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## An analysis of the contribution of the African human rights system to the understanding of the right to health

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**Summary:** *The right to health is one of the important rights guaranteed in international and regional human rights instruments. Over the years the content and nature of this right have evolved through the works of scholars and clarifications provided by human rights treaty bodies. Focusing on the work of the African Commission on Human and Peoples' Rights, this article assesses the contributions of the African human rights system towards the advancement of the right to health. It outlines some of the major achievements in terms of normative framework as exemplified by the provisions of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, the African Youth Charter and the Protocol to the African Charter on the Rights of Older Persons. In addition, it highlights the clarifications provided by the African Commission charged with interpreting the African Charter on Human and Peoples' Rights and the African Women's Protocol. These include the adoption of resolutions, General Comments, guidelines and important decisions which provide a nuanced understanding of the right to health in the African context. The article identifies challenges militating against the full enjoyment of the right to health, including sexual and reproductive health in the region, such as the slow ratification of important human rights instruments, the lack of political will for law*

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*reforms, the failure to timeously submit state reports and interference with the work of the African Commission. The article concludes by calling on African governments to exhibit political will in ensuring the effective implementation of the right to health at the national level.*

**Key words:** *right to health; African human rights system; sexual and reproductive health and rights; African Commission on Human and Peoples' Rights*

## 1 Introduction

It is my aspiration that health finally will be seen not as a blessing to be wished for, but as a human right to be fought for.

Kofi Annan<sup>1</sup>

The right to the highest attainable standard of physical and mental health, often regarded as the 'right to health', is one of the important rights recognised under international law. It is guaranteed in most international, regional and national documents. It was first recognised in article 55 of the UN Charter where it was noted that the international community shall promote a higher standard of living, including health.<sup>2</sup> Since that time the right has evolved and has been given clarifications under international law.<sup>3</sup> It is not in doubt that the right is no longer mere wishful thinking but has become binding on states. The enjoyment of the right to health is crucial in realising other rights and in ensuring the well-being of individuals. Without good health, human beings are unable to function and perform their daily chores. In many parts of the world, millions of people struggle to live a dignified life, lack access to healthcare services, including life-saving medications, and contend with negative attitudes on the part of healthcare providers. The outbreak of pandemics such as Ebola, bird flu, SARS and COVID-19 is a reminder that we are all vulnerable and that there is a need to take a more holistic approach to preventing and treating diseases.<sup>4</sup> The disparity between wealthy and poor nations often contributes to challenges relating to the realisation of the right to health in

1 WHO *25 questions and answers on health and human rights* (2002).

2 United Nations *Charter of the United Nations*, 24 October 1945, 1 UNTS XVI.

3 See eg UN Committee on Economic, Social and Cultural Rights (ESCR Committee) General Comment 14: The Right to the Highest Attainable Standard of Health (Art 12 of the Covenant) 11 August 2000, E/C12/2000/4.

4 See E Durojaye 'Between a rock and a hard place: (Un)balancing the public health interventions and human rights protection in the COVID 19 era in South Africa' (2021) *International Journal of Human Rights*, <https://doi.org/10.1080/13642987.2021.1926238> (accessed 26 October 2021).

developing countries. Africa would seem to have been worst affected by this development.<sup>5</sup> This manifests in various ways, including in the high maternal mortality rates; the prevalence of HIV; high rates of unsafe abortion and sexually-transmitted infections; and a high rate of mortality associated with non-communicable diseases. Africa remains one of the most unsafe places to give birth and access to health goods and services remains difficult.<sup>6</sup> This makes it imperative to address these challenges from a rights-based perspective.

While over the years the norms relating to the right to health have originated from the UN treaty-monitoring bodies, in recent times the African human rights system has made important contributions to our understanding of the right to health, including sexual and reproductive health and rights.<sup>7</sup> However, these contributions are hardly acknowledged at international law and sometimes completely ignored.

Against this backdrop, focusing on the work of the African Commission on Human and Peoples' Rights (African Commission), this article assesses the contributions of the African human rights system towards the advancement of the right to health. It outlines some of the major achievements in terms of normative framework and the clarifications provided by the African Commission – charged with interpreting the African Charter on Human and Peoples' Rights (African Charter) – and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol). It also points out some of the challenges militating against the full enjoyment of the right to health, including sexual and reproductive health in the region. It concludes by offering some recommendations for the way forward.

## 2 Normative framework

After World War II and the horrendous killings and human rights abuses perpetrated by the Germans, the international community rallied to form the United Nations (UN) in 1945. The primary concern of the UN Charter was to ensure the promotion and protection of human rights by all member states to the body.<sup>8</sup> In furtherance of this, article 55 of the Charter provides that states should strive towards ensuring

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5 L Forman 'The evolution of the right to health in the shadow of COVID-19' (2020) 22 *Health and Human Rights* 375.

6 WHO et al *Trends in maternal mortality: 2000 to 2017: Estimates* (2019).

7 See E Durojaye et al (eds) *Advancing sexual and reproductive health and rights in Africa: Constraints and opportunities* (2021) 5-9.

8 As above.

availability of health for all.<sup>9</sup> In 1946 the World Health Organisation (WHO) in the Preamble to its constitution noted that health is a fundamental right of all and defines health as the 'state of complete well-being and not mere freedom from infirmities'.<sup>10</sup> Subsequently, in 1948 the UN adopted its first human rights instrument, the Universal Declaration of Human Rights (Universal Declaration).<sup>11</sup> This was a very important document in the sense that it guarantees both civil and political rights and economic, social and cultural rights. Article 25 of the Universal Declaration recognises the right to an adequate standard of living, including food, water and health for all individuals.<sup>12</sup> While the Universal Declaration is not a binding instrument by any standard, it has remained influential in the drafting of most constitutions of the world. In fact, some commentators have argued that the norms in the Universal Declaration have attained the status of customary international law.<sup>13</sup>

Perhaps the most authoritative provisions on the right to health at the UN is article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). This Covenant recognises the right to the highest attainable standard of physical and mental health. This detailed provision further recognises the right to social determinants of health.<sup>14</sup> Other international human rights instruments, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),<sup>15</sup> the Convention on the Rights of the Child (CRC)<sup>16</sup> and the Convention on the Rights of Persons with Disabilities (CRPD)<sup>17</sup> contain provisions in relation to the right to health of specific groups. They require that states should guarantee the right to the highest attainable standard of physical and mental health to everyone.

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9 As above.

10 Preamble to the Constitution of the WHO as adopted by the International Health Conference, New York, 19-22 June 1946.

11 UN General Assembly Universal Declaration of Human Rights 10 December 1948, 217 A (III).

12 As above.

13 See H Hannum 'The UDHR in national and international law' (1998) 3 *Health and Human Rights* 147.

14 International Covenant on Economic, Social and Cultural Rights adopted 16 December 1966, Preamble, GA Res 2200A (XXI) UN GAOR, Supp 16, UN Doc A/6316 (1966) entered into force 2 September 1990.

15 Convention on the Elimination of All Forms of Discrimination against Women adopted 18 December 1979 GA Res 34/180, UN GAOR, 34th session, Supp 46 193, UN Doc A/34/46, UNTS 13 entered into force 3 September 1981 art 12.

16 Convention on the Rights of the Child (CRC) adopted 20 November 1989, GA Res 44/25, annex, UN GAOR 44th session, Supp 49, UN Doc A/44/49 (1989) entered into force 2 September 1990 art 24.

17 Convention on the Rights of Persons with Disabilities adopted 13 December 2006, GA Res A/RES/61/106, UN GAOR, 61st session UN Doc A/61/6111 entered into force 3 May 2008 (CRPD) art 25.

The Committee on Economic, Social and Cultural Rights (ESCR Committee), responsible for monitoring the implementation of ICESCR, issued General Comment 14 to clarify the implications of the right to health guaranteed in article 12.<sup>18</sup> According to the Committee, the right to health should not be interpreted to mean the right to be healthy but rather an obligation on states to ensure access to healthcare services for all.<sup>19</sup> It further explains that the essential elements of the right to health are freedoms and entitlements. The term 'freedoms' implies that no treatment should be conducted on an individual without informed consent, while 'entitlement' means that every individual should have access to health goods and services.<sup>20</sup> The ESCR Committee further identified the essential elements of the right to health to include availability, accessibility, acceptability and quality.<sup>21</sup> States are to ensure that healthcare services are to be available, accessible, acceptable and of good quality. This is often referred to as the '3As and Q'.

It should be noted that the ESCR Committee has adopted the minimum core content of the right to health to include access to healthcare services without discrimination, access to housing, food, and essential medicines. It urges states to work with civil society groups with a view to adopting indicators to monitor the state's obligations to realise the right to health under the Covenant.<sup>22</sup> The essence of the minimum core is to emphasise the point that some aspects of the right to health are not subject to progressive realisation. Further, the Committee has noted that states have the obligations to respect, protect and fulfil the right to health. It explains that respecting the right to health implies that states, through their actions or omissions, do not interfere with the enjoyment of the right to health.<sup>23</sup> Thus, states should not adopt laws or policies that make it difficult for individuals, especially vulnerable groups, to enjoy access to healthcare services. The obligation to protect requires states to ensure that the activities of third parties do not undermine the enjoyment of the right to health of their people, while the obligation to fulfil requires states to take necessary measures, including budgetary, judicial, legislative and administrative, towards the realisation of the right to health.<sup>24</sup>

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18 General Comment 14 (n 3).

19 As above.

20 As above.

21 General Comment 14 (n 3) para 12.

22 General Comment 14 para 36.

23 As above.

24 As above.

In 2016 the ESCR Committee adopted General Comment 22 on the right to sexual and reproductive health.<sup>25</sup> According to the Committee, the right to sexual and reproductive health is an integral part of the right to the highest attainable standard of physical and mental health.<sup>26</sup> It explains that states are obligated to ensure available, accessible, acceptable, and quality access to sexual and reproductive health services for all, especially vulnerable and marginalised groups.<sup>27</sup>

In addition to the clarification provided by the ESCR Committee, other human rights bodies, such as the CEDAW Committee, the Committee on the Rights of the Child and the Human Rights Committee have made clarifications regarding the nature of the right to health. In its General Recommendation 24 on women and health<sup>28</sup> the CEDAW Committee explains that states have obligations to ensure access to healthcare services to women on an equal basis with men. It further notes that a failure to ensure access to healthcare services specifically needed by women will constitute discrimination under the Convention.<sup>29</sup> The Committee enjoins states to allocate resources and train healthcare providers to guarantee access to healthcare services specifically needed by women.<sup>30</sup> It further notes that states should provide redress for women that have experienced violations of their rights in the healthcare setting.<sup>31</sup>

The CRC Committee has explained in its General Comment 15 that states should adopt a holistic approach, including respect for the general principles of children's rights to ensure unhindered access to healthcare services for children.<sup>32</sup> The Committee further emphasises the role of non-state actors in respecting the right to health of children. In some of its other General Comments, the Committee has made important observations that are crucial for the realisation of the right to health for adolescents. These include

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25 ESCR Committee General Comment 22 (2016) on the right to sexual and reproductive health (art 12 ICESCR).

26 As above.

27 As above.

28 CEDAW Committee General Recommendation 24: Art 12 of the Convention (Women and Health) 1999, A/54/38.

29 As above.

30 As above.

31 As above.

32 CRC Committee General Comment 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art 24) 17 April 2013, CRC/C/GC/15.

General Comments 3 on HIV/AIDS,<sup>33</sup> 4 on adolescents' health<sup>34</sup> and 13 on violence against children.<sup>35</sup>

While the provisions of the International Covenant on Civil and Political Rights (ICCPR) do not specifically guarantee the right to health, the Human Rights Committee has explained in General Comments 6<sup>36</sup> and 36<sup>37</sup> on the right to life that states have the obligation to prevent the loss of lives, including deaths associated with unsafe abortion, and to promote maternal health.

The work of the special mechanisms of the UN has equally played an important role in clarifying the meaning of the right to health. In 2000 the UN created the position of Special Rapporteur on the Right to Highest Attainable Standard of Health. Since that time the Special Rapporteur has played a key role in providing clarifications on the understanding of the right to health. Some of the reports of the Special Rapporteur have addressed important issues relating to the understanding of the right to health.<sup>38</sup> The work of the Special Rapporteur has given more visibility to the right to health and further consolidated the point that this right is not merely an aspiration but rather an enforceable right.

It should also be acknowledged that over the years the understanding of the right to health has emerged through consensus statements, declarations and other works. Thus, the decisions reached at the International Conference on Population and Development, Cairo, Egypt, in 1994 and the Fourth World Conference on Women in Beijing, China, in 1995 all contain important affirmations relating to the right to health, including the sexual and reproductive health rights of women and girls.

These developments at the international level with regard to the right to health are crucial for the realisation of the right at the national

33 CRC Committee General Comment 3 (2003): HIV/AIDS and the rights of the child 17 March 2003, CRC/GC/2003/3.

34 CRC Committee General Comment 4 (2003): Adolescent health and development in the context of the Convention on the Rights of the Child, 1 July 2003, CRC/GC/2003/4.

35 CRC Committee General Comment 13 (2011): The right of the child to freedom from all forms of violence, 18 April 2011, CRC/C/GC/13.

36 Human Rights Committee General Comment 6, art 6 (Right to life) 16th session 1982, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies 176 paras 3, 5 UN Doc HRI/GEN/I/Rev.9 (Vol I) (2008).

37 Human Rights Committee General Comment 36, art 6 (Right to life) 3 September 2019, CCPR/C/GC/35.

38 For the reports of the UN Special Rapporteur on Health, see <https://www.ohchr.org/en/issues/health/pages/srrihealthindex.aspx> (accessed 26 October 2021).

level. The norms and standards serve as important benchmarks to assess the performance of states in their commitments to realise the right to health at the national level. Yamin argues that framing health as a right makes it imperative for states to address health-related issues as a matter of social justice.<sup>39</sup> It equally enables states to consider the allocation of resources towards realising this right for all, especially vulnerable and marginalised groups.<sup>40</sup> More importantly, the framework at the international level requires states to address discrimination and existing inequality in the realisation of the right to health at the national level.

At the regional level, the right to health is guaranteed in article 11 of the European Social Charter;<sup>41</sup> article 10 of the Protocol to the Inter-American Convention;<sup>42</sup> article 16 of the African Charter;<sup>43</sup> article 14 of the African Charter on the Rights and Welfare of the Child (African Children's Charter);<sup>44</sup> and article 14 of the African Women's Protocol.<sup>45</sup> The African Commission has attempted to clarify the provisions of the right to health in the African Charter and the African Women's Protocol through its decisions,<sup>46</sup> resolutions<sup>47</sup> and General Comments.<sup>48</sup> These clarifications are discussed in detail below.

Over the years the right to health has increasingly gained recognition at the national level. A study by Heymann et al has shown that approximately 191 member countries of the UN have provisions on the right to health in their constitutions.<sup>49</sup> After reviewing the

39 AE Yamin 'The right to health under international law and its relevance to the United States (2005) 95 *American Journal of Public Health* 1156-1161.

40 As above.

41 Council of Europe, European Social Charter, 18 October 1961, ETS 35.

42 Organization of American States (OAS) Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) 16 November 1999 A-52.

43 African Charter on Human and Peoples' Rights adopted by the Organisation of African Union (OAU) in 1981, entered into force on 21 October 1986.

44 African Charter on the Rights and Welfare of the Child adopted 11 July 1990 art 5, OAU Doc CAB/LEG/24.9/49 entered into force 29 November 1999 (African Children's Charter).

45 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted by the AU in 2003 entered into force 27 November 2005 (African Women's Protocol).

46 See, eg, *Purohit & Another v The Gambia* (2003) AHRLR 96 (ACHPR 2003); *Social and Economic Rights Action Centre (SERAC) & Another v Nigeria* (2001) AHRLR 60 (ACHPR 2001); *International Pen & Others (on behalf of Saro-Wiwa) v Nigeria* (2000) AHRLR 212 (ACHPR 1998).

47 See, eg, Resolution on Access to Medicines adopted 2008; Resolution on Maternal Mortality; Resolution 265 on Involuntary Sterilisation; and Human Rights and Resolution 275 on Violence Against Persons Based on Gender Identity or Sexual Orientation.

48 See General Comment 1 on arts 14(1)(d) and (e) of the African Women's Protocol; see also General Comment 2 on art 14(2).

49 J Heymann et al 'Constitutional rights to health, public health and medical care: The status of health protections in 191 countries' (2013) 8 *Global Public Health*

constitutions of member states of the UN between 2007 and 2011, the study came to the conclusion that 'seventy-three UN member countries (38 per cent) guaranteed the right to medical care services, while 27 (14 per cent) aspired to protect this right in 2011'.<sup>50</sup> The authors further note that 'while only 33 per cent of the constitutions adopted prior to 1970 addressed at least one health right, 60 per cent of those introduced between 1970 and 1979 included the right to health, public health and/or medical care'.<sup>51</sup> In addition, three-quarters of the constitutions introduced in the 1980s, and 94 per cent of those adopted in the 1990s, protected at least one of these rights.<sup>52</sup> Only one of the 33 constitutions adopted between 2000 and 2011 did not protect at least one health right.<sup>53</sup>

Despite the various norms and standards on the right to health, commentators have not spared the ink in criticising this right. It has been argued that the right to health remains vague, ambiguous, and difficult to enforce.<sup>54</sup> This is more so given that the right to health forms part of socio-economic rights, which have remained the subject of debate and controversy among states.

### 3 Contributions of the African human rights system

As the title of this article indicates, the focus here is to highlight the important contributions the African human rights system has made to the advancement of the right to health. It needs to be clarified at this stage that while the title refers to the African human rights system, most of the discussion here will revolve around the work of the African Commission. This is because the African Commission is the oldest human rights body in the region with extensive experience in interpreting the right to health. Where necessary, appropriate references will be made to the work of the African Committee of Experts on the Rights and Welfare of the Child (African Children's Committee) and the African Court on Human and Peoples' Rights (African Court). The analysis here will be done by examining the normative framework on the right to health, interpretative guidance provided and the jurisprudence of the relevant regional human rights bodies

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639.

50 Heymann et al (n 49) 650.

51 As above.

52 As above.

53 As above.

54 See, eg, JP Ruge 'Toward a theory of a right to health: Capability and incompletely theorised agreements' (2006) 18 *Yale Journal of Law and the Humanity* 3; A Buchanan 'The right to a decent minimum health care' (1984) 13 *Philosophy and Public Affairs* 55.

### 3.1 Normative framework

As discussed above, the UN human rights instruments have served as the pace setter for the conceptualisation of the right to health. Article 12 of ICESCR contains an authoritative provision on the right to health which has been replicated in almost all other regional human rights instruments, including the African Charter. While the provision of article 12 of ICESCR may be said to be authoritative, the provision of article 14 of the African Women's Protocol can be regarded as ground-breaking in a number of ways.<sup>55</sup> Article 14 of the Women's Protocol, which entered into force in 2005, 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 of 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.
- 2 States Parties shall take all appropriate measures 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.

Article 14 of the African Women's Protocol stands out compared to the provisions on the right to health in UN human rights instruments. Indeed, it can be argued that it not only consolidates the recognition of the right to health but also expands its content. For instance, the provision in article 14(2)(c) is unique and bold in the sense that it is the first time in any human rights instrument that a woman's right

<sup>55</sup> African Women's Protocol (n 45).

to safe abortion on certain grounds is recognised. Not even CEDAW contains any provision on abortion. As should be noted, abortion is a very controversial issue and often elicits emotional, religious and cultural sentiments whenever it is discussed at any forum. Moreover, unsafe abortion accounts for most of the maternal deaths in the world, especially in Africa.<sup>56</sup> Efforts at recognising women's rights to abortion at international forums have remained difficult due to religious and cultural reasons. The nearest to addressing this issue was the compromise reached during the International Conference on Population and Development (ICPD) in 1994, where it was noted that a woman may be allowed to undergo abortion if the national law so permits.<sup>57</sup> Given that many countries in the world still maintain restrictive abortion laws, this compromise does not in the true sense improve the situation of many women in need of safe abortion worldwide. Besides, the consensus statement creates no obligation on states to take decisive measures towards liberalising abortion. It, therefore, is a bold move by the drafters of the Protocol to recognise the rights of women in Africa to safe abortion.

Ngwena has argued that ensuring access to safe abortion services, which includes repealing restrictive laws and policies on abortion, will go a long way in addressing inequality in healthcare services and ultimately promote women's rights to reproductive health.<sup>58</sup> He has suggested reforms of abortion laws in Africa to prevent needless deaths often associated with unsafe abortion. More importantly, he has argued that the enjoyment of the right to healthcare services, including reproductive health care, obligates African governments to take women's rights seriously by ending deaths occasioned by unsafe abortion.<sup>59</sup> This will be consistent with the substantive equality approach envisaged by the African Women's Protocol.

The second point that needs to be made regarding the normative framework is that the African Women's Protocol is also the first human rights instrument to specifically protect women's rights in the context of HIV. Articles 14(1)(d) and (e) recognise the rights of women to be protected from sexually-transmitted infections, including HIV, and the right to know one's partner HIV status. The HIV pandemic has since the 1990s impacted negatively on many

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56 WHO 'Preventing unsafe abortion', <https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion> (accessed 27 October 2021).

57 International Conference on Population and Development, Cairo, Egypt, September 1994.

58 C Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 783.

59 C Ngwena et al 'Human rights advances in women's reproductive health in Africa' (2015) 129 *International Journal of Gynaecology and Obstetrics* 184.

lives in Africa. It therefore was a thoughtful decision that the drafters of the Protocol included a provision to protect women in the context of HIV. This is the first time any human rights instrument would recognise the human rights challenge posed by HIV. It is a pragmatic response to the high prevalence of the epidemic in the region. It has been argued that this provision is a pragmatic response to the peculiar challenges women face in Africa with regard to the burden of HIV/AIDS.<sup>60</sup>

Third, while CEDAW does refer to the rights of women to decide freely and responsibly on the number and spacing of their children, article 14 of the African Women's Protocol is more emphatic in recognising the right to sexual and reproductive health of women. As noted above, article 14 provides that the right to health, including the sexual and reproductive health of women, shall be respected and protected. It proceeds to list the various sexual and reproductive health issues to be protected. These include access to contraception, sexuality education, and determining the timing and number of children. This is a bold statement for a continent often referred to as conservative.

Fourth, article 14(2)(a) would seem to have codified the clarification provided by the ESCR Committee in General Comment 14 by urging states to ensure 'adequate, affordable and accessible health services'.<sup>61</sup> This inclusion in a binding instrument such as the African Women's Protocol is important given the debate that often surrounds the legal effects of General Comments. The inclusion in article 14(2)(a) would seem to lay to rest any doubt about the need for African governments to effectively implement the availability, accessibility, acceptability, and quality (3As and Q) framework of the ESCR Committee.<sup>62</sup> The African Commission has issued two important General Comments to clarify the provisions of article 14. These General Comments are discussed in detail below. The codification of the 3As and Q in the African Women's Protocol makes it imperative for African governments to ensure that the right to health, including the sexual and reproductive health rights of women, are effectively implemented at the national level. This requires the appropriate allocation of resources to ensure access to healthcare services required by women. Indeed, in some of its Concluding Observations to African states, the Commission has expressed concerns about poor infrastructure and shortages of healthcare providers in some African

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60 See, eg, RS Mukasa *The African Women's Protocol: Harnessing a potential force for positive change* (2009).

61 General Comment 14 (n 3).

62 As above.

countries.<sup>63</sup> Thus, it has emphasised the need to ensure adequate allocation of resources to improve infrastructure in the healthcare sector.<sup>64</sup>

It should be noted that in interpreting article 14 of the African Women's Protocol, reference should be made to its other important provisions, such as articles 1 and 2 on the definition of non-discrimination; article 3 on dignity; article 4 on violence; article 5 on harmful practices; and article 10(h) on committing resources to realise women's rights.<sup>65</sup> These other provisions will help to elucidate the nature of states' obligations in realising the right to health.

Aside from the African Women's Protocol, the African Youth Charter in article 16 also contains significant provisions relating to the rights to health of young people.<sup>66</sup> This is a unique instrument, which addresses the human rights of youths in the region. The need to address the rights of the youth might have arisen because a large percentage of the African population is made up of young people threatened by various health challenges, including HIV and teenage pregnancy. Thus, the African Youth Charter perhaps is the only human rights instrument dedicated to the youth, internationally. Article 16 of the Youth Charter contains a detailed provision guaranteeing the right to health of African youths. The provision addresses not only access to healthcare services, but also determinants of health as well as the challenges posed by non-communicable diseases in Africa. Drawing from the language of the African Children's Charter, article 16 provides that the right to physical, mental and spiritual health of young people shall be protected.<sup>67</sup> It further addresses peculiar challenges facing the well-being of the youth. These include obligating states to make available youth-friendly healthcare services; confidential counselling and testing for HIV; ensuring healthcare services for youths in rural areas; ensuring the provision of food for youths living with HIV; and addressing tobacco, drug and alcohol use among young people.<sup>68</sup>

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63 See, eg, Concluding Observations and Recommendations – Nigeria: 5th Periodic Report, 2011 – 2014 adopted at 57th ordinary session 4-18 November 2015 Banjul, The Gambia; see also Concluding Observations and Recommendations – Kenya: Combined 8th-11th Periodic Report, 2008-2014 adopted at 19th extraordinary session 16-25 February 2016, Banjul, The Gambia.

64 As above.

65 See E Durojaye & N Murungi 'The African Women's Protocol and sexual rights' (2013) 7-8 *International Journal of Human Rights* 881.

66 Adopted in Banjul, The Gambia on 2 July 2006, entered into force on 8 August 2009.

67 As above.

68 As above.

The African Youth Charter indeed is a pace setter in holistically protecting the rights to health of young people. It serves as a good model for a comprehensive recognition of the right to health. It places obligations on African governments to address non-communicable diseases, which have become serious threats to many lives in the region. The WHO has noted that non-communicable diseases are the leading cause of death globally accounting for 41 million (71 per cent) of the world's 56 million deaths in 2016.<sup>69</sup> Furthermore, it is noted that approximately 15 per cent of non-communicable disease-related deaths occur prematurely (ages 30 to 70), while the burden of non-communicable diseases is disproportionately borne by low and middle-income countries, including Africa.<sup>70</sup> The WHO estimates that these deaths will increase by 17 per cent in 2025, with a 27 per cent increase from Africa.<sup>71</sup> It is also worth noting that in Mauritius, Namibia and Seychelles, non-communicable diseases cause over 50 per cent of all reported adult deaths.<sup>72</sup> Whether or not this provision of the Youth Charter has been utilised by African governments is a different story entirely. It indeed is surprising that such an important provision in the African Youth Charter has not been put to effective use. This requires African governments to be alive to their obligations to protect the continent from the scourge of non-communicable diseases.

More recently the AU has adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons.<sup>73</sup> Although this Protocol is yet to enter into force, it nonetheless contains inspiring provisions on the right to health of older persons. The Protocol in article 15 guarantees the rights of older persons to healthcare services that meet their peculiar needs, to have access to health insurance and ensuring the inclusion of geriatrics and gerontology in the training of healthcare providers. This is a milestone in the recognition of the right to health of older persons. Nowhere else, either at the international or regional level, is such protection found. Therefore, the African human rights system should be applauded for taking a progressive step to address the health needs of older persons. Experience has shown that little attention has been given to the rights of older persons in many parts of the world, including in Africa.<sup>74</sup> It therefore is a positive development that the

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69 WHO *Non-communicable diseases: Country profiles 2018* (2018).

70 As above.

71 WHO 'Africa: Non-communicable diseases', <https://www.who.int/nmh/ncd-tools/who-regions-african/en/> (accessed 25 October 2021).

72 'Non-communicable diseases', <https://www.afro.who.int/health-topics/noncommunicable-diseases> (accessed 25 October 2021).

73 Adopted in 2016, yet to enter into force.

74 See, eg, G Kelly et al "'They don't care about us": Older people's experiences of primary healthcare in Cape Town, South Africa' (2019) 19 *BMC Geriatrics* 98.

AU took the lead by adopting a specific human rights instrument protecting the rights of older persons, in general, and their rights to health, specifically. This instrument provides a shining example for others to follow in the recognition of the rights of older persons.

### **3.2 Interpretative guidance on the right to health through resolutions/General Comments/guidelines**

The African Commission is the body charged with the responsibility of overseeing the implementation of the African Charter and, for the time being, the African Women's Protocol. The African Commission was established in 1987 pursuant to article 30 of the African Charter. It has both promotional and protective mandates. The Commission usually consists of 11 members who are expected to have distinguished themselves in their field of endeavour. The members are to serve in their individual capacity through secret ballot election conducted by the Assembly of Heads of State of the AU. Article 45 of the African Charter empowers the Commission to provide interpretative guidance to the provisions of the African Charter and, by extension, the African Women's Protocol. Relying on this provision, the African Commission has adopted important resolutions and General Comments to provide further understanding of the provisions on the right to health in the African Charter and the African Women's Protocol.

#### **3.2.1 Resolutions**

The African Commission has often relied on article 45(1) of the African Charter in providing interpretative guide to the provisions of the Charter and the African Women's Protocol. In 2008 the Commission adopted two important resolutions in relation to the right to health. The first resolution deals with maternal mortality, which is a serious challenge facing the region.<sup>75</sup> At the time the African Commission adopted its resolution on maternal mortality, the Human Rights Council was yet to adopt its series of resolutions on the same subject. Therefore, one could affirm that the African Commission took the lead in adopting a specific resolution on maternal mortality. In that resolution the African Commission declared maternal mortality a state of emergency in Africa and called on states to take decisive measures to address this concern.<sup>76</sup> It further affirmed that maternal

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75 Resolution on Maternal Mortality in Africa reproduced in E Durojaye & G Mirugi-Mukundi (eds) *Compendium of documents and cases on the right to health under the African human rights system* (2013).

76 As above.

mortality undermines various human rights recognised in the Charter, including the rights to life, dignity, non-discrimination, and health. The Commission called on African governments to adopt a holistic approach towards addressing maternal mortality in the region.<sup>77</sup> The Human Rights Council subsequently adopted the first 52 of its many resolutions on maternal mortality drawing on the inspiration of the African Commission resolution on this issue.<sup>78</sup>

In the same year the African Commission adopted another resolution to address access to medicines in Africa.<sup>79</sup> The resolution was aimed at clarifying states' obligations in relation to the enjoyment of the right to health in article 16 of the African Charter. Concerned about a lack of access to life-saving medications for HIV and inspired by General Comment 14 of the ESCR Committee, the Commission urged African governments to ensure the availability, accessibility, acceptability, and quality of essential medicines for all. It further called on states to respect, protect and fulfil the realisation of access to medicines for everyone. It further urged African governments, when entering into any trade agreements, to consider the implications for access to medicines and the enjoyment of the right to health.<sup>80</sup> This resolution is significant given that at the time of its adoption, access to life-saving medications for HIV was a serious challenge in Africa. Due to patent rights enjoyed by pharmaceutical companies on anti-retroviral drugs under the World Trade Organisation's Trade-Related Aspect of Intellectual Property Rights (TRIPS) Agreement,<sup>81</sup> the costs were far beyond the reach of many Africans. This resolution, therefore, served as a strong statement to African governments not to compromise the enjoyment of the right to health through trade agreements.

More recently the African Commission adopted two important resolutions crucial to the realisation of the right to health, including sexual and reproductive health. In 2013, at the wake of the disturbing incidents of forced sterilisation of HIV-positive women across Africa, the Commission rose to the occasion by adopting Resolution 260

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77 As above.

78 See, eg, Human Rights Council Resolution on Preventable Maternal Mortality and Morbidity and Human Rights 2010; Human Rights Council Resolution on Preventable Maternal Mortality and Morbidity and Human Rights 2011; Human Rights Council Resolution on Preventable Maternal Mortality and Morbidity and Human Rights 2016.

79 Resolution 141 on Access to Health and Needed Medicines in Africa ACHPR/Res 141(XXXIV)08.

80 As above.

81 TRIPS Agreement on Trade-Related Aspects of Intellectual Property Rights 15 April 1994, Marrakesh Agreement Establishing the World Trade Organisation, Annex 1C, 1869 UNTS 1197 (1994) (TRIPS Agreement).

on Involuntary Sterilisation as a violation of human rights.<sup>82</sup> The Resolution condemns all forms of involuntary sterilisation targeted at vulnerable groups, such as women living with HIV, as a violation of the rights to dignity, health, non-discrimination and freedom from cruel, inhuman and degrading treatment.<sup>83</sup> This timely resolution urges African governments to put in place mechanisms that will ensure that HIV-positive women are not subjected to coercive forms of sterilisation. More importantly, the Commission enjoins states to ensure the participation of women living with HIV in the development of laws, policies and programmes relating to their sexual and reproductive health.<sup>84</sup> By this statement, the Commission would seem to be echoing the aphorism 'nothing for us without us', an approach that is grounded in the right to participation for vulnerable and marginalised groups in matters affecting their lives. The Resolution recommends the training of healthcare providers and the need for government to put in place redress mechanisms for victims of involuntary sterilisation.

In 2014 the African Commission adopted the landmark Resolution 275 addressing all forms of violence against an individual based on real or perceived sexual orientation or gender identity.<sup>85</sup> This was the first time the African Commission took a bold step to address this seemingly controversial issue on the continent. Prior to this period, the African Commission had been perceived as homophobic and unwilling to address issues relating to sexual orientation or gender identity.<sup>86</sup> This is hardly surprising given that many leaders of the AU have expressed stiff opposition to advocating the rights of sexual minorities in their countries. In particular, homophobic statements credited to late Zimbabwean President Robert Mugabe and President Museveni of Uganda all point to intolerance of sexual minorities and a lack of respect for their fundamental rights.<sup>87</sup> These attitudes tend to fuel violence and human rights abuses of sexual minorities on the continent. Therefore, it was a momentous occasion for the

82 Resolution 260 on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services – ACHPR/Res 260 (LIV) 2013.

83 As above.

84 As above.

85 Resolution on Protection against Violence and other Human Rights Violations against Persons on the Basis of Their Real or Imputed Sexual Orientation or Gender Identity – ACHPR/Res 275 (2014).

86 For a detailed discussion on this, see V Balogun & E Durojaye 'The African Commission on Human and Peoples' Rights and the promotion and protection of sexual and reproductive health' (2011) 11 *African Human Rights Law Journal* 368.

87 See 'Mugabe condemns gay "filth"' *News24*, <https://www.news24.com/News24/Mugabe-condemns-gay-filth-20110414> (accessed 2 July 2021); see 'Uganda's President Museveni signs controversial anti-gay Bill into law', <https://edition.cnn.com/2014/02/24/world/africa/uganda-anti-gay-bill/index.html> (accessed 2 July 2021).

Commission to adopt this Resolution. The Resolution observes that article 2 of the African Charter prohibits discrimination on various grounds including any 'other status'.<sup>88</sup> It calls on African governments to end all forms of violence and human rights violations perpetrated by the state, its agents or by non-state actors against persons based on their sexual orientation or gender identity.<sup>89</sup> It particularly requires African governments to adopt laws and policies prohibiting or punishing all forms of violence targeting individuals based on their real or perceived sexual orientation or gender identity.<sup>90</sup> If properly implemented at the national level, this significant resolution will go a long way in addressing human rights violations experienced by sexual minorities in the region.<sup>91</sup>

The African Commission has taken a step further by engaging with states during the reporting process on steps taken to protect the rights of sexual minorities. For instance, in its Concluding Observations to Nigeria the Commission expressed concerns with the enactment of the law criminalising homosexuality in the country, noting that such laws have the potential to engender violence in the country.<sup>92</sup> The Commission also expressed concerns that this may drive the activities of sexual minorities underground, thereby making them vulnerable to HIV and unable to seek healthcare services.

### 3.2.2 *General Comments*

In 2012 the African Commission adopted its first General Comment (General Comment 1) to clarify the provision of articles 14(1)(d) and (e) of the African Women's Protocol.<sup>93</sup> As noted above, the provision specifically relates to the protection of women's rights in the context of HIV. In clarifying this provision, the African Commission notes that to prevent women from sexually-transmitted infections, including HIV, states must ensure access to sexual and reproductive health

<sup>88</sup> Resolution 275 (n 85).

<sup>89</sup> As above. For a detailed discussion of this resolution, see BD Nibogora 'Advancing the rights of sexual and gender minorities under the African Charter on Human and Peoples' Rights: The journey to Resolution 275' in E Durojaye et al (eds) *Advancing sexual and reproductive health and rights in Africa: Constraints and opportunities* (2021) 171.

<sup>90</sup> As above.

<sup>91</sup> As above.

<sup>92</sup> See Concluding Observations and Recommendations – Nigeria: 5th Periodic Report, 2011-2014 adopted at 57th ordinary session 4-18 November 2015, Banjul, The Gambia.

<sup>93</sup> General Comment 1 on arts 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted by the African Commission on Human and Peoples' Rights during its 52nd ordinary session in November 2012.

information and services to women and girls.<sup>94</sup> The Commission further notes that states should ensure the provision of sexuality education and evidence-based policies and programmes on the sexual and reproductive health of women and girls.<sup>95</sup> With regard to knowing one's HIV status, the Commission notes that while this provision is intended to protect women, it must not be implemented in a manner that will undermine an individual's rights to privacy and confidentiality.<sup>96</sup> More importantly, the Commission notes that this provision must be carried out in line with international norms and standards. It further explains that the right to self-protection and the right to be protected are intrinsically linked to other rights of women, including the rights to equality and non-discrimination, life, dignity, health, self-determination, privacy and to be free from all forms of violence. The Commission notes that states are to

provide access to information and education, which should address all taboos and misconceptions relating to sexual and reproductive health issues, deconstruct men and women's roles in society, and challenge conventional notions of masculinity and femininity;

provide access to sexual and reproductive health services by ensuring availability, accessibility, acceptability and quality sexual and reproductive health care services for women.<sup>97</sup>

This holistic and gender-sensitive approach by the African Commission is commendable and sets it apart from UN treaty-monitoring bodies such as the ESCR and CEDAW Committees. It would be recalled that as far back as 1990s the CEDAW Committee adopted General Recommendation 15 on Women and HIV/AIDS.<sup>98</sup> However, unlike General Comment 1 of the African Commission, the General Recommendation of CEDAW is short and fails to address contemporary issues relating to women and HIV. To this extent, General Comment 1 of the African Commission is an important contribution to the understanding of the right to health of women in the context of the HIV/AIDS pandemic. The Commission has recommended to states the need to adopt progressive HIV legislation that will address the needs of vulnerable and marginalised groups, especially women and girls.<sup>99</sup>

94 As above.

95 As above.

96 General Comment 1 (n 93) 26.

97 General Comment 1 (n 93) 40.

98 CEDAW Committee General Recommendation 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS), 1990, A/45/38.

99 See, eg, Concluding Observations and Recommendations – Malawi: Initial and Combined Periodic Reports, 1995-2013 adopted at its 57th ordinary session November 4-18 November 2015, Banjul, The Gambia.

In its General Comment 2 on other provisions of article 14 of the African Women's Protocol, the Commission reasons that states are to ensure access to healthcare services on a non-discriminatory basis and in ways that are physically accessible, economically accessible, and in which information is accessible.<sup>100</sup> The Commission explains the relevance of equality and non-discrimination to sexual and reproductive health rights of women.<sup>101</sup> It further calls on states to adopt a purposive interpretation of grounds for abortion similar to the WHO Technical Guidance. The Commission explains that when applying a holistic understanding of health as a ground for abortion, the woman's reasons must be taken into account.<sup>102</sup> More importantly, the Commission notes that where risk to 'mental health' is relied upon, it is not necessary to first establish psychiatric evidence.<sup>103</sup> It explains that states have the duty to remove restrictions that are not necessary for providing safe abortion services such as the requirements of multiple signatures, approval by committees before an abortion can be performed, or restricting the performance of abortion to medical practitioners.<sup>104</sup>

In highlighting the nature of states' obligations, the Commission explains that the duty to respect rights requires state parties to refrain from hindering, directly or indirectly, women's rights to sexual and reproductive health and to ensure that women are duly informed on family planning/contraception and safe abortion services.<sup>105</sup> The duty to protect requires state parties to take the necessary measures to prevent third parties from interfering with the enjoyment of women's sexual and reproductive health rights. It particularly cautions on the use of conscientious objection to hinder access to abortion services for women.<sup>106</sup> This clarification becomes important given the serious obstacle conscientious objection has posed to women seeking abortion services across Africa, including in countries with liberal abortion services.<sup>107</sup> The General Comment further explains that the duty to promote imposes an obligation on state parties to create legal, economic and social conditions that enable women to exercise their sexual and reproductive rights with

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100 General Comment 2 on arts 14(1)(a), (b), (c) and (f) and arts 14(2) (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted by the African Commission on Human and Peoples' Rights during its 54th ordinary session, November 2014.

101 As above.

102 General Comment 2 (n 100) paras 37-38.

103 General Comment 2 paras 39-40.

104 As above.

105 General Comment 2 42.

106 General Comment 2 43.

107 See, eg, S Nabaneh 'Abortion and conscientious objection in South Africa: The need for regulation' in E Durojaye et al (eds) *Advancing sexual and reproductive health and rights in Africa: Constraints and opportunities* (2021) 16.

regard to family planning/contraception and safe abortion, as well as to enjoy these.<sup>108</sup> Regarding the duty to fulfil, it requires that state parties adopt relevant laws, policies and programmes that ensure the fulfilment *de jure* and *de facto* of women's sexual and reproductive rights, including the allocation of sufficient and available resources for the full realisation of those rights.<sup>109</sup> General Comment 2 not only provides guidance for states to adopt legislative and policy frameworks to ensure access to safe abortion services, but is also useful in 'educating all stakeholders – including healthcare providers, lawyers, policymakers, and judicial officers at the domestic level – about pertinent jurisprudence'.<sup>110</sup> It should be noted that General Comment 2 of the African Commission serves as a pace setter to the ESCR Committee's General Comment 22 on the right to sexual and reproductive health, which was adopted in 2016. Thus, the latter builds on the clarification on the understanding of the right to sexual and reproductive health provided by General Comment 2.

In its engagements with states, the African Commission has emphasised the need for African governments to reduce the incidence of unsafe abortion, as this is responsible for the high maternal mortality rate in the region.<sup>111</sup> It has further urged African governments to expedite action with the ongoing legislative reforms on abortion in line with the African Women's Protocol.<sup>112</sup> The fact that the Commission is beginning to engage with states as regards their obligations under article 14(2)(c) of the Women's Protocol is a positive development that can potentially serve as a catalyst for reforms of abortion laws in the region.

In General Comment 3 on article 4 of the African Charter, dealing with the right to life, the African Commission adopted a progressive interpretation of the right to life as imposing positive obligations on states.<sup>113</sup> According to the Commission, states are not only to refrain from interfering with the enjoyment of the right to life, but they must also ensure the prevention of avoidable loss of life. In particular, the Commission obligates states to ensure the prevention of avoidable death during pregnancy and childbirth as this would

108 General Comment 2 (n 100) 43.

109 General Comment 2 44.

110 C Ngwena, E Brookman-Amisshah & P Skuster 'Human rights advances in women's reproductive health in Africa' (2015) 129 *International Journal of Gynaecology and Obstetrics* 184.

111 See, eg, Concluding Observations and Recommendations – Malawi (n 99) paras 106-107.

112 As above; see also Concluding Observations and Recommendations – Nigeria (n 92) para 118.

113 African Commission on Human and Peoples' Rights General Comment 3 on the African Charter on Human and Peoples' Rights: The Right to Life (Article 4), 18 November 2015.

amount to a violation of the right to life as guaranteed under the African Charter.<sup>114</sup> This interpretation is crucial for Africa where the rate of maternal death is alarming and where African governments have not shown enough political will to address this issue. It clearly clarifies states' obligations to take positive steps and measures that would ensure that women do not die during pregnancy or childbirth. The recently-adopted General Comment 36 of the Human Rights Committee on the right to life in article 6 of ICCPR would seem to align with the reasoning of the African Commission on this issue.<sup>115</sup>

In one of its joint General Comments with the African Children's Committee, the African Commission addresses the issue of child/early marriage which has posed serious threats to the health and well-being of the girl child in the region.<sup>116</sup> The joint General Comment is concerned about the prevalence of child/early marriage in the region and its human rights implications. It specifically notes that this practice undermines various rights in the African Charter, the African Women's Protocol and the African Children's Charter. Beyond condemning child marriage as a human rights violation of the girl child, the joint General Comment provides concrete recommendations culturally appropriate for African governments to address this serious human rights concern. These include the need to ensure the verification of births and issuance of birth certificates; to ensure the full implementation of laws and to impose sanctions; education and awareness campaigns; and institutional measures to ensure access to justice and rehabilitation of the girl child already involved in child marriage.<sup>117</sup> Other measures include the need to address the root causes of poverty; research to collect data; the prohibition of all harmful cultural practices; engagement with men and traditional rulers; and, above all, the need to address gender-based discrimination.<sup>118</sup>

This General Comment would seem to take a nuanced approach to addressing a very contentious cultural practice in the region. It not only highlights the health consequences of child marriage to the girl child, but also proffers solutions to African governments to address this. Indeed, the General Comment is a comprehensive diagnosis of

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114 As above.

115 UN Human Rights Committee (HRC) General Comment 36, art 6 (Right to Life), 3 September 2019, CCPR/C/GC/35.

116 Joint General Comment of the African Commission on Human and Peoples' Rights and the African Committee of Experts on the Rights and Welfare of the Child on ending child marriage adopted by the African Commission on Human and Peoples' Rights and the African Committee of Experts on the Rights and Welfare of the Child 2017.

117 As above.

118 As above.

the root causes of child marriage, its attendant consequences, and pragmatic recommendations to African governments. It is a positive response to the suffocating effects of harmful cultural practices on the enjoyment of women's rights. Tamale has denounced the role culture and morality play in perpetuating the low status of women and the attendant consequences for their health and well-being in Africa.<sup>119</sup> She reasons that if women must exercise their sexual agency, then African governments should address structural imbalances that perpetuate poverty and inequality among women.<sup>120</sup> It is hoped that both the African Commission and the African Children's Committee would engage with African governments during states' reporting processes by inquiring into the implementation status of this General Comment.

### 3.2.3 Guidelines

An important document adopted by the African Commission in 2010 is the Principles and Guidelines on the Implementation of the Economic, Social and Cultural Rights in the African Charter.<sup>121</sup> This is often referred to as the Nairobi Principles, given that it was adopted in Nairobi, Kenya. The document provides a detailed clarification of the socio-economic rights guaranteed in the African Charter. It echoes the ESCR Committee's explanation in its General Comment 14 on the right to health in ICESCR. These include the fact that states are to ensure available, accessible, acceptable and quality healthcare services.<sup>122</sup> Furthermore, the Principles affirmed the interdependence and interrelatedness of the right to health with other rights such as the right to life, dignity, non-discrimination and privacy as recognised by the ESCR Committee in its General Comment 14.<sup>123</sup> The Commission explains that the right to health is an inclusive right encompassing both the right to health care and social determinants of health.<sup>124</sup> It identifies the social determinants of health to include access to water, sanitation, adequate food and nutrition, housing and healthy occupational and environmental conditions. The Nairobi Principles further note that the right to health implies refraining from unwarranted interference with one's body, including freedom

119 S Tamale 'Exploring the contours of African sexualities: Religion, law and power' (2014) 14 *African Human Rights Law Journal* 150.

120 S Tamale 'Gender trauma in Africa: Enhancing women's links to resources' (2004) 48 *Journal of African Law* 50.

121 The Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights adopted by the African Commission on Human and Peoples' Rights in November 2010 during its 48th ordinary session.

122 As above.

123 As above.

124 Principles and Guidelines (n 121) para 45.

from non-consensual medical treatment, experimentation, forced sterilisation and inhuman and degrading treatment.<sup>125</sup> According to the Principles, states must recognise the minimum core of the right to health, including access to healthcare services on a non-discriminatory basis; the provision of essential medicines; universal access to immunisation; and measures to prevent and treat epidemic and endemic diseases. The document further enjoins states to link poverty-reduction policies and programmes to the enjoyment of the right to health.

In 2017 the African Commission adopted a very progressive document to combat sexual violence and its consequences in Africa. The Guidelines to Combat Sexual Violence and its Consequences in Africa remains one of the important documents by the African Commission on this issue.<sup>126</sup> Drawing on existing international norms and standards on sexual violence, the Commission adopts a broad and progressive definition of sexual violence. The document further provides comprehensive examples of sexual violence to include rape, including marital rape; sexual harassment; female genital mutilation/cutting; virginity testing; child marriage; forced pregnancy; forced abortion; nudity; and forced sterilisation. This is a progressive approach by the Commission, which complements the provisions of the African Women's Protocol on violence against women. The progressive approach of the Guidelines would seem to have taken into consideration the lived experiences of African women with regard to all forms of sexual violence they encounter daily. The Commission would seem to have broken the silence by highlighting some acts of sexual violence hitherto disregarded as serious violations of women's rights. In many African countries sexual harassment and marital rape are indulged and are not adequately addressed under the law. For instance, when Nigeria enacted its Violence against Persons Prohibition (VAPP) Act of 2015, it ominously excluded the criminalisation of marital rape, which has continued to threaten the lives and health of many women in the country.<sup>127</sup> Equally, the Guidelines highlight the danger and consequences of sexual violence among women and girls. These include sexually-transmitted

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125 Principles and Guidelines (n 121) para 65.

126 The Guidelines to Combat Sexual Violence and its Consequences in Africa were adopted during the 60th ordinary session of the African Commission on Human and Peoples' Rights, 8-22 May 2017, Niamey, Niger.

127 For a comprehensive discussion of the VAPP Act, see C Onyemelukwe 'Legislating on violence against women: A critical analysis of Nigeria's Recent Violence Against Persons (Prohibition) Act, 2015' (2016) 5 *DePaul Journal of Women, Gender and the Law*, <https://via.library.depaul.edu/jwgl/vol5/iss2/3> (accessed 26 October 2021). See also N Chibueze et al 'Violence Against Prohibition Act, the Maputo Protocol and women's rights in Nigeria (2018) 39 *Statute Law Review* 337.

infection, mental, socio-economic, physical and psychological distress and threats to life. While the African Commission notes that women and girls are more likely to be affected by sexual violence, it nonetheless observes that men and boys are sometimes affected by this menace.<sup>128</sup>

The Guidelines will no doubt go a long way in reorienting states and policy makers on how to address sexual violence and all its ramifications. The document contains concrete measures that states should adopt to prevent this type of violence and to support women who have experienced sexual violence. Perhaps one of the weaknesses of the document is that it focuses rather on the consequences more than the prevention of sexual violence. While this is understandable as sexual violence can lead to deleterious consequences for women and girls, taking measures through legislative and other measures to prevent incidents of sexual violence will not only save money but will further ensure the safety and well-being of women and girls in the region.

### 3.3 Jurisprudence on the right to health

Over the years the African Commission has handed down important jurisprudence useful in guiding our understanding of the right to health. Some of these cases are directly related to the right to health, while others relate indirectly to this right. In the *Purohit* case the African Commission affirmed that the right to health goes beyond physical access to healthcare services but also includes access to goods and services in relation to health.<sup>129</sup> More importantly, the Commission made a salient connection between discrimination and the enjoyment of the right to health. The Commission found that the ill-treatment of persons with mental disabilities in an institution was a violation of their rights to health, non-discrimination and dignity guaranteed in the Charter.<sup>130</sup> It made a very strong statement condemning the poor treatment of persons with mental health challenges. The Commission's reasoning in this case clearly resonates with that of activists for mental health. It broke the silence with regard to stigma and discrimination facing persons with mental illness in the region. This progressive decision came years ahead of the adoption of CRPD. It was one of those decisions by a regional human rights body to affirm the right to dignity of persons with mental ill-health. Thus, the Commission was able to make an important

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128 Guidelines to Combat Sexual Violence and its Consequences (n 126).

129 *Purohit* (n 46).

130 As above.

contribution by affirming mental health as part of human rights, in general, and the right to health, in particular. More recently, the UN Special Rapporteur on the Right to Health would seem to have echoed the position of the African Commission in *Purohit* by noting that states should pay attention to mental health as a human rights imperative.<sup>131</sup>

In *Free Legal Assistance Group & Others v Zaire* the African Commission made an important connection between the social determinants of health and the right to health.<sup>132</sup> It noted that a failure by the state to provide basic services such as potable water, electricity and essential medicines constituted a violation of the right to health in article 16 of the African Charter. This decision is crucial for the realisation of the right to health in the African context. It is a known fact that poverty is rife in many African countries, often exacerbated by poor social service delivery. This makes it difficult for vulnerable and marginalised groups to live a dignified life and enjoy their right to health. In his seminal work Farmer explores the notion of structural violence against the poor.<sup>133</sup> By this, he means that structural deprivations in many societies lead to poverty and inequality, which in turn exacerbate ill-health.<sup>134</sup> He argues that promoting the socio-economic rights of the poor is the pathway to upholding their dignity and realising their right to health.<sup>135</sup> While most governments and international agencies are concerned with cost-effectiveness of addressing health crises in poor communities, Farmer shows that little things, such as providing stipends to patients, ensuring access to nutritious food and transport to attend clinics, are far more effective in preventing ill-health and increasing patients' recovery.<sup>136</sup> It would seem that this argument resonates with the capabilities approach that has been championed by Noble laureate Sen and, more lately, Nussbaum.<sup>137</sup> Farmer's analysis speaks directly to the situation in Africa where a significant number of people live in poverty. This implies that for African governments to advance the right to health in the region, they must address inequality and poverty among the people.

131 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health focusing on core challenges and opportunities for advancing the realisation of the right to mental health of everyone (A/HRC/35/21).

132 (2000) AHRLR 74 (ACHPR 1995).

133 P Farmer *Pathologies of power: Health, human rights and the new war on the poor* (1999).

134 As above.

135 As above.

136 As above.

137 For a detailed discussion, see M Nussbaum 'Capabilities and human rights' (1997) 66 *Florida International Law Review* 273.

This decision in *Free Legal Assistance*, therefore, is a wake-up call to African governments to take concrete measures in addressing social determinants of health with a view to mitigating the impact of poverty among the people and ultimately advancing their right to health. This position has been echoed in the *Sudan* case, where the African Commission linked the 'destruction of homes, livestock, farms as well as poisoning of water' of a group of people to the violation of the right to health.<sup>138</sup> It has been noted that in order for states to address inequality and inequity in access to healthcare services, efforts must be geared towards improving the social determinants of health among vulnerable and marginalised groups.<sup>139</sup>

In the *SERAC* case the African Commission affirmed the duty of the state to protect in the context of the right to health.<sup>140</sup> According to the Commission, a violation of the right to health will occur if a state fails to regulate the activities of a third party, which may interfere with the enjoyment of the right to health of the people. In this case the Commission held that the failure by the Nigerian government to prevent the pollution of water and land of the Ogoni people was in violation of various rights in the African Charter, including the rights to health, life, non-discrimination, housing and food. The *SERAC* case is a leading case in our understanding of the duty of states to protect in the context of socio-economic rights, in general, and the right to health, in particular. Moreover, it is an important case affirming the indivisibility and interrelatedness of rights. A similar decision was reached in the *Pen International* case where the Commission found that the denial of healthcare services to a prisoner was in violation of the right to life.<sup>141</sup> It would be recalled that at the Vienna Programme of Action the international community affirmed that all human rights are interrelated, indivisible and interdependent.<sup>142</sup> Similarly, the ESCR Committee in General Comment 14 has noted that the enjoyment of the right to health will dependent on other rights such as the right to life, dignity, equality and non-discrimination, liberty and privacy.<sup>143</sup> Yamin has argued that in order for a state to guarantee the right to health of its people, it must ensure access to life-saving medications for all.<sup>144</sup>

138 *Sudan Human Rights Organisation & Another v Sudan* (2009) AHRLR 153 (ACHPR 2009).

139 See, eg, World Health Organisation Commission on the Social Determinants of Health *Closing the gap in a generation: Health equity through action on the social determinants of health* (2008).

140 *SERAC* (n 46).

141 *International Pen* (n 46).

142 Vienna Declaration and Programme of Action UN General Assembly Doc A/CONF.157/23.

143 General Comment 14 (n 3) para 12.

144 AE Yamin 'Not just a tragedy: Access to medications as a right under international law' (2003) 21 *Boston University International Law Journal* 325.

## 4 Some challenges to the realisation of the right to health in Africa

While the above discussion has shown the significant strides the African human rights system has made in shaping the understanding of the right to health, several factors in the region hamper the effective realisation of this right. First, the slow ratification of some instruments, including the African Women's Protocol, the African Youth Charter and the Protocol on the Rights of Older Persons is a major concern.<sup>145</sup> It is to be regretted that since its adoption in 2016, the Protocol on the Rights of Older Persons has yet to enter into force. This clearly shows the lackadaisical attitudes of African governments towards addressing the human rights of vulnerable groups.

Second, the effective implementation of the norms and standards developed by the relevant regional human rights bodies at the national level remains a source of concern. It should be noted that despite the progressive provision on abortion in the African Women's Protocol, most African countries still maintain a restrictive abortion law regime. This situation has continued to pose threats to the lives and health of African women and has almost rendered illusory article 14(2)(c) of the African Women's Protocol.

Third, of recent the independence of some regional bodies, such as the African Commission, has been threatened by interference by the Executive Council of the AU.<sup>146</sup> Given its quasi-judicial role, any attempt to interfere in the work of the Commission could undermine human rights in the region. This onslaught on the Commission is a cause for concern, which requires the solidarity of all well-meaning persons interested in advancing human rights, in general, and the right to health, in particular. This portends ominous signs for the promotion and protection of human rights in the region.

Fourth, African governments continue to lag behind in their reporting obligations to the African Commission, especially with regard to the African Charter and the African Women's Protocol. The state reporting process is a means of assessing how states have performed in implementing the provisions of a treaty. A failure to

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145 Eg, as of March 2020, 42 countries have ratified the African Women's Protocol. See Centre for Human Rights 'State reporting process under the African Commission', <https://www.maputoprotocol.up.ac.za/index.php/state-reporting> (accessed 25 October 2021).

146 See Executive Council decision EX.CL/Dec.1015(XXIII) adopted at the AU Summit, Nouakchott, Mauritania, 25 June-2 July 2018.

report will make it impossible for a treaty-monitoring body to assess whether a state is living up to its obligations under a treaty. It will make it difficult for the African Commission to monitor progress made by states to realise the right to health guaranteed in the African Charter and the Women's Protocol. Therefore, the reporting process is crucial to the implementation of rights in a treaty at the national level. Currently, while some states are doing well with their reporting obligations, some are falling behind. With regard to the African Charter, so far only two countries are up to date with their reports, while others are in arrears with between one and 15 reports, and seven other countries have never submitted any reports to the Commission since ratifying the African Charter.<sup>147</sup> As for the African Women's Protocol, only nine countries have so far submitted reports to the Commission on the implementation of this instrument.<sup>148</sup> This leaves much to be desired with regard to African governments' commitments to realising women's rights to health in the region.

Fifth, there are many multidisciplinary and multifaceted non-judicial challenges to the realisation of the right to health, of which a discussion is beyond the scope of this article. However, suffice to note the disturbing high level of poverty in the region, which has been exacerbated by the COVID-19 pandemic and is a threat to realising the right to health.<sup>149</sup> As illustrated above, the enjoyment of the right to health will not be possible unless the underlying determinants of health, such as access to housing, food, water, and sanitation, are assured to everyone. Many African countries are lagging behind in ensuring that their citizens lead a dignified life. While progress has been made worldwide in reducing the rate of poverty, a significant number of people in Africa still live in abject poverty.<sup>150</sup> Poverty can aggravate ill-health and, at the same time, ill-health can lead to poverty. Thus, African governments will need to redouble their efforts in combating poverty in line with their commitments under the Sustainable Development Goals and Agenda 2063.<sup>151</sup>

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147 See African Commission on Human and Peoples' Rights 'State reports and Concluding Observations', <https://www.achpr.org/states> (accessed 25 October 2021).

148 African Union 'Maputo Protocol scorecard and index introduced to monitor implementation of Women's Rights', <https://au.int/en/pressreleases/20200623/maputo-protocol-scorecard-and-index-introduced-monitor-implementation-womens> (accessed 25 October 2021).

149 See, eg, R Nanima & E Durojaye *The socio-economic rights impact of COVID-19 in selected informal settlements in Cape Town* (2020)

150 World Bank 'Africa pulse: An analysis of issues shaping Africa's economic future', [http://www.worldbank.org/content/dam/Worldbank/document/Africa/Report/Africas-Pulse-brochure\\_Vol7.pdf](http://www.worldbank.org/content/dam/Worldbank/document/Africa/Report/Africas-Pulse-brochure_Vol7.pdf) (accessed 26 October 2021).

151 See E Durojaye & G Mirugi-Mukundi (eds) *Exploring the link between poverty and human rights in Africa* (2020).

## 5 Conclusion

This article examined the contributions of the African human rights system to the understanding of the right to health. It explored the normative framework on the right to health and discussed some unique features of the African human rights system for the realisation of this right. In this regard, the article argued that while the normative framework for the realisation of the right to health originated from the UN human rights system, in recent times the African human rights system has made significant contributions to the understanding of this right. This is evident in the provisions of some human rights instruments relating to the right to health in the region. These include the provisions of the African Women's Protocol, the African Youth Charter and the Protocol to the African Charter on the Rights of Older Persons. As indicated earlier, the African Women's Protocol contains a number of bold and radical provisions on the right to health, including sexual and reproductive health rights of women.<sup>152</sup> It has been argued that some of the provisions in these instruments not only go beyond what is contained in the UN treaties but have also broadened the understanding of this right in a way that has responded to the peculiar challenges in the realisation of the right to health in Africa. Indeed, other regions can learn from these developments in Africa.

Moreover, while the interpretation and clarification provided by the African Commission to the right to health would seem to align with the position of the UN treaty bodies, the Commission has gone a step further by articulating the nuances regarding the enjoyment of this right for African people. Thus, the Commission has interpreted that the enjoyment of this right will only be meaningful if the social determinants of health are accorded important priority in the region. The Commission has reasoned that a lack of access to electricity, adequate housing and essential medicines would undermine the enjoyment of the right to health. This important conceptualisation of the right to health is in response to the lived experiences of many people in Africa, where millions of people struggle to make a living.

The broad framing of the right to health in specific African human rights instruments and the progressive interpretation provided by the African Commission are a testament to the fact that the African human rights system should be taken seriously for its contribution

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152 Eg, the provision of arts 14(1)(d) and (e) protecting women from sexually-transmitted infections, including HIV/AIDS, and 14(2)(c) allowing for abortion on limited grounds.

to the understanding of the right to health. More importantly, it is a clear indication that the UN human rights system and other regions can learn from this unique African experience. While it is important to acknowledge the contributions made by the African human rights system to the understanding of the right to health, it is imperative that some of the challenges identified as militating against the effective implementation of this right at the national level are addressed.