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Access to Medicines and Health Care in Sub-Saharan Africa: A Historical Perspective

DANWOOD M. CHIRWA[†]

I. INTRODUCTION

Ensuring all citizens equal and equitable access to health care remains one of the most daunting challenges for African governments. Almost all health indicators for sub-Saharan Africa provoke feelings of disappointment, horror, or disbelief. Africa is a continent where maternal and infant mortality rates remain stubbornly the highest¹ and the average life expectancy the lowest in the world.² Millions of Africans continue to die from preventable and curable diseases, such as malaria and infectious diarrhoea.³ Many reasons account for this poor state of affairs. They range from poor governance and leadership, lack of financial and human resources, and general poverty, to the

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[†] Professor of Law, University of Cape Town. This article is an expanded version of the presentation made to a Symposium on Clinical Trials and Access to Essential Medicines in African Countries hosted jointly by the law faculties of the Universities of Maryland Carey King School of Law and Malawi in Baltimore on Oct. 28–29, 2015. I would like to thank Professor Peter Danchin for inviting me to that symposium. I would also like to thank the Editor-in Chief, Jane Kalinina, for her patience and granting me an extension to complete this article.

1. See WORLD HEALTH ORGANIZATION, *Global Health Observatory (GHO) Data: Maternal and Reproductive Health*, http://www.who.int/gho/maternal_health/en/ (last visited Apr. 7, 2016); WORLD HEALTH ORGANIZATION, *Global Health Observatory (GHO) Data: Child Health*, http://www.who.int/gho/maternal_health/en/ (last visited Apr. 7, 2016). According to the World Health Organization (WHO), in 2015 about 4.5 million infant deaths, which represents 75 percent of all deaths under five, occurred in the first year of life. Africa contributes the largest portion of these deaths. *Id.*; see also KPMG, AFRICA LIMITED, *The State of Healthcare in Africa* (2012), <https://www.kpmg.com/Africa/en/IssuesAndInsights/Articles-Publications/Documents/The-State-of-Healthcare-in-Africa.pdf> [hereinafter KPMG].

2. KPMG, *supra* note 1, at 4.

3. See, e.g., R. Lozano et al., *Global and Regional Mortality for 235 Causes of Death for 20 Age Groups in 1990 and 2010: A Systematic Analysis for the Global Burden of Disease Study 2010*, 380 LANCET 2095, 2095–2096 (2012); P.J. Hotez & A. Kamath, *Neglected Tropical Diseases in Sub-Saharan Africa: Review of Their Prevalence, Distribution, and Disease Burden*, PLOS NEGLECTED TROPICAL DISEASES (2009), <http://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0000412>; C.L.J. Murray & A.D. Lopez, *Mortality by Cause for Eight Regions of the World: Global Burden of Disease Study*, 349 LANCET 1269–76 (1997).

persistence of unhealthy cultural practices. Most of the challenges facing access to medicines and medical care in Africa have been widely discussed.⁴ What has not been discussed as much is the historical account of the problem, to which this article turns its attention. One obvious benefit to undertaking this sort of inquiry is that it can help us better understand current manifestations of the problems concerning access to medicines or health care on the continent. As this article will show, some of the current challenges to health care systems in Africa are long standing, going back to precolonial times. Understanding their historical genesis and context is thus critical to finding effective and lasting solutions.

Part II of this article considers the state of health care and nature of health care systems in Africa before colonialism. This discussion provides the context for understanding the impact, discussed in Part III, of Christian missionaries who laid the groundwork for the establishment of colonialism on the continent in the late nineteenth century and of the colonial administrations themselves on access to health care. Part IV discusses the broad legal, political, and economic changes that were brought about by the African nationalists after gaining independence and how these changes affected access to health care and medicines. One of the key economic policies that African governments implemented during the third to the fourth decades of independence involved what are commonly called “structural adjustment programmes.” Part V is dedicated to discussing this policy and how it affected access to medicines and has continued to do so. The discussion culminates in Part IV, which considers the general constitutional reforms that occurred as part of the democratisation wave that most African countries experienced in the 1990s and how these reforms have influenced the manner in which health services are provided and accessed. The final part concludes the discussion.

II. PRE-COLONIAL HEALTH CARE SYSTEMS IN AFRICA

Before colonialism, Africa did not have states, at least as the state is now understood. Instead, African peoples lived in various arrangements ranging from large kingdoms to small groups of people

4. DAN KASEJE, HEALTH CARE IN AFRICA: CHALLENGES, OPPORTUNITIES AND AN EMERGING MODEL FOR IMPROVEMENT (2006), <https://www.wilsoncenter.org/sites/default/files/Kaseje2.pdf>; Pablo Viguera Ester et al., *Factors Associated to Infant Mortality in Sub-Saharan Africa*, 2 J. PUB. HEALTH IN AFR. 112 (2011). See generally M. WRIGHT ET AL., HOSPICE AND PALLIATIVE CARE IN AFRICA: A REVIEW OF DEVELOPMENTS AND CHALLENGES (2006).

held together by an intricate web of kinships and other relationships.⁵ In some ways, as will be seen below, there are some similarities in approaches to health care between the pre-Industrial Revolution Western societies and pre-colonial African communities. The first similarity is that in both societies health was initially considered largely a private concern,⁶ more narrowly taken as a private responsibility of the nuclear family, charities, and churches in the West⁷ and as a communal responsibility of the broader extended family or whole kinship in Africa.⁸ The second similarity is that in both societies sickness was associated with bad luck, lack of spiritual wellbeing, and immorality.⁹ While the Industrial Revolution was a watershed in the shift from health as a private matter to a public matter in the West, in Africa the emergence of formal governance structures among the people saw ruling elites take an increasing part in public health management.¹⁰

Pre-colonial approaches to health were intricately linked to the African communitarian philosophy and beliefs. African communitarian philosophy holds that every member of the community forms part of the larger whole to which one owes his or her personality, values, and duties. The larger community consists not just of the existing members of the community, but also of past members long dead (ancestors) and of the not yet born.¹¹ The ancestors in this way of thinking do not just lie in their graves as decomposed corporeal bodies; they continue to exist in some invisible form and to exert influence on the lives of the living.¹² Ancestors also serve as the intermediaries

5. See, e.g., J. Herbst, *Responding to State Failure in Africa*, 21 INT'L SECURITY 120–44, 120 (1996/7); A. Southal, *State Formation in Africa*, 3 ANN. REV. ANTHROPOLOGY 153, 154–7 (1974).

6. A.R. Chapman, *Core Obligations Related to the Right to Health and Their Relevance for South Africa*, in EXPLORING THE CORE CONTENT OF SOCIO-ECONOMIC RIGHTS: SOUTH AFRICAN AND INTERNATIONAL PERSPECTIVES 35 (D. Brand & S. Russell eds., 2002).

7. Chapman, *supra* note 6.

8. A.J. Njoh, *Ideology and Public Health Elements of Human Settlement Policies in Sub-Saharan Africa*, 26 CITIES 9, 10 (2009).

9. S. Gordon, *Disease, Sin and the Walking Dead in Medieval England, c. 1100–1350: A Note on the Documentary and Archaeological Evidence*, in MEDICINE, HEALING AND PERFORMANCE (E. Gemi-Iordanou et al. eds., 2014); Njoh, *supra* note 8.

10. Njoh, *supra* note 8, at 10.

11. See JOHN S. MBITI, AFRICAN RELIGIONS & PHILOSOPHY 141 (1970); Ifeanyi A. Menkiti, *Person and Community in African Traditional Thought*, in AFRICAN PHILOSOPHY: AN INTRODUCTION 171, 174 (Richard A. Wright ed., 1984); THEO SUNDERMEIER, THE INDIVIDUAL AND COMMUNITY IN AFRICAN TRADITIONAL RELIGIONS 17–18 (1998).

12. See SUNDERMEIER, *supra* note 11, at 16.

between the Supreme Being and the living.¹³ The virtuous person in these communities was conceived of as one who fulfilled his or her given role in society, respected the traditions and customs inherited from past generations, and imparted the received wisdom and customs to the next generation.¹⁴ Failure to obey the moral code of the society was understood to upset the spirits of the ancestors who, in response, could visit ill-health or another form of misfortune upon a particular individual or the whole community.¹⁵

Because the ancestors were considered dead in body but not in spirit and, as such, continued to interact with the living, a role was created for intermediaries between the ancestors and the living. This role was reserved for certain individuals who possessed the power of speaking to the dead and interpreting their needs or advice.¹⁶ These spiritual intermediaries also doubled as medical service providers alongside, or in competition with, non-spiritual herbalists. The claim of the spiritual herbalists to medical knowledge had at least two bases: their profession as a trade and as a calling. A person called to it had to undergo tutelage under an experienced *sangoma*, which meant gaining significant experience in the prevailing medical practices of the time before he or she could practice independently.¹⁷ To be called to the profession, one had to display certain extraordinary capabilities, such as being spoken to by the dead or predicting future events.¹⁸ Having access to the dead meant having access to the privileged knowledge of the dead who knew the worlds of both the living and the dead, were custodians of morality, and had the power over fate, bad luck, or misfortune.¹⁹

The close link between African medicine, morality, and beliefs tends to overemphasize the mythical basis of African medicine and ignore its practical or empirical basis, albeit pre-scientific. Practitioners of traditional medicine worked under others' tutelage for

13. GERALD K. TANYE, *THE CHURCH-AS-FAMILY AND ETHNOCENTRISM IN SUB-SAHARAN AFRICA* 109 (2010).

14. *Id.* at 106.

15. *Id.* at 106–07.

16. Jim Kiernan, *African Traditional Religions in South Africa*, in *LIVING FAITHS IN SOUTH AFRICA* 24 (Martin Prozesky & John de Gruchy eds., 1995).

17. This practice is still prevalent. *See, e.g.*, Pamela Reynolds, *The Training of Traditional Healers in Mashonaland*, in *THE PROFESSIONALISATION OF AFRICAN TRADITIONAL MEDICINE* 165, 175–7 (Murray Last & G.L. Chavunduka eds., 1986).

18. *Id.* at 177; see also P. Fihlani, *BBC NEWS*, *Witnessing a South African Healer*, May 2, 2013.

19. TANYE, *supra* note 13, at 113–16.

a long time and, when they qualified, practiced the trade and trained others. In turn, their methods were tried and tested over many generations, a process that made it possible for ineffective methods to be discarded and those that worked to be retained and preserved for current and future generations.

III. MISSIONARIES AND THE COLONIAL HEALTH CARE SYSTEM

Although Christianity was introduced to North Africa by the first century, efforts to spread Christianity in Africa intensified only in the nineteenth century.²⁰ Attracted in part by the communitarian culture of the African peoples,²¹ Christian missionaries came to Africa to propagate trade, Western culture, education, and medicine.²² In fulfilling this mission, they laid the foundation for the onset of colonialism.²³

One of the most notable contributions of the missionaries in precolonial Africa relates to their efforts to end slave trade in Africa, which was still being practiced by the early nineteenth century. Slave trade was not just a gross human rights violation, it was also a major health disaster.²⁴ It dislocated families and subjected those taken into slavery to intolerable conditions and those left behind to physical and psychological insecurity, socioeconomic hardship, and social

20. See David F. Lindenfeld, *Indigenous Encounters with Christian Missionaries in China and West Africa, 1800–1920: A Comparative Study*, 16 J. WORLD HIST. 327, 328 (2005); BBC, *Index, THE STORY OF AFRICA: CHRISTIANITY*, http://www.bbc.co.uk/worldservice/africa/features/storyofafrica/index_section8.shtml (last visited Oct. 3, 2016). See generally, R. Grove, *Scottish Missionaries, Evangelical Discourses and the Origins of Conservation Thinking in Southern Africa 1820–1900*, 15 J. SOUTHERN AFRICAN STUDIES 163–187 (1989).

21. Gordon L. Chavunduka, *Christianity, African Religion and African Medicine*, (1999), <http://wcc-coe.org/wcc/what/interreligious/cd33-02.html>.

22. Viera Pawliková-Vilhanová, *Christian Missions in Africa and Their Role in the Transformation of African Societies*, 16 ASIAN & AFR. STUDIES 249, 251–54 (2007).

23. See, e.g., Etim E. Okon, *Christian Missions and Colonial Rule in Africa: Objective and Contemporary Analysis*, 10 EUR. SCI. J. 192 (2014); GLOBAL BLACK HISTORY, *Role of Missionaries in Colonization of Africans* (Oct. 8, 2012), <http://www.globalblackhistory.com/2012/10/role-of-missionaries-in-colonization-of-africans.html>.

See, e.g., A. Porter, “Cultural Imperialism” and Protestant Missionary Enterprise 1780–1914, 25 J. IMPERIAL & COMMONWEALTH HIST. 367 (1997).

24. See Amy Maxmen, *Researchers Highlight the Impact of Slavery on Health and Disease*, NATURE.COM (July 8, 2012, 3:54 PM), <http://blogs.nature.com/news/2012/07/researchers-highlight-the-impact-of-slavery-on-health-and-disease.html>; See 2 General History of Africa: Africa Under Colonial Domination 1880–1935 (A.A. Boahen ed., 1990) at 467–71.

discord.²⁵ While Christianity long accepted slavery as natural, subsequently missionaries, such as William Wilberforce and David Livingstone, played an important role in abolitionist campaigns.²⁶

In addition to contributing to the abolition of the slave trade, missionaries established schools and health care centers to cater to themselves and new converts. If education was aimed at freeing Africa from general ignorance and backward beliefs and customs, missionary health care services were aimed at replacing “mythological medicine” with scientific medicine. According to Mkandawire:

Concomitant with spiritual conversation, and increase of adherents; the need for medical services appeared to be a *sine-qua-non* for the conversion of souls to Christianity. Medical services served as a necessary ingredient in bringing the people to medical treatment for their ailments and for relief of their physical suffering: whereas soul healing and salvation were left to the Priest who was endowed with powers of providing spiritual cleansing.²⁷

The missionary clinics were thus set up in competition with traditional health services. In a way, the missionary approach to health was similar to that of the traditional African doctor. For the latter, good health was a function of an individual human being’s physical and psychological wellbeing as well as a function of his or her spiritual wellbeing.²⁸ The causes of ill health, the traditional doctor believed, could be natural—affecting the physical wellbeing of the individual—or unnatural—affecting his or her mental and spiritual wellbeing.²⁹ In practice, the traditional doctor did not always distinguish between the

25. *Id.*; see, e.g., Dr. William Hardy, *Riches & Misery: The Consequences Of The Atlantic Slave Trade*, OPENLEARN (Feb. 25, 2014), <http://www.open.edu/openlearn/history-the-arts/history/riches-misery-the-consequences-the-atlantic-slave-trade>. See generally Babacar M’Baye, *The Economic, Political, and Social Impact of the Atlantic Slave Trade on Africa*, 11 EUROPEAN LEGACY: TOWARD NEW PARADIGMS 607–622 (2006).

26. John Sarfarti, *Anti-Slavery Activist William Wilberforce: Christian Hero*, 21 J. CREATION 121 (2007); Robert D. Woodberry & Timothy S. Shah, *The Pioneering Protestants*, 15 J. DEMOCRACY 47, 55–56 (2004).

27. See, e.g., Austin C. Mkandawire, *David Livingstone’s Medical Dimension in Malawi and How It Is Connected to His Vision 150 Years After His Death*, 62 SOC’Y MALAWI J. 62 (2009).

28. See, e.g., Peter F. Omonzejele, *African Concepts of Health, Disease, and Treatment: An Ethical Inquiry*, 4 EXPLORE 120 (2008).

29. Michael O.S. Afolabi, *Entrenched Colonial Influences and the Dislocation of Health Care in Africa*, 5 J. BLACK & AFR. ARTS & CIVILIZATION 229, 231 (2011).

two aspects of human health as he or she deployed both supernatural and natural powers to diagnose and treat ailments.

As Mkandawire shows above, although the missionaries relied on scientifically tested medicines and methods of treatment, their belief in a supreme being meant that they also believed in spiritual wellbeing. The fact that some missionaries doubled as medical doctors made the similarity between African medicine and Western medicine even starker. This similarity presented problems for missionaries in their health care efforts; it meant that for the African to access missionary medical care, he or she had to abandon his or her religious beliefs and accept Christianity. Unsurprisingly, at the beginning, most missionary converts were those who were at the margins of African society (for example, those who had been banished or abandoned on grounds of accusations of witchcraft, the sick, and the poorest), as the majority was not keen on rejecting their own beliefs and some opposed Western beliefs.³⁰ Even as Christianity and Western medicine have spread to all parts of the world, African traditional medicine is still being practiced and serves a large number of people.³¹

The partition of African among European powers that took place at the Berlin Conference between 1884 and 1885 saw the creation of new states where no complex forms of political organizations had existed before. Relatives, clansmen, kinsmen, tribes, and kingdoms were either merged into a single national identity or split into two, or in some cases more, states. As these drastic measures were resisted by Africans, imperialists resorted to violence, which resulted in many atrocities against Africans.³²

Once colonial administrations were set up, the administrators faced a daunting challenge to establish national systems of governance. It seemed natural to them, as a start, to import the legal systems of their countries of origin to the new colonies.³³ In superimposing their home

30. See, e.g., Ian Linden, *CATHOLICS, PEASANTS AND CHEWA RESISTANCE IN NYASALAND 1889–1939* (1974); Lindenfeld, *supra* note 20, at 357.

31. See, e.g., Abdullahi Ali Arazeem, *Trends and Challenges of Traditional Medicine in Africa*, 8 *AFR. J. TRADITIONAL, COMPLEMENTARY & ALTERNATIVE MED.* 115, 116–17 (2011).

32. See, e.g., *WEST AFRICAN RESISTANCE: THE MILITARY RESPONSE TO COLONIAL OCCUPATION* (Michael Crowder ed., 1971); Matthew Craven, *Between Law and History: The Berlin Conference of 1884–1885 and the Logic of Free Trade*, 3 *LONDON REV. INT'L L.* 32, 54 (2015); D.J. Schaller, *Genocide and Mass Violence in the "Heart of Darkness": Africa in the Colonial Period*, in *THE OXFORD HANDBOOK OF GENOCIDE STUDIES* 345–64 (D. Bloxham & A.D. Moses eds., 2010).

33. For example, the British established common law systems in their colonies while the French and Portuguese established civil law systems. See generally KRISTIN MANN & RICHARD

laws on African customary laws, they reinforced the marginalization of African medicine and customs first promoted by the missionaries. African customary law had to pass the repugnancy test, which stated that it was applicable only if it was neither repugnant to natural justice, equity, good consciousness, nor was incompatible with any enactment of the colonial legislature.³⁴ Colonial law also criminalized African medicine by criminalizing witchcraft.³⁵ The intention was to suppress African beliefs, take the African doctor out of business, and promote a Western way of life.

Unlike the missionaries, who had targeted local people and accommodated the poor, the initial concern of colonial health care policy was not with the health of the African colonial subjects, but rather with the colonial officials and their families, western employees of foreign companies operating in the colonies, and the soldiers stationed in the colonies.³⁶ Indeed, some commentators have argued that colonial conquest in fact worsened the health situation in Africa during the early years of colonialism.³⁷ Soon a discriminatory health care policy would take shape. Quality health care services would be catered to European settlers and inferior services to Africans.³⁸ This was achieved, firstly, by establishing health centers far from local communities, typically on elevated locations that would be difficult to access and mostly in urban areas, and, secondly, by segregating health centers based on race.³⁹ Discrimination within the health sector also manifested itself at the level of the providers of the services. Colonial government took time to establish medical schools for Africans and, when they did, the training of Africans was not aimed at imparting skills and knowledge that would enable them to practice medicine on

L. ROBERTS, *LAW IN COLONIAL AFRICA* (1991); Sandra F. Joireman, *Inherited Legal Systems and Effective Rule of Law: Africa and the Colonial Legacy*, 39 *J. MODERN AFRICA STUD.* 571 (2001).

34. See, e.g., LIBRARY OF CONGRESS, *LEGAL RESEARCH GUIDE: CUSTOMARY LAW IN AFRICA* (2015).

35. The Witchcraft Ordinance was enacted in almost all British colonies. See Chi Adanna Mgbako & Katherine Glenn, *Witchcraft Accusations and Human Rights: Case Studies from Malawi*, 43 *GEO. WASH. INT'L L. REV.* 389, 396 (2011); see also Kenya Colony Witchcraft Ordinance No. 23/1925; South African Witchcraft Suppression Act No. 3 of 1957. Some British scholars were highly critical of such laws.

36. Bruce Fetter, *Health Care in Twentieth Century Africa: Statistics, Theories and Policies*, 40(3) *AFRICA TODAY* 9–23 (1993); KASEJE, *supra* note 4, at 7; HISTORY OF AFRICA, *supra* note 24, at 473, 569.

37. Fetter, *supra* note 36.

38. *Id.*

39. *Id.*; Njoh, *supra* note 8, at 11.

their own, but as assistants to European practitioners.⁴⁰ With time and experience, the African medical personnel improved their skills remarkably, gaining the respect of the expatriate medical personnel and later leading the nationalist movements of the 1940s and 50s.⁴¹ The unequal health care system established by the colonial government stood in contrast to the egalitarian traditional health care system provision that it sought to replace. To date, unequal access to health care remains a characteristic feature of African health systems.

It has been argued that, throughout the colonial administration, no comprehensive health planning took place. Health care was delivered in a piecemeal fashion based on one's race. This does not mean that missionaries and colonial governments achieved nothing as far as health is concerned.⁴² In fact, major Christian denominations, such as the Catholic and Protestant Churches, have continued to provide such public services as clinics, hospitals, and educational institutions. On their part, colonial governments established national systems of health care that independent governments inherited and improved. Some evidence suggests that, by the end of colonialism, the mortality rate had decreased remarkably compared to where it was before colonialism.⁴³ However, in rejecting and demonizing African medicine and customs, the missionaries and, later, colonial administrators threw the baby with the bath water. Some of the traditional knowledge about medicine was effective in treating tropical diseases in which the missionary medical personnel did not have expertise and has been proven to work by modern scientists.⁴⁴ Furthermore, the marginalization of traditional medicine has continued to date although the demand for such medicine has not diminished.⁴⁵ Colonial administrators also ignored the benefits offered by the traditional communal health care system, but now policymakers in health recognize the significance of community health and have tried to

40. *Id.*; Afolabi, *supra* note 29, at 235.

41. J.N. Lasker, *The Role of Health Services in Colonial Rule: The Case of the Ivory Coast*, 1 *CULTURE, MED. & PSYC.* 227, 281 (1977).

42. Significant improvements to health care systems took place after the Second World War and following the formation of the W.H.O.

43. *See, e.g.*, Fetter, *supra* note 36.

44. *See, e.g.*, M.F. Mahomodally, *Traditional Medicines in Africa: An Appraisal of Ten Potent African Medicinal Plants*, in *EVIDENCE-BASED COMPLEMENTARY & ALTERNATIVE MED.* 1 (2013) (citing *Acacia Senegal*, *Aloe Ferox*, *Artemisia Herba-Alba*, *Aspalathus Linearis*, *Centella Asiatica*, *Catharanthus Roseus*, *Cyclopia Genistoides*, *Hypagophytum Procumbens*, *Mormodica Charantia*, and *Pelragonium Sidoides* as some of the plants used for African medicine that have been proven by modern science to work.).

45. Abdullahi, *supra* note 31, 116–17.

integrate communal health care ideas as a means of providing health care to rural communities.⁴⁶ Lastly, the colonial administrators established an unequal system of health care that replaced the egalitarian traditional health care system and has remained in place to date. While previously the inequality of the colonial system was based on race, now it is based on socioeconomic status and place of ordinary residence (whether one lives in rural or urban areas).

IV. INDEPENDENT AFRICAN GOVERNMENTS AND HEALTH

The struggle for independence was about a return to self-rule as much as it was about equal access to public services. In every sense of the word, then, the struggle for independence was a human rights struggle. Colonialism excluded from political participation all Africans. As we have seen above, it also reserved inferior positions for Africans in both public and private work places. Moreover, poor Africans were subjected to poor conditions of work in the farms and companies owned by colonial settlers. African nationalists used all these abuses in their campaigns for political change. Self-determination, accelerated development, and a better life for everyone were what they promised to the people.

Although the struggle against colonialism was evidently fought on a human rights platform, the onset of independence was met with resistance to human rights. At the regional level, the Charter of the Organisation of African Unity⁴⁷ (O.A.U. Charter), which created a new regional body to coordinate the struggle for independence, made cursory references to human rights and codified the principle of non-interference, which later served as a shield from external criticism of human rights records of African countries. At the domestic level, African nationalists began to see the protection of human rights as an impediment to the newly independent governments who saw their

46. See, e.g., UNICEF, ACCESS TO HEALTH CARE THROUGH COMMUNITY HEALTH CARE WORKERS IN EAST AND SOUTHERN AFRICA (2014), http://www.unicef.org/health/files/Access_to_healthcare_through_community_health_workers_in_East_and_Southern_Africa.pdf.

47. Adopted May 23, 1963, 479 U.N.T.S. 39, entered into force Sept. 13, 1963. The adoption of the African Charter on Human and Peoples' Rights in 1981 (adopted June 27, 1981, O.A.U. Doc. CAB/LEG/67/3 Rev. 5, 21 I.L.M. 58 (1982), entered into force Oct. 21, 1986) marked an acknowledgement by African leaders that human rights were a matter of international concern. In 2001, the African Union (A.U.) replaced the O.A.U. The A.U.'s Constitutive Act (adopted on July 11, 2000, O.A.U. Doc. CAB/LEG/23.15, entered into force May 26, 2001) recognizes the limits of state sovereignty over internal human rights.

primary task as being to bring about accelerated development.⁴⁸ Human rights were cynically cast aside by using anti-colonialism rhetoric to claim that they were an imposition of the departing colonial masters on the newly established independent states.⁴⁹ In framing the debate as binary between human rights and development, the newly independent states understood human rights narrowly as civil and political rights. Even so, that civil and political rights were crucial to development was ignored. More importantly, that human rights include economic, social, and cultural rights, which have an important role to play in development, was also neglected.

The consequence of the political rhetoric about development and human rights was that, in a number of countries, new constitutions were hurriedly adopted to replace the ones adopted at independence, removing the bills of rights—that in any case codified predominantly civil and political rights—or reducing their role.⁵⁰ Further constitutional changes were made banning multiparty politics and removing presidential elections. In the end, far from taming and humanizing the colonial state, as the nationalists had promised before independence, the new independent African states consolidated and expanded state authority.⁵¹ The stage was set for the emergence of Africa's strong men, dictatorial regimes, military coups and regimes, civil wars, and politics of ethnicity.

At least during the first decades of independence, an attempt was made, albeit in a one-party dominance context, to accelerate the provision of services to the people. New schools, including tertiary education institutions, were established. This was necessary due to the shortage of skilled people after a considerable number of colonial workers left. Medical centers and clinics were established, particular efforts being made to reach rural areas.⁵² Baah, for example, states:

48. R. Howard, *The Full Belly Thesis: Should Socio-Economic Rights Take Priority over Civil and Political Rights? Evidence from Sub-Saharan Africa*, 5 HUMAN RGTS. Q. 467, 468 (1983); T. MBOYA, FREEDOM AND AFTER 159 (1963).

49. See H.K. Prempeh, Africa's Constitutionalism Revival: New Dawn or False Start, 5(3) INT'L J. CONST. L. 469, 473 (2007); J. Eckel, Human Rights and Decolonization: New Perspectives and Open Questions, HUMANITY J. 111, 115–17 (2014).

50. *Id.* at 474, reporting that between 1960 and 1962, thirteen newly independent African countries amended their independence constitutions. By 1970, many more had followed suit. See also C.M. Fombad, *Constitution-Building in Africa: The Never-Ending Story of Making, Unmaking and Remaking of Constitutions*, 13(4) AFRICAN & ASIAN STUD. 429 (2014).

51. J.I. Elaigwu & A.A. Mazrui, *Nation-Building and Changing Political Structures*, in RETHINKING AFRICAN POLITICS: A HISTORY OF OPPOSITION IN ZAMBIA 435, 447 (Miles Larmer ed., 2011).

52. Fetter, *supra* note 36.

“The new states, therefore, invested heavily in social services, particular education and health. Huge investments also went into the building of economic, infrastructure such as roads, ports, communication facilities and factories.”⁵³

Due in part to feelings of guilt, the first two decades of independence witnessed the most intensive donor support to African governments. Still, special problems were encountered in health. The medical profession takes many years of study and enormous resources to run. Thus, for many years after independence, reliance was placed on expatriate medical personnel and on European universities for education until much later when local education institutions could produce medical personnel locally. But the political repression that took hold in many African states did not help the situation as some of the skilled medical professionals migrated to European countries either in search of better pastures or in flight from political persecution.⁵⁴

At the policy level, although an effort was made to extend medical services to rural areas, the hallmarks of a colonial health system remained in place. Better health care services were concentrated in urban areas, with the elite receiving privileged access, although access to health care was free for everyone. This meant that an unequal health care system prevailed. The elite and urban residents received the best health services that were previously reserved for colonial settlers. The poor in rural areas received inferior care or still made use of traditional medicine. The missionaries, on the other hand, served the communities close by and, depending on their location, they served either the elite or poor communities or both.

At a broader policy level, most African governments were ambivalent, if not demagogic, about African traditions and customs. On the one hand, the laws criminalizing witchcraft were left intact. So too was the subordinate status of African customary law left unchanged.⁵⁵ On the other hand, some of the traditional structures and institutions, such as traditional courts and leadership, were

53. A. Baah, *History of African Development Initiatives*, AFRICA LABOUR RESEARCH NETWORK WORKSHOP (2003), http://www.sarpn.org/documents/d0000407/P373_Baah.pdf.

54. See, e.g., David H. Shin, *African Migration and the Brain Drain*, Inst. for African Studies and Slovenia Global Action (2008), <https://sites.google.com/site/davidhshinn/Home/african-migration-and-the-brain-drain>.

55. Only recently have we seen some efforts to engage with the status of African customary law. See, e.g., *Mifumi (U) Ltd and 12 Others v. Attorney General and Kenneth Kakuru*, Constitutional Petition No. 12 of 2007 (unreported). However, African customary law still has to contend with the strictures of international human rights law.

appropriated and used for political ends. The result was an uneasy relationship between traditional medicine and African customs, and traditions, western medicine, and the received law.

V. THE IMPACT OF STRUCTURAL ADJUSTMENT PROGRAMMES AND HIV/AIDS

By the 1980s, most African countries were in a dire economic situation.⁵⁶ The causes of this state of affairs have been amply discussed.⁵⁷ They include the fact that the policy of nationalisation and state monopolies implemented by most independent states had failed to deliver accelerated development as was expected, and most state enterprises had become a drain on state resources as they persistently needed subsidies to cushion their poor economic performance. Commodity prices also took a dive in the 1980s. Corruption and poor governance also contributed to this disappointing economic outlook. The cumulative result was that governments could not afford to meet the civil service bill, to provide social services, and to service their foreign debts without international assistance. The stage was set for the arrival of the World Bank's infamous Structural Adjustment Programmes (SAPs).

According to the World Bank, SAPs refer to "reforms of policies and institutions covering micro-economic (such as taxes and tariffs), macro-economic (fiscal policy) and institutional interventions; these changes are designed to improve resource allocation, increase economic efficiency, expand growth potential and increase resilience to shocks."⁵⁸ By improving economic performance of African states, it was hoped that economic growth would improve, which would in turn attract foreign direct investment. Improved economic performance would in turn result in improved general standards of living. With these assumptions, SAPs were imposed on African governments as a one-size-fits-all economic prescription without regard to each country's specific and unique context. States were required to liberalise their

56. K. Horta, *The World Bank's Decade for Africa: A New Dawn for Development Aid?*, 4 YALE J. INT'L AFF. 8 (2006).

57. See, e.g., A.B. Zack-Williams et al., *The Long Road to Structural Adjustment*, in STRUCTURAL ADJUSTMENT: THEORY, PRACTICE AND IMPACTS 4 (G. Mohan et al eds., 2000); P.S. MISTRY, *AFRICAN DEBT REVISITED: PROCRASTINATION OR PROGRESS* (1992); J.K. Sandaram et al, *Globalisation and Development in Sub-Saharan Africa*, DESA Working Paper No. 12, Feb. 2011.

58. WORLD BANK, *STRUCTURAL ADJUSTMENT AND POVERTY: A CONCEPTUAL, EMPIRICAL AND POLICY FRAMEWORK* 22 (1990).

economies, float their currency, cut social spending, privatise state enterprises, and deregulate the economy.

The rollout of SAPs did not only fail to improve the economic performance of African countries, but it also in fact precipitated a social crisis.⁵⁹ By the early 1990s, due to budget cuts, public services were in sharp decline. Retrenchments and the rising unemployment rate meant that many could not support themselves and their families. The prices of basic foodstuffs skyrocketed, as did prices of other basic needs such as housing.⁶⁰

The impact of SAPs on education and health are particularly relevant to this discussion. In most African countries, before the introduction of SAPs, education and health care were available for free or at least were highly subsidized by the government. By the early 1990s, user fees were introduced as a means of making up for budget cuts. In education this resulted in massification whereby university administrators turned to student fees as an alternative avenue to make up for the huge deficit in their finances.⁶¹ In a context where the African university had hitherto emphasized skills training to provide the much needed manpower for the newly independent states, massification in higher education institutions only served to accentuate the teaching component of the university at the expense of research, which had in any case not yet been fully established as a central mission of the university. To date, African universities remain ill-equipped to conduct research into the various tropical diseases that continue to afflict the continent.

59. For the social impact of SAPs, see J. Oloka-Onyango, *Beyond the Rhetoric: Reinvigorating the Struggle for Economic, Social and Cultural Rights in Africa*, 25 CAL. WESTERN INT'L L.J. 1 (1995); J.B. Riddell, *Things Fall Apart Again: Structural Adjustment Programmes in Sub-Saharan Africa*, 30 J. MOD. AFRICAN STUD. 53 (1992). S. Weismann, *Structural Adjustment in Africa: Insights from the Experiences of Ghana and Senegal*, 18 WORLD DEVELOPMENT 1621 (1990).

60. By 2000, the World Bank itself conceded thus:

The adjustment decades also saw a substantial deterioration in the quality of public institutions, a demoralisation of public servants and a decline in the effectiveness of service delivery in many countries. Together with falling incomes, these effects— which cannot be speedily reversed – translated into falling social indicators and capabilities in many countries, and to losses of human capital, especially (though not exclusively) in the public service.

WORLD BANK, CAN AFRICA CLAIM THE 21ST CENTURY? 37 (2000).

61. G. Mohammedbai, *The Effects of Massification of Higher Education in Africa* (2008), <http://ahero.uwc.ac.za/index.php?module=cshe&action=downloadfile&fileid=18409092513202791624126>; D. Teferra & P.G. Altbach, *African Higher Education: Challenges for the 21st Century*, 47 HIGHER ED. 21 (2004).

The introduction of user fees for health care⁶² was made in a context where private health care service providers were mushrooming. Both these developments superimposed new layers on an already unequal system of health care. Private medical care facilities began to offer better services, but were inaccessible to the majority who were poor.⁶³ Government hospitals and clinics, barring physical accessibility barriers, were previously open to everyone. The introduction of user fees resulted in preferential treatment between those who could pay at the expense of those who could not. What is more, the introduction of user fees did not improve the finances of public hospitals.⁶⁴ With inadequate funding, medical equipment and supplies and pharmaceutical products could not be maintained or purchased on time. Neither was medical personnel adequately remunerated for their commitment and hard work.

It is in this context that the HIV/AIDS pandemic announced itself in Africa. First reported in the 1980s, the HIV/AIDS crisis reached its summit in the 1990s. It put the health care system modelled on SAPs to its utmost test. While government responses to this crisis ranged from ambivalence and inertia to outright denial, African governments were ill-equipped to respond to HIV/AIDS in almost all respects.⁶⁵ Reliance was therefore to be placed on foreign research agencies to investigate and study the virus and disease. Soon some inroads would be made about the virus in the form of anti-viral drugs (ARVs). The discovery of ARVs by Western research organisations and

62. Whether user fees improve the use of medical services or impede access remains hotly debated. Nevertheless, most research suggests that it adversely affects the poor. *See, e.g.,* F. Ponsar et al, *No Cash, No Care: How User Fees Endanger Health-Lessons Learnt Regarding Financial Barriers to Healthcare Services in Burundi, Sierra Leone, Democratic Republic of Congo, Chad, Haiti and Mali*, 3 INT'L HEALTH 91 (2011); C. James et al, *Impact on Child Mortality of Removing User Fees: Simulation Model*, 331 BRITISH MED. J. 747 (2005); S. Russel & L. Gilson, *User Fee Policies to Promote Health Service Access for the Poor: A Wolf in Sheep's Clothing?*, 27 INT' J. HEALTH SERV. 359 (1997). It is thus not surprising that the WHO has recommended the abolition of user fees. *See* WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT: PRIMARY HEALTH CARE NOW MORE THAN EVER 26 (2004).

63. *See, e.g.,* B. Harris et al, *Inequities in Access to Health Care in South Africa*, 32 J. PUB. HEALTH POL'Y S102 (2011); D.H. Peters et al, *Poverty and Access to Health Care in Developing Countries*, 1336 ANN. THE N. Y. ACAD. OF SCI. 161 (2008). *Compare with* N. Prata et al, *Private Sector, Human Resources and Health Franchising in Africa*, 83 BULL.OF WORLD HEALTH ORG. 274 (2005).

64. *See* the authorities cited in *supra* note 62.

65. *See, e.g.,* A. Whiteside, *Poverty and HIV/AIDS in Africa*, 23 THIRD WORLD Q. 331 (2002). Uganda is often cited as an exception in that the government decided to tackle the HIV/AIDS challenge head-on and devised appropriate response very early. *See, e.g.,* J.O. Parkhurt, *The Responses to HIV/AIDS and the Construction of National Legitimacy: Lessons from Uganda*, 36 DEV. & CHANGE 571 (2005).

corporations would later fuel a huge debate about access to essential medicines, especially in places such as Africa where they are most urgently needed.⁶⁶ At issue was the strong intellectual property regime advocated for by the international financial institutions that promoted SAPs and economic liberalism within the context of the World Trade Organization. After much international horse-trading, ARV drugs became more widely available in Africa, averting a catastrophe that had threatened a whole human race.

VI. THE DAWN OF DEMOCRACY

A. *The Winds of Change*

If the independence movement heralded the first wave of political change in Africa, the democratization movement of the 1990s ushered in the second wave of political change on the continent. Due in part to the fall of the Berlin Wall and end of the Cold War, which served as an obstacle to domestic efforts to challenge Africa's military and other dictatorial regimes, the 1990s saw one African country after another embrace multi-party democracy and civilian political leadership. The dawn of democracy was marked by the adoption of new constitutions that sought to lay down the foundation for the entrenchment of the rule of law and good governance. Provision for regular free and fair elections was at long last made after almost three decades of dictatorial and military regimes.⁶⁷ Presidential limits were set in an attempt to prevent one-man dominant rule, which had become so common on the continent.⁶⁸ Checks and balances in the form of a strong judiciary, independent parliament, and national human rights institutions were also included.⁶⁹ Crucially, the new constitutions entrenched new bills

66. See, e.g., S. Leader, *Trade and Human Rights II*, in 2 THE WORLD TRADE ORGANISATION: LEGAL, ECONOMIC AND POLITICAL ANALYSIS 664 (P.J.F. Macrory et al. eds., 2005); C. Stevens, *Trade and the Environment: The PPMs Debate*, in SUSTAINABLE DEVELOPMENT AND INTERNATIONAL LAW 239–47 (W. Lang ed., 1995); F. Francioni, *Environment, Human Rights and the Limits to Free Trade*, in ENVIRONMENT, HUMAN RIGHTS AND INTERNATIONAL TRADE, 1 (F. Francioni ed., 2001); S. Bal, *International Free Trade Agreements and Human Rights: Reinterpreting Art. XX of the GATT*, 10 MINN. J. GLOBAL TRADE (2001) 62 (2001).

67. See A. REYNOLDS, ELECTORAL SYSTEMS AND DEMOCRATIZATION IN SOUTHERN AFRICA (1999).

68. According to Vencovsky, about 33 of 48 new African constitutions contained provisions on term limits. D. Vencovsky, *Presidential Term Limits in Africa*, CONFLICT TRENDS 15 (2007).

69. See generally ACCOUNTABLE GOVERNMENT IN AFRICA: PERSPECTIVES FROM PUBLIC LAW AND POLITICAL STUDIES (D.M. Chirwa & L. Nijzink eds., 2012); HUMAN RIGHTS UNDER AFRICAN CONSTITUTIONS: REALISING THE PROMISE FOR OURSELVES (A. An-Na'im ed., 2003);

of rights, most of which recognized both civil and political rights and economic, social, and cultural rights, following the example set by the African Charter.

B. The Constitutional Protection of the Right to Health

One of the most notable legal developments since the 1990s in Africa has been the acceptance of economic, social, and cultural rights. African constitutions have increasingly recognised economic, social, and cultural rights,⁷⁰ abandoning the traditional model that recognises civil and political rights only and relegates economic, social, and cultural rights to the status of directive principles of state policy. A decreasing number of African states still adhere to the traditional approach to these rights.⁷¹ Because the provisions relating to what would be called the right to health are included in a chapter enshrining directive principles of state policy, which are not enforceable but merely directory, it is difficult, if not impossible, in these countries for an individual or organisation to sue the government for its failure to provide health services to the people.⁷² In such countries, the government would more appropriately be held accountable for its decisions and policies on health through political processes and action.

The African states that recognize economic, social, and cultural rights directly in the bill of rights of their constitutions include Angola, Burundi, Cape Verde, Chad, Congo, Côte d'Ivoire, Equatorial Guinea, Gabon, The Gambia, Guinea, Kenya, Madagascar, Mali, Mozambique, Niger, Rwanda, Saô Tomé and Príncipe, Senegal, Seychelles, South Africa, and Togo.⁷³ To varying degrees of specificity, detail, and clarity, almost all of the constitutions of these countries recognize the

CONSTITUTIONALISM AND DEMOCRATIC GOVERNANCE IN AFRICA: PERSPECTIVES FROM SUB-SAHARAN AFRICA (M.K. Mbondenji & T. Ojienda eds., 2013).

70. D.M. Chirwa & L. Chenwi, *The Protection of Economic, Social and Cultural Rights in Africa*, in *THE PROTECTION OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS IN AFRICA: INTERNATIONAL, REGIONAL AND NATIONAL PERSPECTIVES* 3, 8 - 10 (D.M. CHIRWA & L. CHENWI EDS., 2016).

71. Countries that still have this model include Botswana, Cameroon, Djibouti, Lesotho, Liberia, Mauritania, Mauritius, Nigeria, Sierra Leone, Sudan and Zambia. Under this group could also be included constitutions that make a broad commitment to human rights in the preamble without entrenching them specifically in a bill of rights. These include the Constitutions of the Comoros, Mauritania, Cameroon and several other Francophone African countries.

72. See, e.g., E. Nwauche, *Indirect Constitutional Protection of Economic, Social and Cultural Rights in Nigeria*, in Chirwa & Chenwi, *supra* note 70, 501 - 526; A.N. Akonumbo, *Indirect Constitutional Protection of Economic, Social and Cultural Rights in Cameroon*, in Chirwa & Chenwi, *supra* note 70, 527 - 549.

73. Chirwa & Chenwi, *supra* note 70.

right to health.⁷⁴ In doing so, these constitutions make it possible for individuals and organizations to challenge state inaction or action concerning the provision of health care in courts of law. As will be shown below, court involvement in health policy has helped in some countries, such as South Africa, to extend access by the people to medicines.

Other African constitutions have taken a middle ground and recognize some economic, social, and cultural rights in the bill of rights and others as directive principles of state policy. The hybrid approach represents a compromise between the need to recognise economic, social, and cultural rights as human rights that are equal in moral and legal value to civil and political rights and the need to take cognizance of the concerns related to lack of resources that present constraints to the realization of economic, social, and cultural rights. This approach allows states to commit to a small number of economic, social, and cultural rights that are recognised as rights in the bill of rights and a few more as directive principles of state policy that are to be implemented progressively. The constitutions of Eritrea, Ethiopia, Ghana, Malawi, Namibia, Swaziland, Tanzania, Uganda, and Zimbabwe represent this model of protection of these rights.⁷⁵ Curiously, the constitutions of Eritrea, Ethiopia,⁷⁶ Ghana,⁷⁷ and Zimbabwe⁷⁸ expressly recognize the right to health or aspects of this right in the bill of rights. This means that this right can be enforced in a court of law in those countries. By contrast, the constitutions of Malawi, Namibia, and Tanzania have health-related provisions only in the chapter on directive principles of state policy, while the constitutions of Swaziland and Uganda do not make any specific provision for health in the bill of rights or in the chapter on directive principles of state policy. Still, countries that have adopted a hybrid

74. See Article 77 of the Constitution of Angola 2010; Article 55 of the Constitution of Burundi; Article 68 of the Constitution of Cape Verde; Article 47 of the Constitution of Chad; Article 30 of the Constitution of Congo; Article 19 of the Constitution of Côte d'Ivoire (right to a healthy environment); Article 22 of the Constitution of Equatorial Guinea, Article 1(8) of Gabon; Article 15 of the Constitution of Guinea; Article 43(1) of the Constitution of Kenya; Article 19 of the Constitution of Madagascar; Articles 15 and 16 of the Constitution of Mali; Article 89 of the Constitution of Mozambique; Article 11 of the Constitution of Niger; Article 49 of the Constitution of Saô Tom . . . and Príncipe; Article 17 of the Constitution of Senegal; Article 29 of the Constitution of Seychelles; Article 27(1) of the Constitution of South Africa; Article 34 of the Constitution of Togo. Only the Constitutions of The Gambia and Rwanda make no specific mention of the right to health.

75. Chirwa & Chenwi, *supra* note 70.

76. Article 41(1).

77. Article 30.

78. Article 76.

model for the protection of economic, social, and cultural rights generally present more scope than countries that do not recognise any economic, social, and cultural rights at all for citizens to use the courts to compel the state to improve the provision of health care services. This is so because some of the economic, social, and cultural rights that are expressly recognized tend to be wide in scope to admit a broad interpretation that may include the rights not expressly recognized.⁷⁹

The overall general impact of the political and constitutional changes described above in Africa has been remarkable. Since the 1990s, African governments have opened themselves up to more accountability than was the case before. Communities and civil society organizations now have a normative framework that they can use, and have used, to challenge state policies or inaction. With specific reference to health, the countries that recognize the right to health as a human right have given their citizens the possibility of using the courts to seek individual or collective remedies regarding access to health.

South Africa represents the clearest example where the right to health has been used to challenge state and international policies and practices on health. As one of the countries that has been most adversely affected by HIV/AIDS, South Africa enacted a law in 1997 authorizing the government to import generic drugs and introducing price controls on the imported drugs.⁸⁰ About 39 international pharmaceutical corporations sued the government of South Africa in the High Court, arguing that the law infringed upon their intellectual property rights.⁸¹ For its part, the United States placed South Africa on a watch list of countries that were potential violators of intellectual property rights. The Treatment Action Campaign (TAC), a local non-governmental organisation, and the Congress of South African Trade Unions (COSATU) led a huge public campaign against the pharmaceutical corporations that resulted in the withdrawal of the case.⁸² This campaign and other mobilisation efforts also forced the United States to take South Africa off the watch list in 1999. More

79. See, e.g., D.M. Chirwa, *A Full Loaf Is Better Than Half: The Constitutional Protection of Economic, Social and Cultural Rights in Malawi*, 49 J. AFRICAN L. 207 (2005).

80. See Medicines and Related Substances Control Amendment Act 90 of 1997, especially Section 15C.

81. R.L. Swarns, *Drug Makers Drop South Africa Suit over AIDS Medicine*, N.Y. TIMES (20 April 2001), <http://www.nytimes.com/2001/04/20/world/drug-makers-drop-south-africa-suit-over-aids-medicine.html>.

82. *Id.*; P. Bond, *Globalization, Pharmaceutical Pricing and South African Health Policy: Managing Confrontation with US Firms and Politicians*, 29 INT' J. HEALTH SERV. 465 (1999).

importantly, the withdrawal of the case emboldened the African Group to push for reform of the international laws on intellectual property within the World Trade Organisation.⁸³

The TAC also won a major health rights case in *Minister of Health v. Treatment Action Campaign*⁸⁴ in which the Constitutional Court of South Africa found that the government's policy on HIV treatment had the effect of restricting access by pregnant women to Nevirapine. Having joined hands with civil society to fight the powerful pharmaceutical industry from 1998 –to 2001, the South African government developed cold feet regarding the distribution of Nevirapine throughout the country, citing concerns about the safety of the drug. As a result, the government allowed this drug to be prescribed and given to pregnant mothers for purposes of reducing the chance of transmitting HIV/AIDS to their children at birth only at 20 pilot sites. The Constitutional Court's holding that the restriction constituted a violation of the right to health led to a major policy shift in South Africa's health policy on HIV/AIDS. The decision dealt a blow to former President Thabo Mbeki's AIDS denialism and forced the government to make Nevirapine and other anti-retroviral drugs widely accessible throughout South Africa.⁸⁵

C. The Enduring Problem of Access

Despite these notable achievements, access to medicines and health care in Africa remains a challenge.⁸⁶ The health care system is

83. See S.S. Marcellin, Sherry Suzette *The Political Economy of Pharmaceutical Patents: U.S. Sectional Interests and the African Group at the WTO: A Case Study in International Trade Decision-Making and the Possibility for Change* 252–53 (2008) (unpublished Ph.D. thesis, University of Warwick).

84. 2002 (5) SA 721 (CC), 2002 (10) BCLR 1033 (CC).

85. See M. Heywood, *South Africa's Treatment Action Campaign: Combining Law and Social Mobilization to Realise the Right to Health*, 1 J. HUMAN RTS. PRAC. 1 (2009); M. Mbali, *The Treatment Action Campaign and the History of Rights-Based, Patient-Driven HIV/AIDS Activism in South Africa*, in DEMOCRATIZING DEVELOPMENT: THE POLITICS OF SOCIO-ECONOMIC RIGHTS IN SOUTH AFRICA (P. Jones & K. Stokke eds., 2005) 213; A. Butler, *South Africa's HIV/AIDS Policy, 1994–2004: How Can It Be Explained?*, 104 AFRICAN AFF. 417, 591 (2006); Z.M. McLaren, *Equity in the National Rollout of Public AIDS Treatment in South Africa 2004–08*, 30 HEALTHY POL'Y & PLANNING 1162 (2015).

86. At the political level, democracy has not yet been fully entrenched as big-man politics, ethnicity, patronage, one-party dominance, vote rigging and similar problems still bedevil the continent. See, e.g., K. Prempeh, *Presidential Power in Comparative Perspective: The Puzzling Persistence of the Imperial Presidency in Post-Authoritarian Africa*, 34 HASTINGS CONST. L.Q. 1 (2008); C.M. Fombad, *Constitution-Building in Africa: The Never-Ending Story of Making, Unmaking and Remaking of Constitutions*, 13 AFRICAN & ASIAN STUD. 429 (2014).

still dependent on substantial Western donor funding.⁸⁷ The recent Ebola crisis in West Africa underlines this enduring problem of dependency. When Ebola broke out, African countries were slow to react and had insufficient means of containing the disease. It had, yet again, to take the intervention of foreign philanthropists, governments, and researchers to bolster the prevention and treatment efforts to contain the outbreak.⁸⁸

Although African states have now established their own medical schools to train of health care professionals, these schools remain few and do not produce enough graduates to tackle the enormous health challenges that the continent faces.⁸⁹ Related to this problem is the problem of lack of sufficient funding and infrastructure among African medical schools and universities to conduct and produce enough medical or health research.⁹⁰ As a result, African universities produce very little health or medical research. Without sufficient research, it is not possible to develop health policies that effectively address the wide-ranging health challenges the region faces. As part of efforts to boost medical research and education in sub-Saharan Africa, various intergovernmental agencies have supported capacity building initiatives and some western Universities have entered into partnerships with African universities.⁹¹ While such efforts have a role to play in alleviating the health challenges faced in the region, the over-reliance on foreign support and funding means that African researchers cannot set the health research agenda. Without such autonomy, much of the medical research in Africa will continue to address health

87. See, e.g., J.M. Kirigia & A.J. Diarra-Nama, *Can Countries of the WHO African Region Wean Themselves off Donor Funding for Health?*, 86 BULL. WORLD HEALTH ORG. 889 (2008); K.A. Grepin, *HIV Donor Funding Has Both Boosted and Curbed the Delivery of Different Non-HIV Services in Sub-Saharan Africa* 31 HEALTH AFF. 1406–14 (2012); R. Maclure, *Primary Health Care and Donor Dependency: A Case Study of Nongovernment Assistance in Burkina Faso*, 25 INT. J. HEALTH SERV. 539 (1995).

88. See generally O. Tomori, *Will Africa's Future Epidemic Ride on Forgotten Lessons from the Ebola Epidemic?*, 13 MED. FOR GLOBAL HEALTH 116 (2015); A. Benton & K.Y. Dionne, *International Political Economy and the 2014 West-African Ebola Outbreak*, 58 AFR. STUD. REV. 223 (2015).

89. F.M. Mullan et al, *Medical Schools in Sub-Saharan Africa*, 377 LANCET 1113 (2011).

90. See, e.g., J.A.G. Whitworth, *Strengthening Capacity for Health Research in Africa*, 372 LANCET 1590 (2008); W.L. Kilama, *The 10/90 Gap in Sub-Saharan Africa: Resolving Inequalities in Health Research*, 112S ACTA TOPICA S8 (2009); Q. Eichbaum, *New Medical Schools in Africa: Challenges and Opportunities: CONSAMS and Value of Working in Consortia*, 81 ANNALS OF GLOBAL HEALTH 265 (2015); Mullan et al., *supra* note 89. at 1118.

91. J. Crane, *Scrambling for Africa? Universities and Global Health*, 377 LANCET 1388–9 (2011).

problems that have little to do with Africa.⁹²

Last but not least, the inequalities embedded in the three-tiered parallel system of public health care, private health care, and traditional health care that has long characterised African health care systems are more pronounced than ever before.⁹³ Traditional medicine is still used mostly by rural dwellers or the poor,⁹⁴ while in some countries public hospitals provide different layers of health services depending on whether one pays or not.⁹⁵ Except perhaps in South Africa, Namibia, and Botswana, the public health care system is such that the political elite itself does not trust it. In some countries, even the private health care providers are not considered good enough.

It is thus not uncommon for the political elite to seek medical care, even for medical check-ups, in Europe or Asia. The late Nigerian President Yar'Adua spent months in a hospital in Saudi Arabia until it was clear he would not survive.⁹⁶ President Robert Mugabe, the late Zambian Presidents Levi Mwanawasa and Michael Sata were all treated in Europe.⁹⁷ The saddest of these tales relates to Malawi's late President Bingu wa Mutharika, who had, through his own actions of antagonising donors, managed to run down the health care system in Malawi. On 5 April 2011, he collapsed in his office following cardiac arrest. The inquiry to establish the cause of his death revealed that the clinic at the state house had no basic equipment and insufficient and incompetent staff. Not only was there no protocol in place of obtaining emergency assistance from the central hospital in Lilongwe, when the President was taken to that hospital there was no VIP section. As a result, patients were hurriedly removed from one ward in order to make

92. See generally Kilama, *supra* note 89.

93. With respect to South Africa, for example, see S. Benatar, *The Challenges of Health Disparities in South Africa* 103 S. AFR. MED. J. 154–5 (2013), <http://www.samj.org.za/index.php/samj/article/view/6622/4918>; B. Harris et al, *Inequities in Access to Health Care in South Africa*, 32 J. PUB. HEALTH POL'Y S102 (2011).

94. See, e.g., N. Nxumalo, *Utilisation of Traditional Healers in South Africa and Costs to Patients: Findings of National Health Survey* 32 J. PUB. HEALTH POL'Y S124 (2011). Some estimate that about 70–80 per cent of Africans still use traditional healers as primary care givers. See S. Ventegodt et al, *The Future of the Traditional African Healers*, 2(4) J. ALTERNATIVE MED. RES. 359, 360 (2010).

95. On the impact of user fees on access to health, see *supra* note 62 and the accompanying notes.

96. M. Tran, *President Umaru Yar'Adua Returns to Nigeria*, GUARDIAN (February 24, 2010).

97. See *Zambia President Levy Mwanawasa Dies*, TELEGRAPH (August 19, 2008); A. Cowell & J. Gettleman, *Zambia's Acerbic Leader, Michael Sata, Dies at 77*, N.Y. TIMES (October 19, 2014).

room for the President. Unfortunately, the hospital did not have essential medicines and equipment to preserve his remains. The President had to be flown to South Africa for preservation as the country prepared for his funeral.⁹⁸

VII. CONCLUSION

There can be no doubt that Western medicine and science have contributed enormously to the lives of millions of Africans since they were introduced. However, despite the great advances in science and medical research that have been made, many people in Africa do not have access to medicines and health care. Some of the key challenges to access to health care and medicines are longstanding. They may have undergone change in their manifestations over the years, but not in their essential character. Two of these are the challenge of dependency and the challenge of unequal access. The introduction of Western medicine to Africa was also an introduction of dependence on the West for health care. At colonization, the West owned and controlled the knowledge about Western medicine; now it still does. As has been shown in this paper, research into tropical diseases remains inadequate and African universities are contributing little to medical research. Without gaining control of the knowledge about disease – how to treat, prevent or control them-- African countries will continue to struggle in their efforts to provide equal access to medicines and health care to their people. The interminable emphasis on achieving economic goals and budget cuts to social services is continuing to cripple health care provision and to aggravate the inequalities in access to those services.

Of course, most of the problems pertaining to access to medicines and health care could well be resolved by eliminating poverty. This is a long-term goal that should relentlessly be pursued. In addition, health-specific strategies need to take seriously bolstering the capacity of medical institutions, personnel, and researchers—and of public health institutions in general—to directly address the ever-growing chasm between African medicine and received medicine, and private and public health service provision.

98. See THE SINGINI COMMISSION OF INQUIRY, REPORT OF THE COMMISSION OF INQUIRY INTO CIRCUMSTANCES OF THE DEATH OF THE LATE PRESIDENT NGWAZI PROF BINGU WA MUTHARIKA AND INTO THE POLITICAL TRANSITION FOLLOWING HIS DEATH (2013), https://zambiareports.com/wp-content/uploads/2014/07/Bingu_Report_Final_without_appendices.pdf.