

**THE MILLENIUM DEVELOPMENT GOALS AND THE RIGHT TO THE HIGHEST
ATTAINABLE STANDARD OF HEALTH**

**AFRICAN STATES' IMPLEMENTATION OF THE MILLENIUM DEVELOPMENT
GOALS & TOWARDS 'THE WORLD WE WANT POST 2015'**

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
AU	African Union
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CERD	Convention on the Elimination of all Forms of Racial Discrimination
FHCI	Free Health Care Initiative
GDP	Gross domestic product
HIV	Human immunodeficiency virus
ICCPR	International Covenant on Civil and Political rights
ICESR	International Covenant on Economic Social and Cultural rights
MDG	Millenium Development Goals
NCDS	Non-communicable diseases
NEPAD	New Partnership for Africa's Development
OAU	Organisation of African Unity
STD	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UDHR	Universal Declaration of human Rights
UN	United Nations
UN CESCR	United Nations Committee on Economic Social and Cultural Rights
UNICEF	United Nations Children's Fund
UNGA	United Nations General Assembly
WHO	World Health Organisation

1. Background

Following a meeting at the United Nations in September 2000 where leaders of 198 nations committed to address human development and world poverty by the year 2015 eight development goals otherwise known as the Millennium Development Goals (hereafter 'MDGs') were developed.¹ A set of seven development goals was developed while an eighth goal encompassed a commitment by the world's stronger economies to assist poorer states in achieving these development goals through provision of development assistance, writing off of debt and provision of suitable markets for agricultural exports produced by developing nations. This year, 2013, is two years shy of the targeted end to attainment of the MDGs. While significant progress has been made towards achievement of the seven development goals, critical analysis has since began so as to evaluate the successes, the opportunities as well as the challenges realized so as to guide the nations to 'The World We Want' post 2015.

African nations account for a significant number of the world's poorest nations with high poverty levels. That notwithstanding, commendable progress has been recorded in several African nations with respect to achieving the MDGs.² Children's right to primary education has been greatly realized. In most African states, there is a marked increase in the number of women who occupy representative office as well as other positions of leadership. There has also been a significant progress with a drop in the rate of HIV / AIDS infection ³ and in making Anti-Retroviral Treatment (ART) more readily available to infected people.

African countries have recorded some positive examples of success and from these lessons can be learned in order to accelerate progress and also inform planned interventions in the period post 2015.⁴ Interestingly, some of the countries where success stories have been recorded are found in post-conflict situation countries such as Liberia and Sierra Leone. Liberia has made significant progress in infant mortality while Sierra Leone has recorded remarkable progress in

¹ 'Achieving the Millennium Development Goals in Africa' United Nations Department of Public Information 1.

² UNDP in Africa <http://web.undp.org/africa/>(accessed 15 April 2013).

³ As above.

⁴ 'Assessing Progress in Africa toward the Millennium Development Goals MDG Report 2011', available at [http://www.nepad.org/system/files/ADFB-MDG-EN_WEB_2%20\(2\).pdf](http://www.nepad.org/system/files/ADFB-MDG-EN_WEB_2%20(2).pdf)(accessed 15 April 2013).

maternal health demonstrating that the MDGs can be achieved notwithstanding difficult conditions that may exist.

However, the quest to attain full realization of MDGs continues to be met with several harsh realities. Implementation of MDGs in Africa was undertaken against the backdrop of global food, fuel and financial crises as well as cases of economic volatility, pressure due to increasing urban populations as well as incidences of political unrest coupled with violence.

The human rights sector is greatly interested in the attainment of MDGs which is inextricably linked to realization of key human rights commitments as set out in various international, regional and domestic instruments. In 'Ships passing in the night' the author, Prof Philip Alston makes a spirited call to the community of human rights players to engage more effectively with the development agenda set out in the MDGs.⁵ Indeed, the United Nations in reviewing progress made in achieving the MDGs at the halfway point of the MDGs in 2007, prescribed the international human rights legal framework,⁶ which all states have subscribed to. The idea is that alignment of MDGs to efforts at realization of human rights is part of the solution to attainment of the MDGs.

As the world moves towards the close of the period for realization of the MDGs, there has been significant effort towards evaluation of states' performance. The Global Classrooms Workshop⁷ will provide yet another platform for value addition to ongoing assessment. This workshop, scheduled for April/May 2013 in Venice, Italy will see the convergence of legal scholars, practitioners and human rights defenders. Discussions will look at different dimensions of

⁵ Phillip Alston 'Ships Passing in the Night: The current state of human rights development debate seen through the eyes of the Millennium Development Goals' Human Rights Quarterly Aug 2005, 27, 3.

⁶ United Nations 'Claiming the Millennium Development Goals: A human rights approach'. Office of the High Commissioner for Human Rights.

⁷ EIUC developed, with the support of the EU, the setting up of the Global Campus of Master's Programmes and Diplomas in Human Rights and Democratization taking the management of six Regional Master's Programmes now taking place in five continents i.e European Inter-University Centre for Human Rights and Democratization European Master's Degree in Human Rights and Democratization Programme, University of Pretoria, University of Sarajevo, University of San Martin Buenos Aires, University of Sydney, Yerevan State University,

implementation both from a rights based approach and also at an evaluation of how different regions have so far performed.

The students representing the LLM/Mphil programme in human rights and democratization in Africa have prepared this report to inform discussions at the MDG Global Classroom. The report seeks to provide an understanding of the place of African states in addressing health related MDGs.

This report is broadly divided into three parts. Part I will set the tone by highlighting the legal and normative framework upon which the right to health is founded. Commitments made by African states will be revisited so as to understand the enabling environment for realization of MDGs. Part II will commence with a discussion of the human rights based approach to implementation of MDGs. It will then provide a focused analysis of performance by African states on specific health related MDGs. In Part III, the report shall concern itself with the projections as we move closer to 'The World We Want' in the period post 2015 drawing lessons from the African implementation experience. Finally, the report shall propose recommendations that may aid programming interventions that will take heed to the sustainability of current interventions and aid planning of new projections.

2. The normative and contextual framework for realisation of health related MDGs

The individual's right to the highest attainable standard of health is an obligation of state parties entrenched in international human rights instruments and echoed in domestic constitutional and legislative frameworks. A cursory glance at the MDGs will reveal that of the eight goals, at least three goals speak directly to the realization of health goals. These are Goal 4, reduce child mortality; Goal 5, improve maternal health; and Goal 6, combat HIV/AIDS, malaria and other diseases. Of the other MDGs, monitoring implementation is undertaken through health-related indicators; they include Goal 1, eradicate poverty and hunger; Goal 7, ensure environmental sustainability; and Goal 8, develop a global partnership for development.

At the making of the Millennium Declaration 2000, several commitments were made towards attainment of the goals. Of note is that special mention was made of Africa and the need for

efforts towards meeting the special needs of Africa.⁸ World leaders pledged to support the growth and consolidation of democracy in Africa so as to align development in Africa to developments in the global economic arena.⁹ World leaders therefore pledged their support towards emerging democracies in Africa, assist in the promotion of conflict prevention and management by Africa's sub regional mechanisms and address some of Africa's challenges including poverty eradication, sustainable development, debt cancellation, improved access to world markets, increased foreign direct Investment, transfer of technology and aid capacity building towards tackling the spread of the HIV/AIDS pandemic and other infectious diseases.¹⁰

The articulation of the right to health is provided in several international human rights legal instruments including the International Covenant on Economic Social and Cultural Rights (ICESR),¹¹ the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),¹² Convention on the Elimination of All Forms of Racial Discrimination.¹³ The right to health is classified as a social and economic right, in much the same way that the content of most of the MDGs do resemble realisation of social and economic rights.¹⁴ Most African states are party to the international human rights instruments and are held accountable at both the international and domestic level for ensuring the promotion and protection of this right.

The right to health is concerned with realization of timely and appropriate health care but will also address the realization of foundational factors that speak directly to health including access to safe and potable water, adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.¹⁵ The Committee on Economic, Social and Cultural Rights in General

⁸ 55/2 United Nations Millennium Declaration part VII 'Meeting the special needs of Africa' <http://www.un.org/millennium/declaration/ares552e.htm> (accessed 10 May 2013).

⁹ UN Millennium Declaration (n 8 above) para 27.

¹⁰ UN Millennium Declaration (n 8 above) para 28.

¹¹ ICESR Article 7, 11, 12. The Convention has been ratified by all African states except Botswana, Comoros, Mozambique, Sao Tome and Principe, South Africa and South Sudan.

¹² CEDAW Article 10, 12 and 14.

¹³ CERD Article 5.

¹⁴ UN Committee on Economic, Social and Cultural Rights general comment 14: The Right to the Highest Attainable Standard of Health. Geneva, Switzerland: United Nations: 2000. UN Document E/C.12/2000/4. Available at: [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument).

¹⁵ The human right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Comment No. 14 also defined the obligations that states parties have to fulfill in order to implement the right to health at the national level.

At the African regional level, the right to health is articulated in various regional human rights instruments. Notably, the African Union Constitutive Act,¹⁶ the African Charter for Human and People's Rights,¹⁷ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women¹⁸ and the African Charter on the Rights and Welfare of the Child.¹⁹

The African Commission on Human and People's Rights has had occasion to pronounce itself on the realization of the right to health through various communications before it.²⁰

3. Commitment to achievement of health related MDGs in Africa

In order to assert greater ownership of the goals, and also formulate continent specific interventions, Africa embarked on various commitments that would aid

"TB remains a major cause of death in our sub-region and we will not defeat HIV without a concerted offensive against TB. We must prioritise action in the hot spots, and one of the hottest of these is TB in the mining industry. The new partnerships that we are witnessing today between government, the corporate sector, and global agencies can and must drive our renewed effort in the next 1000 days."

*Dr Aaron Motsoaledi, Minister of Health of South Africa. 1000 days to reach TB MDGs
<http://www.health-e.org.za/news/article.php?uid=20034107>*

The UN Special Rapporteur on the Right to Health,

<http://www.ohchr.org/EN/Issues/Health/Pages/SRRRightHealthIndex.aspx>.

¹⁶ Article 13 articulates key functions of the AU Executive Council as including coordination and decision making on policies in areas of common interest to member states including in the area of health. A specialized Technical Committee on inter alia Health is constituted in Article 14.

¹⁷ Article 16 provides for the best attainable state of physical and mental health.

¹⁸ Article 14 provides for the right to health including reproductive health rights. In Article 10(3) provision is made to the right to peace calling on states parties to 'take the necessary measures to reduce military expenditure significantly in favour of spending on social development in general, and the promotion of women in particular.'

¹⁹ Article 14 provides for the right to health and health services.

²⁰ Social Economic Rights Action Centre (SERAC) and Another v Nigeria (2001) AHRLR 60 (ACHPR 2001) in which the complainants alleged that the Nigerian government violated the right to health and the right to clean environment as recognized under the Charter by failing to fulfill the minimum duties required by these rights.

realization of MDGs. These commitments would aid in promoting ownership among African states.²¹ African leaders agreed on the need to adopt a radical intervention and adopt a mechanism to address challenges facing African states such as escalating poverty levels, underdevelopment and the continued marginalization of Africa in the globalization process.

Spearheaded by African leaders, the continent adopted the New Partnership for Africa's Development (NEPAD), the development agenda of the African Union.²² AU member states pledged to eradicate poverty and place their countries on the path to sustainable growth and development. African states would carry out periodic peer assessments so as to identify areas for further intervention.

NEPAD is viewed as a strategic response by African leaders to establish a foundation that will facilitate African Countries to attain the Millennium Development Goals (MDGs).²³ Through NEPAD programmes, there has been a contribution towards efforts of AU member states to achieve MDGs. For example, towards MDG 4 and 5, NEPAD runs programmes to develop policies that are informed by scientific evidence and also provides technical assistance to African countries to enable them to harmonize regulations in medicines.

The Africa Health Strategy 2007 -2015²⁴ is another tool employed within the African regional framework to advance the attainment of the right to health. The strategy aimed harmonizing all the existing health strategies as well as the MDGs which can in turn inform and inspire similar strategies by the regional economic communities (RECs), other regional entities and member states. The strategy recognized the weakness of African health systems many of which are too weak and under resourced. It recognized the fact that state funding for health was by far outmatched by the demand for provision of health services. It also took cognizance of the

²¹ Backgrounder – Achieving the millennium development goals in Africa.

http://www.unis.unvienna.org/pdf/MDG_Africa_backgrounder.pdf (accessed 12 April 2013).

²² <http://www.dfa.gov.za/au.nepad/nepadbrief.htm>. NEPAD was adopted as a Programme of the Organisation of African Unity in July 2001 in Lusaka, Zambia as a pledge by African leaders to eradicate poverty, place their countries - both individually and collectively - on a path for sustainable growth and development, and participate actively in the world economy and body politic.

²³ 'NEPAD and the MDGs: Progress, Challenges and the Way Forward'

<http://www.nepad.org/system/files/NEPAD%20Agency%20CEO%20statement%207%2010%202011.pdf>

²⁴ [http://www.nepad.org/system/files/AFRICA_HEALTH_STRATEGY\(health\).pdf](http://www.nepad.org/system/files/AFRICA_HEALTH_STRATEGY(health).pdf)

incidence of poverty, marginalization and displacement in the continent as facts contributing to the poor state of health in most countries. ²⁵The strategy recognized good governance and proper resource management as key drivers to the attainment of the right to health. ²⁶

To further their commitment to achievement of the health related MDGs, heads of state of African Union countries met in April 2001 and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. At the same time, they urged donor countries to "fulfill the yet to be met target of 0.7% of their GNP as official Development Assistance (ODA) to developing countries". This drew attention to the shortage of resources necessary to improve health in low income settings. ²⁷

Against the background of the Abuja Declaration only eight countries are on track with respect to the health Millennium Development Goals (MDGs). Most countries are achieving less than 50% of the gains that would be required to reach the goals by 2015, with progress on MDG 5 (maternal health) being particularly slow. Twenty-seven countries have increased the proportion of total government expenditures allocated to health (GGHE/GGE) since 2001. However, only Rwanda and South Africa have achieved the Abuja Declaration target of "at least 15%".²⁸ Meanwhile, seven countries reduced their relative contributions of government expenditures to health during the period.

"We've made great strides in responding to the triple threat of HIV, tuberculosis and malaria in this region and in expanding healthcare, yet far too many men, women and children are still affected by these diseases. If Africa is to meet the health-related Millennium Development Goals (MDGs) in 2015, our governments must act now to expand treatment and prevention programs for HIV, TB and malaria and expand universal access to quality health care now."

Source: 'Health activists urge East African Governments to Ensure Universal Access to quality Health Care'http://www.africasciencenews.org/en/index.php?option=com_content&view=article&id=789

²⁵ Africa Health Strategy 2007-2015 (n 25, above).

²⁶ Africa Health Strategy 2007-2015(n 25 above).

²⁷ WHO the Abuja Declaration 10 years on- <http://www.who.int/healthsystems/publications/Abuja10.pdf>.

²⁸ See n, 27 above.

The table below provides a snapshot of the performance of African states in relation to the Abuja Declaration. It is an extract of a scorecard that was developed on the status of African states health financing and presented at the AU Summit and Joint Conference of Ministers of Finance and Health.

2012 Africa Health Financing Scorecard²⁹

Table 1: 2nd quarter 2012: AU July 2012 Summit and Joint Conference of Ministers of Finance and Health, July 2012: time tag for verifiable comparable information across countries is 18 to 24 months.

Abuja AU 15% commitment ranking	Country name	Health Financing			life expectancy at birth
		Abuja 15% (Government expenditure on health as a % of total government expenditure	External resources for health as % of total government expenditure	15% plus formula includes dual tracking of per capita government expenditure on health at average exchange rate (us\$)	
1	Rwanda	20.1%	49.0%	US\$25	59

²⁹ Scorecard research, analysis, design and production by Africa Public Health information Service in partnership with Africa Public Health Alliance and 15% Plus Campaign; & Africa Public Health Parliamentary Network @2012 available at http://www.who.int/pmnch/media/news/2012/2012_health_financing_scorecard.pdf (accessed 18 April 2013).

2	Botswana	17.0%	19.5%	US\$442	61
3	Zambia	15.7%	38.5%	US\$37	48
4	Togo	15.4%	13.6%	US\$18	59
5	Madagascar	14.7%	15.1%	US\$11	65
6	Malawi	14.2%	80.0%	US\$17	47
7	Djibouti	14.1%	26.3%	US\$65	60
8	Liberia	13.8%	47.0%	US\$10	56
9	Uganda	13.6%	20.0%	US\$10	52
10	Burkina Faso	13.6%	26.0%	US\$19	52

The Ouagadougou Declaration on Primary and Health Care as well as the African health systems and the 2005 WHO Regional Committee for Africa Resolution on Achieving the Millennium Development Goals. Development partners also made similar commitments through the United States Secretary –General’s MDGs Africa Initiative and the Harmonization for Health in Africa Mechanism.³⁰

4. The human rights approach in addressing health related MDGs

At the Millennium Declaration of September 2000 from which MDGs governments committed to free their citizens from all forms of dehumanising poverty and thus undertook to make the

³⁰ D Kebede. 'Progress in the Health Related MDGs in the African Region'. World Health Organisation, Regional Office for Africa. Issue 11 January –March 2010 11.

'right to development' a reality.³¹ The linkage of the MDGs to the right to development was further emphasized during the 1993 Human Rights World Conference. A rights-based framework ensures that the MDGs are achieved through a process that respects the values, standards and principles outlined in the Universal Declaration of Human Rights (UDHR).³²

Proceeding with implementation of MDGs from a rights perspective is useful for framing of MDGs as rights places a political and moral pressure for their realization even in the absence of clear legal provisions.³³ In terms of the similarities, the substance of the MDGs is similar to human rights as they both cater for some social and economic rights.³⁴ In fact, it has been suggested that MDGs have helped to raise the profile of social and economic rights as envisaged under the international human rights system. Additionally, MDGs have measurable benchmarks in form of indicators while human rights strategies offer increased legitimacy to the type of measures needed to achieve the MDGs.³⁵

5. Achievement of health related MDGs

Useful to the examination of progress made by Africa in addressing health related MDGs is the understanding that all MDGs are inter-linked as the achievement of one contributes to another. Therefore one can argue that all the MDGs can be said to address the right to health either directly or indirectly. Three of the eight MDGs directly address health. These are; goals 4; reduce child mortality, goals 5; improve maternal health and goal 6; combat HIV/AIDS, malaria and other diseases. Three MDGs can be monitored through their health related indicators. These are: Goal 1 eradicate poverty and hunger, goal 7; ensure environmental sustainability and goals 8; develop a global partnership for development.

A critical look at the achievement of MDGs in Africa presents a grim picture as Africa is off track on all 3 of the directly health related goals : 4,5 and 6. There is overall progress on all the 3 indicators but it still falls below the set targets. Despite this, some indicators within the 3 goals

³¹ S Shetty 'Can a Rights -Based approach help in achieving the Millennium Development Goals? IDS Bulletin 36.1.

³² As above.

³³ Office of the High Commissioner for Human Rights, Human Rights and the Millennium Development Goals in Practice (2010).

³⁴ As above.

³⁵ As above.

have seen some marked progress. There are wide disparities between different regions in Africa as well as different countries with North Africa having reached the target set for all the MDGs but conflict threatened to overturn these achievements. The health related goals disproportionately affect women due to their reproductive role. What follows in the next section is an analysis of the progress made in attainment of the MDGs by African states.

5.1 Reduce child mortality (Goal 4)

This goal is measured through target 4A which aims at reducing by two thirds, the under- five mortality rate between 1990 and 2015. This goal specifically addresses infants' right to life. The right to life is protected by article 6 of the International Covenant on Civil and Political Rights (ICCPR).³⁶ In its General Comment No.6, the Human Rights Committee requires states to take all possible measures to reduce infant mortality and to increase life expectancy.³⁷ With the exception of South Sudan and Somalia, the rest of the African countries have ratified the Convention on the Rights of the Child which creates an obligation on states and parents to ensure the highest attainable standard of health for children.³⁸ Of the 26 countries with under-five mortality rates above 100 deaths per 1,000 live births in 2010, 24 are in Africa.

The reduction of infant mortality is echoed in article 12 of the International Covenant of Economic, Social and Cultural Rights (ICESCR).³⁹ In the African region, the African Charter on the Rights and Welfare of the Child which entered into force in 1999 has been ratified by 45 States out of the 54 AU member states.⁴⁰

³⁶ Claiming the Millennium Development Goals. A human rights approach (n 6 above).

³⁷ See General Comment No. 6 (1982) Para 5 .Human Rights Committee is the body charged with monitoring the implementation of the ICCPR.

³⁸ Millennium Development Rights. How Human Rights Based Approaches are achieving the MDGS .Case Studies from the Australian aid and Development Sector. 2009 ACFID 18.

³⁹ Article 12(2)(a) of the ICESCR calls upon States to reduce still birth –rate and infant mortality and for the healthy development of the child.

⁴⁰ The countries that have not ratified the ACRWC are Democratic Republic of Congo , Sao Tome and Principe, Central African Republic, Tunisia, South Sudan, Swaziland ,Sahrawi Arab Democratic Republic and Somalia.

Globally the rate of childhood deaths has declined considerably with an estimated 7.9 million children dying before their fifth birth day in 2011 compared to 12 million in 1990.⁴¹ Northern Africa has reduced child mortality by 67% thus achieving target 4 while Sub-Saharan Africa has achieved about 30% percent reductions thus falling short of the target.⁴² Despite this, Sub-Saharan Africa doubled its average rate of reduction from 1.2 percent a year between 1990-2000, to 2.4 percent during 2000-2011.⁴³ However, Sub-Saharan Africa still accounts for one of the highest under-five mortality rates in the world with 1 in 8 children dying before the age of five more than 17 times in the developed regions.

Some of the best performing countries with falls of at least 50 per cent in 1990-2010 were Madagascar, Malawi, Eritrea, Liberia, Niger and Tanzania. Some of the factors for the high performance are; improved interventions in areas with poor access to health, increased immunization, exclusive breast-feeding, vitamin and mineral supplementation, stronger malaria prevention and treatment, improvements in water and sanitation and fighting pneumonia and diarrhoeal disease. On the other hand, countries like Somalia, DRC, Burkina Faso, Chad and CAR are far from reaching the target. ⁴⁴ Factors that underlie slow progress of some of these countries include; conflict, insufficient funding, low skilled health professionals and failure of government policies to effectively address the situation.⁴⁵

⁴¹ Levels and trends in Child Mortality. Estimates developed by the UN Inter Agency group for child mortality estimation 2011 1.

⁴² The Millennium Development Goals Report 2012 .United Nations New York 26-27.

⁴³ MDG report 2012 (n 42 above)6.

⁴⁴ Assessing progress in Africa toward the Millennium Development Goals MDG Report 2011 (Compiled by UNDP African Union ,Economic Commission for Africa ,African Development Bank Group) 41-50

⁴⁵ n 44 above.

Note should be taken that as the rate of children who die under five reduces, the proportion of children who die in the first month after delivery is increasing (neonatal mortality).⁴⁶ Sub-Saharan Africa experienced a higher neonatal mortality rate compared to the other regions as it recorded 35 deaths per 1,000 live births in 2010.⁴⁷ Diarrhoea, malaria and pneumonia are responsible for more than half the deaths of children under five

5.2: Improve maternal health (Goal 5)

SIERRA LEONE'S FREE HEALTH CARE INITIATIVE

On April 27, 2010, Sierra Leone started free health care for pregnant women, new mothers, and young children. This was a ground breaking move for a country just emerging from war and with 74% of the population living on less than 2 dollars a day. Within months, the number of mothers and children accessing health care tripled. In the month before free health care, an average of 170 000 children received care from Sierra Leone's hospital facilities each month. The free health-care plan also substantially increased services for mothers, and particularly for children. The number of children treated for malaria, for instance, roughly tripled in 2011, a striking example of how the lack of money had proved to be a barrier to care. Among the factors that made this possible was the high level of organisation, cooperation among the Government, donors and development partners. The initiative has however not been without its challenges as the health sector is still faced with poor infrastructure, deficiency in skilled labour insufficient drugs and overcrowding of health centres due to the fact that the services are now free. Source: www.thelancet.com Vol. 381

This goal is measured by two targets; the first one is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio and the second one is to achieve, by 2015, universal access to reproductive health.

Underlying rights within this goal are the right to adequate health and the right to life. Article 10(2) of the ICESCR states that "special protection should be accorded to mothers during a reasonable period before and after childbirth". Article 12 of the CEDAW prohibits discrimination against women in the provision of health services and to ensure appropriate services for pregnant women. The Committee on Economic, Social and Cultural rights has highlighted that failure to take positive steps to reduce maternal mortality ratios

⁴⁶ MDG report 2012 (n 42 above).

⁴⁷ n 42 above 27.

can be a human rights violation.⁴⁸

Adopting a rights based approach to this goal entails the provision of basic and comprehensive emergency and obstetric care.⁴⁹ This includes their availability, equitability, quality, accessibility and affordability. It also calls for the removal of cultural and legal barriers as well as women being provided the right to freely determine the number and spacing of children.⁵⁰ Accountability systems also have to be established to monitor and enforce human rights obligations to provide, care, remove barriers and reduce the maternal mortality ratio.⁵¹ Reproductive health should also be recognised as a human right in government policies, laws and programmes and ensure access to affordable family planning services as well as sexual and reproductive health services.⁵²

The Maternal Mortality Ratio (MMR) continues to be a major challenge in Africa,⁵³ with the exception of North Africa. Between 1990 and 2009, Africa recorded an annual decline of 1.7% which is way below the required 5.5 % and the continent's average MMR was 590 deaths per 100,000 live births in 2008 .⁵⁴ Some of the countries that registered above 1000 per 100,000 live births were Chad, Guinea Bissau and Somalia while some of the best performers included Cape Verde, Egypt, Libya, Mauritius and Tunisia as they recorded an MMR of less than 100 per 100,000 live births in 2008.⁵⁵ The rest of the African countries varied between 100 and 1000 per 100,000 live births. There was some regression that was observed amongst some countries such as; Botswana, Congo, Kenya, Lesotho, Somalia, South Africa, Swaziland, Zambia and Zimbabwe.

The proportion of women who seek antenatal care increased by 25% in North Africa and by 69.6% in the rest of Africa between 2000 and 2009.⁵⁶ However this still falls below the WHO

⁴⁸ General Comment No.14 para 52 .

⁴⁹ Claiming the millennium development goals (n 6 above) 29.

⁵⁰ N 6 above.

⁵¹ N 6 above.

⁵² N 6 above.

⁵³ MDG report 2011 (n 44 above) 52-55.

⁵⁴ n 44 above.

⁵⁵ n 44 above.

⁵⁶ n 44 above 59.

required minimum of at least four antenatal visits as only 15 out of the 38 countries for available data recorded more than 60% of pregnant women who received the recommended visits between 2000 and 2009.⁵⁷ Primary causes of high maternal mortality rate are haemorrhage, sepsis, hypertensive disorders, unsafe abortion and prolonged or obstructed labour coupled with delay in seeking health care, reaching care and receiving care, harmful cultural practices. The presence of a skilled birth health personnel plays an important role in preserving the life of an expectant mother.

5.3 Combat HIV/malaria and other major diseases (Goal 6)

5.3.1 HIV/AIDS

This goal is measured by three targets; halt and begin to reverse, by 2015, the spread of HIV/AIDS, achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it, halt and begin to reverse, by 2015, the incidence of malaria and other major diseases.

In 2001, the General Assembly supplemented this goal with the declaration of commitment on HIV/AIDS. This declaration included human rights commitments aimed at enhancing and enforcing laws and policies prohibiting discrimination on the basis of HIV/AIDS and ensure the full enjoyment of human rights by people with HIV/AIDS.⁵⁸ With this declaration, the MDG targets were connected to the right to health as stipulated in the ICESCR and the UDHR. Article 12 of the ICESCR calls upon states to prevent, control and treat epidemic and endemic diseases.

The United Nations Millennium Project's task force on HIV/AIDS, malaria, tuberculosis and access to essential medicines identified three major areas of integrating a rights based approach; expansion of prevention and treatment programmes, development of specialized AIDS programmes together with the development of general health services and direction of programmes to the poor and to those most in need of them.⁵⁹

⁵⁷ MDG report 2011 (n 44 above).

⁵⁸ Claiming the millennium development goals (n 36 above) 29.

⁵⁹ n 36 above.

There have been significant advances towards the achievement of the targets under this goal and the number of people living positively with HIV/AIDS has increased owing to improved coverage of antiretroviral therapy (ART). This can partly be attributed to various initiatives such as; The Global Funds, the Abuja Declaration, Stop TB, the African Leaders' Malaria Alliance, and an update of the Roll Back Malaria partnership.⁶⁰

In 2009, UNAIDS estimated that the prevalence rate in Africa had decreased to 5% compared with 5.9% in 2001. However, due to the population growth, the HIV prevalence rate does not match the actual numbers as these increased from 20.3 million in 2001 to 22.5 million in 2009.⁶¹ AIDS related deaths have decreased (from 1.4 million in 2001 to 1.3 million in 2009) due to increased supply of ARTs ensuring that people living with HIV/AIDS are surviving longer.

However, Africa still contributes to the highest HIV burden globally with the vast majority being found in Sub-Saharan Africa with women accounting for 60% of new infections.⁶² The HIV prevalence also increased in some countries like Angola, Chad, Equatorial Guinea, the Gambia, Guinea Bissau, Mauritius, Mozambique, Senegal, Sierra Leone, Somalia, South Africa and Swaziland. The number of children living with HIV/AIDS also increased as there was increase by 500,000 between 2001 and 2009. Some countries that had made remarkable progress in the past have experienced setbacks,⁶³ for example Mozambique and Uganda.

UGANDA HIV/AIDS gains being frustrated

Uganda has experienced some setbacks in the fight against HIV and AIDS. While in the past the country was cited as a success story in halting the spread of HIV, the situation today is deteriorating. Uganda made remarkable progress during the 1990s to reduce the spread of HIV and AIDS. For example, the proportion of pregnant women attending antenatal clinics who were identified as HIV-positive fell from a high of 18 percent in 1992 to around 6 percent in 2000. This success was due to a variety of measures that enabled changes in sexual behaviour, as well as the provision of care and support services. However, recent data reveal significant challenges in sustaining past gains. It is estimated that more than 130,000 people were infected with HIV in 2010 alone. The total number of people living with HIV in 2010 was around 1.2 million, which is higher than at the peak of the epidemic in the 1990s. The recent expansion in the number of new infections is related not only to high population growth, but most importantly to the worsening of many indicators of risky behavior (e.g., multiple partners and decreased condom use). The Government of Uganda plans to reassess their national HIV and AIDS policy to refocus on preventing new infections rather than providing ART. Sources: Uganda MDG Progress Report, 2010.

⁶⁰ MDG Africa report 2011 (n 44 above).

⁶¹ n 44 above.

⁶² n 44 above.

⁶³ MDG report 2011 (n 44 above).

5.3.2 Tuberculosis

TB accounted for one in four deaths among HIV-positive people.⁶⁴ The TB epidemic is closely related to that of HIV. It is also caused by other factors such as crowded living and working conditions and poor sanitation. There are two types of TB; Drug –susceptible TB and multi drug –resistant TB.⁶⁵ More than 90 per cent of people with drug-susceptible TB can be cured in six months using combinations of first-line drugs. Treatment of multidrug-resistant TB requires the use of second-line drugs that are more costly and taken up to 2 years. ⁶⁶

5.3.3 Malaria

There have been positive results as regards the reduction of malaria partly due to access to insecticide treated nets especially for children under five. The annual number of malaria cases dropped slightly from 233 million in 2000 to 216 million in 2010. Malaria constitutes 22 per cent of all childhood deaths.⁶⁷ Insecticide treated Nets have helped to lower under-five malaria incidence. However, the announcement by Global Fund in November 2011 that Round 11 of funding is to be cancelled for 2012–2016 is likely to affect the gains made in the reduction of malaria, HIV and Tuberculosis.⁶⁸

6. Health Related indicators in non-health related MDG goals.

6.1 Eradicate extreme poverty and hunger (Goal 1)

MDG 1 aims to eradicate extreme poverty and hunger. Target 1C of this goal is a health related indicator, which aims to halve between 1990 and 2015, the proportion of people who suffer from hunger.

⁶⁴ MDG Report 2012 Assessing progress in Africa toward the Millennium Development Goals .Emerging perspectives from Africa on the post 2015 Development Agenda 80-92.

⁶⁵ n 64 above.

⁶⁶ n 64 above.

⁶⁷ n 64 above.

⁶⁸ n 64 above.

The Rome Declaration of the World Food Summit recognised “the right of every one to have access to safe and nutritious food.⁶⁹ This borrows from a series of international human rights standards including article 11 of the ICESCR, article 24 and 27 of the CRC and article 12 of CEDAW. The UN Millennium Project’s task force on hunger calls upon governments to respect protect and fulfil individuals’ right to food.⁷⁰ Among the measures to be put in place include moving from political will onto action, improving nutrition for the chronically hungry and vulnerable, increasing incomes, making the market work for the poor and reducing the vulnerability of the acutely hungry through productive safety nets.⁷¹

Africa has not improved enough to meet the target as only a few African countries were on track in halving the proportion of people who suffer from hunger by 2010.⁷² These were Algeria, Ghana, Guinea-Bissau, Congo, Angola, Malawi, Mauritania and Sao Tome and Principe. Eighteen countries were making very slow progress and 12 countries had made no progress. The percentage of children who were malnourished in these 38 countries varied from 3% to 44%.⁷³ Among the factors that undermine achievement of this indicator are child malnutrition, volatility in food prices and the ever widening gap between the rich and the poor which means that rural small scale farmers can’t afford to invest in measures to increase productivity.

⁶⁹ Claiming the millennium development goals (n 36 above).

⁷⁰ n 36 above 29.

⁷¹ n 36 above 29.

⁷² Progress in the Health Related MDGs in the African Region (n 30 above) 7.

⁷³ n 30 above.

6.2 Ensure environmental sustainability (Goal 7)

This goal has a crucial health related indicator (target 7C) which aims at halving by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. This target is in line with social economic rights and the right to water also has bearing on elements of the right to housing and health.

Article 27 of the CRC and article 14 of CEDAW address the right to adequate water and sanitation. Despite this, African states continue to grapple with unequal access to water .The United Nations Millennium Project’s task force on water and sanitation recommended to the international community to draw from the UN – CESCR’s General Comment No.15 on the right to water to influence national policy.⁷⁴ Various aspects are vital for the realization of the right to water. These involve; non-interference by government with an individual’s means to water and sanitation, protection of water sources from infringement, pollution, charging of exorbitant prices by private entities or individuals and ensuring that all available resources for the progressive realization of the right to water are in place.⁷⁵

South Africa –Right to Water

*South Africa undertook a rights based legislative framework after apartheid aimed at empowering local communities and fighting in-equalities .Thus the 1996 constitution enshrined the ‘right to adequate food and water’. The National Water Act (1998) gave it legislative content and has seen a lot of progress.10 more million people have been able to access water since 1994 and coverage rates have risen from 60% to 86%.About 31 million people currently have access to basic water. However, there have been several challenges in the implementation of some of the reforms leading to erratic water supplies in some areas, regular water cut-offs and concerns on affordability as well as slow progress in the improvement of sanitation. Despite these challenges, the case of South Africa points out important policy requirements; continuous monitoring of progress, a strong national framework spread out to the local communities and a clearly defined plan with achievable goals. **Source: Human Development Report 2006.Beyond Scarcity: Power poverty and the water crisis.***

⁷⁴ Claiming the millennium development goals (n 36 above)29.

⁷⁵ n 36 above.

The MDG target has been met globally but not in Africa. There was an overall increase from 56% in 1990 to 66% in 2010 but still below 78% which needs to be reached by 2015. In 1990, 26 countries had at least 80 percent coverage to an improved water supply in urban areas, compared to 40 countries in 2008.⁷⁶ Access to an improved water source in rural areas increased from 42% percent in 1990 to 53 percent in 2008, while access in urban areas stagnated fell from 86 in 1990 and 2008 at 85 percent in 2008 which can be attributed to rapid urbanization and growth of slums. In 2010, no country had a coverage rate of less than 50 per cent for urban areas. However, major discrepancies still exist especially in the rural population of the continent which had limited access to an improved drinking water source with the exception of Southern Africa and North Africa.⁷⁷

On the other hand, sanitation has improved by only 5 % over a period of 20 years. The ever increasing population in urban areas is adversely affecting sanitation as it leads to an increase in slum dwellers. Sanitation facilities increased from 54 % in urban areas as opposed to 31% in the rural areas. There are also disparities as regards access to sanitation as studies show greater access to improved sanitation by wealthier populations compared to the poor. The use of improved sanitation facilities generally stood at 41%in 2008. Majority of the countries (33 out of 43) which had available data registered improved but varying magnitudes in the access to improved sanitation facilities.⁷⁸

7. Developing a global partnership for development (Goal 8)

In order to contribute to achievement of health related MDGs, the crucial role of target 8E comes in place. This enumerates the importance of cooperation with pharmaceutical companies, as well as provision of access to affordable essential drugs in developing countries.

The international community has laid a lot of emphasis to health issues, however essential medicines still remain inaccessible. In a General Assembly resolution, member states agreed to work towards achieving the following by 2015: a 50 per cent reduction of sexual transmission of

⁷⁶ MDG report (n 44 above) 2011.

⁷⁷ n 44 above.

⁷⁸ n 44 above.

HIV, the elimination of mother-to-child transmission and substantially reduced AIDS-related maternal deaths, a reduction in deaths caused by tuberculosis (TB) in people living with HIV by 50 per cent, and the provision of antiretroviral (ARV) treatment to 15 million people.

In September 2011, the high-level meeting of the General Assembly on non-communicable disease prevention and control was held at the United Nations. Member states recognized the major challenges that non-communicable diseases (NCDs) pose to development, including limiting progress towards the health-related Millennium Development Goals (MDGs). They agreed that prevention of NCDs should be given high priority on national and global development agendas.⁷⁹ Member states committed to the following: to advance the implementation of interventions to reduce the impact of NCD risk factors; to establish or strengthen national health systems and multi-sectoral policies for the prevention and control of NCDs; to strengthen international cooperation and partnerships in support of plans for the

⁷⁹ Millennium Development Goal 8. The global partnership for development. Making Rhetoric a reality. MDG Gap Task Force Report 2012.

prevention and control of NCDs; and to promote research and development. Some concrete actions include creating a global monitoring framework and setting concrete global (voluntary) goals.

As an example from the private sector perspective, Quality Chemicals, a pharmaceutical manufacturer based in Luzira, Uganda, was pre-qualified by WHO and with the help of the Indian generic manufacturer Cipla and the Ugandan government, began production of tenofovir, an ARV, in February 2012.⁸⁰

8. Challenges in Africa that have frustrated the achievement of Health related MDGs

a) Democracy and Good Governance

Whilst a great deal of effort has been made on governance in Africa, a lot of challenges still exist. Corruption, nepotism, arbitrary rule and marginalization are still common place⁸¹. Bad governance will inhibit the realization of progress and development. For MDG's to be realized, a stable political environment is required. Involving the most marginalized groups in decision making will help ensure that laws, policies and resources are used to create enabling, equitable, health-promoting environments for those most vulnerable to health risks.

b) Increase in Population

Increase in population has also affected many countries in Africa. States have been challenged in relation to provision of resources and basic commodities such as food, clothing, housing, health facilities and schooling due to the increase in population size. For example Nigeria- (150,000,000). Rapid changes in population structure, size and mobility can displace investments in health services and other basic amenities for the population.

c) Conflict/War

Many African states have been in serious internal conflicts since the late 1990's. (Sierra Leone- 1991-2002) DRC-still ongoing, Liberia, Rwanda-1994, Eritrea, Somalia etc. Conflict in Africa has

⁸⁰ The global partnership for development (n 79 above).

⁸¹ G. Bouty 'Corruption in Africa- a scourge to deal with' 23 May 2011, 34

now taken a new dimension. Africa has also become a refuge for terrorist organizations like Boko Haram in Nigeria; Al-shababa⁸² in Somalia and M-16 rebels in MALI. This situation has gravely retarded progress. However, there are countries from brutal war situations that are making tremendous progress, (Sierra Leone and Rwanda).

d) Traditional Practices

There are of course very good traditional practices in Africa such as respect for elders, strangers, communal family living and support etc. However, harmful traditional practices still exist in the continent. In many African States, it has become a way of life of the people e.g. FGM, killing of twins, forced marriage, polygamy⁸³ etc.

e) Lack of Statistics and Accurate Data

Efforts have been made to obliged states to take the issue of statistics seriously within the African Regional System through the formulation of an African Statistics Charter⁸⁴. However, only 5 states in African have ratified this instrument. Lack of statistics and data have affected accurate reporting on many surveys and programs undertaken. States have largely depended on assumptions which have subsequently led to under-estimations or over-estimations. For instance, DRC have not conducted census for over 40 years now⁸⁵.

f) Police Brutality and excess use of force

The Police and forces in Africa Police have contributed significantly to world security and peace. For instance, the ECOMOG interventions in Liberia, Sierra Leone and recently the AU peace keeping forces in Sudan, Mali etc. However, brutality and excessive use of force is also a key challenge in the African Continent. For eg Marikana shootings in South Africa⁸⁶, the fight against Boko Haram in Nigeria by the police, Eritrea, Somalia, Kenya-election violence, Sierra Leone -handling of demonstrations. A lot of lives have been lost as a result of excessive use of force by the police.

⁸² D.Malo 'Terrorism in the Continent of Africa' Vol 2 6th edition 2011.

⁸³ F. Bayer 'Customs and Traditions in Africa' 2006.

⁸⁴ B.Hanty 'African regional instruments' 2010.

⁸⁵ As above.

⁸⁶ www.policekillings.org (accessed on 29 April 2013).

g) Criminalization of Homosexuality

Even though cases of prosecution of homosexuals have been few in Africa, it is however true that in almost all the states in Africa the practice of homosexuality has been criminalized in penal provisions. South Africa however has explicitly prohibited discrimination on the ground of one's sexual orientation.⁸⁷

9. Recommendations for the Post 2015 development agenda in line with health.

Several initiatives have been undertaken both globally and regionally in order to chart a way for the post 2015 development agenda. The UN Secretary-General established the UN System Task Team on the Post -UN Development Agenda chaired by the Department of Economic and Social Affairs and the United Nations Development Programme.⁸⁸ In July 2012, the Secretary-General launched his High-level Panel of Eminent Persons to provide guidance and recommendations on the post-2015 development agenda.⁸⁹ The panel is chaired by the Presidents of Indonesia and Liberia and the Prime Minister of the United Kingdom and members include representatives from the private sector, academia, civil society and local authorities. The report of the Panel will be published in May 2013. **At the African level**, the United Nations Economic Commission for Africa (UNECA) convened a regional workshop on 15-16 November 2011 in Accra, Ghana, attended by 47 representatives from 18 African countries of government, civil society and academia⁹⁰. This was aimed at articulating Africa's position on the post 2015 development agenda. Drawing from these, the following should be undertaken;

- Providing appropriate information to the women regarding available health care, reproductive control methods and leading healthy lives.
- Minimising delays in reaching health centres by providing emergency transportation services such as ambulances improving infrastructure such as roads.
- Improving health facilities and ensuring that basic facilities such as electricity and water and emergency obstetric health care services are in place in health facilities.

⁸⁷ Section 9 Constitution of the Republic of South Africa, 1996.

⁸⁸ G. West, 'Post 2015 Agenda-'The World We Want' 20 January 2012.

⁸⁹ United Nations, Department of Public information, press release.

⁹⁰ INDEPTH Network Website.www.indepth-network.org Accessed on 8 April 2013.

- Provide more incentives for skilled health practitioners and continuous training on the new medical technology.
- Population Control dynamics which involve the continuous use of contraceptives
- Data in the health facilities should be continuously updated, effectively monitored and evaluated.
- An integrated approach should be undertaken to lower the prevalence of HIV/AIDS. These include; Provision of facilities to prevent mother to child transmission of HIV, timely provision of care and treatment for HIV-exposed and HIV-infected children and more campaign, research and resources should be directed towards the prevention of HIV/AIDS.

10. Conclusion

African countries have in the recent past made great strides in growth of their economies and for this growth to remain sustainable; matters of human development ought to be prioritized. The right to health is fundamental to the well-being and thus the resource base of Africa. As we have seen from this report, Africa continues to lag behind in performance of health related MDGs and it is unlikely that all targets will be met.

Accordingly, planning for the period past 2015 is vital as it will allow for strategic interventions to upscale the successes that may have been realized while at the same time propose new interventions to address matters not fully addressed as well as human development issues that now arise as a result of new and emerging matter on the African frontiers. It is only when human beings are living in a healthy state of mind and wellbeing that education, governance, gender empowerment; civil and political rights as well as social rights can make much meaning.