective pledges to “promote an integrated approach to control of communicable diseases.” And, notably, a third objective promises to “foster behavioural change, reduce stigma and improve access to quality care and support services for persons living with HIV/AIDS.” The NHP is silent on issues of stigma and support services for people with TB.

The subsidiary Policy Orientations/Initiatives for TB include to: “Implement comprehensive strategies for case notification, management and control of tuberculosis”; and “Improve access to diagnosis and treatment of [MDR-TB].” For HIV, they include a commitment to “[p]rovide universal access to comprehensive and quality HIV prevention, treatment, care and support services through a multi-sectoral approach.”

The NHP Implementation Framework states that the “legal framework is critical for the implementation” of the policy.<sup>252</sup> Remarkably, in this regard, the NHP states:

“Stakeholders in the health sector shall advocate for a review of the Constitution of the Federal Republic of Nigeria, 1999, as amended, to make health an enforceable right in Nigeria and to include a clear division of responsibilities for health among the three tiers of government in the Constitution.”<sup>253</sup>

To facilitate implementation of the policy, the NHP further declares that “[p]rovision shall be made to revise, update and enact new health legislation,” including the Nigerian Centre for Disease Control Bill, the Public Health Act and the Quarantine Act.<sup>254</sup>

The National School Health Policy, 2006 aims to provide basic services for disease prevention and to build capacity for school communities to identify, treat, and manage simple illnesses and infections.<sup>255</sup> TB is not specifically mentioned in the policy. HIV appears twice: first as a leading cause of death in the school community to be prevented;<sup>256</sup> second as an area to be covered by the “Skill-based Health Education Curriculum.”<sup>257</sup> The policy provides that “School Health Services” should include prevention and control of communicable diseases through “inspections, exclusions, re-admissions, educational measures, immunization, sanitation and epidemic control.”<sup>258</sup> The Implementation Guidelines on National School Health Programme, 2006 are a supplement to the

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<sup>250</sup> *National Health Policy*, *supra* note 3, at § 2.4.

<sup>251</sup> *National Health Policy*, *supra* note 3, at § 4.1.2.

<sup>252</sup> *National Health Policy*, *supra* note 3, at § 5.3.

<sup>253</sup> *National Health Policy*, *supra* note 3, at § 5.3.

<sup>254</sup> *National Health Policy*, *supra* note 3, at § 5.3.

<sup>255</sup> Federal Ministry of Education, *National School Health Policy*, (2006), available at [https://www.unicef.org/nigeria/NG\\_resources\\_schoolhealthpolicy.pdf](https://www.unicef.org/nigeria/NG_resources_schoolhealthpolicy.pdf).

<sup>256</sup> *Id.* at § 2.1.3.

<sup>257</sup> *Id.* at § 2.5.4.

<sup>258</sup> *Id.* at § 2.6.5.

National School Health Policy.<sup>259</sup> They aim to provide a safe and healthy school environment through, among other things, sanitation management and ensuring school health clinics have a “constant and regular supply of drugs and consumables according to the prevailing diseases in the community.”<sup>260</sup> Notably, the guidelines call for “[e]xclusion of children with contagious diseases from the larger body of children,” without distinction between diseases or concern for whether children are actively contagious.<sup>261</sup>

### *TB Policies and Regulations*

The NTBLCP was officially launched in 1991 to coordinate Nigeria’s TB and Leprosy control activities. The NTBLCP is structured along the three tiers of government—Federal, State and Local Government Areas. Development partners, including the WHO, the United States Agency for International Development (USAID) and the Global Fund to Fight AIDS, TB and Malaria, among others, support the NTBLCP’s activities. The National Strategic Plan for Tuberculosis Control: Towards Universal Access to Prevention, Diagnosis and Treatment, 2015 – 2020 (NSP) is the NTBLCP’s current strategy.<sup>262</sup> A comprehensive, detailed analysis of the 200-plus page NSP is beyond the scope of this assessment. Instead, the analysis will highlight key components and notable gaps in the policy related to the legal environment assessment and promotion of a human rights-based approach to TB in Nigeria.

The NSP establishes the NTBLCP’s primary goal “to achieve a 50% reduction in TB prevalence rate and 75% reduction in TB mortality rate (excludes HIV-related TB) in Nigeria [by 2025] compared to 2013 figures.”<sup>263</sup> The NSP’s overarching goal is to:

“Ensure universal access to high-quality, patient-centred TB prevention, diagnosis and treatment services for Nigerians with all forms of TB, regardless of geographic location, income, gender, age, religion, tribe or other affiliations, as a necessary interim step in achieving reductions in TB prevalence and mortality.”<sup>264</sup>

The NSP defines “universal access” to include “equitable access for all to: ... [w]ell-trained, knowledgeable, respectful and motivated health workers; [and] [a] supportive environment, free of stigma and discrimination.”<sup>265</sup> Objective 1 of the NSP is to “rapidly increase case finding activities and diagnostic capacity” to increase the case notification rate of all forms of TB.<sup>266</sup> To this end, the NSP calls for a strategic intervention to “[c]reate an informed public who know TB facts, how to access services, how to get cured and what their rights and responsibilities are to support demand for universal access to services.”<sup>267</sup>

Objective 7 of the NSP is to: “Strengthen the collaboration with and capacity of community-based organizations and networks to support NTBLCP objectives and activities.”<sup>268</sup> To this end, it calls for

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<sup>259</sup> Federal Ministry of Education, *Implementation Guidelines on National School Health Programme*, (2006), available at [https://www.unicef.org/nigeria/NG\\_resources\\_implementationsschoolhealthprog.pdf](https://www.unicef.org/nigeria/NG_resources_implementationsschoolhealthprog.pdf)

<sup>260</sup> *Id.* at § 4.3.

<sup>261</sup> *Id.* at § 4.4.3.

<sup>262</sup> *National Strategic TB Plan*, *supra* note 4.

<sup>263</sup> *National Strategic TB Plan*, *supra* note 4, at p. 6.

<sup>264</sup> *National Strategic TB Plan*, *supra* note 4, at p. 6.

<sup>265</sup> *National Strategic TB Plan*, *supra* note 4, at pp. 78-79.

<sup>266</sup> *National Strategic TB Plan*, *supra* note 4, at p. 7.

<sup>267</sup> *National Strategic TB Plan*, *supra* note 4, at p. 7.

<sup>268</sup> *National Strategic TB Plan*, *supra* note 4, at p. 9.

building “the technical, managerial and administrative capacities” of community-based organizations, strengthening “community monitoring and evaluation system[s] in planning, managing and improving” program performance, and strengthening “the administrative functions of civil society organisations working on TB.”<sup>269</sup>

The NSP includes brief sections on gender and human rights and acknowledges the need to eliminate TB-related stigma and discrimination. The section on gender notes that the 2012 prevalence survey found a higher TB burden among men than women. It nonetheless highlights that prevalence is high in both men and women and emphasizes that interventions must take into account the gender-specific barriers faced by both genders. The NSP states that men’s access to TB services is “likely influenced by working hours and locations, incarceration, stigma, competing priorities and lack of perceived threat to their health.”<sup>270</sup> Women, by contrast, face “religious and cultural restrictions on their independent movement, a lower family priority placed on their health, stigma and fear of being outcast from [their] family or considered unmarriageable.”<sup>271</sup>

The NSP human rights section affirms that the “right of all Nigerians to enjoy the highest level of health attainable and to have access to health services and other means needed to protect health” is enshrined in the ICESCR and UDHR, “as well as related conventions on the rights of the child, of women and of people with disabilities.”<sup>272</sup> It further states that, in light of the challenges people face in accessing TB services, in practice the “right to health is not guaranteed for Nigerians at this time.”<sup>273</sup> The section highlights that “TB continues to be highly stigmatized and people with TB have reported poor treatment by health care providers, employers, family members and other social contacts.”<sup>274</sup> It adds that “existing religious law and new legislation may threaten the ability of the NTBLCP to reach” some key populations at risk for TB.<sup>275</sup> In this respect, the NSP states that laws criminalizing men who have sex with men (MSM) and organizations working on their behalf will prevent MSM from seeking health care and fuel discriminatory treatment by health care workers.<sup>276</sup>

The NSP emphasizes the central role stigma and discrimination play in fueling the TB epidemic in Nigeria. It notes the results of a 2012 knowledge, attitude and practice (KAP) survey that found “[s]tigma related to TB remains high and is sometimes linked to misconceptions around the cause of TB as due to spirits or punishment from God.”<sup>277</sup> The NSP lists the “[f]ear of stigma and discrimination” as a Priority Contributing Factor to, among other things, low case detection and treatment success rates.<sup>278</sup> It states that “[m]isconceptions about TB further fuel stigma and discrimination,” which are “major barrier[s]” to case finding and treatment adherence.<sup>279</sup> The NSP also stresses that stigmatizing and discriminatory “behavior and attitude[s]” of health care workers toward people with TB are barriers to TB services.<sup>280</sup> Elaborating on this concern, the NSP explains

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<sup>269</sup> *National Strategic TB Plan*, *supra* note 4, at p. 9.

<sup>270</sup> *National Strategic TB Plan*, *supra* note 4, at p. 73.

<sup>271</sup> *National Strategic TB Plan*, *supra* note 4, at p. 73.

<sup>272</sup> *National Strategic TB Plan*, *supra* note 4, at p. 73.

<sup>273</sup> *National Strategic TB Plan*, *supra* note 4, at p. 73.

<sup>274</sup> *National Strategic TB Plan*, *supra* note 4, at p. 73.

<sup>275</sup> *National Strategic TB Plan*, *supra* note 4, at p. 73.

<sup>276</sup> *National Strategic TB Plan*, *supra* note 4, at p. 74.

<sup>277</sup> *National Strategic TB Plan*, *supra* note 4, at p. 61.

<sup>278</sup> *National Strategic TB Plan*, *supra* note 4, at pp. 63-64.

<sup>279</sup> *National Strategic TB Plan*, *supra* note 4, at p. 64.

<sup>280</sup> *National Strategic TB Plan*, *supra* note 4, at p. 199.

that the 2012 KAP found that health care workers’ “knowledge and attitudes toward TB were positively related to the amount and timing of training” they had received.<sup>281</sup>

In addition to stigma and discrimination, the NSP highlights several other key factors that impact the NTBLCP’s program performance. These include a lack of information about TB among the general population and “vulnerable sub-groups,” lack of access to health facilities, “hidden fees” for TB services, a lack of adequate engagement of communities, and a preference for alternative health care, noting that “up to 60% of health care is delivered outside the public sector.”<sup>282</sup>

Notably, the NSP is silent on issues of privacy and confidentiality, and it does not address isolation.

Along with the NSP, the NTBLCP has promulgated several other regulations related to the prevention, control and treatment of TB. These include the NTBLCP Workers’ Manual, 2008<sup>283</sup> the National Guidelines for TB Infection Control, 2008,<sup>284</sup> and the Guidelines for Clinical Management of TB and HIV/AIDS Related Conditions in Nigeria, 2008.<sup>285</sup> A detailed analysis of each of these regulations is beyond the scope of this assessment; instead, a few key aspects and concerns are addressed here.

First and foremost, none of these regulations mention the rights of people with TB. The term “right,” used in the context of human rights, constitutional rights or legal rights, does not appear in the text of these regulations. Second, all three regulations use the stigmatizing term “TB suspect,” identified in the Stop TB Partnership technical language guide *United to End TB: Every Word Counts* as “stigmatizing and harmful, transferring the ‘suspicion’ of the disease to the person with TB and suggesting the person is guilty of a crime or offence.”<sup>286</sup> The language guide suggests use of the term “person to be evaluated for TB” in place of “TB suspect.”<sup>287</sup> The Workers’ Manual and Clinical Management Guidelines also use the stigmatizing term “defaulter” to refer to people with TB whose treatment is interrupted.<sup>288</sup> *Every Word Counts* explains that the term “defaulter” places unnecessary and unfair blame on people with TB and contributing to social exclusion, poor quality of life, low self-esteem and clinical depression of people with TB.<sup>289</sup> The language guide suggests use of the term “person lost to follow-up” in place of “defaulter” because it acknowledges that poor quality health services and failure to take a people-centered approach more often than not leads to the interruption or failure to start treatment.<sup>290</sup>

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<sup>281</sup> *National Strategic TB Plan*, *supra* note 4, at p. 61.

<sup>282</sup> *National Strategic TB Plan*, *supra* note 4, at pp. 64-65.

<sup>283</sup> NTBLCP, Department of Public Health and Federal Ministry of Health, *Workers’ Manual*, Revised 5<sup>th</sup> ed. (2008) [hereinafter *Workers’ Manual*], available at [http://www.who.int/hiv/pub/guidelines/nigeria\\_tb.pdf](http://www.who.int/hiv/pub/guidelines/nigeria_tb.pdf).

<sup>284</sup> Federal Ministry of Health, *National Guidelines for TB Infection Control*, (2008) [hereinafter *Infection Control Guidelines*], available at [http://www.who.int/hiv/pub/guidelines/nigeria\\_hiv\\_tb.pdf](http://www.who.int/hiv/pub/guidelines/nigeria_hiv_tb.pdf).

<sup>285</sup> Department of Health and Federal Ministry of Health, *Guidelines for Clinical Management of TB and HIV/AIDS Related Conditions in Nigeria*, (2008), available at <http://www.who.int/hiv/pub/guidelines/nigeria.pdf>.

<sup>286</sup> Stop TB Partnership and UNOPS, *United to End TB—Every Word Counts: Suggested Language and Usage for Tuberculosis Communications*, 1st ed., p. 3 (2015) [hereinafter *Every Word Counts*], available at [http://www.stoptb.org/assets/documents/resources/publications/acsm/LanguageGuide\\_ForWeb20131110.pdf](http://www.stoptb.org/assets/documents/resources/publications/acsm/LanguageGuide_ForWeb20131110.pdf).

<sup>287</sup> *Id.* at p. 34.

<sup>288</sup> *Workers’ Manual*, *supra* note 283, at §§ 2.10, 2.11, 7.6, 9.7.5, 9.7.6.

<sup>289</sup> *Every Word Counts*, *supra* note 286, at pp. 5, 39.

<sup>290</sup> *Every Word Counts*, *supra* note 286, at p. 40.

Third, the three regulations are silent on the conditions and circumstances related to isolation or involuntary isolation of people with TB. The Infection Control Guidelines state that health facilities should implement infection control plans that include “[a]dministrative policies with regards to triage and screening, referral and diagnosis, separation and isolation,” but they provide no further direction on the content of such policies.<sup>291</sup> The Infection Control Guidelines do provide instruction on separation of people with TB in health facilities, establishing that they “must be **separated** from other patients and requested to wait in a separate well-ventilated waiting area or patient ward” (emphasis in original).<sup>292</sup> Notably, they also explain that “infection control interventions such as the wearing of masks by patients ... and separation may be perceived as stigmatizing or as an impediment to patient-provider communication.”<sup>293</sup> To mitigate these negative effects, they instruct that infection control programs “should attempt to *normalize* separation of coughing clients [and] use of masks ... within the context of *promoting patient safety* and provision of quality care” (emphasis in original).<sup>294</sup> The Infection Control Guidelines also clarify that:

“Social stigma is a recognized barrier to effective TB care.

- In the community, stigma can discourage health-seeking behaviour thereby delaying TB diagnosis and treatment.
- Among HCWs, fear and uncertainty can negatively impact on services and patient-centred care.”<sup>295</sup>

The Workers’ Manual also notes that social stigma contributes to high TB morbidity and mortality.<sup>296</sup>

Finally, the Clinical Management Guidelines fail to mention the right to privacy or confidentiality related to prevention, testing, treatment and care of people with TB; confidentiality is only discussed as a requirement of HIV counseling services. The Worker’s Manual also mentions confidentiality in the context of HIV testing and counseling. But it does instruct TB treatment supporters to respect a “patient’s confidentiality” and it directs health care workers to, “where possible[,] ensure some privacy to the patient” before collecting sputum.<sup>297</sup> The Worker’s Manual fails to instruct NTBLCP health workers, more generally, to treat people with TB with respect and dignity during their diagnosis and treatment.

### *HIV/AIDS Policies and Regulations*

The National Agency for the Control of AIDS (NACA) and the Ministry of Health’s National AIDS and STIs Control Program (NASCP) lead the response to HIV/AIDS in Nigeria. NACA and NASCP coordinate public and private sector activities and formulate policies and guidelines for HIV/AIDS prevention, treatment, care and support.<sup>298</sup> There is an array of policies, guidelines and regulations on HIV/AIDS at the federal level. These include, among others: the National Policy on

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<sup>291</sup> *Infection Control Guidelines*, *supra* note 284, at § 3.2.3.

<sup>292</sup> *Infection Control Guidelines*, *supra* note 284, at § 3.3.3.

<sup>293</sup> *Infection Control Guidelines*, *supra* note 284, at § 3.3.2.

<sup>294</sup> *Infection Control Guidelines*, *supra* note 284, at § 3.3.2.

<sup>295</sup> *Infection Control Guidelines*, *supra* note 284, at § 3.3.2.

<sup>296</sup> *Workers’ Manual*, *supra* note 283, at § 1.1.

<sup>297</sup> *Workers’ Manual*, *supra* note 283, at §§ 2.5.1.2, 7.5.1.

<sup>298</sup> NACA, *NACA Mandate*, at <https://naca.gov.ng/naca-mandate/>; NASCP, Federal Ministry of Health, *Vision and Mission*, at <http://nascp.gov.ng/index.php/vision-and-mission/>.

HIV/AIDS, 2009;<sup>299</sup> the National Guidelines for HIV Prevention, Treatment and Care, 2016;<sup>300</sup> the National HIV/AIDS Strategic Plan, 2010-2015;<sup>301</sup> the National HIV/AIDS Prevention Plan, 2014-2015;<sup>302</sup> and the National HIV and AIDS Monitoring and Evaluation Plan, 2011-2016.<sup>303</sup> A detailed analysis of each policy, regulation and guideline is beyond the scope of this assessment; instead, some key components are highlighted here.

Recognition and protection of the human rights of people living with HIV is central to the HIV/AIDS policy and regulatory framework in Nigeria. For example, the National Policy on HIV/AIDS establishes this “key consideration” that informs the policy:

“Effective response to HIV/AIDS requires respect for, protection of and fulfillment of all human rights civil, political, economic, social, and cultural and upholding the fundamental freedoms of all people in accordance with the country's constitution and existing international human rights principles, norms and standards.”<sup>304</sup>

The National Policy includes an entire section titled Human Rights and Legal Issues<sup>305</sup> and commits to these guiding principles, upon which the policy is based and governed:

- “Protection and promotion of the rights and access of PLHIV to comprehensive health care and other social services.
- Commitment to protecting rights of PLHIV, reduction of stigma and discrimination and ensuring greater involvement of PLHIV in national HIV/AIDS program at all levels.
- Commitment to promote and protect rights and reduce vulnerability of women, children, young people and marginalised groups to HIV infection.”<sup>306</sup>

The very first sentence of the National HIV Guidelines declares: “The 2016 Guidelines are informed by the basic principles of equality, equity and social justice and they align strongly with the universal declarations of human rights.”<sup>307</sup> The second of eight core principles of the National HIV Guidelines is the “Promotion of human rights and equity.” This principle explains that “[a]ccess to quality ... HIV prevention, treatment, care and support is a basic human right” and “informed consent (for HIV testing and initiation of [antiretroviral therapy]) and adequate health information safeguards should be put in place to ensure consent and confidentiality.”<sup>308</sup> The National HIV Guidelines establish the rights to informed consent, confidentiality, counseling and to refuse testing.<sup>309</sup> The section on Service Delivery lists a set of core concepts underlying the prescribed client and family-centered approach that include dignity and respect, information sharing and

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<sup>299</sup> Federal Government of Nigeria, *National Policy on HIV/AIDS*, (Oct. 2009) [hereinafter National HIV/AIDS Policy], available at [http://www.africanchildinfo.net/cfr/policy%20per%20country/nigeria/nigeria\\_hivaids\\_2009\\_en.pdf](http://www.africanchildinfo.net/cfr/policy%20per%20country/nigeria/nigeria_hivaids_2009_en.pdf).

<sup>300</sup> *National HIV Guidelines*, *supra* note 15.

<sup>301</sup> NACA, *National HIV/AIDS Strategic Plan, 2010-2015*, (Jan. 2010), available at [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/legaldocument/wcms\\_146389.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_146389.pdf).

<sup>302</sup> NACA, *National HIV/AIDS Prevention Plan, 2014-2015*, (2013), available at <http://sbccvch.naca.gov.ng/sites/default/files/National%20HIV%20PrevPlan%202014-2015%281%29.pdf>.

<sup>303</sup> NACA, *National HIV and AIDS Monitoring and Evaluation Plan, 2011-2016*, Nigeria National Response Information Management System Operational Plan II (3<sup>rd</sup> ed., 2011) [hereinafter National HIV/AIDS M&E Plan], available at [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/legaldocument/wcms\\_201321.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_201321.pdf).

<sup>304</sup> *National HIV/AIDS Policy*, *supra* note 299, at § 2.2.

<sup>305</sup> *National HIV/AIDS Policy*, *supra* note 299, at § 7.

<sup>306</sup> *National HIV/AIDS Policy*, *supra* note 299, at § 2.3.

<sup>307</sup> *National HIV Guidelines*, *supra* note 15, at p. 1.

<sup>308</sup> *National HIV Guidelines*, *supra* note 15, at p. 1.

<sup>309</sup> *National HIV Guidelines*, *supra* note 15, at p. 12.



participation.<sup>310</sup> Finally, the National HIV Guidelines acknowledge and provide guidance throughout on how to reduce stigma and discrimination in the delivery of HIV prevention, treatment, care and support services.

The National HIV/AIDS Strategic Plan includes a section on Policy, Advocacy, Human Rights, and Legal Issues that makes several key recommendations. These include:

1. “The coalition of [HIV/AIDS] Civil Society Organizations ... should have their capacities strengthened to spearhead advocacy efforts to government ...[.]”
2. All HIV/AIDS stakeholders should work together for the passage of the HIV-AIDS antidiscrimination bill through intensification of advocacy[.]
- ...
4. The capacity of the national human rights institutions such as National Human Rights Commission and Public Complaints Commission should be strengthened to protect the rights of [people living with HIV] ...[.]
5. Advocate for the establishment of a legal frame and bill that will protect prospective employees and people intending to marry from mandatory HIV testing ...”<sup>311</sup>

The National HIV Prevention Plan recognizes human rights violations as a key driver that increases vulnerability to HIV infection.<sup>312</sup> The critical role protection of human rights plays in the national HIV response is established throughout the National HIV and AIDS Monitoring and Evaluation Plan. In particular, the plan resolves to ensure key national goals are achieved, including to “[p]rotect the rights of [people living with HIV] ... and empower them to reduce their cultural, legal, and socioeconomic vulnerabilities and ensure their full participation in the National response.”<sup>313</sup> The plan also monitors the number of states with anti-stigma or anti-discrimination laws as one of the Operational Plan Indicators.<sup>314</sup>

### *Prison Policies and Regulations*

The Controller-General of Prisons in Nigeria promulgated the Nigerian Prisons Service Standing Orders (Revised Edition) in 2011.<sup>315</sup> The Orders establish that a medical officer will examine upon admission prisoners with “pulmonary tuberculosis, ... suspected infectious diseases or a suspected contact with an infected person,” “make recommendations” as to whether such prisoners should engage in prison labor, and “recommend in writing for the separation of prisoners having infectious diseases.”<sup>316</sup> The Orders also state that when a prisoner with an infectious disease is to be discharged, but is “still in a condition in which he could spread the disease, arrangements shall be made for the person to be admitted into the nearest hospital and detained there at the discretion of the Hospital Authorities until fit to travel without danger to the public.”<sup>317</sup>

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<sup>310</sup> *National HIV Guidelines*, *supra* note 15, at p. 193.

<sup>311</sup> *National HIV/AIDS Strategic Plan*, *supra* note 301, at p. 22.

<sup>312</sup> *National HIV/AIDS Prevention Plan*, *supra* note 302, at § 1.3.4.

<sup>313</sup> *National HIV/AIDS Me&E Plan*, *supra* note 303, at § 3.13.

<sup>314</sup> *National HIV/AIDS Me&E Plan*, *supra* note 303, at p. 91.

<sup>315</sup> Nigerian Prisons Service Standing Orders (Revised Edition), S.I. 46 of 2011, Cap. B 1425 (Dec. 29, 2011), available at <http://www.prawa.org/wp-content/uploads/2013/01/NIGERIAN-PRISONS-STANDING-ORDER.pdf>.

<sup>316</sup> *Id.* at §§ 464, 465, 592.

<sup>317</sup> *Id.* at § 75.

## Labor and Employment Policies and Regulations

The National Employment Policy, 1998 (NEP)<sup>318</sup> is still in place, but is currently undergoing a consultative review process.<sup>319</sup> One of NEP's main objectives is to “[s]afeguard the basic rights and interest of workers, and to that end, promote respect for ... the Principle of Non-Discrimination and Equality.”<sup>320</sup> The NEP does not mention TB, but it includes a section entitled HIV/AIDS and the Workplace, as part of a larger chapter on Improving Working Conditions, Occupational Safety and Health. This section directs the government to “intensify efforts to implement the WHO/ILO guidelines on HIV/AIDS in the workplace, aimed amongst other things, at minimizing discrimination against ... and maximizing the labour productivity of” workers living with HIV.<sup>321</sup> The NEP also directs the government “to adopt the National HIV/AIDS Policy ... as well as enact the enabling legislation for its implementation.”<sup>322</sup>

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<sup>318</sup> Federal Republic of Nigeria, *National Employment Policy: Objectives, Measures, Strategies and Institutional Framework to Meet the Challenges of Rising Unemployment and Underemployment* (1998) [hereinafter *Employment Policy*], available at <http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/90973/105241/F-1938473397/NGA90973.pdf/>.

<sup>319</sup> See Chijioke J. Eboh and Ugochukwu O. Agu, *The National Employment Policy (Nep) of Nigeria: A Review*, (2016), available at <http://www.nelexnigeria.com/sites/default/files/Draft%20NEP>.

<sup>320</sup> *Employment Policy*, *supra* note 318, at § 3.1.

<sup>321</sup> *Employment Policy*, *supra* note 318, at § 4.7.7.

<sup>322</sup> *Employment Policy*, *supra* note 318, at § 4.7.7.

## APPENDIX

### In-Country Assessment Schedule

DATE (2017)	ACTIVITY
Saturday, 15 July Abuja	Brian Citro, <i>Northwestern Pritzker School of Law</i> and Ryan Maher, <i>University of Chicago Law School</i> arrived in Abuja.
Sunday, 16 July Abuja	LEA Task Team and Technical Expert Group Meeting with: <ul style="list-style-type: none"> <li>• Brian Citro, <i>Northwestern Pritzker School of Law</i></li> <li>• Ryan Maher, <i>University of Chicago Law School</i></li> <li>• Mayowa Joel, <i>Communication for Development Centre</i></li> <li>• Jumoke Adebari, <i>NTBLCP</i></li> <li>• Barr. Rommy Mom, <i>Lawyers Alert</i></li> </ul>
Monday, 17 July Abuja	Stakeholder Interviews: <ul style="list-style-type: none"> <li>• Prof. Lovett Lawson, <i>Zankli Medical Centre</i></li> <li>• Hon. Ombugadu Davematics, <i>HIV/AIDS, TB and Malaria Control Committee of the National Assembly, House of Representatives</i></li> <li>• Dr. Adebola Lawanson and Staff, <i>NTBLCP</i></li> </ul> <p>Colleen Daniels, <i>Stop TB Partnership</i> arrived Abuja.</p>
Tuesday, 18 July Abuja	Abuja Stakeholder Dialogue at Crystal Palace Hotel
Wednesday, 19 July Abuja	Stakeholder Interviews: <ul style="list-style-type: none"> <li>• Han Kang, <i>USAID Nigeria</i></li> <li>• Minal Amin, <i>USAID Nigeria</i></li> <li>• Matron Chioma Okoronkwa, <i>Omega Public Health Clinic</i></li> <li>• Person with MDR-TB, <i>Omega Public Health Clinic</i></li> </ul> <p>Site Visit:</p> <ul style="list-style-type: none"> <li>• Omega Public Health Clinic</li> </ul>
Wednesday, 19 July Lagos	Stakeholder Interviews: <ul style="list-style-type: none"> <li>• Dr. Hussein Abdulrazak, <i>Lagos State TB Control Program</i></li> </ul> <p>LEA Task Team and Technical Expert Group Meeting with:</p> <ul style="list-style-type: none"> <li>• Brian Citro, <i>Northwestern Pritzker School of Law</i></li> <li>• Ryan Maher, <i>University of Chicago Law School</i></li> <li>• Barr. Kema Ufelle, <i>Capitalfield Attorneys</i></li> </ul>
Thursday, 20 July	Lagos Stakeholder Dialogue at Primal Hotel – The Annex

Lagos	LEA Task Team and Technical Expert Group Meeting with: <ul style="list-style-type: none"> <li>• Brian Citro, <i>Northwestern Pritzker School of Law</i></li> <li>• Ryan Maher, <i>University of Chicago Law School</i></li> <li>• Dr. Temitayo Odusote, <i>USAID Nigeria</i></li> </ul>
Friday, 20 July Lagos	Stakeholder Interviews: <ul style="list-style-type: none"> <li>• Barr. Josephine Odikpo, <i>Centre for Rights and Development</i></li> <li>• Dr. Abimbola Bowale, <i>Mainland Hospital MDR-TB Treatment Centre</i></li> <li>• Monisola Ajiboye, <i>Citadel of Hope</i></li> <li>• Michael Uvri, <i>Citadel of Hope</i></li> <li>• Tope Olojeda, <i>Citadel of Hope</i></li> </ul>
Saturday, 21 July Lagos	Brian Citro, <i>Northwestern Pritzker School of Law</i> and Ryan Maher, <i>University of Chicago Law School</i> departed Nigeria.

## In-Depth Stakeholder Interview Questionnaires

### Physicians / Health Workers

- Where do you practice medicine and for how long have you been a physician or health worker?
- What are the challenges you face in providing care to those affected by TB?
- What do you consider to be the major obstacles facing those affected by TB in obtaining testing and treatment?
- How do you feel people with TB are generally treated in healthcare settings?
- Have you experienced any shortages of resources, including drugs, diagnostics or funding?
- Have any of your patients interrupted or stopped treatment? If yes, do you know why it happened?

### People with TB and TB Survivors

- Where are you from and what is your profession? What is your community and residence like? (to assess environmental determinants)
- How long have you had TB? Is it drug-resistant?
- Did your family or community treat you differently after they learned you had TB? If so, how? If not, why do you think you were not treated differently?
  - Have you been treated differently by your employer or coworkers because you have TB?
- Did you think you had TB before you were diagnosed?
- How much did you know about TB before you were diagnosed?
- What information did you receive about TB once you were diagnosed and undergoing treatment?
- What were some of the difficulties you faced in obtaining testing and treatment for TB?

- Was there a delay between when you thought you had TB and when you were diagnosed?
- Have you ever considered stopping your treatment for any reason? If so, for what reason?
- How do you feel people with TB are generally treated in healthcare settings?

### Judges

- On what court do you sit and for how long have you been a judge?
- What are some of the major problems in accessing justice, or in the legal system generally, faced by the average citizen?
  - Are most litigants aware of their rights before they enter the courtroom, or even after?
- Have the Fundamental Rights (Enforcement Procedure) Rules of 2009 had a large impact on human rights cases in the legal system?
- Have you heard any cases involving people with TB? If so, what was the issue and how was it decided? If not, have you heard cases involving other infectious diseases, such as HIV?
  - What major sources of law do you draw upon when deciding a case involving TB or other infectious diseases, such as HIV? (Constitution, African Charter, Fundamental Rights (Enforcement Procedure) Rules, policies)
- How do you feel those affected by TB or other infectious diseases, such as HIV, are treated in the legal system?

### Lawyers

- Where do you practice law and for how long have you been a lawyer?
- What are some of the major problems in accessing justice, or in the legal system generally, faced by the average citizen?
  - Are most litigants aware of their rights before they enter the courtroom, or even after?
- Have the Fundamental Rights (Enforcement Procedure) Rules of 2009 had a large impact on human rights cases in the legal system?
- Have you argued any cases involving people with TB? If so, what was the issue and how was it decided? If not, have you argued cases involving other infectious diseases, such as HIV?
  - What arguments and sources of law do you utilize when representing a client with TB or another infectious disease, such as HIV? (Constitution, African Charter, Fundamental Rights (Enforcement Procedure) Rules, policies)
- How do you feel those affected by TB are treated in the legal system?
- What legal or policy reforms would improve the prevention, testing, treatment and care for those affected by TB?

### Policymakers

- What ministry do you work in, what is your position and for how long have you been a policy-maker?
- How do you feel those affected by TB are treated in their communities and healthcare settings?

- What are the most effective policies in Nigeria promoting prevention, testing, treatment and care for people affected by TB?
- What are some of the policy barriers to effective prevention, testing, treatment and care for people affected by TB? For example, are there policy barriers that impede access to testing and treatment?
  - If so, how can these policy barriers be removed to promote more effective prevention, testing, treatment and care for people affected by TB?
- Are TB key populations, such as the urban and rural poor, prisoners and migrants, a focus of healthcare policy?
- Do you think legislation specifically targeting TB is needed, in addition to existing policies of the National Tuberculosis and Leprosy Control Programme?
- What policies are in place for the involuntary isolation, quarantine or detention of people with TB?
  - Under what circumstances are these measures permitted?
  - Is there a legal standard governing the isolation, quarantine or detention of people with TB? If so, what law governs? (Nigeria Public Health (Quarantine, Isolation and Emergency Health Matters Procedure) Act, 2014 (SB 210)?)

### Legislator

- What area do you represent and for how long have you been a legislator?
- How knowledgeable are legislators about TB disease, including the nature of the contagion?
- How aware are legislators of the legal and human rights issues related to TB?
- What do you consider to be the major obstacles faced by those with TB in obtaining testing and treatment?
- How is TB prioritized relative to other national issues, including with regard to allocation of funding and other resources? Is TB a topic of discussion in the National Assembly/state House of Assembly?
  - If so, are legislators receptive to legal reforms targeting TB?
- Is there interest in National Assembly/state House of Assembly to consider TB-specific legislation?
  - What would be the major barriers to the introduction of legislation specifically targeting TB?
- What legislative reforms to healthcare are underway that may impact TB?
  - For example, is the Nigeria Public Health (Quarantine, Isolation and Emergency Health Matters Procedure) Act, 2014 (SB 210) still under consideration?
- How do you and other legislators view the African Charter? What role or impact, if any, should the Charter have in Nigerian legislation?

### Members of Civil Society and Community-Based Organizations

- What organization do you work for, in what position, and for how long have you worked in civil society?
- What kind of work does your organization do in the area of TB?
- What are the major CSOs working in the area of TB?
  - What level of influence do they have in affecting government policy related to TB?

- How receptive is the government to the input and advocacy of civil society and community-based groups?
- What are the major barriers, including legal or policy barriers, for people affected by TB in accessing testing, treatment and care?
  - How can these barriers be removed to promote more effective prevention, testing, treatment and care for people affected by TB?
- What are the major human rights issues faced by people with TB?
- Does civil society focus on TB key populations, such as the urban and rural poor, prisoners and migrants, in their work?
- What legal or policy reforms would improve the prevention, testing, treatment and care for those affected by TB? What reforms do you think are realistic?

## Abuja Stakeholder Dialogue

### Abuja Stakeholder Dialogue Agenda

#### Nigeria Tuberculosis Legal Environment Assessment: Abuja Stakeholder Dialogue

**Abuja, Nigeria  
18 July 2017**

#### AGENDA

**Dialogue Objective:** To identify and discuss key legal and human rights issues in TB prevention, testing, treatment and care in Nigeria.

TIME	SESSION	FACILITATOR
8.30 am – 9.00 am	Arrival and Registration	<i>Communication for Development Centre</i>
9.00 am – 9.15 am	Welcoming Remarks	Dr. Adebola Lawanson, <i>NTBCLP National Coordinator</i>
9.15 am – 9.30 am	Introductions	Brian Citro, <i>Northwestern Pritzker School of Law</i>
9.30 am – 10.00 am	Setting the Scene: Purpose and scope of the TB Legal Environment Assessment (LEA)	Colleen Daniels, <i>Stop TB Partnership</i>

10.00 am – 11. 00 am	<p>TB Prevention, Testing, Treatment and Care in Nigeria: Successes and challenges</p> <p><i>Panel Discussion:</i></p> <ul style="list-style-type: none"> <li>• Dr. Adebola Lawanson, <i>NTBLCP</i></li> <li>• Dr. Ayodele Awe, <i>WHO Nigeria</i></li> <li>• Dr. Taofeek Ali, <i>Institute of Human Virology Nigeria (IHVN)</i></li> <li>• Dr. Josephine Okechukwu, <i>FCT TB and Leprosy Control Program</i></li> </ul>	<p>Moderator: Brian Citro, <i>Northwestern Pritzker School of Law</i></p>
<b>11.00 am – 11.30 am</b>	<b>COFFEE/TEA BREAK</b>	
11.30 am – 12.00 pm	<p>TB and Human Rights: Foundations of a human rights-based approach to TB prevention, testing, treatment and care.</p>	<p>Brian Citro, <i>Northwestern Pritzker School of Law</i></p>
12.00 pm – 12.30 pm	<p>Nigeria TB LEA Desk Research: Overview of TB-related constitutional law, legislation and policies in Nigeria</p>	<p>Ryan Maher, <i>University of Chicago Law School</i></p>
12.30 pm – 1.00 pm	<p>Plenary Discussion: TB, human rights and the law in Nigeria</p>	<p>Moderator: Colleen Daniels, <i>Stop TB Partnership</i> Rommy Mom, <i>Lawyers Alert</i></p>
<b>1.00 pm – 2.00 pm</b>	<b>LUNCH</b>	
2.00 pm – 3.00 pm	<p>TB Prevention, Testing, Treatment and Care in Nigeria: View from community and civil society</p> <p><i>Panel Discussion:</i></p> <ul style="list-style-type: none"> <li>• Funke Dosumu, <i>TB Survivor</i></li> <li>• Grace Iho, <i>TB Survivor</i></li> <li>• Maureen Onyia-Ekwuozu, <i>National Labour Congress</i></li> </ul>	<p>Moderator: Ryan Maher, <i>University of Chicago Law School</i></p>
3.00 pm – 4.00 pm	<p>Plenary Discussion: Next steps and recommendations to the Nigeria TB LEA</p>	<p>Moderators: Brian Citro, <i>Northwestern Pritzker School of Law</i> Colleen Daniels, <i>Stop TB Partnership</i></p>
4.00 pm – 4.15 pm	Closing Remarks	<p>Mayowa Joel, <i>Communication for Development Centre</i></p>
	<b>COFFEE/TEA AND DEPARTURE</b>	

## Abuja Stakeholder Dialogue List of Participants



**Nigeria Tuberculosis Legal Environment Assessment:  
Abuja Stakeholder Dialogue**

**Abuja, Nigeria  
18 July 2017**

**LIST OF PARTICIPANTS**

<b>s/n</b>	<b>NAME</b>	<b>ORGANIZATION</b>
1.	Ryan Maler	University of Chicago Law School
2.	Brian Citro	Northwestern Pritzker School of Law
3.	Colleen Daniels	Stop TB Partnership
4.	Rommy Moore	Lawyers Alert
5.	Ademoroti Sheriff	LPI Foundation
6.	Sheshi Michael	TLMN
7.	Habiba Giwa Bello	KNCV/Challenge TB
8.	Edor Agnes	ICW-WA
9.	Ebute Ada	APYIN
10.	Gloria Asuquo	ICW-WA
11.	Alheri Mamman	Aswatu Abuja
12.	Grace Iho	TB Survivor
13.	Christiana Essien	CSO
14.	Lady Christie Uche	FFVHOE
15.	Oluwafunke Dosumu	TB Survivor/Advocate
16.	Akinwunmi Dosumu	TB Advocate
17.	Dr. Okechukwu Josephine	FCT TBLCO
18.	Jumoke Adebari	NTBLCP
19.	Dr. Ayodele Awe	WHO Nigeria
20.	Dr. Emperor Ubochioma	NTBLCP
21.	Dr. Basure Tesfaye	USAID/NTBLCP
22.	Nwanneka okere	University of Maryland
23.	Maureen Onyia-Ekwuozu	NLC/CCM Nigeria
24.	Kampoer Bertrand	FIS Cameroon
25.	Olawale Mary	ASWHAN
26.	Helen Aphan	ASWHAN
27.	Faith Omu	ICW-WA
28.	Ogwuche Iberi Deborah	National Assembly
29.	Mohammed Zainab	FCT High Court
30.	Folorunsho Eyitayo	CDC
31.	Ikharia Nagubatu	Private Practitioner
32.	Babayi Aminu	FHI-360
33.	Madinatu Salihu	Women in Dawatu Nigeria
34.	Sanni Rekiya	Global Community Mobilization
35.	Dr. Ahmad Muhammad	NTBLCP
36.	Olowu Joseph	LUCAP
37.	Kingsley Ochei	FHI-360
38.	Winifred Iho	Communication for Development Centre
39.	Mayowa Joel	Communication for Development Centre

## Lagos Stakeholder Dialogue

### Lagos Stakeholder Dialogue Agenda

#### Nigeria Tuberculosis Legal Environment Assessment: Lagos Stakeholder Dialogue

Lagos, Nigeria  
20 July 2017

#### AGENDA

**Dialogue Objective:** To identify and discuss key legal and human rights issues in TB prevention, testing, treatment and care in Nigeria.

TIME	SESSION	FACILITATOR
8.30 am – 9.00 am	Arrival and Registration	<i>Communication for Development Centre</i>
9.00 am – 9.15 am	Welcoming Remarks	Dr. Hussein Abdulrazak, <i>Program Coordinator, Lagos State TB Control Programme</i>
9.15 am – 9.30 am	Introductions	Brian Citro, <i>Northwestern Pritzker School of Law</i>
9.30 am – 10.00 am	Setting the Scene: Purpose and scope of the TB Legal Environment Assessment (LEA)	Mayowa Joel, <i>Communication for Development Centre</i>
10.00 am – 11.00 am	TB Prevention, Testing, Treatment and Care in Nigeria: Successes and challenges <i>Panel Discussion:</i> <ul style="list-style-type: none"><li>• Dr. Hussein Abdulrazak, <i>Lagos State TB Control Programme</i></li><li>• Dr. Bukola - <i>KNCV</i></li></ul>	Moderator: Brian Citro, <i>Northwestern Pritzker School of Law</i>
<b>11.00 am – 11.30 am</b>	<b>COFFEE/TEA BREAK</b>	
11.30 am – 12.00 pm	TB and Human Rights: Foundations of a human rights-based approach to TB prevention, testing, treatment and care.	Brian Citro, <i>Northwestern Pritzker School of Law</i>
12.00 pm – 12.30 pm	Nigeria TB LEA Desk Research: Overview of TB-related constitutional law, legislation and policies in Nigeria	Ryan Maher, <i>University of Chicago Law School</i>

12.30 pm – 1.00 pm	Plenary Discussion: TB, human rights and the law in Nigeria	Moderator: Kema Ufelle-Smith, <i>Capitalfield Attorneys</i>
<b>1.00 pm – 2.00 pm</b>	<b>LUNCH</b>	
2.00 pm – 3.00 pm	<p>TB Prevention, Testing, Treatment and Care in Nigeria: View from community and civil society <i>Panel Discussion:</i></p> <ul style="list-style-type: none"> <li>• Monisola Ajiboye, <i>Citadel of Hope</i></li> <li>• Nike Arigbabu, <i>Health Advocate</i></li> <li>• Philomena Okure, <i>PEO</i></li> <li>• Josephine Odikpo, <i>Center for Rights and Development</i></li> </ul>	Moderator: Ryan Maher, <i>University of Chicago Law School</i>
3.00 pm – 4.00 pm	Plenary Discussion: Next steps and recommendations to the Nigeria TB LEA	Moderators: Brian Citro, <i>Northwestern Pritzker School of Law</i> Ryan Maher, <i>University of Chicago Law School</i>
4.00 pm – 4.15 pm	Closing Remarks	Mayowa Joel, <i>Communication for Development Centre</i>
<b>COFFEE/TEA AND DEPARTURE</b>		

## Lagos Stakeholder Dialogue List of Participants

### Nigeria Tuberculosis Legal Environment Assessment: Lagos Stakeholder Dialogue

Lagos, Nigeria  
20 July 2017

#### LIST OF PARTICIPANTS

S/No	Name	Organization
1.	Abu Yakubu	Hope of Glory
2.	Aderonke Adefolaju	Women's Rights and Health Project
3.	Adebari Jumoke	NTBLCP/FMoH
4.	Philomena Okure	People Empowerment Organization
5.	Ukazu Ogadinma	TB Network
6.	Onobun Lucky	Dave Enechikwu Foundation
7.	Evans Enwefah	Community Aid Development Foundation
8.	Barr. Josephine Odikpo	Odikpo, Okpe & Associates and Center for Rights and Development
9.	Zainab Adeyeni	CARE

10.	Ryan Maler	University of Chicago Law School
11.	Brian Citrio	Northwestern Pritzker School of Law
12.	Kema Ufelle-Smith	Capitalfield Attorneys
13.	Toburn Adeola	TBLS Surulere LGA
14.	Godwin Adekunle	Women Protection Organization
15.	Dr. Adebukola Adegbola	KNCV/Challenge TB
16.	Adenike Arigbabu	Nikari Lifestyle
17.	Adeyemi Taiwo	Totalcare Support Group
18.	Monisola Ajiboye	Citadel of Hope
19.	Dr. Hussein Abdul-Razzak	LSMOH/STBLCO
20.	Ajayi Akintunde	Community Empowerment for Peace and Health
21.	Bashir Opeyemi	Centre for Positive Health Organizations
22.	Moronfolu Olanike	LSMOH/STBLCO
23.	Toyin Ajayi	Tendercare Initiative
24.	Adepeju Onilude	Gabasawa Women and Children Foundation
25.	Bose Ironsi	WRAHP
26.	Idris Olanike	LSMOH/STBLCO
27.	Chibuike Amaechi	The Good Neighbour
28.	Seyi Jimoh	ASHWAN
29.	Obi Monica	Positive Proof
30.	Babaagba Mamuda	AGPNP
31.	Sadiq Ogoveche	AGPNP
32.	Durueke Florita	NHVMAS
33.	Tunde Patrick	JAKIN NGO
34.	Kadiri Oluseyi	CEPHO
35.	Jenet Lenya	Communication for Development Centre
36.	Mayowa Joel	Communication for Development Centre

## National Validation Workshop

### National Validation Workshop Agenda

#### Nigeria Tuberculosis Legal Environment Assessment: National Validation Workshop

Abuja, Nigeria  
13 August 2018

#### AGENDA

##### Validation Workshop Objectives:

1. Provide a platform for stakeholders to engage in dialogue and reach consensus on the LEA findings and recommendations;
2. Mobilize and coordinate human and financial resources to implement the LEA recommendations; and
3. Develop a mechanism to monitor and evaluate progress toward implementing the LEA recommendations.

TIME	SESSION	FACILITATOR
8.30 am – 9.00 am	Arrival and Registration	<i>Communication for Development Centre</i>
9.00 am – 9.15 am	Welcome Remarks	Dr. Adebola Lawanson, <i>NTBLCP</i>
9.15 am – 9.30 am	Distinguished Introduction: Ending TB in Nigeria	Hon. Davematics Ombugadu, <i>Chairman, HIV/AIDS, TB and Malaria Control Committee of the National Assembly</i>
9.30 am – 10.00 am	Setting the Stage: The Role of Community, Rights and Gender in the Fight against TB  Purpose and Scope of the Nigeria TB LEA	Thandi Kattholo, <i>Stop TB Partnership</i>  Mayowa Joel, <i>Communication for Development Centre</i>
10.00 am – 10.30 am	Presentation of the Nigeria TB LEA Findings and Recommendations	Prof. Brian Citro, <i>Northwestern School of Law; Stop TB Partnership</i>
10.30 am – 11.15 am	Reaction from Government and Distinguished Physicians:  <i>Panel Discussion</i> <ul style="list-style-type: none"> <li>• Dr. Adebola Lawanson, <i>NTBLCP</i></li> <li>• Dr. Hussein Abdul-Razak, <i>Lagos State TB Control Program</i></li> <li>• Dr. Josephine Okechukwu, <i>FCT TB and Leprosy Control Program</i></li> <li>• Dr Ibrahim Ade Yusuf, <i>Nigeria Prison Service</i></li> <li>• Prof. Lovett Lawson, <i>Zankli Medical Centre</i></li> </ul>	<i>Moderator:</i>  Prof. Brian Citro, <i>Northwestern School of Law; Stop TB Partnership</i>
<b>11.15 am – 11.30 am</b>	<b>COFFEE/TEA BREAK</b>	
11.30 am – 12.15 pm	Reaction from the Community and Civil Society:  <i>Panel Discussion</i> <ul style="list-style-type: none"> <li>• Obatunde Oladapo, <i>TB Rep. CCM</i></li> <li>• Ibrahim Umoru, <i>PLHIV Rep. CCM</i></li> <li>• Ijeoma Nnaji, <i>Alternate TB Rep. CCM</i></li> </ul>	<i>Moderator:</i>  Olayide Akanni, <i>Journalist Against AIDS (JAAIDS)</i>

	<ul style="list-style-type: none"> <li>Assumpta Reginald, <i>ASHWAN</i>.</li> <li>Funke Dosumu, <i>TB Survivor</i></li> </ul>	
12.15 pm – 1.00 pm	<p>Reaction from the Legal Community:</p> <p><i>Panel Discussion</i></p> <ul style="list-style-type: none"> <li>Josephine Odikpo, <i>Odikpo, Okpe &amp; Associates; Center for Rights and Development</i></li> <li>Bamidele A. Jacobs, <i>Lanviers Alert</i></li> <li>Merama Yusuf Balami, <i>Coalition of Lawyers for Human Rights</i></li> <li>Danjuma Abdullahi, <i>Federal Ministry of Justice</i></li> <li>Folusho Olakunle, <i>Nigeria Human Rights Commission</i></li> </ul>	<p><i>Moderator:</i></p> <p>Rommy Mom, <i>Lanviers Alert</i></p>
1.00 pm – 2.00 pm	<b>LUNCH</b>	
2.00 pm – 2.45 pm	<p>Reaction from Donors and Development Partners:</p> <p><i>Panel Discussion</i></p> <ul style="list-style-type: none"> <li>Dr Ayodele Awe, <i>WHO Nigeria</i></li> <li>Dr Temitayo Odusote, <i>USAID</i></li> <li>Dr. Bethrand Odume, <i>US-CDC</i></li> <li>Dr. Ikpezeazu, <i>FHI-360</i></li> <li>Dr. Vivian Ibeziako, <i>IHVN</i></li> <li>Dr. Adewale Osho, <i>ARFH</i></li> <li>Tajudeen Ibrahim, <i>CCM Nigeria</i></li> </ul>	<p><i>Moderator:</i></p> <p>Thandi Katlholo, <i>Stop TB Partnership</i></p>
2.45 pm – 3.45 pm	<p>Plenary Discussion:</p> <p>Reaching Consensus—The Nigeria TB LEA Findings and Recommendations</p>	<p><i>Moderators:</i></p> <p>Prof. Brian Citro, <i>Northwestern School of Law; Stop TB Partnership</i></p> <p>Mayowa Joel, <i>Communication for Development Centre</i></p>
3.45 pm – 4.00 pm	<b>COFFEE/TEA BREAK</b>	
4.00 pm – 4.45 pm	<p>Plenary Discussion:</p> <p>The Way Forward—Implementing the Nigeria TB LEA Recommendations and Monitoring their Impact</p>	<p><i>Moderators:</i></p> <p>Rommy Mom, <i>Lanviers Alert</i></p>

		Thandi Katlholo, <i>Stop TB Partnership</i>
4.45 pm – 5.00 pm	Closing Remarks	Hon. Dr Daniel Ogbuabor, <i>Chairman, Committee on Health Enugu State House of Assembly</i>
<b>DEPARTURE</b>		

## National Validation Workshop List of Participants

### Nigeria Tuberculosis Legal Environment Assessment: National Validation Workshop

Abuja, Nigeria  
13 August 2018

#### LIST OF PARTICIPANTS

S/N.	NAME	SEX	ORGANIZATION	STATE
<b>ABUJA</b>				
1.	Debra Iberi	F	Nigeria TB Caucus	Abuja
2.	Jumoke Adebari	F	NTBLCP	Abuja
3.	Dr Ayodele Awe	M	WHO/ Participant at CRG Meeting in Bangkok	Abuja
4.	Dr Amos Omoniyi	M	WHO	Abuja
5.	Dr Adebola Lawanson	F	NTBLCP	Abuja
6.	Dr Emperor	M	NTBLCP	Abuja
7.	Mrs Shofowora	F	NTBLCP	Abuja
8.	Ronke Agbaje	F	IHVN	Abuja
9.	Dr Bethrand Odume	M	US-CDC	Abuja
10.	Dr Temitayo Odusote	F	USAID	Abuja
11.	Debby Nongo	F	USAID	Abuja
12.	Tosin Akinmeji	F	Stop TB Nigeria	Abuja
13.	Deborah Olulade	F	Stop TB Nigeria	Abuja
14.	Dr Popoola Israel	M	WHO	Abuja
15.	Segun Olorunfemi	M	Nigeria TB Community Forum	Abuja
16.	Tajudeen Olaitan	M	CCM Nigeria	Abuja
17.	Dr Rupert Eneogu	M	KNCV/Challenge TB	Abuja
18.	Amaka Ememo	F	KAP	Abuja
19.	Michael Amalumilo	M	KAP	Abuja
20.	Dr Josephine Okechukwu	F	FCT TB Control	Abuja
21.	Bamidele Jacobs	M	Lawyers Alert	Abuja
22.	Victor Olaore Omosehin	M	NEPWHAN	Abuja
23.	Assumpta Reginald	F	ASHWHAN	Abuja
24.	Dr Babagana	M	TB Network	Abuja
25.	Dr Ibrahim Ade Yusuf	M	Nigeria Prison Service	Abuja

26.	Dr Falola-Anoemuah Olayinya		NACA	Abuja
27.	Andrew Adeoluwa Aiyewumi		NACA	Abuja
28.	Folusho Olakunle		Nigeria Human Rights Commission	Abuja
29.	Merama Yusuf Balami		Coalition of Lawyers for Human Rights	Abuja
30.	Okoye Tsema Yvonne		Global Rights Nigeria	Abuja
31.	Prof. Lovett Lawson	M	Zankli Medical Centre	Abuja
32.	Mr. Danjuma Abdullahi	M	Ministry of Justice, Department of International and Comparative Law (danjuma999@yahoo.com)	Abuja
<b>OUTSIDE ABUJA</b>				
1.	Ibrahim Umoru	M	Good Health Educators Initiative	Lagos
2.	Femi Fasinu	M	Action for Sustainable Development in Border Communities	Lagos
3.	Bolaji Musa	F	Shepherd for Health, Environment, Advocacy and Development (SHEAD)	Kwara
4.	Ijeoma Nnaji	F	Youth Child Initiative Support	Enugu
5.	Felix Ukam Ngwu	M	Centre for Healthworks, Development and Research Initiative	
6.	Obatunde Oladapo	M	PLAN	Ibadan
7.	Fakande Ibiyemi	F	Living Hope Care for PLWHA Society	Osun
8.	Kolawole Ekanoye	M	Advocates for Health and Development Initiative	Ogun
9.	Akinpelu Akintayo	M	The Youth Future Savers Initiative.	Ogun
10.	Esther Oluwakemi	F	Girl to Women Research and Development Centre	Ondo
11.	Aminu Ibrahim	M	Health Development Alternative Initiative	
12.	Josephine Odikpo	F	Lawyer/ participated in LEA	Lagos
13.	Nike Arigbabu	F	Communication for Development Centre	Lagos
14.	Dr Hussein Abdul-Razak	M	Lagos State TB/LCO/participated in LEA	Lagos
15.	Hon Dr Daniel Ogbuabor	M	Participant at CRG Meeting in Bangkok	Enugu
16.	Prof. Lawal Umar	M	Participant at CRG Meeting in Bangkok	Kaduna
17.	Dr Aniwada Elias	M	Participant at CRG Meeting in Bangkok	Owerri
<b>RESOURCE PERSONS</b>				
1.	Hon. Davematics Ombugadu	M	NASS, House of Representatives	Abuja
2.	Brian Citro	F	Northwestern Pritzker School of Law	US
3.	Rommy Rom	M	Lawyers Alert	Abuja
4.	Austin Obiefuna	M	Africa Coalition on TB (ACT)	Ghana
5.	Olayide Akanni	F	Journalist Against AIDS (JAAIDS)	Lagos
6.	Martin-Mary Falana	M	Kids & Teens Resource Centre	Ondo
7.	Mayowa Joel	M	Communication for Development Centre	Abuja