**Canadian/Anglophone African Human Rights Engagement: A Critical Assessment of the Literature on Health Rights**

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**I Introduction**

This paper sets out to critically assess the literature documenting the nature, attainments, problems and prospects of Canada’s cooperation with countries of Anglophone Africa in the area of health rights. In international discourse, health rights are known by the short hand phrase “the right to health”.[[2]](#footnote-2) This right derives principally from Article 12 of the *International Covenant on Economic Social and Cultural Rights* (ICESCR)[[3]](#footnote-3) which defines the right, amongst other things, as “…the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”[[4]](#footnote-4) A number of international treaties, apart from the ICESCR, have also made provisions for the right to health in international law. In doing so, they advance the right amongst different categories of people, such as women and children; and in in different geo-political settings such as the African Union system and the Organisation of American States. Together, these international instruments (guaranteeing the right to health) are referred, to in this paper, as the treaty framework.[[5]](#footnote-5) It is noteworthy however that the understanding of the right to health informing the discussion in this paper derives from the ICESCR and the work of the Committee on Economic, Social and Cultural Rights (CESCR) in interpreting and monitoring the fulfillment of that right by states.

The broad discourse on the right to health in international law remains quite controversial in a number of key areas: for instance in the question of its theoretical foundations;[[6]](#footnote-6) in the identification of its meaning;[[7]](#footnote-7) in the development of its content;[[8]](#footnote-8) and in the specification of the obligations imposed on State parties to fulfill the right to health.[[9]](#footnote-9) A major source of this controversy is the way *health* has been broadly defined in the Constitution of the World health Organisation (WHO) as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”[[10]](#footnote-10) This definition has been the subject of intense criticism by the scholarship for, amongst other things, including the notion of “social well-being” into the definition of health, thus making “the enduring problem of human happiness one more medical problem to be dealt with by scientific means.”[[11]](#footnote-11)

Despite these controversies the CESCR, through *General Comment 14* – the most authoritative interpretation of the right to health in international law – has clarified that the right to health is not to be understood as a right to be healthy. On the contrary, it is a right containing both freedoms and entitlements.[[12]](#footnote-12)

The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.[[13]](#footnote-13)

*General Comment 14* notes further that “in all its forms and at all levels”, the right to health contains “interrelated and essential elements” that have to be applied by each state on the basis of prevailing conditions.[[14]](#footnote-14) It identifies these elements as *availability* (i.e. functioning public health and health facilities, goods, services and programmes in sufficient quantity in the state); *accessibility* (i.e. ability of everyone, without discrimination, to access health facilities, goods and services in the state); *acceptability* (i.e. health facilities, goods and services must respect medical ethics and be culturally appropriate); and *quality* (i.e. health facilities, goods and services must be scientifically and medically appropriate and of good quality).[[15]](#footnote-15)

*General Comment 14* also identifies six *core obligations* and five *obligations of comparable priority* arising from the right to health. The core obligations are listed as ensuring: non-discriminatory access to health facilities, goods and services; access to the minimum essential food which is nutritionally adequate and safe; access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; provision of essential drugs as defined under the WHO Action Programme on Essential Drugs; equitable distribution of health facilities, goods and services; and the adoption and implementation of a national public health strategy and plan of action based on epidemiological evidence, and addressing the health concerns of the whole population.[[16]](#footnote-16)

The obligations of comparable priority are ensuring: reproductive, maternal (pre-natal and post-natal) and child health; provision of immunisation against the major infectious diseases in the community; the adoption of measures to prevent, treat and control epidemic and endemic diseases; the provision of education and access to information concerning the main health problems in the community, and methods for preventing and controlling them; and the provision of appropriate training for health personnel, including education on health and human rights.[[17]](#footnote-17)

In critically examining the literature documenting the nature, attainments, problems and prospects of Canada’s engagement Anglophone Africa in the fulfilment of the right to health, this paper focuses on how the “interrelated and essential elements” of availability, accessibility, acceptability and quality of health goods and services have been impacted upon by that engagement. The structure of the paper is thus as follows: Part II examines Canada/Anglophone Africa health rights engagement and the availability of health goods and services. Part III discusses Canada/Anglophone Africa health rights engagement and the accessibility of health goods and services. Part IV examines Canada/Anglophone Africa health rights engagement and the acceptability of health goods and services. Part V discusses Canada/Anglophone Africa health rights engagement and the quality of health goods and services. Part VI concludes the chapter by offering a summary of the tentative findings from the literature about the nature, attainments, problems and prospects of the cooperation between Canada and Anglophone Africa in the area of health rights.

**II The Availability of Health Goods and Services**

Although scholarly works documenting Canada’s engagement with countries of Anglophone Africa in the provision of health goods and services were not encountered in the desk review conducted for this paper, there was sufficient evidence of a strong, vibrant and ongoing engagement between Canada and countries of Sub-Saharan Africa (SSA)[[18]](#footnote-18) in the area of the provision of health goods and services. The nature of this engagement is such that Canada is identified as a strong supporter and big contributor to various initiatives and programs targeted at “strengthening health systems and improving access to high-quality basic health services in a number of African countries.”[[19]](#footnote-19) The majority of these contributions were channelled through the Canadian International Development Agency (CIDA), or administered through the Department of Foreign Affairs and International Trade (DFAIT), the Department of Finance Canada and/or the International Development Research Centre (IDRC).[[20]](#footnote-20)

For instance, a number of official records of Canada show that CIDA-funded a project executed in fifteen states and the federal capital territory of Nigeria between 2011 and 2015 (inclusive) for the accelerated reduction in the rate of maternal, newborn and child mortality in those states. The project was designed to “strengthen the delivery of maternal, newborn and child health services through evidence-based, gender-responsive interventions, using existing health and community structures in the focus states.”[[21]](#footnote-21) CIDA also contributed to a project fund executed by the WHO between 2011 and 2015 (inclusive) in Zimbabwe, Malawi and Nigeria with the aim of working towards the elimination of mother-to-child transmission of HIV by providing sustained support in these countries where a high prevalence rate of HIV/AIDS was manifest.[[22]](#footnote-22) CIDA contributed to Nigeria’s AIDS Responsive between 2003 and 2010 (inclusive);[[23]](#footnote-23) and to the Polio Eradication Program of Nigeria which was executed by the WHO between 2012 and 2015 (inclusive).[[24]](#footnote-24) Through these contributions, Canada situated itself as a strong supporter and contributor to programs that were targeted at increasing the availability of health goods and services.

However the engagement in this area has not been a ‘one-way street’. Canada has also benefitted immensely from many Anglophone African countries in the area of health personnel. The literature shows that Canada has been a major recipient of foreign-trained health professionals, notably physicians from South Africa, Nigeria and other SSA countries and the rate of influx of these professionals into Canada is noted to be on the increase.[[25]](#footnote-25) The pull-factors for the migration of these health professionals to Canada is the prospects of better living and working conditions to those obtainable in their home countries. The detriment to Anglophone countries where these health professionals originate from is the critical shortage of these highly sought-after health professionals. [[26]](#footnote-26)

**III The Accessibility of Health Goods and Services**

Canada is recorded to have made direct contributions towards promoting access to health in many Anglophone African countries. Accessibility in this context, as clarified by *General Comment 14,* refers to the ability of everyone, without discrimination, to access health goods and services.[[27]](#footnote-27) Canada’s contribution in this regard was towards a projected executed by the UN Entity for Gender Equality and the Empowerment of Women between 2010 and 2013 (inclusive). The goal of this project was to improve women’s access to legal, property and inheritance rights in order to reduce their vulnerabilities to HIV/AIDS. The benefitting Anglophone African countries included Uganda, Zimbabwe, Kenya, Ghana, Tanzania, Malawi and Nigeria.[[28]](#footnote-28)

The reciprocal contributions of Anglophone African countries to Canada in this area arises by virtue of the earlier discussion about the influx of health professionals from many Anglophone African countries to Canada: through the influx of this health professionals to Canada, the health workforce of Canada has been positively impacted and health services have become more easily accessible to Canadians as a result of the presence and contributions of these health professionals to the health system of Canada.[[29]](#footnote-29)

**IV The Acceptability of Health Goods and Services**

This element of the right to health states that health facilities, goods and services must respect medical ethics and be culturally appropriate.[[30]](#footnote-30) Although the desk review carried out for this paper did not directly confirm how this aspect of the right to health fared in the engagement between Canada and countries of Anglophone Africa in the advancement of health rights, it is safe to assume that Canada must have taken on board all of these considerations in the funding of its programs across Anglophone Africa. However, this is an area where more specific evidence is required to be able to comment effectively on whether Canada was able to advance this element of the right to health in its interactions with these countries. A similar position is taken with respect to the contributions made by Anglophone African countries to Canada in the advancement of the health rights of the Canadian population.

**V The Quality of Health Goods and Services**

This element of the right to health states that health facilities, goods and services must be scientifically and medically appropriate and of good quality.[[31]](#footnote-31) Canada’s contribution in this area is exemplified through its funding of a project in Nigeria (from 2003 to 2013, inclusive) that aimed to improve primary health care provision in two states (Bauchi and Cross River States) by “strengthening the capacity of Schools of Health Technology to provide appropriate, quality education to primary health care workers.”[[32]](#footnote-32) The unavailability of records in this area makes it difficult to identify the reciprocal contributions of Anglophone African countries (if any) to the health care system, and the situation of the right to health, in Canada.

**VI The Nature, Attainment, Problems and Prospects of the Engagement**

The foregoing literature review, whilst limited in many respects, reveals a number of important findings that can support a tentative conclusion as to the nature, attainments, problems and prospects of the cooperation between Canada and countries of Anglophone Africa in the

[A] *Nature of the Engagement*

The principal conclusion that can be drawn about the nature of the engagement is that Canada has been a strong supporter of health rights in many Anglophone African countries, demonstrating this support by funding projects that advance the right to health in these countries. In a similar manner, many Anglophone African countries have made substantial, but indirect, contributions to the advancement of the state of health rights in Canada. This is by virtue of the exodus of health professionals from these Anglophone African countries to Canada in search of better working and living conditions. The presence of these health professionals in Canada has significantly increased the availability of highly trained health professionals to meet the needs of Canada’s ageing population.

[B] *Attainments*

In many respects, the engagement between Canada and countries of Anglophone Africa has been quite beneficial to the two parties. On the part of Anglophone African countries, significant foreign assistance to meet critical infrastructural and other health needs have come from Canada. On Canada’s part, it has benefitted from the critical harvest of the best of health professionals that many countries of Anglophone Africa have to offer.

[C] *Problems*

A key issue in the relationship between Canada and countries of Anglophone Africa has to do with the unsustainability of the massive exodus of health professionals from Africa to Canada. This is because it is occurring at the expense of the health system of many of these countries where there is a severe lack of well-trained health professionals working to stem the increasing burden of communicable and non-communicable diseases on the African continent. As the literature indicates, this is an area where Canada may need to show leadership in charting the path towards address some of the pull-factors for the migration of health professionals from Anglophone Africa countries to Canada.[[33]](#footnote-33)

[D] *Prospects*

There is no doubt that there are more positives, than negatives flowing from the engagement between Canada and countries of Anglophone Africa in the area of health rights. In setting an agenda for research in this area, it is needful to identify ways in which Canada’s contribution to countries of Anglophone Africa can be directed more towards strengthening the health institutions of these countries to be able to serve effectively as a first line of defence against epidemic and endemic diseases. This is against the backdrop of the Ebola Virus Diseases outbreak in 2014 which affected Nigeria and some other countries of the African continent. While Nigeria was able stem the tide of the disease before many lives were claimed because of the vigilance, sacrifice and experience of its health workforce, those other countries that did not have the same “opportunity structures”[[34]](#footnote-34) in their health system paid dearly for it with human lives. As Alicia Yamin rightly observed, in the context of the Ebola crisis, “…neither universal health *insurance*, without real access to public health as well as effective care, nor case transfers, without connections to functioning systems, would have thwarted Ebola or the social devastation it wreaked.”[[35]](#footnote-35)

Another issue that should perhaps feature prominently in the research agenda is the question of what Canada can do, by way of technical or financial support, to help countries of Anglophone Africa meet the target of universal health coverage set by member states of WHO in 2005.[[36]](#footnote-36) Three dimensions are captured in the vision of universal health coverage by the *World Health Report 2010*, namely: the health services that are needed, the number of people that need them, and the costs to whoever must pay – users and third party funders.[[37]](#footnote-37) If Canada can direct its engagement with countries of Anglophone Africa towards this direction, it is likely that the situation of the right to health in these countries will be significantly fortified.

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15. Ibid. [↑](#footnote-ref-15)
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