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MILLENNIUM DEVELOPMENT GOAL 6 AND THE TRIFECTA OF HIV/AIDS, MALARIA, AND TUBERCULOSIS IN AFRICA: A HUMAN RIGHTS ANALYSIS

DR. OBIAJULU NNAMUCHI*

I. INTRODUCTION AND PRELIMINARY BACKGROUND

At the Millennium Summit, convened as a key part of the Millennium Assembly of the United Nations,[1] in September 2000, participating world leaders unanimously ratified the Millennium Declaration—a set of objectives grounding the Millennium Development Goals ("MDGs" or "Goals").[2] The MDGs consist of the commitment by the global community to pursue a number of objectively and quantitatively verifiable Targets, with the deadline for reaching most of these Targets set at 2015.[3] Strikingly, of the eight Goals to which each country aspires to attain within the specified time frame, one—MDG 6—is devoted to combating HIV/AIDS, malaria, and other diseases.[4] Considering the devastation these diseases have inflicted, and continue to inflict, upon the lives and wellbeing of Africans, it is clear that this Goal holds special significance for people in the region. But whether the benchmarks of MDG 6 would actually be attained, come 2015, is mired in controversy as pessimism remains rife about Africa's capability to achieve this or any of the other Goals.

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1. G.A. Res. 53/202, ¶ 2, U.N Doc. A/RES/53/202 (Dec. 17, 1998).

2. United Nations Millennium Declaration, G.A. Res. 55/2, U.N. Doc. A/RES/55/2 (Sept. 8, 2000) (stating the objectives as being values and principles; peace, security, and disarmament; development and poverty eradication; protecting the environment; human rights, democracy, and good governance; protecting the vulnerable; meeting the special needs of Africa; and, strengthening the U.N.).

3. *Id.*; 2005 World Summit Outcome, G.A. Res. 60/1, U.N. Doc. A/RES/60/1 (Sept. 16, 2005); *see also Official List of MDG Indicators*, UNITED NATIONS STAT. DIVISION, http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm (last updated Jan. 15, 2008) [hereinafter *MDG Indicators*].

4. The remaining MDGs are to: eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, ensure environmental sustainability, and develop a global partnership for development. *MDG Indicators*, *supra* note 3.

The African Union Conference of Health Ministers was quite categorical, "Africa is still not on track to meet the health Millennium Declaration Targets and the prevailing population trends could undermine progress made."[5] More recently, New York University professor of economics William Easterly documents other instances[6] including, inter alia, a statement by the U.N. Department of Public Information, "[a]t the midway point between their adoption in 2000 and the 2015 target date for achieving the [MDGs], sub-Saharan Africa is not on track to achieve any of the Goals."[7] But Professor Easterly vehemently disagrees with the conclusion, blaming the bleak picture on "poorly and arbitrarily" designed MDGs, the effect of which, in his view, has been widespread and misguided portrayal of Africa in a worse light than the true circumstances warrant.[8] Other scholars identify the "overly-ambitious" nature of the Goals themselves as the culprit.[9]

But regardless of design flaws or the overly-ambitious nature of the MDGs, evidence is beginning to percolate indicating that whilst challenges abound, there are bright spots in several countries in the region. Even in nations seriously lagging behind, new initiatives continue to be rolled out, aimed at bridging the gap between current realities and the MDGs. The political leadership is adamant about its commitment to achieving the Goals. Speaking at the 2008 World Economic Forum in Davos, Switzerland, Umaru Yar'Adua, the late president of Nigeria, echoed the regional attitude, "[f]or us in Africa, the achievement of the MDGs is our sacred duty."[10] This is quite an encouraging proclamation; nonetheless, whether this rhetoric is being or will be acted upon by authorities in the region, and if the strategies would be sufficient to pull the region out of its present doldrums, will begin to unfold as the various benchmarks specified in Goal 6, the focus of this discourse, are examined and will become even clearer as the 2015 deadline draws nigh. A critical aspect of this paper is its identification of what it calls "special population groups" (the most vulnerable groups in relation to the diseases) as worthy of being put "in front of the line," so to speak, in terms of receiving necessary interventions. Prioritizing the interest of vulnerable groups in the overall scheme of attending to population-wide challenges is a key requirement of human rights. It is a catechism forcefully advanced in this discourse.

This paper consists of six sections. Following the introduction, Part II examines global attempts to get a handle on the scourge of HIV/AIDS as well as

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5. African Union Conference of Ministers of Health, *African Health Strategy: 2007-2015*, at 2, AU Doc. CAMH/MIN/5(III) (Apr. 13, 2007), *available at* http://www.nepad.org/system/files/AFRICA_HEALTH_STRATEGY(health).pdf.

6. William Easterly, *How the Millennium Development Goals are Unfair to Africa*, 37 WORLD DEV. 26, 26 (2009).

7. UNITED NATIONS, AFRICA AND THE MILLENNIUM DEVELOPMENT GOALS: 2007 UPDATE 1 (2007), *available at* http://www.unicnairobi.org/Africa_and_MDGs_07_final.pdf.

8. Easterly, *supra* note 6, at 26.

9. *See* MICHAEL CLEMENS & TODD MOSS, CTR. FOR GLOBAL DEV., CGD BRIEF: WHAT'S WRONG WITH THE MILLENNIUM DEVELOPMENT GOALS? 1-2 (2005), *available at* www.cgdev.org/files/3940_file_WWMGD.pdf.

10. *World Leaders Issue Call to Action on MDGs*, PAMBAZUKA NEWS (Jan. 28, 2008), http://pambazuka.org/en/category/development/45713.

factors standing in the path to success in Africa. It also identifies measures that hold prospect for reversing the *status quo*. Part III continues this theme, albeit with a different focus, by interrogating efforts to control malaria in the region. The section analyzes the wide disparities between countries in the region in terms of incidence and resulting mortalities and proffers suggestions on how to bridge the divide—a necessity for attaining Goal 6. In Part IV, the paper zeroes in on the prevalence of TB in Africa and the adoption of the World Health Organization's ("WHO") directly observed treatment short course ("DOTS") as part of the Stop TB Strategy, which was recommended by the WHO as the cornerstone of national anti-TB strategies. The section argues that although this approach has resulted in significant improvement in the control and management of TB, a lot more still needs to be done, including scaling up a range of critical interventions via increases in budgetary allocation to TB. Part V seeks a human rights solution to the tragedy resulting from the trifecta of HIV/AIDS, malaria, and TB. Its central argument is that while health care-based interventions are certainly critical to making inroads into the situation, it must be strengthened with deploying resources to the conditions that combined to subject people to these diseases and conditions in the first place. The section projects underlying or social determinants of health as holding the key to freedom from the stranglehold that these diseases hold on human lives and, borrowing from liberation theology, calls for prioritizing the needs of vulnerable groups. The conclusion—Part VI—is that operationalizing the human rights-based recommendation of the paper is fundamental not only to consigning HIV/AIDS, malaria, and TB in Africa to the abyss of history, but also to positioning the region on a sustainable path toward attaining Goal 6.

II. HIV/AIDS

A. Impact and Relevant Benchmarks

There are two HIV/AIDS-related Targets: (i) to "[h]ave halted by 2015 and begun to reverse the spread of HIV/AIDS;" and (ii) "[a]chieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it."[11] Definitionally, at least, the first arm of the Target appears to have been met in most regions of the world, including Africa.[12] The most recent data shows a decline in the number of new infections globally. A total number of 2.5 million people (including adults and children) were infected in 2011, 20 percent less than 2001.[13] There have been dramatic changes in infection pattern and incidence in the last decade. The incidence of HIV infection declined amongst adults by more than 25 percent in

11. *MDG Indicators*, *supra* note 3 (referencing Goal 6).

12. JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, GLOBAL REPORT: UNAIDS REPORT ON THE GLOBAL AIDS EPIDEMIC 2010, at 7 (2010), *available at* http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf.

13. JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, GLOBAL REPORT: UNAIDS REPORT ON THE GLOBAL AIDS EPIDEMIC 2012, at 8 (2012) [hereinafter UNAIDS REPORT 2012], *available at* http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf.

thirty-nine countries, twenty-three of them in sub-Sahara Africa.[14] In fact, sub-Sahara Africa ranks second only to the Caribbean in reduction level, at 25 percent.[15] Despite these improvements, however, the region, comprising just 12 percent of the global population, bears the worst brunt of the pandemic,[16] accounting for nearly 70 percent of the global population of people living with HIV/AIDS ("PLWHA"), nearly one in every twenty adults (4.9 percent of people in the region).[17]

In 2011, deaths resulting from AIDS-related causes totaled 1.7 million globally, representing a 24 percent decline in AIDS-related mortality in comparison to 2005 when the number was 2.3 million.[18] Although the number of people dying from AIDS-related causes in sub-Sahara Africa declined by 32 percent from 2005 to 2011, the region was still responsible for 70 percent of such deaths in 2011.[19] Of the 17.1 million children around the world who were estimated to have lost one or both parents to AIDS in 2009, 15 million of them lived in sub-Saharan Africa.[20] Although the number of PLWHA is growing, the growth represents an increase in longevity due to improved access to treatment and other support services.[21]

The second arm of the Target, obligating countries to provide universal access to treatment for all those who need it by the year 2010,[22] appears to be more problematic as the deadline has passed and yet, except for Western countries, no other region met the Target.[23] Nevertheless, recent data indicate significant progress even in some of the worst affected countries. In fact, some dramatic result could have been recorded had it not been for the WHO's new recommendation on when antiretroviral therapy ("ART") should be initiated (CD4 count of or below 350 cells/mm3 in contrast to the previous criterion of CD4 count of or below 200 cells/mm3).[24] This change and its result notwithstanding, 2011 represents huge advances in scaling up access to ART. For the first time ever, a majority (54 percent) of those in need of treatment in low and middle-income

14. *Id.* at 11.

15. *Id.* at 8.

16. U.N. DEP'T OF ECON. & SOC. AFFAIRS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 2012, at 39, U.N. Sales No. E.12.I.4 (2012) [hereinafter MDGS REPORT 2012], *available at* http://mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2012/English2012.pdf.

17. UNAIDS REPORT 2012, *supra* note 13, at 8.

18. *Id.* at 12.

19. *Id.*

20. MDGS REPORT 2012, *supra* note 16, at 41.

21. UNAIDS REPORT 2012, *supra* note 13, at 12.

22. *See id.* at 51-55.

23. *See* U.N. DEP'T OF ECON. & SOC. AFFAIRS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 2010, at 45, U.N. Sales No. E.10.I.7 (2010) [hereinafter MDGS REPORT 2010], *available at* http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf.

24. WORLD HEALTH ORG. [WHO] ET AL., TOWARDS UNIVERSAL ACCESS: SCALING UP PRIORITY HIV/AIDS INTERVENTIONS IN THE HEALTH SECTOR: PROGRESS REPORT 2010, at 6 (2010), *available at* http://whqlibdoc.who.int/publications/2010/9789241500395_eng.pdf?ua=1.

countries actually received it.[25] Even sub-Sahara Africa was not left behind. The region attained 56 percent coverage within the same period.[26] To grasp the real impact of this growth in the number of eligible people receiving ART, one has to see it in economic terms, in the sense of the effect on economic productivity (as mentioned in the abstract) in affected countries. At the end of 2011, 8 million people were receiving ART, representing "a 20-fold increase since 2003."[27] The availability of this life-saving intervention in low and middle-income countries has had dramatic impact, adding 14 million lived-years in these countries, including 9 million in sub-Sahara Africa.[28]

The WHO defines "universal access" as the existence of "an environment in which HIV prevention, treatment, care and support interventions are available, accessible and affordable to all who need them."[29] A critical element of this definition is that achieving universal access does not necessarily mean that everyone in need receives ART, for even if treatment is available, accessible and affordable, there is no guarantee that some people would not, for whatever reason, decide against treatment. Given this consideration, one could surmise that the obligation incumbent on countries is to create conditions that are conducive for the "participation" of affected individuals in the "planning and implementation of their health care," including ensuring that cost does not constitute an obstacle to treatment.[30] What constitutes "participation," in terms of health care implementation would vary according to the socioeconomic circumstances of those seeking treatment—meaning that for some individuals, free or subsidized coverage would be provided but not for others. Therefore, it is possible to achieve universal access in the sense indicated above, by removing obstacles to accessing treatment, even though 100 percent coverage is not reached. In fact, the WHO's specific parameter for achieving universal access to ART is achieving at least 80 percent coverage of those in need.[31] So, how does Africa fare? At the end of 2010 three countries, namely, Botswana, Namibia, and Rwanda achieved universal access to ART, whereas Swaziland and Zambia are not far off, having achieved an estimated coverage of 70-79 percent.[32]

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25. UNAIDS REPORT 2012, *supra* note 13, at 51.

26. *Id.*

27. *Id.* at 50.

28. *Id.*

29. WHO, PRIORITY INTERVENTIONS: HIV/AIDS PREVENTION, TREATMENT AND CARE IN THE HEALTH SECTOR 1 (2009), *available at* http://www.who.int/hiv/pub/priority_interventions_web.pdf.

30. International Conference on Primary Health Care, Alma-Ata, USSR, Sept. 6-12 1978, The Declaration of Alma-Ata, art. IV, *available at* http://whqlibdoc.who.int/publications/9241800011.pdf.

31. WHO ET AL., GLOBAL HIV/AIDS RESPONSE: EPIDEMIC UPDATE AND HEALTH SECTOR PROGRESS TOWARDS UNIVERSAL ACCESS: PROGRESS REPORT 2011, at 89 (2011) [hereinafter HIV/AIDS RESPONSE PROGRESS REPORT 2011], *available at* http://whqlibdoc.who.int/publications/2011/9789241502986_eng.pdf.

32. *Id.* at 90.

B. Special Population Groups

Although HIV/AIDS is no respecter of persons or territories, affecting every demography throughout Africa, the impact is disproportionately felt by certain population groups, namely, women, sex workers, and prisoners.[33] True, illness produces vulnerability, but even amongst the sick, some are more vulnerable than others. For this reason, arresting the spread of HIV/AIDS must start with identifying and attending to the special needs of these especially at-risk vulnerable groups.

There is a higher incidence of infection amongst women in Africa than men.[34] Over the last few years, HIV infection has stabilized everywhere else in the world, affecting both genders equally, except in sub-Saharan Africa and the Caribbean, where the rate of infection amongst women stand at 59 and 53 percent respectively of all people living with HIV.[35] This is a major problem; it not only touches on MDG 6, it also affects meeting the obligation of countries in sub-Sahara Africa regarding MDG 5 (reducing maternal mortality) and MDG 4 (reducing child mortality).[36] This is especially critical given that latest figures indicate that not only did the region record the largest proportion of maternal deaths attributable to HIV (10 percent), it was also responsible for 17,000, or 91 percent, of the 19,000 worldwide deaths formally known as "AIDS related indirect maternal deaths."[37] Failure to stem the tide of HIV amongst women in Africa has a domino-like impact on children and negatively impacts the ability of countries in the region to reduce child mortality as required under MDG 4.[38] This is because pregnancy for women living with HIV poses a real risk to their unborn children. Intrapartum transmission of HIV is common in most countries in the region due to massive drug unavailability and even where availability is not a problem, high cost

33. *E.g.*, MDGS REPORT 2012, *supra* note 16, at 39; UNAIDS REPORT 2012, *supra* note 13, at 70; WHO, INTEGRATING GENDER INTO HIV/AIDS PROGRAMMES IN THE HEALTH SECTOR, at xi-xii (2009) [hereinafter INTEGRATING GENDER], *available at* http://whqlibdoc.who.int/publications/2009/9789241597197_eng.pdf?ua=1 (reporting that although 50 percent of global HIV population are women, in Africa, the percentage is 60 percent); Stefan Baral et al., *Burden of HIV Among Female Sex Workers in Low-Income and Middle-Income Countries: A Systematic Review and Meta-Analysis*, 12 LANCET INFECTIOUS DISEASES 538 (2012); *Tuberculosis in Prisons*, WHO, http://www.who.int/tb/challenges/prisons/story_1/en/index.html (last visited Feb. 17, 2014) (reporting that HIV and TB are more common amongst prisoners).

34. INTEGRATING GENDER, *supra* note 33, at xi.

35. MDGS REPORT 2012, *supra* note 16, at 39; UNAIDS REPORT 2012, *supra* note 13, at 70 (putting the figure for sub-Sahara Africa at 58 percent).

36. *See* UNITED NATIONS DEV. GROUP, THEMATIC PAPER ON MDG 4: REDUCE CHILD MORTALITY, THEMATIC PAPER ON MDG 5: IMPROVE MATERNAL HEALTH, THEMATIC PAPER ON MDG 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES 4 (2010), *available at* http://www.undg.org/docs/11421/MDG4-6_1954-UNDG-MDG456-LR.pdf.

37. MDGS REPORT 2012, *supra* note 16, at 31.

38. United Nations Millennium Declaration, G.A. Res. 55/2, ¶ 19, U.N. Doc. A/RES/55/2 (Sept. 8, 2000) (MDG 4: reduction of child mortality).

effectively keeps the door shut for most women in those countries.[39] The complexity and interconnectedness of these problems threaten the ability of Africa to meet the Targets of the health-MDGs. It is essential, therefore, in order to make meaningful headway, that policy makers pay special attention to women, particularly maternal health, in formulation of strategies to deal with HIV pandemic in their respective jurisdictions.

The second vulnerable group in need of special protection is female sex workers. There are two reasons why taking concrete steps to deal with this group of HIV-infected women is very important to the entire MDGs project. First, akin to the multidimensional nature of the problems implicated in the case of pregnant women who are HIV positive (in terms of being a source of infection to the child and, therefore, touching on MDGs 4 and 5), paying particular attention to the special needs of female sex workers living with HIV/AIDS also impacts MDG 1 (poverty eradication). As more fully argued in Part V, prostitution is not a choice. Trading oneself for money is not a vocation one chooses upon careful reflection on its suitability or otherwise to the individual's aptitude and future wellbeing. It is not a source of individual fulfillment; instead, it is the direct result of a combination of circumstances in respect to which the individual lacks any real control. HIV/AIDS is symptomatic of the gruesome conditions under which these women must survive; it is not the root cause. Therefore, HIV/AIDS-related therapeutic interventions in isolation of sustainable strategies capable of expurgating the circumstances that makes sex work attractive in the first place is a move in the wrong direction.[40]

Countries seriously committed to solving HIV/AIDS problems amongst female sex workers must also be prepared to meet their obligation to efface poverty amongst its population, prostitute or otherwise.[41] Poverty breeds prostitution and vice versa, as evidenced by the high incidence of deprivation and want amongst this population.[42] Both set their victims on a path to HIV/AIDS. A resolution adopted by the U.N. captures this nexus and the need for synergistic response: "Recognizing that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS, and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or

39. *See* JAMES MCINTYRE, UNAIDS, HIV IN PREGNANCY: A REVIEW 9-10 (1998), *available at* http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub01/jc151-hiv-in-pregnancy_en.pdf.

40. *See* G.A. Res 65/277, ¶ 25, U.N. Doc. A/RES/65/277 (June 10, 2011).

41. *See MDG Indicators*, *supra* note 3 (describing the message of MDG 1 as demonstrating the linkages amongst the various MDGs and inviting countries to eradicate extreme poverty and hunger in their territories).

42. *See* JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, UNAIDS GUIDANCE NOTE ON HIV AND SEX WORK 18 (2012), *available at* http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf.

impeding development in many countries and should therefore be addressed in an integrated manner."[43]

Another undergirding rationale for taking seriously the uniquely different circumstances of this vulnerable population is the consequence of inaction on others. More than any other demography, female sex workers constitute the most formidable source of HIV infection.[44] The rate of infection amongst them is staggering, up to 76.6 percent in some studies,[45] although a more recent large cohort study (involving the review of 102 articles and surveillance reports and covering nearly 100,000 female sex workers in fifty countries) found the overall prevalence rate to be near 12 percent; or, to put it differently, this population group is 13.5 times more likely to contract HIV than other women.[46] Direct cause of high infection rate amongst this population is the very low rate of condom use. A study of sexual behavior of female sex workers conducted in Guangzhou province, China, found consistent condom use—100 percent—with clients only amongst 30 percent of the women.[47] Of those who reported having a steady partner in the last twelve months, 41 percent of them, of which only 8 percent reported always using condom, and more than half, 53 percent, never did.[48] Worse still, their reported knowledge of prevention of sexually transmitted diseases/HIV and self-efficacy for condoms use was abysmally low.[49] A study describes male clients of these female sex workers as forming "a 'bridging population' for HIV/STD transmission" in that upon infection, they become a risk not only to female sex workers but also to the general population of females, particularly their regular partners.[50] Apparent from these studies is the high risk female sex workers pose to the general public, making their situation a case of utmost importance.[51]

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43. Declaration of Commitment on HIV/AIDS, G.A. Res S-26/2, ¶ 11, U.N. Doc. A/RES/S-26/2 (June 27, 2001).

44. Baral et al., *supra* note 33, at 543.

45. Geneviève Deceuninck et al., *Improvement of Clinical Algorithms for the Diagnosis of* Neisseria Gonorrhoeae *and* Chlamydia Trachomatis *by the Use of Gram-Stained Smears Among Female Sex Workers in Accra, Ghana*, 27 SEXUALLY TRANSMITTED DISEASES 401, 401 (2000).

46. Barel et al., *supra* note 33, at 538.

47. Anneke van den Hoek et al., *High Prevalence of Syphilis and Other Sexually Transmitted Diseases Among Sex Workers in China: Potential for Fast Spread of HIV*, 15 AIDS 753, 755 (2001).

48. *Id.* at 756.

49. *Id.* Note that although the rate of HIV infection in this study was very low (1.4 percent), and although other sexually transmitted diseases such as chlamydia (32 percent) were high, this is explicable on the basis that most of the women are new entrants to the sex work labor force. *See id.* at 756, 758.

50. Catherine M. Lowndes et al., *Management of Sexually Transmitted Diseases and HIV Prevention in Men at High Risk: Targeting Clients and Non-Paying Sexual Partners of Female Sex Workers in Benin*, 14 AIDS 2523, 2523 (2000).

51. *Id.* at 2524. Countries are beginning to scale up coverage of HIV prevention programs among sex workers within their territories. *See* UNAIDS REPORT 2012, *supra* note 13, at 21-22. Amongst the sub-Saharan African countries reporting in 2012, only Nigeria recorded less than 25 percent coverage. *Id.* at 24. Seven countries in the region recorded 75-100 percent coverage. *Id.* Nevertheless, the fact that African's largest country (Nigeria) performed poorly is worrisome given the high number of its HIV population. *HIV & AIDS in Nigeria*, AVERT, http://www.avert.org/hiv-aids-nigeria.htm#footnote3_pxmp1gn (last visited Feb. 18, 2014).

Related to female sex workers, although a distinct category in itself, are men who have sex with other men. Amongst this group, akin to female sex workers, condom use is quite low. Of ninety-six countries that reported on the use of condoms amongst men who have sex with men during their last episode of sex, only in thirteen was more than 75 percent compliance rate achieved.[52] Even more alarming is the low number of this population that gets tested for HIV infection. Current data indicates that amongst men who have sex with men, the median proportion of those who underwent test for HIV virus in the last twelve months is 38 percent.[53] This is problematic. Knowing one's status is a necessary first step in the prevention of the disease, especially among high risk groups such as men who have sex with men, an opportunity that is missed by refusal or neglect to submit to necessary screening.

On a positive note, countries in sub-Sahara Africa have shown considerable policy shift in the way it deals with this vulnerable group.[54] Rather than pretend that these people do not exist, sort of wish them away, their presence has gradually been publicly acknowledged in various countries in the region.[55] In 2012, twenty-two African nations reported on men who have sex with men in their territories, up from eleven in 2010.[56] This is significant because acknowledging their existence is a crucial preliminary step in recognizing the challenge, a necessary condition for dealing with the special needs of this marginalized population. Nonetheless, national expenditures on preventive strategies do not reflect this importance. Although funding levels for HIV programs for men who have sex with men has increased, the funds are mostly provided from foreign donors.[57] Of all the funds available for HIV programs for men who have sex with men in 2010-2011, 92 percent was provided by foreign donors.[58] This is a worrisome development not only on sustainability concerns but also on ownership of the programs.

Although prisoners "comprise one of the least represented populations in national HIV strategies,"[59] they are a significant vulnerable group in respect to which special intervention is urgently needed in order to meet the obligations imposed by MDG 6.[60] This is because infection rate amongst prisoners in most countries in sub-Sahara Africa far exceeds that of the general population. Consider these alarming statistics: in South Africa, an estimated 40 percent of its prison population is HIV-positive compared to 25 percent amongst the general population;[61] infection in Cameroonian and Ivorian prisons is 12 and 28 percent

52. UNAIDS REPORT 2012, *supra* note 13, at 28.

53. *Id.*

54. *See id.*

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.*

59. UNITED NATIONS OFFICE ON DRUGS AND CRIMES ET AL., HIV AND PRISONS IN SUB-SAHARAN AFRICA: OPPORTUNITIES FOR ACTION 5 (2007), *available at* http://www.unodc.org/documents/hiv-aids/Africa%20HIV_Prison_Paper_Oct-23-07-en.pdf [hereinafter HIV AND PRISONS].

60. *See id.* at 21.

61. *Id.*

respectively, double or triple the HIV prevalence outside the prisons in these countries;[62] and at 5 percent, Mauritius' prisoner HIV prevalence is almost 50 times more than that of the adult general population.[63] This is worrisome on two levels. First, homosexual activity—a major transmission mode—is not uncommon in prisons in the region,[64] the implication being that the level of infection is likely to worsen overtime. Second, reintegration into the community upon release from prison would result in transmission to unsuspecting members of the public, causing a rise in the number of PLWHA[65] and making the task of meeting the obligations of MDG 6 even more daunting.

C. *Challenges and Key Interventions*

Treatment is difficult to come by in most parts of the region, even in countries with large HIV-positive population.[66] The reason nearly half of those in need of ART are not receiving it is, simply, cost.[67] Not many people in Africa can afford the cost of treatment, neither are the respective governments in the region in a position to provide *gratis* coverage.[68] With very few exceptions, resources allocated to HIV/AIDS interventions in most African countries, even those that are relatively well-off, are generally low. Take Nigeria, as an example. The proportion of its HIV population receiving ART is only 21 percent, leaving out more than three-quarters without any form of access.[69] The country's total allocation to HIV/AIDS in 2008 was $395 million, out of which 7.6 percent was contributed by the government, with the rest coming from external sources.[70] This

62. *Id.*

63. *Id.*

64. *Id.* at 16.

65. Rucker C. Johnson & Steven Raphael, *The Effects of Male Incarceration Dynamics on Acquired Immune Deficiency Syndrome Infection Rates Among African American Women and Men*, 52 J.L. & Econ. 251, 251-52 (2009) (finding a link between the exponential rise in the 1980s in African-American AIDS patients, particularly amongst African-American women—19 times at greater risk of being diagnosed with the virus than white women—with the surge in number of incarnated African-American men within the same period).

66. *See* WHO ET AL., GLOBAL UPDATE ON HIV TREATMENT 2013: RESULTS, IMPACT AND OPPORTUNITY 97 (2013) [hereinafter GLOBAL UPDATE ON HIV TREATMENT 2013], *available at* http://apps.who.int/iris/bitstream/10665/85326/1/9789241505734_eng.pdf.

67. The cost of ART treatments in South Africa are estimated to be between $500 and $900 per person per year. Brandon Bryn, *Science: Antiretroviral Therapy for HIV Worth the Price*, ADVANCING SCI., SERVING SOC'Y (Feb. 21, 2013), http://www.aaas.org/news/science-antiretroviral-therapy-hiv-worth-price.

68. GLOBAL UPDATE ON HIV TREATMENT 2013, *supra* note 66, at 96-97.

69. WHO, WORLD HEALTH STATISTICS 2011, at 96-97 (2011) [WORLD HEALTH STATISTICS 2011], *available at* http://www.who.int/whosis/whostat/EN_WHS2011_Full.pdf?ua=1; *see also* UNAIDS REPORT 2012, *supra* note 13, at 57 (putting the figure between 20 and 39 percent at the end of 2011).

70. NATIONAL AGENCY FOR THE CONTROL OF AIDS ET AL., FEDERAL REPUBLIC OF NIGERIA, NATIONAL AIDS SPENDING ASSESSMENT (NASA) FOR THE PERIOD 2007-2008: LEVEL AND FLOW OF RESOURCES AND EXPENDITURES OF THE NATIONAL HIV AND AIDS RESPONSE 20 (2010), *available at* http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2008/NASA_Nigeria_2007-2008_en.pdf.

level of dependence on foreign funds raises questions about the sustainability of the advances, albeit minimal, that have been made.

The unpredictability of donor funding ought to be a source of concern to policy makers in the region, especially, given—as is the case in several countries such as Nigeria—low internal budgetary allocation to HIV/AIDS programs.[71] There is no guarantee of continued availability of external resources to take the place of deficits in internally generated resources of affected countries. Still, whether universal access to ART becomes a reality in sub-Sahara Africa anytime soon will hinge on the ability of each country to drastically narrow the gap between ART availability and need for treatment—and this, in turn, is dependent on monumental scaling up of HIV/AIDS budgets. The fact that only three countries (Botswana, Namibia, and Rwanda) in the region have been able to achieve universal access to ART is worrisome.[72] Halting the spread of HIV is indubitably a great achievement but it represents just one side of the equation that would need to be crunched in order to gain an upper hand against a disease that has cut short millions of productive lives in the region and created millions of widows and orphans. Sub-Sahara Africa alone is responsible for 70 percent of AIDS-related deaths globally.[73] Scaling up access to ART is urgently needed to reverse this atrocity.

The aphorism "prevention is better than cure" is one with which public health experts are quite familiar. The notion is that preventing the onset of illness is vastly more beneficial than having to subsequently expend scare resources upon falling ill—a notion that is defensible on the ground that adopting the former approach spares the individual the agony and suffering that could result from pain, discomfort, and even death as well as the financial resources involved in physician and hospital services.[74] Nowhere is this principle truer than in cases of illnesses for which there is no known cure such as HIV/AIDS. For the vast majority of people in Africa, the onset of HIV signals doom ahead since, as indicated previously, ART is in very limited supply in virtually all the countries in the region. This makes knowledge of ways to shield oneself from contracting the disease very critical. Yet, on this count, the region lags seriously behind others. Gender-desegregated data shows the number of males aged 15-24 years with comprehensive correct knowledge of HIV/AIDS in Africa to be 33 percent, with some countries such as Niger and Madagascar recording as low as 16 percent.[75]

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71. *Id.* at xvi.

72. HIV/AIDS RESPONSE PROGRESS REPORT 2011, *supra* note 31, at 90.

73. UNAIDS REPORT 2012, *supra* note 13, at 12.

74. Note that although for ages preventive health services have generally been considered more cost effective than curative care, a recent study disputes whether the difference is really significant. *See* Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661, 661 (2008).

75. WORLD HEALTH STATISTICS 2011, *supra* note 69, at 33 ("This [data refers to] the percentage of males who correctly identify the two major ways of preventing the sexual transmission of HIV, who reject the two most-common local misconceptions about HIV transmission and who know that a healthy-looking person can transmit HIV."). *See also* MDGS REPORT 2012, *supra* note 16, at 40.

Females fare even worse. Just 25 percent of females between the ages of 15 and 24 in Africa have comprehensive correct knowledge of HIV/AIDS.[76] This huge knowledge deficit portends trouble for policy makers in affected countries, an issue that will be discussed shortly.

Related to the problem of lack of information about HIV/AIDS is risky sexual behavior. There are two ways to analyze this problem, namely, as (a) deriving from lack of knowledge about safe sexual practices, or (b) refusal or neglect to apply already acquired knowledge. Taboos, myths, politics, and misconceptions surrounding sex and sexual activities militate against appropriate sexual practices.[77] This is among the principal reasons for the high rate of HIV/AIDS in Africa, particularly if one considers that the prevalence of condom use by adults aged 15-49 years during higher risk sex in most countries in the region is the lowest anywhere in the world. For instance, the prevalence rate of condom use, for males and females respectively, in Madagascar, Niger, and Ethiopia, between 2000 and 2009 was 9:2 percent,[78] 7:8 percent,[79] and 9:11 percent.[80] Regardless of one's opinion as to the appropriate means of protecting oneself against infection—abstinence (official policy of the Bush administration and the Catholic Church)[81] or condom use—the key is that unprotected sex among high-risk population, such as female sex workers, derives from ignorance.

Ignorance, in the form of lack of comprehensive knowledge of HIV/AIDS or how to protect oneself against infection, implicates the responsibility of policy makers in this very critical area. This is particularly true in the case of young people initiating sex very early in life; that is, males and females 15-24 years old having sex before attaining 15 years.[82] There is no denying that campaigns have been mounted in various countries, via multiple outlets, to educate the citizenry on these issues.[83] Nonetheless, the data recited above indicates gaps and ineffectiveness, either with the message itself or its delivery. Innovative strategies, designed with the most-at-risk populations in contemplation would go a long way in turning things around. The introduction of sex education in school curricula of

76. WORLD HEALTH STATISTICS 2011, *supra* note 69, at 34. *See also* MDGS REPORT 2012, *supra* note 16, at 40.

77. Charbel Ragy, *HIV/AIDS: Tackling Taboos in Africa*, U.N. WORKS FOR PEOPLE AND THE PLANET, http://wayback.archive.org/web/20090206084408/http://www.un.org/works/sub3.asp?lang=en&id=57 (last visited Sept. 20, 2013); *see generally* Shereen El Feki, *Middle-Eastern AIDS Efforts are Starting to Tackle Taboos*, 367 LANCET 975, 976 (2006).

78. WORLD HEALTH STATISTICS 2011, *supra* note 69, at 108-09.

79. *Id.*

80. *Id.*

81. Elaine Unterhalter et al., *Essentialism, Equality, and Empowerment: Concepts of Gender and Schooling in the HIV and Aids Epidemic*, *in* GENDER EQUALITY, HIV, AND AIDS: A CHALLENGE FOR THE EDUCATION SECTOR 11, 26 (Shelia Aikman et al. eds., 2008); Cynthia Dailard, *Abstinence Promotion and Teen Family Planning: The Misguided Drive for Equal Funding*, GUTTMACHER REP. ON PUB. POL'Y, Feb. 2002, at 1, 1.

82. UNAIDS REPORT 2012, *supra* note 13, at 17.

83. MDGS REPORT 2012, *supra* note 16, at 40.

many countries is a step in the right direction.[84] But to serve as an effective tool in the campaign against HIV/AIDS, the curricula should be regularly modified and revised in tandem with emerging public health threats, amongst which now includes comprehensive knowledge about HIV/AIDS and preventive measures against infection. Furthermore, the method of communicating the message should mirror the communication tendencies of the target population, such that where the intended recipient of the message is adolescents, movies, drama, and cartoon characters (featuring people within relatively similar age and experience bracket) should be part of the project.[85] Another strategy worth pursuing is employing credible voices in the campaign such as religious, civic, and youth leaders as well as other respectable figures in the community.

Another area where appropriate intervention could yield dramatic dividend in reducing HIV infection is male circumcision in countries where the procedure is not routine. This recognition underscored the WHO's endorsement of the procedure as an "efficacious intervention for HIV prevention in countries and regions with heterosexual epidemics, high HIV and low male circumcision prevalence," citing, as evidence, approximately 60 percent reduction in heterosexual infection resulting from the procedure.[86] Although most countries in which male circumcision has been recommended have adopted the intervention and adopted necessary implementation schemes, actual operationalization in several countries has been lethargic, at best. By the end of 2011, six countries—Malawi, Mozambique, Namibia, Rwanda, Uganda, and Zimbabwe—have managed to circumcise fewer than 5 percent of the target population.[87] These are also amongst the countries with the highest proportion of HIV/AIDS population; and, for these countries to woefully fail to appropriately scale up its intervention strategy in an area, such as this, requiring minimal deployment of resources is a source of serious concern:

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84. Obiajulu Nnamuchi, The Right to Health in Nigeria 11 (2007) (Draft Report, 'Right to health in the Middle East' project, Law School, University of Aberdeen), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1622874 (noting, in respect to Nigeria, the government's approval of the introduction of Family Life and HIV Education (FLHE) curriculum (formerly National Sexuality Education Curriculum) for implementation at the state and local government levels and use in teaching reproductive sex education at secondary schools, in addition to a national campaign promoting the use of contraceptives).

85. *See* MDGS REPORT 2012, *supra* note 16, at 40-41 (reporting, against the backdrop of targeted media campaign on behavior change amongst adolescents, the widely positive impact of dramatizing the experiences relating to HIV/AIDS in Kenya, Zambia, Trinidad and Tobago, and Ukraine in terms of not only watching and learning from the program but discussing the issues raised (need to get tested, avoidance of risky behavior, stigma, safe sex and so forth) with friends, thus spreading the message).

86. *Male Circumcision for HIV Prevention*, WHO, http://www.who.int/hiv/topics/malecircumcision/en (last visited Oct. 3 2013). *Contra* Maria J. Wawer et al., *Circumcision in HIV-Infected Men and its Effect on HIV Transmission to Female Partners in Rakai, Uganda: A Randomized Controlled Trial*, 374 LANCET 229, 229 (2009) (finding, in contrast to the previous studies, that male circumcision does not reduce vaginal-penile HIV infection and recommending use of condom, even after circumcision, as a more effective prevention method).

87. UNAIDS REPORT 2012, *supra* note 13, at 21.

> The unit cost of voluntary medical male circumcision is relatively low, and unlike most other prevention or treatment efforts, requires only one-time rather than lifelong expenditure. Nevertheless, countries have allocated relatively few resources towards scaling up this intervention, with less than 2 [percent] of total HIV expenditure allocated to voluntary medical male circumcision in 6 of the 14 priority countries with data available (Botswana, Kenya, Lesotho, Namibia, Rwanda and Swaziland).[88]

Although some of these countries (Botswana, Kenya, Namibia, and Swaziland) have infused more resources into their national expenditure for "rolling out" male circumcision,[89] the question which continues to resurface remains: what about lives that could have been saved or human suffering that could have been avoided had the urgency of the situation been a prime consideration? An appropriate response to this question may never come. In the final analysis, making headway in regional efforts at meeting the relevant benchmarks of MDG 6 must involve scaling up initiatives aimed at inducing behavior change, access to condoms, encouraging male circumcision, programs specifically focused on sex workers and men who sex with men, and access to ART.[90]

D. Discrimination Against People Living With HIV/AIDS: An Affront to Human Rights

The central question this sub-section grapples with is whether the prohibition of international human rights law on discrimination against PLWHA has any relevance to meeting the various benchmarks of MDG 6. This question is necessary because in many cases, the worst aspect of the injury suffered by PLWHA is not rooted in the physiological consequences of the disease itself but the way society treats them, the social loss that would follow them everywhere they go on account of their HIV/AIDS status. Meeting the relevant benchmarks of MDG 6, particularly universal access to ART, hinges most profoundly on how society treats its HIV/AIDS population. The heinous nature of discrimination and the importance the international community attaches to its elimination, particularly in the realm of health, is underscored by the requirement in the foremost international instrument on health—the International Covenant on Economic, Social and Cultural Rights ("ICESCR")[91]—for immediate implementation, not subject to progressive realization.[92]

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88. *Id.*

89. *Id.*

90. *Id.* at 16.

91. International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) [hereinafter ICESCR].

92. United Nations, Comm. on Econ., Soc. & Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (article 12 of the International Covenant on Economic, Social and Cultural Rights), ¶ 30, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), *reprinted in* United Nations, Compilation of General Comments and General Recommendations Adopted by Human

The major international human rights instruments—Universal Declaration of Human Rights,[93] the International Covenant on Civil and Political Rights ("ICCPR"),[94] and the ICESCR[95]—protect individuals, including PLWHA, against being subjected to discrimination. In addition, virtually all modern constitutions and major international and regional treaties on human rights contain similar provision.[96] Prohibition against discrimination is a legal as well as an ethical issue. Two ethical principles are critical here. The first, principle of beneficence, or the moral obligation to act for the benefit of other, demands that vulnerable populations, such as PLWHA, should be treated humanely, compassionately, and with respect.[97] The second ethical principle, nonmaleficence, proscribes actions that would harm others, captured most eloquently in the maxim *primum non nocere* (first do no harm).[98]

What would count as discrimination? Instances abound but discrimination is typically manifested in verbal abuse,[99] physical assault,[100] denial[101] or termination of employment,[102] denial or revocation of tenancy or other accommodation rights,[103] denial of medical services,[104] and so forth. Many of these breaches of human rights arise out of ignorance; yet, in others, the act was purposeful. The

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Rights Treaty Bodies, at 94, U.N. Doc. HRI/GEN/1/Rev.7 (May 12, 2004) [hereinafter General Comment No. 14].

93. Universal Declaration of Human Rights, G.A. Res. 217 (III) A, art. 2, U.N. Doc. A/RES/217(III) (Dec. 10, 1948) ("Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.").

94. International Covenant on Civil and Political Rights arts. 2, 26, Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976).

95. ICESCR, *supra* note 91, art. 2(2).

96. *See, e.g.*, S. AFR. CONST. 1996, ch. 2, § 9; Convention on the Rights of the Child art. 2, Nov. 20, 1989, 1577 U.N.T.S. 3 (entered into force Sept. 2, 1990); Convention on the Elimination of All Forms of Discrimination against Women arts. 1, 2, Dec. 18, 1979, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981); International Convention on the Elimination of All Forms of Racial Discrimination arts. 1, 2, Dec. 21, 1965, 660 U.N.T.S. 195 (entered into force Jan. 4, 1969); African Charter on Human and Peoples' Rights arts. 18(3), 28, June 27, 1981, 1520 U.N.T.S. 217; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa art. 2, July 11, 2003, OAU Doc. CAB/LEG/66.6, *reprinted in* 1 AFR. HUM. RTS. L.J. 40, 53-63 (2001) (entered into force Nov. 25, 2005) [hereinafter Maputo Protocol]; African Charter on the Rights and Welfare of the Child art. 3, July 11, 1990, OAU Doc. CAB/LEG/24.9/49 (entered into force Nov. 29, 1990).

97. *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 166 (5th ed. 2001).

98. *See id.* at 113.

99. UNAIDS REPORT 2012, *supra* note 13, at 79 tbl.8.1 (reporting that 56 percent, or more than half of PLWHA in Kenya, have been verbally abused as a result of their HIV status).

100. *Id.* (reporting that 28 percent of PLWHA in Nigeria have been victims of physical assault on account of their HIV status).

101. *Id.* (reporting that 37 percent of PLWHA in Rwanda were denied employment as a result of their HIV status).

102. *Id.* (reporting that 65 percent of PLWHA in Rwanda lost their jobs due to their HIV status).

103. *See id.*

104. *Id.* (reporting that 21 percent of PLWHA in Nigeria were denied health services as a result of their HIV status).

case of *Georgina Ahamefule v. Imperial Medical Center & Dr. Alex Molokwu* is quite illustrative.[105] The plaintiff, who lost her job as a nurse on account of her HIV status, was barred from entering the courtroom in which her lawsuit was being heard because of fear that her presence would expose others in the courtroom to risk of infection.[106] Whether the presiding judge acted purposefully or out of ignorance is yet to be determined. What is important is the harsh tenor of the decision handed down by Judge Idowu, to whom the case was subsequently transferred, "that the purported termination of the Plaintiff's employment is illegal, unlawful and actuated by malice and extreme bad faith";[107] in other words, the termination was blatantly discriminatory. The ethical implication of discrimination is critical both for PLWHA and those whose professional lives would involve dealing with them, individuals upon whom PLWA would rely for therapeutic and legal protection. There are two prongs to this problem. First, fear of discrimination, particularly by health professionals, would dampen the motivation to get tested. Knowing one's HIV/AIDS status is a necessary first step to therapeutic intervention and this could be defeated by the way individuals perceive their treatment options. An argument that has been advanced by gay rights activists is that "fear that test result might be released to people that could stigmatize or in some other ways negatively treat the individual would hardly incentivize testing."[108] This could have a domino-like effect on the health of the community.

The second problem is related to the first. Upon knowing their status, would PLWHA be open to receiving treatment if they fear negative consequences on account of their newly-discovered status? The answer is clearly negative. One may seek to undermine the critical nature of this second concern by pointing out the number of PLWHA in various countries who are eager to receive ART but cannot find any.[109] True, the number in some countries is quite staggering, but what nobody knows for certain is the number of people who, out of fear of possible

105. Ahamefule v. Imperial Med. Centre & Dr. Alex Molokwu, [2012] (unreported) Suit No. ID/1627/2000 (Nigeria), *available at* http://www.escr-net.org/sites/default/files/Mrs%20Georgina%20Ahamefule%20v.%20Imperial%20Medical%20Centre%20%26%20Alex%20Molukwu.pdf.

106. *Id.* at 1; *see also* Ebenezer Durojaye, *So Sweet, So Sour: A Commentary on the Nigerian High Court's Decision in the* Georgina Ahamefule v Imperial Hospital & Another *Relating to the Rights of Persons Living with HIV*, 13 AFR. HUM. RTS. L.J. 464, 466 (2013).

107. *Ahamefule*, Suit No. ID/1627/2000, at 22 (Nigeria).

108. Obiajulu Nnamuchi & Remigius N. Nwabueze, *Duty to Warn of the Risks of HIV/AIDS Infection in Africa: An Appropriate Legal Response?*, 22 ANNALS HEALTH L. 386, 399 (2013), *referencing* Martha Swartz, *Is There a Duty to Warn?: Does Safety Ever Warrant Releasing Confidential Information About HIV-infected People?*, HUM. RTS., Spring 1990, at 40, 45.

109. This claim is defensible on the ground that in virtually all the countries in Africa the need for ART far outstrips supply, and this is true even in countries that are said to have achieved universal access. *See* Sydney Rosen et al., *Rationing Antiretroviral Therapy for HIV/AIDS in Africa: Choices and Consequences*, 2 PLOS MED. 1098, 1098-99 (2005) (discussing rationing ART because demand outweighs supply).

negative repercussions, should their status become known, are dying in silence.[110] This number is usually not accounted for in official statistics because these people typically disappear, never, in some cases, to be heard from or seen by anyone in a position to document their need or attend to it. This, clearly, does not advance the march toward attaining the target of universal access to ART, a key component of MDG 6.

An obvious response to discriminatory attitudes toward PLWHA is to establish prohibitory legal and policy frameworks especially in countries where the vice is substantial. Because this suggestion is in tune with not only logic but common sense, one would assume universal existence of such frameworks. Yet, in 2012, only 61 percent of countries report the existence of such laws in their territories; meaning, as UNAIDS laments, "in the epidemic's fourth decade, nearly 4 in 10 countries worldwide still lack any specific legal provisions to prevent or address HIV-related discrimination."[111] But merely having such laws in national criminal codes or in some other legislative regime does not automatically ensure protection for PLWHA. For such result to materialize, two things are necessary. First is awareness. PLWHA need to be educated about the existence of such laws and how they protect their interests. A knowledge gap in this area has meant that, as attested to in surveys conducted in more than forty countries, very few of those that have been victims of HIV-related discrimination knew where or how to access legal remedy.[112] Second, the effectiveness of any legislative regime is measured by the rate of compliance; and the compliance level itself is a product of consciousness about the rationales undergirding the framework. Establishing a punitive legal regime without laying the necessary background for attitudinal changes in the desired direction would amount to an exercise in futility. Many of the negative treatments received by PLWHA in sub-Sahara Africa are products of ignorance or misperception of the state of affairs by the general public. The case of *Ahamefule* above is illustrative.[113] Sensitization campaigns aimed at educating the people about the disease and the true risk posed by sufferers would go a long

110. *See, e.g.*, Bradford McIntyre, *Understanding HIV/AIDS*, POSITIVELY POSITIVE (Dec. 2001), http://www.positivelypositive.ca/articles/aids.html (explaining the fear that people have about revealing their disease and the consequences involved, including the lack of proper treatment).

111. UNAIDS REPORT 2012, *supra* note 13, at 80. But this conclusion should be approached with caution. Apart from the fact that the numbers were derived from submissions by NGOs, some of which, presumably, might not represent the most credible sources of that kind of information, absence of HIV-specific anti-discrimination legal regime does not necessarily translate to non-protection for PLWHA. *See id.* at 81. For instance, Nigeria was amongst the countries represented as lacking an HIV-specific anti-discrimination statute, yet as the case of *Ahamefule*, discussed previously, shows the country has a robust framework that adequately protects PLWHA. *Id.* fig.8.2.

112. *Id.*

113. *See* notes 105-08 and accompanying text; *see also* Nnamuchi, The Right to Health in Nigeria, *supra* note 84, at 11, 13-15 (suggesting that increasing the public's awareness and knowledge regarding reproductive health information and services are crucial to PLWHA).

way in ensuring optimal protection of the interests of PLWHA in all aspects of living.[114]

III. MALARIA

> *Behind the statistics and graphs lies a great and needless tragedy: malaria—an entirely preventable and treatable disease—still takes the life of an African child every minute. The most vulnerable communities in the world continue to lack sufficient access to long-lasting insecticidal nets, indoor residual spraying, diagnostic testing, and artemisinin-based combination therapies.*[115]
>
> – Margaret Chan, WHO Director-General

A. Impact and Relevant Benchmarks

Target 6C—to have halted and begun to reverse the incidence of malaria by 2015—is of special relevance to Africa.[116] Because Africa shoulders the greatest burden of the disease, it stands to reap greater benefit than any other region from reduction in its occurrence. In 2011, an estimated 3.3 billion people were at the risk of malaria worldwide, with the highest number of cases (80 percent) in sub-Sahara Africa.[117] The region also leads the rest of the world in the number of malaria-related deaths, accounting for 90 percent of all mortalities reported within the same period.[118] As high as 25-35 percent of outpatient visits, 20-45 percent of hospital admissions, and 15-35 percent of hospital deaths are attributable to

114. Dividends inevitable from this type of intervention, resulting from attitudinal changes, are already evident in countries seriously committed to improving the socioeconomic circumstances of PLWHA. *See* UNAIDS REPORT 2012, *supra* note 13, at 84 (reporting that an overwhelming majority of people in Lesotho, 80 percent of the population, would accept as teachers people who are HIV positive and would buy farm produce from an HIV infected vendor, and in Haiti, a community-based, anti-stigma campaign resulted in significant growth in the number of people submitting to screening for HIV and TB).

115. Margaret Chan, *Foreword* to WHO, WORLD MALARIA REPORT 2012, at v, v (2012) [hereinafter WORLD MALARIA REPORT 2012], *available at* http://www.who.int/malaria/publications/world_malaria_report_2012/report/en.

116. More ambitious targets have since been adopted. *See, e.g.*, World Health Assembly Res. 58.2, Rep. of the World Health Assembly, 58th Sess., May 16-25, 2005, WHA58/2005/REC/1, at 4-5 (May 23, 2005) (setting a new target of reducing malaria cases and mortalities by 75 percent by 2015 from 2000 levels); ROLL BACK MALARIA, REFINED/UPDATED GMAP OBJECTIVES, TARGETS, MILESTONES AND PRIORITIES BEYOND 2011, at 1 (stating the retention of the target of achieving a 75 percent reduction in malaria cases by 2015, like the WHA Resolution, but adding an objective of reducing malaria mortalities to near zero by the end of 2015). The two new targets were established in 2005 and 2011 respectively. *See* WORLD MALARIA REPORT 2012, *supra* note 115, at 13.

117. WORLD MALARIA REPORT 2012, *supra* note 115, at 1.

118. *Id.*

malaria in high-burden African countries ("HBCs") (that is, the top twenty two countries ranked in terms of absolute number of cases).[119]

There is also an economic dimension to this problem. Annually, malaria slows economic growth in the region by 1.3 percent,[120] resulting in 32 percent lower regional GDP than would have been the case without the occurrence of the disease.[121] The huge toll exacted by malaria on Africans is such that countries in the region have made its eradication a centerpiece of regional health strategies.[122] Thus, even before the MDGs, these countries have joined forces to mitigate the impact of the disease amongst their respective populations. The Abuja Declaration on Roll Back Malaria in Africa, adopted by African heads of state and government in April 2000, set a target of halving malaria mortality in Africa by 2010, by ensuring that by 2005 at least 60 percent of those suffering from, or at the risk of, malaria have timely access to appropriate preventive or curative measures.[123]

B. Special Population Groups

Pregnant women and children are particularly vulnerable to malaria attack. Due to reduced immunity during pregnancy and low immunity in the case of children, they are more susceptible to malaria than the general population.[124] Although other regions are also affected, the situation is worst in Africa. For instance, the post-neonatal child death rate attributable to malaria in 2010 was 7 percent globally but 15 percent in Africa.[125] The good news is that countries are increasingly becoming cognizant of the special risk category of these vulnerable segments of the population, explaining, for instance, the creative ways being adopted in the distribution of insecticide-treated bed nets ("ITNs"). In Africa, thirty-three of the forty countries that distribute ITNs free of charge do so through antenatal clinics whereas twenty-seven countries distribute them through children's immunization clinics.[126] For these two groups, intermittent preventive malaria ("IPT") therapy is recommended.[127]

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119. ROLL BACK MALARIA, WHO & UNICEF, WORLD MALARIA REPORT 2005, at xvii, 21 (2005) [hereinafter WORLD MALARIA REPORT 2005], *available at* http://whqlibdoc.who.int/publications/2005/9241593199_eng.pdf?ua=1.

120. ROLL BACK MALARIA & WHO, THE ABUJA DECLARATION AND THE PLAN OF ACTION 1 (2003) [hereinafter THE ABUJA DECLARATION], *available at* http://sa.au.int/en/sites/default/files/Abuja_Declaration_2000.pdf.

121. *Id.*

122. *E.g.*, *id.*

123. *Id.* at 4-5.

124. Julianna Schantz-Dunn & Nawal M. Nour, *Malaria and Pregnancy: A Global Health Perspective*, 2 REVIEWS IN OBSTETRICS & GYNECOLOGY 186, 188-90 (2009); *Lives at Risk*, WHO (Apr. 25, 2003), http://www.who.int/features/2003/04b/en.

125. WORLD MALARIA REPORT 2012, *supra* note 115, at 13 (citing Li Liu et al., *Global, Regional, and National Causes of Child Mortality: An Updated Systematic Analysis for 2010 with Time Trends Since 2000*, 379 LANCET 2151, 2156 (2012)).

126. WORLD MALARIA REPORT 2012, *supra* note 115, at 23.

127. *Id.* at 6 (defining IPT as the "administration of a full course of an effective antimalarial treatment at specified time points to a defined population at risk of malaria, regardless of whether they are parasitaemic, with the objective of reducing the malaria burden in the specific target population").

C. *Prevention, Control, and Treatment Challenges*

> *Defeating malaria will require a high level of political commitment, strengthened regional cooperation, and the engagement of a number of sectors outside of health, including finance, education, defence, environment, mining, industry and tourism. The fight against this disease needs to be integrated into the overall development agenda in all endemic countries.*[128]
>
> – Margaret Chan, WHO Director-General

The Abuja Declaration on Rollback Malaria is strikingly similar to the commitment explicit in Target 6C.[129] Both are aimed at arresting the incidence of, and mortality associated with malaria through a set of preventive, management, and curative interventions.[130] The availability of these interventions to children under five is a proxy for the likelihood of attaining the Target since children in this age group are at the greatest risk of developing and dying from malaria.[131] MDG 6 specifies two relevant indicators for gauging country progress: (i) the proportion of children under five sleeping under ITNs; and (ii) those with fever that are treated with appropriate anti-malarial drugs.[132] On these two fronts, African countries have historically lagged behind—the reason, in part, for the high mortality associated with the disease in the region. But recent changes in strategy are beginning to bear fruits. Owing to increased funding, global distribution of mosquito nets by manufacturers has witnessed an astronomical growth, rising from 6 million in 2004 to 145 million in 2010.[133] This has resulted in the delivery of about 326 million nets by manufacturers from 2009 to 2011—a significant achievement, although to reach universal coverage, a total of about 450 million are needed.[134]

See also id. at 31-34. As of 2011, 34 of the 43 countries in Africa described as "endemic countries/areas with ongoing transmission of *P. falciparum*" have adopted policies for IPT for Pregnant Women (IPTp). *Id.* at 32. Regarding IPT for infants (IPTi), only Burkina Faso has incorporated the strategy in its antimalarial policy, although plans are underway in several countries to follow suit. *Id.*

128. Margaret Chan, *Foreword* to WORLD MALARIA REPORT 2012, *supra* note 115, at v.

129. *Compare* THE ABUJA DECLARATION, *supra* note 120, at 4 ("Halve the malaria mortality for Africa's people by 2010 . . . ."), *with MDG Indicators*, *supra* note 3, Target 6.C ("Have halted by 2015 and begun to reverse the incidence of malaria . . . .").

130. THE ABUJA DECLARATION, *supra* note 120, at 4-5; *MDG Indicators*, *supra* note 3.

131. *See* WORLD MALARIA REPORT 2012, *supra* note 115, at 1.

132. *MDG Indicators*, *supra* note 3, Indicators 6.7, 6.8.

133. WORLD MALARIA REPORT 2012, *supra* note 115, at 23-24. There has been a steady annual upsurge in the level of "[i]nternational disbursements to malaria-endemic countries [that have] increased . . . from less than US$ 100 million in 2000 to US$ 1.71 billion in 2010 and were estimated to be US$ 1.66 billion in 2011 and US$ 1.84 billion in 2012." *Id.* at 15. Most of the funds disbursed to malaria endemic countries for malaria control came from the Global Fund to Fight AIDS, Tuberculosis and Malaria, which accounted for 39 percent and 40 percent of estimated disbursed funds in 2011 and 2012 respectively. *Id.* Other major sources of funding are "the US President's Malaria Initiative (PMI) and the United Kingdom's Department for International Development (DFID), which accounted for 31% and 11% respectively of estimated disbursements in 2011-2012." *Id.*

134. *Id.* at 23-24.

Despite this apparent gap, the huge increase in net production and distribution has boosted the number of children sleeping under ITNs, from 2 percent in 2000 to 22 percent in 2008 in twenty-six African countries for which data is available (representing 71 percent of children less than five in the region).[135] More recent data indicates that the proportion of children sleeping under ITNs in Africa has risen to 39 percent in 2010.[136] This is quite an encouraging development but the proportion of children covered is still far from adequate, especially when viewed in light of more concrete targets such as 60 percent access to ITNs for children less than five by 2005 set by the Abuja Declaration.[137] Parental poverty is to blame for the low coverage rate as evident in a finding showing that children under five in wealthier households are more likely than their counterparts in poorer families to sleep under ITNs.[138] While most countries in the region subscribe to the WHO's policy of providing ITNs free of charge or at subsidized rates,[139] dwindling resources has constrained full operationalization of the measure.[140]

The second of the two indicators noted above is the proportion of children under five with fever who are treated with appropriate anti-malarial drugs. The standard treatment, as recommended by the WHO, for treating *P. falciparum* malaria—the most common in Africa—is artemisinin-based combination therapies ("ACTs").[141] This was in response to growing resistance of *P. falciparum parasites* to "conventional antimalarial drugs such as chloroquine and sulfadoxine-pyrimethamine."[142] Similar to ITNs, rising levels of funding led to increased procurement of anti-malarial drugs but the need for ACTs was not met in any country for which data is available, the most recent derived from a 2008 survey.[143] The survey (covering 10 countries) shows that just 32 percent of children with fever in the two weeks preceding the survey received any anti-malarial treatment.[144] An even lower number (16 percent) of children with fever received any ACT, although only seven countries submitted data.[145] Again, as with low

135. MDGS REPORT 2010, *supra* note 23, at 47-48.

136. MDGS REPORT 2012, *supra* note 16, at 43.

137. THE ABUJA DECLARATION, *supra* note 120, at 5.

138. MDGS REPORT 2010, *supra* note 23, at 48; *see also* WORLD MALARIA REPORT 2012, *supra* note 115, at 26 fig.4.1b.

139. WHO, WORLD MALARIA REPORT 2011, at 27 (2011), *available at* http://apps.who.int/iris/bitstream/10665/44792/2/9789241564403_eng_full.pdf [hereinafter WORLD MALARIA REPORT 2011].

140. Notwithstanding resource constraints, Africa leads the rest of the world in the number of ITNs distributed free of charge (thirty-eight of eighty-nine countries) and ITNs sold at subsidized rates (twenty-one of twenty-four countries). *See* WORLD MALARIA REPORT 2012, *supra* note 115, at 23 tbl.4.1.

141. WORLD MALARIA REPORT 2005, *supra* note 119, at 14.

142. *Id.*

143. WHO, WORLD HEALTH STATISTICS 2010, at 16 (2010), *available at* http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf.

144. WHO, WORLD MALARIA REPORT 2009, at 20 (2009) [hereinafter WORLD MALARIA REPORT 2009], *available at* http://whqlibdoc.who.int/publications/2009/9789241563901_eng.pdf.

145. *Id.*

ITNs coverage, resource constraints are to blame for limited access to anti-malarial medicine.

Against the background of low ownership of mosquito nets and inadequate access to anti-malarial therapy, one might ask whether it is not quite unrealistic to expect that malaria incidence in Africa will have been halted and in decline by 2015, as required by Target 6C. To be sure, there has been large-scale infusion of resources, especially from external sources, to national malaria control strategies in the region.[146] But the investments have been insufficient to make up for the deficits in national strategies. According to the 2008 Global Malaria Action Plan, the amount of resources required annually between 2011 and 2015 for global malaria control will exceed $5.1 billion annually[147] and in Africa alone, an estimated $2.3 billion will be required every year within the same period.[148] Yet, the total amount of funds (from domestic and international sources) in 2011 was estimated to be $2.3 billion, leaving a whopping deficit of $2.8 billion in the global budget.[149] And, to make matters worse, current projection indicates no respite any time soon; in fact, total funding package will stagnate at less than $2.7 billion annually between 2013 and 2015.[150] Considering that many African countries are dependent on foreign support for major portions of their malaria budgets[151] (and, therefore, cannot look inward), the implication of this resource gap is that unless funds are sourced elsewhere, this shortfall might mean the difference between progress, or lack thereof, in the fight against malaria in the region.

Indeed, there appears to be a strong correlation between external funding and incidence of malaria. Evidence is beginning to emerge showing that increased receipt of external funding leads to a decrease in malaria burden.[152] Amongst countries receiving more than $7 per person at risk, 60 percent reported a decline in malaria cases since 2000, versus only 26 percent of those receiving $7 or less.[153] But the exact impact on countries is unclear as other factors such as the capacity of individual countries to produce funds internally in order to offset decline in external support cannot be discounted and can affect the overall picture, positively or otherwise. This might explain why the result is mixed, even amongst endemic countries, some of which are highly aid-dependent. Uganda's malaria cases declined by more than 3 million in 2006 from its 2005 level (16 million); Tanzania reported 11.5 million cases in 2005 but improved to 10.5 million the following year; and, in Nigeria, there were around 3.5 and 3 million episodes of malaria in 2005 and 2007 respectively, a reduction of one-half million cases in just two

146. *Id.* at 58 (reporting that funding for malaria control has gone up fivefold from $0.3 billion per year in 2003 to $1.7 billion in 2009); WORLD MALARIA REPORT 2012, *supra* note 115, at 17.

147. WORLD MALARIA REPORT 2012, *supra* note 115, at 17.

148. *Id.*

149. *Id.*

150. *Id.*

151. ROLL BACK MALARIA, THE GLOBAL MALARIA ACTION PLAN: FOR A MALARIA-FREE WORLD 36 (2008), *available at* http://www.rollbackmalaria.org/gmap/gmap.pdf.

152. WORLD MALARIA REPORT 2009, *supra* note 144, at 65.

153. *Id.*

years.[154] On the other hand, in Niger, cases skyrocketed from nearly 900,000 in 2006, to 1.3 million the following year, and in Malawi, the number rose from 3.7 million cases in 2005 to 4.2 million in 2007.[155] Is there any lesson to draw from these disparities?

What the disparities demonstrate quite starkly is that the paramount determinant of whether Africa would succeed in its fight against malaria is the capacity of governments in the region to scale up the key elements of national anti-malaria strategies. And this finds support in recent experiences in some countries. In Eritrea, the distribution of more than a million mosquito nets between 2000 and 2006 forced a decline in malaria cases and mortality by more than 70 percent.[156] The strategy has been replicated in South Africa. Following the introduction of ACTs and better mosquito control in response to increasing resistance to drugs and insecticides in the country, its number of cases and mortality plummeted by 80 percent between 2000 and 2006.[157]

IV. OTHER DISEASES (TUBERCULOSIS)

A. Impact and Relevant Benchmarks

Though the term "other diseases" in MDG 6 is not defined, scholars have focused on TB as the most critical of the diseases.[158] TB is considered the most critical for three reasons: (i) high prevalence in several countries; (ii) high mortality (second after HIV); and (iii) close association with HIV/AIDS (they drive and reinforce one another),[159] the reason the two are sometimes referred to as "co-epidemics" or "dual epidemics."[160] The Target committed to by countries regarding TB is to have halted and begun to reverse its incidence by 2015.[161] This obligation is measurable by the incidence ("number of new and relapse cases of TB arising in a given time period, usually one year or absolute numbers"),[162]

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154. WHO, WORLD MALARIA REPORT 2008, at 146 (2008) [hereinafter WORLD MALARIA REPORT 2008], *available at* http://whqlibdoc.who.int/publications/2008/9789241563697_eng.pdf. *See also supra* note 140.

155. WORLD MALARIA REPORT 2008, *supra* note 154, at 146.

156. U.N. DEP'T OF ECON. & SOC. AFFAIRS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 2008, at 31-32, U.N. Sales No. E.08.I.18 (2008) [hereinafter MDGS REPORT 2008], *available at* http://www.un.org/millenniumgoals/2008highlevel/pdf/newsroom/mdg%20reports/MDG_Report_2008_ENGLISH.pdf.

157. *Id.* at 32.

158. *See, e.g.*, David H. Molyneux, *Combating the "Other Diseases" of MDG 6: Changing the Paradigm to Achieve Equity and Poverty Reduction?*, 102 TRANSACTIONS ROYAL SOC'Y TROPICAL MED. & HYGIENE 509, 510 (2008).

159. MDGS REPORT 2010, *supra* note 23, at 50; WHO, GLOBAL TUBERCULOSIS REPORT 2012, at 3 box.1.1 (2012) [hereinafter GLOBAL TUBERCULOSIS REPORT 2012], *available at* http://apps.who.int/iris/bitstream/10665/75938/1/9789241564502_eng.pdf.

160. WHO, WHO POLICY ON COLLABORATIVE TB/HIV ACTIVITIES: GUIDELINES FOR NATIONAL PROGRAMMES AND OTHER STAKEHOLDERS 10 (2012), *available at* http://whqlibdoc.who.int/publications/2012/9789241503006_eng.pdf?ua=1.

161. *MDG Indicators*, *supra* note 3.

162. GLOBAL TUBERCULOSIS REPORT 2012, *supra* note 159, at 8.

prevalence ("number of cases of TB at a given point in time" or rate of occurrence),[163] and death rates, as well as proportion of cases detected and cured under directly observed treatment short course ("DOTS").[164] In 2006, two additional targets, linked to the MDGs, were added by the Stop TB Partnership's Global Plan to Stop TB[165]—to halve TB prevalence and death rates by 2015, using 1990 as a baseline; and by 2050, eliminate TB as a public health threat.[166] The original Target, to have halted and begun to reverse the incidence of TB by 2015, has already been achieved.[167] The TB incidence has been declining globally for some years and between 2010 and 2011 declined at 2 percent.[168] TB-related mortality rate has also been declining in all regions, 41 percent since 1990 (excluding deaths amongst HIV-positive people).[169] Despite this positive development, however, TB remains a critical public health challenge. In 2011, there were an estimated 8.7 million incidences of TB (13 percent co-infected with HIV) and 1.4 million TB-related deaths.[170]

Most cases of TB infection (raw number) occur in South-East Asia and Western Pacific regions (60 percent), and although Africa accounts for 24 percent of the global burden, the region shoulders the highest rates of cases and mortalities per capita.[171] It also leads the rest of the world in terms of proportion of TB cases co-infected with HIV, at 39 percent.[172] Of the twenty-two countries classified by the WHO as HBCs, nine or nearly half are in Africa, with South Africa, Zimbabwe, and Mozambique listed as the top three countries in total incident cases (per 100,000) reported in 2011.[173]

In terms of global prevalence, there were an estimated 12 million cases in 2011 or 170 cases per 100,000 population.[174] The prevalence rate has been

163. *Id.*

164. *MDG Indicators*, *supra* note 3, Indicators 6.9, 6.10.

165. This is the second Global Plan to Stop TB (effective 2006-2015). STOP TB PARTNERSHIP, THE GLOBAL PLAN TO STOP TB: 2006–2015, at 24-25 (2006) [hereinafter GLOBAL PLAN TO STOP TB], *available at* http://www.stoptb.org/assets/documents/global/plan/GlobalPlanFinal.pdf. The first covered the period 2001-2005. *Id.* The Plan (a WHO initiative) is a funding program that was launched at the World Economic Forum in Davos, Switzerland, on January 26, 2006, under the auspices of Stop TB Partnership. *See* WORLD ECON. FORUM, ANNUAL REPORT 2005/06, at 27 (2006), *available at* http://www.weforum.org/pdf/AnnualReport/2006/annual_report.pdf. Designed to bridge funding gaps in global TB prevention and treatment, the Plan aims to raise and spend $56 billion between 2006 and 2015 on: ensuring that TB-related MDG Target is met, saving 14 million lives, providing universal access to treatment, and developing new diagnostic tests, new drugs and vaccines. GLOBAL PLAN TO STOP TB, at 49.

166. STOP TB PARTNERSHIP & WHO, THE STOP TB STRATEGY: BUILDING ON AND ENHANCING DOTS TO MEET THE TB-RELATED MILLENNIUM DEVELOPMENT GOALS 8 (2006) [hereinafter THE STOP TB STRATEGY], *available at* http://www.who.int/tb/publications/2006/stop_tb_strategy.pdf.

167. GLOBAL TUBERCULOSIS REPORT 2012, *supra* note 159, at 8.

168. *Id.* at 8.

169. *Id.* at 8, 17.

170. *Id.* at 8-9.

171. *Id.* at 2.

172. *Id.* at 11.

173. *Id.* at 11 tbl.2.2.

174. *Id.* at 16.

declining since 1990 in all regions, including Africa, although the rate of decline varies widely around the world.[175] This regional variation suggests that the Stop TB Partnership's target of cutting the TB prevalence by half by 2015 from its 1990 level will not be met worldwide.[176] Whereas in some regions, such as the Americas, where the target has been attained, and in Europe and South-East Asia, where the target appears feasible, Africa is off track.[177] Globally, an estimated 990,000 deaths (14 per 100,000 population) occurred in 2011 among incident TB cases who were HIV-negative and an estimated 0.43 million deaths among those that were HIV-positive.[178] The Stop TB Partnership's target of halving TB deaths by 2015 compared to its 1990 level appears likely to be met in all regions except two, including Africa.[179]

B. Special Population Groups

No population group stands at greater risk of TB infection than HIV patients. This is because decreased immunity resulting from HIV infection renders the person more susceptible to contracting TB.[180] This explains why many HIV-positive individuals are also TB-positive, the reason as indicated above, the two are sometimes referred to as dual or co-epidemics. In 2011, 23 percent of people living with TB who were screened for HIV tested positive.[181] Mortality amongst this population, although falling, is still very high. TB-related deaths amongst people living with HIV have declined by 25 percent globally since 2004, and in sub-Sahara Africa—home to nearly 80 percent of all people living with both TB and HIV—by 28 percent.[182]

For this vulnerable population group, a somewhat different intervention protocol is warranted by their special circumstances. Access to ART for people living with HIV, especially from the onset of the infection, is needed to prevent them from subsequently acquiring and dying from TB.[183] As a recent study shows, prompt access to ART resulted in 65 percent reduction in risk of TB illness amongst people living with HIV.[184] In sharp contrast to the general population, for people living with HIV and TB, it is recommended that ART should be initiated as early as possible irrespective of their CD4 count,[185] the idea being to protect them against contracting TB. Yet, in 2011, just 46 percent of people living with both

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.* at 17.

179. *Id.* at 17-19.

180. CTRS. FOR DISEASE CONTROL, TUBERCULOSIS: THE CONNECTION BETWEEN TB AND HIV (THE AIDS VIRUS) (2012), *available at* http://www.cdc.gov/tb/publications/pamphlets/TB-HIVEng.PDF.

181. UNAIDS REPORT 2012, *supra* note 13, at 58.

182. *Id.*; GLOBAL TUBERCULOSIS REPORT 2012, *supra* note 159, at 2.

183. UNAIDS REPORT 2012, *supra* note 13, at 59.

184. *Id.* (citing Amitabh B. Suthar et al., *Antiretroviral Therapy for Prevention of Tuberculosis in Adults with HIV: A Systematic Review and Meta-Analysis*, PLOS MED., July 2012, at 1, 11).

185. *Id.*

HIV and TB in sub-Sahara Africa received ART.[186] But aside from early initiation of treatment, TB testing should also be integrated into national HIV prevention and management strategies, and vice versa. In that case, a positive test to HIV automatically triggers TB screening and vice versa. Knowledge of one's status, TB or HIV, is a necessary first step in initiating treatment and protecting oneself from preventable morbidity and even death.

A subset of this special population or vulnerable group is pregnant women living with HIV. Their vulnerability is striking because apart from reduced immunity to a multitude of pathogenic conditions, including TB, ordinarily occasioned by pregnancy, for those living with HIV, the risk of developing TB is more than ten times higher than amongst HIV-negative pregnant women.[187] As in all cases involving maternal health, a prime consideration is the unborn child. In the case of TB, there has been a number of adverse obstetric and perinatal outcomes identified, including a very high risk of mother-to-child transmission of HIV and increased risk of maternal as well as infant mortalities.[188] To reduce these risks, it is recommended that (since, as noted above, ART reduces the risk of TB by 65 percent irrespective of CD4 level) early ART should be combined with regular TB screening at prenatal clinics to ensure that the women receive isoniazid preventive therapy[189] or early treatment for active TB.[190]

C. Prevention, Control, and Treatment Challenges

To achieve the 2015 global targets, the WHO recommends that every country adopt the Stop TB Strategy.[191] The major components of the Stop TB Strategy are to: (i) pursue high quality DOTS expansion and enhancement; (ii) address TB/HIV, multidrug resistant TB (MDR-TB), and the needs of poor and vulnerable populations; (iii) contribute to health system strengthening based on primary health care; (iv) engage all care providers; (v) empower people with TB and communities through partnership; and (vi) enable and promote research.[192] Among these six components, the most critical is the DOTS protocol.[193] This is because success in eradicating TB hinges most crucially on early detection and effective treatment, both of which are the pillars of DOTS.[194] The introduction of DOTS by the WHO in the mid-1990s led to significant strides in the international effort to control and manage TB.[195] The DOTS protocol is multipronged, involving scaling up of TB financing, appropriate diagnosis of TB, standardized treatment, continuous access

186. *Id.* at 60.

187. *Id.* at 47.

188. UNAIDS REPORT 2012, *supra* note 13, at 47 (citing Haileyesus Getahun et al., *Prevention, Diagnosis, and Treatment of Tuberculosis in Children and Mothers: Evidence for Action for Maternal, Neonatal, and Child Health Services*, 205 J. INFECTIOUS DISEASES S216, S216-27 (2012)).

189. GLOBAL TUBERCULOSIS REPORT 2012, *supra* note 159, at 3.

190. UNAIDS REPORT 2012, *supra* note 13, at 47.

191. *See* GLOBAL PLAN TO STOP TB, *supra* note 165, at 16.

192. GLOBAL TUBERCULOSIS REPORT 2012, *supra* note 159, at 4 box.1.2.

193. THE STOP TB STRATEGY, *supra* note 166, at 9.

194. *Id.* at 4.

195. *Id.*

to high quality anti-TB drugs, and tracking treatment outcomes.[196] DOTS has been adopted by virtually every country as the foundation of national TB control programs, and the result has been successes on multiple fronts.[197] The case detection rate for new smear-positive cases is on the rise globally,[198] although the least improvement was reported in Africa (at around 60 percent).[199] Likewise, the treatment success rate for new smear-positive cases has steadily increased since 1995[200] and now stands at 87 percent (based on 2010 data).[201] Despite Africa's failure to attain 85 percent treatment success rate, which was the benchmark set by the World Health Assembly in 1991, the region fared well compared to other regions, at 82 percent compared to 77 percent in the region of the Americas and 67 percent in Europe.[202]

The positive development across the globe can be traced to growing investment in TB control programs in the 22 HBCs, which began in 2002 and has consistently gone up each year.[203] Despite increased funding, however, gaps still remain. The National TB control program ("NTP") budgets in most African countries have fallen prey to this deficit, resulting in scaling back of a range of critical interventions. Funding deficit projected for 2013 among HBCs in Africa ranges from $36 million (NTP budget of $51 million) in Kenya to $5.2 million ($14 million NTP budget) in the Democratic Republic of Congo.[204] The huge gap between NTP budgets in these countries and available funds does not bode well for scaling up of interventions that are vital to reaching the various global TB targets enumerated above.

Each component of the Stop TB Strategy, particular DOTS, requires huge capital outlay, without which progress cannot be assured. Not surprisingly, the result is mixed. As to incidence of TB (Target 6C), the rate is declining in Africa (3.1 percent between 2010 and 2011), as in the rest of the regions of the world.[205] The second (and more important) target set by the Stop TB Partnership's Global

196. *Id.* at 9-11.

197. *Id.* at 4.

198. GLOBAL TUBERCULOSIS REPORT 2012, *supra* note 159, at 35 (reporting that the attainment of 66 percent, a significant improvement from 53-59 percent in 2005 and 38-43 percent in 1995).

199. *Id.* (meaning that Africa failed to meet the first Global Plan (2000-2005) Target of detecting by 2005, at least 70 percent of new sputum smear-positive cases—that is, three years past the Target deadline).

200. *Id.* at 36 (reporting that regarding the latest year for which data was available (2010) treatment success rate of 87 percent was achieved, marking the fourth consecutive year that the target of 85 percent, which was set by the World Health Assembly in 1991, was met or exceeded worldwide); *see also* WHO, GLOBAL TUBERCULOSIS CONTROL: A SHORT UPDATE TO THE 2009 REPORT 11 tbl.5 (2009) [hereinafter GLOBAL TUBERCULOSIS CONTROL], *available at* http://reliefweb.int/sites/reliefweb.int/files/resources/34D6472DD50D01F94925768C00245048-WHO_Dec09.pdf (charting out the treatment success rates among new smear-positive cases between 1994-2007).

201. GLOBAL TUBERCULOSIS REPORT 2012, *supra* note 159, at 36.

202. *Id.*

203. GLOBAL TUBERCULOSIS CONTROL, *supra* note 200, at 20.

204. GLOBAL TUBERCULOSIS REPORT 2012, *supra* note 159, at 55.

205. *Id.* at 11-12.

Plan to Stop TB—halving the 1990 TB prevalence and mortality rates by 2015[206]—is more problematic for African countries. Since TB prevalence rate (including HIV-positive population) in the region was 300 cases per 100,000 population in 1990, achieving the target requires reducing the number of cases to 150 by 2015,[207] a herculean task considering that prevalence rate in the region is going in the opposite direction, rising to 490 cases per 100,000 population in 2008.[208] The WHO notes that the target has been achieved in one region and within reach in others, but not in Africa and one other region.[209] The mortality rate remains equally grave. The 2010 TB mortality rate of 30 deaths per 100,000 population (excluding HIV-positive people) is just slightly less than the 1990 level (37 deaths),[210] indicating significant progress has not been accomplished. These troubling statistics led the WHO to conclude, rather trenchantly, that reaching these targets by 2015 "appears impossible in African countries."[211] So what to do?

V. HUMAN RIGHTS ANALYSIS: MORE THAN ACCESS TO MEDICINE

An apt point to initiate a discussion on a human rights-driven analysis of the obligation of governments in Africa in respect to the scourge of HIV/AIDS, malaria, and TB is to emphasize two crucial points that are essential to properly contextualize the issues. First, is to note that neither MDG 6 nor any of the other health-MDGs imposes substantially novel obligations on the governments in the region or, for that matter, anywhere else. Previous global or regional legal and policy frameworks have sought to address these problems by targeting specific diseases[212] or seeking their elimination through a broader umbrella, the health-as-a-human right approach.[213] An instance of the former is the Abuja Declaration which commits African countries to "[h]alve the malaria mortality for Africa's people by 2010."[214] This commitment is remarkably similar to Target 6C of MDG 6 (to "[h]ave halted by 2015 and begun to reverse the incidence of malaria"), the only difference being a five year interval in the deadlines.[215] The Abuja Declaration was adopted four months earlier than the MDGs.[216]

An international policy document that espoused a more cosmopolitan approach is the WHO's *Global Strategy for Health for All by the Year 2000*, which was adopted in 1979, with the goal of attainment by all people of the world by the

206. THE STOP TB STRATEGY, *supra* note 166, at 8.

207. *See* MDGS REPORT 2010, *supra* note 23, at 51.

208. *Id.*

209. GLOBAL TUBERCULOSIS REPORT 2012, *supra* note 159, at 16.

210. MDGS REPORT 2012, *supra* note 16, at 44.

211. GLOBAL TUBERCULOSIS CONTROL, *supra* note 200, at 26.

212. *See MDG Indicators*, *supra* note 3.

213. *See* WHO, GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000, at 7, 15 (1981) [hereinafter GLOBAL STRATEGY FOR HEALTH], *available at* http://whqlibdoc.who.int/publications/9241800038.pdf.

214. THE ABUJA DECLARATION, *supra* note 120, at 4.

215. *MGD Indicators*, *supra* note 3.

216. THE ABUJA DECLARATION, *supra* note 120, at 4 (the Abuja Declaration was adopted in April 2000 while the MDGs were adopted in September 2000).

year 2000 of a level of health that would permit them to lead socially and economically productive lives.[217] The year set aside for achieving the goal of the strategy has come and gone, and yet the world remains as far off from achieving health for all as when the thirty-second World Health Assembly adopted the original resolution establishing the strategy. This important global policy framework shares several similarities with the MDGs project, particularly in terms of the end goal and associated programs. Had this previous attempt by the WHO at radically improving global health succeeded, there would certainly have been no need for the health MDGs. Moreover, as recognized in the Millennium Development Project, "human rights (economic, social, and cultural rights) already encompass many of the Goals, such as those for poverty, hunger, education, health, and the environment."[218] This means the existence of extant obligations on those African countries (the vast majority) that have ratified the foremost international bill on economic, social and cultural rights—the ICESCR.[219] Will international health policy succeed where international human rights legal framework failed? Only time will tell.

The second point worthy of note (and very critical to positioning human rights as a key contributor to attaining Goal 6) relates to how to conceptualize health. A recent explanation was quite on point:

> Diseases and illnesses do not just reveal a subpar performance of the physiological and biochemical functioning of the human system; they represent something more sinister. Morbidities (and human suffering that accompanies it) are manifestations of a much deeper socioeconomic and political pathology: the factors responsible for excess exposure or susceptibility to circumstances that combine to create the need for therapeutic intervention in the first place. More than anything else, including improving access to health services, reversing the *status quo* requires sustainable and unwavering action on multiple fronts . . . . This

217. GLOBAL STRATEGY FOR HEALTH, *supra* note 213, at 7, 15. The Global Strategy was launched in 1979 at the 32nd World Health Assembly via resolution WHA32.30, although the original idea for global pursuit of health for all by the year 2000 was conceived at the 30th World Health Assembly in 1977 (WHA 30.43). World Health Assembly Res. 32.30, Rep. of the World Health Assembly, 32nd Sess., May 7-25, 1979, WHA32/1979/REC/1, at 56 (May 25,1979); *see generally* DON A. FRANCO, POVERTY AND THE CONTINUING GLOBAL HEALTH CRISIS 63 (2009) (analyzing the link between the Global Strategy and the MDGs) (where in the author's opinion, the MDGs constitute 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").

218. U.N. MILLENNIUM PROJECT, INVESTING IN DEVELOPMENT: A PRACTICAL PLAN TO ACHIEVE THE MILLENNIUM DEVELOPMENT GOALS 119 (2005), *available at* http://www.unmillenniumproject.org/documents/MainReportComplete-lowres.pdf.

219. United Nations, Multilateral Treaties Deposited with the Secretary-General, *International Covenant on Economic, Social and Cultural Rights* (Dec. 16, 1966), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (last visited Apr. 10, 2014) (showing that only three countries in Africa—South Africa, Comoros, and Sao Tome and Principe—are yet to ratify the treaty).

> is the real antidote to the paralytic performance that has dogged health systems in Africa for decades.[220]

This statement speaks to a broader conceptualization of health, one that is more intimately aligned with the WHO's definition of health as achieving "a state of complete physical, mental and social well-being."[221] This is the prism from which the various obligations undertaken by countries in Africa regarding the health of the population should be evaluated, despite the seemingly parochial constriction of the terms of specific legal provisions. By becoming parties to the treaty, these countries obligate themselves to, inter alia, "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[222] An almost identical, although somewhat broader, obligation is imposed by the Africa Charter on Human and Peoples' Rights.[223] In addition to recognizing the right to health, countries in Africa voluntarily took the additional step of committing themselves to "take . . . necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."[224] Would the various governments in the region be in compliance with their treaty obligations were they to successfully scale up access to preventive, life-saving, or curative health services for individuals suffering HIV/AIDS, malaria, or TB? Regarding HIV/AIDS, for instance, would countries such as Botswana, Namibia, and Rwanda, that have achieved universal access to ART, be said to have fulfilled their obligation regarding the right to health as far as that specific population is concerned?

Medicine-oriented response to health problems, without more, is not enough. Access to therapy, while undeniably crucial, is just one of the essential elements needed to ensure optimal health, or as a U.N. General Assembly resolution puts it, in the context of HIV/AIDS, "medication . . . is one of the fundamental elements to achieve progressively the full realization of the right of everyone to . . . health."[225] The implication, then, is that in order to be in full compliance with the right of the population to health, more is needed. Of greater importance is the condition under which people live and work, the socioeconomic and regulatory conditions, or factors that operate to facilitate or constrain human flourishing. Where people are born and raised, also taking into consideration their life circumstances, not the availability of health services per se, are responsible for health outcomes. When these conditions are positive, population health flourishes and vice versa. These conditions, known as underlying or social health determinants, are the major

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220. Obiajulu Nnamuchi, *Health and Millennium Development Goals in Africa: Deconstructing the Thorny Path to Success*, *in* THE RIGHT TO HEALTH: A MULTI-COUNTRY STUDY OF LAW, POLICY AND PRACTICE (Obiajulu Nnamuchi et al. eds., forthcoming 2014).

221. WHO, BASIC DOCUMENTS 1 (47th ed. 2009) (quoting the preamble of WHO's Constitution) (entered into force Apr. 7, 1948).

222. ICESCR, *supra* note 91, art. 12(1).

223. African Charter on Human and Peoples' Rights, *supra* note 96, art. 16(1).

224. *Id.* art. 16(2).

225. Declaration of Commitment on HIV/AIDS, G.A. Res. S-26/2, ¶15, U.N. Doc. A/RES/S-26/2 (June 27, 2001).

drivers of health and consist of, inter alia, "food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."[226] Availability or lack thereof is responsible for health disparities within and amongst nations. The WHO Commission for Social Health Determinants helpfully puts it this way, "[a]t all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health."[227] The Commission continues:

> The poor health of poor people, the social gradient in health within countries, and the substantial health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives—their access to health care and education, their conditions of work and leisure, their homes, communities, towns, or cities—and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a natural phenomenon but is the result of a combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and cause much of the health inequity between and within countries.[228]

This can be seen as a restatement or an elucidation of the right to health.[229] As to what precisely needs to be done to establish this right in people's lives, this author has argued, in a related context:

> Health policy decisions should be based on the principle that social determinants of health such as food, housing, *et al* are, *stricto sensu*, not within the mandate of a Ministry of Health but, even so, their availability and equitable distribution are crucial to . . . improving overall health and wellbeing. This is the crux of multisectoral dimension of health and has two critical implications for Africa. First, health sector reform must be operationalized in tandem with strengthening other sectors (agriculture, industries, housing and so forth) connected with providing or creating an enabling environment for availability of goods or conditions that promote good health. Second, multisectoral interventions must not only be harnessed, it must also be harmonized and streamlined to achieve a common goal: improving health. The leadership role of the Ministry of Health must involve active cooperation and collaboration with other sectors, including

226. General Comment No. 14, *supra* note 92, ¶ 4.

227. Michael Marmot et al., *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, 372 LANCET 1661, 1661 (2008).

228. *Id.* at 1661.

229. General Comment No. 14, *supra* note 92, ¶¶ 4, 11, 12, 36; *see also id.* ¶ 12(b) n.6 (providing that in absence of an explicit contrary provision, references in the General Comment "to health facilities, goods and services" should be read as including "the underlying determinants of health" outlined in ¶¶ 11 and 12(a) of the General Comment).

> bilateral and multilateral partners, to find cost-effective and sustainable solutions to the numerous health challenges facing the region.[230]

Short of a multipronged and holistic approach to solving Africa's health woes, all the investments toward restoring the health of people suffering from any of the diseases under consideration, particularly in respect to vulnerable populations, would amount to naught. In fact, deploying resources toward access to the "socio-economic [goods] that promote conditions in which people can lead a healthy life" is an important indicator of the commitment of countries to the health of its citizenry.[231] Proof, if there is need for one, is that countries in which these goods are reasonably (even if not abundantly) available are also those, as a WHO Report makes quite clear, with better overall health outcomes—and the reverse is equally true.[232] Even stronger proof that access to health care does not (alone) translate to optimal health is provided by health outcomes in the United States. In 2000, the U.S. led the world in health spending (medical care);[233] still, its overall health system performance and attainment was ranked 37th globally, worse than even some third-world countries such as United Arab Emirates.[234] A notable distinction between the United States and other affluent countries is that the latter invest heavily in underlying health determinants for its vulnerable populations (in form of welfare packages).[235] Attempts could be made to weaken this point by claiming that investment in underlying health determinants was not among the indicators used in the 2000 ranking of global health systems.[236] That is true; nonetheless, it is

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230. Nnamuchi, *Health and Millennium Development Goals in Africa: Deconstructing the Thorny Path to Success*, *supra* note 220.

231. General Comment No. 14, *supra* note 92, ¶ 4.

232. WHO, THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE 152-55 (2000) [hereinafter WORLD HEALTH REPORT 2000], *available at* http://www.who.int/whr/2000/en/whr00_en.pdf (showing that poorer nations, as a group, fared worse than affluent ones, invariably where the basic and super structures of decent lives are more easily available).

233. David A. Squires, *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality*, COMMONWEALTH FUND, May 2012, at 1, 2, 9-10, *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf (finding that the United States far outspends other countries in healthcare and yet does not reap commensurate dividend).

234. WORLD HEALTH REPORT 2000, *supra* note 232, at 155.

235. *See, e.g.*, Social Welfare, UAE INTERACT, http://www.uaeinteract.com/society/welfare.asp (last visited June 4, 2014) (official government source describes the social welfare system in United Arab Emirates) ("Despite the UAE's economic success there are, inevitably, individuals who are not in a position to benefit directly from the country's good fortune. Therefore, a social welfare network has been put in place to assist these vulnerable members of society. This takes the form of social security benefits administered by the Ministry of Labour and Social Affairs, in addition to the practical help offered by the network of Ministry-supported social centres run by the General Women's Union, and the government-supported social welfare and rehabilitation centres providing assistance to the disabled.").

236. WHO & COMM'N ON SOC. DETERMINANTS OF HEALTH, CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 185 (2008), *available at* http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf ("As part of global and national

argued that the result would be the same had health determinants been one of the parameters of measurement. In Glasgow, Scotland, although everyone is entitled to health care provided by the United Kingdom's National Health Service (NHS), there is a wide gulf in life expectancies between poor and affluent males in that city, fifty-four years compared to eighty-two.[237] This disparity is inexplicable on any other ground except greater access to underlying health determinants such as housing, proper nutrition, education, and so forth by the latter group.

Attending to social health determinants becomes even more critical when inertia accentuates the vulnerability of an already susceptible population as has historically been the case. It is in this context that the special circumstances of those most affected by HIV/AIDS, malaria, and TB become the burden of human rights. Take HIV/AIDS, as an illustration. More than any other segment of the population, sex workers stand out, as shown previously, as disproportionately impacted by the disease. Sex workers deserve to be singled out because no amount of intervention would be successful in absence of fundamental restructuring of their life circumstances in terms of provision of, for instance, access to education and employment. The link is simple and straightforward. At the root of sex trade is adverse socioeconomic circumstances on the part of its victims, the sex workers. Securing better remunerating and less risky employment, a possibility best offered by acquiring education, provides an escape route from poverty and want—a key element in instilling the kind of attitudinal change needed for exodus from the hazards of the dark world of sex trade.[238] It is one thing to create awareness of the hazardous nature of an enterprise but quite a different challenge to equip the proselytized person with the means with which to escape the hazard. The latter, more difficult because it involves deployment of resources, is where serious efforts should be concentrated.

Dehumanizing and debasing one's prized possession via prostitution is hardly a product of volition; instead, and this is very important, it starkly illustrates an instance of the consequences of what has been described as "structural violence."[239] This is not the sort of violence or harm perpetrated with guns or knives; its reach and tentacles are far more damaging and deadly.[240] It is quite a

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surveillance systems, data on health inequities and determinants should be made publicly available and accessible and disseminated widely for advocacy purposes and to support coherent policy-making.").

237. Gail R. Wilensky & David Satcher, *Don't Forget About the Social Determinants of Health*, 28 HEALTH AFFAIRS w194, w195 (2009).

238. *See, e.g.*, G.A. Res 65/277, ¶ 25, U.N. Doc. A/RES/65/277 (June 10, 2011); KIMBERLY A. MCCABE, THE TRAFFICKING OF PERSONS 35 (2008).

239. Johan Galtung, *Violence, Peace, and Peace Research*, 6 J. PEACE RES. 167, 170-71 (1969).

240. *See id.* at 171 ("There may not be any person who directly harms another person in the structure. The violence is built into the structure . . . ."); *see also* Gernot Köhler & Norman Alcock, *An Empirical Table of Structural Violence*, 13 J. PEACE RES. 343 (1976). Structural violence is also a concern of liberation theology. *See* LEONARDO BOFF & CLODOVIS BOFF, INTRODUCING LIBERATION THEOLOGY 24-27 (Paul Burns trans., 1987). In fact the movement against the evil of structural violence has a lot in common with liberation theology. Both reject vice (laziness, ignorance, or human wickedness) and backwardness as explanatory of poverty; and see poverty as a manifestation or consequence of oppression. *Id.* at 25-27 (defining poverty as oppression; meaning that poverty is the

different kind of attack on social equilibrium. The violence is termed "structural" because the circumstances or factors that cause and sustain harm are embedded in the structure of the society.[241] It manifests itself as "unequal power and consequently as unequal life chances" for its victims.[242] Although he might not have known it, an informant in Zimbabwe alludes to this kind of violence when he points out, in a recent interview, that massive poverty in his country leaves parents with no choice than to "force their children to go out and prostitute themselves" or force them into "early marriages at the age of 10 and 11."[243] A similar explanation is given by a sex worker in Swaziland: "Here in Swaziland there are no jobs . . . . I have no choice to be a sex worker, whether I like it or not, I must do that."[244] As to how this really impacts her life, she continues, "[r]ight now I don't feel that I am a human being . . . . Right now I am scared to greet my family because if I say that I am a prostitute all of the people will just say that I am a prostitute."[245] Despite this shame, rejection, isolation, and, as would likely be her fate, premature death (likely from HIV/AIDS),[246] she remains a sex worker—thanks to overwhelming combination of forces that, over the years, insidiously succeeded in stripping her of any sense of real freedom. These invisible forces are continually at work, holding her and others like her in suffocating bondage, all the while wrecking havoc in their lives and that of the general population (by being a source of infection, with all that it entails). But sex workers are not alone. A similar argument could be advanced regarding other diseases, including malaria and TB.[247]

The Biblical statement, "[t]hey that are whole need not a physician; but they that are sick" is not only a theological admonition with canonical significance,[248] it is also a powerful human rights catechism. It is trite that human rights inhere in human beings equally but in practice, they make more meaning to the downtrodden, the poor and destitute, those whose daily existence are structured and constrained by forces outside their control which, in turn, render them susceptible to "high levels of illness and premature mortality."[249] It is particularly

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"product of the economic organization of society itself, which *exploits* some—the workers—and *excludes* others from the production process—the underemployed, unemployed, and all those marginalized on one way or another").

241. Paul E. Farmer et al., *Structural Violence and Clinical Medicine*, 3 PLOS MED. 1686, 1686 (2006).

242. Galtung, *supra* note 239, at 171.

243. *Poor People's Testimony: Living on a Dollar a Day in Zimbabwe*, VATICAN RADIO (Nov. 29, 2012), http://en.radiovaticana.va/articolo.asp?id=642566.

244. Victoria Eastwood, *Sex Worker: I Sleep with Five Men a Day Just to Eat*, CNN (Oct. 19, 2012), http://edition.cnn.com/2012/10/18/world/africa/swaziland-sex-unemployment-economy/index.html.

245. *Id.*

246. Swaziland leads the world in the proportion of its population infected with HIV (25.9 percent). WORLD HEALTH STATISTICS 2011, *supra* note 69, at 72.

247. Malaria and TB are diseases of the poor, and this fact is unaltered by geography. *Id.* at 76. Whether in rural villages in Africa or behind the walls of a Russian prison, Malaria and TB disproportionately impact those lower on the socioeconomic ladder. *See id.*

248. *Luke* 5:31 (King James).

249. Marmot et al., *supra* note 227, at 1661.

for the benefit of these people, their welfare and fulfillment, that human rights really exist. Yet, for the vast majority of them, forces set in motion by others, by and large, determine their life chances even, in some cases, before birth. "One of the worst things," laments an unemployed 25-year old man in Zimbabwe, "is you're not involved in any key decision-making in life."[250] This type of disempowerment or disenfranchisement represents the worst abuse of human rights, a grave infraction on individual autonomy (the cornerstone of human rights) and it has significant implication for health. As more forcefully argued elsewhere, the importance of individual empowerment—in the sense of enabling individuals to take charge of their own affairs, particularly health—cannot be ignored in any health policy framework.[251]

> The obvious advantage . . . is the element of democracy it embodies. But this sort of democracy has a somewhat different appeal in the sense that the interest of those on the higher end of socioeconomic ladder is not, as often is the case in developing countries, taken as representative of the entire population.[252]

It is this sort of democracy that is the task of human rights. Rather than maintain the *status quo*, the way things have always been done, it calls for prioritizing the needs and interest of the poor, including soliciting their views as to how best to meet their needs. This is human rights pragmatism borne out of solidarity with the people whose needs and exposure to diseases and illnesses is greater vis-à-vis the general population. The productivity of human rights is at its peak, much like liberation theology, when it is "on the side of the poor" and "struggle[s] alongside them against the poverty that has been unjustly created and forced on them."[253] To suggest that human rights should serve as a liberating or emancipating force, freeing vulnerable and other marginalized groups from the cold clutches of poverty, deprivation and other harmful conditions, the consequence of which has been disproportionate burden of HIV/AIDS, malaria, TB, and other largely preventable diseases, is not to reconceptualize the doctrine. Rather, the suggestion merely emphasizes practicalization, the way things ought to be. It is, in reality, about making human rights work to the advantage of its primary subjects, the people who need it most.

VI. CONCLUSION

When, in 1962, Angelo Giuseppe Roncalli, better known as Pope John XXIII, proclaimed what he perceived as the appropriate role of the Church in her dealings with underdeveloped countries, that the Church not only "present herself as she is," but also "as she wants to be—as the Church of all men and especially the Church

250. VATICAN RADIO, *supra* note 243.

251. Nnamuchi, *Health and Millennium Development Goals in Africa: Deconstructing the Thorny Path to Success*, *supra* note 220.

252. *Id.*

253. BOFF & BOFF, *supra* note 240, at 4.

of the poor," his overarching concern was theological pragmatism.[254] But he might as well have been speaking about human rights and related obligation of the international community. The beloved Pontiff was suggesting that although the mission of the Church is centrally cosmopolitan—in other words, service to the entire world, a special ministry deserves to be carved out for those on the fringes of society, individuals whose lives are constrained by daily struggles against misery, want and deprivation, the "wretched of the earth", as psychiatrist/philosopher Frantz Fanon aptly describes them.[255] This adjuration, on particularizing the plight and needs of the poor, is a strong moral imperative whose reach transcends theology howsoever reconceptualized. It has also a very powerful secular resonance.

The role of human rights can be summed up as improving the wellbeing of each and every individual. This is indeed true, and human rights does (at least in principle) have a special outreach, a kind of special treatment—if you will—for individuals or groups who are disadvantaged in some material respect vis–à–vis the general population.[256] Proof is General Comment No. 14, arguably the most important interpretive document on the right to health, which uses the term "vulnerable" and/or "marginalized" population at least eleven times to emphasize countries' obligation to prioritize the needs of the poor.[257] But theory often differs (vastly, in some cases) from practice and this is at the core of the plight of marginalized and vulnerable populations in the realm of health as well as in other dimensions of wellbeing.

This dissonance (between theory and practice) is visible in the grotesquely disproportionate burden of diseases suffered by people in sub-Sahara Africa. Within this long-suffering population, some distinct groups—identified in the paper as "special population groups"—are at greater risk than the rest of the general population. Unjustifiable disproportionality, most especially of adverse outcomes, represents one of the most brazenly ubiquitous forms of inequity. When confronted with inequity, the task of human rights is remediation, to expurgate the inequity as comprehensively and expeditiously as possible.[258] This is the thrust of

254. GUSTAVO GUTIÉRREZ, A THEOLOGY OF LIBERATION: HISTORY, POLITICS AND SALVATION 287 n.2 (Sister Caridad Inda & John Eagleson trans., 1973) (citing *Radio Message Sept. 11, 1962*, 8 POPE SPEAKS 396 (1963)).

255. *See generally* FRANTZ FANON, THE WRETCHED OF THE EARTH (Richard Philcox trans., 2004).

256. It is no coincidence that MDG 8 was formulated solely for the benefit of the Global South, to uplift countries in that part of the world. *See* MDG GAP TASK FORCE, MILLENNIUM DEVELOPMENT GOAL 8: THE GLOBAL PARTNERSHIP FOR DEVELOPMENT: MAKING RHETORIC A REALITY 1 (2012) [hereinafter MILLENNIUM DEVELOPMENT GOAL 8], *available at* http://www.un.org/millenniumgoals/2012_Gap_Report/MDG_2012Gap_Task_Force_report.pdf. The idea behind the goal was to cushion the effect of impoverishment on the lives of people in targeted countries, to bridge the ever-widening gap between the two worlds. *See id.*

257. General Comment No. 14, *supra* note 92, ¶¶ 12(b)(i), 12(b)(ii), 18, 35, 37, 40, 43(a), 43(f), 52, 62, 65.

258. *See* JACK DONNELLY, UNIVERSAL HUMAN RIGHTS IN THEORY AND PRACTICE 7-8 (2d ed. 2003) (explaining that human rights are entitlements that allow humans to make certain claims if these rights are threatened or denied).

the human rights bent of this paper, in examining the ravages on human lives brought about by the trifecta of HIV/AIDS, malaria, and TB, particularly on those most vulnerable to these diseases in the vast majority of countries in Africa. Strategies, initiatives, and overall efforts in attacking these diseases must go beyond the general population to attend to the people most at risk of infection (sex workers, for instance, in the case of HIV/AIDS). Greater attention (in the nature of deployment of resources) to prevention, treatment, and caring for these individuals is not only in consonance with the catechism of human rights, it also has practical benefits. The best health strategy is one that is aimed squarely at the source of the problem (in this case, most-at-risk population), and that is also the most effective way to reduce infection and thereby begin to get a firm grip on the problem.

A secondary level solution to the problem involves addressing population-wide needs as elucidated in the fifth section of this discourse. Meeting the needs of the sick is, of course, very important; yet, of more importance is preemptive action, radically rearranging the socioeconomic dynamics in such a way that exposure to the conditions that result in diseases and illnesses are, to the extent sustainable by available resources, banished. Attending to underlying health determinants is the key to rescuing people in Africa from countless and ever-rising morbidities and mortalities that have come to define life in that part of the world. Numbers are powerful in that they (where negative) are silent indictments of affected persons or institutions. That key health indicators in Africa are overwhelmingly negative is not explicable on the basis of resource constraints. Otherwise how does one explain strikingly similar health outcomes in Nigeria as in Somalia, Ethiopia, and elsewhere (countries on different tiers of socioeconomic development)? In fact, in some cases, resource poor nations have fared better than wealthier ones.[259] Yet, all these countries solemnly pledged to commit themselves to protecting and promoting the right to health.[260] Had these commitments been taken seriously, the health situation in the region would surely have been different. The latest UNDP Human Development Report is aptly titled *Sustainability and Equity: A Better Future for All.*[261] Of the forty-four countries classified as having "low human development" (worst category) only eight are not African.[262] In Niger, 64 percent of the population lack access to clean water as does 89 percent who lack improved sanitation.[263] Other countries in the region are not far behind. Does the future really hold any better health prospects for people in Africa? Would

259. For example, see *supra* note 235 and accompanying text.

260. African Charter on Human and Peoples' Rights, *supra* note 96, art. 16. *See also supra* notes 218-19 and accompanying text.

261. UNITED NATIONS DEV. PROGRAMME, HUMAN DEVELOPMENT REPORT 2011: SUSTAINABILITY AND EQUITY: A BETTER FUTURE FOR ALL (2011) *available at* http://www.us.undp.org/content/dam/undp/library/corporate/HDR/2011%20Global%20HDR/English/HDR_2011_EN_Complete.pdf [hereinafter HUMAN DEVELOPMENT REPORT 2011]. The Report identifies "the right of future generations everywhere to live healthy and fulfilling lives" as the "great development challenge of the 21st century." Helen Clark, *Foreword* to HUMAN DEVELOPMENT REPORT 2011, at iv, iv. This challenge is, beyond doubt, greatest in Africa.

262. *Id.* at 144-145 tbl.5.

263. *Id.* at 145 tbl.5.

people in the region be able to claim victory over HIV/AIDS, Malaria, and TB any time soon? These are critical human rights questions whose unraveling hinges on a number of issues, some of which were addressed in preceding sections.

In his book, *Pathologies of Power*, physician/human rights advocate Paul Farmer explains: "Human rights violations are not accidents; they are not random in distribution or effect. Rights violations are, rather, symptoms of deeper pathologies of power and are linked intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm."[264] In other words, lack of access to basic goods that make life worthwhile and, in most cases, protect people from unnecessary pain, suffering and death, such as potable water and improved sanitation (basic essentials of life), is not the result of some combination of circumstances over which authorities in the region lack control. It was the 19th century English jurist and legal scholar Frederick William Maitland who wrote, "[t]he forms of action we have buried, but they still rule us from their graves."[265] In like manner as archaic rules of common law still rear their ugly heads in procedural and substantive law, centuries after they have been thought to have been consigned to oblivion, institutional insensitivity to human rights, which ought to have been buried with the demise of military dictatorships in Africa, remains an inescapable part of African polity, even unto this day.

Despite obeisance at the altar of democracy, leaders in the vast majority of countries in the region retain the mold of their predecessors in military garbs, the old ways of doing things. Avarice, kleptocracy, and other, no less odious, forms of malgovernance still hold sway. Opulence has become the reward for governance—indeed, the two now go hand in hand, sort of bounty for winning (often rigged) election—even as a large chunk of the governed miserably strives to survive. Here is an illustration. Although, by their own national count, nearly half (46 percent) of Kenyans and 55 percent of Nigerians subsist in poverty,[266] legislators in the two countries are the best remunerated worldwide, at $175,000 annual compensation package for parliamentarians in Kenya[267] and over $100,000 monthly salary for senators in Nigeria.[268] To put this in proper perspective,

264. PAUL FARMER, PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS, AND THE NEW WAR ON THE POOR 7 (2003).

265. F. W. MAITLAND, THE FORMS OF ACTION AT COMMON LAW: A COURSE OF LECTURES 2 (A. H. Chaytor & W. J. Whittaker eds., 1936).

266. HUMAN DEVELOPMENT REPORT 2011, *supra* note 261, at 144 tbl.5.

267. Jason Straziuso, *Kenya Outraged Over Parliament's $175K Pay Vote*, BOSTON.COM (July 2, 2010), http://www.boston.com/news/world/africa/articles/2010/07/02/kenya_outraged_over_parliaments_175k_pay_vote (reporting that in mid-2010, legislators in Kenya voted themselves an annual pay package of $175,000, covering compensation for housing, entertainment, transportation, parliamentary meeting attendance, constituency allowance, and a miscellaneous allowance).

268. Denrele Animasaun, *Nigerian Lawmakers are the Highest Paid in the World*, VANGUARD (Aug. 25, 2013, 12:03 AM), http://www.vanguardngr.com/2013/08/nigerian-lawmakers-are-the-highest-paid-in-the-world ("A senator in Nigeria earns 240 million naira (about 1.7 million US dollars) in salaries and allowances and a member of the House of Representatives earns 204 million naira (about

senators in the United States will be paid $174,000 in total annual compensation package this year[269] compared to $1.7 million for their counterparts in Nigeria (in just salaries, exclusive of other benefits). The latter is notoriously a third-world country, its health system ranks 187th in the world (amongst 191 countries surveyed),[270] the corruption perception index ("CPI") in the country places it 139th out of 174 countries,[271] and its human development index ("HDI") rank is 156th (out of 181 countries);[272] still, its leaders are compensated multiple times above the earnings of their peers anywhere in the world. An outrage indeed, but that, nonetheless, is governance—African style, explaining why Zambian economist Dambisa Moyo wants to end foreign aid to the region.[273]

Moyo certainly has a great point, but another worthwhile solution might be found in the MDGs themselves. Goal 8—which explicitly requires international cooperation as a means to achieving the MDGs—carves out a special role for affluent countries, to hold poor countries accountable for the way received aid is spent.[274] And this critical obligation, especially considering that "he who pays the piper dictates the tune," might be what is needed to force political leadership in Africa to rethink their insensitivity to massive human suffering in the region. But even this path would fall short of a sustainable panacea in absence of serious complementary effort on the part of the citizenry. The complementarity envisaged here involves the people ridding themselves of docility and demanding good

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1.45 million US dollars) per annum. It definitely rubs insult to injury for the average Civil servant who earns about 46 to 120 US dollars per month.").

269. *Senate Salaries Since 1789*, U.S. SENATE http://www.senate.gov/artandhistory/history/common/briefing/senate_salaries.htm (last visited Apr. 11, 2014).

270. THE WORLD HEALTH REPORT 2000, *supra* note 232, at 152-55 tbl.1. Strikingly, the only countries that fared worse than Nigeria are countries involved (at the time of the report) in civil war or other forms of armed conflicts, namely, Democratic Republic of Congo (188th), Central African Republic (189th), Myanmar (Burma, 190th), and Sierra Leone (191st). *Id.*

271. TRANSPARENCY INT'L, CORRUPTION PERCEPTIONS INDEX 2012, at 3-5 (2012), *available at* http://issuu.com/transparencyinternational/docs/cpi_2012_report/1?e=2496456/2010281 (defining CPI as an index which ranks countries and territories based on how corrupt their public sector is perceived to be).

272. HUMAN DEVELOPMENT REPORT 2011, *supra* note 261, at 126. The HDI measures wellbeing in a country using the following three basic dimensions of human development: health, education, and income. *Id.* at 23.

273. DAMBISA MOYO, DEAD AID: WHY AID IS NOT WORKING AND HOW THERE IS A BETTER WAY FOR AFRICA 48-68 (2009).

274. 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. 178, 181 (2012) (analyzing the role of MDG 8 as a means to overcoming poverty (on an individual and institutional level) and corruption in Africa and, consequently, positioning the region on a path to achieving the MDGs).

governance as a right[275]—the key, ultimately, to real freedom from preventable diseases—be it HIV/AIDS, malaria, TB, or anything else.

275. *Id.* at 190-91 (defining "docility" as "acquiescence to misappropriation of public resources" which "arises when people go about their business as if looting the treasury is somehow an unavoidable reward for holding a political position" and arguing that it is a "common feature of developing economies and, lamentably, a powerful factor that sustains treating public resources as *res nullius* in many . . . countries").