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**PROMOTING ACCESS TO ASSISTED REPRODUCTIVE TECHNOLOGY IN NIGERIA THROUGH THE RIGHTS TO BENEFITS OF SCIENTIFIC PROGRESS: AN APPRAISAL**

By

Folakemi O. Ajagunna<sup>1</sup>

**Abstract**

The prevalence of infertility in Nigeria has risen gradually over the years to 30% in 2015. Assisted Reproductive technologies (ART) are therefore relevant to the Nigerian society where infertility is a major problem. The increase in prevalence of infertility has invariably led to increase in number of clinics offering fertility services. However, this increase in fertility clinics has not translated into increased access to ART services. Restricted access to medical treatment for infertility is one of the injustices obtainable in the field of reproductive medicine. Due to many factors, including financial incapacity, some people have easier access to treatment than others. Against this background, this paper explores the intersections between balancing rights to benefits of scientific progress of which ART is and promoting access to ART services for Nigerians through legislation. The paper leans on the utilitarian theory which promotes welfare for the greatest good of all. At present, the cost of obtaining standard procedures in ART range over One Million Naira (\$3,290) which is way far above the means of an average Nigerian. This paper answers the question "should ART be regulated by legislation to provide comprehensive health care to allow individuals reap benefits of scientific progress or should it be left as a private sector driven concern where forces of demand and supply dictates its cost and accessibility?" This paper which gives further impetus to research on the legal framework for regulating ART in Nigeria concludes that infertility is a pervasive public health issue in Nigeria which exposes the sufferers to injustice and discrimination socially. Infringement of reproductive rights occurs when access to ART is not available, then via the instrumentality of law and policy, government could offer succor to this segment of the Nigerian society by ensuring cheaper access to ART services.

**Keywords:** Assisted Reproductive Technology, Rights to benefits of scientific progress, ART regulation

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## I. Introduction

Infertility is a problem of global health concern and a source of social stigma to most infertile individuals. This is because childbearing is strongly associated with the ultimate goal of completeness and family integration. Child bearing and ability to conceive remains very important in many Nigerian cultures, for example, amongst the Igbos and the Yorubas of Southern Nigeria. Studies have shown that the burden of infertility has risen gradually over the years. According to previous reports, an estimated 34 million women predominantly from developing countries are infertile.<sup>2</sup> Assisted Reproductive technology has been reported to alleviate about fifty percent of infertility cases.<sup>3</sup> By implication, Assisted Reproductive technologies (ART) are relevant to the Nigerian society where infertility is a major problem. Since the first successful IVF procedure in 1978, the use of ART and related technologies has expanded to become commonplace around the globe. More specifically, over the past decade, the use of ART services has increased at a rate of 5–10% annually.<sup>4</sup> However, in developing countries such as Nigeria, to set up this technology requires a lot of money and access to treatment is thus high. The high cost of treatment stands as a barrier to the availability and uptake of ART services in Nigeria where the technology is highly needed to alleviate infertility.

Article 15 of the International Covenant on Social and Economic Rights (Economic Covenant) provides that states parties to the present covenant recognise the rights of everyone to enjoy the benefits of scientific progress and its applications. This right may be invoked in situations where reproductive and sexual health services are not financially or geographically accessible to individuals. Against this background, this paper explores the intersections between balancing rights to benefits of scientific progress of which ART is and promoting access to ART services for individuals in Nigeria via legislation. This paper answers the question “should ART be regulated by legislation to provide comprehensive health care to allow individuals reap benefits of scientific progress or should it be left as a private sector driven concern where forces of demand and supply dictates its cost and accessibility?”

The paper is divided into five parts. Part I contains an introduction of the work. Part II examines the burden of infertility and the emergence of Assisted Reproductive Technology in Nigeria. Part III explores the right to health and reproductive health in Nigeria. It also examines some international human rights instruments that guarantee the right to health, in particular the International Covenant on Social and Economic Rights 1966. Part IV examines applicability of the rights to benefits of scientific progress to ART services, Part V discusses arguments for and against applications of the right to benefits of scientific progress to ART. Part VI concludes the paper.

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<sup>2</sup>World Health Organization ‘Sexual and Reproductive Health: Infertility definitions and terminology’ <<https://www.who.int/reproductivehealth/topics/infertility>> accessed 8 July 2019

<sup>3</sup>Cookie I. D. ‘The globalization of reproductive technology’ in Kruger T.F., Spuy, Z and Kemper, B.D.(eds.) *Advances in Fertility Studies and Reproductive Medicine* (Juta and Co 2007) 234-240

<sup>4</sup>G.M. Chambers, E.A Sullivan, O. Ishihara, M.G. Chapman and G.D. Adamson ‘The economic impact of Assisted Reproductive Technology: A review of selected developed countries’ [2009] *Fertility and Sterility* 91(6) 2281-2294

## II. Burden of infertility and Emergence of Assisted Reproductive Technology in Nigeria

According to the World Health Organization, infertility is “a disease of the reproductive system that is characterized by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.”<sup>5</sup> It has also been described as the inability of a sexually active, non-contracepting couple to achieve pregnancy in one year.<sup>6</sup> Various definitions of infertility have been given but according to Cook et al<sup>7</sup>, a general estimate is that between eight to twelve percent of couples experience some form of infertility during their reproductive years. Infertility is said to affect about 186 million around the globe. In some parts of sub-Saharan Africa, the prevalence of infertility could be as high as thirty percent.<sup>8</sup> More specifically, an infertility belt has been described in Africa, this lies from West Africa, through Central to East Africa. Several countries with high rates of infertility that are within this belt include Nigeria, Cameroon, Gabon, Democratic Republic of Congo, Central African Republic, Chad, Burundi, Uganda and Kenya.<sup>9</sup> By contrast, in the United Kingdom, infertility is estimated to be in the region of 6%.<sup>10</sup> In the United States of America it is about 10%.<sup>11</sup> In Nigeria, it has been shown that the prevalence of infertility is about twenty five percent, with 1 in 4 women of child-bearing age<sup>12</sup> experiencing delay in conception.<sup>13</sup> Over the years, the importance placed on child bearing in several African societies has been documented, which makes infertility a major disaster for couples. Several adverse consequences of infertility for women’s reproductive health in Africa are now being increasingly recognized. Apart from being a major cause of marital disharmony, infertility can lead to distress and depression, as well as discrimination, ostracism and physical violence.<sup>14</sup> The burden and social expectation placed on the childless couple particularly the woman often leads to the anxiety to have a child by any means whether through ART or other unconventional or illegal transactions; considered less expensive, less intrusive and quicker than ART.<sup>15</sup> These advances in reproductive technology that have made it possible

<sup>5</sup> World Health Organization “Sexual and Reproductive health: Infertility definitions and terminology” <[www.who.int/reproductivehealth/topics](http://www.who.int/reproductivehealth/topics)> Accessed May 1 2019.

<sup>6</sup> Ibid

<sup>7</sup> Rebecca J Cook, Bernard M. Dickens and Mahmoud F. Fathalla, *Reproductive Health and Human Rights: Integrating Medicine, Ethics and the Law* (Oxford University Press 2005) 20

<sup>8</sup> Fadare, J.O and Adeniyi, A.A. ‘Ethical issues in newer assisted reproductive technologies: A view from Nigeria’ [2015] *Nigerian Journal of Clinical Practice* 18(7) 57- 61

<sup>9</sup> Etuk S.J. “Reproductive Health: Global Infertility Trend” [2009] *Nigerian Journal of Physiological Sciences* 24(2) 85- 90

<sup>10</sup> National Institute for Health and Clinical Fertility ‘Assessment and Treatment for people with fertility problems’ NICE clinical guidelines [2013]

<sup>11</sup> Marie E. Thoma, Jean Fredo Louis, Rosalind B. King ‘The Prevalence of infertility in the United States as estimated by the current duration approach and a traditional approach’ [2013] *Fertility and Sterility* 99(5) 1324- 1331

<sup>12</sup> According to the National Demographic Health Survey 2013, age 15-49 is considered to be the reproductive years of a woman.

<sup>13</sup> Ajayi, R. A. and Osadolor, O. J ‘Opinion of obstetricians and gynecologists on ethical issues in the practice of IVF and embryo transfer in Nigeria’ [2013] *African Journal of Reproductive Health* 17(1) 130- 136.

<sup>14</sup> Okonofua F E. et al ‘Serological and Clinical Correlates to Gonorrhoea and Syphilis in fertile and infertile Nigerian women’ [1997] *Genitourinary Med* 73:194-197.

<sup>15</sup> Roupia Z., Polikandrioti M., Sotiropoulou P., Faros E., Koulouri A., Wozniak Gourni M ‘Causes of infertility in women at reproductive age’ [2009] *Health Science Journal* 3(2) 80-87

to produce human pre-embryos *in vitro* have been among the most significant scientific achievements of the past forty years. For many couples who were previously considered sterile, the emergence of these new techniques to alleviate infertility has offered new opportunities to conceive. Assisted Reproductive technologies therefore are relevant to the Nigerian society where infertility is a major problem.

Assisted Reproductive Technology include treatment in which both sperm and eggs are handled.<sup>16</sup> It includes procedures that involve the *in vitro* handling of human oocytes and sperm or embryos for the purpose of establishing a pregnancy such as, *in vitro* fertilization, transcervical embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, tubal embryo transfer, gamete and embryo cryopreservation, oocyte and embryo donation and gestational surrogacy<sup>17</sup>

In Nigeria, the first recorded success of ART was in 1989 after series of attempted documented pregnancies in 1984 and 1986.<sup>18</sup> This feat was achieved by the Lagos State University Teaching Hospital team led by Drs. Giwa- Osagie, Ashiru and Abisogun. The successes from IVF at the Lagos University team were the first in West, East and Central Africa then.<sup>19</sup> By 2001, there were eight assisted conception centres carrying out IVF in sub-Saharan Africa, as well as numerous other centers offering artificial insemination. Successes recorded from IVF in the whole of West, East and Central Africa showed that assisted reproductive technologies are feasible and successful in low resource settings where staff are trained and equipment are available. Though data on the number of babies born via *in vitro* fertilization in Nigeria is sketchy due to poor or no record keeping, it is estimated that about 11,000 test tube babies have been delivered since inception with an average turnover rate of about 1000 babies yearly. As at 2017, there were about 50 fertility clinics in Nigeria offering an array of assisted reproductive services and the list is growing.<sup>20</sup>

Presently, ART practice in Nigeria is mainly private sector driven with over 80% of the fertility clinics carrying out basic IVF, and other advanced procedures such as Intra Cytoplasmic Sperm Injection, Gamete Intra-Fallopian Transfer and Zygote intra-fallopian Transfer. Most of these fertility clinics are owned and operated by Nigerians with some technical, collaborative support from institutions from Europe and the United States of America. Equitable access to ART remains a fundamental issue in Nigeria where only a small fraction of the populace have access to health insurance, which in most instances does not cover expensive procedures of ART. The average cost of obtaining ART treatment in Nigeria at the moment varies between Five Hundred Thousand to Three Million Naira depending on the procedure requested for and the facility in which the procedure is carried out, this in a country, where the national monthly minimum wage is Eighteen Thousand

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<sup>16</sup> Medina, J. 'In-vitro fertilization: the right to give life or taking the fundamental right to take life' [2015] *Law School Student Scholarship Paper* 795: 1.

<sup>17</sup> Samson O. Koyonda. 'Assisted reproductive technology in Nigeria: Placing the law above the law above medical' [2009] *Journal of Indian Law Institute* 25.

<sup>18</sup> Mustapha Oyeyemi 'The history of IVF in Nigeria' <[www.ivfhistorynigeria.blogspot.com](http://www.ivfhistorynigeria.blogspot.com)> accessed 29 May 2019

<sup>19</sup> Giwa- Osagie, F. O. 'ART in developing countries with particular reference to sub-Saharan Africa' in Effy Vayena, P. Rowe and P. Griffin (eds) *Current practices and controversies in assisted reproduction* Geneva. 22.

<sup>20</sup> Eshemokha, U. 'IVF babies in Nigeria; the history, myths, stigma and facts of test tube babies in Nigeria' <[www.nimedhealth.com.ng](http://www.nimedhealth.com.ng)> accessed 22 April 2018.



Naira which is just about \$50.<sup>21</sup> As stated by Vayena,<sup>22</sup> three ethical concerns about ART in developing countries are magnitude of infertility, access to ART and issue of resource allocation. According to Omokanye,<sup>23</sup> a major challenge to the utilization of ART services in Nigeria is cost. Nigeria has been classified a lower-middle income country by the World Bank with 46% of her population below the poverty line.<sup>24</sup> Many patients who require infertility treatment and ART services cannot afford it. Although the demand for assisted reproductive technologies is growing in all regions. One needs to examine the justifiability of the technology with its high cost and success rate of less than 30% in developing countries like Nigeria with poorly developed health services and high rate of infectious diseases such as malaria and HIV.

### III. Right to health and Reproductive Health

The right to health is recognized in a number of international instruments and conventions. This right is simply defined as the right of every individual to the highest attainable standard of physical and mental health. This includes access to all medical services, sanitation, adequate food, decent housing, healthy working conditions and a clean environment. Components of this right include:

1. A system of health protection for everyone;
2. Accessible right to healthcare and to living conditions that enable one to be healthy and
3. Provision of healthcare as a public good for all, financed publicly and equitable to all.

The right to healthcare stipulates that essential healthcare including hospitals, clinics, medication and medical services must not only be accessible but also available to everyone on an equitable basis wherever and whenever needed.<sup>25</sup> The right to health is an inclusive right which extends to appropriate healthcare as well as the underlying determinants of health such as access to safe and potable water, safe food and nutrition, healthy occupational and environmental conditions and information on sexual and reproductive health. Health is defined in the World Health Organization as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Reproductive health within the context of health is a state of complete physical, mental and social well-being in matters relating to the reproductive system and its functions and processes. Reproductive health implies that individuals are able to have a safe sex life and rights of access to appropriate healthcare services which includes assisted reproductive health services.<sup>26</sup>

Nigeria recognizes the right to health and has committed itself to its protection by assuming obligations under international treaties and domestic legislation mandating specific conduct with respect to the health of individuals within its jurisdiction. The right to health is protected under some international conventions and treaties for instance, Article 25 of the Universal Declaration on Human Rights of 1948 provides that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including food,

<sup>22</sup> Effy Vayena, 'Ethical issues in Assisted Reproductive Technologies' <[www.gfmer.ch/medical\\_education](http://www.gfmer.ch/medical_education)> accessed 24 May, 2019

<sup>23</sup> Lukman Omotayo Omokanye et al 'Assisted Reproduction Technology: Perceptions among infertile couples in Ilorin, Nigeria' [2017] *Saudi Journal for Health Sciences* 6(1) 14-18

<sup>24</sup> World Bank 'World Development Indicators' <<http://data.worldbank.org/country/nigeria>> accessed 5 May 2019.

<sup>25</sup> National Economics and Social Rights Initiative 'What is the human right to health care ' <[www.nesri.org/programs](http://www.nesri.org/programs)> accessed 4 May 2019

<sup>26</sup> Rebecca J Cook, Bernard M. Dickens and Mahmoud F. Fathalla, *Reproductive Health and Human Rights: Integrating Medicine, Ethics and the Law* (Oxford University Press 2005) 12

clothing, housing and medical care. Similarly, Article 24 of the Convention on the Rights of the Child recognizes the rights of the child to the highest attainable standard of health and to facilities for the treatment of illness and the rehabilitation of health. Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) enjoins state parties to take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure on a basis of equality of men and women, access to healthcare services including those related to family planning. Nigeria is signatory to the above mentioned international human rights instruments having ratified them. Ratification of the instruments alone do not make them applicable in the country until they have been domesticated. Nigeria has acceded to the Universal Declaration of Human Rights 1948 so also the Convention on the Rights of the Child (this convention having been domesticated as the Child Rights Act 2003). However, CEDAW is yet to be domesticated in Nigeria.

The 1999 Constitution of the Federal Republic of Nigeria as amended arguably does not explicitly provide for the right to health but the Fundamental Objectives and Directive Principles of State Policy which have invariably become a part of the Constitution require that Government pursue policies targeted towards ensuring economic, social, political and cultural objectives. A part of this commitment is to guarantee the health and welfare of all Nigerians and the provision of adequate medical and health facilities for all. This constitutional provision is thought to be unenforceable as a result of S6 6(c). Various writers<sup>27</sup> have argued extensively on the justiciability of the provisions of Chapter II of the Constitution, and the inference of the right to health amongst other rights arising therefrom. This however is not within the scope of this paper.

According to Donders,<sup>28</sup> the right to health does not mean the right to *be healthy*<sup>29</sup> There are evidently non-medical factors and/or factors beyond the control of the State that influence one's health, including social factors such as education, income, and behavioural lifestyle. The right to health mainly means that States should create conditions in which everyone can be as healthy as possible, bearing in mind the definition of health given by the World Health Organization. Such conditions may vary from ensuring the availability of health services, vaccines and medicines, to healthy and safe working conditions, adequate housing and nutritious food. All these aspects have a direct link with scientific progress. The freedom to

<sup>27</sup> Edoaba Bright Omeregje and Daud Momodu 'Justifying the Right to Healthcare in Nigeria: Some comparative Lessons' [2014] 12, 13, *The Nigerian Juridical Review* Taiwo A. Olaiya, 'Interrogating the non-justiciability of Constitutional Directive Principles and Public Policy Failure in Nigeria' [2015] (8)(3) *Journal of Politics and Law*; 11 Ikpeze O.V., 'Non justiciability of Chapter II of the Nigerian Constitution as an impediment to development' [2015] (5) (18) *Developing Country Studies*; 48; G. N. Okeke and C. Okeke "The justiciability of the Non- Justiciable constitutional policy of Governance in Nigeria" [2013] (7) (6) *IOSR Journal of Humanities and Social Sciences* 9-14; Duru Onyekachi Wisdom 'The justiciability of the fundamental objectives and directive principles of state policy under Nigerian law' [2012] <ssrn/downloads.id2140361.pdf> accessed 16 August, 2018; A. O. Popoola "Fundamental Objectives and Directive Principles of State Policy: Executive Responsibility and the Justiciability Dilemma" in Epiphany Azinge & Bolaji Owasanoye (eds) *Justiciability and Constitutionalism: An Economic Analysis of Law* (Nigerian Institute of Advanced Legal Studies Press, 2010), 324; Halima Doma Kutigi 'Towards Justiciability of Economic, Social and Cultural Rights in Nigeria: A Role for Canadian-Nigerian Cooperation?' [2017] (4) *The Transitional Human Rights Review* 144

<sup>28</sup> Yvonne Donders 'The Right to enjoy the benefit of scientific progress; in search of state obligation in relation to health' [2011] *Medicine, Healthcare and Philosophy* 14(4) 371- 381

<sup>29</sup> Paragraph 8, UN Committee on Economic, Social and Cultural Rights 2000

conduct science and the right to enjoy the benefits of science and its applications are crucial for the implementation of the right to health.

#### IV Right to the benefit of scientific progress

The right to the benefits of scientific progress has been described as one of the least known human rights.<sup>30</sup> The right has its origins in Article 27 of the 1948 Universal Declaration of Human Rights, which was adopted in the wake of World War II. In 1966, the United Nations turned these commitments into binding obligations under international law. The implication is that, as governments are expected to respect the rights such as, freedom of speech and due process, they must also adopt measures to respect and ensure the rights to benefits of scientific progress. The right has also been reaffirmed in more recent declarations such as the Universal Declaration on Bioethics and Human Rights. This right was framed in recognition of the contribution research and science being the driving forces behind technological advancement to the economic growth of many developing countries. Scientific research in medical technology has brought about the development of medicines which invariably has increased life expectancy, however, scientific research is not always inspired by human rights concerns but rather by commercial interest.<sup>31</sup>

Article 12 of the International Covenant on Social and Economic Rights (Economic Covenant) provides that states parties to the present covenant recognise the right of everyone to the enjoyment of the highest attainable standard of health both physically and mentally. The Right to enjoy the benefits of scientific progress and its applications was proclaimed for the first time in Article 13 of the American Declaration of the Rights and Duties of man which states that every person has the right to participate in the benefits that result from intellectual progress, especially scientific discoveries. This right was further enshrined in Article 27 of the Universal Declaration on Human Rights 1948 which provides that everyone has the right to share in scientific advancement and its benefits. This right has acquired an increased importance in today's globalized world. Improved scientific and technological development result in changes in the daily lives of individuals and the societies they live in.<sup>32</sup>

Prior to the declaration of the International Covenant of Economic and Social Rights, other international instruments<sup>33</sup> were adopted by states and these focused on duties of states as well as scientists to engage science and research in a responsible manner. Through these instruments, states were expected to advance scientific and technological cooperation to foster the transfer of technology to developing countries to enhance access to achievements of modern science and technology. About twenty years after, the Universal Declaration on Human Genome and Human Rights and the International Declaration on Human Genetic Data were adopted. Amongst other things, these declarations focused mainly on preventing potential abuses of science and research by scientists. These international declarations are not legally binding as they are declarations and not treaties that could be legally binding on states.<sup>34</sup>

<sup>30</sup> Yvonne Donders 'The Right to Enjoy the Benefits of Scientific Progress and its applications' <<http://unesdoc.unesco.org>> accessed 5 May 2019

<sup>31</sup> Ibid.

<sup>32</sup> UNESCO 2009. "The Right to enjoy the benefits of scientific progress and its applications" France, 2

<sup>33</sup> For instance, the Charter of Economic Rights and Duties of States which was adopted in 1974 by the United States General Assembly

<sup>34</sup> Yvonne Donders 'The Right to enjoy the benefit of scientific progress; in search of state obligation in relation to health' [2011] *Medicine, Healthcare and Philosophy* 14(4) 371- 381; Audrey R. Chapman 'Towards an

### **The Right to the benefit of scientific progress within the context of the right to health**

The general comment of the covenant gives guidance on what states are expected to do in compliance with the right to benefits of scientific progress. Within the context of the right to health, the right to benefits of scientific progress connotes the following:

1. Availability of services: this requires that a state ensures functioning public health care facilities, goods and services and essential drugs are available in sufficient quantity. Availability of services has four aspects
2. Accessibility: this includes non- discrimination in the provision of health services especially for the vulnerable and marginalized parts of the society, physical accessibility for all health services to all the populace. Economic accessibility relates to the affordability for health services to all. Payments for health services must be based on the principles of equity.
3. Acceptability: this connotes that health services are ethnically and culturally appropriate.<sup>35</sup>

### **Can applications of the Right to benefits of scientific progress apply to ART treatment?**

It should be noted that under the Economic Covenant, states are required to take immediate and progressive steps to achieve health standards. It is thus expected that state parties take appropriate budgetary, economic and other measures to the extent of their available resources. International human rights instruments also enshrine the right to receive the benefits of scientific progress. Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in particular provides that state parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure on a basis of equality of men and women, access to healthcare services including those related to family planning. Article 27 of UDHR became the basis for Article 15(1)(b) of the International Covenant on Economic, Social and Cultural Rights which provides that state parties must recognise the right of everyone to enjoy the benefits of scientific progress and its applications. When this provision is read together with Article 12 which establishes that every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life of dignity, and this right entails the right to control one's health and body, including sexual and reproductive freedom, it then infers that one can possibly locate a right of individuals to receive the benefits of technology that could improve their reproductive and sexual lives. The scientific progress to which individuals arguably have rights include Assisted Reproductive Technology (ART). This is because these technologies are often the only methods that could enable infertile persons to have children of their own. The rights of everyone to enjoy the benefits of scientific progress and its applications may be invoked in situations where reproductive and sexual health services are not financially or geographically accessible to individuals.

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understanding of the Right to enjoy the benefits of Scientific progress and its applications [2009] *Journal of Human Rights* 8, 1-36

<sup>35</sup> Rebecca J Cook, Bernard M. Dickens and Mahmoud F. Fathalla, *Reproductive Health and Human Rights: Integrating Medicine, Ethics and the Law* (Oxford University Press 2005) p.20

## V. Arguments for and against the applications of the right to benefits of scientific progress to ART

The essence of legal theory is to enable a juxtaposition between social phenomenon and how law can respond to contemporary social needs and problems.<sup>36</sup> In this study, the social need is curbing the incidence of infertility and the social problem is inequitable access to ART services in Nigeria. This study relies on the sociological school of jurisprudence to advocate for easier access to ART services. The main theme of the sociological school is that while one must accept positive laws as a means of social control, it must however always be with an awareness that laws should and can always be constantly improved upon both as a system and a catalyst of progress and positive change in the society. The forerunners of the sociological school include the utilitarians of which Jeremy Bentham's principle of utility stands out. According to Bentham, the function of laws in the society should be the promotion of the greatest happiness of the greatest number. The task of laws should be to bring about the maximum happiness of each individual for the happiness of each will result in the happiness of all. Bentham favoured legislation on a drastic scale to remedy the evils which he saw around him. But once the evils had been eradicated, legislation should aim at providing subsistence, abundance, security and equality of opportunity for all.<sup>37</sup> The utilitarian justification for having laws at all is that they are an important means of ensuring the happiness of the members of the community generally. Hence the sovereign power of making laws should be wielded, not to guarantee the selfish desires of individuals, but to consciously secure the common good. Bentham argued further that the public good ought to be the object of the legislator and general utility the foundation of his reasoning. Thus, laws by the standards of the utilitarian can be used to create happiness for more people in the society. Making laws to regulate the cost of ART and thus promoting more equitable access to ART services on the basis of the applications of the rights to benefits of scientific progress is justified because it would promote greatest happiness for the greatest number. In addition, from a utilitarian perspective, ART would hold value because it would be in the best interests of a large portion of society. The inability to have children may significantly hinder some people from living a fulfilling life. Many individuals would benefit from bypassing the obstacles in their path toward parenthood. Also, since parenthood is one of the major ways in which human beings pass on knowledge, culture, and belief systems, the whole of society could potentially benefit from this technology.

According to Pennings,<sup>38</sup> at the mention of provision of infertility treatment in developing countries, people's reaction is usually negative because of the belief from western countries that overpopulation is the major problem of developing countries, and thus the high cost and inequitable access to ART services should be a means of curbing infertility. This conviction was and still is the main barrier to even consider infertility treatment in resource-poor countries. This conviction leads to a bias in western people's way of looking at the provision of contraception and fertility control in resource-poor countries. For them, these technologies are ways to reduce population growth, not means to address the needs of people to control when and how many children to have. Pennings explained further the arguments canvassed for and against providing and regulating infertility treatment to resource poor

<sup>36</sup> Funso Adaramola, *Basic Jurisprudence* 2<sup>nd</sup> edition (Nayee Publishing Lagos 2003) 289

<sup>37</sup> RWM Dias *Jurisprudence* 5<sup>th</sup> edition (Lexis Nexis India 2013) 428

<sup>38</sup> Guido Pennings 'Ethical issues of infertility treatment in developing countries [2008] *ESHRE Monographs* 1 15-20

countries. The arguments propounded were reproductive autonomy and the huge burden of infertility in these countries. He ranked the arguments against the applications of providing infertility treatment as overpopulation, prioritization of limited resources and risk of abuse.<sup>39</sup> Therefore, the use of ART to manage infertility is a contested issue in the context of attitude to overpopulation and the availability of scarce health resources in developing countries. Infertility as a problem faces stiff competition for available resources in this context. Given that "current health spending in most low-income countries is insufficient for the achievement of the health sustainable development goals," it is debatable that infertility reasonably has a place in *public* sector financing, though it has a place in privately financed options via established fertility clinics in Nigeria.

Even in developed countries, however, where infertility patients stand a better chance of receiving infertility treatment, access to ART is limited. The generally high cost of ART procedures and national policies regarding accessibility and reimbursement leave many infertile people without the option of treatment. Arora<sup>40</sup> asked if there was a right to access reproductive technologies. She considered whether there is a solid argument for unrestricted access to reproductive technology and legal conditions for exercising this right. She found that the argument for and against the uninterrupted access to reproductive technologies for individuals can be understood as a clash of ideologies among libertarian advocates and utilitarian thinkers. She concluded that there was no international consensus concerning regulation of access to reproductive technologies, and there were no enforceable, international obligations for states to allow access to reproductive technologies in their healthcare systems in each and every case or to provide public funding to aid access to these technologies.

In the South African case of *Soobramoney v Minister of Health KwaZulu Natal*<sup>41</sup> the South African constitutional court considered if the South African government could provide long-term dialysis for a claimant's chronic renal failure and found that the government was not so required because the constitutional provisions relating to access to healthcare were dependent upon the resources available for such purposes and the corresponding rights were limited due to a lack of the resources. In the *Soobramoney* case, the court's reasoning was that there was no duty for the government to provide extraordinary care but rather a duty to provide ordinary care, thus in instances such as provision of anti-retroviral treatment for pregnant women, this would be seen as ordinary care which ought to be made available for all women.<sup>42</sup>

In line with the reasoning above, the writer is of the opinion that in the provision of healthcare services within the context of the Economic covenant, one should consider whether the Federal Government of Nigeria can provide ART services within the available resources. In 2001, Nigeria hosted the Heads of States of member countries of the African Union in which the declaration was made and the leaders pledged to commit 15 percent of their annual budgets to improving the health sector. Since then, the highest percentage of the country's health sector in the national budget has been 5.95 percent in 2012. In 2018, an amount totaling N340.45 billion was allocated to the health sector. This represents 3.9

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<sup>39</sup> Ibid

<sup>40</sup> Puneet Arora Right to Access Reproductive Technologies- A Right or a Wrong [2017] *Journal of Forensic Medicine and Legal Affairs* <www.elynogroup.com> accessed 29 May 2019

<sup>41</sup> (1998) 1 SA 765

<sup>42</sup> Ibid at p 771

percent and a further reduction from the 4.23 and 4.16 in the 2016 and 2017 budgets respectively. In terms of ranking, health was twelfth on the present administration's priority list with the allocation given to power, works and housing almost 8 times that of health.<sup>43</sup> Most developing countries like Nigeria are struggling to provide a basic minimum of care. They are confronted with immense problems of poverty and deprivation of the most basic goods like clean drinking water and food, which also affect the general health of the population. A mean life expectancy around 50 years is no exception in developing countries. The question then becomes whether governments should not spend their money trying to resolve these problems rather than embarking on expensive high-technology programmes for non-life threatening conditions like infertility. When considering this question, we have to look at the broader picture of the allocation of the total national budget. Most developing countries spend less than five percent of their gross national product on health care and the largest part thereof is private money,<sup>44</sup>

Arora<sup>45</sup> had concluded that most arguments against the provision of infertility treatment in developing countries cannot be sustained. On the contrary, a combination of measures such as increased investment in health care and considerable reduction of the cost of ART would justify at least some public funding. However, given the difficulties of resource-poor countries, the lion's share of the effort should be directed at the prevention of infertility.

The funding and regulatory framework for the provision of ART treatment differs considerably around the world and is in line with the level of public and private responsibility for purchasing healthcare. Financing of ART from public funds ranges from virtually no subsidization in the USA and most developing countries such as Nigeria, to funding of a limited number of cycles based on female age in most European countries. Progressively, it is being recognized that the ability to pay for treatment plays an important role in the overall access to fertility treatment, as well as the choice of fertility treatment. The National Survey of Family Growth in the USA found that neither income nor insurance influenced the probability of and access to seeking advice for infertility, but rather that the choice to pursue expensive treatments, such as ART, was highly influenced by each individual's level of income. It is not just the cost of ART treatment that is important in terms of access to care, but also how affordable treatment is. Affordability is a measure of the economic burden placed on couples to fund their own treatment, therefore an ART treatment cycle may be very costly, but if it is highly subsidized it may become highly affordable for many patients. It has been discovered that affordability is a powerful determinant of whether couples will pursue ART treatment or not.<sup>46</sup>

In a study carried out by Chambers et al<sup>47</sup> on the cost of ART treatment cycles and resultant live-birth events, it was found that in developed countries, the cost of a new ART cycle as a percentage of an individual's annual disposable income ranged from 50 percent in the USA,

<sup>43</sup> Peju Adepoju 'Breakdown of Nigeria's 2018 budgetary allocation for health' <[www.healthnews.ng](http://www.healthnews.ng)> accessed on 21 May 2019

<sup>44</sup> Puneet Arora 'Right to Access Reproductive Technologies- A Right or a Wrong' [2017] *Journal of Forensic Medicine and Legal Affairs* <[www.elynogroup.com](http://www.elynogroup.com)> accessed 29 May 2019

<sup>45</sup> Ibid

<sup>46</sup> Mark P. Connolly, Shitijn Hoorens and Georgina M. Chambers 'The costs and consequences of Assisted Reproductive Technology: An economic perspective' [2010] *Human Reproduction Update* 16(6) 603-613

<sup>47</sup> Georgina M. Chambers, Elizabeth A. Sullivan and Maria T. Ho 'Assisted reproductive technology treatment costs of a live birth: an age-stratified cost-outcome study of treatment in Australia' [2006] *Medical Journal of Australia* <<https://onlinelibrary.wiley.com/doi/>> accessed 30 May 2019

and approximately 20 percent in the United Kingdom, Scandinavian countries and Australia, to 12 percent in Japan. After accounting for government subsidies, the ensuing cost to the patient of an ART cycle was unchanged in the USA and Japan (due to negligible public funding for ART treatment) but fell to approximately 12 percent of annual disposable income in the UK and Scandinavian countries. As expected, the greatest effect of subsidization was in Australia with a 71 percent reduction in the cost of an ART cycle as a percentage of disposable income, from 19 percent before government subsidy to 6 percent after government subsidy. The differences in the affordability of treatment would predict differences in the level of uptake of ART services in the different jurisdictions.<sup>48</sup>

### Assisted Reproductive Technology and Islamic Law

Islam acknowledges that infertility is a significant hardship but frowns on any use of ART without medical justification. Accordingly, seeking a cure for infertility is not only permissible but also encouraged in Islam. However, assisted reproduction is allowed provided the source of the sperm, ovum and uterus comes from a legally married couple during the span of their marriage. No third party is allowed to intrude upon the marital function of sex and procreation.<sup>49</sup> Yahaya<sup>50</sup> is of the opinion that Muslims should not step beyond the confines of the methods of reproduction created by Allah. If conception does not occur through normal and natural means, then Muslims should resign themselves to the will of Allah because if Allah has not decreed a life, it will never come into existence no matter what method and technique are employed. If Allah decrees the creation of life, there is nothing to prevent its coming into being.

IVF, with its various variations such as gamete intra-fallopian transfer, intracytoplasmic sperm injection and zygote intra-fallopian transfer have been declared permissible in Islam only if the following conditions are met. First, the IVF must involve a married couple. Second, the sperm must be from the husband, and the eggs from the wife. Third, the procedure must occur within the context of a valid marriage. Fourth, the procedure must be conducted by an experienced team in order to reduce the chances of failure. Further, there is a need for meticulous handling of the process so as to ensure that the gametes of the husband and wife are the ones actually being used in the procedure. Finally, no more than the appropriate number of fertilized eggs should be transferred to the uterus of the woman. Freezing the remaining fertilized ova is permissible as long as they are only used in subsequent cycles for the same couple, and the couple is still married.<sup>51</sup>

Adebisi et al<sup>52</sup> found that despite the fair knowledge of respondents on assisted reproductive technology information in parts of Northern Nigeria, societal institutions were still slow to

<sup>48</sup> Georgina M. Chambers, Elizabeth A. Sullivan and Maria T. Ho 'Assisted reproductive technology treatment costs of a live birth: an age-stratified cost-outcome study of treatment in Australia' [2006] *Medical Journal of Australia* <<https://onlinelibrary.wiley.com/doi/>> accessed 30 May 2019

<sup>49</sup> Hossam E. Fadel, 'The Islamic viewpoint on new Assisted Reproductive Technology' [2002] *Fordham Urban Law Journal* 30(1) 147-149, Al-Bar M.A and Chamsi-Pasha H. 'Contemporary Bioethics: Islamic Perspective' <<http://www.ncbi.nlm.nih.gov/books/NBK500194/>> accessed 3 July 2019

<sup>50</sup> Yahya Ibraheem Yero, 'Current Assisted Reproduction Technologies: An Islamic perspective' [2015] *Journal of Modern Education Review* 5(10) 1008- 1016

<sup>51</sup> Hossam E. Fadel, 'The Islamic viewpoint on new Assisted Reproductive Technology' [2002] *Fordham Urban Law Journal* 30(1) 147-149, Al-Bar M.A and Chamsi-Pasha H. 'Contemporary Bioethics: Islamic Perspective' <<http://www.ncbi.nlm.nih.gov/books/NBK500194/>> accessed 3 July 2019

<sup>52</sup> Adesiyun Adebisi, Ameh Nkeiruka, Avidine Solomon and Muazu Abdulsalam 'Awareness and Perception of Assisted Reproductive Technology practice amongst women with infertility in Northern Nigeria' [2011] 1



cope with the idea and practice of the technology. This was attributed to issues of contention such as reproduction without sex, sanctity of family genetic lineage, involvement of third party and commercialization of gametes and embryos. Contrary to this finding, Zubairu et al<sup>53</sup> investigated the factors responsible for low acceptance of ART in Kano, Northern Nigeria. Amongst others, the study found that education and religion were significant predictors of acceptance of ART.

## VI Conclusion

This paper has examined the rights to benefits of scientific progress and its application to assisted reproductive technology. It has shown that although this right may be invoked to allow women have access to assisted reproductive technology through reduced or subsidized costs, this may be a difficult task to achieve with the current economic reflections in the country. The rights to the benefits of scientific progress support the claim that governments should spend public funds on research designed to benefit reproductive and sexual health. Government through national reproductive health policies ought to provide and cater for reproductive health services, even to finance reproductive health services for infertile men and women so that they could access the services through subsidized costs for ART services when necessary, and where these resources are available, government should be able to provide free services for indigent people.

As stated by Ombelet and Campo,<sup>54</sup> the problem of infertility in developing countries is frequently introduced by pointing at the large impact of infertility on the lives of men and especially women. Common scenarios of such impact include unstable marriages, divorce, polygamy and ostracism of the women. Especially for women, social status and female identity depend on their ability to produce children. They are usually blamed for infertility and can be ostracized and assaulted by their families, even driven to suicide or killed. By supporting the development of low-cost IVF, governments can help make such treatments more widely available. A considerable subsidy regime via legislation might be impracticable to achieve currently, however, minimal subsidy can still be allowed that would enable more infertile women have access to ART services and at the same time allow fertility clinics and operators recoup financial returns on their investment.

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*Open Journal of Obstetrics and Gynecology* <<http://www.researchgate.net/publication/266370422>> accessed 25 April 2019

<sup>53</sup> Zubairu Iliyasu, Isa Sadeeq Abubakar and Hadiza Gaidanci 'Perception of infertility and acceptability of assisted reproductive technology in Northern Nigeria' [2013] *Nigerian Journal of Medicine* 22(4) 341-347

<sup>54</sup> Ombelet W and Campo R. 'Affordable IVF for developing countries' [2007] *Reproduction Biomed Online* 15(3) 257-265 [www.ncbi.nlm.nih.gov/pubmed](http://www.ncbi.nlm.nih.gov/pubmed) accessed 30 May 2019