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# The Right to Health

## A Multi-Country Study of Law, Policy and Practice

Brigit Toebes
Rhonda Ferguson
Milan M. Markovic
Obiajulu Nnamuchi *Editors*

Springer

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# Foreword

The key challenge confronting the health and human rights movement is the translation of international and national human rights law into operational policies, programmes and other health-related interventions. Nowhere is this more challenging—and more important—than within countries.

How can the right to the highest attainable standard of health ('the right to health') shape national policies? Does the right to health require that a national hospital—or a district health system—be organized differently? If so, what changes are needed? Does this human right demand that a country give more attention to community-level health promotion, for example via radio messages, poster campaigns, street theatre or primary education? Does it mean that the government has an obligation to regulate the sugar content of children's beverages? Does the right to health require the government to improve access to safe drinking water and adequate sanitation for rural communities and, if so, how can this be done within a finite budget?

This is just a tiny sample of the challenging questions facing those who wish to operationalise the right to health—and other health-related rights—in communities, districts and at national level.

One of the problems is context. What works well in one country might not work at all in another. It might not even work in a country of the same size and same stage of economic development. However, despite the enormous challenge of context, lessons can be learnt from the rich experiences of others. Indeed, it is crucial that we learn how different countries implement (or not) health-related rights.

That is why this book is so useful and important. It opens a right-to-health window onto different countries and continents. With a particular focus on eleven countries and five regions, it provides studies on the realization of the right to health (or dimensions of the right to health) from all regions of the world. It introduces research from a diverse group of authors operating through different disciplinary and cultural lenses, and demonstrates how scholars use the right to health framework and how they understand its strengths and weaknesses in relation to a particular country or region. In this way, we learn how the right to health framework is (and is not) being implemented in practice, and also how the authors envision the possibilities and limits of the framework for promoting health and well-being.

Some of the authors are representatives of a new generation of health and human rights academic-activists in the field of health-rights. They deserve—demand—our attention.

Each contribution focuses on a theme that is of specific relevance to the country in question, varying from access to health care for vulnerable groups (e.g., Aboriginal peoples in Canada and migrant workers in Saudi Arabia), to the use of indicators (in Brazil) and healthcare privatization (in the US and the Netherlands). Many of these themes overlap across countries and regions; for example, vulnerable populations exist in every country and region and are the focus of multiple chapters.

How many books on health-rights include contributions on the right to health in China, Japan, Saudi Arabia, Jordan and Peru? In this sense, this collection breaks new ground while emphasizing the need for deeper analysis and more studies.

Crucially, the contributors' examination of context-specific laws, policies and practices contributes to cross-cultural dialogue on the best practices and shortcomings, and provides insights that will be useful in a wide-range of countries.

So I warmly recommend this excellent volume to everyone interested in the great challenge of operationalising health-rights for all.

Paul Hunt
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# Abbreviations

| | |
|---|---|
| AAAQ | Availability, Accessibility, Acceptability and Quality |
| ACA | Affordable Care Act |
| ACHPR | African Charter on Human and People's Rights |
| AHWS | Aboriginal Healing and Wellness Strategy (Canada) |
| AU | Africal Union |
| AWBZ | Exceptional Medical Expenses Act (the Netherlands) |
| BIG | Dutch Health Care Professionals Act |
| CAT | Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN, 1984) |
| CEDAW | Convention on the Elimination of All forms of Discrimination Against Women (UN, 1979) |
| CHA | Canada Health Act |
| CHIP | Comprehensive Health Insurance Plan (USA) |
| CHRA | Canadian Human Rights Act |
| CIE | Committee of Independent Experts (ESC, CoE) |
| CoE | Council of Europe |
| CONAMUSA | National Multisectoral HIV-Related Coordination Mechanism (Peru) |
| CPT | European Convention for the Prevention of Torture (CoE, 1987) |
| CRPD | UN Convention on the Rights of Persons with Disabilities |
| CRC | Convention on the Rights of the Child (UN, 1989) |
| CRPD | Convention on the Rights of Persons with Disabilities (UN, 2006) |
| CSDH | Committee on the Social Determinants of Health (WHO) |
| CVZ | Dutch Health Care Insurance Board |
| DRCSC | Development Research Centre of the State Council (China) |
| ECHR | Convention for the Protection of Human Rights and Fundamental Freedoms (CoE, 1950) |
| EComHR | European Commission of Human Rights |
| ECtHR | European Court of Human Rights (CoE) |
| EC Treaty | Treaty establishing the European Community (EU, 1993) |
| ECSR | European Committee of Social Rights (ESC, CoE) |

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|---|---|
| ECFR | Charter of Fundamental Rights of the European Union (EU, 2000) |
| ECJ | European Court of Justice |
| ESC | European Social Charter (CoE, 1961) |
| EU | European Union |
| EUCFR | EU Charter of Fundamental Rights |
| FLACSO | Facultad Latinoamericana de Ciencias Sociales |
| General Comment 14 | General Comment 14 to the ICESCR (on the right to health) (UN, 2000) |
| GHWA | Global Health Workforce Atlas |
| GHO | Global Health Observatory |
| GMS | General Medical Services Scheme (Ireland) |
| GOJ | Government of Jordan |
| GP | General Practitioner |
| GPPHP | Global public-private health partnerships |
| GTE Health | Technical-Executive Group on Health (Brazil) |
| HIA | Health Insurance Authority (Ireland) |
| HIV | Human immunodeficiency virus |
| HIQA | Health Information and Quality Authority |
| HRW | Human Rights Watch |
| HS | Health System |
| HSE | Health Services Executive (Ireland) |
| IACHR | Inter-American Commission on Human Rights |
| IBGE | Brazilian Institute for Geography and Statistics |
| ICCPR | International Convention on Civil and Political Rights (UN, 1966) |
| ICERD, CERD | International Convention on the Elimination of All Forms of Racial Discrimination (UN, 1965) |
| ICESCR | International Covenant on Economic, Social and Cultural Rights (UN, 1966) |
| ICF | International Classification of Functioning, Disability and Health |
| IFHHRO | International Federation on Health and Human Rights Organizations |
| IGZ | Dutch Health Care Inspectorate |
| ILO | International Labour Organization |
| IPEA | Applied Economic Research Institute (Brazil) |
| JHS | Jordanian Health System |
| KZi | Dutch Qualities of Health Facilities Act |
| MDGs | Millennium Development Goals |
| MENA | Middle East and Northern Africa |
| MMR | Maternal Mortality Ratio |
| MWC | International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (UN, 1990) |

| | |
|---|---|
| NAFDAC | National Agency for Food and Drug Administration and Control of Nigeria |
| NAHO | National Aboriginal Health Organization (Canada) |
| NCCAH | National Collaborating Centre for Aboriginal Health (Canada) |
| NEPAD | New Partnership for Africa's Development |
| NHAD | National Health Accounts Directory |
| NHRI | National Health Rights Indicators (Brazil) |
| NHRP | National Human Rights Program (Brazil) |
| NHS | National Health Service |
| NIHB | Non-Insured Health Benefits (Canada) |
| NRCMIS | New Rural Cooperative Medical Insurance Scheme |
| NZA | Dutch Health Authority |
| OCAP | Ownership, Control, Acces and Possession Principles |
| OECD | Organisation for Economic Co-Operation and Development |
| OHCHR | Office of the High Commissioner for Human Rights |
| OHIP | Ontario Health Insurance Plan |
| OOP | Out-of-pocket Payment |
| PAHO | Pan-American Health Organization |
| PHC | Primary health care |
| PLWHA | People Living with HIV or AIDS |
| PQP | Prequalification of Medicines Program |
| (Revised) ESC | Revised European Social Charter (CoE, 1996) |
| RMS | Royal Medical Services (Jordan) |
| SCOTUS | Supreme Court of the USA |
| SERAC | Social and Economic Rights Action Center (Nigeria) |
| SHP | Skilled Health Personnel |
| TB | Tuberculosis |
| TEPCO | Tokyo Electric Power Company |
| THSTP | Traditional Healer Services Travel Policy (Canada) |
| UAE | United Arab Emirates |
| UDHR | Universal Declaration of Human Rights (UN, 1948) |
| UHC | Universal Health Coverage |
| UN | United Nations |
| UNAIDS | UN Programme on HIV and AIDS |
| UNCRC | United Nations Committee on the Rights of the Child |
| UNDP | United Nations Development Program |
| UNESCO | UN Educational, Scientific and Cultural Organization |
| UNICEF | United Nations International Children's Emergency Fund |
| UNPAN | UN Public Administration Network |
| UNRWA | UN Relief and Works Agency |
| ULMIS | The Urban Labour Medical Insurance Scheme (China) |
| VHI | Voluntary Health Insurance |
| WB | World Bank |

| | |
|---|---|
| WDI | World Development Indicator |
| WGBO | Dutch Medical Treatment Agreement Act |
| WHO | World Health Organization |
| WIPO | World Intellectual Property Organization |
| WMCZ | Dutch Client Representation Act |
| WMA | World Medical Association |
| WMO | Dutch Social Support Act |

# Introduction

The ‘right to the highest attainable standard of health’ (or right to health) is by now firmly embedded in international law. Over the past 20 years there has been a steady stream of documents, reports and other publications clarifying the meaning and contents of the right to health. The most important explanatory source is General Comment 14 of the UN Committee on Economic, Social and Cultural Rights (CESCR), which gives an authoritative explanation of the right to health in Article 12 ICESCR. As a result of this clarification process the right to health is by now a norm under international law which has a considerable legal weight and which has the potential to impact on the health and well-being of individuals all over the world.

As we now have a fairly clear picture of the normative content of the right to health, the next step is to find out more about how these standards are to be applied in practice. We should assess their content in the light of national realities and current findings in the public health arena, social medicine, health economics and related fields. In other words, if we want to obtain a proper understanding of this norm, we should also look beyond its international definition and doctrinal foundation. We must not look at human rights norms in a vacuum, rather we must reconsider them consistently in the light of national and regional realities and particularities, new trends and developments, and for this we must also look beyond our own disciplinary borders. Examples of such developments are the increasing health inequalities between and within nations, continued health problems such as HIV/AIDS and maternal mortality, the lack of medicines in the developing world, as well as the way in which health systems are organized, such as the increasing worldwide trend of healthcare privatization, and the magnitude of health sector corruption.

This study focuses on the implementation of the right to health at regional and national levels. This project brings together a set of experts from thirteen different countries in the world, with each of them analyzing the implementation of the right to health in his or her country or region. The foundations for this project were laid during a modest project that we ran at the University of Aberdeen School of Law, where I worked as a Lecturer between 2006 and 2009. The project enabled advanced students to write a report about the implementation of the right to health in their country, or another country of their choice. Some of the issues that the reports addressed were the legal status of the right to health, the way health

systems are organized, healthcare commercialization trends, the position of vulnerable groups and the underlying determinants of health.

Gradually, we were able to entice more experienced scholars for this project, and it grew into a more substantial research project. The project was moved to the Right to Health Wiki of the International Federation of Health and Human Rights Organisations (IFHHRO).[1] Some of the reports placed on this website had a considerable impact in the country under scrutiny. For example, the report on the right to health in Nigeria was adopted by the Association of Commissioners for Health as an authoritative statement on the state of health in that country.[2] The report about Brazil was published in Portuguese by the Brazilian government and was thus made available to a wider public in Brazil. Other reports that were made available included reports on Canada, Iran, Russia and Serbia.

The current follow-up project builds on the country reports by publishing a number of theme-oriented country studies in connection with the right to health. With theme-oriented country reports we mean reports that do not give a mere assessment of the implementation of the right to health in general, but that focus on a particular theme. For example, while the Millennium Development Goals are an important issue in relation to the implementation of the right to health in Africa, important issues in Europe are the social determinants of health, and the identification of vulnerable groups when it comes to accessing healthcare services. This approach enables us to focus on those issues that are of particular relevance to a certain country or region, so as to gain a greater understanding of these themes, and their applicability in a particular national or regional context. In addition, as a collection of tangentially connected themes, it helps to enrich our understanding of the right in practice. As mentioned, this project brings together experts from 13 different countries in the world, with each of them analysing the implementation of the right to health in his or her country or region. The authors are all scholars with considerable expertise in the right to health (see attached bibliography). As they all write about their own country or region, they can build a bridge between their expertise on the right to health with their specific backgrounds and expertise in his or her country or region. By covering countries from every region, the project can truly be called a global project which at the same time has relevance for every particular region in the world.

In the conclusions to this book, Rhonda Ferguson, Milan Markovic and Obi Nnamuchi distill the most important findings from the contributions and draw some conclusions in relation to the national implementation of the right to health. This may inspire scholars, policy makers and civil society to set the stage for a more effective implementation of the right to health at a national level.

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[1] See http://righttohealthifhhro.pbworks.com—Health and Human rights by Country. Last visited 16 June 2014.

[2] In addition, an abridged version of the report was published (in Dutch) as “The Right to Health in Nigeria: A Challenge for a Young Democracy”. See *Dutch Physicians for Human Rights*, *Newsletter* 14–17 (2007). See http://www.johannes-wier.nl/userfiles/file/Nieuwsbrief%20nr10_JWS.pdf.

Compiling this work has meant collaborating with scholars from all over the world and has, therefore, been a complicated process. I am entirely grateful to editors Rhonda, Obi and Milan, for their ongoing dedication to this project. Without them this book would never have materialized. We have never met in person, but after the many emails and Skype conversations I feel I know them well, which is both a huge pleasure and a tremendous honour. I also thank Zlatka Koleva, student at the University of Groningen, for her fantastic editorial work, and Asser Press for turning our work into an appealing book. Last but not least: a big thank you to all the authors in the book for their wonderful submissions and for providing us with inspiration. We trust their contributions will lead to interesting discussions regarding the implementation of the right to health in their country, their region and beyond.

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# Part I
# Africa

# Chapter 1
# Health and Millennium Development Goals in Africa: Deconstructing the Thorny Path to Success

**Obiajulu Nnamuchi**

**Abstract** This chapter seeks to detangle the complex web of challenges paralyzing health in Africa and militating against the attainment of the various benchmarks of the Millennium Development Goals (MDGs), particularly the ones that are health-related (health MDGS). By relying on the health MDGs as a proxy for interrogating the right to health in the region, the chapter makes a case that the process which would eventuate in meeting the required benchmarks precariously perches on the threshold of being stifled by seemingly insuperable challenges. It projects surmounting these challenges as holding the key to rescuing the various health systems in the region from their current paralytic stupor. Adopting a human rights approach, the chapter identifies critical interventions both within and outside the health sector that must ground and propel national initiatives aimed at reversing the status quo and repositioning the region on a sustainable path to achieving the health MDGs and realizing the right to health.

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## 1.1 Introduction

Desirous of repositioning and strengthening the United Nations (U.N.) to more effectively deal with the challenges of the twenty-first century, the General Assembly adopted resolution 53/202, convening the Millennium Summit as a key part of the Millennium Assembly of the organization.[1] The Summit, which was held at the U.N. headquarters in New York in September 2000, was attended by the largest cohort of world leaders ever. Its distinctive highlight was the ratification by all 189 U.N. member countries in attendance of the Millennium Declaration—a set of objectives upon which the Millennium Development Goals (MDGs or Goals) are based.[2] The MDGs commit countries to pursue a series of specific, monitorable, and quantifiable targets (Targets), with 2015 as the deadline for achieving most of them. Numbering 21, each of the Targets has corresponding indicators designed to guide countries in setting their national policies, priorities, and strategic initiatives as well as measuring progress toward the various Goals.[3]

There are eight Goals to which each country aspires to attain within the specified period. Of these Goals, three are directly related to health (health MDGs), namely, to: (i) reduce child mortality, (ii) improve maternal health, and (iii) combat HIV/AIDS, malaria, and other diseases. To this list may be added a fourth, (iv) to eradicate poverty.[4] Although the term "health MDGs" is most

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[1] See G.A. Res. 53/202, U.N. GAOR, 53rd Sess., Agenda Item 30, U.N. Doc. A/Res/53/202 (1999).

[2] The Millennium Declaration is an expression of global commitment to peace, security and disarmament; development and poverty eradication; protecting the environment; promoting human rights, democracy and good governance; protecting the vulnerable; meeting the special needs of Africa; and, strengthening the U.N. See G.A. Res. 55/2, U.N. GAOR, 55th Sess., Supp. No. 49, at 4, U.N. Doc. A/55/49 (2000).

[3] See U.N. Statistics Div., 'Official List of MDG Indicators', 15 January 2008, available at http://unstats.un.org/unsd/mdg/Resources/Attach/Indicators/OfficialList2008.pdf (accessed 18 February 2013).

[4] The remaining MDGs are to: achieve universal primary education, promote gender equality and empower women, ensure environmental sustainability and develop a global partnership for development. See Ibid.

commonly associated with the first three, there is no legitimate reason for excluding poverty reduction. A more expansive interpretation is justified by the close link between poverty and ill-health. Poverty is both a cause and a consequence of ill-health and vice versa; the two are mutually reinforcing.[5] Moreover—and, for this discourse, perhaps most important—progress (or lack thereof) toward the first three Goals crucially hinges on the extent to which the fourth (poverty reduction) is being (or has been) actualized. That is, the latter makes the former possible. In fact, a consequential discourse on the MDGs must proceed on the premise that all the "goals and targets are interrelated" and, as such, deserving of no less than a holistic approach.[6]

Nevertheless, as the 2015 deadline draws nigh, it is becoming increasingly clear that Africa is not on target to meet the MDGs. A recent admission by the African Union Conference of Health Ministers is quite striking: "Africa is still not on track to meet the health Millennium Declaration targets and the prevailing population trends could undermine progress made."[7] Why Africa is not on track to meet the MDGs, particularly those related to health, as well as suggestions on the path that would crystallize to success constitute the major task of this chapter.

The chapter consists of five sections. Following the Introduction, Part II lays the background to the study. In Sect. 1.3 the chapter discusses the major obstacles to attaining the health MDGs in Africa. Though legion, the section focuses on health system deficiencies, with particular attention to dearth of health professionals, shortage of essential drugs and medicine, resource constraints, and misalignment of health priorities. In addition, the section considers the devastating challenge posed by corruption and bad governance. Having situated the challenges, Sect. 1.4 suggests major interventions that could turn things around, namely addressing underlying health determinants, remediating poverty, integrating human rights into health systems and empowerment of individuals as well as civil society. The conclusion—Sect. 1.5—is that although the present state of health in Africa gives little room for optimism, it is possible for countries in the region to make significant headway by being innovative and incorporating reform initiatives identified in this discourse.

---

[5] Referring to this link as a "vicious cycle," the African Union Conference of Health Ministers explained: just as "poverty and its determinants drive up the burden of disease," so too "ill-health contributes to poverty." See The African Health Strategy: 2007−215, Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, April 9–13, 2007, CAMH/MIN/5(III), 4, available at http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf (accessed 28 August 2013) [hereinafter African Health Strategy]. See also WHO 2005 (acknowledging that "emphasis on health reflects a global consensus that ill-health is an important dimension of poverty in its own right. Ill-health contributes to poverty. Improving health is a condition for poverty alleviation and for development. Sustainable improvement of health depends on successful poverty alleviation and reduction of inequalities").

[6] U.N. Dev. Group, Indicators for Monitoring the Millennium Development Goals: Definitions, Rationale, Concepts and Sources, U.N. Doc. ST/ESA/STAT/SER.F/95, U.N. Sales No. E.03.XVII. 18 (2003).

[7] African Health Strategy p. 3.

## 1.2 Background to the Study

The Goals and Targets relating to health provide a yardstick, a concrete barometer for measuring the outcome of socioeconomic and political investments in health by all member nations of the U.N. They serve, in a sense, as human rights tools for assessing the degree of commitment of governments to the health and wellbeing of individuals within their respective jurisdictions. For stakeholders, being apprised of such information (knowledge of specific policies, including implementation strategies) positions them on a firm footing to demand accountability on the part of responsible authorities in their various countries. And this, in itself, is a crucial driver of health sector development.

The specific Targets attached to each Goal are as follows: Goal 4 (reduce by two-thirds, between 1990 and 2015, the under-five mortality rate); Goal 5 (reduce by three quarters, between 1990 and 2015, the maternal mortality rate); Goal 6 (to have halted by 2015 and begun to reverse the spread of HIV/AIDS and achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it; to have halted and begun to reverse the incidence of malaria by 2015; and to have halted and begun to reverse the incidence of tuberculosis by 2015); and, Goal 1 (to halve, between 1990 and 2015, the proportion of people whose income is less than $1 (reversed to $1.25 in 2005) or suffering from hunger). While not denying the importance or relevance of these Goals and associated Targets to the objective of this chapter, space constraint forecloses an in-depth discussion. This is not a discourse on specificities of a particular MDG or Target. Instead—and this is critical—the chapter's objective is very cosmopolitan. Its focus is on the big picture. It adopts a broader approach, by concentrating on the major obstacles in the path to meeting MDG obligations in the region and incorporating specific interventions that would dramatically turn things around.

This chapter, inspired by the African Health Strategy: 2007–2015,[8] the objective of which is to "strengthen health systems in order to reduce ill-health and accelerate progress towards attainment of the [MDGs] in Africa,"[9] is essentially a critical analysis of the state of health in Africa. The chapter argues that the poor state of health in Africa is a product not only of deficiency of access to health care but, more fundamentally, other socioeconomic and environmental health determinants (positively defined) and related problems. This deficiency is most apparent in data showing stagnating or downward spiraling of key health indices in most countries

[8] Ibid. Additional inspiration is provided by the New Partnership for Africa's Development (NEPAD) Health Strategy, the second leading policy document on health in Africa. Its vision and goal is to rid Africa of "the heavy burden of avoidable ill-health, disability and premature death" by "[dramatically reducing] the burden of disease, especially for the poorest in Africa." The NEPAD Health Strategy was adopted at the first African Union Conference of Health Ministers held in Tripoli in April 2003 and endorsed by the African Union in Maputo in July 2003, http://www.sarpn.org.za/documents/d0000612/NEPAD_Health_Strategy.pdf (accessed 12 March 2013). Ibid., p. 14.

[9] African Health Strategy, p. 7.

in the region. While not denying the monstrous reality of resource constraints (particularly on an individual level), the paper blames the status quo on irresponsible governance, which is sustained by docility on the part of the citizenry, in terms of not using the democratic process to demand and force necessary changes. It identifies crucial interventions both within and outside the health sector that must ground regional and national initiatives aimed at achieving the desired outcome.

Four critical facts shape the thrust of this chapter. First, the MDGs are not exactly novel obligations. Juxtaposed against previous international agreements, they are far-reaching and embody more specific obligations. But they are, on a more in-depth analysis, restatements of previous unmet commitments. For instance, WHO's "Global Strategy Health for All by the Year 2000," which was launched in 1979, had as its goal, the attainment by all people of the world by the year 2000 of a level of health that would permit them to lead socially and economically productive lives.[10] This goal, sweeping as it is, clearly encompasses all the health MDGs and had the goal been met as envisaged, there would certainly have been no need for the MDGs. Even more specific to Africa, Target 6.C (to "[h]ave halted by 2015 and begun to reverse the incidence of malaria …") is substantially similar to an earlier pledge (in April 2000, 4 months before the Millennium Declaration) by African countries (to "[h]alve the malaria mortality for Africa's people by 2010…"),[11] the only material difference being a five-year interval between the cutoff dates for meeting the obligations. Moreover, as the Millennium Development Project acknowledges, "human rights (economic, social, and cultural rights) already encompass many of the Goals, such as those for poverty, hunger, education, health, and the environment."[12] What all these signify is that the Millennium Declaration, despite its omnibus reach, does not hold a magic wand in terms of radically improving the health of Africans, or anyone else for that matter, versus earlier international initiatives. The key would be whether the political leadership in Africa is prepared, this time around, to extirpate the obstacles retarding progress toward achieving health for all in the region, thereby positioning the region on a fast track to meet its MDGs obligations.

The second point worthy of note is whether countries in the region are on pace to meet the obligations imposed by the health MDGs? Aside from the statement of the African Union Conference of Health Ministers, referenced previously, New York University professor of economics William Easterly recently documented

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[10] The Global Strategy was launched in 1979 at the 32nd World Health Assembly by adopting resolution WHA32.30, although the original idea for global pursuit of health for all by the year 2000 was conceived at the 30th World Health Assembly in 1977 (WHA 30.43). See WHO 1981, p. 7, 15. On the link between the Global Strategy and the MDGs, see Franco 2009, p. 63. The author describes the MDGs as a "sequel to one of the most ambitious commitments of the twentieth century to health through the objectives outlined in Health for All by the Year 2000".

[11] African Union, 2000, available at http://www.usaid.gov/our_work/global_health/id/malaria/publications/docs/abuja.pdf (accessed 12 March 2013).

[12] U.N. Millennium Project 2005, p. 119.

several instances of skepticism[13] including, inter alia, a statement by the U.N. Department of Public Information, "[a]t the midway point between their adoption in 2000 and the 2015 target date for achieving the [MDGs], sub-Saharan Africa is not on track to achieve any of the goals," including those that are health-related.[14] Take MDG 4 as an illustration. Its Target is to reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate (U5MR). In this key area, sub-Sahara Africa is seriously lagging behind other regions, as evident in the following devastating statistics. Out of every eight children born in Africa, one dies before his or her fifth birthday.[15] The U5MR, at 142 deaths per 1,000 live births, is abysmal in comparison to other regions (the rates in America and Europe are 18 and 14 deaths per 1,000 live births respectively.)[16] More specifically, there are 31 countries with U5MR exceeding 100, all of which are African, except one (Afghanistan).[17] And in 2008, sub-Sahara Africa accounted for half of the 8.8 million under-five deaths in the world.[18] Quite a bleak picture indeed, which raises the question whether Africa is on pace to reduce its U5MR by 66 % in 2015, relative to 1990 level as called for by MDG 4. All available data suggest that this is very unlikely. Since the U5MR in 1990 was 182,[19] meeting the Target would require reducing the number to 62. This is a very difficult feat to accomplish, especially considering that the current figure is 127, a couple of years before the deadline.[20]

Third, it has to be noted, as mentioned in the Abstract, that the MDG project is used in this chapter as a proxy, sort of shorthand, for analyzing broader human right to health issues. The various benchmarks and indicators of the health MDGs are relevant markers for assessing also the commitment of countries to actualizing the right to health in their respective jurisdictions. In other words, advancement toward the health MDGs is tantamount to progress toward realizing the right to health or vice versa. The two are intimately related. Underlying this chapter, therefore, is concern about the right of the people of Africa to health and how to concretize it in their lives.

The final issue (and closely related to the first) is the place of corruption in the overall scheme of attaining the Goals. What proportion of disbursed aid would translate to concrete programs and completed projects in the region? What accountability measures are in place to guarantee the desired result? Remarkably, despite the hue and cry about making aid dependent on good governance, there is, thus far, very minimal evidence of international practice denying aid to countries for

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[13] Easterly 2009, p. 26.

[14] U.N., Africa, and the Millennium Development Goals 2007 Update, p. 1, available at unstats.un.org/unsd/mdg/resources/…/Africa/Africa-MDGs07.pdf (accessed 9 January 2013).

[15] U.N. 2011, The Millennium Development Goals Report 2011, p. 25.

[16] WHO 2010, p. 24.

[17] U.N. 2011, The Millennium Development Goals Report 2011, p. 25.

[18] U.N. 2010a, The Millennium Development Goals Report 2010, p. 27.

[19] WHO 2010, pp. 56–57, UNICEF 2009, p. 121.

[20] WHO 2011, pp. 54–55.

insufficient commitment to good governance and corruption eradication measures.[21] This is of critical importance as a central claim of this chapter is that the current state of health in Africa, contrary to extant orthodoxy, is not explicable on the basis of finitude of resources. The roots, as the next section clearly shows, are much more ominous.

## 1.3 Major Challenges to Achieving the Health MDGs

One can sum up the major obstacles to achieving the health MDGs in Africa as systemic deficiencies—that is, gaps, inefficiencies, and other drawbacks that negatively impact health system capability to respond to the needs of the people dependent on it.[22] A health system consists of "all the activities whose primary purpose is to promote, restore or maintain health."[23] Merging these two definitions yields the proposition that "health system deficiencies" amount to failure of health-related activities to effectively contribute to health promotion, restoration or maintenance. This failure is gauged by the responsiveness of the health system to the demand placed upon it by its users, and the response curve itself is influenced by the availability or otherwise of several factors, particularly health personnel, essential drugs, equipment, infrastructure, and whether equity is built into the system in terms of access and health outcomes. The pendulum swings up and down in tandem with the response curve. That is, the availability and equitable access to these goods pushes the response curve up and vice versa. Decrepit and dilapidated infrastructure, poorly staffed hospitals and clinics, drought of essential medicines, and escalating cost of services—all too common in most African nations—combine to perennially hold the pendulum down. The depressing health data animated in the various sections of this discourse is directly linked to health system deficiencies throughout the region.

Each year, WHO publishes two authoritative reports on global state of health, namely the World Health Statistics and the World Health Report. Common to both reports is the consistency of atrocious health indices in sub-Sahara Africa. Indeed, in the 2000 edition of the World Health Report, which analyzed health system

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[21] To the contrary, Alberto Alesina and Beatrice Weder found that "there is no evidence that bilateral or multilateral aid goes disproportionally to less corrupt governments" or that "debt relief programs [another form of foreign aid] have been targeted to less corrupt countries." See Alesina and Weder 2002, p. 1126.

[22] The NEPAD Health Strategy notes, as the reason "Africa is not on track to achieve [the MDGs]," the following: health systems and services are too weak to support targeted reduction in disease burden; disease control programs do not match the scale of the problem; safety in pregnancy and childbirth has not been achieved; people are not sufficiently empowered to improve their health; insufficient resources; widespread poverty, marginalization and displacement on the continent; and, the benefits of health services do not equitably reach those with the greatest disease burden. See NEPAD Health Strategy, pp. 6–13; Africa Health Strategy, pp. 4–5.

[23] WHO 2000, p. 5.

attainment and performance of 191 countries, only two countries in the region (Senegal and Seychelles) were ranked in the top 50 percentile.[24] The dismal state of the rest of the countries' health systems stridently testifies to the multifarious public health challenges facing the region, none of which is really new but now poised, more than ever, to obstruct the attainment of health MDGs in the region.

### *1.3.1 Shortage of Health Professionals*

Foremost among the systemic challenges is accessibility of health professionals. Although there is worldwide shortage, no place is worse hit than Africa. Notwithstanding that the region bears a whopping 24 % of the disease burden in the world, it has only 3 % of the global health workforce compared, for instance, to the Americas which shoulders just 10 % share of the global diseases but is home to 37 % of the world's health workers.[25] The situation in some African countries is so dire that even where urgently needed resources such as drugs and equipments are available, severely limited human capacity constrains rapid and efficient deployment of the resources. There are dual dimensions to this problem. Medical schools in Africa do not graduate sufficient number of physicians, nurses, midwives, and other paramedical professionals to adequately staff available health facilities. And notwithstanding this deficit, a significant portion of the few available hands migrate abroad, most to Western countries, in search of better conditions of service.[26] Having less than adequate hands to deliver critical services does not bode well for health systems in the region. The true impact of this deficiency, however, is dependent on the severity of the circumstances in each country.

WHO projects that for a country to be able to deliver essential health interventions and achieve the MDGs, the availability of its health personnel (doctors, nurses and midwives) must be higher than 2.28 per 1,000 people.[27] Countries not meeting this threshold are said to be suffering critical shortages. There are 57 such countries, 36 of them in Africa.[28] To make up the shortfall, estimated at 817, 992, Africa needs to boost its recruitment (doctors, nurses, and midwives) by 139 %.[29] Regrettably, a 2009 study of the density of physicians and nurses in 12 African countries found that not only is the workforce inadequate to meet current demand,

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24 Ibid., pp. 152–155.

25 WHO 2006, pp. XVIII–XIX.

26 Other factors responsible for health worker shortage in Africa include early retirement of health workers, morbidity, and mortality. See Kinfu et al. 2009, p. 225, Kumar 2007, pp. 2564–2567, Naicker et al. 2009, pp. S1-60–64.

27 WHO 2006, pp. 11–12.

28 Ibid., p. 12.

29 WHO 2006, p. 13 citing WHO, Global Atlas of the Health Workforce.

in at least half of the countries surveyed, there is no capacity in existing training programs to produce sufficient number of graduates to maintain existing levels.[30]

Worse still, thousands continue to flee the region's hospitals and clinics. As much as 37 % of South African doctors (29 and 19 %, respectively, in Ghana and Angola) are employed in just eight countries belonging to the Organization for Economic Co-operation and Development (OECD).[31] The level of migration to the United States is even more alarming. The health system of Liberia ranks among the worst globally (186th out of 191 countries surveyed),[32] but 43 % of its physicians work in the United States, with Ghana and Uganda next in line, contributing 30 and 20 %, respectively, of their doctors.[33]

For nascent and fragile health systems in Africa, cushioning the effect of such massive brain drain is quite a daunting task. Consider, for instance, that one of the factors contributing to high number of maternal deaths across Africa is insufficiency of skilled health personnel (SHP). Deaths resulting from this single factor are blamable, in large part, on efflux of the region's nurses and midwives to foreign countries. With 880 deaths per 100,000 live births,[34] Zimbabwe stands afar, as most African nations, from meeting its MDG obligation regarding maternal mortality. Yet, more than one-third of its nurses and midwives (3,183 out of 9,357) are employed in OECD countries, as do 18 %, respectively, from Lesotho and Mauritius, two other countries with equally abysmal MMR.[35]

### *1.3.2 Shortage of Essential Drugs and Medicine*

Since the Declaration of Alma-Ata, countries in Africa, as elsewhere, have been striving to secure universal coverage for everyone in their territories. Even health systems that have succeeded in attracting and retaining ample number of health practitioners will falter unless regular supply of essential drugs is secured. There is, as noted previously, a crunching shortage of health personnel throughout Africa, and the same goes for essential drugs—defined as "those that satisfy the priority health care needs of the population" and "are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness."[36] Key attributes of essential medicines is that they address priority

[30] Kinfu et al. 2009, p. 227.

[31] WHO 2006, p. 100 citing Trends in international migration.

[32] WHO 2000, p. 53.

[33] Hagopian et al. 2004, p. 2.

[34] WHO 2010, p. 68.

[35] WHO 2006, p. 100.

[36] WHO, 'Essential Medicines', available at http://www.who.int/topics/essential_medicines/en/ (accessed 8 January 2013). Since 1977, WHO has published a list of essential medicines that is updated biennially. The current version, the 16th list, dates from March 2009. See WHO, 'Model

needs, are available at all times, are of acceptable quality and are sold "at a price the individual and the community can afford."[37] Viewed in light of these attributes, it becomes clear that Africa faces difficult hurdles in making essential drugs available to its people.

Owing to the embryonic state of the drug industry in Africa, a sizeable amount of pharmaceutical products dispensed in the region are imported, often at exorbitant prices. Because these drugs are largely unsubsidized and are mostly paid for out-of-pocket, those unable to pay the price are denied the benefit of the drugs. To address this problem, African countries have begun purchasing generics (cheaper than patented drugs) from other developing countries, especially India and China, resulting in substantial price reductions, although for the very poor, access still remains problematic. The most obvious response to this challenge is to develop capacity for local production, as has been explicitly called for by the African Union.[38] A sound idea, but then developing a drug manufacturing base requires huge capital outlay, advanced technology and technical expertise, all of which are in short supply in Africa. This explains the difficulties local production plants are having in meeting the needs of the population they serve.

But the situation is gradually improving. In addition to South Africa, production is rising in several other countries. In Nigeria, for instance, over 30 % of all medicines in the country are produced by local pharmaceutical industries, numbering more than 80.[39] This is certainly an encouraging development; still, a different concern remains—the quality of the finished product. It is striking that other than companies in South Africa, only one other country in sub-Saharan Africa (Uganda) has a plant that has successfully gone through the WHO Prequalification of Medicines Program (PQP)[40]—a process through which WHO determines the quality, safety, and efficacy of drugs based on a comprehensive evaluation of the drugs and manufacturing facilities.[41] Nonetheless, there is no evidence of substandard products being churned out at production facilities in Africa.

Aside from high prices, another problem affecting access to essential medicines in Africa is widespread circulation of counterfeit and adulterated medicines in the region's drug supply chain. The combined forces of poverty, lax rules and regulations, and avarice on the part of vendors combine to ensure that adulterated drugs populate pharmacy store shelves throughout the region. Weak enforcement regime feeds into the greed of unscrupulous vendors who import and distribute fake drugs

(Footnote 36 continued)
List of Essential Medicines', available at http://www.who.int/medicines/publications/essentialmedicines/en/ (accessed 8 January 2013).

37 Ibid.

38 African Union 2007, CAMH/MIN/8(III) (on file with author).

39 See Mohammed 2009, p. 42, available at http://www.medicinestransparency.org/fileadmin/uploads/Documents/MeTA-Uganda_AfricaHealth.pdf (accessed 2 March 2013).

40 Anderson 2010, p. 1597.

41 WHO 2009, Technical Report Series No. 953, Annex 3 apps.who.int/prequal/info general/documents/…/TRS_953-Annex3.pdf (accessed 8 February 2013).

without regard to adverse impact on users. In 2004, 70 % of pharmaceuticals marketed in Angola were fake, as was the case in Nigeria in 2002.[42] But the situation has shown remarkable improvement in recent years. As of September 2010, the proportion of counterfeit drugs in Nigeria has shrunk to 5 %.[43] How was this feat accomplished?

Sanitizing the chaotic pharmaceutical industry in Nigerian began with the appointment of a woman of integrity, a fearless "warrior," to lead the National Agency for Food and Drug Administration and Control (NAFDAC), the nation's food and drug regulator, in 2001. Within months of assuming office, Dora Akunyili had fired corrupt employees, shut down shady pharmaceutical businesses, and blacklisted several foreign-based manufacturers of counterfeit drugs, mostly in India and China.[44] Both countries are now cooperating with Nigeria in stemming the flow of counterfeits from their countries.[45] NAFDAC officials have assumed a more visible presence and proactive role at the nation's airports, seaports, major markets, and distribution centers, confiscating and burning tons of seized drugs.

Prosecution of crooked dealers is up. In addition, the agency is seeking active cooperation of members of the public in its efforts. There is an ongoing awareness campaign aimed at empowering individuals to detect counterfeits and report offending vendors. In February 2010, NAFDAC launched the Mobile Authentication Service (MAS), an innovation of Sproxil Technology, which allows drug purchasers to use their mobile phones to verify the authenticity of the product.[46] The process is not cumbersome. Purchasers simply text a unique number on a scratch card attached to the medicine to a database in the United States and instantly receive a message confirming authenticity or warning that the product is fake. These bold moves are continuing to drive down counterfeits in Africa's most populous country, and should have an even more dramatic impact on smaller countries facing similar problems.

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[42] WHO, Around the World: Reports of Counterfeit Medicines, http://www.who.int/medicines/services/counterfeit/impact/ImpactF_S/en/index1.html (accessed 8 February 2013); Abiodun Raufu, 'Influx of Fake Drugs to Nigeria Worries Health Experts', Lancet 324, no. 7339 (2002), p. 698.

[43] Obinna and Duru 2010, available at http://www.vanguardngr.com/2010/09/fake-drugs-down-to-5-says-nafdac/ (accessed 8 February 2013).

[44] For a list of companies on the list, see 'NAFDAC, Blacklisted Companies', http://www.nafdacnigeria.org/drugs.html (accessed 8 February 2013).

[45] Securing Industry, Chinese fake drug traders receive death sentence, 15 December 2009, available at http://www.securingindustry.com/pharmaceuticals/chinese-fake-drug-traders-receive-death-sentence/s40/a333/ (accessed 28 August 2013) (reporting that China imposed death sentence on six of its nationals for exporting substandard drugs to Nigeria).

[46] The Sproxil Blog, NAFDAC Launches Mobile Authentication Service in Nigeria with Sproxil's Technology, available at http://www.sproxil.com/blog/?p=78 (accessed 12 March 2013).

### 1.3.3 Inadequate Resources

Resource deficit is at the root of challenges facing health systems in Africa and a formidable obstacle to achieving the health MDGs. This is basic economics. Without adequate budgetary allocation, Ministries of Health are forced to scale back spending on health sector needs. Critical interventions such as hiring and retaining health workers, immunization drives, procurement of essential medicines, and public health emergency preparedness are scrapped or curtailed. This is the bane of health sector development in Africa. Inability to match needs with funds is the reason programs and strategies targeting the region's disease burden often end in failure. The WHO Commission on Macroeconomics and Health projects that developing countries need to spend about $34 per person each year to provide a package of essential preventive and curative healthcare services.[47] While per capita health spending in industrialized economies is hundred or more times this sum, the stark reality is that for many African countries, such level of spending is simply unthinkable. Democratic Republic of Congo and Zimbabwe, for instance, were able to spend just $17 and $20 per capita on health in 2007.[48]

The Abuja Declaration, adopted at the conclusion of the African Summit on HIV/AIDS, TB, and Other Related Infectious Diseases in April 2001, aims to plug this hole by committing African countries to allocate at least 15 % of their annual budgets to the health sector.[49] But a decade after adoption, the Declaration has not been matched with action. As of 2010, just six countries—Rwanda, Botswana, Niger, Malawi, Zambia, and Burkina Faso—have met the benchmark.[50] Even Nigeria, on whose shores the Declaration was adopted, is yet to boost its health spending in accordance with the Declaration. But even though the target remains largely unmet, significant strides have been made in several countries. Notable instances include Gabon which has increased its health budget to 14 %, Chad and Tanzania (nearly 14 %) and many others hovering around 10 % or more.[51] For those still to show progress, the temptation is great to demand that they step up efforts in that direction, but such demand glosses over the difficult financial circumstances of many of these countries.

[47] WHO 2001, Report of the Commission on Macroeconomics and Health, p. 11.

[48] Kaiser Family Foundation, Health Expenditure Per Capita 2007, available at http://www.globalhealthfacts.org/topic.jsp?i=66 (accessed 12 March 2013).

[49] Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, OAU/SPS/ABUJA/3, para 26.

[50] Africa Public Health Alliance, 2010 Africa Health Financing Scorecard, available at http://resultsuk.files.wordpress.com/2010/05/MDGs-africa-health-financing-scorecard-wha-summary-draft-april-may-2010.pdf (accessed 12 March 2013).

[51] Id.

### 1.3.4 Misalignment of Priorities

The canonization of primary health care (PHC) as "the central function and main focus" of health systems[52] at the 1978 International Conference on PHC received the imprimatur of 134 governments and 67 representatives of U.N. organizations, specialized agencies and accredited non-governmental organizations (NGOs) in attendance.[53] Participants at the conference affirmed PHC as providing the most effective and cost efficient path for governments to fulfill their responsibility for the health of their peoples, an affirmation that has been strengthened by the Committee on ESCR. In 2000, the ESCR Committee declared that the provision and availability of "minimum essential levels of … [PHC]" is a core obligation incumbent upon States Parties to the ICESCR.[54] A core obligation differs from an ordinary obligation in that whereas resource constraints, for instance, can justify non-compliance with the latter, there are no circumstances that would excuse non-performance of a core obligation.[55] As of September 2010, 46 out of 53 countries in Africa have ratified the Covenant and are therefore bound by its non-derogable provisions.[56]

The essence of PHC approach is its emphasis on deployment of more resources toward basic health care and disease prevention services at PHC centers (in contrast to concentrating primarily on hospitals and sophisticated technologies) as a means to achieving universal coverage.[57] Indeed, the centrality of PHC to achieving universal access and reducing global disease burden was the impetus for its adoption as the key to attaining the target of the Global Strategy for Health for all by the Year 2000,[58] the precursor to the MDGs. As indicated in the introductory section, the health MDGs share similar objective as the Global Strategy for Health, to wit, the attainment by everyone of a level of health that would enable them to

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[52] WHO/UNICEF 1978, Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, p. 16, para 15.

[53] Ibid., p. 13, para 5.

[54] U.N. Committee on ESCR (CECSR), General Comment No. 14: The right to the Highest Attainable Standard of Health, para 43, U.N. Doc. E/C.12/2000/4 (11 August 2000), reprinted in Compilation of General Comments and General Recommendations, adopted by Human Rights Treaty Bodies; U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003); U.N. Econ. & Soc. Council [ECOSOC], U.N. Committee on ESCR, General Comment No. 3: The Nature of States Parties' Obligations, para 10, U.N. Doc. E/1991/23, annex III, p. 86 (1991), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 p. 14 (2003).

[55] General Comment No. 14, para 47; Nnamuchi 2008, pp. 32–33.

[56] See U.N., Treaty Collection, Chapter IV, Human Rights, No. 4: ICESCR, Status of Ratification, as of Dec. 20, 2010, available at http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&Chapter=4&lang=en (accessed 12 March 2013).

[57] Pan American Health Organization (PAHO), 44th PAHO Directing Council: Ministers Urge New Push Toward 'Health for All' in the Americas, available at http://www1.paho.org/english/dd/pin/PAHOTodayOctp03.pdf, p. 1 (accessed 12 March 2013).

[58] See WHO 2000, Global Strategy, p. 12, at pp. 17–18.

lead socially and economically productive lives.[59] As such, the 2015 target for attainment of the MDGs can be legitimately construed as an extension of the 2000 deadline of the Global Strategy for Health.

To accelerate efforts toward the Global Strategy for Health, WHO recommends that in national health policies, countries should give priority to PHC.[60] By seeking prioritization of PHC, WHO was reiterating one of the pillars of the Declaration of Alma-Ata.[61] Since the Declaration was adopted, all WHO member countries have incorporated this approach as the cornerstone of their national health systems. But operationalizing this prescription requires that the PHC system of each country receives a lion share of human and material resources available for health. Especially for Africa, sticking to this prescription has enormous benefits in terms of better use of its lean resources. To reap the dividend, however, entry point to the health system must be relocated from higher tiers (specialized clinics, hospitals, and outpatient and emergency services) to generalist primary care in close-to-client settings.[62] The advantages to this relocation include alleviation of suffering, prevention of avoidable illness and death, and health equity improvement.[63] There is also a cost–benefit. Because generalists prescribe fewer invasive interventions,[64] fewer and shorter hospitalizations[65] and are more preventive care oriented,[66] the overall healthcare cost is reduced. Besides, quality of care does not suffer as there is virtually no difference in adherence to clinical practice guidelines between generalists and specialists.[67] Are these benefits being harnessed in Africa?

Evidence abounds that the rhetoric of PHC approach is not aligned with appropriate policy initiatives in most African countries. Declining health indicators in the region present the strongest proof of this misalignment. Paradoxically, most of the region's health problems are diseases of the poor—the so-called

[59] Ibid., at p. 15.

[60] Ibid., at pp. 39–40. The African Health Strategy also emphasized this approach: "The basic unit of a well organised health system is the district [PHC system], which needs to be strengthened and adequately resourced, in a balanced manner with the higher levels of health care." See African Health Strategy, 8. Pursuit of PHC prioritization, in other words, should not lead to the neglect of secondary and tertiary tiers, but must be balanced in such a way as not to detrimentally affect the availability or quality of services provided at that level.

[61] Declaration of Alma-Ata, Article V (which states that "A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. [PHC] is the key to attaining this target as part of development in the spirit of social justice.").

[62] WHO 2008, p. 53.

[63] Ibid.

[64] Rose et al. 2000, pp. 1103–1118, Krikke and Bell 1989, pp. 637–643, WHO 2008, p. 53.

[65] Abyad and Homsi 1993, pp. 465–470, Heuston et al. 1995, p. 435, pp. 351–435.

[66] Ryan et al. 2001, pp. 184–190.

[67] Beck et al. 2001, pp. 33–40, WHO 2008, p. 53.