The Transnational Human Rights Review

Volume 4 *Canadian-African Human Rights Engagements: A Literature Review and an Agenda for Future Research*

Article 10

8-31-2017

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Citation Information

Ngwaba, Uchechukwu. "Canadian-Anglophone African Human Rights Engagement: A Critical Assessment of the Literature on Health Rights." *The Transnational Human Rights Review* 4. (2017) :
DOI: https://doi.org/10.60082/2563-4631.1072
https://digitalcommons.osgoode.yorku.ca/thr/vol4/iss1/10

CANADIAN-ANGLOPHONE AFRICAN HUMAN RIGHTS ENGAGEMENT: A CRITICAL ASSESSMENT OF THE LITERATURE ON HEALTH RIGHTS

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Abstract

Contrary to common expectations, the engagement between Canada and Anglophone African countries on the issue of health rights has not been a "one-way-street" whereby Canada is the "giver" and Anglophone African countries are the "takers" of health benefits. This article, which undertakes a preliminary and critical assessment of the literature documenting this engagement, finds that both Canada and Anglophone African countries have mutually benefitted from their engagement in the area of health rights. These benefits have taken the form of Canada's financial and technical contributions to various initiatives that seek to improve the availability and accessibility of health-related goods and services in some Anglophone African countries. Canada has benefitted from the significant influx of highly skilled health workers from Anglophone African countries. However, by framing an agenda for research in this area, this article identifies the attainments, problems, and prospects of this engagement. This article further argues, amongst other things, for a recalibration of this engagement to ensure its sustainability, and to ensure that it advances the objectives of universal health coverage in the health systems amongst Canada and Anglophone African countries alike.

1.THIS ARTICLE SETS OUT to critically assess the literature documenting the nature, attainments, problems, and prospects of Canada's engagements with the countries of Anglophone Africa in the area of health rights. In international discourse, health rights are known by the short hand phrase "the right to health".[1] This right derives principally from Article 12 of the *International Covenant on Economic Social and Cultural Rights* (ICESCR),[2] which defines the right to health as, amongst other things, "…the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[3] Apart from the ICESCR, a number of other international treaties also guarantee the right to health in international law. In doing so, these treaties advance this right both for different

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[1] Virginia A Leary, "The Right to Health in International Human Rights Law" (1994) 1:1 Health & Hum Rts 24 at 26.

[2] 16 December 1966, 993 UNTS 3 art 12 (entered into force 3 Janaury 1976).

[3] *Ibid*.

categories of people, such as women and children, and within different geo-political settings, such as the African Union system and the Organization of American States. All of the international instruments, which guarantee the right to health, are referred together in this article as "the treaty framework."[4] It is noteworthy, however, that the understanding of the right to health which informs the discussion in this article derives from the ICESCR and the work undertaken by the Committee on Economic, Social and Cultural Rights (CESCR) with respect to its mandate of interpreting and monitoring states' fulfillment of this right.

The broader discourse on the nature and implementation of the right to health in international law remains quite controversial, especially in relation to a number of its key aspects including the following: its theoretical foundations;[5] the identification of its meaning;[6] the development of its content;[7] and the issue of specifying the obligations

[4] See *Constitution of the World Health Organization*, 22 July 1946, 14 UNTS 185 at Preamble (entered into force 7 April 1948) [*WHO 1946*]; *Universal Declaration of Human Rights*, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948) art 25; *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3 art 12 (entered into force 3 Janaury 1976); *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, 1249 UNTS 13 art 12 (entered into force 3 September 1981); *Convention on the Rights of the Child*, 20 November 1989, 1577 UNTS 3 art 24 (entered into force 2 September 1990); *African (Banjul) Charter on Human and Peoples' Rights*, 27 June 1981, OAU Doc CAB/LEG/67/3 rev 5, 21 ILM 58 art 16 (entered into force 21 October 1986); International Conference of American States, *American Declaration of the Rights and Duties of Man*, OAS Res XXX (1948) art XI; *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador"*, 17 November 1988, 69 OASTS art 10 (entered into force 16 November 1999).

[5] For literature that rejects the view that the right to health has a conceptual foundation, see James Griffin, *On Human Rights* (New York: Oxford University Press, 2008); Philip Barlow, "Health Care is not a Human Right" (1999) 319:7205 Brit Med J 321; Griffin Trotter, "No Theory of Justice Can Ground Health Care Reform" (2012) 40:3 JL Med & Ethics 598; Onora O'Neill, "The Dark Side of Human Rights" (2005) 81:2 Intl Affairs 427. For literature supporting the view that the right to health can be conceptually framed, see Norman Daniels, *Just Health: Meeting Health Needs Fairly* (New York: Cambridge University Press, 2008); Jennifer Prah Ruger, "Towards a Theory of a Right to Health: Capability and Incompletely Theorized Agreements" (2006) 18:2 Yale JL & Human 273.

[6] For further reading on the debate about the meaning of the right to health, see Aart Hendriks, "The Right to Health in National and International Jurisprudence" (1998) 5:4 Eur J Health L 389; Leary, *supra* note 1; Eleanor D Kinney, "The International Human Right to Health: Whats Does This Mean For Our Nation and World?" (2001) 34 Ind L Rev 1457; Steven Jamar, "The International Human Right to Health" (1994) 22 SUL Rev 1.

[7] For literature on this question, see Manisuli Ssenyonjo, "Reflections on State Obligations with Respect to Economic, Social and Cultural Rights in International Human Rights Law" (2011) 15:6 The Intl J Hum Rts 969; David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (New York: Oxford University Press, 2007); Katharine G Young, "The Minimum Core of Economic and Social Rights: A Concept in Search of Content" (2008) 33 The Yale J Intl L 113.

imposed on State parties to fulfill it.[8] A major source of this controversy arises from the fact that *health* has been broadly defined in the Constitution of the World Health Organization (WHO) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[9] This definition has been the subject of intense criticism in the literature because of the inclusion of the notion of "social well-being", amongst other things, thus making "the enduring problem of human happiness one more medical problem to be dealt with by scientific means."[10]

Despite these controversies, the CESCR has clarified through *General Comment 14* (the most authoritative interpretation of the right to health in international law), that the right to health is not to be understood as a right to be healthy. On the contrary, it is a right containing both freedoms and entitlements:[11]

> The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.[12]

General Comment 14 notes further that "in all its forms and at all levels," the right to health contains "interrelated and essential elements" that have to be applied by each state on the basis of prevailing conditions.[13] It identifies these elements as *availability* (*i.e.* functioning public health and health facilities, goods, services, and programs in sufficient

[8] CESCR, *General Comment No 3: The Nature of States Parties' Obligations (Art 2, Para 1, of the Covenant)*, 5th Sess, UN Doc E/1991/23 (14 December 1990).
[9] WHO 1946, *supra* note 4 at Preamble.
[10] See Daniel Callahan, "The WHO Definition of 'Health" (1973) 1:3 The Hastings Center Stud 77 at 80. For other critiques of this definition, see Thana Cristina de Campos, "Health as a Basic Human Need: Would This Be Enough?" (2012) 40:2 JL Med & Ethics 251; Sissela Bok, "WHO Definition of Health, Rethinking the" in Kris Heggenhougen & Stella Quah, eds, *International Encyclopedia of Public Health*, 6th ed (San Diego: Academic Press, 2008) 590; Lawrence O Gostin, "The Human Right to Health: A Right to the 'Highest Attainable Standard of Health'" (2001) 31:2 Hastings Center Report 29.
[11] CESCR, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art 12)*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000) at para 8.
[12] *Ibid* at para 8.
[13] *Ibid* at para 12. This particular interpretation takes into account the fact that through article 2(1) ICESCR, the right to health and other rights in the Covenant are to be progressively realized by states on the basis of their maximum available resources.

quantity in the state); *accessibility* (*i.e.* ability of everyone, without discrimination, to access health facilities, goods, and services in the state); *acceptability* (*i.e.* health facilities, goods, and services must respect medical ethics and be culturally appropriate); and *quality* (*i.e.* health facilities, goods, and services must be scientifically and medically appropriate and of good quality).[14]

General Comment 14 also identifies six *core obligations* and five *obligations of comparable priority* arising from the right to health. The core obligations are listed as ensuring the following: non-discriminatory access to health facilities, goods, and services; access to the minimum essential for food which is nutritionally adequate and safe; access to basic shelter, housing, and sanitation, and an adequate supply of safe and potable water; provision of essential drugs as defined under the WHO Action Program on Essential Drugs; equitable distribution of health facilities, goods, and services; and the adoption and implementation of a national public health strategy and plan of action based on epidemiological evidence, addressing the health concerns of the whole population.[15]

The obligations of comparable priority include ensuring the following: reproductive, maternal (pre-natal and post-natal), and child health; provision of immunization against major infectious diseases in the community; adoption of measures to prevent, treat, and control epidemic and endemic diseases; provision of education and access to information concerning the main health problems in the community as well as methods for preventing and controlling them; and provision of appropriate training for health personnel, including education on health and human rights.[16]

In critically examining the literature that documents the nature, attainments, problems, and prospects of Canada's "right to health" engagements with Anglophone Africa, this article focuses on what the literature does and does not say regarding how the "interrelated and

[14] *Ibid*.
[15] *Ibid* at para 43.
[16] *Ibid* at para 44.

essential elements" of availability, accessibility, acceptability, and quality of health goods and services have been impacted by that engagement.

The structure of this article is thus as follows: Part II examines Canada-Anglophone Africa health rights engagement and the availability of health goods and services. Part III discusses this issue in relation to the accessibility of health goods and services. Part IV examines the same issue in relation to the acceptability of health goods and services. Part V discusses it in connection with the quality of health goods and services. Part VI concludes by offering a summary of the tentative findings from the literature about the nature, attainments, problems, and prospects of the cooperation between Canada and Anglophone Africa in the area of health rights.

II. THE AVAILABILITY OF HEALTH GOODS AND SERVICES

Although no scholarly work that documents Canada's engagements with the countries of Anglophone Africa in relation to the provision of health-related goods and services was encountered in the desk review conducted for this article, there was nevertheless sufficient primary evidence of a strong, vibrant, and ongoing engagement between Canada and countries of Sub-Saharan Africa (SSA)[17] in the provision of health-related goods and services. The nature of these engagements is such that Canada is consistently identified as a strong supporter and major contributor to various initiatives and programs that are targeted at "strengthening health systems and improving access to high-quality basic health services in a number of African countries."[18]

[17] This comprises Anglophone and Francophone countries. It is fair to say, however, that the Anglophone countries are the predominant group here since those countries with the largest population and economy on the African continent (*i.e.* Nigeria and South Africa, respectively) are also Anglophone countries.

[18] Government of Canada, *National Reporting to CSD-16/17: Thematic Profile: Africa* (2008-2009), online: United Nations Department of Economic and Social Affairs, Division for Sustainable Development <www.un.org/esa/agenda21/natlinfo/countr/canada/africa.pdf>.

The majority of Canada's contributions were historically channeled through the now defunct Canadian International Development Agency (CIDA) (which has merged with what is now referred to as "Global Affairs Canada"), or administered through the former Department of Foreign Affairs and International Trade (DFAIT) (which is now also a part of "Global Affairs Canada"), the Department of Finance Canada, and/or the International Development Research Centre (IDRC) in Ottawa.[19] For instance, a number of official records show that CIDA funded a project that was executed in fifteen African states including the federal capital territory of Nigeria, between 2011 and 2015 (inclusive). The project was aimed at accelerating a reduction in the rate of maternal, newborn, and child mortality in those states. The project was designed to "strengthen the delivery of maternal, newborn and child health services through evidence-based, gender-responsive interventions, using existing health and community structures in the focus states."[20] CIDA also contributed to a project fund executed by the WHO between 2011 and 2015 (inclusive) in Zimbabwe, Malawi, and Nigeria. The aim of the project was designed to work towards the elimination of mother-to-child HIV transmission by providing sustained support in countries where there existed a high prevalence rate of HIV/AIDS.[21] CIDA also contributed to Nigeria's AIDS Responsive between 2003 and 2010 (inclusive),[22] and to the Polio Eradication Program of Nigeria that was executed by the WHO between 2012 and 2015 (inclusive).[23] Through these

[19] *Ibid*.
[20] Government of Canada, Global Affairs Canada, *Project profile: Accelerating the Reduction of Maternal and Newborn Mortality*, online: <w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/a034616001>.
[21] Government of Canada, Global Affairs Canada, *Project Profile: Enhancing the Prevention of Mother-To-Child Transmission of HIV*, online: <w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/m013430001?Lang=eng>.
[22] Government of Canada, Global Affairs Canada, *Project Profile: Nigeria AIDS Responsive Fund (NARF) - Phase II*, online: <w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/a031523002>; Government of Canada, Global Affairs Canada, *Project Profile: Nigeria AIDS Responsive Fund - Phase III*, online: <w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/A031523003>.
[23] Government of Canada, Global Affairs Canada, *Project Profile: Polio Eradication Program*, online: <w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/a035485001>.

contributions, Canada has situated itself as a strong supporter and contributor to programs aimed at increasing the availability of health goods and services in Anglophone Africa.

Although this point may be controversial, the Canadian-Anglophone African engagement in the area of human rights has not, however, appeared to have constituted a 'one-way' street. Canada has also benefitted immensely from its many engagements with Anglophone African countries with respect to its health personnel. The literature shows that Canada has become a major recipient of foreign-trained health professionals, notably physicians from South Africa, Nigeria, and other SSA countries, and it has been noted that the influx of these professionals to Canada is on the rise.[24] Pull-factors for the migration of these health professionals to Canada include prospects related to better living and working conditions to those attainable in their home countries. The detriment to Anglophone African (*i.e.* countries from where these health professionals originate) is marked by a critical shortage of these highly skilled and sought-after health professionals.[25] Some would, however, question whether these individual migration decisions constitute a form of engagement between Canada and the countries of Anglophone Africa.

III. THE ACCESSIBILITY OF HEALTH GOODS AND SERVICES

Primary records show that Canada has made direct and appreciable contributions towards promoting access to health resources in many Anglophone African countries. Accessibility in this context, as clarified by *General Comment 14*, refers to the ability of everyone, without discrimination, to access health goods and services.[26] Canada's main contribution in this regard has been through its resource donations to a project executed by the United Nations

[24] Ronald Labonté, Corrinne Packer & Nathan Klassen, "Managing Health Professional Migration From Sub-Saharan Africa to Canada: A Stakeholder Inquiry into Policy Options" (2006) 4:22 Hum Resources Health 1; WHO, *Recruitment of Health Workers from the Developing World: Report by the Secretariat,* 114th Sess, EB114/5 (19 April 2004) [provisional] [*WHO 2014*].
[25] Labonté, Packer & Klassen, *supra* note 24.
[26] CESCR, *supra* note 11.

Entity for Gender Equality and the Empowerment of Women between 2010 and 2013 (inclusive). The goal of this project was to improve women's access to legal, property, and inheritance rights in order to reduce their vulnerabilities to HIV/AIDS. African countries that formed the focus of this project included Uganda, Zimbabwe, Kenya, Ghana, Tanzania, Malawi, and Nigeria (which are all Anglophone African countries).[27]

Despite some reasonable objections, it could be argued that reciprocal contribution of Anglophone African countries to Canada in this area is constituted by the influx of health professionals from many Anglophone African countries to Canada. The point here would be that through the influx of these health professionals to Canada, the health workforce of Canada has been positively impacted and health services are more easily accessible to Canadians as a result.[28]

IV. THE ACCEPTABILITY OF HEALTH GOODS AND SERVICES

One element of the right to health, as it is defined in the *General Comment 14*, is that health facilities, goods, and services must respect medical ethics and be culturally appropriate.[29] Although the desk review for this article did not directly confirm how this aspect of the right to health has fared in the engagement between Canada and countries of Anglophone Africa in the health rights area, it may be assumed that Canada has considered all of these when funding of programs across Anglophone Africa. However, this is an area where more specific evidence is required to comment effectively on whether Canada has been able to advance this particular element of the right to health in its interactions with these countries. A similar position is taken with respect to the contributions made by Anglophone African countries to Canada in the advancement of health rights for Canada's population.

[27] Government of Canada, Global Affairs Canada, *Project Profile: Legal Empowerment of Women in the Context of HIV/AIDS*, online: <w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/m013070001>.
[28] *WHO 2014*, *supra* note 24; Labonté, Packer & Klassen, *supra* note 24.
[29] CESCR, *supra* note 11.

V. THE QUALITY OF HEALTH GOODS AND SERVICES

A final element of the right to health, as it is defined in the *General Comment 14*, is that health facilities, goods, and services must be scientifically and medically appropriate and of good quality.[30] Canada's contribution in this area is exemplified through its funding of a project in Nigeria (from 2003 to 2013, inclusive). The project was aimed at improving primary health care in two states (Bauchi and Cross River States) by "strengthening the capacity of Schools of Health Technology to provide appropriate, quality education to primary health care workers."[31] Records are largely unavailable in this area, at least thus far, which makes it difficult to identify any reciprocal contributions by Anglophone African countries to Canada's health care system. Further research is therefore required in this aspect as well.

VI. THE NATURE, ATTAINMENT, PROBLEMS AND PROSPECTS OF THE ENGAGEMENT

The review of the literature above, whilst limited in many respects, nevertheless reveals a number of important findings that can support a tentative conclusion as to the nature, attainments, problems, and prospects of Canada's engagement with countries of Anglophone Africa for the fulfilment of the right to health.

A. NATURE OF THE ENGAGEMENT

The principal conclusion that can be drawn is that Canada is a strong supporter of health rights in many (but not necessarily all) Anglophone African countries. This support has been demonstrated through its funding projects, aimed at advancing the right to health in its living form. In a similar manner, it may be argued that many Anglophone African countries have

[30] *Ibid*.
[31] Government of Canada, Global Affairs Canada, *Project Profile: Schools of Health Technology and Primary Health Care*, online: <w05.international.gc.ca/projectbrowser-banqueprojets/project-projet/details/a031272001>.

made substantial, albeit indirect, contributions to the advancement of state of health rights in Canada. This is by virtue of the exodus of health professionals from Anglophone African countries to Canada who often migrate in search of better working and living conditions. The presence of these health professionals has significantly increased the availability of highly trained health professionals in Canada to meet the needs of Canada's ageing population. Some, however, would strongly dispute that this is a form of engagement between Canada and the countries of Anglophone Africa.

B. ATTAINMENTS

In many respects, the engagement between Canada and countries of Anglophone Africa has been quite beneficial for both parties. On the part of Anglophone African countries, Canada has provided significant foreign assistance to meet critical infrastructural and other health needs have come from Canada. On the other hand, Canada has benefitted from a critical harvest of the highly-skilled health professionals that many countries of Anglophone Africa have to offer.

C. PROBLEMS

A key issue in the health relationship between Canada and countries of Anglophone Africa arises with the unsustainable nature of the massive exodus of health professionals from African states to Canada. This phenomenon is occurring at the expense of African health systems where the supply of well-trained health professionals that are working to stem the increasing burden of communicable and non-communicable diseases is already lacking. As the literature indicates, this is an area in which Canada may need to demonstrate greater leadership to chart a path towards addressing the pull-factors that incentivize health professionals to migrate out of Anglophone African countries.[32]

[32] Labonté, Packer & Klassen, *supra* note 24.

Secondly, a shortcoming of the engagement, as evidenced from the review undertaken this article, is that not every Anglophone African country has benefitted equally from this engagement. Health system-related challenges rank among the most critical areas of need for many Anglophone African countries – it is indeed a challenge that cuts across the entire continent. As such, engagements that encourage health promotion and disease prevention, are the most visible ways of fulfilling international responsibilities with respect to the right to health as espoused by the treaty framework.

Thirdly, a consistent and theoretically grounded basis appears to be missing for engagement in the area of health rights by Canada and Anglophone African countries. In order to derive better benefits for all parties involved in the engagement, a theoretically-grounded premise for this engagement needs to emerge. Having regard to the important work being done by the World Health Organization in pushing for "universal health coverage" as the premise for health system action in global community, there are a number of approaches that can be taken in this regard.[33] Canada and Anglophone African can ground their engagement in line with a vision for achieving universal health coverage as part of a larger strategy of fulfilling the right to health in their respective countries.

D. PROSPECTS

As a preliminary point, one can argue that there appears to be more positive than negative aspects that flow from the engagement between Canada and Anglophone African countries in the area of health rights. In setting an agenda for research in this area, it is necessary to identify ways in which Canada's contribution to Anglophone African countries can be better directed towards strengthening health institutions in these countries so that they may be able to serve more effectively as a first line of defense against epidemic and endemic diseases.

[33] World Health Organization, *The World Health Report – Health Systems Financing: The Path to Universal Coverage* (Geneva: World Health Organization, 2010) at 2, online: <apps.who.int/iris/bitstream/10665/44371/1/9789241564021_eng.pdf> [WHO, *World Health Report*].

This necessity exists against the backdrop of the Ebola Virus Disease outbreak in 2014 which affected Nigeria and other countries of the African continent. While Nigeria was able to stem the tide of the disease before many lives were lost, thanks to the vigilance, sacrifice, and experience of its health workforce, other countries that did not have the same "opportunity structures"[34] in their health system faired much worse and suffered significant loss of human lives. As Alicia Ely Yamin rightly observed in the context of the Ebola crisis, "…neither universal health *insurance*, without real access to public health as well as effective care, nor case transfers, without connections to functioning systems, would have thwarted Ebola or the social devastation it wreaked."[35]

Another issue that should perhaps feature prominently in a research agenda is the question of what Canada can do, by way of technical or financial support, to help Anglophone African countries meet universal health coverage targets set by member states of the WHO in 2005.[36] Three considerations are captured in the vision for universal health coverage by the *World Health Report 2010* that includes, namely: the health services that are needed, the number of people that need them, and the costs to whomever must pay (*i.e.* users and third party funders).[37] If Canada can shepherd its engagements with countries of Anglophone Africa in this direction, it is likely that the enjoyment of the right to health in these countries will be significantly enhanced.

[34] See Varun Gauri & Daniel M Brinks, eds, *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (New York: Cambridge University Press, 2008) at 4.
[35] Alicia Ely Yamin, "Ebola, Human Rights, and Poverty - Making the Links" *Open Democracy* (23 October 2014), online: <www.opendemocracy.net/openglobalrights-blog/alicia-ely-yamin/ebola-human-rights-and-poverty-%E2%80%93-making-links>.
[36] *Sustainable Health Financing, Universal Coverage and Social Health Insurance,* WHA Res 58.33, 9th Plen Mtg, Doc A58/20 (25 May 2005).
[37] WHO, *World Health Report*, *supra* note 33.