

2014

Millennium Development Goal 4, Children's Health and Implementation Challenges in Africa: Does A Human Rights Based Approach Suffice?

Obi Nnamuchi

Follow this and additional works at: <http://lawcommons.luc.edu/lucilr>

 Part of the [Health Law and Policy Commons](#), and the [International Law Commons](#)

Recommended Citation

Obi Nnamuchi *Millennium Development Goal 4, Children's Health and Implementation Challenges in Africa: Does A Human Rights Based Approach Suffice?*, 11 Loy. U. Chi. Int'l L. Rev. 103 (2014).

Available at: <http://lawcommons.luc.edu/lucilr/vol11/iss2/3>

This Feature Article is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in Loyola University Chicago International Law Review by an authorized administrator of LAW eCommons. For more information, please contact law-library@luc.edu.

MILLENNIUM DEVELOPMENT GOAL 4, CHILDREN'S HEALTH AND IMPLEMENTATION CHALLENGES IN AFRICA: DOES A HUMAN RIGHTS BASED APPROACH SUFFICE?

Obi Nnamuchi*

Every disadvantaged child bears witness to a moral offense: the failure to secure her or his rights to survive, thrive and participate in society. And every excluded child represents a missed opportunity – because when society fails to extend to . . . children the services and protection that would enable them to develop as productive and creative individuals, it loses the social, cultural and economic contributions they could have made.

– Anthony Lake: UNICEF Executive Director

As the 2015 deadline for the Millennium Development Goals draws closer, the challenge for improving . . . newborn health goes beyond meeting the goals; it lies in preventing needless human tragedy. Success will be measured in terms of lives saved and lives improved.

– Ann M. Veneman: Former UNICEF Executive Director

To look into some aspects of the future, we do not need projections by supercomputers. Much of the next millennium can be seen in how we care for our children today. Tomorrow's world may be influenced by science and technology; but more than anything, it is already taking shape in the bodies and minds of our children.

– Kofi A. Anan: Former UN Secretary-General

Abstract

That the state of children's health in Africa is abysmal is incontrovertible. Proof, if there is need for one, is the perennial underperformance of the vast majority of countries in the region in key dimensions of children's health and wellbeing. Nonetheless, the point of interest in health policy literature is not on the underperformance per se but on the underlying causes and possible antidotes – a reason Millennium Development Goal (MDG) 4 (on reducing child mortality) holds special significance for countries in the region. This paper advances scholarship in this very critical area by projecting human rights as holding the key that could unlock the suffocating stranglehold ill-health irrepressibly wields over the lives of millions of children in Africa.

* LLB (NAU, Nigeria), LLM (Notre Dame), MIL (Lund), LLM (Toronto), MA (Louisville, Kentucky), SJD (Loyola, Chicago).



Does a Human Rights Based Approach Suffice

I. introduction and preliminary background

The adoptions of the United Nations Convention on the Rights of the Child (“CRC”) in 1989¹ and the African Charter on the Rights and Welfare of the Child (“ACRWC”) the following year² were significant achievements in the global protection of the health and wellbeing of children throughout the world. Remarkably, the CRC has received more signatures, ratifications or accessions than any other human rights treaty – a total of 193 countries as of March 2014.³ The ACRWC has also been widely endorsed in Africa. With 42 of the 54 countries in Africa being signatories to the ACRWC (46 of them ratifying it),⁴ it is clear that vulnerability of children and the need for their protection is a commonly shared value in the region.⁵ Ratification binds these countries to, among other things, ensure the right of children in their respective jurisdictions to “the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.”⁶ As to how this goal would be attained, the CRC mandates States Parties to adopt appropriate legislative and administrative measures to diminish infant and child mortality, ensure the provision of necessary medical assistance and health care for all children, combat disease and malnutrition, and develop preventive care.⁷

¹ Convention on the Rights of the Child, G.A. Res. 44/25, U.N. GOAR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49, at 167 (Nov. 20, 1989) [hereinafter CRC]. The CRC is unique in more ways than one. Aside from being the most highly ratified human rights instrument, it entered into force sooner following adoption than any other treaty and it set a record in the number of States Parties that participated in the signing ceremony (60) amongst treaties adopted under the auspices of the United Nations. See THOKO KAIME, *THE AFRICAN CHARTER ON THE RIGHTS & WELFARE OF THE CHILD: A SOCIO-LEGAL PERSPECTIVE* 1 & n.2 (2009). See also Cynthia Price Cohen, *The United Nations Convention on the Rights of the Child: Implications for Change in the Care and Protection of Refugee Children*, 3 INT’L J. REFUGEE L. 675, 676 (1991).

² African Charter on the Rights and Welfare of the Child, July 11, 1990, OAU Doc. CAB/LEG/24.9/49 (entered into force Nov. 29, 1999) [hereinafter ACRWC].

³ *Status of Convention on the Rights of the Child*, UNITED NATIONS TREATY COLLECTION (Mar. 24, 2014, 8:03 PM), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en; see UNICEF, *THE STATE OF THE WORLD’S CHILDREN 2012: CHILDREN IN AN URBAN WORLD* 16 (2012) (listing Somalia, South Sudan and the United States of America as the only nations that have not ratified the treaty).

⁴ See AFRICAN COMM. OF EXPERTS ON THE RIGHTS OF THE CHILD, LIST OF COUNTRIES WHICH HAVE SIGNED, RATIFIED/ACCEDED TO THE AFRICAN UNION CONVENTION ON THE RIGHTS AND WELFARE OF THE CHILD, available at <http://acerwc.org/wp-content/uploads/2011/03/French-and-English-ACERWC-Updated-Status-of-the-ACRWC.pdf>.

⁵ ACRWC, *supra* note 2, para. 4, 6 (noting “that the situation of most African children remains critical due to the unique factors of their socio-economic, cultural, traditional and developmental circumstances, natural disasters, armed conflicts, exploitation and hunger, and on account of the child’s physical and mental immaturity he/she needs special safeguards and care” and recognizing “that the child, due to the needs of his physical and mental development requires particular care with regard to health, physical, mental, moral and social development, and requires legal protection in conditions of freedom, dignity and security.”).

⁶ Convention on the Rights of the Child, *supra* note 1, art. 24, para. 1; ACRWC, *supra* note 2, art. 14, para. 1.

⁷ Convention on the Rights of the Child, *supra* note 1, art. 24, para. 2; ACRWC, *supra* note 2, art. 14, para. 2.



Does a Human Rights Based Approach Suffice

This vital human rights obligation closely mirrors the commitment explicit in Millennium Development Goal (“MDG”) 4, to reduce child mortality or, more specifically, to “[r]educe by two-thirds, between 1990 and 2015, the under-five mortality rate” (“U5MR”).⁸ In fact, it can be said that MDG 4 is encapsulated within the CRC and ACRWC obligations and, on that basis, can be construed as a policy reformulation of extant legal obligations. But there are differences. In contrast to these treaties, there are time constraints and measurable targets attached to MDG 4.⁹ Moreover, MDG 8 – to develop a global partnership for development – is a multilateral compact between affluent and low income nations explicitly demanding action from the former to facilitate the latter’s progress toward meeting their MDG obligations, making MDG 8 (and other MDGs) unique in international development relations.¹⁰ Strikingly, neither the CRC nor the ACRWC has such financial teeth.

Given this disparity, the question that arises is whether this advantage or the new commitment itself has resulted in better health for children in the region? Or, rather, does MDG 4 hold potential for improving the health of African children? What is the current situation and what are the factors sustaining the status quo? What strategies and initiatives are needed in order to position the region toward meeting the targets and benchmarks of the MDGs? These are some of the critical questions that are confronted in this paper.

This paper consists of five sections. Following the introduction, Part II of this paper considers the state of infant and child health in Africa. By examining recent data on key indicators relating to children’s health such as the U5MR, infant mortality rate (“IMR”), and proportion of 1 year-old children immunized against measles, the section shows that the state of health of children in the region is abysmal and in urgent need of remedial measures. In Part III, the paper explores critical challenges militating against securing the health of African children. Its

⁸ U.N. STATISTICS DIV., OFFICIAL LIST OF MDG INDICATORS (2008), available at <http://unstats.un.org/unsd/mdg/Resources/Attach/Indicators/OfficialList2008.pdf>.

⁹ See *id.* Aside from the target of reducing by two-thirds, between 1990 and 2015, the U5MR, there are three indicators or benchmarks that were designed to assess country progress (or lack thereof) toward the goal, namely, U5MR, the infant mortality rate, and the proportion of one-year-old children immunized against measles. See *id.* These are the crucial tools that will be employed in determining whether the MDG will be attained in 2015. See *Id.*

¹⁰ WORLD HEALTH ORG., HEALTH AND THE MILLENNIUM DEVELOPMENT GOALS 63 (2005). Subsequent multilateral agreements attest to the obligatory dimension of assistance toward achieving the MDGs. For instance, signatories to The Global Compact for Achieving the Health Millennium Development Goals, adopted under the auspices of the International Health Partnership in 2007, explicitly commit themselves to be held accountable “in implementing this compact” and to hold an annual meeting for the purpose of reviewing progress against the commitments. See International Health Partnership, *A Global ‘Compact’ for Achieving the Health Millennium Development Goals*, WORLD HEALTH ORG. (Sept. 5, 2007), http://www.who.int/healthsystems/IHP_compact.pdf. See also Obiajulu Nnamuchi & Simon Ortuanya, *The Human Right to Health in Africa and its Challenges: A Critical Analysis of Millennium Development Goal 8*, 12 AFR. HUM. RTS. L. J. 198 (2012); The Accra High Level Forum, *The Accra Agenda for Action on Aid Effectiveness*, (2008), <http://www.ppdafira.org/docs/accra.pdf>; Fourth High Level Forum on Aid Effectiveness, *The Busan Partnership for Effective Development Co-operation*, (2011), <http://www.oecd.org/dac/effectiveness/49650173.pdf>; United Nations High-level Event on the Millennium Development Goals, July 25, 2008, *Committing to Action: Achieving the Millennium Development Goals*, ¶ 1 (Sept. 25, 2008), available at <http://www.un.org/millenniumgoals/2008highlevel/pdf/committing.pdf>.



Does a Human Rights Based Approach Suffice

focus is on five factors it considers paramount: early or child marriage, maternal illiteracy, parental poverty, dearth of skilled health professionals, and institutional poverty and leadership deficit. The section also enumerates a number of interventions it projects as holding the key to reversing the trend and positioning the region toward attaining MDG 4. While not claiming that the list is exhaustive of the factors militating against health of children in the region, it argues that they are the most vital, and addressing them via the interventions identified is indispensable to success. Part IV casts challenges in the realm of children's health as human rights issues and posits that a human rights based approach is foundational to any sustainable eradication program. Specifically, the section demonstrates the inextricable relationship between human rights and children's health, contending that the indivisibility and interdependence paradigm invites a comprehensive and multifaceted response to the health quandary in Africa. In other words, other needs that are linked with the health of children, such as maternal health and literacy, must receive priority attention in policy frameworks designed to catapult nations in the region toward attaining the objectives of MDG 4. The conclusion – Part V – rejects resource constraints as explanatory of the dismal state of children's health in Africa; instead, it identifies what it calls “political cabalism” as the main culprit. Relying on the pro-poor vision of Pope Francis, it calls upon the citizenry to jettison docility and demand good governance as a human right.

ii. state of infant and child health in Africa

Examining the state of infant and child health in Africa involves making one critical assessment – determining whether progress has been made or is being made on three crucial fronts, namely, (i) U5MR, (ii) IMR and (iii) proportion of 1 year-old children immunized against measles. These are the indicators for monitoring progress toward MDG 4. In other words, the indicators are proxies for assessing the health status of infants and children within particular health systems or jurisdictions. Positive numbers in any of these three areas indicate progress and, of course, the reverse is equally true. So, how are countries in Africa faring?

In all these key areas, sub-Saharan Africa is not on par with other regions. Not only does the region account for 38 percent of neonatal deaths globally and the highest neonatal mortality rate (34 deaths per 1,000 live births in 2010), it remains the region with the least improvement over the last two decades, a record it shares with Oceania.¹¹ In 2011, there were 24 countries with an U5MR above 100 deaths per 1,000 live births, 23 of them in sub-Saharan Africa.¹² Even worse, one in every nine children born in the region dies before age five.¹³ The U5MR in Africa, at 107 deaths per 1,000 live births, is astronomically high in

¹¹ U.N. DEP'T OF ECON. & SOC. AFFAIRS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 2013 26, U.N. Sales No. E.13.I.9 (2013), available at <http://www.un.org/millenniumgoals/pdf/report-2013/mdg-report-2013-english.pdf> [hereinafter U.N. MDG REPORT 2013].

¹² *Id.* at 25.

¹³ *Id.*

Does a Human Rights Based Approach Suffice

comparison to other regions; America and Europe suffer just 16 and 13 deaths per 1,000 live births, respectively.¹⁴

But the region has also witnessed some progress. Although not by any means contained, the region's U5MR is on a downward trend. From 175 per 1,000 live births in 1990, the U5MR declined to 153 in 2000, and even further to its current level of 107.¹⁵ The IMR is also falling; it now stands at 68 deaths per 1,000 live births, compared to 106 in 1990.¹⁶ Disaggregated figures reveal a deep gulf between the performances of individual countries. The U5MR in Botswana plummeted from 53 deaths per 1,000 live births in 1990 to 26 in 2011, and its IMR fell from 41 in 1990 to 20 in 2011.¹⁷ Some nations have fared even better. Liberia has cut its U5MR at least two-thirds since 1990 whereas Ethiopia, Madagascar, Malawi, Niger, and Rwanda have achieved reductions of at least 60 percent.¹⁸ But although Sierra Leone also showed some progress, its U5MR having dropped from 267 in 1990 to 185 in 2011 and IMR declining from 158 in 1990 to 119 in 2011, the numbers are still unacceptably high.¹⁹ High mortality among children in Africa is rooted in several factors, including malnutrition,²⁰ pneumonia, diarrhea, malaria, under-nutrition, and measles.²¹

A critical issue worth noting is that most of these conditions and pathologies are easily preventable and treatable and yet, inexplicably, have continued to ravage the lives of children in the region. The fact that Africa leads the rest of the world in child morbidity and mortality powerfully demonstrates a lack of capacity to take appropriate remedial actions which, in most cases, is the direct result of unwillingness to commit resources that would strengthen health systems in the region and enable them to swiftly respond to the needs of this vulnerable segment of society.²² This is a governance issue. It is less taxing to explain malnutrition of children in countries prone to climatic vagaries (droughts in particular) such as Niger²³ and Ethiopia²⁴ than in the vast majority of countries, which are dissimilarly situated. Still, 31 percent of children less than five years old in Africa were

¹⁴ WORLD HEALTH ORG., WORLD HEALTH STATISTICS 2013 59 (2013) [hereinafter WORLD HEALTH STATISTICS 2013].

¹⁵ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 59.

¹⁶ *Id.*

¹⁷ *Id.* at 51.

¹⁸ U.N. MDG REPORT 2013, *supra* note 11, at 25.

¹⁹ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 57.

²⁰ African Union, *The African Health Strategy: 2007 – 2015, Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa*, ¶ 9, CAMH/MIN/5(III) (2007) [hereinafter *The African Health Strategy*] (reporting that in some parts of Africa, malnutrition accounts for as much as 60 percent of deaths of children less than five).

²¹ U.N. MDG REPORT 2013, *supra* note 11, at 26.

²² U.N. MDG REPORT 2013, *supra* note 11, at 24 (reporting that one in nine children in sub-Saharan Africa die before age five, more than 16 times the average for developed regions).

²³ *Niger Drought Leaves Millions on the Brink of Starvation*, HUFFINGTON POST (June 9, 2010, 2:15 PM), http://www.huffingtonpost.com/2010/06/09/niger-drought-leaves-mill_n_606085.html (reporting that as a result of severe drought in Niger, almost half of the country's population of 15 million are battling malnutrition, three million of them on the brink of starvation).

Does a Human Rights Based Approach Suffice

underweight in 1990; that number marginally improved to 27 percent in 2008.²⁵ Although recent data shows further decline to 21 percent, the number is still unjustifiably high, as there are 30 million underweight children in sub-Saharan Africa.²⁶ Thus, like other easily surmountable challenges in Africa, being underweight (the inevitable result of malnutrition or undernourishment) continues to pose a major threat to children's health in the region.²⁷ The cure is simple – adequate nutrition.²⁸ It is one that cannot elude any responsible government, in Africa or elsewhere. Yet, in what is best described as an ironic twist of fate, undernourishment remains a stark reality in many households despite the fact that 60 percent of the world's uncultivated arable land is in Africa.²⁹

Aside from the high number of underweight children, there is also the problem of measles. Measles are easily and cheaply preventable with timely inoculation but remain a pervasive killer disease in several African countries. Together with Southern Asia, sub-Saharan Africa accounts for 90 percent of all measles deaths globally.³⁰ And notwithstanding affordability (the cost of measles vaccination is a paltry \$1),³¹ weak health systems and institutional misprioritization combine to deny this life-saving measure to millions of children in the region. Obviously, accelerating the pace of immunization coverage is possible with stronger political and financial commitment in countries lagging behind.³² But whether this commitment will be made is a different question altogether. True, the rate of immunization against measles is increasing but not at a fast enough pace to annihilate the menace posed by the disease any time soon.³³

Measles immunization coverage for one-year-old children in Africa is lower than in any other part of the world, at 75 percent, compared to 92 and 94 percent respectively in the Americas and Europe.³⁴ There are also wide differences amongst countries. Seven countries in the region – Seychelles, Mauritius, Malawi, Cape Verde, Eritrea, Rwanda, and Swaziland – achieved coverage rates

²⁴ Luc Van Kemenade, *Ethiopia: Hunger during Worst Drought in 60 Years*, HUFFINGTON POST (Aug. 17, 2011, 12:03 PM), http://www.huffingtonpost.com/2011/08/17/ethiopia-hunger-drought_n_928989.html (blaming severe drought for rising number of people, up to 700,000, in need of food aid).

²⁵ U.N. DEP'T OF ECON. & SOC. AFFAIRS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 2010 13, U.N. Sales No. E.10.I.7 (2010), available at <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf>. Only Southern Asia fares worse. *Id.*

²⁶ U.N. MDG REPORT 2013, *supra* note 11, at 11.

²⁷ The African Health Strategy, *supra* note 20, ¶ 9.

²⁸ See UNICEF, *State of the World's Children 2009: Maternal and Newborn Health*, at iii, U.N. Sales No. E.09.XX.1 (2009).

²⁹ J. O'S., *Farming in Africa: Cold Comfort Farms*, THE ECONOMIST (Sept. 4, 2013, 6:10 PM), <http://www.economist.com/blogs/baobab/2013/09/farming-africa>.

³⁰ U.N. MDG REPORT 2013, *supra* note 11, at 27.

³¹ *Measles Pre-Elimination*, WORLD HEALTH ORG., (<http://www.afro.who.int/en/clusters-a-programmes/mte/measles-pre-elimination.html>) (last visited Mar. 31, 2014).

³² U.N. MDG REPORT 2013, *supra* note 11, at 27.

³³ See *id.* (noting that as of 2011, 74 percent of children in sub-Saharan Africa had received at least one dose of measles-containing vaccine compared to 53 percent in 2000).

³⁴ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 104.

Does a Human Rights Based Approach Suffice

of 95 to 99 percent in 2011.³⁵ Others do not fare as well. Chad, for instance, managed to provide coverage to just 28 percent of children within its territory.³⁶ Still another menace is malaria. Children can be protected from this disease by increasing ownership and use of insecticide-treated mosquito nets; and where prevention fails, by treatment with appropriate anti-malaria therapy.³⁷ On these two counts, progress has been slow.³⁸ But there are other factors obstructing the march toward optimal health for infants and children in Africa.

iii. key challenges and necessary interventions

The abysmal state of infant and child health in the vast majority of countries in Africa is a strident testament to the multifarious nature of the difficulties confronting the region. Akin to maternal health in Africa,³⁹ there is never a shortage of challenges in the realm of children's health. What is lacking – critically, in some cases – is the means, or rather the will, to surmount these difficulties. Indeed, even in affluent regions of Europe and North America, lingering resource constraints remain the primary bane to complete victory, in the sense of universal access to health care and availability of social health determinants. Nonetheless, the near total inertia in deploying the kind of resources needed to lessen the health burden on the citizenry in Africa is not explained solely on the basis of finite resources. Even amidst scarcity, there are a number of resource-friendly, low cost interventions that could have enormous remedial impact but have, inexplicably, been relegated to the back burner. In many cases, what political leadership in the region unabashedly packages and sells to the global community as “resource constraints” is nothing more than evidentiary of governance vacuum in the region. To put it differently, the atrocious state of the health of children in sub-Saharan Africa is the direct result of the failure of various governments in the region to meet their obligations to children and the rest of the population.

There are, of course, multiple areas of difficulty in protecting children's health in Africa but, for the sake of brevity, this section focuses on the major ones, namely, early marriage, maternal illiteracy, parental poverty, unavailability of skilled health personnel, institutional poverty, and leadership void in the region.

(i) *Early Marriage*

A statement credited to an organization whose professed mission centers on women empowerment, advancing gender equality, and fighting poverty in the developing world aptly summarizes the circumstances surrounding early or child marriage in many third world countries:

³⁵ *Id.* at 95-102.

³⁶ *Id.* at 96.

³⁷ Obiajulu Nnamuchi, *Millennium Development Goal 6 and the Trifecta of HIV/AIDS, Malaria and Tuberculosis in Africa: A Human Rights Analysis*, 40 *DENV. J. INT'L L. & POL'Y* (forthcoming 2014).

³⁸ *Id.*

³⁹ See Obiajulu Nnamuchi, *Millennium Development Goal 5, Human Rights, and Maternal Health in Africa: Possibilities, Constraints and Future Prospects*, 23 *ANNALS HEALTH L.* 92, 97 (discussing the challenges Africa is confronting in its effort to attain MDG 5 and suggesting remedial measures).



Does a Human Rights Based Approach Suffice

Child marriage most often occurs in poor, rural communities. In many regions, parents arrange their daughter's marriage unbeknownst to the girl. That can mean that one day, she may be at home playing with her siblings and the next, she's married off and sent to live in another village with her husband and his family – strangers, essentially. She is pulled out of school. She is separated from her peers. And once married, she is more likely to be a victim of domestic violence and suffer health complications associated with early sexual activity and childbearing.⁴⁰

This is not a uniquely African problem. Instead, it is a challenge confronting many countries in poorer regions of the world. In fact, Africa is not the worst affected. A study on women aged 15 to 24 reveals that in South Asia, 48 percent (equivalent to 9.7 million girls) were married before reaching 18 years old whereas in African and the Caribbean, the figures are 42 and 29 percent respectively.⁴¹ Although the rate is high in Africa, disaggregated figures show that the numbers are unevenly spread amongst countries in the region, ranging from as low as 8 percent in South Africa to as high as 77 percent in Niger.⁴²

The geographic prevalence of this practice suggests a causal link with poverty. The regions implicated in this menace are poorer than the rest of the world. In fact, cross country analysis shows the practice to be most prevalent among the poorest 20 percent of the population.⁴³ Thus, it is no coincidence that the African country in which the practice is most common, Niger,⁴⁴ ranks amongst the poorest in the world,⁴⁵ as do Chad⁴⁶ and Mali,⁴⁷ two other nations with high rates of child marriage.⁴⁸ A useful way to evaluate the link between poverty and child marriage is to see the latter as a consequence of the former, a symptom of a much deeper social pathology. In every country where early marriage is common, poverty is a perpetuating factor.⁴⁹ And just as a therapeutic intervention targeting

⁴⁰ *Child Marriage*, INTERNATIONAL CENTER FOR RESEARCH ON WOMEN, <http://www.icrw.org/what-we-do/adolescents/child-marriage> (last visited Mar. 31, 2014).

⁴¹ UNICEF, *EARLY MARRIAGE: A HARMFUL TRADITIONAL PRACTICE 4* (2005), available at http://www.unicef.org/publications/files/Early_Marriage_12.lo.pdf [hereinafter *EARLY MARRIAGE: A HARMFUL TRADITIONAL PRACTICE*].

⁴² *Id.* at 4 (limiting the study to women aged 20–24 married by the exact age of 18).

⁴³ *Early Marriage: A Harmful Traditional Practice*, *supra* note 41, at 6, 12.

⁴⁴ *Id.* at 4.

⁴⁵ UNDP, *HUMAN DEVELOPMENT REPORT 2013: THE RISE OF THE SOUTH: HUMAN PROGRESS IN A DIVERSE WORLD* 161 (2013) (reporting that 43.6 percent of the population lives below the international poverty line, on less than \$1.25 per day).

⁴⁶ *See id.* (Reporting that nearly 62 percent of the population lives below the poverty line).

⁴⁷ *See id.* (Finding that 50.4 percent of the population lives below the poverty line).

⁴⁸ *See EARLY MARRIAGE: A HARMFUL TRADITIONAL PRACTICE*, *supra* note 41, at 4 (reporting that nearly 72 and 66 percent of women aged 20 – 24 in Mali and Chad respectively were married at exact age of 18, third and second worst in Africa, after Niger).

⁴⁹ UNICEF Innocenti Research Centre, *Early Marriage: Child Spouses* INNOCENTI DIG. 1, 1 (Mar. 2001), available at <http://www.unicef-irc.org/publications/pdf/digest7e.pdf> [hereinafter *Early Marriage: Child Spouses*] (citing economic considerations as a factor prompting parents to submit their under-age children to marriage and using the term “economic arrangement” to describe the process). *See also* Robert Jensen & Rebecca Thornton, *Early Female Marriage in the Developing World*, 11 *GENDER & DEV.* 17 (2003) (citing high cost of raising children as a reason parents marry off their daughters quite early).



Does a Human Rights Based Approach Suffice

symptomatic manifestations of an illness, in isolation of the underlying pathology, is bound to fail, efforts at eliminating the menace of early marriage risk failing in the absence of incorporating credible and sustainable antipoverty strategies in eradication frameworks. This is a lesson that needs to be imbibed by countries committed to meeting its MDG obligations relating to child health, in Africa and elsewhere.

Aside from economic difficulties, there are other factors contributing to high rates of child marriage in affected countries, including tradition, family honor, sexual purity, and out-of-wedlock pregnancy protection strategy.⁵⁰ There is no gainsaying that these rationales are sensible. Reasonable persons would agree that sexual purity is a moral value parents should desire for their children. The same is true, at least in conservative societies, of the need to protect young girls from premarital pregnancy. Nevertheless, these seemingly well-grounded rationales would quickly evaporate when weighed against the adverse consequences that would inevitably befall these children on account of early marriage.

There are several deleterious consequences resulting from early marriage. These problems may be subsumed under a number of headings such as physical violence, adverse health consequences, psychological, emotional, and human rights abuses. The key to understanding the health risks of early marriage is to pay attention to the end result: early or teenage pregnancy, which in itself is an adverse health factor.⁵¹ The younger a girl is at the time of pregnancy, the greater the health risk for the baby and herself.⁵² Teenagers are more likely than adult women to die as a result of childbirth or other pregnancy-related complications.⁵³ Pregnant girls who are fifteen years or younger are five times more likely to die during childbirth than women in their twenties.⁵⁴ Furthermore, children begotten by mothers aged less than eighteen years have a 60 percent greater chance of dying within their first year of birth than those born to mothers who are above eighteen.⁵⁵ High rates of mortality resulting from these circumstances demonstrate the seriousness of the challenges posed by child marriage. Alarmingly, despite the fact that of all maternal deaths amongst teenagers fifteen to nineteen years old, 70,000 annually are associated with early pregnancy (the inevitable consequence of early marriage),⁵⁶ 42 percent, of the girls in Africa are married before they turn eighteen.⁵⁷

⁵⁰ *Early Marriage: Child Spouses*, *supra* note 49, at 2.

⁵¹ UNICEF, *THE STATE OF THE WORLD'S CHILDREN 2009: MATERNAL AND NEWBORN HEALTH*, at iii, U.N. Sales No. E.09.XX.1 (2009).

⁵² *Id.*

⁵³ DEP'T OF ECON. & SOC. AFFAIRS OF THE U.N. SECRETARIAT, *THE MILLENNIUM DEVELOPMENT GOALS REPORT*, at 28, U.N. Sales No. E.09.I.12 (2009), available at http://www.un.org/millenniumgoals/pdf/MDG_Report_2009_ENG.pdf.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*; UNICEF, *THE STATE OF THE WORLD'S CHILDREN 2009*, *supra* note 51, at iii.

⁵⁷ UNICEF, *EARLY MARRIAGE A HARMFUL TRADITIONAL PRACTICE 4* (2005), available at http://www.unicef.org/publications/files/Early_Marriage_12.lo.pdf.



Does a Human Rights Based Approach Suffice

Obstetric fistula – perforation in a woman’s birth canal from prolonged obstructed labor which leaves her incontinent – is yet another harmful consequence of early marriage. Aptly described as “Africa’s silent epidemic,”⁵⁸ the condition disproportionately affects pregnant girls.⁵⁹ Evidence of causal relationship between child marriage and obstetric fistula is provided by the fact that the condition is more prevalent in areas where child marriage is common.⁶⁰ In Nigeria, for instance, there is greater prevalence of the condition in the less developed northern part of the country, the same area with the highest number of child marriages.⁶¹ An often glossed over misconception is that there is a causal link between female circumcision and obstetric fistula.⁶² This is false. There is a great amount of credible scientific evidence that debunks this claim.⁶³ Tackling obstetric fistula involves adopting policies aimed at preventing early pregnancy, abolition of harmful traditional practices (such as self-delivery or use of the services of unskilled traditional birth attendants), improving access to prenatal services and promoting access to timely obstetric care.⁶⁴

Another stark reality of early marriage is inter-spousal or domestic violence, “a major contributing factor to the ill-health of women”⁶⁵ and one of the most insidious forms of gendered violence.⁶⁶ Aside from the degrading nature and cruelty, which are its defining features, the indignity, disability, fatality, and other forms of harm that result when women suffer violence at the hands of their husbands make it a human rights issue.⁶⁷ Although domestic violence cuts

⁵⁸ Alan White, *Obstetric Fistula: Africa’s Silent Epidemic*, NEWSTATESMAN, (July 4, 2013, 11:08 AM), <http://www.newstatesman.com/world-affairs/2013/07/obstetric-fistula-africas-silent-epidemic>.

⁵⁹ L. Lewis Wall, et al., *The Obstetric Vesicovaginal Fistula: Characteristics of 899 Patients from Jos, Nigeria*, 190 AM. J. OBSTET. GYNECOL. 1011–1016 (2004); D.P. Ghatak, *A Study of Urinary Fistulae in Sokoto, Nigeria*, 90 J. INDIAN MED. ASSOC. 285-287 (1992).

⁶⁰ UNFPA & ENGENDER HEALTH, *OBSTETRIC FISTULA NEEDS ASSESSMENT REPORT: FINDINGS FROM NINE AFRICAN COUNTRIES* 58 (2003), available at <http://www.unfpa.org/fistula/docs/fistula-needs-assessment.pdf>.

⁶¹ *Id.*

⁶² White, *supra* note 58.

⁶³ Birgitta Essén et al., *Is There an Association Between Female Circumcision and Perinatal Death?*, 80 BULL. WORLD HEALTH ORG. 629, 630 (2002) (finding that none of the perinatal deaths in study was related to circumcision); Andrew Browning et al., *The Relationship Between Female Genital Cutting and Obstetric Fistulae*, 115 OBSTET. GYNECOL. 578, 580-82 (2010) (reporting absence of causality between FGR and obstetric fistulae); Amber Peterman & Kiersten Johnson, *Incontinence and Trauma: Sexual Violence, Female Genital Cutting and Proxy Measures of Gynecological Fistula*, 68 SOC. SCI. & MED. 971-79 (2009) (finding that there is no association between genital cutting and fistula formation from obstructed labor).

⁶⁴ *10 Facts on Obstetric Fistula*, WORLD HEALTH ORG. (Mar. 2010), http://www.who.int/features/factfiles/obstetric_fistula/en/index.html.

⁶⁵ WORLD HEALTH ORG., *WHO MULTI-COUNTRY STUDY ON WOMEN’S HEALTH & DOMESTIC VIOLENCE AGAINST WOMEN: INITIAL RESULTS ON PREVALENCE, HEALTH OUTCOMES AND WOMEN’S RESPONSES* vi (2005) [hereinafter *WHO MULTI-COUNTRY STUDY*].

⁶⁶ U.N. Comm. on the Elimination of Discrimination Against Women, *General Recommendation 19, Violence Against Women*, 1, U.N. Doc. A/47/38 (1992), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, 243 ¶ 23, U.N. Doc. HRI/GEN/1/Rev.6 (2003) [hereinafter *General Recommendation 19*].

⁶⁷ WHO MULTI-COUNTRY STUDY, *supra* note 65, at 15 (noting the rate of injury amongst women who were ever-abused women in the countries studied as ranging from nineteen to fifty-five percent, with



Does a Human Rights Based Approach Suffice

across all ages, affecting women throughout their life cycle, from birth through death, younger women are disproportionately impacted.⁶⁸ Unlike women who were married as adults, child brides are typically much younger than their husbands, in some cases by ten or more years, – the so-called husband-wife age gap.⁶⁹ Unequal relationships fostered by such gaps, including a difference in physical strength, means that child brides are more prone to violence than older and invariably more experienced women. Moreover, women who married at younger ages are more likely not only to accept that it is justifiable for a husband to beat his wife, but also to have experienced physical violence.⁷⁰ In a recent study, 62 to 67 percent of women who were married before the age of fifteen approve of wife battery by husband under certain circumstances, compared to 36 to 42 percent of women who married between the ages of twenty-six and thirty.⁷¹ This is troubling. According to a WHO study, women who had experienced spousal abuse are more likely to accept the conduct as normal compared to those who had not.⁷²

The danger in such widespread acceptance or normalization is that it accentuates the vulnerability of such women by rendering them more susceptible to future physical abuse since one cannot accept a particular conduct as normal and subsequently turn around to challenge it.⁷³ An informant, who was once herself a victim, seems to be echoing the same point in this response to an interviewer's questions: "I suffered for a long time and swallowed all my pain. That's why I am constantly visiting doctors and using medicines. No one should do this."⁷⁴ Obviously, this is an outcome no prudent person would endorse. It is also one that calls for urgent action. For countries interested in tackling this challenge, a productive starting point would be to reexamine their human rights commitments to women.

some sustaining serious injuries such as broken bones, injuries to ears and eyes and asserting that poor health is more prevalent amongst women who had experienced domestic violence compared to those who had not). See also African Comm'n on Human and Peoples' Rights, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, pmb. ¶ 9, art(s). 1(j), 3, 4, 5(d), 11(3), 22(b), 23(b), Sept. 13, 2000, CAB/LEG/66.6 [hereinafter Maputo Protocol], reprinted in 1 AFR. HUM. RTS. L.J. 40 (calling, in line with the African Platform for Action and the Dakar Declaration of 1994 and the Beijing Platform for Action of 1995, upon States to "take concrete steps to give greater attention to the human rights of women in order to eliminate all forms of discrimination and of gender-based violence against women"). See also Convention on the Elimination of All Forms of Discrimination Against Women art(s). 2(f), 3, 5, 6, 10(c), 11, 12, 14, 16, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW]; *General Recommendation 19*, supra note 66, ¶¶ 1 – 11, 23, 24.

⁶⁸ WHO MULTI-COUNTRY STUDY, supra note 65, at 8 (reporting that girls aged fifteen to nineteen are at higher risk of violence from their partners).

⁶⁹ Robert Jensen & Rebecca Thornton, *Early Female Marriage in the Developing World*, 11 GENDER DEV. 9, 13 – 14 (2003) (finding that women who marry at a young age are more likely to marry older men).

⁷⁰ *Id.* at 16.

⁷¹ *Id.*

⁷² WHO MULTI-COUNTRY STUDY, supra note 65, at 10.

⁷³ WHO MULTI-COUNTRY STUDY, supra note 65, at 19 (finding that twenty-nine to eighty-six percent of respondents in the country studied cited, as the most common reason given for not seeking help, their perception of the violence as normal or not serious).

⁷⁴ WHO MULTI-COUNTRY STUDY, supra note 65, at 16.



Does a Human Rights Based Approach Suffice

Both the Maputo Protocol and the Convention on the Elimination of All Forms of Discrimination against Women (“CEDAW”),⁷⁵ to which many countries in Africa are States Parties, explicitly prohibit discrimination in all facets of life, including domestic violence, and additionally require the adoption of “appropriate legislative, institutional and other measures” to achieve this purpose.⁷⁶ Compliance with these provisions would include awareness campaigns, sensitization on the dangers of domestic violence, swift prosecution and punishment of offenders, and the empowerment of women by effacing obstacles to acquiring education and boosting independent ownership of resources.

Apart from domestic violence, there are still several other human rights issues inhering in children who are imperiled by early marriage. Some of these rights are freedom of association,⁷⁷ right to movement,⁷⁸ right to education,⁷⁹ and freedom of religion.⁸⁰ Betrothal and marriage of children infringe upon these rights by fostering inequality in the marital relationship.⁸¹ The age, experience, socio-economic and other differences between teenage wives and their husbands skew power dynamics to the advantage of husbands, an unfair advantage that is traditionally exploited by the latter.⁸² Evidence of this exploitation is found in restrictions imposed upon child-wives regarding their movement,⁸³ with whom they may associate,⁸⁴ denial of educational opportunities (those already in school are usually withdrawn), and forcible adoption of the religion of their husbands.

At the root of all these infractions is a breach of two crucial human rights at the time of the marriage: autonomy⁸⁵ and consent.⁸⁶ Although parents tend to

⁷⁵ CEDAW, *supra* note 67, art. 2.

⁷⁶ *Id.*; Maputo Protocol, *supra* note 67, art. 2(1).

⁷⁷ Int’l Covenant on Civil & Political Rts. art. 22(1), Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976); Org. of African Unity, African Charter on Hum. & Peoples’ Rts. art. 10, OAU Doc. CAB/LEG/67/3 rev. 5 (June 27, 1981) (entered into force Oct. 21, 1986).

⁷⁸ Int’l Covenant on Civil & Political Rts., *supra* note 77, art. 12; African Charter on Hum. & Peoples’ Rts., *supra* note 77, art. 12.

⁷⁹ Int’l Covenant on Econ., Soc. & Cultural Rts. art. 13, Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976); African Charter on Hum. & Peoples’ Rts., *supra* note 77, art. 17.

⁸⁰ Int’l Covenant on Civil & Political Rts., *supra* note 77, art. 18; African Charter on Hum. & Peoples’ Rts., *supra*, note 77, art. 8.

⁸¹ Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) , art. 16(1) (Dec. 10, 1948) (“Men and women of full age . . . have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.”).

⁸² Robert Jensen & Rebecca Thornton, *Early Female Marriage in the Developing World*, 11 GENDER DEV. 9, 14 (2003).

⁸³ *Id.* (noting that seventy percent of women who marry under the age of fifteen in India are required by their husbands to obtain permission before they could go to market, or to visit family or friends).

⁸⁴ *Id.*

⁸⁵ Jensen & Thornton, *supra* note 82 (reporting, as an instance of greater susceptibility to breach of autonomy, that forty-three percent of women who marry before the age of fifteen and thirty-five percent of those marrying before twenty, are not allowed to keep money, compared to only twenty-one to twenty-five percent of those who marry when they are twenty-one or older).

⁸⁶ Universal Declaration of Hum. Rts., *supra* note 81, art. 16(2) (“Marriage shall be entered into only with the free and full consent of the intending spouses”); Convention on Consent to Marriage, Minimum Age for Marriage & Registration of Marriages art. 1, Dec. 9, 1964, 521 U.N.T.S. 231 (stating that “no marriage shall be legally entered into without the full and free consent of both parties. . .”); Int’l Cove-

Does a Human Rights Based Approach Suffice

arrogate to themselves the power of proxy consent in child marriage, this is legally as well as ethically wrong. It is an illegitimate usurpation of the right of the child. Even though surrogacy powers generally inhere in parents in circumstances where the child lacks capacity to understand the nature and consequences of the act in question, such proxy powers must be exercised to advance the interests of the child. The power is nullified when its exercise, as in child marriage, jeopardizes the health and wellbeing of the child.⁸⁷ Moreover, as argued elsewhere:

While, for very good reasons, parents enjoy wide latitude in determining and pursuing interests they consider congruent with the well-being and security of their children, they are, nonetheless, not at liberty to make decisions that would detrimentally impact the children . . . Under normal circumstances, the court would step in to protect the right of parents to raise their children according to the dictates of their . . . conscience . . . The best interest of the children is always the guiding principle . . . On the other hand, where there is evidence that this right has been or is at the risk of being abused, the court will step in to protect the children . . . In other words, the right of parents to raise their children is not absolute . . . It may be abridged where non-intervention by the State will expose the child to unnecessary risk or harm.⁸⁸

Since marriage contracted in absence of true consent harbors deleterious consequences for teenage wives, it may be argued, following the reasoning in *Prince v. Massachusetts*,⁸⁹ that parental consent obtained in such cases is suspect and should be abrogated. The exposure to or potential for harm is the critical and decisive consideration. In this sense, child marriage, regardless of the so-called parental consent, is tantamount to forced marriage, which is a breach of autonomy.

One of the dark sides of this kind of marriage is that it strips the wife of decision-making powers, even those that are health-related, and vests the same

nant on Econ., Soc. & Cultural Rts., *supra* note 79, art. 13; African Charter on Hum. & Peoples' Rts., *supra* note 77, art(s). 17, 23 (stipulating that "[m]arriage must be entered into with the free consent of the intending spouses."); CEDAW, *supra* note 67, art. 16 (recognizing equality in men and women in respect to entering into marriage with free and full consent as well as the same rights and responsibilities in marriage and dissolution).

⁸⁷ Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery art. 1, Apr. 30, 1957, 226 U.N.T.S. 3 ("Each of the States Parties to this Convention shall take all practicable and necessary legislative and other measures to bring about progressively and as soon as possible the complete abolition or abandonment of . . . (c) Any institution or practice whereby: (i) A woman, without the right to refuse, is promised or given in marriage on payment of a consideration in money or in kind to her parents, guardian, family or any other person or group.") See also CEDAW, *supra* note 67, art. 16(2) (prohibiting child marriage and requiring States Parties to specify a minimum age); ACRWC, *supra* note 2, art. 21(2) (barring child marriage but requiring States Parties to specify eighteen years as the minimum age of marriage and make registration of marriages in an official registry compulsory).

⁸⁸ Obiajulu Nnamuchi, *Harm or Benefit? Hate or Affection? Is Parental Consent to Female Genital Ritual Ever Defensible?*, 8 J. HEALTH BIOMEDICAL L. 377, 418 (2013).

⁸⁹ *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944) (ruling that parental rights are not absolute and may be abridged where its exercise is inconsistent with the welfare and best interests of the child).



Does a Human Rights Based Approach Suffice

powers in the husband whose interests may not be the same as the wife's. Sadly, of the thirty countries reported by UNICEF in 2009 as countries where women have no say in their own healthcare needs, only twelve were non-African.⁹⁰ The problem with having health decisions made by husbands, particularly amongst women who married at an early age as opposed to those married as adults,⁹¹ is that it goes against the principle of individual empowerment or, in public health language, "health promotion", which is defined as a "process of enabling people to increase control over, and to improve, their health."⁹² Health promotion (as a form of individual empowerment) is a public health tool predicated on making each individual responsible for his or her own health.⁹³ Its importance lies in enabling the individual to reduce exposure to conditions or circumstances, such as the denial of access to reproductive services, for instance,⁹⁴ that results in illness, thereby protecting her against the pain, suffering and other losses which she may have otherwise suffered.⁹⁵

(ii) Maternal Illiteracy

The fact that international law recognizes universal education as a fundamental human right is incontrovertible.⁹⁶ The foremost international human rights instrument on socioeconomic rights – ICESCR (31 articles in all) – mentions the word "education" at least 18 times.⁹⁷ Similarly, CEDAW employ the word 14 times⁹⁸ and there are at least 20 uses of it in the CRC.⁹⁹ For countries in Africa, regional treaties incorporate comparable provisions. In the context of child health and education, the regional women-centered human rights instrument adopted in July 2003 is particularly striking.¹⁰⁰ Article 12(2) of the Maputo Protocol mandates States Parties to: (a) promote literacy among women; (b) promote education and training for women at all levels and in all disciplines, particularly in the fields of science and technology; and, (c) promote the enrolment and reten-

⁹⁰ UNICEF, *supra* note 28, at 40.

⁹¹ UNICEF, *EARLY MARRIAGE: A HARMFUL TRADITIONAL PRACTICE* 24 (2005), available at http://www.unicef.org/publications/files/Early_Marriage_12.lo.pdf.

⁹² WHO, *The Ottawa Charter for Health Promotion: First Int'l Conference on Health Promotion*, (Nov. 21, 1986).

⁹³ Obiajulu Nnamuchi, *Health and Millennium Development Goals in Africa: Deconstructing the Thorny Path to Success*, in *THE RIGHT TO HEALTH: A MULTI-COUNTRY STUD. OF L., POL'Y & PRAC.* (Obiajulu Nnamuchi et al., eds., forthcoming, 2014).

⁹⁴ CEDAW, *supra* note 67, art. 10(h) (vesting in wives and husbands the same rights pertaining to family planning and access to reproductive health services).

⁹⁵ Nnamuchi, *Health and Millennium Development Goals in Africa*, *supra* note 93.

⁹⁶ Universal Declaration of Hum. Rts., *supra* note 81, art. 26; Int'l Covenant on Econ., Soc. & Cultural Rts., *supra* note 79, art. 13; CEDAW, *supra* note 67, art. 10; CRC, *supra* note 1, art. 28.

⁹⁷ Int'l Covenant on Econ., Soc. & Cultural Rts., *supra* note 79, art(s). 10(1), 13(1), 13(2)(a), 13(2)(b), 13(2)(c), 13(2)(d), 13(3), 13(4), 14.

⁹⁸ CEDAW, *supra* note 67, pmb. ¶ 8, art(s). 5(b), 10 (¶ 1), 10(a), 10(c), 10(e), 10(g), 10(h), 14(2)(d), 16(e).

⁹⁹ CRC, *supra* note 1, art(s). 19(1), 23(3), 23(4), 24(2)(e), 24(2)(f), 28(1), 28(1)(a), 28(1)(b), 28(1)(c), 28(1)(d), 28(3), 29(1), 29(2), 32(1), 32(2), 33, 40(3)(b).

¹⁰⁰ Maputo Protocol, *supra* note 67, art. 12(2).

Does a Human Rights Based Approach Suffice

tion of girls in schools and other training institutions and the organization of programs for women who leave school prematurely. Obviously literacy is important to all human demographics, but is even more so for children considering their vulnerability and dependence on others, particularly mothers, for their survival.

Titling this subsection “maternal illiteracy” speaks to the danger that awaits children born to illiterate mothers and the sense of urgency that should guide strategies for curative measures. As to why this is important, this author explains, in a related context:

A key reason maternal health should occupy center stage in health policy formulation is that its neglect often has drastic domino-like consequences – consequences that extend far beyond the corridors of maternal wards to affect other segments of the population, particularly children. This is particularly true in the realm of literacy or illiteracy amongst women.¹⁰¹

The best way to understand these domino-like consequences and the link between maternal literacy (or illiteracy) and the health of their children is to think of education in terms of empowerment. An empowered individual is one who knows how to attend to life challenges even if, despite her best efforts, she is unable to conquer them. In its most elementary form, being empowered connotes knowledge as to navigating the complexities of life; that is, the capacity to surmount challenges to human wellbeing, and knowing how to overcome obstacles that are in the path to acquiring basic needs. It is in this box that we must place this factor plays in their children’s health and wellbeing. The maxim *nemo dat quod non habet* is apposite here: a woman who is unempowered or illiterate in the sense that she cannot, for instance, navigate the health system for her own benefit cannot reasonably be expected to attend to the health needs of her child. As argued elsewhere:

The kernel of individual empowerment is that it reduces exposure to [health] 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.¹⁰²

Thus situated, it becomes easy to understand how illiteracy can transform mothers into risk factors for the healthy development of their children. To put this in proper perspective, children whose mothers are uneducated have about a

¹⁰¹ Nnamuchi, *Millennium Development Goal 5, Human Rights and Maternal Health in Africa*, *supra* note 39, at 110.

¹⁰² Nnamuchi, *Health and Millennium Development Goals in Africa*, *supra* note 93.



Does a Human Rights Based Approach Suffice

2.5 times higher risk of death than those born to mothers that have acquired secondary school or higher level of education.¹⁰³

Since the health of children is intimately intertwined with the health and well-being of their mothers and the health of the latter is, aside from genetic factors, a product of her level of knowledge or education, it follows that there is a strong correlation between academic attainment of mothers and the health of their children. The two critical predictors of the likelihood of giving birth to a healthy baby are a willingness to adopt necessary lifestyle changes and the ability to access reproductive health services, including antenatal and prenatal care. Greater compliance with these measures is more likely to be found amongst educated women than uneducated ones. In fact, studies show that women who are literate are more likely to seek reproductive health and family planning services than uneducated ones¹⁰⁴ – meaning that the higher the level of maternal education, the better for the health of the child. This realization, perhaps, explains the stance of the ICESCR, in mandating compulsory and free primary education and progressive (gradual introduction of free tuition) availability of secondary and tertiary education to everyone.¹⁰⁵ For countries interested in protecting the health and wellbeing of their children, this is an obligation that should be taken seriously.

The inclusion of education as one of the MDGs¹⁰⁶ makes this point abundantly clear, by bringing to the forefront the interdependence, indivisibility, and interconnectedness of human rights. One human right, to achieve universal primary education (MDG 2), leads directly to the attainment of a number of other human rights, namely, to eradicate poverty and hunger (MDG 1), to promote gender equality and empower women (MDG 3), to reduce child mortality (MDG 4), to reduce maternal mortality (MDG 5), and to combat HIV/AIDS, malaria, and other diseases (MDG 6).¹⁰⁷ This is not to project education as an all-encompassing cure for everything. Instead, the argument merely suggests that acquiring education (an empowering factor) greatly enhances one's chances of surmounting the obstacles targeted by the mentioned MDGs.

UNICEF sums it up quite succinctly, “[e]ducating girls and young women is one of the most powerful ways of breaking the poverty trap and creating a sup-

¹⁰³ WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2005: MAKE EVERY MOTHER AND CHILD COUNT 26 (2005) (reporting specifically on Nigeria, although there is no reason the result would be any different in countries similarly placed; that is, in terms of comparable level of socioeconomic development).

¹⁰⁴ See generally Chryssa McAlister & Thomas F. Baskett, *Female Education and Maternal Mortality: A Worldwide Survey*, 28 J. OBSTET. GYNECOL. CAN. 983 (2006); Saffron Karlsen et al., *The Relationship between Maternal Education and Mortality Among Women Giving Birth in Health Care Institutions: Analysis of the Cross Sectional WHO Global Survey on Maternal and Perinatal Health*, 11:606 BMC PUBLIC HEALTH 1 (2011), <http://www.biomedcentral.com/content/pdf/1471-2458-11-606.pdf>; Jose Luis Alvarez et al., *Factors Associated with Maternal Mortality in Sub-Saharan Africa: An Ecological Study*, 9:462 BMC PUBLIC HEALTH 1 (2009), <http://www.biomedcentral.com/content/pdf/1471-2458-9-462.pdf>; Sarah McTavish et al., *National Female Literacy, Individual Socio-Economic Status, and Maternal Health Care Use in Sub-Saharan Africa*, 71 SOC. SCI. & MED. 1958 (2010).

¹⁰⁵ Int’l Covenant on Econ., Soc. & Cultural Rts., *supra* note 79, art. 13(2).

¹⁰⁶ See U.N. STATISTICS DIV., *supra* note 8, at MDG 2.

¹⁰⁷ See generally *id.*

Does a Human Rights Based Approach Suffice

portive environment for maternal and newborn health.”¹⁰⁸ The reverse is equally true. When girls marry early or suffer early pregnancies, HIV/AIDS, sexual violence, and other abuses, then the risk of dropping out of school escalates (lack of education equals disempowerment).¹⁰⁹ The inevitable result will be a “vicious cycle of gender discrimination, poverty and high rates of maternal and neonatal mortality.”¹¹⁰ This link, clearly evident in the MDG philosophy, is a pointer to the importance of solving global problems via a human rights approach – a theme developed more fully in Part IV of this discourse. It is one that strongly commends itself to countries in Africa.

(iii) Parental Poverty

To fully appreciate resource deficit as a significant factor in health woes of children in Africa, one must think of poverty as “marginalization” or “social exclusion,” the ultimate determinant of who gets what or, in the tragic context of Africa, who lives or dies. Incapacity on the part of parents to provide necessary care for their children, or vital social conditions (underlying health determinants) such as adequate nutrition and shelter, dooms such children to a bleakly uncertain future. Namibia is a typical illustration. Although like the rest of the region, Namibia is still struggling to attain the objectives of MDG 4, virtually all births (98 percent) of the wealthiest 20 percent of the population in that country are attended by skilled health professionals, compared to just 60 percent for the poorest 20 percent.¹¹¹ The result of this wide parental poverty gap is unmistakable – substantially lower U5MR amongst the wealthiest 20 percent of the country.¹¹² For the remainder of the children under the age of five, as well as their parents, this is social exclusion of the worst kind. It is decisively disempowering. But Namibia is hardly atypical. Parental poverty and its destructive force on the well-being of children throughout Africa evidence quite strongly the inextricable relationship between different kinds of human rights, a concept explored previously in this article.

This relationship becomes even more glaring when one considers household poverty in the context of health and individual empowerment. Certainly education is empowering, but it is not in itself a sufficient panacea to the numerous health challenges that might arise during a woman’s reproductive years or the pre-adult years of her children. More is needed in order for the knowledge or awareness to be of material benefit to the mother or her children. Indeed, as argued elsewhere:

¹⁰⁸ UNICEF, *supra* note 28, at iii.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ Special Rapporteur on Extreme Poverty and Human Rights, *On Her Mission to Namibia from 1 to 8 October 2012*, U.N. Human Rights Council, ¶ 62, A/HRC/23/36/Add.1 (May 17, 2013) (by Magdalena Sepúlveda Carmona), available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G13/137/27/PDF/G1313727.pdf?OpenElement>.

¹¹² *Id.* (citing World Health Org., Namibia: Health Profile, Apr. 4, 2011).



Does a Human Rights Based Approach Suffice

[The] success of individual empowerment goes beyond knowledge transfer [education] to include material resources needed for attending to underlying health determinants. Knowing how to protect oneself . . . is a good start but, to be an effective public health tool, the knowledge must be coupled with access to [vital goods and services]. . .¹¹³

And this is the paradox of global health. The very region with the greatest burden of childhood diseases and illnesses¹¹⁴ is also where resources needed for health or related projects are in most dire shortage.¹¹⁵ Atrocious health indices in Africa, including in the realm of child and maternal health, are directly traceable to overwhelming resource deficit in the vast majority of households in the region.¹¹⁶

The health of children is particularly unique in that its protection hinges crucially on the health of another demographic, namely, mothers. Akin to a pendulum which must swing in a consistent manner, the health of children swings up and down in tandem with that of their mothers, meaning that both must be addressed simultaneously to record a positive and sustainable outcome for children. This synergistic relationship may be illustrated with antenatal care – a basic element of child health. It is a common knowledge that attendance at antenatal clinics is a surefire way not only to guard against pregnancy and childbirth complications, but also to shield the child from preventable morbidities, and even death. This dual dimension advantage underscores the requirement by UNICEF and WHO of at least four antenatal visits by pregnant women.¹¹⁷ Yet, as current data (2000 to 2010) indicates, only 44 percent of pregnant women in African met this threshold, the worst globally.¹¹⁸ The reason is not far-fetched.

Despite regional attempts at embracing an insurance-based system of health care financing, access to health services, including antenatal care, remains largely dependent on cash in most countries in the region. Given the high poverty rates, coupled with the escalating cost of services and competing household needs, funds available for health services, antenatal or otherwise, range from little to nothing. Perhaps in a bid to cushion the impact of this burden, a handful of

¹¹³ Nnamuchi, *Health and Millennium Development Goals in Africa*, *supra* note 93.

¹¹⁴ U.N., MDG Report 2013, *supra* note 11, at 25 (reporting that the poorest regions of the world account for the majority of child deaths, with sub-Saharan Africa and Southern Asia responsible for 5.7 million of the 6.9 million deaths of children under the age of five worldwide or 83 percent of the global total in 2011).

¹¹⁵ Africa suffers 24 percent of the disease burden in the world but commands less than 1 percent of global health expenditure compared, for instance, to the region of Americas which shoulders just 10 percent share of the global diseases but accounts for more than 50 percent of the world's health financing. See WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2006: WORKING TOGETHER FOR HEALTH xviii – xix (2006) [hereinafter THE WORLD HEALTH REPORT 2006].

¹¹⁶ UNDP, HUMAN DEVELOPMENT REPORT 2009: OVERCOMING BARRIERS: HUMAN MOBILITY AND DEVELOPMENT Table II (2009); UNDP, HUMAN DEVELOPMENT REPORT 2013: THE RISE OF THE SOUTH: HUMAN PROGRESS IN A DIVERSE WORLD 27 (2013) (showing larger proportion of people living below poverty line, on less than \$1.25/day, in countries in Africa than anywhere else).

¹¹⁷ U.N., MDG Report 2009, *supra* note 53, at 27.

¹¹⁸ WORLD HEALTH ORG., WORLD HEALTH STATISTICS 2011 100 (2011). Eastern Mediterranean region shares the same record. *Id.*

Does a Human Rights Based Approach Suffice

countries in the region have introduced free or subsidized care for pregnant women and children.¹¹⁹ This strategy is laudable for two critical reasons. First, it recognizes the peculiar vulnerability of this demographic. Physiological and anatomical immaturity renders infants and children susceptible to a greater number of diseases than adults,¹²⁰ as does diminished immunity in respect to pregnant women.¹²¹ Second, by targeting the health care needs of particularly at-risk groups, such as women and children, the strategy adds to the improvement of the health of the entire population.¹²²

It is noteworthy that although mothers are usually the primary care givers, the overall health and well-being of children are not their exclusive responsibility. Particularly in communal social units, as in African societies, fathers as well as extended family members do play significant roles. Therefore, domestic or regional measures aimed at mitigating maternal poverty as a factor in the poor health of African children must move beyond the specific needs of women to also efface obstacles confronting other household members in their struggles to extricate themselves from the cold clutches of poverty.¹²³ There must be a recognition of inter-household resource differentials as key contributors to disparities in the health of children, within and across countries. Children born to parents on the lowest income percentile are nearly twice as likely to die before age five as those born to parents on the highest income bracket.¹²⁴

Resource constraint at the household level is visible throughout the region, more so than anywhere else, and its elimination must be seen in the context of the holistic approach of human rights.¹²⁵ Remarkably, this point was not lost on the experts that crafted the MDGs in 2000. The very first objective (“MDG 1”) is

¹¹⁹ Nnamuchi, *Millennium Development Goal 5, Human Rights and Maternal Health in Africa*, *supra* note 39, at 112.

¹²⁰ *Children and Infant*, FLU.GOV, <http://www.flu.gov/at-risk/children/> (last visited Mar. 31, 2014) (explaining, in reference to flu, that children are more susceptible to the virus because their immune systems are still developing).

¹²¹ *People at High Risk of Developing Flu-Related Complications*, Centers for Disease Control & Prevention, http://www.cdc.gov/flu/about/disease/high_risk.htm (last updated Mar. 31, 2014) (listing children and pregnant women at higher risk of flu than the general population).

¹²² The problem with a user fee system is that it is regressive. Even where payment is pegged at what the average person considers low, this does not necessarily mean affordability by everyone. The very poor might still be unable to pay the sum, especially when added to the cost of transportation, drug costs, et al that would be involved in accessing care. See Special Rapporteur on Extreme Poverty, *supra* note 111, ¶ 62 (finding that even though the user fees payable in the public health care system of Namibia seems to be low (between 4 – 8 Namibia dollars), the fee might still pose an insurmountable barrier to accessing health care services for those on the lowest income quintile).

¹²³ UNICEF, *supra* note 28, at 58 (noting that the vital role played by families or household members in ensuring the health and wellbeing of children cannot be ignored by health systems). Moreover, the Kangaroo mother care (KMC) for low-birth weight babies, an innovative system introduced in Colombia in 1979 by Drs. Hector Martinez and Edgar Rey, and now adopted by many developing countries, identifies provision of support for the mother and other household members caring for the baby as one its four components. *Id.* at 62.

¹²⁴ U.N., MDG REPORT 2013, *supra* note 11, at 26.

¹²⁵ Mfonobong Nsehe, *The African Billionaires 2013*, FORBES (Mar. 6, 2013), <http://www.forbes.com/sites/mfonobongnsehe/2013/03/06/the-african-billionaires-2013/> (reporting that of the 1,426 billionaires who made it to FORBES’ annual ranking of the world’s richest people, African billionaires occupied just a little over one percent of the positions on the list).



Does a Human Rights Based Approach Suffice

aimed at eradicating extreme poverty, the kind that wreaks havoc in the lives of Africans and the most important factor stunting development in the region – in health as well as in other sectors.¹²⁶ This premier positioning is not merely coincidental. It recognizes that in order to effectively address the health needs of children in the severest resource-deficit region in the world, one of the more potent underlying causes, namely poverty, must also be expurgated. By echoing the indivisibility and interdependence of the needs of human beings as well as the challenges to addressing them, this international policy document validates a core principle of human rights, that human needs should be tackled as an indivisible, not an isolated, unit. It is a principle that should inform national responses and strategies throughout the region.

(iv) *Dearth of Skilled Health Personnel*

A major cause of the deteriorating state of children's health throughout Africa is the shortage of adequately trained health professionals. Starting from conception, through birth, and continuing after birth, the survival of children depends on the quality of care that the health system offers. A health system that is bereft of the right mix of physicians, nurses, and other ancillary staff is a failing health system. Not surprisingly, this is the state of most health systems in the region. Indeed, as revealed in the 2000 edition of the World Health Report, which compared the performance and attainment of health systems in the world, most African countries ranked in the bottom 30 percent of the nations surveyed.¹²⁷ Unavailability of physicians, as well as nurses and midwives in hospitals, coupled with high cost of services force parents into making unhealthy choices.

In contrast to other regions of the world, pregnancy is still a formidable risk in Africa. Poverty forces women in the region who are pregnant to either resort to home delivery, more than 60 percent,¹²⁸ or risk the services of traditional birth attendants.¹²⁹ Recent data (2005 to 2012) positions Africa as the region with the least proportion of births attended by skilled health personnel – at 49 percent compared to, for instance, Europe, which recorded 98 percent.¹³⁰ There are two major reasons for the situation. Medical and nursing training programs in virtually all sub-Saharan Africa nations do not graduate enough physician and nurses to fill positions in their respective hospitals and clinics. The consequence is that even where resources (drugs, equipment et al.) are available, there might not be adequate manpower to actually employ the resources to productive use. Manuel

¹²⁶ The Targets of this goal (MDG 1) are (a) to halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day; (b) achieve full and productive employment and decent work for all, including women and young people; and (c) halve, between 1990 and 2015, the proportion of people who suffer from hunger. See U.N. STATISTICS DIV., *supra* note 8, at MDG 1 (to eradicate extreme poverty and hunger).

¹²⁷ WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE 152 – 54 (2000) [hereinafter WORLD HEALTH REPORT 2000].

¹²⁸ UNICEF, *supra* note 28, at 58.

¹²⁹ *Id.* at 2 (noting that most deliveries in poor countries are at home, unassisted by skilled health professionals).

¹³⁰ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 104.

Does a Human Rights Based Approach Suffice

Dayrit, a senior WHO official, was quite on point, “[e]ven if you have the medicine, the vaccines, and the bed nets, you need the health workers to deliver the service.”¹³¹ Indeed, there have been cases where, although resources were available, care was not dispensed on account of manpower deficit.¹³² And the situation is likely to worsen. As a recent study documents, not only is the existing manpower level insufficient to meet current needs, the training capacity in half of the countries surveyed is inadequate to maintain the current workforce level.¹³³

Aside from the low number of available training spots for physicians and nurses, another factor responsible for the deficit of skilled health professionals in Africa is the substantial number of those who succeed in graduating from these schools quickly fleeing to Western countries in search of greener pastures. For instance, Angola has just 881 physicians but 168 of them are working in eight OECD countries as do 22 of Mozambique’s 514 doctors.¹³⁴ Overall, 22 percent of physicians trained in Africa are employed outside the region five years following graduation.¹³⁵

The same bleak picture is repeated in the realm of nursing services. For instance, despite dire shortages in their respective national health systems, 18 percent of nurses trained in Lesotho and 34 percent of Zimbabwean nurses are employed in seven OECD countries.¹³⁶ Remarkably, these are some of the countries with the worst health indices in the world. In 2011, the U5MR in the two countries were 67¹³⁷ and 86¹³⁸ deaths per 1000 live births respectively, amongst the worst worldwide. With such large efflux from an already depleted workforce, it stands to reason that these countries will certainly continue to experience a manpower shortage into the foreseeable future. The proportion of births attended by skilled health personnel in Zimbabwe is 66 percent¹³⁹ and 62 percent in Lesotho, respectively.¹⁴⁰

Although health worker shortage is a worldwide phenomena, in no other region is the brunt felt worse than in Africa. Whereas the densities of physician and nurses/midwives in Europe are 33.3 and 84.2 per a population of 10,000, the

¹³¹ Pooja Kumar, *Providing the Providers — Remediating Africa’s Shortage of Health Care Workers*, 356 NEW ENG. J. MED. , 2564, 2564 (2007).

¹³² *Id.* (quoting a frustrated WHO official, “[w]ith the experience of the last few years, where you have had huge global funds move into an activity to provide resources . . . we’ve found that the bottleneck is really the delivery”).

¹³³ Yohannes Kinfu, et al., *The Health Worker Shortage in Africa: Are Enough Physicians and Nurses being Trained?*, 87 BULL. WORLD HEALTH ORG. 225, 227 (2009).

¹³⁴ WORLD HEALTH REPORT 2006, *supra* note 115, at 100.

¹³⁵ Fitzhugh Mullan et al., *Medical Schools in Sub-Saharan Africa*, 377 LANCET 1113, 1117 (2011), <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673610619617.pdf>.

¹³⁶ WORLD HEALTH REPORT 2006, *supra* note 115, at 100.

¹³⁷ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 57.

¹³⁸ *Id.* at 53.

¹³⁹ *Id.* at 102.

¹⁴⁰ *Id.* at 98.



Does a Human Rights Based Approach Suffice

figures in Africa are 2.5 and 9.1, the worst globally.¹⁴¹ Obviously, reversing the trend is vital to positioning the region on a sustainable track toward meeting its obligation under MDG 4. However, to be successful, the strategy must be situated within the context of the two major problems identified above, by increasing capacity in the region's medical and nursing/midwifery programs as well as by addressing the so-called push factors, particularly remuneration, job security and equipment.

(v) *Institutional Poverty and Leadership Void*

Bemoaning poverty as a reason for the current paralytic stupor in virtually all sectors in most African countries is not uncommon amongst the political class in the region. Whether at national or international fora, Africa's problems are cleverly packaged by its leaders as easily surmountable only if they had access to adequate resources. As often as the message has been preached, it is not without some factual basis. Each year, the World Bank ranks global economies on the strength of gross national income ("GNI") per capita in each country—in descending order—high income, upper middle income, lower middle income and low income.¹⁴² Although there are just 36 countries categorized in the latest report as low income countries (\$1,035 GNI or less), 27 of them are in Africa.¹⁴³ Of the 49 nations classified as "least developed," only 15 are not in Africa.¹⁴⁴ With a GNI per capita of \$760, a life expectancy of 61 years at birth and a 64 percent primary education completion rate, these countries represent the poorest group in the world.¹⁴⁵ Pragmatism dictates against expecting these same countries to respond to the health or any other challenges in their respective territories with the same vigor as their high income (\$12,616 GNI or more) counterparts.¹⁴⁶ On this basis, therefore, it is unsurprising that the region with the worst poverty indices also lags behind the rest of the world in attending to the health of its population, including children.

Making inroads into child health challenges in Africa must start with identifying the factors that cumulatively create and sustain the problem. Aside from the factors previously identified, namely, child marriage, maternal illiteracy, parental poverty and deficit of skilled health personnel, there are other no-less difficult problems that would need to be vanquished. Direct causes such as malnutrition and preventable diseases like malaria, acute respiratory infections, diarrhea, and measles are responsible for 70 percent of child mortality in the region.¹⁴⁷ Mea-

¹⁴¹ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 128.

¹⁴² *New Country Classifications*, THE WORLD BANK (July 2, 2013, 12:42 AM), <http://data.worldbank.org/news/new-country-classifications>.

¹⁴³ *Country and Lending Groups*, THE WORLD BANK, <http://data.worldbank.org/about/country-classifications/country-and-lending-groups> (last visited Oct. 21, 2013).

¹⁴⁴ *Least Developed Countries: UN Classification*, THE WORLD BANK, <http://data.worldbank.org/region/LDC> (last visited Oct. 21, 2013).

¹⁴⁵ *Id.*

¹⁴⁶ *New Country Classifications*, *supra* note 142.

¹⁴⁷ WORLD HEALTH ORG., CHILD SURVIVAL: A STRATEGY FOR THE AFRICAN REGION ¶ 12 (2007).

Does a Human Rights Based Approach Suffice

sles is a particularly worrisome menace, wrecking havoc in the lives of children in Africa. Although the disease can be easily prevented by administering two doses of a safe and inexpensive vaccine, outbreaks continue to occur in many countries in the region.¹⁴⁸ In 2011, 90 percent of all measles deaths occurred in sub-Saharan Africa and Southern Asia.¹⁴⁹

There is a reason the enumerated diseases are known collectively as “diseases of the poor” – the causes are deeply rooted in, and disproportionately suffered by, people living in poverty. This means that appropriate remedial measures must go deeper than the diseases or the illnesses they are meant to cure in order to address the underlying conditions that made people susceptible to it in the first place. Not only is lack of funds responsible for millions of childhood deaths in Africa, it is also the reason parents submit their children to early marriage. It is equally the reason teenage wives resign themselves to violence and other forms of cruel and harsh treatment by their husbands and their families. This implicates the responsibility of governments in the region.

Whilst undeniable that resource deficit hampers, to an extent, the capability of various governments in the region to adopt the kind of institutional responses needed to prevent unnecessary childhood morbidities and mortalities, this does not explain the almost hands-off approach in many of these countries. Malaria is illustrative. Although the disease is inexpensive to prevent (mosquito nets cost approximately \$5),¹⁵⁰ easily diagnosable (pyrexia is a common symptom), and treatable for next to nothing (\$1.50 to 2.40 for adults and \$0.40 to 0.90 for children),¹⁵¹ it continues to be a major cause of outpatient morbidity and a major contributor to high mortality in the region. In 2008, Africa accounted for 768,070 deaths or 89 percent of the global malaria mortality.¹⁵² “This has little or nothing to do with resources. It is simply a question of misallocation and misalignment of resources with need.”¹⁵³

When the 2001 African Summit on HIV/AIDS, TB, and Other Related Infectious Diseases resulted in a commitment by African leaders to allocate at least 15 percent of their annual budgets to the health sector,¹⁵⁴ the international health community applauded. But the optimism that heralded this commitment is gradually giving way to frustration as only six countries – Rwanda, Botswana, Niger, Malawi, Zambia, and Burkina Faso – have met the benchmark.¹⁵⁵ Why is this

¹⁴⁸ U.N., MDG REPORT 2013, *supra* note 11, at 27.

¹⁴⁹ *Id.*

¹⁵⁰ See PROJECT MOSQUITO NET, <http://www.projectmosquonet.org/> (last visited Oct. 21, 2013).

¹⁵¹ *Malaria - Facts and Figures*, MÉDECINS SANS FRONTIÈRES (Apr. 25, 2004), <http://www.msf.org/article/malaria-facts-and-figures>.

¹⁵² WHO, WORLD MALARIA REPORT 2009 27 (2009).

¹⁵³ Nnamuchi, *Health and Millennium Development Goals in Africa*, *supra* note 93.

¹⁵⁴ Organisation of African Unity, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases ¶ 26, Apr. 24-27, 2001, OAU/SPS/ABUJA/3, *available at* http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

¹⁵⁵ 2010 Africa Health Financing Scorecard, AFRICA PUBLIC HEALTH ALLIANCE, *available at* http://www.who.int/pmnch/events/2010/ausummit_2010healthfinancingscorecard.pdf (last visited Mar. 12, 2013).



Does a Human Rights Based Approach Suffice

important? Non-fulfillment of this pledge is proof that lackluster performance of the health sector in Africa is not resource oriented, that poverty is not explanatory of the high number of children whose health and lives are continually compromised by the region's political leadership. Because there was no monetary figure demanded of any of the countries in the region, non-availability of funds cannot be an exculpatory factor.

What was required was a rearrangement of national priorities such that important sectors, like health, receive a defined proportion of the overall government expenditure. Even so, the vast majority of African leaders failed, demonstrating that irresponsible governance, not poverty, is the real culprit. A statement on the launching of the 2012 African Human development Report is quite helpful:

This report is a damning condemnation of decades of governance in the Sub-Sahara Africa . . . It tells us what we know, that the poverty of Africa is the making of African leaders over the years. African leaders have made the option of taking us along the path of poverty. We don't need to be told.¹⁵⁶

This statement, credited to a notable figure in the region, Olusegun Obasanjo, speaks volumes. As president of Nigeria in 2001, Obasanjo was the host of the African Summit where the pledge by African leaders to commit at least 15 percent of their national budgets to health was made. Yet, throughout his tenure, Nigeria never came close to meeting this benchmark even though he remained in office until 2007. Subsequent administrations have fared no better. But despite the shortcomings of his administration, his conclusion is one that should resonate with those seriously committed to improving the health and wellbeing of children in Africa. “[L]et us be the change that we desire. We can do it and we must do it.”¹⁵⁷

iv. human rights and children's health/well-being

Human rights regimes governing children's right to health may be categorized into two distinct but related groups, namely, general and child-specific treaties. The first group consists of treaties that impose obligations on authorities to respect, protect and fulfill the right to health of the general population while the second category comprises regimes that specifically target the health and well-being of children. An exception to this rule is the Universal Declaration of Human Rights which, in addition to recognizing the right to health of all and sundry, specifically carves out special protection for children. Art. 25 stipulates:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in

¹⁵⁶ Onyinye Nwachukwu, *Obasanjo Blames African Leaders for Poverty on the Continent*, BUSINESS-DAY (May 22, 2012), <http://www.businessdayonline.com/NG/index.php/news/284-breaking-news/38135-obasanjo-blames-african-leaders-for-poverty-on-the-continent>.

¹⁵⁷ *Id.*

Does a Human Rights Based Approach Suffice

the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Singling out children and mothers for “special care and assistance” speaks to the vulnerability of this demographic.¹⁵⁸ Aside from typically occupying the lowest rung of socioeconomic ladder, children and pregnant women not only bear a greater burden from disease than the rest of the population but are also disproportionately impacted by access barriers and negative social determinants of health.

Amongst human rights frameworks pertaining specifically to children, the most important are the CRC and, for African children, the African Charter on the Rights and Welfare of the Child (“ACRWC”). The CRC, as pointed out in the introductory section, is the most ratified human rights treaty. Except for Somalia and newly-independent Southern Sudan, all African countries are States Parties to the treaty.¹⁵⁹ Art. 6 (2) commits States Parties to “ensure to the maximum extent possible the survival and development of the child.”¹⁶⁰ The language, “maximum extent possible,” signifies a cosmopolitan approach to implementing the obligations of the treaty. Nations are required to channel as many resources as it can muster toward ensuring the rights of all children within their jurisdictions. This is made more explicit regarding health in Art. 24(1). The provision recognizes the right children have to the “enjoyment of the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health.” Discernible from Art. 6(2) and 24(1) is the proposition that the highest attainable standard of health is an impossible feat in absence of optimal effort in the nature of deployment of maximum resources, human and material, toward the goal. This, as will become evident shortly, is consistent with the holistic approach of human rights to health and well-being.

The CRC is all-inclusive, requiring States Parties to “ensure that no child is deprived of his or her right of access to . . . health care services.”¹⁶¹ The implication is that socioeconomic circumstances, status of birth (biological or adopted, legitimacy issues) or other differentials will not be a bar to equal access for all

¹⁵⁸ See, e.g., UNICEF, *MALARIA AND CHILDREN: PROGRESS IN INTERVENTION COVERAGE* 8 (2007), available at [http://www.unicef.org/health/files/Malaria_Oct6_for_web\(1\).pdf](http://www.unicef.org/health/files/Malaria_Oct6_for_web(1).pdf) (explaining that as a result of not-yet-developed and reduced immunity children and pregnant women respectively are more susceptible to malaria than the general population).

¹⁵⁹ *UN Treaty Collection: Status of Treaties, Status as at April 28, 2014*, UNICEF, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en (last visited Apr. 28, 2014).

¹⁶⁰ “Development of the child” is an omnibus term encompassing the physical, mental, moral, spiritual and social dimensions of development of children. This requires eliminating factors that threaten the life, survival, growth and development of the child through designing and implementing appropriate mechanisms that address social health determinants. See CRC, *supra* note 1, art. 6; Committee on the Rights of the Child, General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health, 62d Sess., art. 24 ¶ 16, U.N. Doc. CRC/C/GC/15 (2013) [hereinafter Committee on the Rights of the Child: General Comment No. 15].

¹⁶¹ Convention on the Rights of the Child, *supra* note 1, art. 24(1).

Does a Human Rights Based Approach Suffice

children.¹⁶² In fact, as the Committee on the Rights of the Child¹⁶³ subsequently explains, “all children have the right to opportunities to survive, grow and develop, within the context of physical, emotional and social well-being, to each child’s full potential.”¹⁶⁴ This authoritative exposition places children’s right to health within the broader context of other dimensions of well-being, not just health. In other words, for a State Party to be in full compliance with its obligation under the CRC, it must not only design and implement a health system that ensures “timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services” for children in its territory, it must also incorporate “programmes that address the underlying determinants of health” in its national policy.¹⁶⁵

Underlying or social determinants of health consist of conditions or circumstances that influence the health of individuals or communities, positively or otherwise. Interestingly, there has been a tendency in some quarters to conceptualize underlying health determinants solely in terms of provision of facilities (goods and services) that aid in healthy life. This is probably as a result of a description of the term by the U.N. Committee on Economic, Social and Cultural Rights (“Committee on ESCR”) in 2000.¹⁶⁶ The Committee on ESCR

¹⁶² This is critical because some health systems tend to apportion health coverage on the basis of considerations which violate their international law obligations. *See, e.g.,* Obiajulu Nnamuchi, *The Nigerian Social Health Insurance System and the Challenges of Access to Health Care: An Antidote or a White Elephant?*, 28 *MED. L.* 139, 139-40 (2009) (criticizing Nigeria’s National Health Insurance Scheme for denying coverage to non-biological children of covered parents as a blatant violation of §42 of the Constitution which prohibits discrimination based on circumstances of birth). This kind of restriction on dependant coverage runs afoul of Art. 2 of the Convention on the Rights of the Child which enjoins States Parties to respect and ensure the rights set forth in the Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, color, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. *See also* Committee on the Rights of the Child, General Comment No. 15, *supra* note 160, ¶ 8.

¹⁶³ Established under Art. 43(1) of the Convention on the Rights of the Child, the Committee on the Rights of the Child consists of independent experts charged with monitoring the implementation of the CRC as well as the two optional protocols to the Convention, on involvement of children in armed conflict and on sale of children, child prostitution and child pornography. In addition, the Committee is responsible for examining reports submitted by States Parties on how the rights are being implemented in their respective territories. An important function of the Committee is issuance of general comments or interpretation of the human rights obligations resulting from the CRC and its optional protocols. *See* Arts. 43 – 45. General comments are aimed at providing guidance and support to States Parties and other duty bearers as to the right strategies and mechanisms to be adopted in implementing their duty regarding respecting, protecting and fulfilling children’s right to the enjoyment of the highest attainable standard of health. *See Committee on the Rights of the Child, General Comment No. 15, supra* note 160, ¶ 1. For a detailed analysis of the work of the Committee as a human rights implementation body, *see* David Weissbrodt, Joseph C. Hansen & Nathaniel H. Nesbitt, *The Role of the Committee on the Rights of the Child in Interpreting and Developing International Humanitarian Law*, 24 *HARVARD HUM. RTS. L. J.* 115 (2011); Cynthia Price Cohen & Susan Kilbourne, *Jurisprudence of the Committee on the Rights of the Child: A Guide for Research and Analysis*, 19 *MICH. J. INT’L L.* 633 (1998).

¹⁶⁴ Committee on the Rights of the Child, General Comment No. 15, *supra* note 160, ¶ 1.

¹⁶⁵ *Id.* ¶ 2.

¹⁶⁶ U.N. Econ. & Soc. Council, Committee on Econ., Soc. & Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, ¶ 11, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), *reprinted in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies 85, U.N. Doc. HRI/GEN/1/Rev.6 (2003) [hereinafter Committee on Econ., Soc. & Cultural Rights: General Comment No. 14]. The Committee on ESCR consists of independent

Does a Human Rights Based Approach Suffice

describes social or underlying health determinants as including access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health, in addition to facilitating the participation of the population in all health-related decision-making at the community, national, and international levels.¹⁶⁷ This positively-couched characterization is likely responsible for the understanding. But this is wrong. Adverse factors or circumstances impacting health, such as lack of access to safe water supply or good schools, poor living conditions, hunger, starvation, poverty, etc., come within the definition of underlying determinants of health. In fact, in its final report to WHO, the Commission on Social Determinants of Health makes it quite explicit that it takes a broad view of underlying or social determinants of health.¹⁶⁸

The Commission defines social determinants of health as comprising “the structural determinants and conditions of daily life.”¹⁶⁹ These “structural determinants” encapsulate circumstances impacting upon “people’s lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities” as well as “their chances of leading a flourishing life.”¹⁷⁰ The implication, therefore, is that social health determinants comprise positive and adverse circumstances that impact health. When the conditions or circumstances promote health, they are positive social determinants. Otherwise, they are negative. Attending to these determinants requires innovations that although are not primarily health-oriented, nonetheless, contribute to good health. Examples include improving education and employment opportunities.

This broad conceptualization is consistent with the jurisprudence of the Committee on the Rights of Children. The Committee favors a holistic approach, placing the obligations imposed by the CRC “within the broader framework of

experts charged with the duty of monitoring the implementation of the International Covenant on Economic, Social and Cultural Rights by States Parties. Established under ECOSOC Resolution 1985/17 of May 28, 1985, the Committee undertakes monitoring functions assigned to the Economic and Social Council in Part IV of the International Covenant on Economic, Social and Cultural Rights. States Parties to the treaty are required to submit regular reports (within two years of ratification of, or accession to, the treaty and every five years thereafter) to the Committee which, in turn, examines the reports and issues “concluding observations,” outlining its concerns and recommendations. Furthermore, since the entry into force of the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights on May 5, 2013, the Committee has gained competence to receive and consider communications from individuals claiming violation of their rights under the ICESCR. The Committee is empowered, under certain circumstances, to investigate allegations of grave or systematic violations of ECOSOC rights of the ICESCR. In addition, inter-state complaints are also entertained by the Committee. See Committee on Economic, Social and Cultural Rights: Monitoring the Economic, Social and Cultural Rights, OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS, *available at* <http://www2.ohchr.org/english/bodies/cescr/> (last visited Oct. 28, 2013).

¹⁶⁷ Committee on Econ., Soc. & Cultural Rights: General Comment No. 14, *supra* note 166.

¹⁶⁸ THE COMMISSION ON SOC. DETERMINANTS OF HEALTH, CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 1(2008).

¹⁶⁹ THE COMMISSION ON SOC. DETERMINANTS OF HEALTH, *supra* note 168.

¹⁷⁰ THE COMMISSION ON SOC. DETERMINANTS OF HEALTH, *supra* note 168.

Does a Human Rights Based Approach Suffice

international human rights obligations.”¹⁷¹ In essence, realizing the right children have to health requires the consideration of other human rights as well. A child’s right to health cannot be secured unless those other rights, such as the right to shelter or to adequate nutrition, are also respected. Seen in this light, it becomes clear why the Committee on the Rights of the Child enumerates a gamut of factors touching on other human rights as social determinants that are critical to actualizing the right to health.¹⁷² These factors are comprised of age, sex, educational attainment, socioeconomic status, and domicile; determinants at work in the immediate environment of families, peers, teachers, and service providers, notably the violence that threatens the life and survival of children as part of their immediate environment; and structural determinants including policies, administrative structures and systems, and social and cultural values and norms.¹⁷³ For States Parties to the CRC, this interpretation could be construed as requiring that productive attention to social determinants of health with respect to children incorporate attention to the needs of mothers also. This evokes some important concepts.

Aside from children being the most vulnerable, as previously stated, the vulnerability of mothers has a direct bearing on the well-being of their children. For instance, a mother who is in a violent relationship constitutes a risk for the health and well-being of the child. Moreover, a significant number of infant deaths occur during the neonatal period, related to the poor health of the mother prior to, and during the pregnancy and the immediate post-partum period, as well as to suboptimal breastfeeding practices.¹⁷⁴ Therefore, since the health and health-related behaviors of mothers and other significant adults have a major impact on children’s health,¹⁷⁵ attending to social determinants of health in respect to children must also address the needs of their mothers and other caregivers. This dual responsibility (to the mother and other caregivers on account of the dependence or needs of the child) brings to the forefront the significance of interdependence, interconnectedness and indivisibility of human rights, core human rights values.¹⁷⁶ Ideally, the implementation of one human right leads (or ought to lead) to the actualization of one or more other human rights. This is an important lesson for States Parties to the CRC as well as other human rights treaties. In structur-

¹⁷¹ Committee on the Rights of the Child, General Comment No. 15, *supra* note 160, ¶ 2.

¹⁷² *Id.* ¶ 17.

¹⁷³ *Id.*

¹⁷⁴ *We Can End Poverty: Millennium Development Goals and Beyond 2015 Factsheet*, UNITED NATIONS, 1 (Sept. 2013), http://www.un.org/millenniumgoals/pdf/Goal_4_fs.pdf (reporting that 45 percent of all U5MR is blamable on undernutrition and that for the first six months of life, exclusively breastfed children are 14 times more likely to survive than children who were not breastfed).

¹⁷⁵ Committee on the Rights of the Child, General Comment No. 15, *supra* note 160, ¶ 18.

¹⁷⁶ See the Maastricht Guidelines on Violations of Econ., Soc. & Cultural Rts., ¶ 4, *reprinted in* 20 HUM. RTS. Q. 691–705 (1998) [hereinafter Maastricht Guidelines]; Limburg Principles on the Implementation of the Int’l Covenant on Econ., Soc. & Cultural Rts. ¶ 3, U.N. Doc E/CN.4/1987/17, *reprinted in* 9 HUM. RTS. Q. 122–35 (1987); 37 INT’L. COMM. JURISTS REV. 43–55 (1986) [hereinafter Limburg Principles]; Committee on the Rights of the Child, General Comment No. 15, *supra* note 160, ¶ 7; Obiajulu Nnamuchi, *Kleptocracy and its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria*, 52 J. AFR. L. 3 (2008).

Does a Human Rights Based Approach Suffice

ing a response to one or more needs predicated on a particular human right, the impact on other needs or human rights should be carefully reflected upon and taken into consideration as a basis of action.

Remarkably, the CRC shares a striking similarity with MDG 4. Akin to MDG 4, the aim of which is to “reduce child mortality” and “under-five mortality rate,”¹⁷⁷ Art. 24(2)(a) of the CRC mandates States Parties to pursue full implementation of children’s right to health and, in particular, take appropriate measures to “diminish infant and child mortality.”¹⁷⁸ This link or similarity is critical and is subject to a number of interpretations. As of 2000, when the Millennium Declaration was adopted,¹⁷⁹ the international community had already subscribed to the obligation to reduce child mortality – by virtue of the CRC (adopted in 1989).¹⁸⁰ For this reason, it is arguable that MDG 4 does not impose novel obligations since these obligations were already binding upon the vast majority of these same nations by the force of international law to which they voluntarily subscribed. Moreover, the thrust of an even older international policy document, the “Global Strategy Health for All by the Year 2000,” was to the same effect.¹⁸¹ The Global Strategy was adopted under the aegis of WHO in 1979 and specified its goal as 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.¹⁸² The goal of attaining health for all is obviously broad enough to incorporate reduction of child mortality envisaged by MDG 4 and the CRC. To this extent, MDG 4 represents a fresh attempt at remedying a problem that has failed to be addressed by previous international legal and policy instruments.

Aside from the child-specific legal frameworks considered above, there are several general human rights that also address the health of children, notably the ICESCR¹⁸³ and the African Charter on Human and Peoples’ Rights.¹⁸⁴ Article 12 of the ICESCR not only recognizes the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” it mandates that

¹⁷⁷ See U.N. STATISTICS DIV., *supra* note 8.

¹⁷⁸ Interventions that could be pursued in attaining this goal include attention to still-births, pre-term birth complications, birth asphyxia, low birth weight, mother-to-child transmission of HIV and other sexually transmitted infections. Additional strategies consist of addressing neonatal infections, pneumonia, diarrhea, measles, under- and mal- nutrition, malaria, accidents, violence, suicide and adolescent maternal morbidity and mortality. Health systems need to be strengthened to be responsive to the needs of children. See Committee on the Rights of the Child, General Comment No. 15, *supra* note 160, ¶¶ 34–35.

¹⁷⁹ G.A. Res. 53/202, U.N. Doc. A/RES/53/202 (Feb. 12, 1999).

¹⁸⁰ CRC, *supra* note 1.

¹⁸¹ Although the project was launched in 1979 at the 32nd World Health Assembly by virtue of resolution WHA32.30, the original idea for a united global effort at achieving health for all by the year 2000 was a product of the 30th World Health Assembly in 1977 (WHA 30.43). See WORLD HEALTH ORG., GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000 7 – 18 (1981) [hereinafter GLOBAL STRATEGY FOR HEALTH]. See also DON A. FRANCO, POVERTY AND THE CONTINUING GLOBAL HEALTH CRISIS 63 (2009) (describing 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 . . .”).

¹⁸² GLOBAL STRATEGY FOR HEALTH, *supra* note 181.

¹⁸³ Int’l Covenant on Econ., Soc. & Cultural Rts., *supra* note 79, art. 12.

¹⁸⁴ African Charter on Hum. & Peoples’ Rts., *supra* note 77.



Does a Human Rights Based Approach Suffice

States Parties adopt a “provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.”¹⁸⁵ Article 12 also mandates the “creation of conditions which would assure to all medical service and medical attention in the event of sickness.”¹⁸⁶ Here, again, there is an explicit link with MDG 4. The African Charter on Human and Peoples’ Rights imposes similar obligations on States Parties to the Charter.¹⁸⁷

The relatedness of this genre of frameworks with child-specific human rights treaties is that although they are more cosmopolitan, they also recognize children’s right to health as part and parcel of the general population. Their recognition of the right to health of the general population also includes children. Moreover, child-specific and general human rights treaties share close affinity with the MDGs. 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.”¹⁸⁸ This means that MDG4 does not, as pointed out earlier, impose new obligations. These very African nations now struggling to attain the requisite targets by 2015 are also States Parties to human rights treaties which, for several decades, demanded compliance with the same obligations. No matter how States Parties package their reasons, the issue is that they have not taken concrete measures to meet the health needs of the people within their respective jurisdictions. Had adequate resources been deployed toward ensuring compliance with their human rights obligations, there would certainly have been no need for MDG 4.

The question, then, becomes would international health policy (MDG project) succeed where international law (in the nature of human rights treaties) has failed? The answer is neither here nor there. Perhaps MDG 8, which requires affluent Western countries to support developing ones in their efforts toward attaining the various benchmarks of the MDGs, might be the clincher.¹⁸⁹ But the extent to which this goal would be realized depends on the seriousness of wealthy countries in terms of doling out funds to support struggling health systems in the global South. But is resource really the issue? Hardly. This concern is not new and has, for several years, been expounded by the Committee on ESCR.

Particularly relevant is the Committee’s articulation of a standard it referred to as “minimum core obligations” in 1990.¹⁹⁰ General Comment No. 3 was the first attempt by the Committee on ECSR to interpret the nature of the obligation (its precise contours and boundaries) States Parties assumed under Art. 2(1) of the

¹⁸⁵ Int’l Covenant on Econ., Soc. & Cultural Rts., *supra* note 79, art. 12(2)(a).

¹⁸⁶ *Id.* art. 12(2)(d).

¹⁸⁷ African Charter on Hum. & Peoples’ Rts., *supra* note 77, art. 16.

¹⁸⁸ U.N. MILLENNIUM PROJECT, INVESTING IN DEVELOPMENT: A PRACTICAL PLAN TO ACHIEVE THE MILLENNIUM DEVELOPMENT GOALS 119 (2005).

¹⁸⁹ MDG requires affluent countries to assist poor countries that has committed to good governance, development and poverty reduction. *See* U.N. STATISTICS DIV., *supra* note 8.

¹⁹⁰ U.N. Econ. & Soc. Council, Committee on Econ., Soc. & Cultural Rights General Comment No. 3: The Nature of States Parties’ Obligations, 5th Sess., ¶ 10, U.N. Doc. E/1991/23 (1991) [hereinafter Committee on Econ., Soc. & Cultural Rights: General Comment No. 3].



Does a Human Rights Based Approach Suffice

ICESCR.¹⁹¹ According to the Committee on ESCR, “a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights [contained in the Covenant] is incumbent upon every State party.”¹⁹² As to how exactly this standard relates to the obligation of States Parties, the Committee explains, “a State party in which any significant number of individuals is deprived of . . . essential primary health care . . . is, prima facie, failing to discharge its obligations under the Covenant.”¹⁹³ The Committee emphasizes the importance of the standard in stating, “[i]f the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its *raison d’être*.”¹⁹⁴ This means that underlying the ICESCR itself is a critical requirement, namely, that even if the rights of the Covenant cannot be optimally guaranteed, a basic threshold must be met, otherwise the State Party risks being considered non-compliant with its obligations.

In a subsequent interpretive instrument, adopted in 2000, the Committee on ESCR elaborated the standard, particularly in its specific application to the right to health under Art. 12 of the ICESCR.¹⁹⁵ In General Comment No.14, the Committee defines minimum core as imposing at least the obligations to:¹⁹⁶

- (a) ensure access to health facilities and related goods and services;
- (b) ensure access to the minimum amount of essential food;
- (c) ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;¹⁹⁷
- (e) ensure equitable distribution of all health facilities, goods and services;

¹⁹¹ Int’l Covenant on Econ., Soc. & Cultural Rts., *supra* note 79, art. 13.

¹⁹² *Id.*

¹⁹³ *Id.*

¹⁹⁴ *Id.*

¹⁹⁵ See generally Committee on Econ., Soc. & Cultural Rights: General Comment No. 14, *supra* note 166.

¹⁹⁶ *Id.* ¶ 43.

¹⁹⁷ See generally *Model List of Essential Medicine*, WORLD HEALTH ORG. (Apr. 2013), <http://www.who.int/medicines/publications/essentialmedicines/en/index.html>; see also, WORLD HEALTH ORG., MODEL LIST OF ESSENTIAL MEDICINES FOR CHILDREN: 3RD LIST (March 2011), available at http://whqlibdoc.who.int/hq/2011/a95054_eng.pdf. (WHO describes “essential medicines” 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. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford. The WHO Model Lists of Essential Medicines has been updated every two years since 1977. The current versions are the 17th WHO Essential Medicines List and the 3rd WHO Essential Medicines List for Children updated in March 2011. The flexibility allowed countries in tailoring the list to meet their public health priorities recognizes the differences in health challenges each country faces. Endemic diseases in Africa, such as malaria, should receive consideration in configuring the list in African countries but would have no relevance to countries in Europe and North America, which have virtually no incidence of the disease).



Does a Human Rights Based Approach Suffice

- (f) adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.

In addition, the Committee specifies a number of other obligations, which it projects as having “comparable priority,” including the obligation to:¹⁹⁸

- (a) ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- (b) provide immunization against the major infectious diseases occurring in the community;
- (c) take measures to prevent, treat and control epidemic and endemic diseases;
- (d) provide education and access to information concerning the main health problems in the community;
- (e) provide appropriate training for health personnel, including education on health and human rights.

Each of these obligations speaks powerfully to the challenges presently encountered in the area of child health, particularly in the developing world, and which MDG 4, depending on seriousness of implementation in each country, is poised to vanquish. For instance, paragraph (b) above, to “provide immunization against the major infectious diseases occurring in the community,” is strikingly similar to a key indicator of MDG 4, namely, “proportion of 1 year-old children immunised against measles.”¹⁹⁹

So, how are these obligations different from the general obligations imposed in respect to other aspects of the ICESCR or even in regard to the right to health under Art. 12? Because fulfilling the obligations imposed by the ICESCR is predicated on availability of resources (goods and services needed to actualize the right), States Parties are allowed some flexibility in pacing their march toward ensuring the rights of the Covenant for their respective populations.²⁰⁰ This flexibility recognizes that poor nations would not be in the same position as affluent ones in terms of resources needed for adequate response to the economic and social needs or rights of their peoples. The expectation is that States Parties “progressively,” as dictated by economic circumstances, achieve the realization of the rights – in a sense, recognizing the interface between resources and ability to protect the rights.²⁰¹ So long as a country has deployed the “maximum of its available resources” toward fulfilling its obligations under the Covenant, it cannot be held to have breached its obligations, even if the resources are inade-

¹⁹⁸ Committee on Econ., Soc. & Cultural Rights: General Comment No. 14, *supra* note 166, ¶ 44.

¹⁹⁹ U.N. STATISTICS DIV., *supra* note 8; Committee on Econ., Soc. & Cultural Rights: General Comment No. 14, *supra* note 166, ¶ 44.

²⁰⁰ Int’l Covenant on Econ., Soc. & Cultural Rts., *supra* note 79, art. 2(1); Committee on Econ., Soc. & Cultural Rights: General Comment No. 14, *supra* note 166, ¶¶ 30 – 31.

²⁰¹ Int’l Covenant on Econ., Soc. & Cultural Rts., *supra* note 79, art. 2(1); Committee on Econ., Soc. & Cultural Rights: General Comment No. 14, *supra* note 166, ¶¶ 30 – 31.

Does a Human Rights Based Approach Suffice

quate.²⁰² Regarding minimum core obligations, however, the position is different.

Although, as explained above, resource constraints could operate as an exculpatory factor, as a shield against non-compliance with country obligations under the ICESCR, the position is not the same in respect to those specific elements designated as minimum core obligations or of comparable priority. These latter obligations are non-derogatory, and non-compliance cannot be justified by any circumstances, including paucity of resources.²⁰³ This non-derogability characterization of minimum core obligations represents a marked divergence and a laudable improvement over the previous interpretation (General Comment No. 3), which excused performance on the basis of resource constraints.²⁰⁴ The Maastricht Guidelines is quite emphatic: “[s]uch minimum core obligations apply irrespective of the availability of resources of the country concerned or any other factors and difficulties.”²⁰⁵ This is consistent with an earlier document, the Limburg Principles, which mandated State Parties, regardless of the level of economic development, to ensure respect for minimum subsistence (meaning, minimum core or threshold) rights for all.²⁰⁶

Justification for non-derogation rests on the notion that the resource implication of compliance, given the very basic nature (affordability) of the requisite goods and services, will not overwhelm natural resources. Indeed, it is recognized that governments can meet these obligations “with relative ease, and without significant resource implications.”²⁰⁷ Non-derogability is premised on the idea that no sovereign nation is so impecunious as to be incapable of providing basic goods and services, the kind that is needed to satisfy the minimum core obligations.²⁰⁸ Significantly, in determining the amount of resources at the disposal of each country, consideration is given to both the national resources and those sourced externally through international cooperation and assistance,²⁰⁹ including support obtained within the context of MDG 8 from wealthy nations – official development assistance (“ODA”).²¹⁰

²⁰² Int’l Covenant on Econ., Soc. & Cultural Rts., *supra* note 79, art. 2(1).

²⁰³ Committee on Econ., Soc. & Cultural Rights: General Comment No. 14, *supra* note 166, ¶ 47.

²⁰⁴ Committee on Econ., Soc. & Cultural Rights: General Comment No. 3, *supra* note 190, ¶ 10.

²⁰⁵ Maastricht Guidelines, *supra* note 176, ¶ 9 (The Maastricht Guidelines have been recognized by the U.N. and published as an official U.N. Document with the following reference: E/C.12/2000/13).

²⁰⁶ Limburg Principles, *supra* note 176, ¶ 25.

²⁰⁷ Maastricht Guidelines, *supra* note 176, ¶ 10.

²⁰⁸ Obiajulu Nnamuchi, *Kleptocracy and its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria*, 52 J. AFR. L. 1, 33 (2008).

²⁰⁹ Limburg Principles, *supra* note 176, ¶ 26.

²¹⁰ See U.N. STATISTICS DIV., *supra* note 8.



Does a Human Rights Based Approach Suffice

v. conclusion

Solutions don't have to be complicated. There are inexpensive and simple responses that save children's lives, by preventing and by treating illnesses. These interventions must be made available to those who need them the most.

– U.N., We can End Poverty: Millennium Development Goals and Beyond 2015

Having fleshed out the numbers, the question that must necessarily be unearthed is whether Africa is on track to meet the benchmark of MDG 4 – to reduce its U5MR by two-third or 66 percent in 2015, relative to 1990 level. All available data suggest that this is very unlikely. Since the U5MR in 1990 was 175 deaths per 1000 live births,²¹¹ meeting the target would require reducing the number to 59.5.²¹² This is not an easy feat to accomplish, especially considering the current figure of 107,²¹³ less than two years before the deadline. The latest MDG report affirms this difficulty as sub-Saharan Africa has achieved reductions of just 39 percent.²¹⁴ Despite this bleakness, however, there are several innovative changes that countries in the region could embrace in order to advance themselves toward the goal of reducing child morbidity and mortality in their respective territories. Factors identified in this paper as key challenges such as early marriage, maternal illiteracy, poverty on the part of parents, death of skilled health personnel, as well as institutional poverty and leadership deficit must be expeditiously and completely annihilated. As elaborately discussed in Parts III and IV, these are human rights violations and would need to be addressed as such.

Implementation strategies and initiatives targeting diseases and illnesses as well as conditions or circumstances that combine to produce them (negative socioeconomic environment or adverse social determinants of health) should be mainstreamed into national and regional policies and adequately funded. This echoes the thinking of the Committee on the Rights of the Child, that “most mortality, morbidity and disabilities among children could be prevented if there were political commitment and sufficient allocation of resources directed towards the application of available knowledge and technologies for prevention, treatment and care.”²¹⁵ This, precisely, is the problem – whether African leaders are seriously committed to the health and wellbeing of children under their stewardship. Starkly presented, the question is whether Africa is so poverty-stricken that, despite its best efforts, it is simply incapable of responding to the needs of its people, health or otherwise. Development economists who have investigated this question, notably Dambisa Moyo²¹⁶ and William Easterly²¹⁷ project corruption,

²¹¹ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 59.

²¹² *Id.* (Figure derived by subtracting 66 percent or two-thirds from the 1990 figure (175) – which equals 115.5).

²¹³ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 59.

²¹⁴ U.N. MDG REPORT 2013, *supra* note 11, at 25.

²¹⁵ Committee on the Rights of the Child, General Comment No. 15, *supra* note 160, ¶ 1.

²¹⁶ See generally DAMBISA MAYO, DEAD AID: WHY AID IS NOT WORKING AND HOW THERE IS A BETTER WAY FOR AFRICA 48 – 97 (2009).



Does a Human Rights Based Approach Suffice

not finite resources, as the culprit for the stagnation in the region's socio-economic fundamentals. But beyond corruption, an emerging menace that is more consequential in the damage it inflicts upon health and wellbeing in Africa is political cabalism.

Perhaps as an inoculation against charges of kleptocracy, political elites in various countries in the region have fashioned another disingenuous, albeit legal, scheme of siphoning public resources into their individual pockets: bloated perquisites. A typical example is Africa's most populous and petroleum-rich nation, Nigeria. Its health system ranks 187th in the world, out of 191 countries surveyed.²¹⁸ The under-five mortality rate in the country—124 deaths per 1000 live births²¹⁹ – is 14th worst globally.²²⁰ Yet, its political class is the most remunerated (calculated as a ratio of GDP per capita) worldwide.²²¹ This is not to suggest that Nigeria is an oddity, sort of pariah, in the region. To the contrary, in a recent study of basic salary of lawmakers throughout the world, two other African nations, Kenya and Ghana, ranked second and third respectively.²²² Paradoxically, these are amongst the countries with the worst health indicators in the world,²²³ the same countries who are on the threshold of not meeting their MDG4 obligations on account of imaginary resource constraints.

To put this into perspective, the political class in Nigeria, including elite public servants (numbering just 18,000), is paid N1.26trn in salaries and allowances or 23 percent of the 2013 budget (N4.9trn).²²⁴ A distraught chairman of a government panel constituted to review and harmonize all the reform processes in the country's federal public service was quite explicit, "it is certainly not morally defensible from the perspective of social justice or any known moral criterion that such a huge sum of public fund is consumed by an infinitesimal fraction of the people."²²⁵ Indeed, to allow 18,000 people out of a population of 167 million²²⁶ to pocket 23 percent of the national resources is indefensible on any account. Worse, when you add an estimated average of \$4 to \$8 billion annually

²¹⁷ See generally WILLIAM EASTERLY, *THE WHITE MAN'S BURDEN: WHY THE WEST'S EFFORTS TO AID THE REST HAVE DONE SO MUCH ILL AND SO LITTLE GOOD* 42-44 (2006).

²¹⁸ WORLD HEALTH REPORT 2000, *supra* note 127, at 154.

²¹⁹ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 55 (Countries faring worse than oil-rich Nigeria are those considered amongst the poorest in the world: Niger, Mali, Guinea, Guinea Bissau, Angola, Burkina Faso, Burundi, Cameroon, Chad, Central Africa Republic, Congo, Sierra Leone and Somalia); see also WORLD HEALTH REPORT 2000, *supra* note 127, at 55.

²²⁰ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 50 – 57.

²²¹ J.S., I.B., & L.P., *Rewarding Work: A Comparison of Lawmakers' Pay*, THE ECONOMIST (July 15, 2013, 2:54 PM), <http://www.economist.com/blogs/graphicdetail/2013/07/daily-chart-12>.

²²² *Id.*

²²³ WORLD HEALTH REPORT 2000, *supra* note 127, at 153 – 54 (ranking the health systems of Ghana and Kenya as 135th and 140th globally).

²²⁴ Adebolu Arowolo, *Lecturers Too Deserve Good Pay*, DAILY INDEPENDENT (Aug. 16, 2013), <http://dailyindependentnig.com/2013/08/lecturers-too-deserve-good-pay-2/>.

²²⁵ *Id.*

²²⁶ *Id.*



Does a Human Rights Based Approach Suffice

during the eight years of Obasanjo administration (1999 to 2007)²²⁷ that evaporated into offshore bank accounts of these same leaders, it becomes easy to understand why the health of children in the country flounders. There are simply not enough funds left for legitimate business of the people, health or otherwise. The story is much the same throughout sub-Saharan Africa. It is a story of governance gone amok. In 2010, Nigeria allocated a measly 5.7 percent of its national budget to health.²²⁸ So, what is there to be done?

Western governments might invoke accountability mechanisms imbedded in MDG 8 to compel desired action on the part of political leadership in the region²²⁹ but unless citizens themselves rise *en masse* to demand good governance, no meaningful progress is possible in the realm of health or on any other front in the region. The Committee on the Rights of the Child was quite emphatic, the CRC imposes obligation upon States Parties to render appropriate assistance to parents in the performance of their child-rearing responsibilities, including assisting them in providing appropriate living conditions for the healthy development of their children.²³⁰ Therefore, failure on the part of governments in the region to discharge this duty foists upon the citizenry an obligation to stand up for their rights, to demand attention to their needs.

When, in the last quarter of 2013, news reached the Vatican that Franz-Peter Tebartz-van Elst, then Bishop of Limburg, Germany, had spent \$43 million in renovating his residence, he was hurriedly summoned to Rome.²³¹ Aside from his luxurious residence, Tebartz-van Elst—dubbed the “Bishop of Bling” by the media to emphasize his extravagance—is notorious for wasting church funds on expensive automobiles and trips.²³² A statement credited to the Vatican in explanation of Tebartz-van Elst’s unspecified leave, is quite telling, “a situation has been created in which the bishop can no longer exercise his episcopal duties.”²³³ This is not an insignificant statement. It echoes most provocatively the pro-poor

²²⁷ *Criminal Politics: Violence, “Godfathers”, and Corruption in Nigeria*,” HUMAN RIGHTS WATCH 31-32 (Oct. 2007), <http://www.hrw.org/reports/2007/nigeria1007/nigeria1007/webwcover.pdf>.

²²⁸ WORLD HEALTH STATISTICS 2013, *supra* note 14, at 136.

²²⁹ See Nnamuchi & Ortuanya, *supra* note 10 (This means that MDG 8 (to develop a global partnership for development) requires wealthy nations whose development assistance fuels much of the abuse in Africa to hold erring governments accountable, for instance, by denying further assistance in absence of clear demonstration of good governance. See also *Paris Declaration on Aid Effectiveness*, *supra* note 10, ¶ 4(v) (stipulating that donors and recipients of development assistance commit themselves to tackling the remaining challenges in the path to development of third world countries, including, “[c]orruption and lack of transparency, which erode public support, impede effective resource mobilization and allocation and divert resources away from activities that are vital for poverty reduction and sustainable economic development . . .”).

²³⁰ U.N. Committee on the Rights of the Child, General Comment No. 7: Implementing Child Rights in Early Childhood, ¶ 20, U.N. Doc.CRC/C/GC/7/Rev.1 (2006).

²³¹ Nicole Winfield & Geir Moulson, *Pope Expels German ‘Luxury Bishop’ from Diocese*, MSN NEWS (Oct. 23, 2013), available at <http://news.msn.com/world/pope-expels-german-luxury-bishop-from-diocese>.

²³² Carol J. Williams, *Suspended ‘Bishop of Bling’ was Bound to Irk Austere Pope Francis*, L.A. TIMES (Oct. 23, 2013), available at <http://www.latimes.com/world/worldnow/la-fg-wn-german-bishop-bling-suspended-pope-20131023,0,6762660.story#axzz2ihL4q3Um>.

²³³ *Id.*

Does a Human Rights Based Approach Suffice

vision of Pope Francis, that lavish and ostentatious lifestyle by church hierarchy should give way to Christian humility and service to the poor, the true symbol of leadership.²³⁴ This statement is particularly poignant when one considers that children at risk “tend to be among the poorest and the most marginalized in society,”²³⁵ the “wretched of the earth”, to borrow the title of a 1963 classic by psychiatrist/philosopher Frantz Fanon.²³⁶ Secularly translated, the papal pro-poor vision means that avarice, apathy and ostentatious lifestyles of the political class in Africa, projected in this paper as responsible for the health quandary in the region, must yield to responsible governance. It is a vision that should be co-opted by the citizenry in Africa.²³⁷ It is also one that is powerfully consistent with a human rights approach to health.

²³⁴ *Pope Francis Urges Church to Focus on Helping Poor*, BBC NEWS EUROPE (Oct. 4, 2013), available at <http://www.bbc.co.uk/news/world-europe-24391800> (Citing Pope Francis as saying the “Roman Catholic Church must strip itself of all ‘vanity, arrogance and pride’ and humbly serve the poorest in society” – in other words, for the Church to be transformed as the “Church of the poor”).

²³⁵ *We Can End Poverty: Millennium Development Goals and Beyond 2015 Factsheet 1*, UNITED NATIONS (2013), http://www.un.org/millenniumgoals/pdf/Goal_4_fs.pdf.

²³⁶ FRANZ FANON, *THE WRETCHED OF THE EARTH*, TRANSL. Richard Philcox (1963).

²³⁷ *We Can End Poverty*, *supra* note 235 (The fact that resource strapped countries in Africa such as Ethiopia, Malawi, Tanzania and even war-torn Liberia have been able to lower the U5MR in their respective territories by two-thirds or more since 1990 signals that the task is attainable: is a question, ultimately, of commitment of the leadership of the various countries in Africa to responsible governance).