Chapter 2
Ensuring the Realization of the Right to Health Through the African Union (AU) System: A Review of Its Normative, Policy and Institutional Frameworks

Getahun A. Mosissa

Abstract The African continent has been and continues to be at the epicentre of a global public health crisis. Each year millions of lives in the continent continue to be wasted from diseases preventable with relative ease such as malaria, diarrhoea, tuberculosis (TB), pneumonia, measles, HIV/AIDS, malnutrition, etc. It is the continent where individuals have the lowest life expectancy in the world by any standard of measures. Maternal, under-five and adult mortality rate is the highest in the world. Evidence also show that the continent, sub-Saharan region in particular, is the most food insecure part of the world where over one in four persons are undernourished. In spite of these staggering facts, Africa's average total expenditure on health is one of the lowest in the world. The continent hosts poorly resourced health infrastructures and systems. Ordinary individuals, especially vulnerable persons, in the continent have the least possible access to health care and the underlying determinants of health as well as to other related social protection mechanisms such as social security and health insurance. These all raise very serious issues with the obligations of the States Parties to ensure the right to health for everyone within their jurisdictions. This contribution has accordingly the following two main objectives. The first is to identify the underlying obstacles

PhD Candidate, Dept. International and Constitutional Law, University of Groningen, The Netherlands and Lecturer, Jimma University, Ethiopia. I would like to thank Toebes and Nnamuchi for their insightful comments; and Koleva for her worthwhile contribution to the editorial works. Any errors or mistakes whatsoever, however, remain on my shoulder. For reactions and comments the author can be reached through the below e-mail addresses.

G. A. Mosissa (✉)
Department of International and Constitutional Law, University of Groningen, Groningen, The Netherlands
e-mail: getalex2000@yahoo.com; g.a.mosissa@rug.nl

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to the realization of the right to health in the continent. In this respect, it particularly asks the extent to which the alleged lack of resources can be said to explain the inaccessability of health care and the underlying determinants of health. The second is to describe the relevant legal, policy and institutional frameworks available at the African Union (AU) level with the view to assessing their effectiveness in ensuring the right to health. In this regard, it is asked if and to what extent the two principal human rights organs of the AU with remedial powers, the Court and Commission, are able to practically hold the Member States accountable for their gross failures in realizing the right to health. Overall, it emerges from the discussion that the violation of the right to health in the continent is only a mirror of persistent socioeconomic injustices mainly resulting from lack of systemic accountability. This suggests that it is impossible to ensure the effective realization of the right to health without first addressing the structural accountability deficits not just in the health sector but also in the respective socioeconomic and political systems of the Member States as a whole.

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> There is still an enormous gap between the rhetoric of African governments, which claim to protect and respect human rights and the daily reality where human rights violations remain the norm.
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> So many people are living in utter destitution; so few of them have any chance to free themselves from poverty. Their dire situation is exacerbated by the failure of governments in the Africa region to provide basic social services, ensure respect for the rule of law, address corruption and be accountable to their people.[1]

2.1 Introduction

It would not take much effort to appreciate the extremely severe problem of poor health in Africa. Facts and figures abound and each source confirms that Africa has been and is still at the epicentre of a global public health crisis. The life expectancy in Africa is unacceptably the lowest in the world by any standards of measures.[2] According to one of the recent WHO reports, for instance, the average life expectancy in the continent was 53 years (against 68 years of global average) in 2008. Adult mortality rate (described as the probability of dying between 15 and 60 years per 1,000 population) was 392 (globally 180) in 2008. The distribution of disease burden estimated by percentage of total Disability Adjusted Life Years (DALYs) per 2004 data shows that over 70 per cent of deaths occurred from communicable diseases (compared to global average of 39.7 per cent) of which infectious and parasitic diseases such as HIV/AIDS, diarrhoea, malaria, TB accounted for the largest proportion.[3] Most Africans have the least possible access to basic goods and services: there are few health and other social services available to the population at large.[4] They are also the least protected against socioeconomic causes of vulnerability such as sickness, unemployment, low income, ageing, drought, famine, etc., because there are no or insufficient social protection

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[1] Amnesty International Report 2009: The State of World's Human Rights (hereinafter Amnesty International Report 2009, available at www.amnesty.org last accessed 27 June 2013), p. 9.

[2] See the World Health Report 2000: Health Systems: Improving Performance, World Health Organization, Geneva (hereinafter World Health Report 2000, available at www.who.int/whr/2000/en/whr00_en.pdf last accessed 24 March 2013), Tables 2.2 and 2.3, pp. 29–30. In addition to those cited here and below, documents cited at footnote 48, 59, 88, 70 and 97 also provide interesting facts and figures confirming this assertion.

[3] See Health Situation Analysis in the African Region: Atlas of Health Statistics 2011, World Health Organization Regional Office for Africa (hereinafter Atlas of Health Statistics 2011, available through www.afro.who.int/en/clusters-a-programmes/ard/research-publications-and-library-services.html last accessed 24 March 2013), pp. x–xi.

[4] See the World Health Report 2010: Health Systems Financing: the Path to Universal Coverage, the World Health Organization, Geneva (hereinafter World Health Report 2010, available at www.who.int/whr/2010/10_summary_en.pdf last accessed 24 March 2013), Executive Summary, pp. x–xi.

mechanisms it was, for instance, estimated in the World Health Report 2010 that only between 5 and 10 per cent of the population were covered by some form of social protection systems.[5]

Ill-health and related impoverishments due to lack of access to basic health entitlements disproportionately affects those vulnerable parts of the population in Africa such as children, women, the poor and rural population (note that the majority of the African population live in rural areas mostly on subsistence farming). For instance, under-five and maternal mortality still remain to be grave concerns for most countries in the continent. This was shown in one of the most recent reports concerned with assessing Africa's progress towards MDGs.[6] According to this report, of 26 countries worldwide with under-five mortality rates above 100 deaths per 1,000 live births in 2010, 24 were in Africa.[7] Sub-Saharan Africa was the worst in this regard where 'one in around eight children die before the age of five (121 deaths per 1,000 live births)' and this was 'nearly twice the average in developing countries overall and more than 17 times the average in developed countries'.[8] The report also shows an unacceptably high rate of maternal mortality: the continent's average mortality ratio (MMR) was said to be 590 deaths per 100,000 live births in 2008. 'This means that, in 2008, a woman in Africa died as a result of pregnancy or childbirth every 2.5 min–24 h, 576 a day, and 210,223 a year.'[9]

The Africa Human Development Report, the first of its kind, can also help us to see the dire situation of health impoverishment through the prism of food insecurity in the continent which is, again, most severely affecting the vulnerable parts of the population. In particular, this is most severe in sub-Saharan Africa, the most food insecure part of the world, where it continues to impoverish the health of the population. As it states

> For too long the face of sub-Saharan Africa has been one of dehumanizing hunger. More than one in four Africans is undernourished, and food insecurity—the inability to consistently acquire enough calories and nutrients for a healthy and productive life—is pervasive. The spectre of famine, which has virtually disappeared elsewhere in the world,

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[5] Ibid.

[6] See MDG Report 2012: Assessing Progress in Africa towards the Millennium Development Goals: Emerging Perspectives from Africa on the post-2015 Development Agenda, Economic Commission for Africa et al. (hereinafter MDG Report 2012: Assessing Africa's Progress, available at www.undp.org/dam/undp/library/MDG/english/MDGRegionalReports/Africa/MDGReport2012_ENG.pdf(final).pdf last accessed 25 August 2013), pp. 56–64.

[7] Ibid.

[8] Ibid., p. 59. 'The four main global killers of children under-five are pneumonia (18 per cent), diarrhoeal diseases (15 per cent), pre-term birth complications (12 per cent) and birth asphyxia (9 per cent). Malnutrition is an underlying cause in more than a third of under-five deaths. Malaria is still a major cause of child mortality in Africa (excluding North Africa), causing about 16 per cent of under-five deaths.' Ibid.

[9] Ibid., p. 65. In the report, Malaria, HIV/AIDS, TB were mentioned as among major driving factors behind MMR in the continent.

> continues to haunt parts of sub-Saharan Africa. Famines grab headlines, but chronic food insecurity and malnutrition are more insidious, often silent, daily calamities for millions of Africans.[10]

Paradoxically, the average proportion of expenditure on health is the lowest in the world, which does not reflect the state of ill-health in the continent.[11] It was in 2001 that the African leaders promised to increase the average national health expenditure on health to 15 % of the annual national budget by 2015[12] but only negligible number of countries has met or is on track to meet the target.[13]

These alarming figures raise very serious questions with respect to the international human rights obligations of the AU and its Member States. They particularly compel us to question the relevance and effectiveness of the international mechanisms for the protection of human rights mechanisms in Africa. Narrowing this question to the context of the right to health, the following discussion provides a review of the normative, policy and institutional frameworks in place at the AU level for the realization of the right to health in the continent. The following discussion shows that a great majority of countries in Africa are parties to numerous major international (that is, global and continental) human rights instruments providing for the right to health.[14] There have also been series of global and continental policy initiatives and commitments concerned with addressing the health situation in the continent including the most recent AU Social Policy Framework adopted in 2008. Nevertheless, only very little has been achieved on the ground.[15]

Several factors can be blamed for such gross infectiveness and failures. Resource constraint (scarcity), poor socioeconomic conditions, lack of

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[10] See Africa Human Development Report 2012: Towards a Food Secure Future, UNDP (here inafter Africa Human Development Report 2012, available at www.undp.org/content/dam/undp/library/corporate/HDR/Africa HDR/UNDP-Africa HDR-2012-EN.pdf#page = 10&zoom = auto,0,243 last accessed 25 August 2013), p. 1.

[11] Africa's average total expenditure on health was only for 6.2 % of GDP in 2007 (global average by then was 9.7). See Atlas of Health Statistics 2011.

[12] See Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious Diseases 2001, Abuja, Nigeria, Doc. OAU/SPS/ABUJA/3 (hereinafter Abuja Declaration, available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf last accessed 30 April 2013), para 26.

[13] See 'State of Health Financing in the African Region, Discussion Paper for the Interministerial Conference: Achieving Results and Value for Money in Health, 4–5 July 2012, Tunis, Tunisia', WHO Regional Office for Africa (hereinafter WHO 2012: State of Health Financing in Africa, available at http://www.hha-online.org/hso/system/files/health_financing_in_africa_edited_03_july_-_copy.pdf last accessed 30 April 2013), p. 7.

[14] These include the Universal Declaration of Human Rights (UDHR), International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of the Child (CRC), Convention on Elimination of All Forms of Discrimination Against Women (CEDAW), International Convention on the Elimination of All Forms of Racial Discrimination (CERD), African Charter on Human and Peoples' Rights (African Charter or the Banjul Charter), African Charter on the Rights and Welfare of Child, the Protocol to the African Charter on the Rights of Women in Africa (Protocol on Rights of Women in Africa). See also footnote 52.

[15] See Sect. 2.3.3.

infrastructure development and poverty are among commonly cited factors impeding the realization of the right to health in the continent. This, however, sharply contradicts with overwhelming evidence indicating, for instance, the presence of abundant resources and endemic corruption. This author argues that the major underlying reason behind gross failures in ensuring the right to health has more to do with systemic, structural problems and less with scarcity. In making this argument, the author proposes to analyse the right to health in terms of three key pillars of protections that it guarantees under international law: the right to freedom of choice, basic health entitlements and access to justice. This approach provides us with very helpful framework in appreciating the extent to which the alleged lack of material resources could in fact be blamed for violation of the right to health in the continent. Accordingly, it will be seen that the obligation to ensure the first two key pillars falls within the elementary institutional responsibility of the State and by no means could be blamed on lack of resource constraints. Admittedly, ensuring the second element may involve substantial resource investment but this is not always the case. Not all the State Party failures in this respect can be attributed to the problem of scarcity as such.

The discussion, then, continues to ask if there exist strong and effective legal mechanisms, enforcement measures, so as to deal with the problem identified therein. In relation to this, the discussion proceeds from the basic normative principle regarding the responsibility of intergovernmental organizations like the AU which have joint responsibilities with its Member States for the protection of human rights in the continent. These responsibilities of the AU are clearly enshrined in its Constitutive Act and other relevant continental and global human rights treaties; that is, it is both a matter of constitutional and international legal responsibility for the AU to ensure the effective protection of human rights in the continent.[16] From this follows the obligation to ensure the existence and effective functioning of legal mechanisms to redress (potential) violations of human rights at the continental level. In this regard, the discussion assesses if and the extent to which the Court and Commission, the two principal human rights organs of the AU with remedial powers, have been playing meaningful role in addressing the problem of structural accountability in the continent. For reasons to be seen, the finding in this respect is quite disappointing.

Overall, by engaging in such a comprehensive review of legal, policy and institutional frameworks and practices of the protection of the right to health through the AU systems, this contribution intends to provide a useful insight into the underlying factors paralysing global and continental efforts to improve

[16] For the objectives and purposes of the AU, see Preamble *cum* Articles 3 and 4 of the Constitutive Act of the AU (AU Constitutive Act) adopted 11 July 2000 entered into force 26 May 2001 (available through www.au.int/en/treaties last accessed 10 May 2013). See also, *mutatis mutandis,* the responsibility of the AU enshrined in the Banjul Charter especially at Part II (concerning measures of safeguard) and in the ACRWC at Part II; Article 46 Statute ACtJHR and Articles 30 and 31 Protocol ACtHPR (both instruments cited at footnote 107). See generally Viljoen 2012, p. 156f, Yusuf and Ouguergouz 2012, Doumbé-Billé 2012.

conditions resulting from systematic exclusion, marginalization and impoverishment. To this extent, it particularly aims to inform, from the perspective of the right to health, future academic and policy debates concerning the collective international responsibilities of the AU and its Member States in ensuring the realization of human rights and basic social justice in Africa.

2.2 Human Dignity, the Right to Health and Social Justice

But before proceeding to the review of the realization of the right to health through the AU system, the overarching theoretical arguments inspiring this discussion as regards the normative foundation and implications of the right to health in general are discussed. The objective here is to show how fundamental it is for individuals to have their right to health respected and, correspondingly, how compelling it is on the part of the State to ensure, in certain respects as a matter of priority, the right to health for everyone within its jurisdiction. The principal argument is that the right to health directly flows from the principle of respect for human dignity.[17] It is notable that international human rights law provides human dignity as the foundational normative principle[18] of all human rights. Thus, all persons have equal and inalienable rights derived from the inherent dignity of human being solely because they are all born free and equal in dignity and the rights thereof and that the recognition of this is the foundation of freedom, justice and peace in the world.[19]

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[17] From the outset it should be stated that the theoretical idea and significance of human dignity has been debated generally and in relation to the right to health but here the sole focus is on its importance for the practical understanding of the normative essence and implications of the right to health as enshrined under international human rights law. For a general discussion on human dignity, see Klein and Kretzmer 2002, Rosen 2012, Dworkin 2011, Riley 2011, Kateb 2011, Spijkers 2011, Malpas 2010, Malpas and Lickiss 2010, Waldron 2007, Dworkin 2006, 1997, Weinrib 2005, Carozza 2003, Feldman 1999, 2000, Meyer and Parent 1992, Schacter 1983. In the context of the right to health, see generally Kaufmann et al. 2011, Malpas and Lickiss 2010, Aasen et al. 2009, Andorno 2009, Schroeder 2010, Eibach 2008, Chan and Pang 2007, Chochinov 2007, Häyry 2004, Harris and Sulston 2004, Brownsword 2003, Gentzler 2003.

[18] In this discussion the notion of 'norm' and 'principle' should be understood in the sense they are used in Alexy 2010a, b. According to Alexy, there are three essential aspects to deontic norms: command, prohibition and permission which he also analysed in the context of constitutional rights theory (see Alexy 2010b, pp. 114–138); on his theory of principle see ibid., at Chap. 3.

[19] This is the normative statements enshrined in the preambles of the United Nations Charter (UN Charter) and almost all of the international human rights treaties. For instance, the Preamble to UDHR provides, 'recognition of the inherent dignity and of equal and inalienable rights of all members of the human family is the foundation of freedom, peace and justice in the world… the disregard and contempt of the same has been the source of all forms of indignity and injustice…'. The Preambles to the twin Covenants, International Covenant on Civil and Political Rights (ICCPR) and ICESCR, repeat this saying, 'The States Parties to the present Covenant …

But what does the principle of human dignity practically entail? There seems to be a general consensus that the concept of human dignity in human rights law refers to the inherent value that everyone possesses just by virtue of being a human person and hence worthy of unconditional respect;[20] an 'intrinsic', 'unconditional', 'incomparable', 'transcendental' value of humanity.[21] It is possible to construe the term 'by virtue of being a human person' as meaning by virtue of being a biological and moral person because a human being has, in essence, a biological and moral existence. This means the value of dignity pertains equally and inseparably to both the biological and moral aspects of humanness.[22] As having both the biological and moral existence, every person has equal and inherent needs required to live and function as such.[23] Based on this we can say that the core and primary essence of the principle of human dignity concerns the safeguarding of the physical and moral inviolability (respect-worthiness, respectfulness) of a person by asserting respect for the inherent being and needs of every person.[24] The ideal of

(Footnote 19 continued)
[recognize] that [the equal and inalienable rights of all members of human family declared in UDHR] drive from the inherent dignity of the human person'. The Preamble to the Banjul Charter also states, '[the States Parties recognize] on the one hand, that fundamental human rights stem from the attributes of human beings, which justifies their international protection and on the other hand, that the reality and respect of peoples' rights should necessarily guarantee human rights'….

[20] See footnote 17.

[21] See Rosen 2012, pp. 19–31 (discussing Kant's usage of the concept of dignity), Parfit 2011, Chap. 10 at Sections 34 and 35, (also discussing Kant's notion of value and dignity), Sulmasy 2010, pp. 13–17, Malpas 2010, pp. 19–20, Parent 1992, pp. 62–63. This does not mean that there is a universal conception on the idea and function of human dignity both generally and in human rights law. For more on this see the exchange between Carozza 2003, 2008, MCCrudden 2008, Riley 2010, at Sect. 1.2 (providing a very helpful intervention in the debates between the former two and several others); M'Honey 2012a, b and White 2012. See also Henry 2011, Rao 2011. There are also authors who reject the relevance of the notion of human dignity in the current human rights discourse altogether. See particularly Macklin 2003, Fyfe 2007, Hennette-Vauchez 2011.

[22] Usually the discussion on dignity concentrates on the moral aspects of being a human person and it rarely expresses the fact that the value of dignity equally pertains to the biological aspect of being human. For the purpose here we can say that by the natural fact of being born as free biological and moral beings, all human beings have equal dignity and, on this very basis, have the right to enjoy equally those basic biological and moral human needs inherent to their dignity.

[23] For more on the practical construction of the idea of human dignity see Nussbaum 2006, p. 69ff. (referring to the idea of life in dignity in its intuitive sense), Spijkers 2011 (discussing the sense in which the practical concept of human dignity has over the years been consistently employed in the legislative practices of the UN General Assembly); Henkin 1992, Parent 1992. The following authors have attempted to apply the principle of human dignity to the practical context of right to health and health care: Lickiss 2010, Malpas 2010, Sulmasy 2010 and in some of the essays in Aasenet et al. 2009, Kaufmann et al. 2011.

[24] In the Oxford Advanced Learner's Dictionary the word 'inviolable' is defined as 'that must be respected and not attacked or destroyed'. See also Articles 4 and 5 ACHPR, Article 1 Charter of Fundamental Rights of the European Union (EUCFR). Article 1 of EUCFR states, 'Human dignity is inviolable. It must be respected and protected'. For commentary on this provision, see Olivetti 2010. See Rosen 2012, pp. 57–58 (discussing the notion of respect-as-observance and

respect signified by human dignity itself has both negative and positive aspects. In the negative sense, it implies a prohibition of actions or behaviours infringing upon the inviolability of a human being. Whereas in the positive sense it prescribes a performance of positive actions required to ensure the inviolability of the same.[25] This shows that the principle of respect is the conceptual and normative essence of the notion of human dignity; in fact, it can be argued that without this ideal of respect there would not be any substantive meaning of human dignity as such.[26]

This brings us to the next important question: how does this principle of respect for human dignity inform our understanding of the nature of the right to health—that is, the nature of freedoms and entitlements that it guarantees and the State obligations thereof? My argument in this respect proceeds in two steps. The first pertains to the foundation of the normativity of the right to health and the second to general overarching aim of socioeconomic rights, where the right to health is provided as one among such rights. Ultimately, we arrive on the conclusion that, in the context of the right to health, respect for the dignity of human being means respect for those basic biological and moral health needs of everyone. In practical terms, this entails the realization of the right to health care and its underlying determinants in strict accordance with the principle of social justice.

2.2.1 The Normativity of the Right to Health

With regard to the first point, it is needless to say that many have discussed at great length the meaning and implications of the right to health under international law.[27] It is not my intention to repeat those discussions here but to state the nature of the normativity of the right to health in light of the principle human dignity. We have just said above that the principle of respect for human dignity implies respect for the inherent biological and moral needs of a person; health stands out as one among such fundamental needs. It is a matter of common sense that a person must have access to his or her daily biological and moral needs so as to live a healthy

(Footnote 24 continued)
respect-as-respectfulness, Parent 1992, p. 63 (discussing the idea of dignity as moral inviolability), Chaskalson 2002, pp. 134–135, Frowein 2002, pp. 121–124, Riley 2010, p. 133f, Klein 2002, p. 146ff, Kretzmer 2002, p. 167ff, Harris and Sulston 2004, p. 799ff, Dworkin 1997, pp. 198–199, 2006, pp. 9–21, Andorno 2009, Schacter 1983. See also Parfit 2011, Chap. 10, Sections 33 through 35.

[25] See Riley 2010, *especially* at Sect. 2.5; Parent 1992, p. 61ff.

[26] See footnote 17 & 24. This principle is referred to as the principle of respect for human dignity, the principle of human dignity or, in short, human dignity throughout this discussion.

[27] See generally Tobin 2012, Backman 2012, Toebes et al. 2012, and Toebes 1999. See also UN Doc. E/CN.4/2003/58, at Section I (Paul Hunt, discussing sources, contours and contents of right to health).

life.[28] In fact, at some basic level one would not be able to dispense with such conditions and still be able to live as a being with dignity: at such basic level they become matters of existential needs.[29]

Interestingly, this implies that a human life in which the essential conditions of life are not adequately available, is not a life of dignity and, hence, not a healthy human life.[30] This, in turn, establishes health as an integral component of the very notion of life of dignity. The essence of the right to health, its normativity, is clearly constituted by the nature of interest that it ultimately seeks to safeguard: a dignified human life. It does so by specifically requiring the realization of basic biological and moral health needs inherent in and indispensable for a life in dignity.[31] Based on this, it is logical to hold that the normativity of the right to health is one of the principal constitutive elements of the principle of respect for human dignity. In Sect. 2.4, we will be considering specific kinds of guarantees and corresponding State Party responsibilities flowing from the right to health. But for the purposes of this contribution it suffices to stress that because of such substantive relationships between human dignity and the right to health it is impossible for the State to satisfy the core normative demands of the former without properly attending to the requirements of the latter: the realization of basic material and moral health needs of a person.[32]

2.2.2 The Principle of Social Justice

The requirement of the right to health is part and parcel of the overarching State Party obligation under socioeconomic rights recognized in international law which, as I argue, concerns the realization of basic social justice for everyone in a society.[33]

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[28] This is just one of the many vital imports of the capability approach developed by Nussbaum and Sen. See Nussbaum 2000, 2006, 2011, and Sen 1999, 2004, 2009.

[29] Nussbaum 2006, p. 71 (referring to the idea of 'threshold level' beneath which each central human capability need should not fall so as to ensure 'a truly human functioning').

[30] Ibid., pp. 76–78 (listing the ten central human capabilities need which, as she argues, is worked out from 'an intuitive idea of a life that is worthy of the dignity of the human being'; this is also discussed earlier in Nussbaum 2000 and more recently in Nussbaum 2011). See Shue 1996, at Chap. 1, Chaskalson 2002, p. 142 (stating that there can be little dignity in living under the conditions socioeconomic deprivations).

[31] See also Sect. 2.3.

[32] *Compare* this generally with the views of the Committee on Economic Social and Cultural Rights (CESCR) in, inter alia, General comment No. 3: The nature of States parties' obligations (Article 2, para 1) (Annex III), UN Doc. E/1991/23(SUPP) (hereinafter General Comment 3); General comment No. 14(2000): The right to the highest attainable standard of health (Article 12 of the International Covenant on economic, social and cultural rights), UN Doc. E/C.12/2000/4 (hereinafter General Comment 14).

[33] But we should not, however, see the argument from social justice as a new addition to this discussion. As it is to be seen in the subsequent paragraphs, the obligation of the State to ensure

That the realization of basic social justice constitutes the underlying aim of socioeconomic rights can be substantiated with reference to the major human rights treaties providing for the same.[34] In essence, socioeconomic rights guarantee material and socioeconomic conditions of human dignity and, hence, wellbeing. There are several substantive principles of social justice that should guide the State Party's performance towards the realization of the socioeconomic rights but which cannot obviously be considered here. So, of the several principles of social justice, the following paragraphs pay attention to the principle of equality (and non-discrimination) and solidarity because of their vital importance in relation to the whole system of socioeconomic rights protection and the topic under discussion. In explaining these, I would like to focus on Articles 21 through 26 of UDHR which, taken together with other subsequent treaties such as ICESCR and ACHPR, provide a comprehensive account of basic social justice and impose commensurate obligations on States Parties towards their people.[35] In substance, these provisions establish that the State Party bears particularly compelling obligations in guaranteeing an adequate standard of living worthy of human dignity for all members of the society.[36]

Article 21 of UDHR is a crucial provision in that it, inter alia, recognizes the will of the people as the foundation of socioeconomic and political governance of a given society.[37] The provision also recognizes important rights flowing from or closely related to this: the right to equal participation in the government and the right to equal access to public services available in one's country.[38] Everyone has these rights of equality simply by virtue of being a member with equal dignity and worth.[39] These rights, in turn, have significant bearings on the ability of individuals to obtain those material conditions indispensable for their wellbeing and the

(Footnote 33 continued)
basic social justice flows directly from the fundamental principle of human dignity described above. In fact, to the extent social justice concerns the realization of those basic and indispensable material conditions of human life, it can be regarded as a sub-normative principle of human dignity. See generally Shue 1996, pp. 22–29 and 55–64 (discussing the notion of subsistence rights and the generic obligations flowing therefrom).

[34] Note that by socioeconomic rights regime I am referring to all those international legal norms (treaties) providing for the rights of individuals to have access to basic material goods and services available within their countries or systems.

[35] For commentaries on these provisions see several essays in Eide et al. 1992, Morsink 1999, *especially* at Chap. 6. See also Oraá 2009, pp. 197–203.

[36] See particularly Articles 22, 23, 25 and 26. See Morsink 1999 ibid, Eide et al. 1992 ibid.

[37] See Article 21 (3) which partly reads, 'The will of the people shall be the basis of the authority of the government; this shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage …'; for commentary on this provision see Rosas 1992.

[38] Article 21(1) and (2).

[39] See also Dworkin 1997, pp. 180–182 (critiquing the underlying assumption behind Rawls' contractual theory of justice. For Dworkin 'individuals have a right to equal concern and respect in the design and administration of the political institutions that govern them' and that this is 'a natural right of all men and women' in the sense that it is 'a right they possess not by virtue of birth or characteristic or merit or excellence but simply as human beings with the capacity to make plans and give justice') (emphasis added).

realization of their life-projects.[40] And, it is the State, a principal political institution which, as a matter of human rights law, bears a primary responsibility in ensuring the right to equal participation and access for all within its jurisdiction.[41]

Another equally important principle that should be mentioned here is the principle of solidarity. As enshrined in, inter alia, Articles 22 and 25 of UDHR, this principle essentially refers to the protection that must be afforded to vulnerable members of a society, those to whom basic material conditions of life are not available or who may be under an imminent risk of losing the same due to reasons beyond their control.[42] Both Articles recognize, among other things, the right of everyone to be secured against different causes of vulnerability. Article 22 states, 'Everyone, as a member of society, has the right to social security and is entitled to realization, …, of economic, social and cultural rights indispensable for his dignity and free development of his personality'.[43] And, Article 25(1) partly states, 'Everyone has … the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his [or her]'.

The principle of solidarity is not quite different from the principle of equality (and non-discrimination) just mentioned above; in fact, they are complementary normative principles. Hence, by directly speaking to the needs of vulnerable persons and the corresponding State obligations, the principle of solidarity clearly seeks to reaffirm the general right of everyone to equal respect and concern. This is so because as long as vulnerable persons do not, in fact, have equal access to basic material conditions of life, it is very difficult to say that the State is treating them as persons with equal worth and, hence, respect and concern. Accordingly, the principle of equality (and non-discrimination) and solidarity are both fundamental regulative principle(s) that States Parties to treaties providing for socioeconomic rights must comply with in the realization of basic social justice for everyone

[40] According to Gould, this right is justified on the basis of what she calls the principle of equal positive freedom, which she also considers as the foundation of (social) justice and democracy. See Gould 2004, pp. 37–39 and 71–74.

[41] See generally Fredman 2008, at Chaps. 1 and 2.

[42] Note that in referring to the principle of solidarity here I am specifically concerned with the legal obligation of the state to towards those vulnerable members of the society who are or might be, for reasons beyond their control, unable to cater for themselves and their dependents those basic material conditions of life. See General Comment 3, para 12; General Comment 14, *especially* at para 18 through 27 *cum* para 52); 'Principles and Guidelines on Implementation of Economic Social and Cultural Rights in the African Charter' adopted by the African Commission on its 50th Ordinary Session, 24 October 2011, (available at http://www.achpr.org/files/instruments/economic-social-cultural/achpr_instr_guide_draft_esc_rights_eng.pdf last accessed 20 March 2013) (hereinafter Principles and Guidelines), where the African Commission specifically underscores this obligation of the States with respect each of the socioeconomic rights guaranteed under the African Charter. See also Shue 1996, pp. 29–34. For some theoretical discussions on the idea of solidarity see generally Lotito 2010, p. 171, Hestermeyer 2012, pp. 46–51, Koroma 2012, Rangel 2012, Nussbaum 2006, pp. 36–39, 41–45 and 85–86 (discussing the Grotian, Aristotelian, Lockian and Marxian account of society and sociability), Fredman 2008, pp. 25–30.

[43] See also Articles 11(1) and 9 ICESCR; Article 18(3) ACHPR (compare this with Article 29(4) of the same on the duties of individuals towards their community).

within their jurisdictions.[44] This is even more crucial with respect to the State Party's obligation to realize the right to health, for, as stated above, the interest that the right to health seeks to protect go to the very heart of human dignity and social justice.

Interestingly, it has clearly been shown that the most fundamental and pressing question pertaining to the right to health is the realization of the right to health care and the social determinants of health for everyone in a society in accordance with such principles as equality, fairness, justice and equity.[45] It is, thus, imperative that the right to health be ensured for everyone in society: 'not just the wealthy, but also those leaving in poverty; not just majority ethnic groups but minorities and indigenous peoples, too; not just those leaving in urban areas, but also remote villagers; not just men, but also women'.[46] So it is noteworthy that the question of social justice in the context of the right to health does not just refer to the distribution of goods and services to certain individuals as such but rather to the ensuring of background justice, fairness and equity in the distribution of those goods and services in a society.[47] Such a question of systemic justice is indeed 'a matter of life and death'.[48] The reason is that, as articulated by the Commission on the Social Determinants of Health (CSDH):

> [social justice] affects the way people live, their consequent chance of illness, and their risk of premature death. … [The] inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social and economic forces. Social and economic policies have a determining impact on whether a child can grow and develop to its full potential and live a

[44] See generally General Comment 16(2005): The equal rights of men and women to the enjoyment of all economic, social and cultural rights (Article 3 of the International Covenant on Economic, Social and Cultural Rights), UN Doc. E/C.12/2005/4; General Comment 20: Non-Discrimination in economic, social and cultural rights (Article 2, para 2, of the International Covenant on Economic, Social and Cultural Rights) UN Doc. E/C.12/GC/20. See also 'Report of the United Nations High Commissioner for Human Rights', UN Doc. E/2008/76 discussing the role of the twin principle of equality and non-discrimination in the protection of women's socioeconomic rights.

[45] On this see series of reports by Paul Hunt, the former UN Special Rapporteur on the Rights of everyone to the Highest Attainable Standard of Physical and Mental Health, between 2002 and 2008, available through UNOHCHR website http://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx last accessed 15 April 2013). See also his Report to UN Human Rights Council (UN Doc. A/HRC/7/11, available at http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/105/03/PDF/G0810503.pdf?OpenElement last accessed 15 April 2013) and to UN General Assembly (UN Doc. A/63/263).

[46] Clapham 2007, p. 128 (citing Paul Hunt).

[47] See generally Hunt and Backman 2008, Backman 2010.

[48] '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, Geneva, World Health Organization (hereinafter, Final Report CSDH 2008, available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf last accessed 28 March 2013), p. 1.

> flourishing life, or whether its life will be blighted. … The development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health.[49]

It may be very difficult to exaggerate how precarious and pervasive it is especially for vulnerable persons not to have access to the material conditions of life and, therefore, how aggravated the obligations of the State responsibilities towards the same should be. It should, however, be clear enough that '[a] life that achieves the full promise of human dignity requires, among other things, escape from premature death, the resources to withstand debilitating disease, the ability to read and write, and, in general, opportunities and freedoms unavailable in the amidst of extreme poverty and deprivation'.[50] In my view, this is essentially what comes out of the core normative demands of the principle of respect for human dignity, the right to health and principle of social justice.

2.3 The Legal Basis of the Right to Health in the AU System

2.3.1 Its Basic Features

An apt starting point in considering the legal frameworks for the protection of the right to health in Africa is an insight into the sources of the responsibilities of the AU and, by extension, its Member States. The vast majority of African countries are parties, to the major international (those adopted under the aegis of both the UN and AU) human rights treaties providing for the right to health.[51] While it is not necessary to discuss the contents of each of the treaties here, it is essential to highlight the commonalities they share regarding the protection of the right to

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[49] Final Report CSDH 2008, ibid. See Toebes 2012, p. 112ff. (referring to this same report in her discussion of the social determinants of the right to health). See also Rio Political Declaration on Social Determinants of Health, adopted at World Conference on Social Determinants of Health, Rio De Jeneiro, Brazil, 19–21 October 2011 (hereinafter Rio Political Declaration, available at http://www.who.int/social_determinants/en/ last accessed on 20th March 2013), paras 1–13; Alma-Ata Declaration, para V. See generally Filho 2008 (discussing, especially drawing on the experiences from Latin America, the role of human right-based approach to health policies and programmes for the realization of social justice).

[50] Gauri and Brinks 2008, p. 1.

[51] For the recent update concerning the status of ratifications of African countries of international human rights law, see Viljoen 2012, pp. 143–145 at Table 3.2 and pp. 285–287. Thus, at UN level more than 90 % of African Countries (calculated at the exclusion of the new South Sudan) have ratified ICESCR; ICCPR; CERD; CRC; CEDAW; at continental level it stands that out of 53 countries (excluding South Sudan) ACHPR is ratified by all countries; ACRWC by 46; Protocol on the Rights of Women in Africa by 30 countries. As Nnamuchi and Ortuanya 2012 notes, all 53 member countries had ratified African Charter as of 15 March 1999 (at p. 179).

health. Therefore, notwithstanding their formal sources (whether originating from global or regional frameworks) and the scope of protections afforded by each treaty,[52] there are several basic features that treaties providing for the right to health have in common. I would like to state three of such commonalities that I found pertinent for this discussion. One is that they all expressly recognize the right to health as a fundamental human right flowing from inherent human dignity aimed at ensuring basic material and moral health needs of a person. In fact, it is already argued above that the right to health is an integral component of the very notion of the right to human life in dignity.

The other is that they all define a particularly compelling obligation of the State Party.[53] The overarching compelling obligation of the State Party prescribed under international law ensuring the best (highest) attainable standard of physical and mental (moral) health for everyone within its jurisdiction.[54] From this of course follows several other specific obligations of both immediate and progressive nature.[55] But it is important to note that whether a given obligation of a State Party

[52] The following treaties recognize the rights of every person to the highest attainable standard of physical and mental health for every person. Article 25 UDHR, Article 12 ICESCR and Article 16 ACHPR. The protections enshrined in these treaties are further heightened by numerous thematic treaties aimed at safeguarding the interests of persons or group of persons who are or may be more vulnerable to discrimination, marginalization or exclusion in a society because of different background factors impairing, in one way or another, the equal and full enjoyment of their human rights. The following are major thematic treaties providing also for the protection of the right to health in Africa: CRC; CERD; CEDAW; Convention on the Rights of Persons with Disabilities (CRPWD); ACRWC; Protocol on Rights of Women in Africa. Hence, by subscribing to these binding legal instruments, States Parties have specifically undertaken to address those background factors as minority (childhood), gender, race, ageing, disability and other prohibited grounds of discriminations impairing the fullest enjoyment of the human right to health with utmost priority and urgency. In accordance with Articles 60 and 61 ACHPR, Article 31 Protocol AfCtJHR (footnote 107) and Article 7 Protocol AfCtHPR (footnote 107), all of these treaties are directly enforceable before the Commission and the Human Rights Court to the extent they are ratified by the State Party concerned. Further, the right to health is also enshrined in national constitutions as well. See Heyns and Kaguongo 2006, noting that the right health has been recognized 'in various formulations, in the constitutions of 39 African countries' (see at p. 706 and the accompanying footnote 246). See generally Marks and Clapham 2005, p. 199 (noting that right to health has been recognized in one way or another in more than a hundred national constitutions). For more on the right to health in the African Human Rights Systems, see for instance Yeshanew 2011, pp. 244–249; Viljoen 2012.

[53] This, in turn, is to contrast the characterization of the right to health as implying some sort of discretionary or programmatic policy measures. If the realization of the right to health is to be seen as constituting the discretionary policy choices of the State, then, it is up to the State concerned to take whatever steps it deems fit or not to take any actions at all—in either ways the State is under no obligation whatsoever (see generally Alexy 2010b, pp. 334–337). However, such a characterization is basically incompatible with the core demands of the principle of human dignity from which the normativity of the right to health directly flows.

[54] See for instance Article 16(1) ACHPR; Article 12(1) ICESCR.

[55] For the specific treatment of immediate and progressive State obligation, see Sepulveda 2003, at Chaps. 5 and 7, Fredman 2008, at Chap. 3. See also Arambulo 1999, Langford 2008.

(flowing from the right to health) is immediate or progressive requires a careful analysis of all the relevant factors including the nature of the interests in question; the specific circumstances of the individuals; the nature of measures (that should be) adopted; the level of available resources in a given country; and the expenses associated with operationalizing those measures.[56] In particular, the analysis of the immediate or progressive nature of those specific obligations treads differently on the different pillars of protections afforded by the right to health in international law. For instance, it will be demonstrated below that ensuring the right of individuals to freedom of choice in decisions affecting their health entails an immediate obligation. In addition, it can also be argued that the obligation to ensure access to basic health care for vulnerable persons in a society is also a matter of an immediate State obligation.

Finally, the way international treaties define the right to health and the obligations thereof essentially expresses its systemic character. So we can say that the right to health is also a systemic right in the sense that it requires the State Party to adopt, rationalize and operationalize multiple kinds legal, policy and institutional measures that must function together, as a system, in order to give effect to the protections afforded by the right.[57] This, of course, is not unique to the right to health because the same is more or less true for the protection of other human rights as well.[58] Nevertheless, the understanding of the right to health as a systemic right means that the responsibility of the state flowing from it essentially consists not just in providing specific material goods and services to certain individuals but also in (ensuring) the establishment of those underlying systems through which basic material conditions of health are continuously produced and made available to all members of a society.[59]

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[56] Hence, it is accordingly suggested here that the Committee's distinction between the immediate and progressive realization of the State under ICESCR as expressed first, in General Comment 3, then, in other subsequent general comments should be understood in this sense. See also Sepulveda 2003, at Chap. 5 (Sect. 2.3) and 7, Fredman 2008, pp. 70–87.

[57] See generally General Comment 14.

[58] See Hunt and Beckman 2008, p. 82 (making a helpful analogy between the implications of the protection of the right to fair trail and right to health, in which they argued that as right to fair trial implies the establishment of court systems, the right to health also implies the establishment of health systems (the paper is available at http://www.hhrjournal.org/index.php/hhr/article/view/22/106 last accessed on 1 March 2013). See also Backman 2012, p. 113ff.

[59] In this sense it can be said that the following documents generally recognize the systemic nature of the right to health: General Comment 14; Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978 ((hereinafter Alma-Ata Declaration, available at http://www.who.int/publications/almaata_declaration_en.pdf last accessed in February 2013); Rio Political Declaration, Social Policy Framework for Africa adopted at the First Session of the AU Conference of Ministers in Charge of Social Development', Windhoek, Namibia, 27–31 October, CAMSD/EXP/4(I) (hereinafter AU Social Policy Framework 2008, available at http://sa.au.int/en/content/social-policy-framework-africa (last accessed on 24 March 2013).

2.3.2 Its Key Pillars of Protections

The other point worth discussing here is the kind of protections afforded by the right to health under international law. Here, I would like to show that the right to health as enshrined under international law incorporates three key pillars (or components) of protections. These are the right to freedom of choice, the right to basic health entitlements and the right to access to justice.[60] Analysing the right to health in terms of its key components is very useful especially to disentangle and shed light on some of the issues often raised in connection with the corresponding nature of the State Party obligations. This is particularly so in relation to the discussion in this contribution which, among other things, is concerned with assessing the extent to which the often claimed lack of resources (i.e. scarcity) is, in fact, a major impediment to the effective realization of the right to health in Africa. After considering each of these components, we are able to see that the right to basic health entitlements indeed requires an investment from the State Party but this is not the case with respect to the obligation to ensure freedom of choice and access to justice. In fact, it is to be seen that, in Africa, it is not lack of resources as such but critical structural (systemic) problems that can best explain the unacceptable low level of health care and its underlying determinants (see Sect. 3.3). This assertion is to some extent also supported by the relevant jurisprudence of the African Commission on Human and Peoples' Rights (the African Commission, the Commission) (Sect. 4.2.1): the discussion thereof shows that almost all of the violations of the right to health occurred in the context of detention and grave humanitarian crisis but so far there is no single communication before the Commission claiming the violation of the right to health on account of lack of resources as such.

Here, I might be criticized for not following the tripartite (i.e. respect, protect and fulfil) or quadruple (respect, protect, promote, fulfil) approach that both the CESCR and the African Commission use for assessing the state party obligations. I am aware of both the merits and demerits associated with such approaches but I may also have to mention that not all human rights tribunals follow this dimensional analysis.[61] It should, however, be noted that my aim here is neither to depart from nor to confirm such categorization of State Party obligations, both generally and in relation to the right to health. In fact, it is my understanding that, one the one hand, the key components of the right to health I have just mentioned concern

[60] See generally General Comment 14, para 8 where the CESCR stated, 'The right to health is not to be understood as a right to be healthy. 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' (*emphasis added*).

[61] For a recent critical review of the typologies of State obligations see *particularly* Koch 2009, especially at Chap. 2.

the general normative contents of the right to health (that is, what it guarantees for the right holder under international law). On the other hand, the tripartite (or quadruple) and other related standards such as availability, accessibility and quality[62] are clearly about the quantitative and qualitative analysis of the State Party obligations in relation to each of these key components of the right to health (but this is not, at least directly, the focus of my discussion in this contribution).[63]

2.3.2.1 Right to Freedom of Choice

The right to have and make free choices in respect of matters affecting one's health forms one of the core pillars of the right to health under international law. In this sense, the right to health guarantees the right to be free from any sorts of external interferences, obstructions or influences in making decisions pertaining to one's health as well as in the enjoyment of one's healthy living.[64] In addition, it includes the right of every woman to autonomously choose and decide on matters of, for instance, family planning and the use of contraceptives.[65] To this extent, it is possible to say that the right to freedom of choice in matters affecting one's health is the least disputed component of the right to health under international law. However, it is also worth noting that it may involve some complex and controversial ethical and policy issues as well. For instance, should public institutions interfere legitimately to prevent choices that may harm individual's health in such cases as smoking, unsafe sexual behaviours, alcohol, drug; should health benefits or allowances be based on private conducts and to what extent and so forth.[66]

In my opinion, the protection of this intimate and fundamental interest of a person is part and parcel of the elementary justification and, hence, responsibility

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[62] See General Comment 14, para 12, where the CESCR stated that the right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State Party: availability, accessibility, acceptability and quality of health facilities, goods and services. See also Tobin 2012, at Chap. 4.

[63] For the sake of clarity, it can therefore be stated that when we speak of the State Party obligations vis-à-vis the right to health under international law, we are essentially concerned with the obligation to respect, protect, promote, facilitate and fulfil the right to freedom of choice, the right to basic health entitlements and the right to effective justice for everyone within its jurisdiction.

[64] See General Comment 14, para 8; Principles and Guidelines, paras 5 and 65; Tobin 2012, at Chap. 4 (III); Jayawickrama 2002, p. 883.

[65] See Articles 3, 4, 5 and 14 Protocol on Rights of Women in Africa; Article 12 CEDAW. See also Yeshanew 2011, pp. 248–249; Tobin 2012 ibid.; Toebes 1999, pp. 52–55; Jayawickrama 2002, pp. 886–887.

[66] Tobin 2012 assesses some of the issues the right to freedom of health involves particularly in the context of reproductive health, adolescence sexuality and related risks thereof (such as HIV/AIDS and other sexually transmitted diseases), medical treatment and medical experimentation (see at pp. 132–158).

of a State. This means that it is required to ensure the right to freedom of choice immediately and with utmost priority for everyone under its jurisdiction. In other words, this obligation is not the subject of progressive realization[67] because the right to freely choose and pursue decisions regarding one's health goes to the very essence of human dignity. As such it aims to safeguard interests so intimate and fundamental to the wellbeing of a person such as autonomy, integrity and security. Accordingly, a State Party can hardly justify, even on account of lack of resources, its failure to, for instance, protect individuals against physical and mental pain; safeguard a patient against a treatment which he or she has not given effective consent to; and guarantee for every woman her reproductive health rights.

2.3.2.2 The Right to Basic Health Entitlements

The second key pillar of the right to health is the right to have access to basic health entitlements.[68] This generally entails, depending on the specific circumstance of the individuals concerned, both the right to have access to health care and the underlying determinants of health (such as adequate and safe drinking water, nutritious food, housing and essential medicines) in kind and the right to have access to the means required to obtain those goods and services.[69] Interestingly, the major theoretical arguments behind the right to health entitlements have already been presented above when discussing the principle of social justice as enshrined in the major UN and AU human rights treaties providing for the protection of socioeconomic rights (Sect. 2.2).

It should however be mentioned that this component of the right to health explains the reason why its human 'right-ness' was contested in the past. For instance, the background document to the 1978 Alma-Ata Conference on Primary Health Care makes it clear that the provision of the underlying determinants of health was considered for so long as a discretionary power of the State, not as something to be claimed on the part of the State as a matter of right and justice.[70]

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[67] See General Comment 14, paras 30–37.

[68] See General Comment 14, para 8; Jayawickrama 2002, pp. 883–884. See also generally the Final Report CSDH 2008, the Rio Political Declaration; Alma-Ata Declaration, paras VI–VII. For the treatment of the idea of entitlements in general see Alexy 2010b, at Chap. 9.

[69] *See for instance* Article 25 UDHR; Articles 11 and 12 ICESCR; Article 16 African Charter. See also General Comment 14, paras 11–13; Principles and Guidelines, para 61ff; Alma-Ata Declaration, paras V–VII; the Rio Political Declaration; the Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa, 21 November 1986 (available at http://www.who.int/healthpromotion/conferences/previous/ottawa/en/ last accessed on 10 May 2013) (hereinafter the Ottawa Charter). See generally Toebes 2012, pp. 112–118; Toebes 1999, at Chap. V; Jayawickrama 2002, pp. 871–880 and 888–889, Tobin 2012, Alexy 2010b, Chap. 9, at Sect. IV.

[70] Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978, World Health Organisation (hereinafter Background Report to Alma-Ata Conference 1978, available at http://whqlibdoc.who.int/publications/9241800011.pdf last

While it goes beyond the scope of this contribution to consider those arguments here, it can certainly be said that one of the major reasons behind such contestation was the fact that the obligations flowing from it entails, inter alia, the adoption of specific social and economic measures including those that concern direct provision of those basic goods and services to the vulnerable members of the society.[71] In any case, it now seems that only few would deny, at least in theory, that the protections afforded by the right to health under international law also and necessarily include the right to have access to those basic health entitlements.[72]

This should not, however, be taken as suggesting that the debate surrounding this component of the right to health has fully been resolved. In particular, the question whether a State Part bears an immediate or progressive obligation vis-à-vis the right to basic health entitlement is still ongoing. This, in turn, has to do with, admittedly, the complex nature of the measures that the State Party should adopt and the corresponding level of resources required to operationalize those measures. Indeed, given the substantial amount of resources that it requires, it may be difficult for the State Party to ensure an immediate access to basic health entitlements for everyone in a society and this is even more so for countries in Africa especially as a result of the fragility of their economies. But, under human rights law, the complexity of the measures and the level of expenses involved therein are not the sole determining factors in judging whether the State obligation to realize a given right is immediate or progressive. As suggested above, it is also equally significant to take into account other important factors such as the nature of the right and the interest it seeks to safeguard; the particular circumstances of

(Footnote 70 continued)
accessed 24 March 2013). See generally AU Social Policy Framework 2008; the 'Africa Health Strategy 2007–2015: *Strengthening of Health Systems for Equity and Development in Africa*', CAMH/MIN/5(III), adopted at the Third Session of the AU Conference of Ministers of Health, Johannesburg, South Africa, 9–13 (hereinafter Africa Health Strategy 2007–2015, available at http://www.nepad.org/system/files/AFRICA_HEALTH_STRATEGY%28health%29.pdf (last accessed 25 March 2013).

[71] This is generally part and parcel of general justiciability debate on ESCR. On this see generally essays in the following publications: Auweraert et al. 2002, Ghai and Cottrell 2004, Coomans 2006, Baderin and Mccorquodale 2007, Langford 2008. See also Fredman 2008, Yeshanew 2011, Viljoen 2012.

[72] This does not suggest that there is a universal consensus to that effect. See Tobin 2012, pp. 1–6 (providing a concise overview of the current state of debate on right to health). But seeing particularly in the light of the substantive contents of the international human rights law, it clearly seems to me a *contra legem* to say that the right to health does not provide for the right to have basic entitlements. Especially since the 1978 Alma-Ata Conference the underlying conditions of health have, at least theoretically, become the dominant part of the discussions on the right to health. In this regard, the works of the CESCR (especially in General Comment 14) and Paul Hunt, in his capacity as the former UN Special Rapporteur on the Rights of everyone to the Highest Attainable Standard of Physical and Mental Health from 2002 to 2008 (cited at n. 45 above) have been very pivotal in expounding the practical understanding of the contents of the right to health and State obligations thereof.

the individuals concerned; the level of available resources; and the overall performance of the State in realizing the right.

Seen in this light, it can be argued that the right to basic health entitlements entails both immediate and progressive State obligations. For instance, it seems to me that a complete eradication of some of the social causes of ill-health solely through the actions of a State may be an impossible goal. But I also believe that, as a matter of human rights law, a State Party cannot justify its failure to provide basic health entitlements for vulnerable and disadvantaged individuals or groups in a society because doing so would essentially amount to repudiating the very *raison d'etre* of recognizing the right in the first place.[73]

2.3.2.3 The Right to Access to Justice

The third core pillar of protection incorporated in the right to health is the right to access to justice. Possibly the right to access to justice has rarely been discussed not just in relation to the right to health but also with respect to socioeconomic rights in general because these categories of human rights were previously not seen as giving rise to a justiciable claim as such.[74] This contribution is of course not the right place to discuss the idea of the right to access to justice in socioeconomic rights[75] for my aim is simply to argue that it is one of the key components of the right to health. But it is important to note that the right to access to justice essentially consists of the right to individual justice and constitutional justice.[76] The right to individual justice is very familiar in human rights scholarship as it refers to the rights of a person (victim) to obtain a relief from those competent organs in relation to the personal damage(s) that he or she has suffered due to the acts (or omissions) directed against his or her person or property.[77] In this regard, both the suffering and relief sought are essentially personal to the victim. So, we

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[73] For the view of the CESCR see General Comment 14, para 30ff; General Comment 3, para 9. See generally Sepulveda 2003, Fredman 2008.

[74] See *for instance* footnote 71.

[75] For an interesting report on the role of the right of access to justice for the realization of socioeconomic rights see Inter-American Commission on Human Rights (IACoHR), Access to Justice as a Guarantee of Economic, Social, and Cultural Rights. A Review of the Standards Adopted by the Inter-American System of Human Rights, OEA/SER.L/V/II.129, Doc. 4, 7 September 2007 (also available through www.oas.org/en/iachr/reports/thematic.asp last visited 25 May 2013). See also IACoHR, the Work, Education and Resources of Women: the Road to Equality in Guaranteeing Economic, Social and Cultural Rights, OEA/SER.L/V/II.143, Doc. 59, 3 November 2011; IACoHR, Access to Justice for Women Victims of Sexual Violence: Education and Health, OEA/SER.L/V/II. Doc 65, 28 December 2011 (both documents available through the link mentioned hereinbefore).

[76] In making this distinction I generally follow the approach of Wildhaber and Greer who discussed the merits of such an approach in the context of the European Court of Human Rights (ECtHR). See Wildhaber 2002, 2006, 2007, Greer 2006. See also Mowbray 2010.

[77] See Greer 2006, pp. 165–169. See generally Shelton 2005; Francioni 2007.

can say that the main focus of the individual justice proceeding is essentially to retroactively condemn and redress previous violation(s) to the rights of an individual.

In contrast, there is also a notion of constitutional justice which concerns the right to have remedies against wider structural or systemic problems generally affecting the enjoyment of human rights in a given country. This, in turn, is premised on the understanding that the existence of a structural or systemic problem in a given country means that a violation to individual rights is certainly inevitable. When this is the case in a given country or system, a particular violation of an individual right is simply a mirror of what is in fact affecting the rights of everyone concerned in that country or system in general.[78] Thus, in constitutional justice the principal concern is to proactively identify and address those underlying structural defects or systemic obstacles impeding the effective realization of human rights in general. For instance, the right to constitutional justice in the context of the right to health means the removal of underlying structural factors impeding the realization of right to health for the population at large rather than a mere remedying of previous individual violations per se.[79] Such is the case when an issue before a tribunal, as an example, concerns structural policies resulting in the systematic exclusion and marginalization of the poor and other vulnerable persons in a society from health care and other social services. It should, however, be said that this notion of constitutional justice is more of a recent phenomenon in human rights discourse although there have been practices here and there, especially within some national legal systems, reflecting certain of its core elements.[80]

Both of these elements of the right to access to justice are very crucial components of the international protection of the right to health but I would like to emphasis the particular relevance of the notion of constitutional justice especially in the context of this discussion. As we have said above, the right to health is characteristically a systemic right requiring the adoption of a complex set of measures aimed at materializing the underlying health needs of the society as a whole. The reason is that health is a public good par excellence. As a result, any corresponding measures taken by the State Party should target a wider population and be in strict accordance with the principles of social justice. As such it is crucial that health care and related social services be rendered for everyone in accordance

[78] See citations at footnote 76.

[79] In this regard individual justice proceeding may also have some element of proactive dimension, at least in theory. But in practice, this is in fact not the case: there is simply little evidence that ensuring individual justice would also and necessarily result in constitutional justice for all. See generally Brinks and Gauri 2008, Landau 2012.

[80] To my knowledge a more structured discussion on the notion of constitutional justice dimension of right to access to justice began by former judge of the ECtHR, Wildhaber followed by the extensive treatment of the subject by Greer and more recently by Mowbray, all cited at footnote 76. With respect to the practices at national level such notions as 'writ action', '*actio popularis*', 'public interest litigation', 'class action', '*amparo action*' can be seen as approximating the ideal of constitutional justice mentioned in this discussion.

with such principles as of fairness, justice, equality and equity.[81] The failure of the State to ensure access to health care and its underlying determinants in such a manner affects not just one or two persons but almost all individuals in the society. And it is the addressing of such systemic failures that characteristically falls within the scope of the right to constitutional justice thus described.

As it is the case with the right to freedom of choice, the obligation to ensure the right to access to justice is part and parcel of the elementary obligations of the State Party both generally and in human rights law;[82] it is the right that the State Party is required to realize immediately for everyone within its jurisdictions. In this regard, it should be stressed that the right to access to justice is the core element of the accountability of the States Parties for the realization of human rights.[83] For instance, in the context of the right to health, the interconnection between the right to access to justice and accountability can vividly be seen from a recent exposition of accountability by Potts.[84] Potts sees accountability as 'the process which requires government to show, explain and justify how it has discharged its obligations regarding the right to the highest attainable standard of health'. As such, it also 'provides rights-holders with an opportunity to understand how government has discharged its right to health obligations' and to vindicate their rights 'to effective remedies' if it is established the government has failed in discharging its obligations thereof.[85] It is therefore clearly observable that in

[81] See Hunt and Backman 2008; Backman 2012 (both discussing health systems in the light of the values enshrined in the Alma-Ata Declaration); Nnamuchi and Ortuanya 2012, p. 187 (discussing certain elements of governance that should be in place to meet the promises of human right to health through Millennium Development Goals (MDGs). See also World Health Report 2000, 'Health Systems: Improving Performance', World Health Organization (hereinafter World Health Report 2000, available at http://www.who.int/whr/2000/en/whr00_en.pdf last accessed 24 March 2013); the Report of Special Rapporteur on Right to Health, Paul Hunt, UN Doc. A/HRC/7/11 (available at http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/105/03/PDF/G0810503.pdf?OpenElement last accessed 15 April 2013).

[82] See generally Francioni 2007, IACoHR (footnote 75).

[83] Hunt and Backman 2008, Potts, Accountability (footnote 84), pp. 17–18; Amnesty International Report 2009, pp. 8–9. See particularly UN Docs. A/63/263 at Section III, and A/59/422, paras 36–45 (Paul Hunt articulating the special significance of accountability in ensuring the effective realization of the right to health and health-related MDGs).

[84] See Potts 2008, Accountability and the Right to the Highest Attainable Standard of Health, Human Rights Centre, University of Essex (hereinafter, Potts, Accountability, available at http://www.essex.ac.uk/hrc/research/projects/rth/docs/HRC_Accountability_Mar08.pdf last accessed 21 February 2013).

[85] Ibid., p. 13. Interestingly, it has 'both prospective and retrospective' dimensions. In the former sense, 'it draws attention to its potential to improve performance: to identify what works, so it can be repeated, and what does not, so it can be revised'; in the latter sense, 'it draws attention to the remedies that should be available when there has been failure on the part of government to fulfil its obligations'. Ibid. This shows that Potts notion of accountability incorporates both aspects of the right to access to justice—the right to individual justice and constitutional justice thus described in this discussion.

Potts's conception of accountability, the right of individuals to an effective remedy, that is, the right to access to justice, holds significant place.

Hence, without the fundamental right of access to justice, which, in turn, goes to the very essence of accountability, it is almost inevitable that any legislative or policy commitment by the State remains utterly rhetorical. Hunt is very clear on this. 'Without accountability', says Hunt, 'human rights can become no more than window-dressing. Whether human rights are applied to development, poverty reduction, trade, health systems, neglected diseases, maternal mortality, HIV/AIDS or anything else, they require that accessible, transparent and effective mechanisms of accountability be established.'[86]

To summarize, it emerges from the discussion in this part that the treaties providing for the right to health, to which almost all of the AU Member States are parties to, define the right to health as a fundamental and systemic right consisting of the right to freedom of choice, basic health entitlements and access to justice. It also emerges that the obligations flowing from the right to freedom of choice and access to justice correspond to the core of the State Party's obligations both generally and in human rights law in such a way that they ought to ensure the same for everyone within the State's jurisdiction immediately. The realization of the right to basic health entitlements, however, entails both immediate and progressive obligations because of the nature of measures and level of resources involved in the materialization of the same for everyone in a society. Nevertheless, when it comes to the right to basic health entitlements of the vulnerable persons in the society, the State Party concerned still shoulders particularly aggravated, heightened, responsibilities that it cannot easily dispense with even on such grounds as resource constraints. This being said in general, we now have to specifically assess if the alleged lack of material resources indeed explains the dire shortage of access to health care and the underlying determinants of health.

2.3.3 Impediment to the Realization of Basic Health Entitlements in Africa: Lack of Resources or Systemic Problem?

The facts and figures provided in the introductory part clearly and alarmingly show the dire shortage of health care and the underlying determinants of health in Africa, most seriously in sub-Saharan region.[87] So it remains to be seen if the gross failures to ensure the right to basic health entitlements could be attributed to the alleged lack of resources. As revealed in the Background Report to Alma-Ata Conference 1978 (and, since then, in many other reports including the ones already cited in this writing), the following factors were responsible for the then existing

[86] UN Doc. A/63/263, para 8 (referring also to the work of Potts cited at footnote 84).

[87] See footnote 2–13.

dysfunctional health services in many countries, particularly in the developing world, where African countries line from the bottom up. According to the report, the then existing health services and systems were characterized by gross injustices, inequalities and inequities resulting, in turn, in the loss of millions of lives from what could have been prevented with relative ease. For instance, national health systems were described therein as essentially inefficient, poorly resourced and structured; available resources were particularly skewed towards expensive and tertiary health services only accessible to the rich and to those in political power; public health issues were not seen as forming the integral component of the wider social and economic development agenda of the countries. All these were further compounded by the problems pertaining to bad governance systems both generally and in relation to health sectors.[88]

For the participants of the said Conference, responding to these major global public health crises was a matter of urgent concern. Nonetheless, access to health care and related services in the African continent are still as fragile as they were 30 years ago. Thirty years after the Alma-Ata Conference, the health systems of most African countries still remain 'too weak' and 'too under-resourced' 'to support targeted reduction in disease burden and achieve universal access' to health services as well as to provide 'interventions' that could 'match the scale of the [existing health] problems' mainly because of the reasons pertaining to the fragmentations of national policies and the inefficient utilization of available resources.[89] Still 30 years later, the health systems in the continent are infected with gross injustices, inequalities and inequities. For instance, the AU Social Policy Framework 2008 stresses that '[t]he benefits of health services do not equitably reach those with the greatest disease burden'; that there is no 'social protection' systems in place to safeguard the vulnerable and marginalized persons including those in a dire economic situations; that there is lack of community empowerment and participation at the national level; and that there is no effective administrative and accountability mechanisms in place to monitor and remedy those injustices in the sector, indicating, in turn, the 'vicious circle' between ill-health, poverty and bad governance in the continent.[90]

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[88] See Background Report to Alma-Ata Conference 1978, pp. 37–38. See also the Final Report CSDH 2008; World Health Report 2007: Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action, World Health Organization, Geneva (hereinafter World Health Report 2007, available at http://www.who.int/whr/2007/en/index.html last accessed 10 February 2013); World Health Report 2008: Primary Health Care (Now More Than Ever), World Health Organization, Geneva (hereinafter World Health Report 2008, available at http://www.who.int/whr/2008/en/index.html last accessed 15 April 2013).

[89] See AU Social Policy Framework 2008, at Sect. 1.1; Africa Health Strategy 2007–2015, at in this chapter See Abuja Declaration, para 26; WHO 2012: State of Health Financing in Africa.

[90] See AU Social Policy Framework 2008 at Executive Summary and Section 1; Africa Health Strategy 2007–2015 at in this chapter. See also citations at footnote 2–13 and 88. The AU Social Policy Framework 2008, Africa Health Strategy 2007–2015 and the Rio Political Declaration also mention problems relating to the global economic order affecting in one way or another the African national health systems but this will not be discussed here. On the role of international

These observations indicate that the fragility of the health services in Africa has less to do with the lack of resources than it has to do with the institutional decision-making system of the States Parties concerned.[91] In fact, many agree that it is not scarcity as such but, following Acemoglu and Robinson, the lack of 'inclusive' governance systems or, conversely, the prevalence of the 'extractive' nature of the continent's political and economic institutions that underlie the current state of structural and systematic exclusion of the population at large from practically every aspect of socioeconomic and political domain.[92] The AU Social Policy Framework 2008 emphatically confirms this fact by expressing the presence of endemic corruption in the continent. It clearly recognizes that corruption is 'the single greatest obstacle to development globally'; it has 'significantly contribute[d] to a skewed distribution of the benefits of development and growth'; '[m]ost profoundly, corruption and associated crimes [has destroyed] the trust relationship between the people and the state'.[93]

In fact, the longstanding and recurrent problem of Africa is a resource-curse much less than it is a resource-scarcity. The continent's abundant resources have for so long been a 'curse', a source of 'misery' to most peoples in the continent instead of being a means to ensuring their wellbeing and dignity.[94] As an example, the African Human Development Report 2012 clearly states that the most food insecure part of the world, the sub-Saharan Africa, has abundant agricultural resources.

> But shamefully, in all corners of the region, millions of people remain hungry and malnourished—the result of glaringly uneven local food production and distribution and chronically deficient diets, especially among the poorest. This is a daily violation of people's dignity, with many governments not fulfilling their basic responsibility of protecting their citizens from hunger. […]
>
> Agricultural productivity remains low—much lower than in other regions. Many sub-Saharan African countries are net food importers and even depend on food aid during all-too-frequent humanitarian crises. Where food is available, millions cannot afford it or are

(Footnote 90 continued)
cooperation for the realization of right to health in Africa, see Nnamuchi and Ortuanya 2012. See generally A/59/422, paras 32–35 and 42–46; Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Right, adopted on 28 September 2011, Maastricht, The Netherlands (available at http://www.rtfn-watch.org/uploads/media/Maastricht_ETO_Principles__EN.pdf last accessed 20 April 2013).

[91] See also (footnote 78) above.

[92] Acemoglu and Robinson 2012, p. 70ff. See the reports cited at footnote 2–13 and 88; Amnesty International Report 2009, footnote 1.

[93] See AU Social Policy Framework 2008, at Sect. 2.2.18. See also Africa Health Strategy 2007–2015, at Sect. 4.1.1, para 31ff.

[94] See particularly Viljoen 2012, p. 544. In its 2009 report, footnote 1, Amnesty International also indicated that 'Millions across the region continued to be deprived of their basic needs in spite of the sustained economic growth in many countries in Africa during past years. People faced enormous challenges in securing a daily livelihood, often aggravated by marginalization or political repression, attempts to muffle their voices and render them powerless' (at p. 1).

> prevented from buying or trading it by underdeveloped markets, poor roads, long distances to markets and high transport costs. […]
>
> Misguided policies, weak institutions and failing markets are the deeper causes of sub-Saharan Africa's food insecurity. This tainted inheritance is most evident in households and communities, where unequal power relations trap vulnerable groups—subsistence farmers, the landless poor, many women and children—in a vicious cycle of deprivation, food insecurity and low human development….[95]

Therefore, rather than resource constraints, the critical stumbling block obstructing the effective realization of basic health entitlements in the continent is essentially systemic in nature which mainly results from the extractive socioeconomic and political institutions in the continent. This, in turn, also speaks indirectly to the failure of the respective national legal systems in addressing the underlying systemic problem affecting not just the health sector but the entire socioeconomic spectrum of the Member States.[96] No doubt, in some respects financial constraint may indeed be a genuine problem of governments in Africa but it cannot justify decades of acute ill-health and impoverishment in the continent. On the contrary, there is overwhelming evidence here and there indicating decades of systematic and widespread social and political exclusion, marginalization, highly endemic and institutionalized corruption practices and absence of any meaningful accountability mechanisms in the continent.[97] In the presence of such evidence, the claim from resource-scarcity is nothing more than a smokescreen.

There have been series of initiatives, both globally and at the AU level, aimed at addressing the structural problems obstructing the realization of the right to health and other human rights. This is in fact one of the overarching aims of the AU Social Policy Framework 2008 mentioned above. The Policy Framework intends to deal with this persistent structural problem through continental policy-making and coordination. The approach taken therein is identifying the major continent-wide social problems and their underlying causes and, then, providing

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[95] See footnote 10 at p. 2ff.

[96] Amnesty International Report 2009, footnote 1, pp. 8–9 (describing the problem of accountability and prevalence of impunity in the region).

[97] See particularly World Health Report 2010; Africa Human Development Report 2012; MDG Report 2012: Assessing Africa's Progress). See also Durojaye 2010, Alao 2010, Nnamuchi and Ortuanya 2012, p. 184ff, Viljoen 2012, p. 272ff. Since its first launch in 1995, African countries have been consistently in the category of low Corruption Perception Index of the Transparency International with the score of well below average (it is not more than one or two countries that approach the average 5/10 or 50/100 scale). For its recent report, see Corruption Perceptions Index 2012 (available at http://cpi.transparency.org/cpi2012/results/ last accessed 10 May 2013). Similarly, the Ibrahim Index of Africa Governance (IIAG) also provides us with the detailed account of governance crisis in the continent by breaking down into specific thematic issues as safety and rule of law (which covers rule of law, accountability, personal and national security) and participation and human rights (which covers participation, human rights and gender). Looking at its key findings of the 2012 index, it only shows a fragmented and unsustainable nature of any record of progress in each area since 2006. The 2012 IIAG can be found at http://www.moibrahimfoundation.org/iiag/ last accessed 10 May 2013).

policy recommendations that should be adopted by all stakeholders, especially national authorities. Accordingly, it has identified eighteen core thematic or priority areas[98] at the heart of which lies the problem of lack of access to basic health entitlements and structural accountability in the continent.[99]

To this extent, the Policy Framework could be hailed as both comprehensive and a landmark. However, the old question still remains: how effective would it be in bringing structural changes and thereby ensuring the right to health and basic social justice for those most in need? This question arises because the effectiveness of any legislative or policy commitment regarding the protection of human rights is essentially tied to the existence of a strong legal accountability mechanism through which the State Party can be held responsible both at the national and international level.[100] In addition to what has already been said in this section, an epigraphic note to this contribution also well-summarizes the fact that 'there is still an enormous gap between' the numerous legislative and policy rhetoric of the governments in the continent, on the one hand, and 'the daily reality where human rights violations remain the norm', on the other.[101] Interestingly, lack of effective legal accountability mechanisms is not limited to the national system. As the following discussion also shows, the legal accountability mechanisms available at the AU level are almost dysfunctional which undermines the practical value of not just the AU Social Policy Framework 2008 but the entire framework of human rights commitments and policy initiatives of the AU and its Member States.

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[98] These are population and development, labour and employment, social protection, health (including HIV/AIDS, TB, malaria and other infectious diseases), migration, education, agriculture, food and nutrition, the family, children, adolescents and youth, ageing, disability, gender equality and women's empowerment, culture, urban development, environmental sustainability, the impact of globalization and trade liberalization in Africa and good governance, anti-corruption and rule of law. And there are also four additional areas of special concern: drug and substance abuse and crime prevention; sport; civil strife and conflict situations; and foreign debt (see at Executive Summary and Section 2).

[99] Ibid. at Sect. 1.1, paras 1–2.

[100] It should be mentioned that the AU Social Policy Framework 2008 envisages some kind of political accountability mechanisms. Among other things, the AU Commission is tasked with the monitoring of the actual implementation of the policy recommendation by receiving and reviewing of biennial progress reports from each Member State. It is also responsible to produce the overall status of social development in the continent every 2 years highlighting particularly the emerging issues and continuing challenges as well as to issue a comprehensive evaluation report on the implementation of the social policy framework every 5 years' (see at Sect. 3.2.3). Nonetheless, this mechanism is immaterial for the States can still refuse to cooperate with its specific recommendations and still face no legal consequence whatsoever; it may even be very doubtful if failure to implement those recommendations would be met with any sort of political consequences both from the Commission and other political institutions of the Union as such. This actually means that this mechanism has a limited role, if any, in addressing the kind of systemic injustices and failures I have been stressing in this discussion.

[101] See footnote 1 above citing Amnesty International Report 2009, p. 9.

2.4 The Enforcement Mechanisms of the Right to Health in the AU System

2.4.1 Introduction

There is no question that AU has the legal responsibility to ensure not just the availability but also the effective functioning of the human rights protective (enforcement) mechanisms especially at the continental level. Currently, the Court and Commission are the two principal AU human rights institutions with the mandate to remedy violations of human rights in the continent. Although the statutory mandates of the Court and the Commission differ (in scope and nature), the two regimes are complementary to one another.[102] While the Court's principal function is essentially adjudicatory (protective mandate in the strict sense of the term);[103] the Commission is tasked with broader protective[104] and promotional[105] mandates but, awkwardly, it cannot directly compel the States Parties concerned to comply with its decisions as such.[106] It should be noted that it is not the aim of this discussion to compare and contrast the functions of the two institutions but to see the extent to which they are practically contributing to addressing the structural accountability deficits impeding the effective realization of the right to health in the continent.

Seen in this light, there is nothing that could be said about the actual role of the Court because, though it formally became operational in 2004, it is yet to become the Court of the continent in the full sense of the term due to the low rate of

[102] See Article 2 Protocol ACtHPR; para 6 of Preamble to Protocol ACtJHR (see footnote 107).

[103] See Article 3 Protocol ACtHPR; Article 28 Statute of ACtJHR (see footnote 107).

[104] See Articles 30 *cum* 45 (2), 48, 55 and 62 African Charter. The protective function of the Commission, which is quite broader than the protective function of the Court, concerns the power to examine periodic State reporting and individual communications and to conduct on-site investigations.

[105] See Article 30 *cum* (1) (a–c), (3), (4) 45 African Charter. Hence, as part of its promotional mandate, the Commission is tasked with broad range of activities as studying, researching and documenting human rights problems in the continent and organizing seminars, symposiums and conferences as well as providing trainings for particularly national institutions, issuing guiding principles and rules for the national legislations and practices relating to fundamental human and peoples' rights.

[106] According to the Banjul Charter, after consideration of communications (interstate or individual), the Commission shall prepare reports indicating its findings and recommendations thereof. See at Articles 52, 53, 58 and 59. This means that it does not have a legal power to make a binding judgment. It seems from the wording and spirit of the Charter that the findings and recommendations of the Commission would become binding and hence compelling on the State concerned if and when adopted accordingly by the Assembly of OAU/AU.

ratifications to its statute and related complications.[107] It is also yet to pronounce any judgment in relation to the topic under consideration. This means that it is a very important institution but with untested remedial power. Obviously, one can speculate on the immense potential of the Court in enhancing the standard of human rights protection in the continent but this goes beyond the scope of this contribution. However, the future ability of the Court to address the structural obstacles to the realization of social justice in general and the underlying conditions of the right to health in particular are determined by the extent to which it would be able to integrate issues of individual justice with that of constitutional justice.[108]

In fact, it is possible to see the call upon the Court in the AU Social Policy Framework 2008 to '[a]ccord high priority' to the questions of basic social justice as particularly suggesting the careful examination of the background factors underlying those complaints over which it will assume jurisdiction in the light of the structural accountability deficits in the continent, not just in the light of the individual justice as such. In this way it may be possible that some of the structural problems could be exposed to rigorous continental judicial scrutiny which, if so decided, the State concerned is legally bound to remedy within the period that the Court indicates under the pain of possible legal sanctions from the Assembly of the AU.[109] The hope is that this might ultimately push Member States to strengthen their national accountability mechanisms as well—but, it might have to wait for a while before its full judicial authority will be put to test over cases concerning

[107] The establishment and full operationalization of the African continental judicial organ is complicated with various institutional hurdles and fragmentations. The first instrument, the Protocol to the African Charter on Human and Peoples' Rights, was adopted on 9 June 1998 and entered into force on 2 January 2004 (available at http://www.au.int/en/sites/default/files/PROTOCOL_AFRICAN_CHARTER_HUMAN_PEOPLES_RIGHTS_ESTABLISHMENT_AFRICAN_COURT_HUMAN_PEOPLES_RIGHTS_1.pdf, last accessed 10 May 2013) (hereinafter Protocol ACtHPR). As it stands now this Protocol has only 26 ratifications of which only five countries have accepted the individual complaint mechanisms (the status of ratification can be accessed through http://www.au.int/en/sites/default/files/achpr.pdf, last visited on 13th May 2013). In parallel, there was also an initiative to establish the Court of Justice of the Union and the protocol to that effect was adopted on 11th July 2003 and entered into force on 11th February 2009 (available at http://www.au.int/en/sites/default/files/PROTOCOL_COURT_OF_JUSTICE_OF_THE_AFRICAN_UNION.pdf, last accessed 10 May 2013) (hereinafter Protocol CJAU). This protocol has only 16 ratifications (see at http://www.au.int/en/sites/default/files/Court%20of%20Justice.pdf , last visited 13 May 2013). To further complicate the matter (or one would say, to solve the problem before it gets worse), it was decided to merge the two judicial organs into one judicial organ which will have dual jurisdictional functions and henceforth be known as the African Court of Justice and Human Rights. The 'merger' protocol was adopted on 1 July 2008 (available at http://www.au.int/en/sites/default/files/PROTOCOL_STATUTE_AFRICAN_COURT_JUSTICE_AND_HUMAN_RIGHTS.pdf, last accessed 10 May 2013) (hereinafter Protocol ACtJHR and its Statute as Statute ACtJHR). This Protocol has so far only five ratifications (it will need 10 more to enter into force) (see at http://www.au.int/en/sites/default/files/Protocol%20on%20Statute%20of%20the%20African%20Court%20of%20Justice%20and%20HR.pdflast visited 13 May 2013).

[108] See AU Social Policy Framework 2008, at Sect. 3.2.4.

[109] See Article 46 Protocol ACtJHR.

basic social justice in the continent. This makes the Commission the only functioning human rights organ so far as the practical assessment of the legal enforcement of the right to health through the AU system is concerned.[110]

2.4.2 The Right to Health in the Practices of the Commission

The Commission is the oldest, in fact, the only human rights organ established in the Banjul Charter with fairly broad promotional and protective mandates and it has now been in operation for about 30 years.[111] The question is, therefore, if it has been able to deal with those issues of structural injustices undermining the realization of the right to health in the continent in its nearly 30 years of operation. Answering this question obviously requires a review of some of its decisions raising relevant issues with the protection and promotion of the right to health.

2.4.2.1 Decisions of the Commission on the Right to Health

It seems that the Commission's decisions raising, in a more relevant sense, the violation of the right to health can generally be seen as concerning the following three major situations[112]: detention (including prisons and medical institutions), humanitarian crisis and poverty (lack of access to basic socioeconomic means needed to obtain health care and related goods and services). It should be noted that this categorization is merely based on the underlying situations leading to the alleged violations of the right to health (and nothing more) with the view to provide a clear picture as to the contexts engaging the responsibility of the State concerned. In this regard, it can be said that the major part of the Commission's decisions concerns detention situations and that only few of them deal with situations of humanitarian crisis. With respect to the third situation we cannot find any (relevant) substantive discussion by the Commission but only a very general and indirect reference to the right to health in some of its decisions; that is, in all the communications concerning the third situation, we could only find the Commission making a general normative statement in just a paragraph or so but without providing substantive arguments to that effect. For this reason it is not necessary to

[110] But one should note that because of what is just said above (footnote 106) the term 'legal enforcement' is employed here only in its loose sense to express its decisions would become enforceable if and when approved by the Assembly of the AU.

[111] The Commission was officially inaugurated on 2 November 1987 (note that the Banjul Charter entered into force on 21 October 1986).

[112] For the discussion on the practices of the Commission vis-à-vis the protection of socioeconomic rights, see *for instance* Yeshanew 2011, Viljoen 2012, Ssenyonjo 2011, 2012.

discuss them here and I will, therefore, make reference to such communications just for the sake of completeness.[113]

As will be discussed below, the nature of violations established by the Commission under these three scenarios (though we cannot say much on the third one) raise very serious issues with each of the core pillars of the protections afforded by the right to health already discussed above expressing as such the gross contempt for the fundamental principle of respect for human dignity. For instance, it is to be observed that the Commission's decisions pertaining to detention situations clearly show violations of the core elements of the right to have freedom of choice such as the right to have respect for one's integrity, autonomy and wellbeing; the right to basic health entitlements commensurate with the circumstances and needs of the detainees. Most importantly, the decisions also show absence of systemic accountability (pertaining to the third core pillar of the protections afforded by the right to health) as the nature of the violations addressed by the Commission were not isolated incidents as such but rather carried out by the direct participation of or aid from the State Party. The absence of systemic accountability is even more serious in relation to the decisions of the Commission pertaining to the second scenario (situations of humanitarian crisis) which express gross, systematic and widespread violations of not just the right to health but of virtually all human rights recognized in the Banjul Charter and other human rights treaties.

In the Context of Detention

The right to health of persons in detention clearly engages a special kind of State Party responsibility which directly emerges from the very fact of the detention itself. Without going into detail, the Commission emphasized that this responsibility has both a substantive and a procedural element. So, in its substantive sense, the State Party is required to ensure respect for the dignity of the detainees by making available to them all those basic material and moral conditions of human life and health and by securing them against all forms of violence, inhumane and degrading treatments; in its procedural sense, it is required to guarantee due process of law and access to prompt and effective remedies.[114]

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[113] Communication 276/03 , *Centre for Minority Rights Development (Kenya) and Minority Rights Group International (on behalf of Endorois Welfare Council)/Kenya* (hereinafter *Endorois case*, decided on merits, 46th Ordinary Session (November 2009), Communication 157/96, *Association pour la sauvegarde de la paix au Burundi/Kenya et al. (hereinafter ASP-Burundi)*, decided on merits, 33rd Ordinary Session (May 2003), Communications 25/89-47/90-56/91-100/93, *Free Legal Assistance Group* et al*./DRC* (joined) (hereinafter *Free Legal Assistance*), decided on merits, 18th Ordinary Session (October 1995).

[114] This can be seen from the following decisions of the Commission: Communication 241/01, *Purhoit and Moore/The Gambia* (hereinafter *Purhoit*), decided on merits, 33rd Ordinary Session (May 2003); Communications 105/93-128/94-130/94-152/96, *Media Rights Agenda* et al*./Nigeria* (joined) (hereinafter *Media Rights Agenda* et al.), decided on merits, 24th Ordinary Session (31 October 1998); Communications 137/94-139/94-154/96-161/97, *International PEN et al./Nigeria*

Thus, in *Purhoit and Moore/The Gambia* (*Purhoit*), for instance, subject of the complaint were the arbitrary and discriminatory nature of the legislation governing persons with mental disability and the substandard living condition in the detention centre.[115] As the Commission stated, the right to the health 'is vital to all aspects of a person's life, wellbeing, and is crucial to the realization of all the other fundamental human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind.'[116] It emphasized that this obligation, especially owing to their conditions and needs, is more compelling in relation to those persons with mental disability who ought to be accorded a special treatment that aims to ensure the attainment and sustenance of optimal level of independence and integration. In particular, persons with mental disability 'should never be denied their right to proper health care, which is crucial for their survival and their assimilation into and acceptance by the wider society'. Accordingly, the Commission found that the respondent State had failed to ensure the availability of clear therapeutic objectives and resources necessary to ensure a treatment required by and commensurate with the special conditions and needs of persons with disabilities[117] and for this reason they were denied the right to have a decent, dignified and normal human life.[118] The *Purhoit* case also revealed serious violations of the State responsibility to ensure equal and effective access to procedural guarantees for persons with mental disabilities including the right to have equal access to free and effective legal aid, the right to have the review of treatment or diagnosis resulting in their detention and the right to appeal against the decision of detention.[119]

The Commission has also addressed the particular significance of the right to health of persons particularly detained in the context of criminal law.[120] This entails the right to be provided with those basic conditions indispensable for their health and wellbeing,[121] the right to have prompt and effective access to medical services

(Footnote 114 continued)
(hereinafter *International PEN et al.*) (joined), decided on merits, 24th Ordinary Session (31 October 1998); Communications 54/91-61/91-96/93-98/93-164/97-196/97-210/98, *Malawi Africa Association* et al./*Mauritania* (joined) (hereinafter *Malawi Africa Association* et al.), decision on merits, 27th Ordinary Session (11 May 2000); Communication 334/06, *Egyptian Initiative for Personal Rights and INTERIGHTS/Arab Republic of Egypt* (hereinafter *EIPR/INTERIGHTS*), decided on merits, 9th Extraordinary Session (01 March 2011). For very helpful discussion on the normative function of human dignity in the detention situation see generally Riley 2011.

[115] *Purhoit*, paras 4–8.

[116] Ibid., para 80.

[117] Ibid., paras 81–85.

[118] Ibid., para 61.

[119] Ibid., paras 50–54 and 70–72.

[120] The relevant decisions of the Commission in this regard are the following: *Media Rights Agenda et al., International PEN* et al., *Malawi Africa Association et al. and EIPR/INTERIGHTS* (all cited at footnote 114).

[121] See *Media Rights Agenda* et al. at para 91; *International PEN* et al. at para 112, *Malawi Africa Association et al.* at paras 120 and 122. See also *Purhoit* at para 61.

such as access to qualified physicians and (adequate) medications and the right to have effective access to a legal counsel (lawyers).[122] As the Commission makes it clear in each of the communications just referred to, the State concerned bears a heightened, in fact, an absolute and exclusive responsibility to ensure the personal safety, integrity and wellbeing of persons under detention not just as a matter of law but because of the fact of detention itself which creates a complete situation of dependency of those persons on the State for their livelihood. Especially in the case of *EIPR/INTERIGHTS* mentioned above, the Commission underscored the two most important rationales behind the right to have prompt and effective access to medical services for persons under custody: that it is an indispensable element of the protection of detainees against torture, cruel, inhuman and degrading and other kinds of ill-treatments and that it is an integral element of the right to fair trial.[123] Hence, the right to have prompt access to medical services constitutes the most effective mechanism to ensure the protection of detainees against abusive treatments as well as to bring meaningful accountability to the detention systems.[124] It also plays a critical role in ensuring that illegally obtained confessions and evidence will not be adduced against those persons accused of criminal offenses, a matter which becomes an absolute necessity for those accused of serious offenses leading to grave punishments. Hence, the State is under a heightened legal obligation to prevent torturous confessions and other evidence obtained through such methods as well as to facilitate and avail individuals with effective opportunities to have access to medical expertise without any conditions whatsoever so that they will be able to challenge the evidence brought against them.[125]

In the Context of Humanitarian Crisis

The second instance in which the Commission has addressed the violations of the right to health pertains to the situations of humanitarian crisis, which in fact one can call *human crisis*,[126] which at their background have some basic systemic

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[122] The Commission discussed this in detail in relation to *EIPR/INTERIGHTS*.

[123] See at paras 163–190 and 209–232.

[124] Ibid., at para 172 (stating that right to medical services should be provided promptly and regularly), paras 180–81 (stating that the link between effective prevention of torture and other inhuman treatments, and right to have access to prompt and regular access to lawyer has been established in the works of international human rights bodies).

[125] Ibid., at para 212ff.

[126] This in turn, may be due to either a 'constitutional' crisis or armed conflicts of both internal and international character. For the purpose here, constitutional crisis essentially refers to the gross violations of basic human rights through the direct actions or involvement of State machineries (usually police, military, security and secret service agents). This may be manifested through massive and arbitrary detentions, tortures, summary and extrajudicial killings. Internal armed conflicts on the other hand concern a fighting between a government and other groups (rebellions, insurgents, etc.) and hence does not, at least theoretically, involve civilian populations.

failures in the countries concerned, affecting the entire population or certain specific groups of the population.[127] For instance, the case of *Malawi Africa Association* et al. shows the worst and egregious form of violations committed by the Respondent State against certain ethnic communities following the incident of military takeover of government. As the series of communications filed before the Commission show, there were widespread, massive, arbitrary and routine arrests, detentions (in extremely harsh, deplorable and inhumane conditions, also referred to as 'death camps'), torture (and other forms of inhumane treatments), massacres, persecutions, extrajudicial killings, summary executions, slavery, discriminations, expulsions, confiscations and destructions of livestock, harvests and villages by the State machineries particularly military forces just because those populations happen to be members of certain ethnic groups.[128] In declaring violations of, inter alia, the rights guaranteed under Articles 4[129] and 16[130] of the African Charter, the Commission stated that:

> 120. […] Denying people food and medical attention, burning them in sand and subjecting them to torture to the point of death point to a shocking lack of respect for life, and constitutes a violation of Article 4 (see para 12). Other communications provide evidence of various arbitrary executions that took place in the villages of the River Senegal valley (see paras 18 and 19) and stress that people were arbitrarily detained between September and December 1990 (see para 22).
>
> 122. The State's responsibility in the event of detention is even more evident to the extent that detention centres are its exclusive preserve, hence the physical integrity and welfare of detainees is the responsibility of the competent public authorities. Some prisoners died as a result of the lack of medical attention. The general state of health of the prisoners deteriorated due to the lack of sufficient foo[d]; they had neither blankets nor adequate hygiene. The Mauritanian state is directly responsible for this state of affairs and

[127] This is particularly the case in *Malawi Africa Association et al.* (footnote 114); Communication 155/96, *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR)/Nigeria* (hereinafter *SERAC*), decided on merits, 30th Ordinary Session (27 October 2001); Communications 279/03-296/05, *Sudan Human Rights Organisation & Centre on Housing Rights and Evictions (COHRE)/Sudan (*joined) (hereinafter *Darfur case*), decided on merits, 45th Ordinary Session (27 May 2009); Communication 27/99, *Democratic Republic of Congo/Burundi, Rwanda, Uganda* (hereinafter *DRC case*), decided on merits, 33rd Ordinary Session (03 May 2003).

[128] See paras 115–122 (describing in part some of the situations that took place in detention places). See also its overall holdings in which it 'Declare[d] that, during the period 1989–1992, there were grave or massive violations of human rights as proclaimed in the African Charter; and in particular of Articles 2, 4, 5 (constituting cruel, inhuman and degrading treatments), 6, 7(1)(a), 7(1)(b), 7(1)(c) and 7(2)(d), 9(2), 10(1), 11, 12(1), 14, 16(1), 18(1) and 26', basically finding violations of, for all intents and purposes, the entire substantive provisions of the African Charter.

[129] Which reads, 'Human beings are inviolable. Every human being shall be entitled to respect for his life and integrity of his person. No one may be arbitrary deprived of this right'.

[130] This provision reads as follows, '1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. State parties … shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick'.

> the government has not denied these facts. Consequently, the Commission considers that there was a violation of Article 16.

In the *DRC case* the Commission found, more or less, a similar kind of gross human rights violations by Respondent States contravening their international obligations under general humanitarian law and the African Charter. The relevant part of its decisions reads as follows:

> 79. The [African] Commission finds the killings, massacres, rapes, mutilations and other grave human rights abuses committed while the Respondent States' armed forces were still in effective occupation of the eastern provinces of the Complainant State reprehensible and also inconsistent with their obligations under Part III of the *Geneva Convention Relative to the Protection of Civilian Persons in Time of War* of 1949 and *Protocol 1 of the Geneva Convention*.[131]
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> 88. The looting, killing, mass and indiscriminate transfers of civilian population, the besiege and damage of the hydro-dam, stopping of essential services in the hospital, leading to deaths of patients and the general disruption of life and state of war that took place while the forces of the Respondent States were occupying and in control of the eastern provinces of the Complainant State are in violation of Article 14 guaranteeing the right to property, Articles 16 and 17 (all of the African Charter), which provide for the rights to the best attainable state of physical and mental health and education, respectively.

The *SERAC* case, a complaint against the former military regime of Nigeria concerning the situation of Ogoni people, also expresses gross human rights violations ensuing from basic constitutional crisis in the sense employed in this writing. This was basically triggered by the military junta's decision to engage in oil exploration in the Niger Delta in complete disregard to the basic rights and interests of the population, especially as regards the project's impact on human health and the surrounding environment.[132] As the communication shows, the Ogoni people had become victims of double sufferings. On the one hand, the pollution that resulted from the toxic substances and hazardous wastes from the oil exploration destroyed their wellbeing and livelihoods particularly because the 'contamination of water, soil and air [had] had serious short and long-term health impacts, including skin infections, gastrointestinal and respiratory ailments, and increased risk of cancers, and neurological and reproductive problems' and 'the pollution and environmental degradation to the level humanly unacceptable has made it living in the Ogoni land a

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[131] See this also with para 89 of the same stating, 'Part III of the *Geneva Convention Relative to the Protection of Civilian Persons in Time of War 1949*, particularly in Article 27 provides for the humane treatment of protected persons at all times and for protection against all acts of violence or threats and against insults and public curiosity. Further, it provides for the protection of women against any attack on their honour, in particular against rape, enforced prostitution, or any form of indecent assault. Article 4 of the Convention defines a protected person as those who, at a given moment and in any manner whatsoever, find themselves, in case of a conflict or occupation, in the hands of a Party to the conflict or Occupying Power of which they are not nationals'.

[132] See paras 1–9 (describing background reasons leading to the violations in the case). These allegations were admitted by the (new civilian) Government of Nigeria in its Note Verbale ref. 27/2000 addressed to the Commission saying that 'there is no denying the fact that a lot of atrocities were and are still being committed by the oil companies in Ogoni Land and indeed in the Niger Delta area' (ibid., at para 42).

nightmare'.[133] On the other hand, their livelihoods were also shattered by the ruthless military operations and other agents destroying their homes, villages, source of foods (farms, water sources, crops and animals) and causing massive displacements, evictions, detentions, torturing, killings and other forms of ill-treatments and terrorizations.[134] As the Commission states, '[t]hese and similar brutalities not only persecuted individuals in Ogoniland but also the whole of the Ogoni community[…]. They affected the life of the Ogoni society as a whole'.[135]

The *Darfur case,* which alleged the atrocities committed against the people of Darfur, can be seen as a typical example of the gross violations of human rights (including the right to health) resulting from internal armed conflicts. Among other things, the *Darfur case* reveals the practice of large-scale killings (including extrajudicial executions), rape and torture, forced displacements, evictions, looting, destruction of foodstuffs, crops, livestock, poisoning of wells, denial of access to other water sources, and the destruction of public facilities and private properties and the disruption of the livelihoods of the Darfurian people, all through the direct participation of the state concerned and the agents it has sponsored.[136] For instance, the Commission concluded that 'the Respondent state and its agents, the Janjawid militia, actively participated in the forced eviction of the civilian population from their homes and villages' and that '[i]t failed to protect the victims against the said violations'; moreover, it, 'while fighting the armed groups, targeted the civilian population, as part of its counter insurgence strategy'. According to the Commission, all these acts and omissions clearly amount to cruel and inhuman treatment which threaten the very essence of the dignity of the said population.[137]

In finding the violation of the right to health, the Commission also held that 'the destruction of homes, livestock and farms as well as the poisoning of water sources, such as wells, exposed the victims to serious health risks and', therefore, 'amounts to a violation of Article 16 of the Charter'.[138] There are several more violations that the Commission has established in the *Darfur case*. For instance, in finding the violations under Article 22 of the African Charter,[139] the Commission stated the following.

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[133] See Ibid., together with paras 51–54 and 67.

[134] Ibid., at paras 55 and 61–67.

[135] Accordingly, the Commission declared violation of, inter alia, right to inviolability of human life and wellbeing, health (which embraces right to food, shelter and water) and health environment all by the direct actions of the state and by sponsoring of or tolerating other non-state actors. In essence therefore, the Government has failed in terms of its elementary duty to respect and ensure respect (protect) for the basic rights and freedoms of the Nigerians living in Ogoniland (see ibid., at paras 54, 55, 58, 62–67).

[136] See for instance at paras 145–68. It concluded that by not acting diligently to protect the population concerned against violations perpetrated by its forces and other agents, the State Party violated Articles 4 and 5 of the African Charter (see at paras 205–216).

[137] Ibid., para 164.

[138] Ibid., para 112 (see also at paras 206–11 making reference to General Comment 14 as well).

[139] Article 22 states, '1. All peoples shall have the right to their economic, social and cultural development with due regard to their freedom and identity and in the equal enjoyment of the

> The attacks and forced displacement of Darfurian people denied them the opportunity to engage in economic, social and cultural activities. The displacement interfered with the right to education for their children and pursuit of other activities. Instead of deploying its resources to address the marginalization in the Darfur, which was the main cause of the conflict, the Respondent State instead unleashed a punitive military campaign which constituted a massive violation of not only the economic social and cultural rights, but other individual rights of the Darfurian people. Based on the analysis hereinabove, concerning the nature and magnitude of the violations, the Commission finds that the Respondent State is in violation of 22 of the Africa Charter.[140]

At this point, it may be important to stress that the *Malawi Africa Association et al., Darfur case, SERAC* and *DRC case*—all pertaining to the situation of humanitarian crisis in the sense described above—have one basic feature in common: they all manifest very serious systemic failures. In other words, the facts and evidence recorded therein overwhelmingly establish gross, massive and widespread violations of human rights where the States Parties concerned directly participated, through highly orchestrated means, in the shattering of the dignified existence and livelihood of the entire populations in question. This means that there is hardly any right recognized in the African Charter that the actions and omissions of the States Parties did not violate. In addressing the violations therein, the Commission took, in four of the communications, the painstaking approach to disentangle the facts and restate them in the terms of the substantive provisions of the Charter. Although this kind of approach is not wrong per se, I would argue that it is both redundant and ineffective in situations like this. For instance, it was the very same facts that the Commission addressed under almost all of the substantive provisions of the African Charter including right to life, bodily integrity, security, prohibition of torture and degrading treatments, property, housing, food, health, peaceful existence, so and so forth. More fundamentally, such an approach gives the false impression that the violations are the result of isolated incidents while, in fact, they are highly systematic and widespread in nature. It is generally true that it is the claim of the parties to a dispute that sets a general framework as to how a tribunal should analyse a given case but it is also true that the tribunal has an inherent power not just to determine the issues involved in the case but also how to resolve the issues. In my opinion, it would have been more effective had the Commission declared in *Malawi Africa Association et al., Darfur case, SERAC* and *DRC case* that the States Parties concerned committed gross, massive, widespread and systematic violations of the African Charter and other related treaties of the AU.[141]

(Footnote 139 continued)
common heritage of mankind. 2. States shall have the duty, individually and collectively, to ensure the exercise of the right to development'.

[140] Ibid., at para 224. Similarly, it also found violation of the right to property under Article 14 (para 205), right of the family under Article 18 (para 216).

[141] This is supported by Article 58 of the Banjul Charter which refers to communications concerning a 'special case' expressing 'series of serious or massive violations of human and peoples' rights'.

In this regard, it should be clear that I am not in any way suggesting that the declaration of violations under the relevant substantive provisions of the Charter is superfluous. Indeed, it might be necessary to specify the individual rights violated by the States Parties concerned but this could have easily been indicated in the operating part of the Commission's decisions under consideration. The facts stated in four of the communications clearly indicate, for instance, that the right to health of the populations was violated in the worst ever possible manner one could imagine. We should, however, note the fact that this violation of the right to health was part and parcel of the widespread actions of the States Parties systematically carried out in order to silence those populations—the facts do not prove that the violations of the right to health was due to an isolated actions of the States Parties. That is why, in the situation where the very existence and livelihood of the population is actually under attack, analysing the facts and evidence therein as concerning the violation of a particular human right (as the right to health) is less effective and redundant.

All in all, the foregoing discussion on the jurisprudence of the Commission provides us with useful insights as to how it addressed the violations of the right to health in the context of detention and humanitarian crisis. Apart from this, we may not find any relevant authoritative normative guidance regarding the general positive obligations of the State Party to ensure equal access to health care and its underlying determinants for all within its jurisdiction. This is so because, on the one hand, in each of these communications the Commission found violations of the right to health on account of the direct actions or participation of the State Parties in the said violations. On the other hand, the positive obligation of the State to ensure the realization of the right to health care and its underlying determinants for the socioeconomically vulnerable parts of the society entails the adoption of deliberate, concrete and targeted legislative, policy and institutional measures. This clearly and minimally presupposes the existence of a thin functioning of the elementary principles of the rule of law for, this should be obvious, in the absence of this principle the normative basis upon which individuals can make a claim to have access to health care and basic social justice is simply non-existent. In any case, and as far as I am concerned, none of communications before the Commission so far has engaged, in a direct and relevant manner, the positive obligations of the State Party to realize the right to health and basic social justice.

2.4.2.2 The Right to Health in Other Activities of the Commission

The Commission has also dealt with some of the issues affecting the enjoyment of the right to health in its promotional and standard setting functions, especially in its Special Mechanisms. Ten out of sixteen Special Mechanisms[142] currently in

[142] The list of the special mechanisms is available through http://www.achpr.org/mechanisms/ (last visited 9 May 2013). For an interesting discussion the types, possible legal basis, function and effectiveness of the Commission's Special Mechanisms, see Viljoen 2012, pp. 369–378.

operation concern, directly or indirectly, the promotion of right to health.[143] Since the Commission started establishing these mechanisms in the late 1990s, the commission has issued a series of resolutions and declarations based on the works of or certainly with the participation from these special mechanisms. Beyond this, it is very difficult to explain their impact on the identification of specific systemic obstacles existing at the national level.

It should be mentioned that some have hailed the Commission's adoption of the Principles and Guidelines on the implementation of socioeconomic rights in the continent (already referred to in this discussion) and the Guidelines on State Reporting under the Banjul Charter (Reporting Guidelines) which, in turn, is a short-hand version of the Principles and Guidelines.[144] Both are notable works of the Working Group on ESCR. Nonetheless, neither the Principles and Guidelines nor the Reporting Guidelines add any new substantive legal principles or standards to the area of socioeconomic rights. They are mere consolidations of already existing principles of interpretations of socioeconomic rights and the corresponding State obligations being developed in its own decisions, in the works UN human rights institutions and its specialized agencies (such as WHO and IFAO) as well as in the jurisprudence of various national and supranational human rights tribunals. One might, however, be surprised to observe that neither the Principles and guidelines nor the Reporting Guidelines makes any reference to the 2008 AU's Social Policy Frameworks discussed in this contribution.[145] Thus, while it is not worth repeating here, it should be said that the protection of the rights of vulnerable persons is particularly emphasized in each of the documents. Both the Principles and Guidelines and Reporting Guidelines stress the need to pay due and appropriate regard to equality, non-discrimination, equity and accessibility in the provision of health care and other social services and to provide social protection measures for those without minimum income. Also, they both emphasize institutional principles such as accountability, transparency and participation as

[143] Thus, it can be said that the Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV or risking HIV/AIDS; the Working Group on Rights of Older Persons and People with Disabilities, the working Group on Extractive Industries, Environment and Human Rights Violations; the Working Group on Indigenous Populations/Communities, the Working Group Economic Social and Cultural Rights (ESCR); the Special Rapporteur on Refugees and Internally Displaced Persons; and the Special Rapporteur on the Rights of Women deal as part of their mandate with the socioeconomic dimensions of right to health whereas Special Rapporteur on Prisons and Conditions of Detention, Committee for the Prevention of Torture, Working Group on Death Penalty and Extrajudicial, Summary or Arbitrary Killings can address some of the issues pertaining to the promotion and protection of right to health as well.

[144] Also referred to as Tunis Reporting Guidelines, adopted on 24 November 2011 (available at http://www.achpr.org/instruments/economic-social-cultural-guidelines/ last accessed 22 December 2012).

[145] One apparent reason may be that which is mentioned by Viljoen 2012, p. 297 that 'to a large extent, the Commission has performed its activities in splendid isolation from the rest of the continent, including the AU organs'.

fundamental norms that must be ensured and complied with not only in the delivery of health services but also in the designing and execution of other public policies aimed at the realization of human rights in general.[146]

2.4.2.3 Effectiveness of the Commission's Practices

Thus, the main question is whether the above discussions would give us a reason to believe that the Commission is playing a meaningful role in the effort to ensure the realization of right to health and its underlying conditions. That is, whether the practices of the Commission could be said to match the kind of underlying obstacles behind lack of systemic justice and therefore could be seen as a strong legal accountability mechanism of the AU System. This question may need further exploration in itself but remaining within the scope of this discussion it is possible to make the following observations.[147]

It could be said that there are some achievements that the Commission has been able to accomplish in its nearly 30 years of existence. Among these are the establishment of the Special Mechanisms and the examination of the individual communications (although it has decided very few cases compared to the number of years

[146] See Principles and Guidelines, at para 60 ff (concerning Right to Health under Article 16 of the African Charter).

[147] On the recent assessment of the effectiveness of the Commission's functions see Viljoen 2012, particularly pp. 295–299, Yeshanew 2011, particularly pp. 210–215; Chirwa 2008, pp. 334–336

See also Ssenyonjo 2011 (reviewing Commission's 30 years of jurisprudence, Ssenyonjo certainly sees its jurisprudence especially since 2001 as positive development. Okafor 2010 also sees the Commission as institution of collective human security struggle with important positive contribution to that vision but the Commission is yet to live up to that expectation and I am afraid the following assessments does not seem to be as positive as that of Okafor and Ssenyonjo. I should say that both authors discuss the Commission's work in terms of the ideal normative developments it has brought to the field but they are also quite aware of the ineffectiveness of those decisions as well. Okafor, whose argument is basically more of the constitutional and institutional design of the Commission than its current practical functioning (at p. 317), clearly notes that the Commission's engagement with socioeconomic rights is minimal (at p. 332). For Ssenyonjo, it is up to the States Parties and other relevant actors as CSOs/NGOs to support the Commission's decisions by practically implementing those norms developed by the Commission (at pp. 395–397). To this extent there may not be disagreements between their arguments and what is to be said in the following. However, the following assessment is basically about the effectiveness of the Commission's works in fact not just in theory vis-à-vis its (actual and potential) ability to bring strong legal accountability regime required to address those background injustices and inequities, i.e. systemic problems, impeding the effective realization of basic social justice in the continent (the collective human security that Okafor is also concerned with). In this regard, a normative development on the right to health, if any, is important but insufficient to give the Commission's office a positive assessment. Its methods, areas of concentrations, creativeness, practical outcomes and relevance (especially to the continent's urgent needs), authoritativeness, legitimacy, ability to influence grassroots level decision-making must also be part of that assessment as well.

it has been in operation). There are, however, several reasons to doubt the viability and effectiveness of these mechanisms in addressing the problem of structural accountability deficits—i.e. the lack of constitutional justice—in the continent. As far as the Special Mechanisms are concerned, the Commission may be criticized for being too late in establishing mechanisms aimed at addressing issues of socioeconomic rights and for being driven more by 'pressures from interest groups' than by its own 'careful and proactive' considerations and rationalization of its functions and the goals enshrined in the Banjul Charter.[148] What is even more disappointing is that, in the context of this discussion, there has been no practically meaningful outcome that could be hailed wholeheartedly (one should note that I have already stated my reservations as regards the Principles and Guidelines just mentioned above).[149]

In relation to the examination of the individual communications, there is an abundance of reasons to criticize the practices of the Commission. To begin with, its decisions mostly come far too late to constitute an effective remedy.[150] So, restating the old saying, 'justice delayed, justice denied', one may say here that judgment delayed is remedy denied. For instance, even though almost all of the communications discussed above concern very grave situations of human rights violations, the time taken by the Commission to render its final decisions do not, by any standard, reflect that sense of urgency and gravity.[151] This, in turn, has very serious negative implications for the capacity of the Commission in bringing accountability for violations of human rights. This is so because there would not be any meaningful point in rendering a decision on a particular communication after

[148] As Viljoen 2012 (at p. 297 and 299), 2009 (at pp. 512–513) and Murray 2010 (at p. 356ff.) observe, the Commission's activities (agenda) are essentially drawn by and in the interest of NGOs/CSOs and has nothing to do with its readiness to critically engage with the continent's major social issues.

[149] Viljoen is also critical about their effectiveness and efficiency as follows. 'While these mechanisms are important promotional tools, they confront States with allegations of specific violations only to a limited extent. Time, energy and resources devoted to these mechanisms have detracted from the Commission's core protective function. Again, delays and the failure to adopt reports by these mechanisms, their omission from the Commission's Activity Reports, and the lack of dissemination of these reports are major impediments to their effectiveness and impact'. See Viljoen 2012, at p. 297.

[150] Viljoen 2012, p. 296ff, Yeshanew 2011, p. 210ff; Ssenyonjo 2011, p. 395.

[151] For instance, the *Malawi Africa Association et al.* (cited at footnote 114) was decided nearly 10 years after the receipt of the first communication. The first communication against Mauritania (No. 54/91) was filed by Malawi Africa Association on 16 July 1991 and decided (joined communications) on 11 May 2000. The *SERAC case* (cited at footnote 127) was decided after five and half years after the receipt of the communication (on 14 March 1996 and decided at its 30th Ordinary Session held between 13 and 27 October 2001). The *Darfur case* (cited at footnote 127) was decided 6 years after the complaint by Sudan Human Rights Organization was received on 18 September 2003 and it was decided at the 45th Ordinary Session held between 13 and 27 May 2009. The case of *EIPR/INTERIGHTS* (cited at footnote 114) which concerned about situation of death penalty, was decided in nearly 5 years (to be precise, 4 years and nine months) after the communication was received at its 40th Ordinary Session held between 15 and 29 November 2006 and it was decided at its 9th Extraordinary Session held from 23 February to 3 March 2011.

factors responsible for a particular human rights violation had disappeared. For instance, when the Commission delivered its findings in *Malawi Africa Association* and *SERAC* (which represent the worst forms of human rights violations) the regimes responsible for the said violations were no longer in place. As such the decisions of the Commission therein can hardly be regarded as constituting effective remedy for the complainants and, more generally, such is also not in line with the kind of accountability that international human rights law seeks to ensure. Of course it is possible that some of the reasons for the delays may be attributable to the conducts of the parties themselves but not all of them; in fact, the Commission is to blame for most of the postponements, which it can also not justify on the ground that its office functions on a part-time basis.

Besides this, the decisions of the Commission are usually muddled in incoherence, redundancy and inconsistency[152] such that the reasoning therein is generally unable to establish an authoritative normative standard in relation to the issues raised in the communication. As an example, the *SERAC* case was seen by some as a 'landmark' decision concerning socioeconomic rights but looking closely at its reasoning, this is hardly the case. I have argued above that *SERAC* concerns the violation of socioeconomic rights only on its surface while, deep inside, the facts therein indicate a major constitutional crisis resulting from the direct actions of the military junta in the Niger Delta: as the facts clearly show, the police, military and other State machineries (including secret agents sponsored by the regime) directly carried out widespread, systematic and gross violation of the livelihood of the Ogoni people as whole. Leaving this aside, while the standards the Commission employed in deciding *SERAC* was borrowed from the UN CESCR's General Comment 14[153], it did not provide us with any clear justification regarding the particular relevance of those standards especially given the background situations and nature of violations involved in the communication. There is nothing major that the decision added to the already existing jurisprudence of socioeconomic rights that could make *SERAC a* jurisprudentially landmark decision. Of course for those of us who were eager to see the Commission saying something about socioeconomic rights (because it openly refused to do so during the first season of its existence), the decision may be seen as landmark; even then it is only because it somehow shows a change to its own institutional perspective on socioeconomic rights rather than any jurisprudential advancement thereof.[154]

These are all issues that could be resolved by the Commission but there also remain other fundamental problems undermining the effectiveness of the Commission in addressing the accountability deficit in the continent. The decision of

[152] See Viljoen 2012, p. 296.

[153] See at paras 44–47 (in fact, it is almost a common practice of the Commission to rely on jurisprudences drawn from elsewhere without providing the due justification need in a given case).

[154] See Yeshanew 2011, p. 210 n 340 (citing, inter alia, Umozurike 1988); Viljoen 2012, p. 299; Ssenonjo 2011, pp. 366–385 (analysing its practices on ESCR by dissecting into two periods: pre-2001 of scanty decisions and activities and post-2001 of increased engagement).

the Commission is legally non-binding for it only has the power to make non-binding recommendations, which it cannot make public without the approval of the AU Executive Council.[155] In this regard, there are incidents where the latter refused to approve its findings, perhaps indirectly accusing the Commission of being biased. And, in practice, the Member States also did not show any sign of compliance with its decisions as such.[156] One may immediately say that these are not the problems for which the Commission should be responsible. However, the truth is that the Commission has a longstanding legitimacy crisis in the eyes of the AU Member States. In particular, it is seen as being used by NGOs/CSO as a tool to embarrass the States appearing before it and not as an objective human rights institution, a fact we should see in the light of the influence they have in the works of the Commission both practically and financially.[157] As Viljoen, pioneer in African human rights law, observes, its meetings (Sessions) are usually dominated by the activities and statements of CSO/NGOs.[158] It also appears from the discussion by Murray, who has also written a lot on the works of the Commission, that the programmes and activities of the Commission are basically organized around or even designed to serve the interests of CSO/NGOs.[159] It is therefore of little surprise that States are particularly sceptical about anything that comes out of its office.

Further, and even more fundamental, the methods through which the Commission conduct its business are hardly rationalized to the practical contexts and needs of the African continent. The Commission still remains unknown to the overwhelming number of populations who are most in need of the processes and outcomes of its functions. Even if it is theoretically known to some of the ordinary Africans, there are major practical reasons preventing them from approaching its office, among which are illiteracy, poverty, remoteness and the utter ineffectiveness of its decisions. It is also hardly the case that the Commission is even known to the ordinary public servants in the continent. This is mainly because of the fact that, for the last three decades or so, it has been focusing largely on the old-style methods of human rights promotion and protection—conducting litigation, issuing resolutions and organizing elite-driven seminars. So far, conducting litigations (and issuing of resolutions) seems to be the major outcome of the activities of the Commission but soon to be ignored by the Member States they are mainly addressed to. Other authors have already pointed at some of the limitations of litigation-based strategies for ensuring social justice for the poor.[160] For human rights institution like the Commission, which only has the power to make non-

[155] See Article 59 (1) Banjul Charter.

[156] See Viljoen 2012, p. 297, 2009, p. 512, Viljoen and Louw 2007, Chirwa 2008, p. 333, Yeshanew 2011, p. 211, Okafor 2010, p. 335.

[157] See Murray 2010, p. 344ff; Viljoen 2009, pp. 512–513; Viljoen 2012, p. 297.

[158] Viljoen 2009 ibid.

[159] See at footnote 157.

[160] See generally Landau 2012; Brinks and Gauri 2010.

binding recommendations,[161] I do not think litigation can even be considered as an ideal strategy in the first place. This should be seen especially in the light of the fact that only a very negligible number of individuals may be able to practically access its office and that it receives a very low level of cooperation from the Member States. In addition to litigation, the Commission also organizes, as part of its promotional mandate, some elite-driven seminars. In fact, it is fair to say that, for most part of its existence, the Commission has been preoccupied with organizing seminars only to be attended by few professional elites and NGOs/CSO and that its commissioners are often busy with giving lectures and presentations, again, to few professional elite groups including those living overseas.

We have already seen that the jurisprudence of the Commission on poverty-related violations of the right to health is thin. This is because none of the communications discussed above alleged that the State has violated its positive obligation to ensure access to health care and its underlying determinants. So there is little that we could say as regards the Commission's view regarding the obligations of the Member States towards the socioeconomically vulnerable parts of the society. Of course the Commission has indicated that, drawing on the UN CESCR, it would analyse State Party's obligations in the light of the general obligation to respect, protect, promote and fulfil. But what these actually entail in the context of the continent where the great majority of the populations are rural residents and are living under chronic poverty still remains unexplained. Perhaps to one's surprise, even though the Commission operates in the continent where poverty is chronic; ill-health, maternal and child mortality is rampant (one of the highest in the world); corruption is endemic; and democratic accountability is in deficit for so long, it is, to my knowledge, yet to make any systematic or country-specific study; concrete policy recommendations; or establish a special mechanism on any one of these. One should recall that corruption and lack of structural accountability are underscored in this contribution as the major underlying impediments to the effective realization of the right to health care and basic social justice in continent.[162]

Therefore, by looking into its past approaches and practices, it is unfortunately very difficult to conclude that the Commission has been acting in such a way as to respond to the structural injustices and accountability deficits prevailing in the continent. There is simply no evidence that could warrant that conclusion. Instead, the Commission is described by some as 'the least effective human rights institution of the three regions'[163] or as a 'toothless bulldog'.[164] In my opinion, even such characterizations may not fully express the extent to which the Commission has failed, particularly in relation to the promotion and protection of socioeconomic rights in Africa. In this regard, we should note that the African Charter did

[161] Following Okafor, we can say that the Commission is the institution that can only persuade but not compel (Okafor 2010, p. 335).

[162] See also Viljoen 2012, p. 299.

[163] Chirwa 2008, p. 335.

[164] Ibid., at footnote 113 (citing Udombana 2000).

not conceive the office of the Commission as a 'toothless bulldog'. By vesting it with such robust promotional and fairly protective mandates, the Charter envisages the Commission as a continental institution that can engage actively and critically with local institutions and be a vehicle of change by constructively guiding the Member States through in-depth research, training and providing them with articulate, practical and alternative policy recommendations aimed at addressing concrete human rights problems.[165]

In the area of the right to health, for instance, the Commission could have contributed significantly by drawing key crosscutting issues from the wealth of reports of the Member States; launching its own thematic and county-specific investigations into national systems and practices; publishing its own robust reports and recommendations; and by using effectively its findings and experiences in its grassroots level promotional and training activities. This would, in turn, not only play a significant role in enhancing the protection of human rights but also in establishing its authority and legitimacy as an objective voice of human rights and basic social justice in the continent. But this would clearly require the Commission to make some critical programmatic and methodological choices. Thus, it should particularly focus on practical and robust promotional, training and research activities pertinent to the continent's dire needs. Such activities should not repeat its past failures or ineffectiveness. It should adopt methods well-rationalized into the contexts of individuals in need of its protective functions; it should actively and critically engage with local actors; I should aid governments through concrete and practical human rights protective guidelines. In this way, it is very possible that the Commission can contribute substantially to the quest for legal accountability in the area of the realization of basic social justice in Africa.

2.5 Conclusion

Health is an integral component of the very essence of human life in dignity and, hence, the right to health is all about ensuring respect for the inherent dignity of the human being. The right to health secures human dignity by guaranteeing to everyone the right to have those basic biological and moral health needs inherent in and indispensable for his or her dignified living and, to this extent, by imposing a compelling obligation on the State Party to realize the same in strict accordance with the basic principles of social justice such as equality (non-discrimination) and solidarity. It is, therefore, utterly impossible for the State to respect the inherent dignity of a human being without first ensuring the right to health of all persons within its jurisdiction. In particular, we have seen that the right to health as recognized in human rights law incorporates the right to have freedom of choice, the right to have access to basic health entitlements and the right to have access to

[165] See footnote 105–106.

justice. However, the discussion has shown that neither of these is in fact ensured by governments in Africa. The empirical facts with which I have started this discussion shockingly indicate the dire and persistent shortage of access to health care and its underlying determinants; and the decisions of the African Commission also establish very serious violations of the right to health in the continent, particularly in the context of detention and humanitarian crisis. So, whether it is seen through the solid empirical facts or the decisions of the Commission, it is clear that the governments in Africa have failed miserably in ensuring the right to health and, hence, the dignity of most Africans.

Nevertheless, the chronic failure has hardly anything to do with a lack of resources (scarcity) as such. In fact, it emerges from the analysis in this contribution that States Parties cannot, under any circumstances, justify their failure to ensure the right to freedom of choice and access to justice on account of resource constraints. It is equally unacceptable that the State justifies its failure to ensure the right to health care and the underlying determinants of health for the vulnerable members of society on the ground of a lack of material resources. On the contrary, it is argued that the general problem of systemic, structural accountability persisting in the continent can best explain why the continent has been and continues to be at the heart of a global public health crisis for an unacceptably long period of time. Rather disappointingly also, the principal remedial institutions currently available at the AU level, the Court and the Commission, were unable to play meaningful roles in dealing with this underlying systemic problem. It might be encouraging to note that the AU has now integrated the question of the right to health into issues of basic social justice in the continent. But again there is no mechanism to ensure that such discretionary policy recommendations would result in some practical effects at the grassroots level. Ensuring the realization of the right to health through the AU system requires the existence of a strong legal accountability mechanism. Accordingly, it is imperative that the AU and its Member States work, as a matter of priority, towards revitalizing and rationalizing[166] these remedial institutions. Without this, the claim of the AU and its Members as being concerned with the protection and promotion of human dignity, human rights and social justice is simply nothing more than empty political rhetoric.

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[166] See generally Mbondenyi 2009.

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