

The human right to health in Africa and its challenges: A critical analysis of Millennium Development Goal 8

*Obiajulu Nnamuchi**

Assistant Professor, Faculty of Law, University of Nigeria; President/Chief Counsel, Centre for Health, Bioethics and Human Rights, Enugu, Nigeria

*Simon Ortuanya***

Commissioner for Education, Enugu State, Nigeria; previously Associate Dean, Faculty of Law, University of Nigeria

Summary

This article seeks to locate the right to health within the broader frameworks of socio-economic development and political governance. It identifies two critical factors as fundamentally responsible for the dismal state of health and well-being of Africans, despite a robust regional human rights regime that explicitly proclaims health as a human right. First, there is a lack of access to health services – the result of spiralling and crippling poverty amongst the general population. Second, governments in the region are either unwilling or unable to come to the aid of people in their jurisdictions. These unmet challenges ground the need for international intervention, an instance of which is the establishing of the Millennium Development Goals (MDGs). MDG 8 explicitly requires international co-operation and recognises that without enormous assistance, poor countries would be unable to attain the various benchmarks of the MDGs.

* LLB (NAU, Nigeria), LLM (Notre Dame), MIL (Lund), LLM (Toronto), MA (Louisville, Kentucky), SJD (Loyola, Chicago); obi.nnamuchi@yahoo.com/onnamuchi@luc.edu

** LLB (Nigeria), LLM (Lagos), SJD (Loyola, Chicago); simonnjk@yahoo.com. The authors thank Professors Mark A Rothstein, John D Blum and Nancy N Potter for an unquantifiable contribution to the successful completion of the first author's doctoral programme; numerous colleagues whose insights helped to refine many of the ideas espoused in this article; and AdaObi Nnamuchi for her assistance.

However, although MDG 8 could have a transformative impact on health in Africa, given its potential to supply the missing link in the struggle toward improving population health (resources), there are structural and operational difficulties that could undermine this possibility. The article critically analyses these difficulties and offers suggestions on how to surmount them.

1 Introduction

As of 15 March 1999 all 53 member states of the African Union (AU) had ratified the African Charter on Human and Peoples' Rights (African Charter).¹ By becoming parties to the Charter, African countries recognise that individuals within their respective jurisdictions 'have the right to enjoy the best attainable state of physical and mental health'² and, consequently, undertake to adopt measures necessary to protect their health by ensuring 'that they receive medical attention when they are sick'.³ However, more than a decade after entry into force, key provisions of the African Charter remain unimplemented, even as human wellbeing and vital health indicators continue to plunge across the region. One out of every eight children born in sub-Saharan Africa dies before the age of five.⁴ In 2008 there were 8,8 million under-five deaths worldwide, half of them in Africa.⁵ The maternal mortality rate (MMR) in the region is equally abysmal. The global MMR hovers around 536 000 annually,⁶ approximately half (265 000) occurring in sub-Saharan Africa.⁷ Relative to population, the region leads the rest of the world in deaths resulting from HIV/AIDS, malaria and other preventable diseases.⁸ Life expectancy has plummeted to 45 years, worse than anywhere else.⁹ Although this deplorable state of health

1 African [Banjul] Charter on Human and Peoples' Rights, OAU Doc CAB/LEG/67/3 Rev 5 (1981), entered into force 21 October 1986, reprinted in (1982) 21 *International Legal Materials* 58; C Heyns & M Killander (eds) *Compendium of key human rights documents of the African Union* (2010) 29.

2 Art 16(1).

3 Art 16(2).

4 UN The Millennium Development Goals Report 2011 25 http://www.un.org/millenniumgoals/11_MDG%20Report_EN.pdf (accessed 12 November 2011).

5 UN The Millennium Development Goals Report 2010 27 <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf> (accessed 12 November 2011).

6 UN The Millennium Development Goals Report 2009 http://www.un.org/millenniumgoals/pdf/MDG_Report_2009_ENG.pdf (accessed 12 November 2011).

7 As above.

8 WHO *World Health Statistics 2010* (2010) 70.

9 WHO (n 8 above) 56.

may be blamed on a gamut of factors, two are particularly critical.¹⁰ First, there is an acute shortage of health services throughout the region. Second, the vast majority of governments in the region are either unwilling or unable to come to the aid of the people within their respective jurisdictions. These unmet challenges ground the need for international intervention, an instance of which is the compact establishing the Millennium Development Goals (MDGs).

The MDGs, derived from the Millennium Declaration of 2000, consist of eight goals which all 191 member states of the United Nations (UN) have pledged to achieve by 2015.¹¹ Of the MDGs, four are directly related to health, namely, (i) to reduce child mortality; (ii) to improve maternal health; (iii) to combat HIV/AIDS, malaria and other diseases; and (iv) to eradicate poverty.¹² Each of the MDGs has time-bound and quantifiable targets measurable by specific indicators – all designed to assess country progress (or lack thereof) toward the Goals. Meeting these targets, in terms of identifying and vanquishing the various factors responsible for the poor state of health in Africa, is undoubtedly a sure way of advancing human development and overall wellbeing in the region. This awareness found bold expression in MDG 8, which explicitly requires the international community to ‘develop a global partnership for development’.¹³

MDG 8 has an omnibus character in that it charts multiple avenues of assistance for developing countries, including reforming the global trading and financial system, debt relief, improved access to essential drugs, technology transfer, and so forth.¹⁴ Encapsulated within this omnibus provision is a requirement for more generous official development assistance (ODA) to countries committed to poverty reduction.¹⁵ Whilst all the various paths to meeting MDG 8 are relevant to health, none has a more direct bearing than ODA increase. This explains why ODA is a focal point of this article. The fact that most morbidities and mortalities in Africa result from diseases that are easily preventable and inexpensive to treat points to crippling poverty amongst the population as the major culprit. Despite staking contrary positions in health policies and legislative frameworks, obtaining

10 To the list could be added a third factor, namely, socio-economic health determinants. Although we do not want to minimise their importance, space constraint militates against full elaboration.

11 See GA Res 55/2, UN GAOR, 55th sess, Agenda Item 60(b), UN Doc A/RES/55/2 (2000).

12 The remaining MDGs are to: achieve universal primary education, promote gender equality and empower women, ensure environmental sustainability and develop a global partnership for development. See UN Statistics Division, Official List of MDG Indicators, <http://unstats.un.org/unsd/mdg/Resources/Attach/Indicators/OfficialList2008.pdf> (accessed 12 November 2011).

13 As above.

14 As above.

15 As above.

health services is still a function of cash in the region, as those unable to pay are denied care. And because most governments in the region are incapable or unwilling to meet these expenses out of national funds, even for pregnant women and children, the sick are left to their fate. Resource deficit – at the individual or institutional level – is the greatest constraint to health services in the region, a gaping hole which MDG 8 (via increased ODA) is targeted to plug. But although MDG 8 could have a gigantic transformative impact on health, given its potential to supply the missing link (resources) in the struggle toward health for all in the region, there are structural and operational difficulties that could undermine this possibility. The article analyses these difficulties critically and offers suggestions on how to surmount them.

The article consists of five sections. Following the introduction, part 2 analyses how payment is made for health services. It recognises that the transition from user fees to a social health insurance (SHI) model, used in several African countries, bodes well for health in the region, but argues that the full benefits would remain unharnessed unless poverty amongst the population receives priority attention. Part 3 presents the bane of health sector development in the region – corruption – as well as its antidote – good governance. The section's central thesis is that improving population health in Africa hinges on the ability and preparedness of each country to disavow corruption and embrace good governance – a key requirement of MDG 8. Operationalising this requirement is the subject of part 4. The section carves out a special role for donor countries in ensuring that funds meant for health programmes in Africa actually achieve the intended objective. The conclusion is that, whether MDG 8 in fact becomes a panacea to Africa's health woes, depends critically on the extent to which donor nations are prepared to hold their counterparts in Africa accountable for the way ODA funds are spent.

2 Payment for services: An impediment to access to health care

There are two principal methods of paying for health services, namely, user fees and a prepaid system. User fees simply means making payment at the point of service (the individual is treated and he pays the cost of treatment). In prepaid systems, on the other hand, individuals contribute a predetermined amount to a fund from which payment is made when illness strikes. An advantage to prepaid systems is risk pooling: Risks of illness are shared by members of the pool (a sick fund, for instance), and not borne by any one individual or family. Conversely, in a user fee arrangement, individuals bear the full risk of illness, the consequences of which can be catastrophic. Depending on the nature of illnesses, paying for treatment could force the payer into poverty or deleteriously impact other aspects of wellbeing. The

payer gets what he paid for, which, in many cases, might be less than optimal care. Cost often acts as a deterrent to the uptake of care or may force a delay in seeking treatment.¹⁶ These downsides make user fees unattractive as a system of health care financing. In fact, a 2005 study found that abolishing user fees could prevent around 233 000 deaths of children less than five years old in 20 African countries.¹⁷ Despite being the ‘most inequitable method for financing health-care services’, user fees remain the dominant system of paying for health care in Africa, even as countries in other parts of the world are rapidly moving away from the system.¹⁸

The World Health Organisation (WHO) has been an active campaigner for abolishing user fees. Its 2008 Report was explicit in its admonition to countries to ‘resist the temptation to rely on user fees’.¹⁹ In addition, the Fifty-Eighth World Health Assembly (WHA) urged countries to²⁰

ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care.

The resolution reiterates WHO’s concept of ‘fair financing’ – the distribution of health care costs according to individual ability to pay, not the risk of illness.²¹ Even the World Bank, whose structural adjustment programme (SAP) foisted user fees on developing nations (as a condition for the receipt of loans) in the 1980s and 1990s, has completely reversed its position. The Bank’s *Reaching the poor policy brief* series is a periodic publication aimed at disseminating information on policies and practices that have made payment for care more progressive and access less inequitable in various developing nations.

Africa is responding, albeit tepidly, to the message. By the end of the 1990s, several countries in the region had successfully laid the foundation for a health system financing method that is not afflicted

16 Several studies document the impact of user fees as less utilisation of services. See, eg, CD James *et al* ‘To retain or remove user fees? Reflections on the current debate in low and middle income countries’ (2006) 5 *Applied Health Economics and Health Policy* 137-153; S Russell & L Gilson ‘User fee policies to promote health service access for the poor: A wolf in sheep’s clothing?’ (1997) 27 *International Journal of Health Services* 359–379; EK Ansah *et al* ‘Effect of removing direct payment for health care on utilisation and health outcomes in Ghanaian children: A randomised controlled trial’ (2009) 6 *PLoS Medicine* 0048-0058.

17 C James *et al* ‘Impact on child mortality of removing user fees: Simulation model’ (2005) 331 *British Medical Journal* 747-749.

18 WHO *The World Health Report 2008: Primary health care now more than ever* (2008) 24.

19 WHO (n 18 above) 26.

20 WHO Sustainable Health Financing, Universal Coverage and Social Health Insurance, 57th World Health Assembly, 25 May 2005, Agenda item 13.1, Resolution WHA 58.33.

21 WHO *The World Health Report 2000: Health systems: Improving performance* (2000) 35.

with the deficiencies of user fees and which, as urged by WHO, has the potential to provide universal coverage.²² Some of these countries – Nigeria, Ghana, Kenya, Rwanda, Senegal and Tanzania – opted for the SHI model and have reached varying degrees of implementation, whereas debate is ongoing in several other countries (Ethiopia, Liberia, Uganda, South Africa, Sierra Leone, Lesotho, Swaziland, Zambia and Zimbabwe) on the modalities for crafting the new system. Rwanda leads the pack in terms of coverage. As of 2006, 73 per cent of its citizens were covered by the nation's insurance system.²³ Ghana's pace has been extraordinary. Its SHI scheme became fully operational in 2005 (although the law establishing it was enacted in 2003) and by 2008 the coverage rate has jumped to 45 per cent of the population.²⁴ Other countries, such as Kenya and Nigeria, have not fared as well.

SHI as a preferred method of health care financing is consistent with the vision of the AU. In mobilising additional sources of revenue, countries are urged to seek a payment system that is consistent with solidarity and equity, and avoids payment at the point of service.²⁵ The African Health Strategy specifically calls for the adoption of SHI and the abolition of user fees.²⁶ The progressivity of SHI derives from its two core attributes: income and health-related cross-subsidies. Income-related cross-subsidies occur when contributions are tied to income, in which case the rich subsidise the poor since they pay more for the same benefit package. Health-related cross-subsidies, on the other hand, arise where high-risk individuals utilise more services than low-risk individuals even though insurance contributions are not desegregated according to risks. In other words, the 'less sick' subsidise the 'real sick'. If, as has been argued, people on a lower socio-economic ladder suffer a disproportionate burden of illness and substantially shorter life expectancies versus those higher up the ladder,²⁷ and the percentage of population living in poverty is highest in Africa,²⁸ then SHI may be the key that could unlock the health bondage in the region. This claim is based on the benefits that would likely accrue

22 WHO (n 18 above).

23 DE Logie *et al* 'Innovations in Rwanda's health system: Looking to the future' (2008) 372 *Lancet* 258.

24 S Witter & B Garshong 'Something old or something new? Social health insurance in Ghana' (2009) 9 *BMC International Health and Human Rights* <http://www.biomedcentral.com/1472-698X/9/20> (accessed 16 November 2011).

25 See The African Health Strategy: 2007 – 215, Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, 9-13 April 2007, CAMH/MIN/5(III), 11 http://www.africa-union.org/root/UA/Conferences/2007/avrill/SA/9-13%20avr/doc/en/Health_Strategy_Min_Draft.pdf (accessed 16 November 2011).

26 n 25 above 11-12.

27 R Wilkinson & M Marmot (eds) *Social determinants of health: The solid facts* (2003) 7.

28 UNDP *Human Development Report 2009: Overcoming barriers: Human mobility and development* (2009) 176-178.

from extending insurance coverage to those who would otherwise be unable to afford it in terms of access to preventive and curative services. But the fact that the coverage rate remains extremely low in some SHI countries (Nigeria and Kenya, for instance) in the region is a pointer to the difficulties that might frustrate the ambition.

The low uptake of coverage in Africa is primarily a product of poverty. Appreciating the value of insurance is one thing; having the wherewithal to pay for it is a totally different ball game. Consequently, even in countries with a high coverage rate, a great number of the insured makes no payment to the scheme. In Ghana, only a third of the covered population pays anything to the scheme, the rest receiving *gratis* coverage.²⁹ This raises sustainability concerns, especially since a large share of the fund for these schemes are sourced from foreign donors. An additional problem may lie in 'selling' SHI to potential beneficiaries. Mobilisation campaigns aimed at educating the people on the value of insurance and the affordability of contributions could generate mass enrolment. Yet, there is no evidence that this heavy lifting is being done by programme administrators. Take Rwanda, for instance. Contribution to its insurance scheme was pegged at \$2 per year plus 10 per cent fee per illness episode.³⁰ This sum, in all likelihood, is less than the average Rwandese spends annually for health services under the user fees system since, aside from the annual fee, only a fraction of the expenses that would have been incurred under user fees is now paid in the event of an illness.³¹ This sort of information needs to be disseminated as far and wide as possible, employing the services of credible sources such as religious and civic leaders. This is a strategy that must be built into SHI systems in Africa to improve uptake and accelerate progress toward the goal of securing access to universal coverage.³²

3 Corruption and good governance

Not quite long ago, a minister of finance in an African nation was asked to look the other way while funds donated for HIV and AIDS programmes in his country were being siphoned to a privately-held bank account. Outraged, he alerted authorities to investigate

29 Witter & Garshong (n 24 above).

30 Logie *et al* (n 23 above) 259.

31 Rwanda, a small country of 9,5 million people, is categorised as a high-burden malaria nation. In 2008, the country recorded 3,2 million malaria cases. Malaria treatment costs \$1,50 to \$2,40 for adults and \$0,40 to \$0,90 for children. See WHO *World Malaria Report 2008* (2008) 142.

32 For background information on SHI systems in Africa (using the experience of Nigeria), including challenges to uptake of coverage, see O Nnamuchi 'The Nigerian social health insurance system and the challenges of access to health care: An antidote or a white elephant?' (2009) 28 *Medicine and Law Journal* 125–166.

his colleague at the Ministry of Health who had made the request. Shortly afterwards, he was assassinated, his killers unknown. This narrative, although a depiction in a Nollywood epic, is not too distant from reality on the ground in the region.³³ Fast forward to 1 October 2010 – Uganda, East Africa. *The Independent* (a British newspaper) reported that malaria, an easily preventable and treatable disease, kills 300 people every day in that country. The reason: '[w]idespread government corruption and theft of anti-malarial drugs' supplied by the international community to be distributed free to the people.³⁴ Fiction or reality, these vignettes point to the fact that the flagrant conversion of public health resources to private use contributes staggeringly to skyrocketing morbidities and mortalities in Africa. Indeed, in its 2006 report Transparency International considers corruption to be 'a powerful force', the eradication of which 'restores diverted resources to their intended purpose, bringing better health, nutrition and education' as well as 'opportunity and hope' to the affected population.³⁵ Simply put, corruption is a human rights issue. And because corruption is 'the single greatest obstacle to social and economic development',³⁶ measures to alleviate it should occupy centre stage in strategic plans of any country seeking to advance its development agenda and human rights.³⁷

Successful corruption alleviation measures are built on good governance, restructuring the entire socio-economic system to make it more sensitive to people's needs and aspirations. Indeed, no nation can boast of good governance without having first gotten a firm grip on corruption in its basic institutions. The two go hand in hand: '[a] society committed to the fight against corruption is on the right path to good governance' – and, of course, the converse is also true.³⁸ Commitment to good governance (which, obviously, includes credible anti-corruption measures) has gained prominence in the international development arena since the demise of the Cold War. Out of the

33 *The corridors of power*, produced by Ossy Okeke and directed by MacCollins Chidebe (Ossy Affason Production, Nigeria) 2005.

34 O Steeds 'Theft and corruption take malaria drugs away from Africa's poorest' *The Independent* 1 October 2010 <http://www.independent.co.uk/news/world/africa/theft-and-corruption-take-malaria-drugs-away-from-africas-poorest-2094525.html> (accessed 16 November 2011).

35 Transparency International *Global Corruption Report 2006* (2006) xiii.

36 UN Office of Drugs and Crime (UNODC) *Handbook on planning and action for crime prevention in Southern Africa and the Caribbean regions*, UN Publication Sales E.09.IV.1 (2008) 111.

37 B Toebes 'The impact of acts of corruption on the enjoyment of the right to health' paper presented at the International Council on Human Rights, Review Meeting, Geneva, 28-29 July 2007.

38 African Development Bank 'Combating corruption in Africa' Proceedings of the Regional Learning Workshop on Combating Corruption in Africa, 27-30 January 2003 8, http://www.u4.no/helpdesk/helpdesk/queries/query_attach/q44Addisreport.pdf (accessed 17 November 2011).

ashes of blank checks, to despotic leaders whose countries had been of strategic importance to one or the other of the warring powers, grew a demand for good governance as a condition for receipt of aid. Over the years, good governance has emerged as the cornerstone of bilateral and multilateral development agreements and the lexicon for appropriate behaviour on the part of aid-receiving nations – a lexicon that has come to define the MDGs and a host of other global and regional development initiatives.³⁹

MDG 8 is a momentous compact between affluent countries and less developed ones. As *quid pro quo* for tariff concessions, debt relief, more generous ODA as well as greater access to essential medicines and enhanced technology transfer, developing countries covenant to commit to ‘good governance, development and poverty reduction’.⁴⁰ That this compact will be instrumental to attaining the MDGs was clearly apparent at Monterrey:⁴¹

Effective partnerships among donors and recipients are based on the recognition of national leadership and ownership of development plans and, within that framework, sound policies and good governance at all levels are necessary to ensure ODA effectiveness.

As President George W Bush subsequently explained:⁴²

We have a moral obligation to help others – and a moral duty to make sure our actions are effective. At Monterrey in 2002, we agreed to a new vision for the way we fight poverty, and curb corruption, and provide aid in this new millennium. Developing countries agreed to take responsibility for their own economic progress through good governance and sound policies and the rule of law. Developed countries agreed to support those efforts, including increased aid to nations that undertake necessary reforms. My own country has sought to implement the Monterrey Consensus by establishing the new Millennium Challenge Account. This account is increasing U.S. aid for countries that govern justly, invest in their people, and promote economic freedom.

39 Eg in 2001, African leaders pledged to ‘work, both individually and collectively, to promote’ the principles of democracy, good governance, human rights and so forth ‘in their countries and subregions and on the continent’. See The New Partnership for Africa’s Development (NEPAD), October 2001, para 71, http://www.nepad.org/system/files/framework_0.pdf (accessed 17 November 2011).

40 UN Statistics Division (n 12 above) MDG 8, Target 8.A.

41 UN Monterrey Consensus of the International Conference on Financing for Development, Monterrey, Mexico, 18-22 March 2002, Final Text of Agreement and Commitments, para 40 <http://www.un.org/esa/ffd/monterrey/MonterreyConsensus.pdf> (accessed 17 November 2011).

42 See ‘President addresses United Nations high-level plenary meeting’ 14 September 2005 <http://merln.ndu.edu/archivepdf/nss/WH/20050914.pdf> (accessed 17 November 2011). The Millennium Challenge Account is a mechanism through which the United States funds projects in countries meeting the following eligibility criteria: commitment to just and democratic governance, economic freedom and investment in its people.

The implication then, assuming the rhetoric is operationalised by donor nations, is that no longer would aid be given to countries that cannot demonstrate good governance and the rule of law.

This paradigmatic shift is significant for two reasons. Apart from its moral imperativeness (just and fair rule is an intrinsic moral good), good governance is a catalyst that can spur economic development and stem the tide of poverty in Third World countries. Completely unshackling the suffocating stranglehold of corruption, overreaching bureaucratic regulations and institutional ineptness, thereby unleashing the full force of the ingenuity, resourcefulness and creativity of the private sector, is an automatic trigger of economic growth. The root of persistent slow growth in many African countries is traceable to the corruption-driven and power-grabbing centralisation of authority which benefits a select few but impedes the development of a vibrant private sector. As experience shows, the level of economic success or decline in a given society is directly related to its quality of governance. It is no coincidence that upon secession from China and the adoption of a free market economy (and, of course, democracy), the economy of Taiwan blossomed whereas people in mainland China languished in abject poverty. Nor is it fortuitous that when it changed course, by following in the footsteps of its breakaway neighbour, the not-long-ago moribund Chinese economy surged to historical proportions, accounting for one-third of global economic growth in 2004.⁴³

What does good governance entail? What are its components and why are they important to the health component of the MDGs? The essential elements of good governance consist of respect for the rule of law and human rights, the existence of effective state institutions, transparency and accountability at all levels of government and public participation in decision making.⁴⁴ These elements, to varying degrees, form the blueprint for the work of virtually all anti-corruption and governance organisations. One such organisation is Freedom House, an independent research and advocacy organisation whose mission is to promote democracy and human rights. Each year, since 2004, Freedom House had issued its *Countries at the Crossroads* Report – an influential and widely-referenced analysis of government performance in countries considered at ‘a critical crossroad in determining their political future’.⁴⁵ Countries are assessed on the basis of four indicators: (i) accountability and public voice; (ii) civil liberties; (iii) rule of law; and (iv) anti-corruption and transparency frameworks. Certainly,

43 World Bank ‘China quick facts’ <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/EASTASIAPACIFICEXT/CHINAEXTN/0.contentMDK:20680895-pag ePK:1497618-piPK:217854-theSitePK:318950,00.html> (accessed 17 November 2011).

44 K Annan *We the peoples: The role of the United Nations in the 21st century* (2000) 22.

45 Freedom House ‘Countries at crossroad’ <http://www.freedomhouse.org/template.cfm?page=139&edition=9> (accessed 17 November 2011).

each of these indicators is an important measure for gauging the commitment of countries to good governance. So, how are countries in Africa faring?

Freedom House ranks countries on a scale of 0 to 7, from the weakest to the strongest performance. On this ranking, the report card on Africa is troubling. Out of 12 countries reported in 2010, only Ghana and South Africa attained above average scores (over 3,5 points) on all four metrics. Particularly frightening is the data on the availability of an effective system to fight corruption and enforce government transparency. On this critical index, the score ranges from below average (1,04–3,44) – Zimbabwe, Democratic Republic of Congo, Côte d'Ivoire, Nigeria, Liberia, Kenya, Tanzania, Sierra Leone and Malawi – to slightly above average (3,58–3,90) in Uganda, Ghana and South Africa.⁴⁶ These figures translate to less than 50 per cent aggregate score, a gravely disturbing performance that is consistent with findings in another important survey, Corruption Perceptions Index (CPI). CPI is an annual publication by Transparency International of the perceived level of corruption in the public sector in over 150 nations.⁴⁷ Quite unsurprisingly, an overwhelming majority of African countries rank in the bottom half of the table.⁴⁸

The adoption in 2003 of the African Union Convention on Preventing and Combating Corruption has done little to improve the attitude of public officials toward national treasuries.⁴⁹ That this treaty would become a toothless bulldog could have been predicted easily by anyone familiar with the region's sociopolitical dynamics. The problem has never been an absence of a proper legislative framework. Decades-old anticorruption measures are enshrined in the codes of virtually every country in the region, some dating as far back as 1960s,⁵⁰ but all have had very negligible impact.⁵¹ Thus, the concern expressed by African leaders 'about the negative effects of corruption and impunity on the

46 As above.

47 Transparency International 'Corruption Perceptions Index 2009' http://www.transparency.org/policy_research/surveys_indices/cpi/2009/cpi_2009_table (accessed 18 November 2011).

48 As above. Better performing African countries include (in descending order) Botswana, Mauritius, Cape Verde, Seychelles and South Africa.

49 Adopted by the 2nd ordinary session of the Assembly of the Union, Maputo, 11 July 2003, entered into force 4 August 2006 <http://www.africa-union.org/root/au/Documents/Treaties/Text/Convention%20on%20Combating%20Corruption.pdf> (accessed 1 March 2012).

50 See, eg, Nigeria Public Accounts Committee 1966, Tanzania Permanent Commission of Enquiry 1966, Côte d'Ivoire Anti-Corruption Law 1977, Ethiopia Special Anti-Corruption Squad 1977, cited in African Development Bank (n 38 above) 9.

51 Besides the regional framework and country-based legislation against corruption, sub-regional organisations have either adopted measures against corruption (Southern Africa Development Community (SADC) and the Economic Community of West African States (ECOWAS)) or working on one (East African Community (EAC)).

political, economic, social and cultural stability of African States and its devastating effects on the economic and social development of the African peoples' remains as dire today as nearly a decade ago when the provocative declaration was made.⁵²

Although the impact of this devastation is felt in all sectors, it is more visible in the health sector, perhaps because of the seemingly greater availability and easier accessibility of health data. Compared to other sectors, it is less difficult to see how resources illicitly siphoned from public treasuries deprive the Health Ministry of funds that could have been deployed toward the construction of health facilities or improving existing ones, purchasing essential medicines and so forth, and to link the resource deficit to, for instance, high child and maternal mortalities, morbidities and mortalities and other negative health indicators. Consider this very interesting case: Swaziland is a tiny impoverished land-locked country in Southern Africa ruled by a despotic monarch, King Mswati III. In 2002, the King made a down-payment of \$4,75 million for a \$49,03 million private jet,⁵³ the price tag twice as much as the nation's health budget.⁵⁴ In addition to fancy cars and luxurious mansions, the King maintains offshore bank accounts worth billions of dollars.⁵⁵ The treasury loses \$5,7 million a month or \$64 million annually, an amount equal to the national debt.⁵⁶ The aftermath of this depredation is all too evident amongst the King's subjects. In addition to soaring incidence of poverty, health indices are plunging precipitously. The United Nations Development Programme (UNDP) reports that 63 per cent of the population in Swaziland lives on less than \$1,25 per day, among the worst in Africa,⁵⁷ and although, at 26 per cent, Swaziland's HIV infection prevalence rate ranks worst globally,⁵⁸ less than half of its population with advanced HIV infection has access to anti-retroviral drugs.⁵⁹ Paradoxically, blame for this low coverage rate, as in several other African countries, is heaped on resource constraints despite abundant incontrovertible evidence of unabashed squandering of the nation's resources by the ruling family and its acolytes.

52 See the Preamble, African Union Convention on Preventing and Combating Corruption 2003 (n 50 above).

53 Currency converted at the exchange rate of £1=\$1,58, as of 1 October 2011.

54 J Clench 'African king buys jet' *The Sun* 8 July 2002, <http://www.thesun.co.uk/sol/homepage/news/art.151480.ece> (accessed 18 November 2011).

55 J Catsoulis 'An extravagant ruler of a modest kingdom' *New York Times* 25 April 2008, http://movies.nytimes.com/2008/04/25/movies/25king.html?ref=mswati_iii (accessed 18 November 2011).

56 'Swaziland: A leisurely pace in tackling corruption' *Irin News* 14 July 2006, <http://www.irinnews.org/report.aspx?reportid=59657> (accessed 19 November 2011).

57 UNDP *Human Development Report 2010: The real wealth of nations: Pathways to human development* (2010) 162.

58 WHO *World Health Statistics 2010* (2010) 32.

59 WHO (n 58 above) 95.

Egregious health indices in Africa cannot be decoupled from gaping holes in its resources – money siphoned off treasuries by leaders charged with its security. It is estimated that about \$140 billion was stolen by African leaders in the four decades since independence.⁶⁰ For a region as poor as Africa, this is an incalculable loss, the impact of which was captured in a recent testimony before the United States House of Representatives:⁶¹

The West must understand that corruption is part of the reason that African nations cannot fight diseases properly, cannot feed their populations, cannot educate their children and use their creativity and energy to open the doorway to the future they deserve. The crime is not just theft. It is negligence ... corruption is responsible for as many deaths as the combined results of conflicts and HIV/AIDS on the African continent.

This is an undeniable truth which begs the question: Why, in spite of robust legal frameworks, does corruption persist in Africa?

The persistence of corruption in the region is traceable to a number of factors, two of which are particularly noxious. First, despite unrelenting political posturing and grandstanding, African leaders only pay lip service to the fight against corruption. One need not go further than the disdainful treatment of a few honest public officials in the region in proof of this point. For unearthing an intricate web of corruption, cover-ups and cronyism in Kenya, John Githongo, at the time the nation's anti-corruption czar, now lives in exile.⁶² Nuhu Ribadu, the former head of Nigeria's Economic and Financial Crimes Commission, was also forced into exile in 2007 for his zealous pursuit and prosecution of erring politicians. Similarly, in Sierra Leone, Val Collier, chairperson of the Anti-Corruption Commission, was sacked in 2005 for daring to speak out against the embezzlement of public funds by legislators.⁶³ The second reason making corruption incessant in Africa is docility on the part of the citizenry. 'Docility', in this context, means acquiescence to misappropriation of public resources. It arises when people go about their business as if looting the treasury is somehow an unavoidable reward for holding a political position. True, there are always dissenting voices, but they are often drowned out by popular (even if tacit) approval and, in some instances, reward for offending parties. Chieftaincy and other honorary titles, once reserved for respectable and honest men in the region, are now lavished on corrupt politicians – no questions asked. By contesting and

60 WE Williams *Liberty versus the tyranny of socialism: Controversial essays* (2008) 189.

61 N Ribadu 'Capital loss and corruption: The example of Nigeria' testimony before the US House Financial Services Committee, 19 May 2009 4, http://www.house.gov/apps/list/hearing/financialsvcs_dem/ribadu_testimony.pdf (accessed 19 November 2011).

62 For a comprehensive account of corruption in Kenya, see M Wrong *It's our turn to eat: The story of a Kenyan whistle-blower* (2009).

63 Wrong (n 62 above) 326.

winning (often rigged) elections, a great number of corrupt dictators have been allowed to metamorphose into 'honourable' statesmen. Even the few that have been tried and convicted receive no enduring condemnation. In short, there is an astounding lack of what Easterly describes as a 'social norm' – that is, societal protestation of conduct inimical to general welfare.⁶⁴ This is a common feature of developing economies and, lamentably, a powerful factor that sustains treating public resources as *res nullius* in many of these countries.

4 Role of international co-operation in realising the Millennium Development Goals

In a report prepared for the Millennium Summit in 2000, the then UN General Secretary, Kofi Annan, urged the global community to 'do more, and ... do it better'.⁶⁵ Annan's challenge was a clarion call for advanced economies to come to the rescue of developing ones. The response to this call is crystallised in MDG 8, which explicitly proclaims an increase in official development assistance as vital for resource-poor countries to meet their MDG obligations. This increase, as Monterrey Consensus notes, is of significant importance as, in many of these countries, 'ODA is still the largest source of external financing and is critical to the achievement of the development goals and targets of the Millennium Declaration and other internationally agreed development targets'.⁶⁶ Indeed, because Africa has the highest proportion of people living in extreme poverty, a situation worsened by the higher prevalence of internal conflicts, HIV/AIDS and other problems, Annan urges 'special provision for the needs of Africa' and 'full support to Africans in their struggle to overcome the continent's problems'.⁶⁷ The UN remains steadfast in its commitment to this principle. Ban Ki-Moon, who succeeded Annan, reiterates that '[t]he world possesses the resources and knowledge to ensure that even the poorest countries, and others held back by disease, geographic isolation or civil strife, can be empowered to achieve the MDGs', and warns that '[m]eeting the goals is everyone's business'.⁶⁸

Certainly, the Millennium Declaration is by no means the first international poverty reduction initiative sought to be achieved by increasing ODA, but there is clearly a difference: 'They differ from all other global promises for poverty reduction in their comprehensive nature and the systematic efforts taken to specify, finance, implement,

64 W Easterly *The white man's burden: Why the West's efforts to aid the rest have done so much ill and so little good* (2006) 87-88 120.

65 Annan (n 44 above) 17.

66 UN (n 41 above) para 39.

67 Annan (n 44 above) 78.

68 UN (n 6 above) 3.

monitor and advocate them,' notes Professor of Development Studies, David Hulme, in a recent study.⁶⁹ Aside from this critical difference, it must be emphasised that the assistance called for (in the nature of increased ODA as a vehicle to attaining the MDGs) should not be construed as an act of charity on the part of donor nations. Far too often, international development assistance has been characterised in terms of a benevolent Global North pulling along the less privileged nations in the South. But although the very idea of lending a helping hand to another entity has its foundation in benevolence, this is no longer the case when it comes to ODA and other forms of international assistance. Under extant rules of international law, what was once a mere moral obligation has been transformed to a legal duty.⁷⁰

The Millennium Declaration has been strengthened by subsequent international agreements, most notably, the Brussels Programme of Action for the Least Developed Countries for the Decade 2001-2010,⁷¹ the Global Programme of Action for the Sustainable Development of Small Island Developing States,⁷² and the Monterrey Consensus, the last calling on industrialised countries to meet their commitment of allocating 0,7 per cent of Gross National Product (GNP) to ODA,⁷³ a pledge first made in 1970 but which has remained unfulfilled four decades later.⁷⁴ Lethargy on the part of wealthy nations to make good

69 D Hulme 'Governing global poverty? Global ambivalence and the Millennium Development Goals' 6 May 2009 2, http://www.devstud.org.uk/downloads/4b9e9dd2c9394_Hulme_PAPER.pdf (accessed 19 November 2011).

70 This legal duty is enshrined in the United Nations Charter (art 1(3), which requires 'international co-operation' in solving global problems; arts 55 & 56); the Universal Declaration of Human Rights (arts 22 & 28); and the International Covenant on Economic, Social and Cultural Rights (ICESCR), art 2(1) which imposes an obligation to implement the provision of the treaty 'individually and through international assistance and co-operation', and art 23. For a comprehensive analysis of international development assistance as a legal obligation as well as a legal right, including a discussion as to who constitutes the right holders (aid receiving nations) and duty bearers (donor countries) see, generally, O Ferraz & J Mesquita 'The right to health and the Millennium Development Goals in developing countries: A right to international assistance and co-operation?' July 2006 (on file with author); S Skogly *Beyond national borders: States' human rights obligations in international co-operation* (2006); S Skogly & M Gibney 'Transnational human rights obligations' (2002) 24 *Human Rights Quarterly* 781; S Skogly 'The obligation of international assistance and co-operation in the International Covenant on Economic, Social and Cultural Rights' in M Bergsmo (ed) *Human rights and criminal justice for the downtrodden: Essays in honour of Asbjørn Eide* (2003) 403-420.

71 Third UN Conference on the Least Developed Countries, A/CONF.191/11, <http://www.un-documents.net/ac191-11.htm> (accessed 19 November 2011).

72 UN Report of the Global Conference on the Sustainable Development of Small Island Developing States, Bridgetown, Barbados, 25 April-6 May 1994 (UN Publication, Sales No E.94.I.18 and corrigenda), ch I, Resolution 1, annex II.

73 UN (n 41 above) para 42. See also UN Report of the World Summit on Sustainable Development, Johannesburg, South Africa, 26 August - 4 September 2002, A/CONF.199/20 52.

74 UN Millennium Project 'The 0,7% target: An in-depth look' <http://www.unmillenniumproject.org/press/07.htm> (accessed 19 November 2011).

on this pledge derives from growing concerns about questionable accountability and transparency frameworks in many of the countries receiving aid.⁷⁵ In fact, some industrialised countries such as the United States are vehemently opposed to setting specific ODA targets. John Bolton, the then United States Ambassador to the UN, argued in 2005 that the United States never committed to setting aside 0,7 per cent of its GNP to ODA.⁷⁶ However, despite this apparent opposition, the United States did set aside \$5 billion over five years for ODA.⁷⁷

At the Gleneagles Summit in 2005, G8 members agreed to double aid for Africa by 2010 to the tune of at least \$25 billion, out of \$50 billion slated to be doled out annually to all developing countries.⁷⁸ However, as of April 2011, less than half of the funds promised to Africa has materialised,⁷⁹ leading to a concern about how the shortfall would impact upon Africa's progress toward the attainment of the MDGs. This is a legitimate concern; after all, the funds 'are not just numbers. They represent vital medicines, kids in school, help for women living in poverty and food for the hungry,' all of which are in peril unless resources are urgently sourced from somewhere else.⁸⁰

The flipside of worries about the ODA deficit is a larger concern, namely, whether appropriated funds will in fact be deployed to designated programs and projects in Africa. This unremitting worry is the foremost of the challenges facing development experts in the region. 'More aid for Africa' has become a cliché. Year in and year out, international funds are pumped into Africa, no questions asked about the fate of previous disbursements. The fact that Africa's socio-economic fundamentals remain tragically unchanged, decades after a massive transfer of international resources, is morally outrageous – to taxpayers in donor countries whose hard-earned dollars evaporate into an ocean of mismanagement or wind up in private pockets, depriving

75 In addition to fraud-related concerns, another factor that might operate to hamper the remittance of ODA funds to resource-deficit nations is the ongoing global recession. Many members of the Organisation for Economic Co-operation and Development (OECD), the very countries which are expected to increase their ODA, are themselves facing serious internal financial difficulties. With skyrocketing unemployment, a rising budget deficit and a bleak economic future, some of these countries – Greece, Portugal, Spain, Italy, Ireland and so forth – are simply not in a position to give aid as in previous years.

76 P Engardio 'Bush balks at pact to fight poverty' *Bloomberg Business Week* 2 September 2005, http://www.businessweek.com/bwdaily/dnflash/sep2005/nf2005092_5264_db039.htm (accessed 19 November 2011).

77 As above.

78 UN Millennium Project 'The G8 Gleneagles Summit: Doubling aid to Africa' <http://www.unmillenniumproject.org/press/g8overview.htm> (accessed 19 November 2011).

79 L Elliott 'Western countries fail to meet Gleneagles aid pledges' *Guardian* 6 April 2011, <http://www.guardian.co.uk/global-development/2011/apr/06/g8-fails-to-meet-gleneagles-aid-pledges> (accessed 20 November 2011).

80 As above.

residents of receiving countries of the benefits that could have been reaped had the funds been appropriately utilised. The question then becomes: Given the poor record of previous aid to Africa, is there any reason to think that more ODA is desirable?

The response, obviously, depends on who you ask. An observation in a publication by the Cato Institute in 2005 sums up one side of the argument:⁸¹

Helping Africa is a noble cause, but the campaign has become a theatre of the absurd – the blind leading the clueless. The record of Western aid to Africa is one of abysmal failure. More than \$500 billion in foreign aid – the equivalent of four Marshall Aid Plans – was pumped into Africa between 1960 and 1997. Instead of increasing development, aid has created dependence.

Observations such as this have led some scholars to conclude, rather reflectively, that aid hurts Africa and should, for that reason, be halted. The most vocal contemporary proponent of this idea is Zambian economist Dambisa Moyo.⁸² She argues that '[c]orruption is a way of life' in Africa and, as such, all aid does is fuel more corruption and prop up corrupt leaders.⁸³ Awash with cash, these leaders have no difficulty manipulating and interfering with state institutions, have no regard for basic human liberties, trample on the rule of law and invest little in productive ventures. In her view, this creates an unwelcoming environment for domestic and foreign investment, leading to economic decline and poverty, in response to which the donor community 'gives more aid, [continuing] the downward spiral of poverty'.⁸⁴ But not everyone is in agreement with Moyo.

For Jeffrey Sachs, Harvard economist and former Director of the UN Millennium Project, it is unfortunate that '[t]he outside world has pat answers concerning Africa's prolonged crisis. Everything comes back, again and again, to corruption and misrule.'⁸⁵ Sachs decries the tendency to blame every shortcoming in Africa on corruption and poor

81 T Ayodele *et al* 'African perspectives on aid: Foreign assistance will not pull Africa out of poverty' *Cato Institute Economic Institute Development Bulletin* No 2, 14 September 2005 1, <http://www.cato.org/pubs/edb/edb2.pdf> (accessed 20 November 2011).

82 D Moyo *Dead aid: Why aid is not working and how there is a better way for Africa* (2009) 48-68, marshalling evidence on the deleterious impact of aid on Africa; 71-97, suggesting an alternative framework to aid. See also Easterly (n 64 above) 42-44, arguing that poverty and slow growth in Africa are, undeniably, products of bad governance, not some exogenous factors.

83 Moyo (n 82 above) 48.

84 Moyo (n 82 above) 49. See also Easterly (n 64 above) 135-136; ML Tupy 'Poverty that defies aid' http://www.cato.org/pub_display.php?pub_id=3920 (accessed 20 November 2011), noting that despite massive aid receipt totaling more than \$450 billion between 1960 and 2005, the GDP in Africa declined from \$1,770 to \$1,479 between 1975 and 2000, whereas South Asia, which received 21 per cent less in aid, had a GDP growth within the same period from \$1,010 to \$2,056.

85 J Sachs *The end of poverty: Economic possibilities for our time* (2005) 188.

governance, arguing that the region's current predicament cannot be divorced from its history, geopolitics and domestic policies.⁸⁶ In short, '[t]he claim that Africa's corruption is the basic source of the problem,' he contends, 'does not withstand practical experience or serious scrutiny'.⁸⁷ To further substantiate his argument, Sachs uses the Transparency International report to demonstrate that there are several relatively well-governed countries in Africa, such as Ghana and Malawi, that are seriously lagging behind in economic growth compared to Asian countries (Bangladesh and India, for example) which have prospered even though perceived to be more corrupt.⁸⁸

Moyo attempts to reconcile this apparent paradox by projecting what she calls 'positive' corruption as an explanation. Her hypothesis is that kleptocrats in Asia invest their loot in domestic economies, in contrast to their African counterparts who deposit stolen aid in Western banks. Of course, stolen or not, investing in a domestic market is, in principle, a surefire way to generate growth, hence her choice of the term 'positive' to distinguish the scenario in Asia from that in Africa where no dividend results to local economies, and which she describes as 'negative' corruption.⁸⁹ But even without Moyo's elucidation, it is intellectually difficult to delink poverty and human suffering in Africa from corruption and misrule, regardless of support for aid or otherwise. The aforementioned Cato Institute publication was quite emphatic: 'The evidence that foreign aid underwrites misguided policies and feeds corrupt and bloated state bureaucracies is overwhelming.'⁹⁰

So, what to do? Could the 'international co-operation' called for in MDG 8 and, most recently, the outcome document of the MDGs Summit 2010,⁹¹ be interpreted to mean discontinuing parcelling out funds to governments lacking capacity for judicious use of the funds? The United States, as described previously, is attempting to do exactly that. Its Millennium Challenge Corporation (MCC), which replaced the Millennium Challenge Account,⁹² seeks to fund countries that can demonstrate commitment to (i) good governance; (ii) sound economic policies that promote open markets and private enterprise; and (iii) investment in its people, particularly in health

86 As above.

87 Sachs (n 85 above) 190–191. For a concise rebuttal of this claim, see Easterly (n 65 above) 42–44 130–132.

88 Sachs (n 85 above) 191.

89 Moyo (n 82 above) 56–57.

90 Ayodele *et al* (n 81 above) 2.

91 UN General Assembly 'Keeping the promise: United to achieve the Millennium Development Goals' (Draft Resolution), 17 September 2010, 65th session Agenda Items 13 & 115, A/65/L.1 8, <http://www.un.org/en/mdg/summit2010/pdf/mdg%20outcome%20document.pdf> (accessed 20 November 2011).

92 Millennium Challenge Act of 2003, Pub L No 108-199 (codified at 22 USC 7701 *et seq*).

and education⁹³ – all measured by 17 different policy indicators.⁹⁴ For a country to qualify for assistance, it must obtain a score above the median on at least half of the indicators on each of the three categories or baskets mentioned above.⁹⁵ To emphasise its unique importance, corruption is the only indicator in respect to which a country must obtain above median score in order to attain eligibility; failing this, funding is denied regardless of performance on the other indicators.⁹⁶ Although some countries – Benin, Mozambique and Senegal, for instance – with less than median score on corruption have received funding under the programme, this was based on evidence that they were taking concrete actions to remedy the deficiency.⁹⁷ Sheila Herrling, Vice-President for policy and evaluation at the MCC, warns that the agency stands ready to suspend or revoke funding if it finds evidence of ‘a pattern of action that has the government implicated in undermining the institutions of accountability such as the courts, the media or anti-corruption agencies’.⁹⁸ This policy change in the way poverty reduction and development in poor countries are financed by the United States has forced countries to ‘show a new leaf’ in order to access funds. Countries are enacting stronger anti-corruption legislation, strengthening oversight institutions, infusing greater transparency to policy making and increasing investigation and prosecution of corruption-related cases.⁹⁹

A remarkable innovation of the MCC is that funds are disbursed directly to vendors for defined projects, bypassing governments, and thereby reducing the risk of misappropriation.¹⁰⁰ Despite its positives, however, the MCC model is far from perfect. A key weakness is the

93 22 USC 7706(b).

94 C Tarnoff ‘Millennium Challenge Corporation’ 16 November 2010 *Congressional Research Service* 7-5700, RL32427 2, <http://www.mcc.gov/documents/guidance/mcc-policy-fraudandcorruption.pdf> (accessed 20 November 2011).

95 As above.

96 DB Gootnick & JM Franzel ‘Millennium Challenge Corporation: Progress made on key challenges in first year of operations’ testimony before the Committee on International Relations, House of Representatives, United States Government Accountability Office, 27 April 2005, GAO-05-625T 5, <http://www.gao.gov/new.items/d05625t.pdf> (accessed 20 November 2011).

97 C Neubauer & M Cella ‘US aid meant to reward reforms goes to countries listed as corrupt’ *Washington Times* 22 August 2010, <http://www.washingtontimes.com/news/2010/aug/22/countries-on-us-lists-for-corruption-aid/?page=1> (accessed 20 November 2011).

98 As above. This is consistent with the discretionary component of the process the MCC uses for determining eligibility of countries which allows it to approve funding based on (i) whether countries deficient on any of the indicators are taking measures to improve the deficiency; (ii) supplemental information that sufficiently addresses gaps or weaknesses in previous data; and (iii) any other material information. See Gootnick & Franzel (n 96 above) 7.

99 Millennium Challenge Corporation ‘Fighting Corruption’ <http://www.mcc.gov/pages/activities/activity/fighting-corruption> (accessed 20 November 2011).

100 Neubauer & Cella (n 97 above).

failure to pull the plug on projects in countries with a questionable corruption scorecard. But realising that the model has been operational for just a little over seven years (created in January 2004) gives hope that its performance would improve with time. For better or worse, one of the undeniable legacies of the IMF Structural Adjustment Programme in Africa (1980s through 1990s) was that recipient countries were forced to undertake harsh macro-economic and fiscal reforms that they would have otherwise not countenanced but for the funds they desperately needed. The same push might be what is needed to jolt the region out of its present stupor. Africa's desperate need for development cash may ultimately be the catalyst that forces its political leadership to adopt much-needed good governance and anti-corruption reforms. This is not fantasy. In a 2003 article, 'Does foreign aid corrupt?', University of Lisbon economist José Tavares found that foreign aid does in fact decrease corruption due to the fact that 'rules and conditions' attached to the grant 'limit the discretion of the recipient country's officials'.¹⁰¹ Tavares's paper is significant for highlighting the powerful positive effect of linking aid receipt to conditions designed to ensure that funds are spent only on approved projects and programmes – just as embedded in the MCC processes. Given these benefits, the MCC model (or some modified version) should be internalised by all multi-lateral and bilateral development agencies and institutionalised in their dealings with Africa and other emerging democracies similarly challenged.¹⁰²

101 J Tavares 'Does foreign aid corrupt?' (2003) 79 *Economic Letters* 104. For opposing views, see Easterly (n 64 above) 135-136; S Knack 'Aid dependence and the quality of governance: Cross-country empirical tests' (2001) 68 *Southern Economic Journal* 310-329; S Djankov *et al* 'The curse of aid' *The World Bank*, April 2005, <http://www.econ.upf.edu/docs/papers/downloads/870.pdf> (accessed 20 November 2011), noting that aid does not advance democracy.

102 The accountability mechanism imbedded in MDG 8 is noticeably one-sided. This is not inadvertent. Instead, it is a reflection of the widespread assumption that responsibility for the economic woes in the Global South rests squarely on the shoulders of its leaders. It has become increasingly routine to heap blames on mismanagement and inefficient use of resources – in other words, if only aid receiving nations could be better managers of resources flowing into their national treasuries, their situations will be different. But this assumption is wrong. Aside from its imperialistic undertone, the idea presupposes that industrialised countries would always deliver on their promises. This is clearly not borne out by the reality on the ground, as evidenced by the preceding analysis on shortfalls in ODA remittances by these countries. This raises the need for a viable framework to compel desired action on the part of affluent nations. The following accountability mechanisms have been suggested: human rights monitoring bodies such as the Committee on Economic, Social and Cultural Rights via examination of the state's periodic report; shadow reports by civil society organisations; Special Rapporteurs (on the right to health, eg) during formal country visits; peer review process, eg, of the Development Co-operation Directive (DAC) and the OECD; and so forth. See Ferraz & Mesquita (n 70 above) 19-23.

5 Conclusion

That the state of health in Africa remains precarious, more than a decade after its governments uniformly proclaimed health as a human right, is a strident testament to the vacuousness of socio-economic rights in resource deficit settings. Nevertheless, as this discourse shows, this is a handicap which MDG 8 is greatly suited to address – by injecting resources to support existing and new health initiatives. But for MDG 8 to transform the right to health in Africa into a *de facto* entitlement, for it to morph into a real panacea to the region's health quandary, certain fundamental changes would have to be made in the way affluent nations interact with countries in the region. This is the thrust of accountability measures built into MDG 8 and has a significant implication for human rights in Africa.

Human rights, including the right to health, are best protected in an environment where democracy, the rule of law and individual liberty are allowed to flourish. By subjecting ODA to country performances on these benchmarks, the international community signals strongly that the era of blank checks to ill-governed countries is over, that support for country programmes would have to be earned and justified by objectively verifiable criteria. For this venture to succeed, however, affluent countries must show a strong resolve to see it through. Donor nations must be prepared to hold their counterparts in Africa accountable for the way ODA funds are spent, regardless of whether funds are earmarked for specific projects or doled out as budgetary support. The United States MCC system, despite its imperfections, commends itself as a model to be adopted by the rest of the industrialised world. Denying assistance to countries which cannot demonstrate a credible commitment to good governance violates no human rights principle, for a country lacking in good governance is also one where human rights, even those related to health, are not respected. And this, ultimately, is the reason a teeming number of development economists are opposed to more aid (without accountability) for Africa, an opposition that is grounded purely on humanitarianism – the understanding that the poor state of health and wellbeing in Africa is a human rights challenge that can no longer be tolerated.