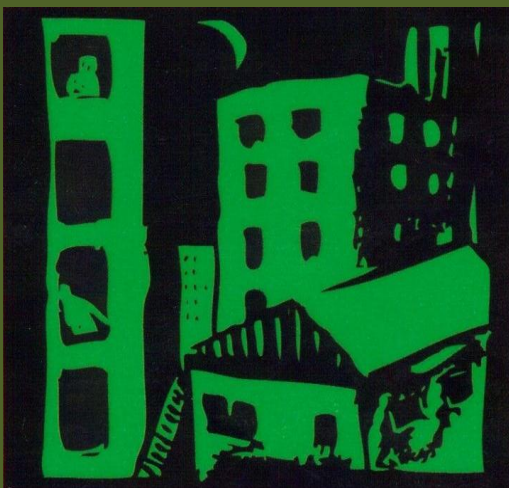


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The approaches of the African Commission to the right to health under the African Charter

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1 INTRODUCTION

In 2012 the African Commission on Human and Peoples' Rights celebrated its 25 years of existence. The Commission was established pursuant to the African Charter on Human and Peoples Rights, which came into force in 1986.¹ Since its establishment the Commission has played significant roles in the advancement of human rights in the region. While it can be argued that the formative stage of the Commission was characterised by administrative inefficiency and lacklustre performance, the Commission would seem to have improved at the latter stage of its

¹ See Art 30 of the African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.

existence. Indeed, the Commission has handed down a number of important and landmark decisions relating to the socio-economic rights guaranteed in the Charter. The African Charter remains one of the few regional human rights instruments that guarantee both civil and political rights and socio-economic rights as enforceable rights. In addition, the African Charter remarkably contains provisions safeguarding people's rights, which is a rare feat when compared with other regional human rights instruments.² The coming into force on 25 November 2005 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)³ marks a momentous occasion in the annals of the promotion and protection of human rights in Africa. The African Women's Protocol contains a number of radical and progressive provisions relating to the rights of women, thereby providing an opportunity for the African Commission to redress human rights violations experienced by women.

The purpose of this article is to examine the right to health guaranteed under the African Human Rights system and the approaches the African Commission has adopted in interpreting the content of this right. The article starts by examining in detail the provisions of the right to health under international human rights law before discussing the provisions of the African Charter and African Women's Protocol. It then discusses the various approaches the African Commission has adopted in interpreting these provisions in some of its decisions and their importance in advancing the right to health in the region. The article further examines some of their important non-binding resolutions and General Comments of the African Commission relating to the right to health and their significance in advancing this right in the region. The article concludes by arguing that national courts in the region can learn from the approaches adopted by the African Commission in interpreting the right to health guaranteed under the Charter and the African Women's Protocol.

2 THE NORMATIVE FRAMEWORK FOR THE RIGHT TO HEALTH

The right to the highest attainable standard of health, commonly referred to as the right to health, is guaranteed in a number of international human rights instruments. However, the first mention of this right was contained in the preamble to the Constitution of the World Health Organisation's where it is provided as follows:⁴

Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of all human beings without distinction as to race, colour, and religion.

Subsequently, the right to health has been guaranteed in Article 25 of the Universal Declaration of Human Rights where it was provided that "everyone has the right to a

² For a detailed discussion about the African Commission and the African human rights system see Viljoen F *International human rights law in Africa* (2012).

³ Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003), (entered into force 25 November 2005).

⁴ The Constitution of the WHO was adopted by the International Health Conference, New York, 19-22 June 1945; opened for signature on 22 July 1946 by the representatives of 61 states; 14 UNTS 185. .

standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services".⁵ However, the most authoritative provision on the right to health is contained in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) where it is provided as follows:⁶

- 1 The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health
- 2 The steps to be taken by States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

In addition to these instruments, article 24 of the Convention on the Rights of the Child (CRC)⁷ and Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)⁸ contain important provisions on the right to health.

The Committee on Economic and Cultural Rights responsible for monitoring the implementation of the ICESCR has attempted to provide clarifications of the nature and content of the right to health in its General Comment 14.⁹ According to the Committee, the right to health guaranteed under Article 12 of the ICESCR does not mean the right to be healthy. Rather, it is an inclusive right, which should be broadly interpreted to include underlying determinants of health. The Committee further explains as follows:¹⁰

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

The Committee notes that the right to health imposes obligations on states to ensure the availability, accessibility, acceptability and quality of health care services for all,

⁵ Universal Declaration of Human Rights, GA Res 217 A (III), UN Doc A/810 (10 December 1948).

⁶ Art 12 International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).

⁷ Convention on the Rights of the Child GA Res 25 (XLIV), UN GAOR Supp No 49 UN Doc A/RES/44/25 1989.

⁸ Convention on the Elimination of All Forms of Discrimination Against Women GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.

⁹ The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment No 14, UN Doc E/C/12/2000/4.

¹⁰The Right to the Highest Attainable Standard of Health; UN Committee on ESCR at para 33.

particularly vulnerable and marginalised groups. The Committee further identifies the minimum core obligations of the right to health to include at least the following obligations:

- (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
- (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- (e) To ensure equitable distribution of all health facilities, goods and services;
- (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalised groups.¹¹

Also, the CEDAW Committee¹² and the Committee on the CRC¹³ have provided clarifications on the right to health guaranteed under these instruments.

In recent times there have been various attempts to give more recognition to the enjoyment of the right to health under the UN human rights systems. For instance, in 2002 for the first time, the Human Rights Commission appointed a Special Rapporteur on the right to the highest attainable standard of health. This was milestone in the promotion and protection of the right to health globally. The first Special Rapporteur on health, Paul Hunt, played an important role in raising the profile of the right to health internationally. In addition, he paid special attention to specific health issues that were hitherto given little attention. For instance, some of his thematic reports to the Human Rights Council dealt with issues such as neglected diseases, right to health indicators, maternal mortality and sexual and reproductive health and rights.¹⁴ The current Special Rapporteur on health has also made efforts to raise the profile of the right to health as an enforceable right at the international level. Moreover, landmark decisions from Latin American countries, as well as the Inter-American Court of Human Rights, would seem to have provided a better understanding of the nature and content of the right to health.

¹¹ The Right to the Highest Attainable Standard of Health; UN Committee on ESCR at para 43

¹² General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1.

¹³ Committee on the Right of the Child, Adolescents Health and Development in the context of the Convention on the Right of the Child, General Comment NO 4 CRC/GC/2003/4 Thirty-Second Session May 2003.

¹⁴ See for instance, Report on Health Systems and the Right to the Highest Attainable Standard of Health [A/HRC/7/11](#) 2008; Report on Persons with Mental Disabilities [E/CN.4/2005/51](#) 2005; Report on Access to Medicines and the Reduction of Maternal Mortality [A/61/338](#) 2006 and the Report on Sexual and Health and Rights; the Link between Poverty and Health; Neglected Diseases; and Violence Prevention [E/CN.4/2004/49](#) 2004.

3 THE RIGHT TO HEALTH UNDER THE AFRICAN HUMAN RIGHTS SYSTEM

Under the African human rights system, the first attempt to guarantee the right to health is found in Article 16 of the African Charter. Article 16 of the Charter provides as follows:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

From this provision it is clear that slight differences exist in the language used when compared with that of Article 12 of the ICESCR. First, while the provision of the ICESCR is addressed to states (duty-bearers), the first part of Article 16 of the African Charter focuses on 'every individual' (right-holders). In essence, while it would seem that the ICESCR is more concerned with holding states parties to the treaty accountable, Article 16 of the Charter would seem to lay emphasis on the real enjoyment of rights by individuals. For the purposes of monitoring human rights, these two approaches are relevant. However, since states are the subject of international law, it is assumed that the focus on individuals does not in any way diminish the obligations imposed on states parties to the African Charter. Indeed, the language of the second part of Article 16 supports this submission. As discussed below, the approach of the Commission has been to hold states rather than individuals responsible for human rights violations arising from Article 16.

Secondly, the specific reference to medical attention for those who are sick would seem to suggest more attention to curative rather than preventive medical services. This provision is not as detailed as Article 12 (2) of the ICESCR and makes no reference to underlying determinants of health, such as, healthy environment, water and sanitation and prevention, treatment and control of epidemic. More importantly, Article 16 of the African Charter fails to address issues, such as, maternal and infant mortality, access to contraception and HIV/AIDS. In particular, these issues affect women more than men in Africa. Given that these are serious health issues that affect Africa more than other regions, it is a serious omission on the part of the drafters of the Charter, although one may argue that at the time the Charter was being finalised HIV/AIDS had not become a major challenge in the region. However, it is inexplicable that issues, such as, infant and maternal mortality, which have always posed great challenges in the region, were not addressed in the Charter. An alternative argument to this would be that the non-specific mention of these issues should not prevent a broad interpretation of Article 16 to include them. As discussed below, the Commission has made attempts to broadly interpret the provisions of Article 16 to cover some of the issues not directly mentioned.

It should be noted that Article 14 of the African Women's Protocol contains one of the most comprehensive provisions on the right to health and sexual and reproductive health under international human rights law. Article 14 provides as follows:

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

- a) the right to control their fertility;
- b) the right to decide whether to have children, the number of children and the spacing of children;
- c) the right to choose any method of contraception;
- d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
- e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
- f) the right to have family planning education.

More importantly and in language similar to that of General Comment 14, the African Women's Protocol enjoins states in Article 14 (2) to:

- a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
- b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
- c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

By these radical and detailed provisions, the African Women's Protocol has recorded a number of firsts under international human rights law.¹⁵ Undoubtedly, the provisions of the African Women's Protocol are more detailed than those of the African Charter and address more contemporary health challenges facing Africa. For the first time in any international human rights instrument, a woman's right to self-protection in the context of HIV is guaranteed. This is a very important provision that will go a long way to addressing women's vulnerability to the HIV pandemic. Studies have shown that the majority of those infected with HIV in Africa are women.¹⁶ Moreover, experience has shown that women's vulnerability to HIV/AIDS is as a result of acts of violence and their low status in society coupled with cultural and religious practices that discriminate against them.¹⁷

Also, Article 14 for the first time explicitly guarantees a woman's right to sexual and reproductive health, including the right to decide about her fertility, access to contraception services and the right to abortion on certain grounds. Unsafe abortion remains a great threat to the lives of many women in Africa. It is estimated that unsafe abortions constitute 13% of all maternal deaths.¹⁸ Discussions on abortion at

¹⁵ See Banda F "Blazing a trail: The African Protocol on Women's Rights comes into force" (2006) 50 *Journal of African Law* 72; see also Mukasa RS, *The African Women's Protocol: Harnessing a potential force for positive change* (2008) at 5.

¹⁶ UNAIDS, *AIDS Epidemic Report* (2012).

¹⁷ UNAIDS, UNFPA, UNIFEM, *Women and HIV/AIDS: Confronting the crisis* (2004).

¹⁸ WHO, *The World Health Report 2005 – make every mother and child count* (2005).

international, regional and national levels have always generated controversies. Even during the Beijing Platform of Action an attempt to recognise abortion as a human rights issue for women failed due to strong opposition by religious “fundamentalists”.¹⁹ It is, therefore, a major victory that the African Women’s Protocol recognises a woman’s rights to abortion, albeit on limited grounds. With this provision the African Women’s Protocol becomes a pacesetter at international law regarding an explicit recognition of abortion rights for women²⁰. It remains unclear how this right will be realised given that many African countries still apply restrictive abortion laws.²¹ Ngwena has argued that while the inclusion of a provision on abortion in the African Women’s Protocol deserves commendation, its half-hearted reform is not faithful to the overall aim of the Protocol to advance women’s rights.²² One hopes that in future the African Commission will adopt a purposive and progressive interpretation of the provisions of the African Women’s Protocol.

4 CHALLENGES TO THE REALISATION OF THE RIGHT TO HEALTH IN AFRICA

Africa is faced with different health challenges ranging from the devastating effects of the HIV/AIDS pandemic, high maternal mortality, and deaths resulting from tuberculosis, to repeated cases of malaria. Today, Africa remains the greatest burden-bearer of sexual and reproductive ill health. While the region accounts for about 15% of the world’s population, it is home to about 70% of the total number of people living with HIV worldwide. According to UNAIDS, about 23 million out of the 34 million people living with HIV worldwide are from Africa.²³ Moreover, the region accounted for about 70%(1.2 million) of the 1.7 million AIDS-related deaths in 2011. Worse still, a recent report by Save the Children indicates that ten of the worst places for a woman to give birth in the world are in Africa.²⁴ The maternal mortality rates in some countries, such as, Chad and Somalia, are about 1, 000 deaths to 100,000 live births.²⁵ Indeed, the odds of a woman dying during pregnancy or childbirth in Africa are 1 in 39 compared to 1 in 3,600 in a country such as Malta. In recent times, maternal death in the region has been exacerbated by the prevalence of HIV/AIDS. The maternal mortality situation in the region is so appalling that many of the countries in the region may not meet the Millennium Development Goals 5 target of reducing maternal deaths from 1990 rates by 75% by 2015.

¹⁹ See Grossman A *et al*, *Beijing betrayed* (2005).

²⁰ Ngwena C “Protocol to the African Charter on the Rights of Women: Implications for access to abortion at the regional level” (2010) 110 *International Journal of Gynaecology and Obstetrics* 163–166.

²¹ Ngwena (2010) at 165.

²² Ngwena C “Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa” (2010) 32 *Human Rights Quarterly* at 843.

²³ UNAIDS, *AIDS Epidemic Report* (2012).

²⁴ Save the Children, *State of the World’s Mothers Report* (2012).

²⁵ WHO, UNICEF and UNFPA, *Trends in Maternal Mortality: 1990 to 2010* (2010) at 14.

Furthermore, notwithstanding concerted efforts to address its menace, malaria remains a threat to lives in the region and deaths resulting from tuberculosis continue to increase by leaps and bounds. Several factors militate against the realisation of the right to health in Africa. These include lack of political will, weak health care systems, non-justiciability of the right to health at the national level, corruption, and a dearth of health care personnel. This article will only consider three of these: non-justiciability of the right to health, lack of political will and corruption. This does not in any way suggest that the other challenges are not important

4.1 Non-justiciability of the right to health

While almost all the member states (with the exception of South Sudan) of the African Union have ratified the African Charter, very few countries (including South Africa and Kenya) have explicitly recognised the right to health as legally enforceable in their national constitutions. This is particularly true for many African countries that are former colonies of Great Britain. Thus, in countries, such as, Ghana, Nigeria and Zambia, provisions relating to socio-economic rights are classified as mere directive principles of governmental policy. For instance, under the 1999 Constitution of Nigeria, provisions relating to socio-economic rights are found in Chapter II captioned “Directive Principles of Government’s Policies” which are not justiciable.²⁶ It should be noted that Nigeria has not only ratified the African Charter but has also incorporated it into domestic law; yet the realisation of the right to health in the country remains a great challenge. The classification of socio-economic rights including the right to health, as directive principles is often hinged on the argument of some scholars who claim that these rights are not amenable to judicial interpretation. Moreover, it has been argued that socio-economic rights, including the right to health, are positive rights that require substantial resources to ensure their implementation. According to Fuller, the adjudication of socio-economic rights is likely to raise polycentric problems. He describes polycentric problems as “situation[s] of interacting points of influence ‘which, when possibly relevant to adjudication, normally, although not invariably’, involve many affected parties and a somewhat fluid state of affairs.”²⁷

Furthermore, it has been argued that courts are not competent to adjudicate on socioeconomic rights since these rights often give rise to raising and spending of resources, a duty belonging to the legislature. In other words, adjudicating on socio-economic rights will undermine the doctrine of separation of powers. An opposing view is that the implementation of civil and political rights is not less expensive than socio-economic rights. For instance, the right to a fair hearing requires equipping the police system, building courts and recruiting competent judicial officers to dispense justice. All of this requires a substantial amount of resources. It is also argued that preventing the courts from scrutinising the actions of the executive or legislature may lead to abuse of

²⁶ See for instance, s 6 (6) of the Constitution.

²⁷ Fuller L ‘The forms and limits of adjudication’ (1978) 92 *Harvard Law Review* 353-409.

powers and undermine the doctrine of checks and balances.²⁸ The South African Constitutional Court in *Minister of Health Others v Treatment Action Campaign and Others* emphasises this point when it notes that courts have an important role to play in ensuring the realisation of the socioeconomic rights guaranteed under the South African Constitution.²⁹

4.2 Lack of political will

Today, Africa has continued to bear the burden of sexual and reproductive ill health. Moreover, the enjoyment of the right to health in many African countries has remained a pipe dream not because Africa lacks the human and natural resources to meet the health needs of its people but due to a lack of political will on the part of African leaders. While it is true that resources are required for the realisation of the right to health and that many of the least developed countries are found in Africa, the major challenge to meeting the health needs of Africans relates to lack of commitment on the part of African countries. Health challenges such as infant and maternal mortality, malaria and polio, can be addressed through cost-effective intervention programmes and strategies. For instance, improvement in primary health care services can go a long way to reducing maternal deaths and preventing other health challenges, such as, HIV/AIDS, tuberculosis or malaria. However, contrary to the Alma Alta Declaration,³⁰ many African countries have failed to give priority to primary health care services. More importantly, despite repeated promises to improve funding for the health sector, many African countries continue to spend too little on the health of their people.

Experience has shown that the average spending by an African country on the health needs of its people is poor compared to that of other regions. The WHO has considered 34 US dollars per person per year as the minimum to provide a population with basic health care. However, many African countries spend far below this figure. For instance, in Madagascar the per capita spending on health is about 24 US dollars, which is extremely low. Other countries, such as, Eritrea and Central African Republic, spend less at 8 and 11 US dollars per person per year, respectively, compared to 2439 US dollars by a country like San Marino.³¹ Since the Abuja Declaration over a decade ago when African governments agreed to commit at least 15% of their annual budgets allocations to the health sector, only few African countries have fulfilled this promise. Allocation to the health sector in some countries has remained stagnant, thereby aggravating the health situation in those countries.³² It is a known fact that many health care settings in Africa are grossly underfunded and health providers poorly

²⁸ See An-Na'im' A 'To affirm the full human rights standing of economic, social & cultural rights' in Ghai Y & Cottrell J (eds) *Economic, social and cultural rights in practice: The role of judges in implementing economic, social and cultural rights*(2004) at 7.

²⁹ 2000 11 BCLR 1169 [CC].

³⁰ International Conference on Primary Health Care, *Alma-Ata*, USSR, 6–12 September 1978.

³¹ The Guardian "Healthcare spending around the World: Country by country." Available at <http://www.theguardian.com/news/datablog/2012/jun/30/healthcare-spending-world-country> (accessed on 30 July 2013).

³² Niacker S *et al* 'Shortage of health care workers in developing countries – Africa' (2009) 19 *Ethnicity and Disease* 60.

remunerated. The appalling living conditions of health care providers often lead to strikes or sometimes a situation where health care providers migrate to wealthy countries in the North in search of the proverbial “greener pastures”. The consequence of this is the dearth of health care personnel that the region is currently experiencing. Nnamuchi has rightly observed that the poor state of health in many African countries is not necessarily due to resource constraints but rather can be attributed to other factors, particularly acts of kleptocracy on the part of African leaders.³³ The WHO has estimated a shortage of almost 4.3 million physicians, midwives, nurses and support workers worldwide.³⁴ It further notes that this shortage is most severe in 57 of the poorest countries, particularly in sub-Saharan Africa. Africa has 2.3 healthcare workers per 1000 population, compared with the Americas, which have 24.8 healthcare workers per 1000 population.³⁵ It has further been noted that only 1.3% of the world's health care workers care for people who experience 25% of the global disease burden. The WHO report attributes the uneven distribution of the health care workforce to a lack of investment in the health sector by most countries in Africa. For a region that is grappling with the devastating effects of the HIV/AIDS pandemic and other health challenges this is a worrisome development.

While the Committee on ESCR recognises the importance of availability of resources in realising the right to health, it has indicated the crucial point to note is whether a state is unable or unwilling to meet its obligations irrespective of its financial position. In essence, even with limited resources a state will be expected to adopt the most cost effective and targeted programmes that will meet the needs of vulnerable and marginalised groups in society. Unfortunately, this has not been the case with many African countries as many of them have continued to rely heavily on foreign donors to meet their obligations regarding the right to health.

4.3 Corruption and the right to health

Corruption exists in every society, however the range and scope differ. Recent reports by Transparency International would seem to suggest that more and more African countries are contending with the ‘epidemic’ known as corruption. According to Transparency International, corruption is the abuse of office for personal gain. Large scale official corruption has become a serious menace in Africa thereby posing threats to the enjoyment of socio-economic rights, including the right to health. Indeed, it has been argued that corruption not only undermines development, but is also a great threat to social wellbeing and the overall security of society.³⁶ Corruption in Africa wears different faces ranging from extortion by government officials, rigging of elections, embellishment, and inflation of contracts to pilfering of state resources. Hanson has noted that “corruption in Africa ranges from high-level political graft on the

³³ Nnamuchi O, “*Kleptocracy and its many faces: The challenges of justiciability of the right to health*”(2008) 52 *Journal of African Law* 36.

³⁴ WHO, *The World Health Report 2006: Working together for health* (2006) at 4.

³⁵ WHO (2006) at 4.

³⁶ Durojaye E “Corruption as a threat to human security in Africa” in Abass A *Protecting human security in Africa* (2010) 217.

scale of millions of dollars to low-level bribes to police officers or customs officials”.³⁷ Although political graft often imposes devastating financial cost on a country, the negative impact of petty bribes cannot be underestimated as they can have corrosive effects on the basic institutions and undermine public trust in the government. Oftentimes, Africans have had to pay bribes for services that were otherwise meant to be free to the public. A 2009 East Africa Bribery Index compiled by Transparency International shows that over half of East Africans polled admitted to having paid bribes to access public services that would have been otherwise freely available.³⁸

Experience has shown that in many African countries resources meant for the social development and wellbeing of the people are either misappropriated or stolen by government officials, thereby contributing to poor infrastructure and decay in the health care setting. A report has shown that in countries where corruption is rampant, the poor and people who live in the rural areas tend to experience longer waiting hours in public hospitals or even accessing medical attention.³⁹ More importantly, it has been shown that health care providers in Zimbabwe and Rwanda often request unauthorized fees from women seeking medical attention in public hospitals.⁴⁰ In another study conducted in Nigeria, it has been shown that health care providers often extort patients, particularly female patients, seeking medical attention in hospitals.⁴¹ This sometime impedes access to health care services by women, thereby resulting in a breach of their obligations on the part of these states. The obligation to protect the right to health implies that government must take the necessary steps to ensure that the actions of a third party do not interfere with the enjoyment of the right. Thus, failure of a state to address endemic corrupt practices in the health sector, particularly among health care providers, will result in a breach of the obligations to realise the right to health.

Furthermore, reports have shown that funds made available by the Global Fund to address the impact of HIV/AIDS in some African countries have been misappropriated. For instance, the Global Fund was forced to suspend funds to Nigeria over allegations of embezzlement and mismanagement of earlier funds made available to the country.⁴² Also, it has been reported in Mali that Global Fund money of about 4 million US dollars was misappropriated. Half of the money meant to address tuberculosis and malaria was supposedly used for “training events”.⁴³ Several arrests

³⁷ Hanson S “Corruption in Sub-Saharan Africa.” Available at <http://www.cfr.org/democracy-and-human-rights/corruption-sub-saharan-africa/p19984> (accessed on 27 October 2013).

³⁸ Transparency International 2009 available at http://www.transparency.org/news_room/latest_news/press_releases_nc/2009/2009_07_02_kenya_index (accessed on 26 October 2013).

³⁹ Transparency International (2009).

⁴⁰ Center for Reproductive Rights, *Briefing paper: Surviving pregnancy and childbirth: An International Human Right* (2005).

⁴¹ Center for Reproductive Rights and Women Advocate Research and Documentation (WARDC), *Broken promises: Human rights, accountability and maternal death in Nigeria* (2008).

⁴² See Averting HIV and AIDS (AVERT) “Global Fund to Fight AIDS, Tuberculosis and Malaria.” Available at <http://www.avert.org/global-fund.htm> (accessed on 23 October 2012).

⁴³ See Rivers B “Africa: Corruption by Global Fund implementers.” Available at <http://allafrica.com/stories/201101280926.html> (accessed on 13 June 2013).

were made regarding this act of corruption. In the end the Global Fund terminated one of the grants to the country and suspended others.

Unfortunately, in most parts of Africa, the institutions established to deal with corruption are either too weak or ineffective. Thus, in most cases persons guilty of corrupt practices are seldom prosecuted or punished for their transgressions. This tends to create an atmosphere of impunity and invariably fuels large-scale corruption in many countries in the region. The obligation to fulfil the right to health in the context of corruption implies that states must take positive steps, including administrative, legal, judicial and budgetary ones, to ensure the enjoyment of the right to health. This will require a state to enact appropriate laws and establish institutions or bodies to deal with corruption in general. It will also require a state to ensure that those guilty of corrupt practices are appropriately dealt with. A government will be in breach of the obligation to fulfil the right to health if money earmarked for the procurement or supply of essential medicines, such as, medicines for HIV/AIDS or for tuberculosis, has been embezzled or unaccounted for by government officials. Given challenges discussed above to the realisation of the right to health in Africa, the African Commission can become a catalyst for advancing this right by developing a rich jurisprudence on this area.

5 THE AFRICAN COMMISSION JURISPRUDENCE ON THE RIGHT TO HEALTH

It is important to note that in the 25 years' existence of the African Commission few cases that directly or indirectly touch on the right to health have been dealt with by it. However, from the few cases that the Commission has considered it would seem that the Commission has adopted two approaches- indivisibility and underlying determinants- to interpreting the right to health provisions in the African Charter. This section of the article discusses some of these cases and their relevance for advancing the right to health in the region.

5.1 Indivisibility approach

During the Vienna Program of Action the international community resolved that all human rights-civil, political and socio-economic – are universal, interrelated, interdependent and indivisible.⁴⁴ The indivisibility approach to human rights became necessary due to the artificial classification of rights as first generation and second generation. This unnecessary classifications of rights accords first generation rights (civil and political rights) more importance than second generation rights (socio-economic rights). As noted earlier, proponents of this artificial classification tend to argue that civil and political rights are negative rights that do not require much resources to accomplish whereas socio-economic rights are positive rights that require a considerable amount of resources to be realised.⁴⁵ However, as noted above, this

⁴⁴ Vienna Programme of Action UN Doc A/CONF 157/24 Part 1 ch III.

⁴⁵ See for instance, Lester L & O'Conneide C "The effective protection of social-economic rights" in Ghai and Cottrell (2004) at 19; see also, Fuller LL "The forms and limits of adjudication" (1978) 92 *Harvard Law Review* 353 - 409. See, however, contrasting arguments by Scott C & Macklem P "Constitutional ropes

argument would seem untenable and unconvincing since the realisation of civil and political rights, especially free and fair elections and fair hearings, require a substantial amount of resources to achieve. Responding to this issue, the South African Constitutional Court in *In re Certification of the Constitution of the Republic of South Africa*,⁴⁶ notes as follows:

It is true that the inclusion of socio-economic rights may result in Courts making orders which have direct implications for budgetary matters. However, even where a court enforces civil and political rights such as equality, freedom of speech and the right to a fair trial, the order it makes will often have such implications . . . In our view, it cannot be said that by including socio-economic rights within a bill of rights, a task is conferred upon the Courts so different from that ordinarily conferred upon them by a bill of rights that it results in a breach of the separation of powers . . . The fact that socio-economic rights will almost inevitably give rise to [budgetary] implications does not seem to us to be a bar to their justiciability. At the very minimum, socio-economic rights can be negatively protected from improper invasion.

The first case the African Commission dealt with relating to the right to health is the celebrated case of *Social Economic Rights Action Centre and another v Nigeria*.⁴⁷ In that case, the applicants on behalf of the people of Ogoniland brought an action against the government of Nigeria for various human rights violations occasioned by the activities of the oil companies in the Niger Delta area. The applicants alleged that oil pollution had occurred due to exploration activities carried out by multinational oil companies in the Niger Delta area. It was further alleged that the Nigerian government has implicitly condoned the violation of rights in Ogoniland by failing to require the oil companies to produce health and environment impact assessment reports. This in turn posed a serious danger to the health and wellbeing of the people. Therefore, the applicants alleged violations of different rights including the rights to life, health, healthy environment and non-discrimination. In adopting the indivisibility approach in the case, the African Commission found that the Nigerian government was in violation of Articles 4 (right to life), 16 (right to health), and 24 (right of peoples to a satisfactory environment), amongst others. The Commission held that the right to enjoy the best attainable state of physical and mental health enunciated in Article 16 (1) of the African Charter and the right to a general satisfactory environment favourable to development obligate governments to desist from directly threatening the health and environment of their citizens. Affirming the indivisibility approach, the Commission notes as follows:

Internationally accepted ideas of the various obligations engendered by human rights indicate that all rights-both civil and political rights and social and economic-generate at least four levels of duties for a State that undertakes to adhere to a rights regime, namely the duty to respect, protect, promote, and fulfil these rights. These obligations universally apply to all rights and entail a combination of negative and positive duties. As a human rights instrument, the African Charter is not alien to these concepts and the order in which they are dealt with here is chosen as a matter of convenience and in no way should it imply the priority accorded to them.⁴⁸

of sand or justiciable guarantees? Social rights in a new South African Constitution" (1992) 141 *University Pennsylvania Law Review* 1.

⁴⁶ *In Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa*, 1996 (4) SA 744 (CC) (1996).

⁴⁷ (2001) AHRLR 60 (ACHPR 2001).

⁴⁸ *Social Economic Rights Action Centre and another v Nigeria* para 44.

Interestingly and despite the fact that the right to housing is not specifically guaranteed under the Charter, the Commission explains that the wanton destruction of the property and housing of the Ogoni people would constitute a violation of the right to housing. In justifying this, the Commission read the right to housing into Article 16 on the right to the highest attainable standard of health.

Sadly, however, the Commission fails to clearly expound on the nature of obligations imposed on states by Article 16 of the African Charter. Rather, the Commission was more interested in assessing the nature of obligations imposed on a state to ensure a clean environment. While it is noted that the right to a clean environment is a component of the right to health, it is not a tidy approach to treat the right to healthy environment as if it is the same as the right to health. In essence, the right to environment is not synonymous with the right to health as the latter is broader than the former. These differences were not clearly explained by the Commission in the case.

In another case involving Nigeria, the Commission has held that failure of the Nigerian government to provide medical attention for a prisoner in its custody constitutes a violation of the rights to health and life guaranteed under the Charter.⁴⁹ The Commission explains further as follows:

The responsibility of the government is heightened in cases where an individual is in its custody and therefore someone whose integrity and well-being is completely dependent on the actions of the authorities. The state has a direct responsibility in this case. Despite requests for hospital treatment made by a qualified prison doctor, these were denied to Ken SaroWiwa, causing his health to suffer to the point his life was endangered ... This is a violation of article 16.⁵⁰

Also, in *Purohit and others v The Gambia*, the Commission has explained that the right to health includes access to health facilities, goods and services on a non-discriminatory basis and that denial of medical attention to people suffering from mental disability will violate the non-discrimination provision of the African Charter.⁵¹ In that case the complainants were mental health advocates, who submitted the communication on behalf of patients detained at a psychiatric unit in The Gambia, under the Mental Health Act of the Republic of The Gambia. They alleged that there were no review or appeal procedures against a determination or certification of one's mental state for both involuntary and voluntary mental patients under the Lunatics Detention Act (LDA) and no remedy for wrong certification/diagnosis. They, therefore, alleged a violation of Article 16 of the Charter. The Commission reasoned that the right to health is vital to all aspects of a person's life and wellbeing, and is crucial to the realisation of all the other fundamental human rights. It further reasoned that the right to health includes "the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind".⁵²

⁴⁹ *International Pen and Others (On behalf of Ken SaroWiwa) v Nigeria* (2000) AHLR 212 (ACHPR 1998).

⁵⁰ *International Pen and Others (On behalf of Ken SaroWiwa) v Nigeria* at para 5.

⁵¹ (2003) AHRLR 96 (ACHPR 2003).

⁵² *Purohit and others v The Gambia* para 80

This is no doubt a purposive interpretation of the right to health, which coincides with recent developments in international human rights law. For instance, the Committee on ESCR in General Comment 14 has noted that the enjoyment of the right to health is dependent on other rights, such as, the rights to life, privacy, dignity, and non-discrimination.⁵³ Similarly, the Human Rights Committee in its General Comment 6 has observed that the right to life guaranteed in Article 6 of the ICCPR should not be construed narrowly but should be given a broad interpretation to include medical services and maternal health.⁵⁴ Leary has noted that any discussion in relation to the right to health must take into account the fundamental principles of human rights, such as dignity, non-discrimination, participation and justice, since they are relevant to issues of health care and health status.⁵⁵

Some decisions of the European Court of Human Rights have tended to support this position. For instance, in *Tavares v France*,⁵⁶ the European Commission was asked to consider whether pregnancy related death would amount to a violation of the right to life guaranteed under the European Convention of Human Rights. A pregnant woman brought a complaint against France alleging that negligence resulted in the loss of her pregnancy. The Commission noted that the right to life does not only impose a negative obligation on states but also a positive obligation to prevent the loss of lives. It further explained that no evidence of negligence was found and that France could have been liable for the loss of pregnancy if negligence had been established.

Also, in *D v United Kingdom*⁵⁷ the European Court of Human Rights held that a forcible deportation of a person living with HIV to another country where access to health care services could not be guaranteed amounted to inhuman, degrading treatment and a violation of the right to dignity as guaranteed in Article 3 of the European Convention. Furthermore, in *Geurra v Italy*⁵⁸ the European Court has found that a state has a positive obligation under Article 8 on the right to family life to protect peoples' homes from smells and nuisance from a waste treatment plant, toxic emissions emanating from a chemical factory, environmental pollution from a steel plant, and noise from bars and nightclubs which made it impossible for local residents to sleep in their homes.

It should be noted that the reading of the right to health into other rights by the European Court of Human Rights is informed by the fact that the right to health is not explicitly guaranteed as an enforceable right under the European Convention. In contrast, Article 16 of the African Charter specifically guarantees the right to health. Therefore, the African Commission should not form the habit of always reading the right to health into other rights. While there might be occasions where the interpretation of

⁵³ The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment 14 para 12.

⁵⁴ The Right to Life UN GAOR Human Rights Committee 37th session Supp No 40.

⁵⁵ Leary V "The right to health in international human rights law" (1994)1(1) *Health and Human Rights* 27

⁵⁶ *Tavares v France* App. No. 16593/90 Euro. Comm. HR.

⁵⁷ *D v United Kingdom* (1997) 24 EHRR 423 (European Court of Human Rights).

⁵⁸ (1998) EHRR 357.

the right to health will intersect with other rights, the proper approach for the Commission is to explore and develop jurisprudence on the content and nature of Article 16 of the Charter. In essence, where the Commission is called upon to determine a case that specifically relates to the right to health, detailed and nuanced analysis of Article 16 should be the starting point and where necessary the Commission can make a link to other rights.

The indivisibility approach has also been adopted by the Inter-American Court of Human Rights. For instance, it held that the government of Guatemala was responsible for loss of life arising from shabby treatment meted out to street children, In arriving at its decision the Court noted as follows;

The fundamental right to life includes not only the right of every human being not to be deprived of his/her life arbitrarily but also the right that he/she will not be prevented from having access to conditions that guarantee a dignified existence.⁵⁹

Some national courts have adopted a similar approach. For instance, the Indian Supreme Court has held that a denial of emergency treatment to a patient by a public hospital constitutes a violation of the right to life guaranteed under Article 21 of the Indian Constitution. Equally, the Supreme Court in Costa Rica has held that a denial of access to life-saving medication for people infected with HIV impugns their right to life.⁶⁰

The significance of this approach is that it allows the African Commission to infer violations of important civil and political rights from the violation of the right to health. This can be very useful in advancing human rights, particularly in some African countries where the right to health is not regarded as legally enforceable. For instance, in the Nigerian case of *Festus Odafe and another v Attorney General of the Federation and another*, a Federal High Court held that denial of medical care to four HIV positive prisoners was not only contrary to the African Charter but also amounted to inhuman and degrading treatment contrary to section 34 of the Nigerian Constitution 1999 (as amended).⁶¹

5.2 The underlying determinants of a health approach

As noted earlier, while Article 12 (2) of the ICESCR recognises the importance of the underlying determinants of health to the enjoyment of the right to health, Article 16 of the African Charter does not contain a similar provision. Similar to Article 12 of the ICESCR, Article 24 (c) of the CRC provides that the right to health includes access to nutritious food, clean drinking water, and environmental sanitation. The Committee on

⁵⁹ *VillagranMarales et al v Guatemala* Series C No 65 19 November 1999 para 144: See also *The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria* Communication 155/96 decided at the African Commission's Ordinary Session held from 1 to 27 October 2001; similarly see the Indian Supreme Court decision in *PachimBangaKhetMajoorSamity v State of West Bengal* [1996] AIR SC 2426.

⁶⁰ *Alvarez v CajaCostarricense de Seguro Social Exp 5778-V-97 No 5934-97* cited by Yamin AE in "Not just a tragedy: Access to medication as a right under international law" (2003) 21 *Boston University International Law Journal* at 326.

⁶¹ (2004) AHRLR 205 (NgHC 2004).

ESCR in its General Comment 14 has explained that the right to health is an inclusive right limited not only to timely and appropriate health care but including underlying determinants of health, such as, safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health related education and information.⁶² More importantly, as mentioned earlier, the Committee has noted that the minimum core obligations of states in relation to this right include ensuring access to sanitation, potable and safe water, primary health care services, food and essential medicines.⁶³

Furthermore, the Committee has explained that patterns of health and ill health are shaped by discrimination, poverty, and exclusion, and that both biological and socio-cultural factors play a significant role in influencing health.⁶⁴ Also, the former Special Rapporteur on the right to health, Paul Hunt, has made the link between underlying determinants of health and the enjoyment of the right to health.⁶⁵ In another report he has observed that an effective and integrated health system, encompassing health care and the underlying determinants of health, is central to the enjoyment of the right to health.⁶⁶

The African Commission has attempted to adopt this approach in a number of cases. For instance, in the *Free Legal Assistance Group* case,⁶⁷ the Commission noted that the failure of the Government to provide basic services, such as, safe drinking water and electricity, and the shortage of medicine amounts to a violation of Article 16. This approach is crucial to alleviating the plight of vulnerable and marginalised groups. In particular, the approach has the potential of meeting the needs of those living in extreme poverty. It is a known fact that in many parts of Africa a significant number of people lack access to basic amenities and services, such as, water, electricity and sanitation that are essential for their daily existence.⁶⁸ Therefore, interpreting the right to health to intersect with underlying determinants of health would seem to “give life” to the meaning of the right to health. It can also be argued that this approach leans towards a substantive equality approach to enjoying rights since it addresses the needs of the vulnerable and marginalised groups.

⁶² The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment 14 para 43.

⁶³ The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment 14 para 43.

⁶⁴ The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment 14 paras 18 & 20.

⁶⁵ Hunt P (UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health) “The right of everyone to the enjoyment of the highest attainable standard of physical and mental health” UN Doc. No. A/62/214 (2007) paras 45-49.

⁶⁶ Hunt P (UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health), “Promotion and protection of all human rights, civil, political, economic, social and cultural rights” UN Doc. No. A/HRC/7/11 (2008) para 15

⁶⁷ *Free Legal Assistance Group and Others v Zaire* (2000) AHRLR 74 (ACHPR 1995).

⁶⁸ Millennium Development Goals Report (2011).

Also, in *Sudan Human Rights Organization and Another v Sudan*,⁶⁹ the Commission noted that the right to health extends not only to timely and appropriate health care services but also to the underlying determinants of health, such as, access to safe and portable water, an adequate supply of safe food, and nutrition. This is a bold step by the Commission that deserves commendation. Rarely has the link been made between the right to health and the underlying determinants of health. Indeed, a 2008 report by the WHO focusing on the social determinants of health fails to make the crucial link between the right to health and underlying or social determinants of health.⁷⁰ This has attracted criticism from commentators who view the failure to make the linkages as a missed opportunity.⁷¹ However, the report does contain important revelations about how socio-cultural factors influence people's health. For instance, the report notes that "the poorest of the poor have high levels of illness and premature mortality...health and illness follow a social gradient: the lower the socio-economic position, the worse the health".⁷²

Undoubtedly, this broad and comprehensive approach to interpreting the right to health has great merit in a region like Africa where several factors, including poor social determinants of health, contribute to ill health. Chapman has noted that the underlying determinants of health are almost indispensable for the enjoyment of good health and as such policy makers must place emphasis on them.⁷³ She further argues that "social and economic policies that invest in the social determinants of health as something far more than the traditional narrow focus on health systems constitute a more promising health policy approach".⁷⁴ According to her, if the goal of the right to health is to improve health status of vulnerable and marginalised groups in a society, then greater emphasis should be placed on the underlying determinants of health.

The "underlying determinants of health approach" adopted by the Commission is commendable and provides an opportunity for national courts in the region to emulate it. National courts may inquire into the sufficiency of underlying determinants of health and how this may interfere with the enjoyment of the right to health. Moreover, courts can hold governments accountable for failing to make the link between the underlying determinants of health and the enjoyment of the right to health. In the *Beja* case,⁷⁵ for instance, the South African High Court held that the failure of the South African government to provide safe and comfortable sanitation amounted to a violation of the rights to dignity and housing of the people. The Court noted that the right to adequate

⁶⁹ *Sudan Human Rights Organisation and Another v Sudan* (2009) AHRLR 153 (ACHPR 2009) (*Darfur* case) paras 205, 212, 216 & 223.

⁷⁰ WHO Commission on Social Determinants of Health (CSDH), *Closing the gap in a generation: Health equity through action on the social determinants of health: Final report of the Commission on Social Determinants of Health* (2008).

⁷¹ See for instance, Hunt P "Missed opportunities: Human rights and the Commission on Social Determinants of Health" *Global Health Promotion* (2009) 16/1 Supp at 36.

⁷² WHO Commission on Social Determinants of Health 2008 at vi.

⁷³ Chapman A "The social determinants of health, equity and human rights" (2010) 12 *Health and Human Rights* 17 at 19

⁷⁴ Chapman (2010) at 21.

⁷⁵ *Beja and Others v Premier of the Western Cape and Others* (21332/10) [2011] ZAWCHC 97.

housing as guaranteed under section 26 of the South African Constitution means more than “bricks and mortar” and includes the provision of social services, such as, safe and clean water, decent sanitation, and health care. In essence, the Court in *Beja* would seem to imply that the right to housing cannot be enjoyed in isolation of other underlying determinants, such as, water, sanitation, good roads and electricity. This decision is faithful to the underlying determinants approach. Although the *Beja* case deals with the right to housing, the reasoning of the Court in the case can be applied to a case dealing with the right to health.

While the two approaches adopted by the African Commission to interpreting the right to health are useful in advancing the right in the region, they are not without limitations. First as pointed out earlier the indivisibility approach should be applied with caution given the express recognition of the right to health in the African Charter and the African Women’s Protocol. Secondly, the underlying determinants of health approach may not appear as simple as it seems in terms of explicitly holding African governments accountable for a breach of obligations as regards the right to health.

Some lessons can be learnt from the jurisprudence of the South African Constitutional Court with regard to the reasonableness test in socio-economic rights cases. In some of its landmark cases on socio-economic rights, the Constitutional Court has tended to scrutinise government’s laws and policies through the lens of the reasonableness test. For instance, in the *Grootboom* case the Constitutional Court found that laws, policies and programmes adopted by the government in relation to access to housing did not respond to those in desperate need and as such fell short of the reasonableness test. The Court further noted that for laws and policies to be reasonable they must address the needs of those that are vulnerable and disadvantaged in society.

This was reiterated in *Minister of Health and Others v Treatment Action Campaign and Others*⁷⁶ where the Constitutional Court held it to be unreasonable government policy to limit Nevirapine to few a public hospitals on account of its inefficacy and lack of capacity to properly manage the prevention of mother-to-child transmission of HIV programme. According to the Court, these excuses were untenable and tended to undermine the constitutional right to health of HIV pregnant women and their unborn babies.⁷⁷ While the Court observed that the constitutional obligations to achieve the right to health should be progressively realised, it nonetheless reasoned that policies that fail to address the urgent need of vulnerable and marginalised groups in society cannot be said to be reasonable.⁷⁸ This approach of the South African Constitutional Court can be useful to the African Commission in assessing states’ obligations in relation to the right to health under the African human rights system. In interpreting Article 16 of the African Charter or 14 of the African Women’s Protocol, the Commission may inquire into the reasonableness of laws, policies and strategies adopted by African governments to address major health challenges facing them. An important advantage of this approach is that it tends to obviate the excuse of a lack of resources often raised

⁷⁶ 2000 11 BCLR 1169 [CC].

⁷⁷ *Treatment Action Campaign* case para 106.

⁷⁸ *Treatment Action Campaign* case para 107.

by African countries regarding their obligations to realise socioeconomic rights in general and the right to health in particular. The reasonableness approach aims to assess the reasonableness of steps or measures adopted by a state irrespective of its financial position. In essence, the focus is not so much on the amount of resources available to a state but rather on how reasonable are the steps and measures taken by it within its available resources. This would seem to coincide with the reasoning of the Committee on ESCR. For instance, the Committee in its General Comment 14 has noted that even where a state raises the issue of a lack of resources, it must still be seen to be taking positive and targeted steps and not retrogressive steps, towards realising the right to health.⁷⁹

6 RESOLUTIONS/GENERAL COMMENT OF THE AFRICAN COMMISSION

In addition to the two approaches discussed above, the African Commission through its promotional mandate as stipulated in Article 45 of the African Charter has adopted important resolutions and a General Comment clarifying the content and nature of the right to health guaranteed in the African Charter. For example, the Commission has adopted a resolution calling on African governments to adopt a human rights-based approach to addressing the impact of HIV/AIDS in the region. According to the Commission, it is imperative that all efforts adopted by African governments towards curbing the spread of HIV must be respectful of individuals' human rights.⁸⁰

Also, the Commission in its resolution on access to medicines urges African governments to ensure the availability, accessibility, acceptability and quality of access to medicines for all.⁸¹ More importantly, the Commission reminds African governments of their obligations to respect, protect and fulfil the right to health in the context of access to medicines.⁸² The Commission particularly emphasises that African governments must refrain from "implementing intellectual property policies that do not take full advantage of all flexibilities in the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)⁸³ that promote access to affordable medicines, including 'TRIPS-Plus' trade agreement".⁸⁴

The Commission's resolution on maternal mortality⁸⁵ noted that African leaders were not doing enough to address the issue of high maternal mortality and morbidity in their respective countries. It is noted that maternal deaths and morbidity in Africa have

⁷⁹ The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment 14.

⁸⁰ Resolution on the HIV/AIDS Pandemic –Threat against Human Rights and Humanity adopted at the 29th Ordinary Session of the African Commission held in Tripoli, Libya ACHPR Res.53/(XXIX)01.

⁸¹ ACHPR/Res.141 (XXXXIII) 08: Resolution on Access to Health and needed Medicines in Africa.

⁸² ACHPR/Res.141 (XXXXIII) 08: Resolution on Access to Health and needed Medicines in Africa

⁸³ The TRIPS Agreement was part of the Final Act establishing the WTO and commonly referred to as the 'Marrakech Agreement' attached as Annex 1C to the WTO Agreement. While it may be argued that most African countries lack the manufacturing capacity to produce life-saving medications, opportunities exist under the safeguard provisions of the TRIPS Agreement, which can be explored by African governments to facilitate access to medicines for their citizens if there really is the political will.

⁸⁴ ACHPR/Res.141 (XXXXIII) 08: Resolution on Access to Health and needed Medicines in Africa

⁸⁵ ACHPR/Res.135 (XXXXIII).08: Resolution on Maternal Mortality in Africa.

shown no sign of abating after several years, as Africa still accounts for more than 250000 deaths annually resulting from pregnancy-related complications. Africa has continued to bear the largest burden of maternal deaths and injuries in the world with many African countries listed among those that have not made appreciable effort to address maternal mortality.⁸⁶ Worried by this situation, the Commission urges that maternal mortality should be declared a state of emergency in Africa.

More recently and for the first time in the history of the Commission, a General Comment on Article 14(1)(d) and (e) of the African Women's Protocol was adopted in October 2012 during the 52nd Ordinary Session of the Commission. The General Comment explains that women and young girls are disproportionately affected by HIV due to a number of factors including multiple forms of discrimination based on various grounds, such as: race, sex, sexuality, sexual orientation, age, pregnancy, marital status, HIV status, and social and economic status. The Commission recognises that "women in Africa have the right to the highest attainable standard of health, which includes sexual and reproductive health and rights".⁸⁷ It further notes that due to the high prevalence and significant risk of HIV exposure and transmission, women are unable to fully enjoy these rights. While noting that Article 14(1)(d) distinguishes between the right to self-protection and to be protected from HIV, the Commission interpreted this provision to refer to overall obligation of "States" to create an enabling, supportive, legal and social environment that empowers women to be in a position to fully and freely realise their right to self-protection and to be protected."⁸⁸

Explaining the importance of Article 14(1)(e), the Commission reasons that "[t]he right to be informed on one's health status includes the rights of women to access adequate, reliable, non-discriminatory and comprehensive information about their health."⁸⁹ The Commission notes that the right to be informed of one's status includes pre-test counselling which enables women to make a decision based on informed consent, as well as post-test counselling on preventative measures or available treatment depending on the outcome of the HIV test. According to the Commission, the right to be informed of one's status applies to all women including young women. The Commission notes that Articles 14(1)(d) and (e) impose obligations on states to respect, protect, promote and fulfil women's rights in the context of HIV.

This is perhaps one of the few occasions when the Commission has attempted to provide a comprehensive interpretative guide to a right. The General Comment is modelled on General Comments or Recommendations by the UN treaty monitoring bodies. It is hoped that this important document will be made known to states parties and non-governmental organisations working on issues affecting women's rights in Africa. More importantly, it is hoped that national courts will use this General Comment

⁸⁶ WHO, UNICEF, UNFPA and World Bank *Maternal mortality in 2005* (2007) at 18.

⁸⁷ General Comment on Art 14 (1)(d) and (e) of the Protocol to the African Charter on the Rights of Women para 5.

⁸⁸ General Comment on Article 14(1)(d) and (e) of the Protocol to the African Charter on the Rights of Women at para 10.

⁸⁹ General Comment on Article 14(1)(d) and (e) of the Protocol to the African Charter on the Rights of Women at para 13.

as an interpretative guide in cases involving women's right to health in the region. One of the ways in which the African Commission can ensure compliance with the General Comment is by requiring states to indicate in their periodic reports the steps and measures they have taken to implement the provisions of Articles 14(1)(d) and(e) of the African Women's Protocol.

It should also be noted that the Commission has adopted Principles and Guidelines on the Implementation of Socio-economic Rights guaranteed under the Charter.⁹⁰ The Principles and Guidelines contain a broad interpretation of the right to health in a manner similar to General Comment 14 of the Committee on ESCR. The Commission explains that African states must ensure availability, accessibility, acceptability and quality health care services to all, giving special attention to the needs of vulnerable and marginalised groups.

7 CONCLUSION

The African Commission has come a long way in advancing human rights in Africa since its inception about 25 years ago. In particular, the African Commission has made great strides regarding the advancement of socio-economic rights, particularly the right to health. While it is noted that very few communications have focused on the right to health, the Commission has adopted two approaches – indivisibility and underlying determinants - to the interpretation of this right in its jurisprudence. This article has discussed the benefits and importance of these approaches as they are capable of advancing the rights of vulnerable and marginalised groups in the region. However, the article has cautioned that in interpreting the provisions of Article 16 on the right to health, these two approaches should not be the starting point. Rather, the Commission should always endeavour to provide guidance on the nature of obligations imposed on states by Article 16 and may adopt the indivisibility and underlying determinants approaches as supplementary interpretative guides. In particular, the article proposes that the African Commission can learn from the reasonableness test approach of the South African Constitutional Court. This approach may serve as an effective accountability mechanism in assessing the commitment of a state towards meeting its obligations under the African Charter. The question to be asked is not how much resources are available to a state but how reasonable are the steps and measures taken by it to fulfil its right to health obligations.

⁹⁰ Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights (African Commission Principles and Guidelines), adopted in 2010 and formally launched in 2011; at para 78. Available at <http://www.escri-net.org/docs/i/1599552> (accessed 23 December 2013).

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