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

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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

[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.

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[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

[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

[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.

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[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.

"neglected diseases"[68]—which are easy to prevent and cheap to treat, precisely the type of disease burden for which PHC system is best suited. Take malaria, for instance. The disease is inexpensively preventable (mosquito nets cost approximately $5),[69] easily diagnosable (pyrexia is a common symptom), and treatable for next to nothing ($1.50–2.40 for adults and $0.40–0.90 for children).[70] Providing information on preventive methods as well as diagnosing and treating such diseases are the core functions of PHC clinics. Yet, the disease remains a leading cause of outpatient morbidity and a major contributor to high mortality in the region, accounting for 768,070 deaths or 89 % of the global malaria mortality in 2008.[71] This has little or nothing to do with resources. It is simply a question of misallocation and misalignment of resources with need. Most countries in the region devote a greater share of their health budgets to specialized tertiary care which, as observed by the World Bank, is less cost-effective while neglecting the low-cost and highly effective programs handled at PHC centers.[72]

Nigeria presents a remarkable illustration. Although its National Health Policy aims to "provide a comprehensive healthcare system that is based on [PHC]"[73] and declares PHC to be "the basic philosophy and strategy for national health development,"[74] appropriate framework to concretize these pronouncements does not exist. Responsibility for the three tiers of care (primary, secondary, and tertiary) is apportioned among the three levels of government, with the federal government in charge of tertiary care, states responsible for provision of secondary care and primary care assigned to local governments. Rather than allot PHC management to the most resourced unit (federal government), the duty was foisted on the weakest link—local governments, the result being that the federal government pours vast sums of money to tertiary care while PHC facilities flounder. The poor state of health in the country is the most visible, but unintended, consequence of this misalignment and misallocation of resources. So, what to do?

The World Bank estimates that by redirecting about half of what is now spent on less cost-effective specialist care to essential public health programs and clinical services (that is, PHC), developing countries could collectively reduce

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[68] These are diseases which are typically concentrated amongst poor third world inhabitants and which generally receive little attention (inadequate research and investment) in global health policy. Examples include malaria, tuberculosis, lymphatic filariasis, onchocerciasis, leishmaniasis, schistosomiasis, African trypanosomiasis and Chagas disease. See WHO 2001, pp. 78–80.

[69] See Project Mosquito Net Website, http://www.projectmosquitonet.org/ (accessed 4 April 2013).

[70] Médecins Sans Frontières (Doctors without Borders), Malaria: MSF Facts and Figures, May 2004, p. 3, http://www.msfaccess.org/fileadmin/user_upload/diseases/other_diseases/malariafactsheetjun04.pdf (accessed 22 March 2013).

[71] WHO 2009, p. 27.

[72] World Bank 1993, iii, pp. 3–4.

[73] Federal Ministry of Health (FMH), Revised National Health Policy 2004, at iv, http://www.herfon.org/docs/Nigeria_NationalHealthPolicy_sept_2004.pdf (accessed 16 March 2013).

[74] Ibid., p. 4.

their disease burden by 25 %.[75] In other words, even without infusion of additional resources, substantial improvement in health is possible with prudent utilization of resources already available for health. For countries with dubious distribution of responsibilities among different levels of government, like Nigeria, a solution might be to vest PHC management in the unit of government best positioned to raise, deploy, and maintain adequate resources for its effective operation (the central government). Alternatively, where the state or local government retains responsibility, a system should be put in place, specifying the level of budgetary allocation to primary care, separate and distinct from allocations to other items on the budget. This ensures that the PHC system would be sufficiently resourced regardless of the unit of government charged with its operation.

This latter alternative is preferable as decentralization of health services to the district level, by "bringing health care as close as possible to where people live and work," provides the best formula for optimal performance of PHC systems.[76] Evidence of the benefit of decentralization is seen in Brazil's Unified Health System (*Sistema Único de Saúde*). The Brazilian health system is strongly marching toward universal coverage (75 % currently) in part because of legislation which vests responsibility for health financing and management in states and municipal governments and requires them to allocate at least 12 and 15 % of their respective budgets to health, with the central government providing additional support.[77] Serious commitment of municipal governments (many exceeding the statutory required budgetary allocation) and emphasis on PHC (provided free) are major drivers of health improvement—in terms of greater access to care and better health outcomes—in that country.

Implicit in the Brazilian experience is this lesson: having determined the entity in charge of PHC, each country must specify the level of resources needed to be set aside for that purpose. In some cases, this would mean hiking the general allocation to the unit of government allotted the responsibility. But since general allocations to local governments are barely enough to cover salaries and infrastructure maintenance, it is not enough to mandate dedicating a set percentage of their budgets to PHC. Instead, once the decision to entrust them with running the PHC system has been made, their receipt from the general revenue must be commensurably increased and intermittently adjusted to reflect fluctuating operational costs.

1.3.5 Corruption and Bad Governance

More than anything else, the most malevolent factor stunting economic growth and development in Africa is corruption. African leaders gathered at Maputo, Mozambique on 11 July 2003 were quite explicit about the "negative effect of corruption" as well as "its devastating effects on the economic and social

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[75] World Bank 1993, World Development Report 1993, iii, p. 6.

[76] Declaration of Alma-Ata, Article VI.

[77] Jurberg and Humphreys 2010, p. 646.

development of the African peoples."[78] The devastating impact of corruption in the region is visible in the dilapidation and waste in all sectors, not just health, and which have combined to wreak havoc in the lives of especially the marginalized and vulnerable populations. As Nuhu Ribadu, erstwhile head of Nigeria's Economic and Financial Crimes Commission explains, in reference to the regimes of three successive military leaders in Nigeria—Babangida, Abacha, and Abdulsalami—which he describes as being responsible for institutionalizing kleptocracy as a permanent fixture of governance in the country[79]:

> The decline we notice in the education sector today also started in that period. The shameless rot in the aviation sector, the absence of an efficient public transport system, the collapse of our public schools, the thievery in the ports and the decay in our healthcare delivery system all of which huge sums had been budgeted and spent are a direct reflection of the poverty of leadership of that era.[80]

While the impact, of course, varies from country to country, none is spared from the fang of this social ill. Consider this particularly striking case. Equatorial Guinea, a sparsely populated country of about half a million people, is the third largest oil exporter in Africa. With annual oil revenue of $3.7 billion,[81] the country undoubtedly deserves a spot among the world's affluent countries, in per capita terms. But its citizens are among the poorest as oil money is deposited into secret bank accounts controlled by the country's ruthless dictator and his coterie.[82] In 2006, the dictator's son, who was earning a monthly salary of $4,000 as the country's Minister for Agriculture and Forestry, was reported to have paid $35 million for a mansion in California,[83] a sum that is more than double what it would take to provide essential medicine for the entire population.[84]

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[78] See Preamble, African Union Convention on Preventing and Combating Corruption, adopted 11 July 2003, entered into force 5 August 2006.

[79] See Corruption: The Trouble with Nigeria, Speech Delivered at the 3rd Media Trust Annual Dialogue in Abuja, Nigeria, 19 January 2006, http://www.againstbabangida.com/news/2006/0106_IBBcorrupt_ribadu.htm (accessed 4 April 2013).

[80] Ibid., echoing a statement by former President Obasanjo in 2005 that "General Babangida is the main architect of the state in which the nation finds itself today, and that General Abacha was his eminent disciple, faithful supporter, and beneficiary". See Akinbode, OBJ on IBB, The Guardian (Nigeria), 11 August 2005 //againstbabangida.com/articles/2005/akinbode_obj-on-ibb.htm (accessed 4 April 2013).

[81] Global Witness 2009, p. 22, citing IMF, Republic of Equatorial Guinea Article IV Consultation, May 2008, p. 24, http://www.globalwitness.org/sites/default/files/pdfs/undue_diligence_text_only.pdf (accessed 7 March 2013).

[82] Ibid., pp. 26–44.

[83] Ibid., p. 27, citing John Reed, Taking a Cut Acceptable, says African Minister, Financial Times, 25 October 2006; Global Witness, African Minister Buys Multimillion Dollar California Mansion, Press Release, 8 November 2006.

[84] Only $17 million is needed to cover everyone in the country. The calculation is based on the WHO's estimate of $34 per person for essential medical care. See Global Witness, Undue Diligence, ibid., p. 32, citing DFID, Working together for better health, 2007, p. 23, http://www.dfid.gov.uk/Pubs/files/health-strategy07.pdf (accessed 2 April 2013).

Equatorial Guinea is not alone. There are countless examples all over Africa. In the much more prosperous Nigeria, for instance, an average of at least $4 billion to $8 billion per year was lost to corruption during the eight years of Obasanjo administration (1999–2007), the man who took over the reins of power from the military dictators mentioned previously.[85] This figure amounts to between 4.25 and 9.5 % of Nigeria's total GDP in 2006.[86] Yet, Nigeria's health system ranks 187th in the world out of 191 countries surveyed,[87] and in terms of human development index was 142nd out of 169 countries.[88] Even worse, although the proportion of those infected with HIV in the country pales in comparison to countries in Southern and Eastern Africa, its antiretroviral therapy (ART) coverage rate is only 26 %.[89] Inexplicably, this is blamed on resource dearth, notwithstanding that "[b]etween 1960 and 1999, Nigerian officials had stolen or wasted more than $440 billion. That is six times the Marshall Plan".[90]

One way to evaluate this perennial claim that finite resources constrain countries in Africa from being responsive to the health of individuals within their jurisdictions is to subject the claim to a governance framework analysis. The Constitution of Nigeria provides a useful guide. It lays down what could rightly be described as the essential components of good governance, namely national integration, abolition of corruption and abuse of power, and management of the economy for the benefit of all.[91] The term "essential components" suggests that these are core elements that are indispensable to responsible governance and, where operationalized, these elements will act as a catalyst to advancement in the health and overall wellbeing of the population. Botswana exemplifies the virtues and benefits of good governance. At independence in 1960, the country was among the poorest in the world, with a GDP per capita estimated at between $70 and $90, and highly dependent on foreign aid.[92] But by 2004, the GDP per capita had risen to $4,771[93] and the national budget had skyrocketed from less than $3 million to

[85] Human Rights Watch 2007 pp. 31–32, http://www.hrw.org/reports/2007/nigeria1007/nigeria1007webwcover.pdf (accessed 18 April 2013).

[86] Ibid.

[87] WHO 2000, p. 154.

[88] UNDP 2010, p. 162.

[89] WHO 2010, p. 93.

[90] Ribadu 2009, p. 4.

[91] Sections 15(3), 15(5), 16(1)(b). For a more robust discussion of good governance as the key to achieving the MDGs (based on the fact that it is one of the prerequisites for receipt of assistance under MDG 8—which calls for increase in aid flowing from the Global North to Global South), see Nnamuchi and Ortuanya 2012, pp. 178–198.

[92] Mogae, Botswana's Development Experience, Lecture by the Former President of Namibia at the Institute of Development Studies, Sussex University, 2 February 2005, http://www.sarpn.org.za/documents/d0001114/index.php (accessed 4 April 2013).

[93] United Nations Conference on Trade and Development (UNCTAD), "Botswana," available at www.unctad.org/sections/ldc_dir/docs//lldc-bot.pdf.

$3 billion,[94] moving the country into the ranks of upper-middle-income economies.[95] This success story has been attributed to "political stability, sound economic management and prudent financial husbandry."[96] Are these not the inevitable result of incorporating the "essential components" identified above into the governance framework of the country? In 2009, Botswana was ranked 37th in Transparency International's Corruption Perception Index, the best record in Africa and a clear testament to its governance credentials.[97] Other countries in the region have not followed suit.

As nation after nation cling unto resource deficit as explicatory of their woes, the gulf between elegant constitutional stipulations on responsible governance and the reality on the ground continues to widen, with the only beneficiaries being worsening health indicators throughout the region. In their 2002 publication, human rights advocates Olisa Agbakoba and Willy Mamah were forceful in their rejection of this state of affairs.[98] The fundamental issue, they argue, "has been corruption … where individuals, using State power have continued to amass so much wealth" for themselves and their coterie, without regard for the common good.[99] Indeed, the abysmal state of health in Africa, the difficulty confronting health systems en route to meeting their MDG obligations as well as the precipitous plunge in other vital statistics cannot be disassociated from orchestrated plunder and pillage of national treasuries by the region's political leadership.[100]

1.4 Interventions for Change

The complexity and multifarious nature of the factors stymieing health improvement in Africa suggest that remedial measures must be comprehensive, targeted, and sustainable in order to have any meaningful chance of success. Because disease burden differs widely across the region, as do resources, the approach to be adopted will, of necessity, vary according to the particular circumstances of each country. Nevertheless, there are certain interventions that would be productive in virtually

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[94] Mogae, Botswana's Development Experience, ibid.

[95] World Bank, Country and Lending Groups, http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Lower_middle_income (accessed 4 April 2013).

[96] Mogae, Botswana's Development Experience, ibid.

[97] Transparency International, Corruption Perceptions Index 2009, http://www.transparency.org/policy_research/surveys_indices/cpi/2009/cpi_2009_table (accessed 4 April 2013).

[98] Towards a Peoples' Constitution in Nigeria: A Civic Education Manual for the Legal Community (Lagos: Human Rights Law Service 2002).

[99] Ibid., p. 43.

[100] For a detailed discussion on the link between poor performance of health systems and misappropriation of public funds in the context of delivery of health services in Nigeria, see Nnamuchi, Kleptocracy and its Many Faces, pp. 12–18.

all the countries irrespective of differing circumstances. The NEPAD Health Strategy specifies some of these interventions. The strategy directs countries to strengthen commitment and the stewardship role of government; build secure health systems and services; strengthen programs to reduce the burden of disease; and, provide skilled care for pregnancy and childbirth.[101] Countries are further directed to enable individual action to improve health, mobilize and effectively use sufficient sustainable resources; and, strive for equity for the poor, displaced and marginalized populations.[102] Aside from these and specific suggestions already put forth (on ways of addressing the various challenges previously identified), there are additional interventions each of which has a broad and far-reaching application and must form an integral component of the overall strategy for repositioning Africa on a sustainable path toward the MDGs and improving overall population health.

1.4.1 Poverty Reduction

The fact that a greater proportion of global diseases and illnesses afflict the most impoverished region in the world (Africa) tells quite a fairly straightforward story—and that is, there is a causal link between diseases and poverty. Hence the main target of MDG 1, to reduce by half between 1990 and 2015 the number of people with income of less than $1.25 per day, is particularly crucial to people in the region. Poverty is both a cause and a consequence of ill-health and vice versa; the two are mutually reinforcing.[103] The sole reason millions of lives are lost each year in Africa to easily preventable and treatable illnesses is no other than poverty, explaining its rather apt description as the world's most lethal diseases.[104] "Poverty … wields its destructive influence at every stage of human life, from the moment of conception to the grave. It conspires with the most deadly and painful diseases to bring a wretched existence to all who suffer from it."[105] This pernicious dimension of poverty makes it a human rights issue. Strikingly, what exactly constitutes poverty is not defined by any of the major international human rights instruments, but the U.N. Committee on Economic, Social and Cultural Rights (Committee on ESCR), the implementation monitoring body of the International

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[101] NEPAD Health Strategy, pp. 17–25.

[102] Ibid.

[103] 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 African Health Strategy, p. 4. See also WHO 2005, p. 8. The report acknowledges 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." Ibid.

[104] WHO 1995, p. v.

[105] Ibid.

Covenant on Economic, Social and Cultural Rights (ICESCR) does. The Committee on ESCR defines poverty as "a human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights."[106]

This expansive definition, a clear departure from the dominant traditional account of poverty as inability to provide basic goods and services for oneself, is compatible with the holistic approach of human rights; that is, in terms of the multidimensional manifestations of poverty and the need for a comprehensive response. These manifestations include lack of income and productive resources sufficient to ensure sustainable livelihoods, hunger and malnutrition, illness, limited or lack of access to education and other basic services as well as increased morbidity and mortality from illness.[107] Other instances of poverty are homelessness, inadequate housing, unsafe environment, social discrimination, and lack of participation in decision-making and in civil, social, and cultural life—all of which contributes to poor health.[108]

Global concern about the destructive impact of poverty on human well-being and the need for its eradication has a long genealogy. The preamble to the Universal Declaration of Human Rights (UDHR)[109] and the common preamble to the International Covenant on Civil and Political Rights (ICCPR)[110] and the ICESCR[111] proclaims "freedom from … want" as a basic human right. This proclamation entitles everyone to a "standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services."[112] Because it negates the enjoyment of this right (to a decent standard of life, life with dignity and so forth) "poverty constitutes a denial of human right"[113] or, as the Brazilian theologian Leonardo Boff postulates, "an evil and an injustice" on those laboring under its yoke.[114]

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[106] U.N. Econ. & Soc. Council [ECOSOC], Committee on ESCR, Report of the Twenty-Fifth Session, 23 April–11 May 2001, Poverty and the International Covenant on Economic, Social and Cultural Rights, E/C.12/2001/10, para 8, http://www.unhchr.ch/tbs/doc.nsf/0/518e88bfb89822c9c1256a4e004df048?Opendocument (accessed 2 February 2013).

[107] U.N., World Summit for Social Development, Programme of Action of the World Summit for Social Development (accessed 4 April 2013) 1995, A/CONF.166/9, Chapter II, para 19, http://www.un-documents.net/poa-wssd.htm (accessed 4 April 2013).

[108] Ibid.

[109] UDHR, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948), adopted December 10, 1948.

[110] ICCPR, G.A.res.2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, adopted 16 December 1966, entered into force 23 March 1976.

[111] International Covenant on Economic, Social, and Cultural Rights (ICESR) opened for signature Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, p. 49, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3, entered into force 3 January1976.

[112] UDHR, Article 25; ICESCR, Article 11.

[113] ECOSOC, Committee on ESCR, Report of the Twenty-Fifth Session, 23 April–11 May 2001, Poverty and the International Covenant on Economic, Social and Cultural Rights, para 1.

[114] Faith on the Edge: Religion and Marginalized Existence 1989, p. 23.

Subsequent human rights documents have been more explicit as to the nexus between poverty and human wellbeing and the need for concerted action toward its elimination. The Vienna Declaration and Program of Action, for instance, recognizes that "extreme poverty inhibits the full and effective enjoyment of human rights," and therefore "its immediate alleviation and eventual elimination must remain a high priority for the international community."[115] And the Heads of States and Government gathered at the World Summit for Social Development in Copenhagen, in 1995, committed their respective countries to the "goal of eradicating poverty in the world, through decisive national actions and international cooperation, as an ethical, social, political and economic imperative of humankind,"[116] marking the first international commitment to eradicate, not merely alleviate, poverty.[117] But whether it would ever be possible to completely eradicate poverty or create a poverty-free world is beside the point. What is important is that whatever the ultimate goal (alleviation or eradication), it must involve a fundamental restructuring of the socioeconomic order in a way capable of remediating inbuilt inequality of opportunities otherwise the entire process risks becoming an exercise in futility.

That the incidence of poverty is severest in Africa is as notoriously a common knowledge as is the fact that poverty is (on an individual or institutional level) singularly more responsible for the tepid pace of economic growth and development in the region than all other factors combined. Beginning in 1990, the United Nations Development Program (UNDP) has published an annual report which ranks countries according to their respective human development[118] and poverty levels.[119] Least performing countries are described as having "low human

[115] Adopted by the World Conference on Human Rights, 14–25 June 1993, A/CONF.157/23, Article 1, para 14 Copenhagen Declaration on Social Development, adopted by the World Summit for Social Development, 12 March 1995, A/CONF.166/9, Chapter 1, Annex 1, see Commitment 2. For other international initiatives at fighting poverty, see "Human Rights and Extreme Poverty," General Assembly Resolution, 17 December 1991, A/RES/46/121; "United Nations Millennium Declaration," General Assembly Resolution, 8 September 2000, A/RES/55/2; and, "2005 World Summit Outcome," General Assembly Resolution, 16 September 2005, A/RES/60/1.

[116] Ibid.

[117] UNDP 1997, Human Development Report 1997: Human Development to Eradicate Poverty, p. 106.

[118] Defined as a "composite index measuring average achievement in three basic dimensions of human development—a long and healthy life, access to knowledge and a decent standard of living." See UNDP, Human Development Report 2009: Overcoming Barriers: Human Mobility and Development, p. 210. A subsequent Report adds three additional criteria (the multidimensional measures of inequality and poverty), namely, (i) Inequality-adjusted HDI (IHDI), a measurement of inequality in health, education and income, (ii) Gender Inequality Index (GII) which assesses gender disparities in reproductive health, empowerment and labor market participation; and, (iii) Multidimensional Poverty Index (MPI), a measurement of overlapping deprivations suffered by households in health, education and living standards. See UNDP 2010, p. 86.

[119] UNDP 2009, p. 210 (which defines human poverty index as a "composite index measuring deprivations in the three basic dimensions captured in the human development index—a long and healthy life, access to knowledge and a decent standard of living").

development."[120] Of countries so designated (listed 128—169) all, except seven, are in Africa.[121] On the ranking on human poverty index, African countries also underperformed countries in other regions. Out of 35 countries with the worst record (ranked 100–135), only seven are not African.[122] The highest proportion of people living in poverty (relative to population), on less than $1.25 a day, is also found in Africa.[123] Understanding these numbers involves asking one basic question: why does poverty rate in Africa consistently exceed that of other parts of the world? The reasons are legion, but one is particularly illuminating: poor governance. Post colonial politicking in Africa has produced vast enclaves of unscrupulous ruling class, leaders with visions of governance that are diametrically opposed to stewardship of national resources and protection of individual liberty and freedom. Decades of unmitigated resource misappropriation and profligate squandermania have left very little for anything else.

But beyond corruption, authorities in the region can be also held culpable for obstructive governance (enacting legislation and policies that obstruct the ability of individuals to create wealth for themselves). Obstructive governance is most commonly manifested in institutionalizing unnecessary bureaucracies and stifling regulations that make it difficult to establish or operate a business. Recently, the World Bank carried out a study to gauge the "ease of doing business" across the globe.[124] It ranked countries (183 in all) according to the following indicators: starting a business, dealing with construction permits, employing workers, registering property, obtaining credit, protecting investors, paying taxes, trading across borders, enforcing contracts, and closing a business. All African countries, except seven, ranked in the bottom 50 percentile.[125] Does this sort of study hold any implication for growth and poverty reduction in the region?

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[120] This contrasts with "medium," "high," and "very high" human development ascribed to better performing countries. Ibid., pp. 176–178.

[121] UNDP 2010, pp. 145–146, 150–151.

[122] UNDP 2009, p. 179.

[123] Ibid., pp. 176–178 (Tanzania holds the worst record (88.5 percent), followed by Liberia (83.7), Burundi (81.3), Rwanda (76.6), Malawi (73.9) and so forth).

[124] World Bank 2010, p. 97.

[125] Ibid., p. 4. A similar report known as the Economic Freedom of the World has been published annually by the Frasier Institute since 1996. Individuals enjoy economic freedom, according to the maiden edition, "when (a) property they acquire without the use of force, fraud, or theft is protected from physical invasions by others and (b) they are free to use, exchange, or give their property to another as long as their actions do not violate the identical rights of others." See Gwartney et al. 1996, p. 12. Countries are rated on five major areas, considered to indicate the degree to which their policies and institutions are supportive of economic freedom, to wit, (i) size of government, (ii) legal structure and security of property rights, (iii) access to sound money, (iv) freedom to trade internationally, and (v) regulation of credit, labor, and business. In the latest report, only five African countries were in the top 50 percentile in the ranking on these indicators. See Gwartney et al. 2010, p. 7.

Indeed, the regulatory environment under which domestic businesses must operate is a crucial measurement of the existence of conditions conducive for economic growth and escaping poverty in that particular geographic location. Difficulty in establishing or running a business is an important consideration in deciding whether to venture into a business enterprise in the first place. Moreover, the degree of this difficulty is a decisive factor that can make or mar a nation's economic growth as evident in the fact that advanced economies consistently outranked developing (and, not coincidentally, poorer) countries in the study and previous ones. The phrase "life, liberty and pursuit of happiness" in the American Declaration of Independence—regarded by many as the foremost contemporary incarnation of the Magna Carta—is declaratory not just of civil and political liberty; it does have some compelling economic undertone. The Declaration was a solemn repudiation of the British imperial authority, including its burdensome confiscatory taxation policies, which the founding fathers saw as inimical to economic prosperity. They were fully cognizant of the price of rebellion (death) but detested the yoke of imperialism even more. They understood that without liberty (civil and political as well as social and economic) there can be no meaningful pursuit of happiness and therefore a life that is seriously impaired. The patriots were under no illusion that an environment in which government interference in business is kept to the barest minimum is one in which happiness is maximized as individuals are most able to pursue their freely chosen ends. In short, the uniquely rugged individualist ethos in the United States is concretized on this principle. From this prism, therefore, it becomes easy to appreciate the economic might and dominance of the United States as no happenstance. This is a paradigm that commends itself to Africa.

Interestingly, when in a World Bank study, 60,000 poor people around the globe were asked how they hope to escape poverty, their unequivocal response was through income generated from owning their own businesses or wages from employment.[126] Neither of these two income-generating paths is actualizable save in a climate where businesses are allowed to thrive and prosper, suggesting that removing obstacles to forming and operating a business is of paramount importance to the success of antipoverty and health-promotion strategies in the region. Less poverty signals better health—a perspective shared by the World Bank which, in 1993, recommended that for governments to improve health in developing countries, they "need to foster an economic environment that enables households to improve their own health."[127]

[126] Narayan et al. 2000, vi–vii.

[127] World Bank 1993, p. iii.

1.4.2 Addressing Underlying Determinants of Health

The Commission on Social Determinants of Health (Commission),[128] in its final report to WHO, tersely describes the interface between poverty and health: "[i]n countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health."[129] Put differently, one's station in life (socioeconomic circumstances) is an accurate predictor of the person's health status at any given point in time. This impact of poverty on health is not necessarily the result of poorer peoples' relative difficulty in accessing health services. Beyond access difficulties, there are other factors, the consequences of which can be more deleterious than lack of medical care. These factors, known as "underlying or social determinants of health," consist of the "structural determinants and conditions of daily life;"—that is, "the conditions in which people are born, grow, live, work, and age."[130] These conditions have more direct and enduring impact on the health and quality of life of individuals than access to medical care (though itself also a health determinant).

The more favorable these conditions are in a given community, the better the health of its members or vice versa. There are, of course, certain illnesses (genetic disorders, for instance) that are not the consequences of the failure of any of these conditions. But those are the exceptions, not the rule. For the most part, the less well-off is more susceptible to illnesses and shorter life span than someone with all the advantages, explaining why, as a 1990 study found, the life expectancy of young black men in Harlem (an impoverished black neighborhood in New York City) is less than men in Bangladesh, a country classified by the World Bank as one of the poorest in the world.[131] The reason was that nearly half of the people in Harlem live below the poverty line (41 %)—and with this burden, a disproportionately higher rate of diseases and deaths compared to the general population.[132] This deplorable situation is not explicable by lack of access to treatment, and this is confirmed in a more recent finding in a country with universal health insurance. In Glasgow, Scotland, the life expectancy of poorest males is 54 years, compared to 82 years for affluent males living in the same city.[133] Yet, the two groups have equal access to health care, guaranteed by the National Health Service (NHS).

Social determinants of health include, inter alia, food, housing, access to potable water and adequate sanitation, safe and healthy working conditions, and a

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[128] The Commission was established to adduce evidence on ways to promote health equity and engineer its global actualization. See Commission on Social Determinants of Health (CSDH), Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health, p. 1.

[129] Ibid., see executive summary; Wilkinson and Marmot 2003, p. 7.

[130] CSDH, p. 1.

[131] McCord and Freeman 1990, pp. 173–177.

[132] Ibid.

[133] Wilensky and Satcher 2009 w195; CSDH, p. 32.

healthy environment.[134] These are basic components of a decent life, and one's access to them greatly influences the person's health, quality of life, and life expectancy. That these goods and conditions are not uniformly available to all is responsible for health disparities within and across nations. Disparities, both in health and well-being, generated by maldistribution of basic components of a decent life are not, as a Harvard medical anthropologist so adroitly puts it, "the result of accident or a force majeure," rather, "they are the consequences, direct or indirect, of human agency."[135] They are, indeed, manmade.

Particularly in terms of sensitivity to the plight of the citizenry or being responsive to their needs, enthronement of democracy in Africa has meant very little. Most governments in the region have shown little or no inclination to distance themselves from the kleptocratic and oligarchic tendencies of their predecessors. Avarice, sectionalism and nepotism have hijacked the stewardship role of elected officials—a tragic case of governance gone amok. The demise of dictatorships in the 1990s was thought to usher in a new dawn for the region. But majority rule has not lived up to its billing. The benefits long hoped for by the people are still nowhere in the horizon. The force of this hope, solid as the Gibraltar rock not quite long ago, is gradually dissipating, giving way to despondency as intense suffering and extreme hardship overwhelm the masses. Food remains scarce, as does housing and, in most countries, virtually all other social goods and services. But—quite tragically—not diseases and illnesses.

The proportion of Africans with access to potable water stagnates at 61 %[136] and just 34 % has access to adequate sanitation, a marginal increase from 30 % in 1990.[137] Low access to safe water supplies and adequate sanitation increases exposure to many diseases such as cholera, typhoid, diarrhea, schistosomiasis, and hepatitis[138] as well as trypanosomiasis and dracontiasis—all of which are pervasive in Africa. Confronting these pathologies requires not just the provision of treatment but, more important, improving the living conditions of the people—restructuring the socioeconomic dynamics which triggered the diseases in the first place. The diversity of these conditions calls for diversified action; that is, in terms of organizing human and material resources necessary for ensuring the availability of goods and conditions that promote good health.

While the Ministry of Health, since its primary charge is protecting the health of the population, has a leadership role in this process, it must seek the collaboration of other Ministries (Agriculture, Housing, Education, Commerce etc.) as well as the private sector (individuals, industries, and civil society). The expertise

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134 General Comment No. 14, paras 4, 11.

135 Farmer 2003, p. 40. See also CSDH, p. 31 (the Commission argues that poor health of the masses is a product of unequal distribution of resources—in itself not a natural phenomenon but the consequence of policies which promote the interests "all too often of a rich and powerful minority over" that "of a disempowered majority").

136 WHO 2010, p. 18.

137 Ibid., p. 19.

138 Ibid., p. 99.

and experiences of non-health institutions should be harnessed and incorporated into strategies aimed at attending to social health determinants throughout the region.[139] This partnership, consisting of diverse sectors (public and private), points to the "multisectoral dimension of health"—meaning that reforming the health sector alone is insufficient to improve overall health. The entire socioeconomic structure of each country must be fully aligned with the trajectory of the health system, the aim being to scale-up the availability of, and access to, each and every good that contributes to health. The necessity of this alignment is borne out by the fact that countries on the upper echelon of health outcomes are also those where education, shelter, safe drinking water, adequate sanitation, health care, jobs, and social protection—in short, the whole armamentarium of social health determinants—are reasonably (if not abundantly) available.

1.4.3 Integrating Human Rights into Health Systems

The adoption of the African Charter on Human and Peoples' Rights in 1981 marked a turning point (or so it was thought) in the protection of human rights in Africa, the Charter being the first human rights instrument to recognize the three genres of human rights—civil and political; economic, social and cultural; and, peoples' rights.[140] Article 16 recognizes the right of every individual "to enjoy the best attainable state of physical and mental health" and obligates States Parties to the Charter to take measures necessary for realizing the right. But even before the adoption of the Charter, many countries in Africa had bound themselves to respect, protect, and promote the right to health. The ICESCR, the first international treaty to recognize the right to health, was ratified by a vast majority of countries in the region (46 out of 53 countries).[141] Have these ratifications resulted in substantial improvement in the health of citizens and residents of ratifying countries? Judging by the health data in these countries, it is difficult to return an affirmative verdict. Evidence of this dissonance (between lofty treaty aspirations and implementation) runs through the length and breadth of health systems in Africa. Yet, erasing the dissonance—by incorporating human rights principles into country health policies—is fundamental to securing the health of the population, thereby advancing the right to health.

Integrating human rights into health systems means positioning human rights as an important component of decisions relating to governance, financing, and

[139] See Declaration of Alma-Ata, Article VII, para 4: "… in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors" must be coordinated to achieve PHC.

[140] Adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).

[141] See U.N., Treaty Collection, Chapter IV: Human Rights, No. 4: ICESCR, Status of Ratification, as of Dec. 20, 2010b.

delivery of health services. From policy formulation stages, through allocatory decisions, down to service delivery, priority is given to strategies that has the greatest potential to yield the best possible outcome for everyone, with preference given to the most marginalized and vulnerable recipient of services. It is de facto operationalization of the right to health, putting concrete measures in place to ensure the full realization of the right for everyone, not just a select few.

The value of anchoring national health systems on human rights principles is to direct the attention of policy makers to inequities that could be generated by certain decisions, enabling them to proactively guard against making such decisions in the first place. In this context, the catechism of human rights is to conceive of health inequities as systemic deficiencies that should be expurgated as expeditiously and exhaustively as possible. As it relates to health, human rights is an invisible hand directing decision makers to plans, initiatives, or programs that would efface access and outcome differentials, thereby infusing equity to the entire chain that make up the health system. An equitable health system is one that caters to the interests of the poor as much as the wealthy, in which, inter alia, the voice of the poor is assigned the same (if not more) weight as everyone else's in decision-making processes.

The place of equity in a health system is of paramount importance, for the more equitable a health system is, the better the health of the population it serves. This is reflected in the fact that better performing health systems, evident in WHO's 2000 ranking of global health systems, are also fairer and more equitable.[142] The converse is also true and precisely the reason health systems in Africa (with remarkably few exceptions) are ranked in the bottom 30 % of the countries surveyed.[143] But the policy landscape in the region seems to be improving. African leaders recently dedicated themselves to ensuring that "[e]quity in health care is a foundation for all health systems" in the region.[144] This is a great beginning, but only a beginning. To be meaningful, the rhetoric must be coupled with concrete action in terms of reforming or overhauling health systems, as the case may be, to better serve the needs of vulnerable populations in the region.

1.4.4 Individual Empowerment

The public health aphorism "prevention is better than cure" is a powerful testament to the advantages inherent in preventing the occurrence of illnesses (in terms

[142] WHO 2000, pp. 152–154.

[143] Ibid.

[144] Africa Health Strategy, p. 6. See also NEPAD Health Strategy, p. 15 (which states, as values underlining the strategy: "Health and access to quality affordable health care is a human right. Equity in health and health care is beneficial to countries as well as individuals …" and so forth).

of cost and avoidance of unnecessary pain and suffering) than treatment.[145] The phrase describes the role expected of individuals in protecting their health. Cognizant of the importance of this role, the African Union Conference of Ministers for Health urges that health systems place "strong emphasis on behaviour change" as part of "an integrated approach" to addressing Africa's disease burden.[146] Even for certain conditions whose etiology is genetic, there are precautions or lifestyle changes that can mitigate an individual's risk.[147] Beyond this, for a great many diseases and illnesses, individual exposure to risks depends on the extent to which appropriate preventive measures have been incorporated into one's daily life. Another term that has been used to describe individual empowerment is "health promotion"—defined as a "process of enabling people to increase control over, and to improve, their health;"[148] that is, putting individuals in charge of their own health. This is preventive care in action—a core principle of a PHC system—and consists of, at the barest minimum, education concerning prevailing health problems (including methods of preventing and controlling them), promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation, family planning, immunization against infectious diseases, prevention and control of locally endemic diseases, and provision of essential drugs.[149]

While the advantages stemming from empowering individuals to be proactively involved in their health cut across regional boundaries, resource-poor settings in Africa stand to reap greater benefit. That much is incontrovertible. Why? First, there is, as already discussed, dearth of appropriately trained health personnel in most countries in the region. And, second, even where availability is not a problem, access might still be constrained due to inability to pay for services. In these circumstances, the kernel of individual empowerment is that it reduces exposure to these problems, saving the individual from the pain, suffering, and expenses to which he could have otherwise been exposed. But there are two challenges that must be overcome to harness this benefit, namely educating individuals about health promotion or preventive care, and creating access to resources that would make it possible for them to put the knowledge to productive use.

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[145] Preventive health services are generally more cost-effective than curative care, although a recent study disputes whether the difference is really significant. See Cohen et al. 2008, pp. 661–663.

[146] Africa Health Strategy, p. 20. But such "behaviour change" is only possible when the individual has attained a certain level of health literacy—that is, acquired "basic knowledge and skills to enhance [his] health." See NEPAD Health Strategy, p. 23.

[147] See Opara and Jiburum 2010, http://wjso.com/content/8/1/73 (accessed 14 April 2013). The authors found that individuals suffering from albinism (a genetic disorder which makes the body unable to produce or distribute melanin) are more susceptible to skin cancer than the general population and that certain precautionary measures can reduce the risk: limited exposure to the sun, wearing protective clothing and avoidance of outdoor activities.

[148] Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa, 2 November 1986, WHO/HPR/HEP/95.1.

[149] Declaration of Alma-Ata, Article VII, para 3.

Cholera has been known for centuries to be deadly but, at the same time, easily preventable by proper sanitation and avoidance of contaminated water sources. It is striking that the Torah does not record any incident of cholera outbreak among the Jews during their 40-year sojourn in the wilderness en route to Israel, even though the living arrangement (camping in tents in close quarters) was a fertile ground for such outbreaks. The reason was that the Jews followed a simple instruction:

> Set up a place outside the camp to be used as a toilet area. And make sure that you have a small shovel in your equipment. When you go out to the toilet area, use the shovel to dig a hole. Then, after you relieve yourself, bury the waste in the hole.[150]

Because human waste was disposed outside their living quarters, the Israelites were spared from cholera and similar outbreaks.

This antediluvian adjuration is expressive of public health at its most archaic form but the principle remains valid today, and straying from it often has disastrous consequences, as a recent experience in Zimbabwe demonstrates. In 2008, seepage of sewage into the Limpopo River (a major source of drinking water) triggered a cholera epidemic in the country, resulting in 3,000 deaths and 60,000 cases.[151] The high casualty is not in the least surprising given that many Zimbabweans, especially the poor and residents of rural communities, lack access to safe drinking water sources. Discernible from this experience is a lesson that the success of individual empowerment goes beyond knowledge transfer to include material resources needed for attending to underlying health determinants. Knowing how to protect oneself from cholera, for instance, is a good start but, to be an effective public health tool, the knowledge must be coupled with access to potable water and sanitation facilities, and the state must be prepared to protect the entire public sewage system.

1.4.5 Civil Society Empowerment

In her opening address at the International Conference on Health for Development in 2007, Margaret Chan, Director-General of WHO, remarked that global efforts at achieving the MDGs will be fruitless "unless we return to the values, principles, and approaches of [PHC]."[152] Her statement translates to saying that these values and principles are crucial drivers of health system development and sustainability, and therefore indispensable to attaining the health MDGs. In other words,

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[150] Deuteronomy 23: 12, 13, The Bible (Contemporary English Version).

[151] Bateman 2009, p. 138. See also Mason 2009, p. 148.

[152] Chan, The contribution of [PHC] to the Millennium Development Goals, Opening Address at the International Conference on Health for Development Buenos Aires, Argentina, August 16, 2007, http://www.who.int/dg/speeches/2007/20070816_argentina/en/index.html (accessed 4 April 2013).

anchoring the operation of health systems—initiatives, programs, and strategies—on the basic principles of PHC is a surefire way to generate positive outcomes for the population dependent on them.

One of the building blocks—indeed, a requirement of a PHC system—is that "[t]he people have the right and duty to participate individually and collectively in the planning and implementation of their health care."[153] The obvious advantage of this requirement is the element of democracy it embodies. But this sort of democracy has a somewhat different appeal in the sense that the interest of those on the higher end of socioeconomic ladder is not, as often is the case in developing countries, taken as representative of the entire population. Here, the importance of democratizing the process lies in what Professor Farmer sums up, in reference to the thrust of liberation theology, as eliciting "the experiences and views of poor people"[154] and integrating these views into health decision-making—views traditionally not given much weight in public policy deliberations, health-related or otherwise.

Contributing to health decision-making, whether on an individual basis or as a collectivity, is not confined to PHC. As the Committee on ESCR made explicit in 2000, an important element of the right to health is "the participation of the population in all health-related decision-making at the community, national and international levels."[155] This declaration envisages a broader involvement of civil society at all levels of health policy formulation, from the smallest unit of government through the central government to international institutions. The Brazilian Health system provides a remarkable instantiation of the utility and reward of engaging community input. As part of the 1996 health reform in that country, provision of comprehensive (and free) care was decentralized to municipalities, with funds provided by states and federal governments.[156] At the municipal level, communities take active part in budgetary decisions, allocation of funds, supervision of accounts and approval of the annual reports.[157] The result has been nothing short of phenomenal—more than 75 % coverage, in a country where half of the population lacked insurance in 1988.[158]

Community input in health decision-making is increasingly being channeled through civil society organizations (CSOs). The African Health Strategy defines CSOs as consisting of NGOs, Faith Based Organizations (FBOs), Community Based Organizations (CBOs), traditional leaders and healers as well as media

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[153] Declaration of Alma-Ata, Article IV, VII, para 5.

[154] Farmer, p. 146. Decisions affecting the health of the population are typically made at the boardrooms of ministries of health, local government health departments or similar settings. Programs, plans or projects chosen at these fora, by and large, reflect the interests of the participants—the privileged few, not the experiences and views of the vast majority of the population whose spokesperson was conspicuously absent. The disservice occasioned by this lack of representation (of the poor) is potentially cured by the PHC principle.

[155] General Comment No. 14, para 11.

[156] Jurberg 2008, p. 248.

[157] Jurberg and Humphreys, p. 646.

[158] Ibid.

organizations, and urges countries to involve them in their national programs.[159] Thanks to globalization and internationalization of human rights, the number of CSOs in the region has risen sharply since the 1990s, with interests as diverse as the criteria for membership in individual organizations. Avenues through which CSOs could be useful in advancing regional and domestic goals are advocacy, community mobilization and, where appropriate, involvement in direct provision of services. And authorities are responding. Unrelenting pressure from CSOs was a catalyst in PHC reform in several countries including Mali.[160]

Aside from these strategies, CSOs have a role as watchdog of government activities. Even where the government reaches out to CSOs in its policy initiatives and agreement is struck on a set of goals and priorities, this does not, in any way, guarantee implementation according to the terms of the agreement. Neither accountability nor transparency of actions is innate to governance. Therefore, to hope for these virtues to mark and permeate government actions, in absence of a robust sanctioning regime, is a mistake. Incredibly, this hope—misplaced as it is—has characterized post-independence governance in Africa. The absence of a watchdog, a robust bulwark against abuse of public office, is a major reason for continuing paralysis of the social and economic fabrics of various nations in the region. Extant health quandary in the region is a visible reminder of years of neglect and abdication of responsibility on the part of public officials entrusted with stewardship of national resources.

Short of activism, the usefulness of the court system—the traditional watchdog of executive and legislative actions—is quite limited as courts can only adjudicate real cases (upon petition by aggrieved parties), and since lawsuits are rarely brought by private citizens to compel performance of a public duty, offending individuals have remained scot-free. This is a vacuum waiting for CSOs to fill. Unlike the judiciary, CSOs are unconstrained by technical rules and can choose from a wide array of options (particularly media campaign or legal action against policies or actions inimical to general welfare) to force fair governance. African CSOs have been particularly successful before the African Commission on Human and Peoples Rights (Commission), prevailing in several landmark cases. In *SERAC v. Nigeria,* for instance, the Commission held the government of Nigeria in violation of Article(s) 16 (right to health) and 24 (right to satisfactory environment) of the African Charter on Human and Peoples' Rights for not protecting the Ogoni people in South Eastern Nigeria from environmental degradation and health problems resulting from oil exploration and drilling by Shell Petroleum Development Corporation in that part of the country.[161]

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[159] Africa Health Strategy, p. 24.

[160] WHO 2008, pp. 110–111.

[161] The Social and Economic Rights Action Center and the Center for Economic and Social Rights v. Nigeria, African Commission on Human and Peoples' Rights, Comm. No. 155/96 (2001).

But the usefulness of CSOs hinges greatly on whether governments regard them as threats or allies committed to the same cause. The former tainted and marred relationships between governments and CSOs prior to the triumph of democracy in most African countries toward the end of the 1990s. But democracy has not brought to an end the sometimes acrimonious relationship between CSOs and civilian administrations in many of these countries. Human rights scholar Makau Mutua's observation that governments in Africa "have historically adopted hostile—even coercive policies" against CSOs, sometimes viewing them "with suspicion, if not outright dread" and, in other cases, have "sought to either co-opt or muzzle them" remains true today, even as the current occupants of political positions in the region sanctimoniously and vociferously proclaim to have charted a different course from their predecessors.[162] A recent example is the enactment, in January 2009, of Ethiopia's Proclamation for the Registration and Regulation of Charities and Societies which prohibits CSOs in the country that receive 10 % or more of its funding from foreign sources from engaging in activities related to, inter alia, "[t]he advancement of human and democratic right …"[163] Former U.N. High Commissioner for Human Rights, Mary Robinson, was exasperated: "I am very concerned about this legislation. … It is regrettable to have legislation which might close the enabling space for civil society because it is actually part of the development of a country."[164] Despite mounting condemnations and criticisms from the United States, the European Union and CSOs, far and wide, the government in Addis Ababa refused to balk.

Conscious of the negative impact on development this sort of acrimonious relationship between CSOs and governments might engender, the African Health Strategy requires countries in the region to ensure not only the "participation of civil society" in the development and implementation of national health programs but also—and more important—to "create a conducive environment" for their meaningful and productive operation.[165] Health Ministries are specifically called upon to facilitate the emergence of CSOs and fund their activities.[166] By facilitating the emergence of CSOs and involving them in the design and implementation of health programs, governments tap into the expertise and insights of these organizations. These are important resources for developing and strengthening health systems in Africa.

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[162] Mutua 2009, p. 1, 5.

[163] International Center for Not-for-Profit Law, 2009, http://www.icnl.org/knowledge/globaltrends/glotrends1-1.htm (accessed 6 January 2013). See Article(s) 2, 14, para 5.

[164] Irin News, Ethiopia: New Law on Charities Passed Despite Objections, 6 January 2009, http://www.irinnews.org/report.aspx?ReportId=82223 (accessed 4 April 2013).

[165] Africa Health Strategy, p. 24. See also NEPAD Health Strategy, p. 23.

[166] Africa Health Strategy, p. 16.

1.5 Conclusion

The arduousness and complexity of health sector constraints in Africa can, at times, be frustratingly overwhelming even to the most seasoned and astute public health scholar. Yet, how to detangle and deconstruct this seemingly inextricable maze is precisely the kind of intellectual resource students of human rights seek in public health scholarship. Steeped in this resource, in addition to reflections and insights from other fields, this chapter has labored not only to animate these challenges but more important, perhaps, also map out routes to extirpating them. The project of health MDGs, particularly in Africa, is facilitation of broader comprehensive health sector development, not just healthcare availability. For countries interested in this project, the first great lesson to imbibe is that improving access to health services, although a critical aspect of any reform initiative, is not per se a sufficient panacea. Diseases and illnesses do not just reveal a subpar performance of the physiological and biochemical functioning of the human system; they represent something more sinister. Morbidities (and human suffering that accompanies them) are manifestations of a much deeper socioeconomic and political pathology: the factors responsible for excess exposure or susceptibility to circumstances that combine to create the need for therapeutic intervention in the first place. More than anything else, including improving access to health services, challenging the status quo requires sustainable and unwavering action on multiple fronts, as meticulously elucidated in this chapter. This is the real antidote to the paralytic performance that has dogged health systems in Africa for decades.

The second lesson is that the tortured reliance on resource constraints as explanatory of the region's health sector woes serves no useful purpose. Even amidst scarcity, proper utilization of available resources would go a long way in improving general health and well-being. The illustration given with malaria (easy to prevent, diagnose, and treat) is a case in point. That malaria remains a prodigious killer disease in Africa in 2013 is an appalling indictment of health and political governance in the region. On this basis, therefore, to conclude as did Sam Nujoma, former President of Namibia and co-chair of the Millennium Summit, that " … despite all these challenges, … with more commitment and dedication, we will emerge victorious and meet most, if not all, of the MDGs come 2015" smacks of wishful thinking, ostensibly oblivious to the political reality and serious governance deficiencies in most countries in the region.[167] Neither Obasanjo's perverse ambition for a third term as president of Nigeria (despite unambiguous constitutional provisions to the contrary), nor continued recalcitrance of President Mugabe to relinquish power (notwithstanding overwhelming rejection and repudiation of his policies by Zimbabweans), was inspired by a burning desire to redirect the fortunes of either country toward health or general welfare. In short,

[167] Nujoma, From the Millennium Summit to 2015: The Challenges Ahead, U.N. Chronicle, http://www.un.org/wcm/content/site/chronicle/home/archive/issues2007/theMDGsareweontrack (accessed 4 April 2013).

there is hardly any evidence that the kind of commitment and dedication envisaged by Nujoma has been or will be embraced any time soon by the political leadership in Africa.

The Abuja Declaration committing African countries to channel at least 15 % of their national budgets to health is undeniably a step in the right direction. Nonetheless, the fact that more than a decade after the agreement, very few countries have met the threshold speaks volumes. Health policies in Africa, both at national and international levels, are replete with dichotomies between goal and action, and this is where the existence of vibrant CSOs becomes crucial. The Committee on ESCR projects accountability and transparency as the principles upon which to anchor national health strategies and plans of action.[168] The accountability principle invites CSOs to demand that governments meet their domestic, regional, and international commitments. The mass media, academics, civic and religious leaders, market women, trade unions, and so forth are members of this partnership. The message to African CSOs is to cast health deterioration in the region as a human rights issue rooted in a subtle, yet insidious, class warfare. Proof (if there is need for one) is the regularity with which senior public officials, including presidents and prime ministers, from Africa are whisked abroad for medical treatment.

There is no more compelling evidence of classism and elitism than usurping public resources for private ends, in this case, to fund the best available treatment anywhere in the world—an exclusive preserve of the ruling class and its cohorts. Why is this important? This privilege, as contended in a pending lawsuit before a federal high court in Nigeria, has become a powerful disincentive to reforming the health system.[169] The lawsuit seeks a perpetual injunction restraining the government from "taking any public officer to foreign hospitals for medical checkup and/or treatment in any manner whatsoever and howsoever."[170] This is instructive for CSOs in Africa. Their operation should be anchored on the principle that populist (human rights) reform does not emanate from the top; instead, it starts with grassroot strident expression of dissatisfaction with, and rejection of, the state of affairs—a bottom-up approach.

To sum it all up, we return to a recurring theme in this discourse—and that is, how to conceptualize health. This is of critical importance for how we think of health powerfully shapes and influences what goes in and out of health policy baskets in Africa. Achieving "a state of complete physical, mental and social well-being" (WHO's definition of health)[171] or a modicum thereof involves tackling the

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[168] General Comment No. 14, para 55.

[169] Suit No. FHC/IKJ/CS/M59/10(Unreported), Federal High Court Ikeja; Sahara Report, 'Falana Sues FG over Conditions of Public Hospitals', 29 July 2010, http://www.saharareporters.com/report/falana-sues-fg-over-conditions-public-hospitals (accessed 4 April 2013).

[170] Ibid.

[171] WHO Constitution, Preamble, adopted by the International Health Conference, New York, 19–22 June 1946, entered into force 7 April 1948.

root causes of diseases and health inequities which, in turn, depends on interventions by sectors other than health. Therefore, appropriate policy frameworks must incorporate, at the minimum, access to life's essentials (underlying health determinants) and basic health care, both of which are considered "core obligations" by the ICESCR and from which no derogation is allowed, even on grounds of resource difficulties.[172] Mechanisms should be put in place to ensure that lofty goals translate to real goods and services that can be readily accessed by anyone in need. This expansive conceptualization of health, especially its application and meaning to those on the lowest rung of social ladder (in terms of drawing attention to a broad spectrum of factors constraining their agency), should underline health policy decisions in every country in Africa. This is not, by any means, an imposition of a novel obligation but merely infuses life to commitments already undertaken in various regional and international human rights treaties to which a vast majority of these countries voluntarily subscribed. It is human rights pragmatism, a richly productive incarnation and reinforcement of a human rights approach to securing health for all.[173]

Health policy decisions should be anchored on the principle that social determinants of health such as food, housing, etc., are stricto sensu, not within the mandate of a Ministry of Health but, even so, their availability and equitable distribution are crucial to attaining the MDGs and advancing the right to health. This is the crux of multisectoral dimension of health and has two critical implications for Africa. First, health sector reform must be operationalized in tandem with strengthening other sectors (agriculture, industries, housing, and so forth) connected with providing or creating an enabling environment for availability of goods or conditions that promote good health. Second, multisectoral interventions must not only be harnessed, it must also be harmonized and streamlined to achieve a common goal: improving health. The leadership role of the Ministry of Health must involve active cooperation and collaboration with other sectors, including bilateral and multilateral partners, to find cost-effective and sustainable solutions to the numerous health challenges facing the region. As to whether attainment of the health MDGs is in the horizon for Africa, the reality is that in the end, it might be that despite massive international development assistance, all the summits and

[172] General Comment No. 14, para(s) 43, 47.

[173] "Human rights pragmatism" counterbalances state practice in Africa, especially in the realm of socioeconomic rights where, for the most part, the doctrine of *pacta sunt servanda* has had negligible impact in the practice of States. The idea goes beyond lofty goals to demand that the letter of human rights instruments mean something tangible, that the fruits of these words (goods and services) are concretized in the lives of designated beneficiaries. In other words, it advocates a new paradigm, separate and distinct from the current practice of subscribing to human rights instruments with little demonstrable consideration to practical implementation, and requires that governments must intend, and there must be a sense among the people, that the benefits of human rights treaties operative in their respective jurisdictions would be readily available to all, regardless of individual socioeconomic differentials.

declarations, the best that can be hoped for is substantial improvement—indeed, a reversal—in the state of health in Africa. And this, in itself, is no mean feat, considering from whence the journey began.[174]

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[174] In so concluding, this author is in total agreement with Clemens & Moss who argued against a literal interpretation (which holds the MDGs as real practical targets) in favor of a "more nuanced view" which sees the "MDGs as a symbol of the kinds of outcomes toward which the world should strive." The reason, as they see it, is that "… there is a real risk that the MDGs, as currently conceived and promoted, could turn real development successes into imaginary failures." See Michael Clemens & Todd Moss, 'What's Wrong with the Millennium Development Goals?' Center for Global Development Brief, September 2005, 3, www.cgdev.org/files/3940_file_WWMGD.pdf (accessed 12 January 2013). In this view, therefore, simply because progress in Africa does not equal or surpass the numerical value designated as necessary to meet a certain benchmark should not be interpreted to mean failure as to do so would tantamount to trivializing lives saved and morbidities averted in the region as a result of MDG-generated initiatives.

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