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The low-hanging fruit: Health, Rights, and the Commission

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Abstract

The year 2022 marked the 35th anniversary of the African Commission on Human and Peoples' Rights. As it is a custom in many communities, when one reaches this milestone, it is an opportune time to introspect and reflect on the successes and challenges encountered in one's journey. It is this template that the paper adopts to measure the prospects and setbacks of the African Commission in the advancement of the right to health. The Article argues that while the body remains the poster child of the continent's human rights architecture, its inability to clearly articulate how states ought to advance the right to health has downplayed its role in this agora. It is, thus, not ironic that whereas health right is guaranteed by the overarching regional human rights instrument, a disproportionate percentage of the continent's population continues to bear the brunt of treatable diseases with insufficient state response. Consequently, the translation of the right to health from paper to practice remains a pipedream to many at the grassroots level. To that end, the Article observes that the Inter-American Commission on Human Rights offers useful lessons that could give impetus to the African Commission in its aspiration towards advancing health right across the continent.

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I. Introduction 34

II. The Right to Health 39

III. The Health of Africa 47

IV. The Commission 53
A. Promotional mandate 54
1. Partnership 55
2. Information dissemination 55
3. Setting Guidelines 56
B. Protective mandate 58
1. Procedural 59
2. Jurisdiction 60
3. Substantive 61

V. The Way Forward 69
A. The 'Isolator' 71
B. Joint venture 72
C. Partnership 73
D. Full-time commissioners 74
E. Amicable settlement 74
F. Reporting procedures 76
G. Piecemeal recommendation 76

VI. Conclusion 77

I. Introduction

In 1963, when a crop of rabble-rousers converged in Addis Ababa to form the Organisation of African Unity ("OAU"), the health of their subjects was not on the agenda.[1] The launch of the OAU (now the African Union,

1. *See* John Markakis, *The Organisation of African Unity: A Progress Report*, 4 J. MOD. AFR. STUD. 135, 138 (1966) ("The O.A.U. Charter consecrated the gradual, functional a to pan-African unity

"AU") was to attain one, and one purpose only: the consolidation of the newly liberated states into a United States of Africa.[2] Whereas Article II of the OAU Charter makes reference to achieving a better life for Africans,[3] and promoting the Universal Declaration of Human Rights,[4] its premium yearning was the solidarity and unity of the African states.[5] The question of human rights, and by extension, the advancement of the health of natives was perceived as the sole discretion of individual states.[6] But, considering the abuse of power and atrocities against women and children in the late 1970s and early 80s, the organization shifted its stance on the core principles of sovereignty and territorial integrity.[7]

Ultimately, this transition resulted in the framing of the African Charter on Human and Peoples' Rights in 1986.[8] The Charter contains landmark provisions on how states could improve not just the civil freedoms of individuals, but the

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advocated by the moderate African nation as opposed to the swift, political method advocated.").

2. *See id*. (acknowledging that the specialized Commissions were established by the OAU Secretariat to ensure the realization of the pan-African unity, which was propagated by both the moderates and radical African nationalists).

3. Org. of African Unity [OAU] Charter art. 2 (stating that the purpose of the Organization is to "coordinate and intensify [African states'] cooperation and efforts to achieve a better life for the peoples of Africa").

4. *See id*. ("The Organization shall have the [purpose] [t]o promote international cooperation, having due regard to the Charter of the United Nations and the Universal Declaration of Human Rights.").

5. *See id*. ("The Organization shall have the [purpose] [t]o promote the unity and solidarity of the African States.").

6. *See* Rose M. D'Sa, *Human and Peoples' Rights: Distinctive Features of the African Charter*, 29 J. AFR. L. 72, 81 (1985) (discussing that African States were made responsible for the development of the African people).

7. *See id*. at 72 (showing how the organization was criticized in the past for its nonchalance about the large-scale human rights abuses suffered by communities at the hands of their statesmen).

8. African Charter on Human and Peoples' Rights, June 27, 1981, 3269 U.N.T.S. 2363.

socioeconomic conditions of the people.[9] The right to physical and mental health is one of such codified, and enforceable rights.[10] From the test of the treaty, one could surmise that the treaty was a clear indication of the commitment of the OAU to safeguard and enhance the welfare of Africans, regardless of their geographic enclave in the continent.[11]

By the same reckoning, the Charter inserts a blanket institution to monitor the operationalization of the rights therein, the African Commission on Human and Peoples' Rights ("Commission").[12] Since its inception, the Commission has served as the principal adjudicator, and in most instances, the ultimate mediator of the plethora of human rights petitions at the regional level.[13] Launched a year after the African Charter, the trajectory of the monitoring body has been marked by two contradictions. [14] On the one hand, it had knocked down a hole through the wall that has for years detached socio-economic rights from civil and political

9. *See* Ebenezer Durojaye, *The Approaches of the African Commission to the Right to Health Under the African Charter*, 17 L. DEMOCRACY & DEV. 393, 394 (2013) (demonstrating how the Charter is incomparable to similarly situated regional instruments, particularly in terms of the overarching civil/political and social/economic rights that it has enshrined).

10. *See id.* at 397 (describing how Article 16 of the Charter states that individuals will have "the right to enjoy the best attainable state of physical and mental health").

11. *See* Bright B. Nkrumah, *Myth and Murder: The African Human Rights System and Persons with Albinism*, 55 COMPAR. & INT'L L. J. S. AFR. 1, 16 (2022) (showing how the Charter aspires to foster the entitlements of Africa's inhabitants, irrespective of their unique physical, cultural or religious traits).

12. *See id.* at 5 (describing the broad mandate of the Commission as raising human rights awareness, monitoring state compliance, and remedying infringements when they occur).

13. *See id.* (explaining how the Commission has been the main arbiter of rights breaches, more so than the two other human rights monitoring bodies, the African Court on Human and Peoples' Rights and the African Committee of Experts on the Rights and Welfare of the Child).

14. *See* Justice C. Nwobike, *The African Commission on Human and Peoples' Rights and the Demystification of Second and Third Generation Rights Under the African Charter: Social and Economic Rights Action Center (SERAC) and the Center for Economic and Social Rights (CESR) v. Nigeria*, 1 AFR. J. LEG. STUD. 129, 130 (2005) (stating that the year of inception was eighteen years before the article was published).

rights.[15] As a result, its groundbreaking decisions have served as precedence and a template for agitating for basic rights at the (sub)national and regional levels.[16] At the same time, its three-decade of existence has been nicked by onerous procedures and a lack of in-depth analysis of the nature and content of one entitlement, the right to health (or health right).[17] Inherent in this drawback is the insufficient monitoring of states' compliance with their treaty obligation to ensure citizens attain the highest standard of mental and physical well-being.[18] Wherefore, the region is rife with multiple non-communicable diseases, with insufficient preventive systems or vibrant facilities to enable local communities adapt to health concerns.[19] The latter include the COVID-19 pandemic, malaria, tuberculosis ("TB"), human immunodeficiency virus ("HIV"), and rising mortality rate.[20]

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15. *See* Nwobike, *supra* note 14, at 135 ("The right to life and respect for the dignity and integrity of all human beings, if expansively interpreted, will give an effective content to all guaranteed rights – economic, civil, political, social and cultural.").

16. *See id*. at 145 (commenting on how the approach of the Commission symbolized a giant stride towards inspiring activists to push for the realization of socioeconomic and cultural rights across the continent).

17. *See* Kofi Oteng Kufuor, *Safeguarding Human Rights: A Critique of the African Commission on Human and Peoples' Rights*, 18 AFR. DEV. 65, 73 (1993) (discussing structural issues with the procedure of the Commission); *see also* Nwobike, *supra* note 14, at 143 (stating that these rights are often said to be vague and incapable of judicial enforcement, although this was not the case in the *Ogoni* case).

18. *See* Nwobike, *supra* note 14, at 143 (stating that violations of people's rights can occur through the state's actions or due to insufficient monitoring by the state).

19. *See* Obinna O. Oleribe, et al., *Identifying Key Challenges Facing Healthcare Systems in Africa and Potential Solutions*, 12 INT'L J. GEN. MED. 395, 398 (2019) (recognizing structural challenges, such as poor supervision, poor maintenance of infrastructure, corruption, high disease burden, professional rivalry, lack of incentives, and incessant industrial actions, as some of the major setbacks to healthcare across the continent).

20. *See* David Bell & Kristian Schultz Hansen, *Relative Burdens of the COVID-19, Malaria, Tuberculosis, and HIV/ADIS Epidemics in Sub-Saharan Africa*, 105 AM. J. TROPICAL MED. & HYGIENE 1510, 1511–12 (comparing the "disease burden" of COVID-19 with malaria, tuberculosis, and HIV/AIDs).

Inspired by the old saw, for every infringement, there is a remedy (*ubi jus ibi remedium*),[21] this analysis explores how the Commission could use its overarching mandate to nudge African states to avert and/or contain health emergencies. While assessing the several challenges that undercut its mandate, the Article will conclude with a reflection on what lessons could be drawn from an external regional establishment in this regard. Part II teases out the legal guarantees afforded the right to health in the region, and provides a cursory review of the codification of the right in the African Charter and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa ("Maputo Protocol").[22] This assessment is trailed by mapping the current misfortunes of the realization of health in rural and urban Africa. To understand the challenges that have undercut the translation of the lofty legal provisions into practice, Part IV explores the attempts taken by commissioners to concretize people's entitlement to mental and physical well-being. The discussion will also explore the barriers that hinder the African Commission's effective execution of its mandate in this realm. Part V considers some of the best practices of the Inter-American Commission on Human Rights ("IACHR") as a launchpad to enhance the mandate of its African counterpart under the present discussion. The IACHR was elected for this assessment as it has made considerable gains in building partnerships to improve its effectiveness and handing down landmark jurisprudence in health rights.[23] The last part, serving as a conclusion, offers suggestions on how the Commission could

21. *See* JONATHAN LAW & ELIZABETH A. MARTIN, A DICTIONARY OF LAW (Oxford Univ. Press, 7th ed. 2009).

22. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, July 11, 2003, 3269 U.N.T.S. 26363 [hereinafter Maputo Protocol].

23. *See* Steven R. Keener & Javier Vasquez, *A Life Worth Living: Enforcement of the Right to Health Through the Right to Life in the Inter-American Court of Human Rights*, 40 COLUM. HUM. RTS. L. REV. 595, 596–97 (2008) (illustrating how the IACHR has broken new ground by reconstructing social and economic rights as imposing both negative and positive responsibilities on states).

transcend its limitation to foster the realization of the right to health across the African region.

II. The Right to Health

'Right', shorthand for 'human right,' signifies human beings are born with an entitlement.[24] In essence, being human entitles one to basic rights that are inherent in one's existence.[25] These claims are diverse and are not bestowed on an individual by the state.[26] Rather, they are the intangible constituents of the human species and cannot be wholly isolated from the physical being.[27]

Ironically, although rights are interlinked, contemporary legal luminaries have classified them into a first, civil and political, generation and a second, social and economic, generations.[28] The right to health falls under the latter.[29] Equally, the attainment of health right could be pursued in two layers.[30] First, the creation of ideal conditions for good health. This is where citizens are provided with fresh water, affordable access to nutrition, and a clean environment that safeguards them from becoming ill. The second layer is the

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24. *See* Christopher McCrudden, *Human Dignity and Judicial Interpretation of Human Rights,* 19 EUR. J. INT'L. L. 655, 656–57 (2008) (tracing the history of the idea that human rights spring from the inherent dignity and worth of a person).

25. *See* Ellen Messer, *Anthropology and Human Rights,* 22 ANN. REV. ANTHRO. 221, 222–24 (1993) (perusing the meaning of rights, and who qualifies as a full human being or person to be eligible for the said rights).

26. *See* McCrudden, *supra* note 24, at 657 (discussing the concept that human beings have dignity regardless of additional status).

27. *See id.* at 662 (outlining philosophers' thoughts as to the physical and metaphysical aspects of human dignity).

28. *See* Bülent Algan, *Rethinking 'Third Generation' Human Rights*, 1 ANKARA L. REV. 121, 124–25 (2004) (contending that the classification of the first-generation right was based on the concept of dignity and the lowering of the bar for socioeconomic and cultural rights was grounded on equality, a virtue considered to be of a lower status than dignity).

29. *See id.* at 124 (classifying the right to health under the "people's rights" or the "rights of solidarity").

30. *See id.* at 132 (observing that the word "people" was given different meanings in the African Charter on Human and Peoples' Rights, reflecting a different approach to matters related to health and environmental rights).

right to care. Put differently, the establishment of structures to contain or manage emergencies or illnesses when they arise. This will entail efficient hospitals, adequate ambulances, well-trained medical staff, medication, and advanced technology for the timely treatment of patients.

Unfortunately, since the adoption of the African Charter, the concretization of citizens' right to health is rarely prioritized at the domestic level.[31] As a result, the continent has been downgraded to a region of high infant/maternal mortality rate, punctuated by epidemics and poor healthcare system.[32] Still, although the right to health is barely recognized by the majority of states in the continent, these states are parties to regional legislation that has enshrined this entitlement.[33]

As its name implies, the primary instrument for safeguarding and advancing the health right of indigenes is the African Charter ("Charter").[34] While the right was entrenched by preceding international instruments,[35] its recognition at the regional level was an indication of the

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31. *See* Oleribe, *supra* note 19, at 400 (attributing Africa's poor service delivery to a plethora of challenges, including decreased budgetary allocation and inadequate capacity building of healthcare staff).

32. *See* Fabian Esami et al., *A System Approach to Improving Maternal and Child Health Care Delivery in Kenya: Innovations at the Community and Primary Care Facilities (A Protocol)*, REPROD. HEALTH, 2017, at 3 ("Maternal and neonatal mortality are unacceptably high in Sub-Saharan Africa compared to Western Europe and Northern America.").

33. *See* Matthew F. Yuyun, et al., *Cardiovascular Diseases in Sub-Saharian Africa Compared to High-Income Countries: An Epidemiological Perspective*, GLOB. HEART, Feb. 2020, at 9 ("Most member States of the African Region of the World Health Organization are still spending far less than the target of allocating at least 15% of annual expenditure to health under the Abuja Declaration.").

34. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 16(1) ("Every individual shall have the right to enjoy the best state of physical and mental health.").

35. *See* G.A. Res. 217 (III) A, Universal Declaration of Human Rights, at art. 25 (Dec. 10, 1948) ("Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family . . . .").

unique health challenges the continent confronts.[36] In terms of its substantive provisions, the Charter begins with Article 1 by obliging leaders to be cognizant of the diverse, yet inextricably related rights in its document.[37] It then proceeds to charge them with the responsibility of forging progressive legislations and institutions to give effect to the subsequent rights.[38]

Thereafter, Article 2 highlights non-discrimination as the benchmark for the fulfillment of the various entitlements in the Charter.[39] In other words, every individual (regardless of class, gender, or race) has a fair claim to the list of first- and second-generation rights contained therein.[40] In light of the scarce resources across the continent, equal access to basic resources is a doctrine that nourishes the spirit of the Charter.[41] For citizens to fully realize their necessities, equal treatment is non-derogable and ought to be respected at all times.[42]

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36. *See* Oleribe, *supra* note 19, at 3957 (listing inadequate human resources, poor resource allocation, poor maintenance of health care infrastructure, and lack of political will as the four major obstacles).

37. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 1 ("The Member States . . . shall recognize the rights, duties and freedoms enshrined in this Charter and shall undertake to adopt legislative or other measures to give effect to them.").

38. *See id*. (charging Member States to "undertake to adopt legislative or other measures to give effect to" the "rights, duties and freedoms enshrined in this Charter").

39. *See id.* at art. 2 (affirming that all individuals are entitled to the rights and freedoms recognized by the Charter, regardless of class, gender, or race).

40. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 2 (asserting that all individuals are entitled to the rights laid out by the charter).

41. *See* Purohit & Moore v. Gambia, Communication, No. 241/2001, African Commission on Human and Peoples' Rights [Afr. Comm'n H.P.R.], ¶¶ 46–55 (2003) (finding that the legal frameworks in The Gambia do not provide sufficient guarantee for the physiological and moral welfare of disabled persons)

42. *See id.* at ¶¶ 80–81 (contending that health rights encompass equal access to goods and services, especially to health facilities but noting that, in light of their unique conditions, mental health patients ought to be granted special treatments for them to achieve their full potential and autonomy).

In light of this background, the African Commission ought to underscore in its deliberation that while a considerable number of countries battle with an infrastructural deficit, they ought to operationalize specific and practical interventions to fulfill their obligations to their citizens.[43] This reasoning resonates with the observation of the Committee on Economic, Social, and Cultural Rights ("CESCR") which hinted that where structural deficits undermine a state's ability to act on its duties, then the onus lies upon the elected officials to demonstrate that all available logistics have been utilized to that end.[44] The Committee's observation is striking, considering that while the landscape of Africa is sprinkled with less developed countries, it is also a region with high levels of corruption and misappropriation of funds.[45]

As a result, the failure to meet healthcare concerns is often not a question of inability, but the unwillingness to diligently use available resources to improve the conditions of the people. This deduction is more compelling given that even with fewer resources, if used prudently, the region could address a multitude of health conditions such as malaria or TB.[46] For example, the removal of stagnant water to avert

43. *See* Leo Hotlz & Chris Heitzig, *Figures of the Week: Africa's Infrastructure Paradox*, BROOKINGS INST. (Feb. 24, 2021) (attributing "Africa's infrastructure paradox" to "insufficient investment in infrastructure projects within the region") [perma.cc/PAQ7-62T3].

44. *See* Comm. On Econ., Soc. & Cultural Rts., *Report on the Fifth Session*, U.N. Doc. E/1991/23 (1991), at 83–87 (commenting that while the International Covenant on Economic, Social and Cultural Rights "acknowledges the constraints due to the limits of available resources," it also imposes immediate obligations towards which a state must begin taking steps within "a reasonably short time" after the Covenant's entry into force).

45. *See* Kempe Ronald Hope, Sr., *Reducing Corruption and Bribery in Africa as a Target of the Sustainable Development Goals: Applying Indicators for Assessing Performance*, 25 J. MONEY LAUNDERING CONTROL 313, 317 (2022) (asserting that corruption remains a major hindrance undercutting the region's potential for attaining the sustainable development goals).

46. See Ruxin et al., *Emerging Consensus in HIV/AIDS, Malaria, Tuberculosis, and Access to Essential Medicines*, 365 LANCET, 618, 619–620 (2005) (arguing that combatting Malaria and TB transcends increased public financing, rather, there is a need for basic interventions

mosquito breeding merely requires conscientiousness and political willingness rather than an enormous amount of capital injection.[47]

Inevitably, the proscribing of discrimination under Article 2 transitions to safeguarding people's right to dignity under Article 5. While both provisions provide the base for concretizing health right, it is Article 16 of the Charter that specifically enshrines this right.[48] The provision is specific: 1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.

"2. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."[49]

The meaning of the attainment of the highest standard of "mental and physical health"' under the first subsection may be seen as encircling five central elements: emotional, intellectual, physical, social, and spiritual well-being.[50]

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with fewer resources such as: (i) well-coordinated national efforts, (ii) management of the environment to avert mosquitoes larval breeding, and (iii) effective judicial systems to forestall corruption and diversion of resources).

47. *See* Solomon Kibret et al., *Can Water-Level Management Reduce Malaria Mosquito Abundance Around Large Dams in Sub-Saharan Africa?*, PLOS ONE, Apr. 19, 2018, at 6–10 (encouraging dam operators to incorporate malaria control mechanisms because of their effectiveness and relatively simple implementation).

48. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 16 (establishing individuals' right to physical and mental health and obligating member states to protect their peoples' health and ensure medical attention is provided in times of sickness).

49. *Id.*

50. *See* Michael P. O'Donnell, *Definition of Health Promotion 2.0: Embracing Passion, Enhancing Motivation, Recognizing Dynamic Balance, and Creating Opportunities*, 24 AM. J. HEALTH PROMOTION iv, iv (2009) (defining "[o]ptimal health" as a "dynamic balance of physical, emotional, social, spiritual, and intellectual health"); s*ee also* Paul Tillich, *The Meaning of Health*, 5 PERSP. BIOLOGY & MED. 92, 94–99 (1961) (identifying different dimensions of life, and, by extension, health, and arguing that these different dimensions of health are inherent in each other and that the biological, chemical, historical, mechanical, psychological, and spiritual constituents of one's being cannot be separated).

Although the wording of Article 16(1) gives prominence to the individual actual realization of the right,[51] Article 16(2) focuses on hammering home the duty of states to fulfill this entitlement.[52] As is often the case with legal instruments, the two subsections are mutually reinforcing rather than contradictory. Thus, while the first subsection seeks to expatiate the individual's entitlement to a robust physical and mental state,[53] the second elaborates on who ought to act to attain the first.[54] For all intents and purposes, this division of labor provides clear guidance to the Commission on whom to prod to accomplish the health right as set out in its mother treaty, the Charter.

Still, Article 16(2) of the Charter was unequivocal in obliging states to "protect the health of their citizens."[55] While it fails to set out the meaning of "protection," one may distill that it implies taking the required steps to preserve the mental and physical health of their citizens and everything else in between. The provision, nonetheless, strikes a note of caution. It entreats states that where they fail to fulfill this primary responsibility, they ought to offset the setback by providing "medical attention" when an individual or people "are sick."[56]

Pivotally, the overarching reference to medical attention under this provision makes the nature of treatment unrestricted, from non-communicable diseases to childbirth. In times of sickness, equal access to medical procedures is

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51. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 16(1) ("Every individual shall have the right to enjoy the best attainable state of physical and mental health").

52. *See id.* at art. 16(2) ("States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.").

53. *See id.* at art. 16(1) (placing equal importance on the right to enjoy mental and physical health).

54. *See id.* at art. 16(2) (charging states with the task of protecting health).

55. *See id.* ("States Parties to the present Charter *shall* take the necessary measures to protect the health of their people . . . .") (emphasis added).

56. *See id.* (stating that states shall "ensure that they receive medical attention when they are sick").

key.[57] Access to medication and treatment ought to be within the reach of every individual, regardless of how shallow one's pocket might be.

Then again, the mention of "medical attention" in times of sickness in Article 16(2) of the Charter seems to indicate that the document prioritizes disease-coping strategies rather than forestalling infection itself.[58] For that reason, there was less ink spilled on mitigation efforts in this provision, particularly in terms of a clean and healthy environment.[59] Put differently, Article 16(2) of the Charter rarely extends the state's duty to address the causative conditions of non-communicable diseases such as malaria, TB, and HIV.[60] With four African countries accounting for more than half of global malaria deaths, and over a quarter of TB-related deaths occurring in the region, it is fair to surmise that the farmers of the Charter underestimated the weight of these indispositions.[61] Having said that, the lack of explicit reference to the prevention of diseases does not liberate duty-bearers from operationalizing interventions to avert causative agents of illness.

In terms of HIV, one could take consolation in the fact that contemporary rulers have become cognizant of its raging

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57. *See* Oleribe, *supra* note 19, at 398 (listing "unequal distribution of healthcare facilities" as a challenge facing healthcare in Africa).

58. *See e.g.* C. David Jenkins, Building Better Health: A Handbook of Behavioral Change, Pan American Health Organization Scientific & Technical Publication No. 590, xv ("Today, the nations of the world devote huge sums of money to 'health care.' Sadly, about 98% of these budgets are actually spent on 'disease care' and only about 1% or 2% on genuine care of health.") [perma.cc/36SQ-R4CF].

59. *See, e.g.*, African Charter on Human and Peoples' Rights, *supra* note 8, at arts. 21, 23, 29 (creating greater specificities in provisions regarding natural resources and international peace).

60. *See id.* at art. 16 (only requiring States to take measures to ensure medical attention when citizens are already sick).

61. *See Marlaria*, WORLD HEATH ORG. (Mar. 29, 2023) (highlighting its regional office in Africa bearing the high percentage of international malaria burden) [perma.cc/GS26-NS67]; *see also Tuberculose (TB)*, WORLD HEALTH ORG. (Mar. 2023) (detailing how Africa accounts for a quarter of Tuberculose deaths, with the evolution of multi-resistant Tuberculose) [perma.cc/H7F2-AD9E].

impact and thus, codified it in the Maputo Protocol.[62] Setting out an elaborate list of sexual and reproductive rights, Article 14(d) of the document obliges state parties to promote and respect the rights of women to safeguard themselves from HIV/AIDs and other sexually transmitted diseases (STDs).[63] Historically, although men have equally borne the effect of HIV infection, women are more vulnerable for three reasons. First, they are sometimes coerced through physical or socioeconomic pressure into intimate interaction.[64] Second, they are either denied or have limited access to protective contraceptives.[65] Third, the social stigma attached to female condoms tends to dissuade some from purchasing them at local pharmacies.[66]

The Protocol's exclusion of men from equally warranting sexual protection is worrying. Since antiquity, African culture has been grounded on patriarchy and polygamy.[67] To

62. *See* Maputo Protocol, *supra* note 22, at art. 14(1)(d), (e) (specifying the right to self-protection from HIV/AIDS and the right to be informed of a partner's HIV/AIDS status).

63. *See id.* at art. 14(d) (listing specific rights including the right to control fertility, to decide whether to have children, to be informed of one's health status and on the health status of one's partner, and to family planning education, amongst others).

64. *See* Ebenezer Durojaye, *Realizing Access to Sexual Health Information and Services for Adolescents Through the Protocol the African Charter on the Rights of Women*, 16 WASH. & LEE J. CIV. RTS. & SOC. JUST. 135, 137 (2009) (explaining that with limited or denied access to medical services, coupled with unprotected sex, women, particularly adolescents, are more vulnerable to sexual and reproductive ill health).

65. *See id.* at 137–38 (detailing the challenges that women face in accessing sexual and reproductive services in communities).

66. *See* Nomsa B. Mahlalela & Pranitha Maharaj, *Factors Facilitating and Inhibiting the Use of Female Condoms Among Female University Students in Durban, Kwazulu-Natal, South Africa*, 20 EUR. J. CONTRACEPTION & REPROD. HEALTH CARE 379, 379 (2015) (explaining how stigma, coupled with insufficient awareness, insertion complications, partner objection, and limited availability hinder female condom use at the grassroots level).

67. *See* Theophilus T. Mukhuba, *The Representation of Patriarch Perception in Selected African Literary Works*, 15 GENDER & BEHAVIOUR 8561, 8567 (2017) (highlighting the widespread of polygamy and oppressive features of traditional patriarchies in African communities); Also *see*, Isabel A. Phiri & Sarojini Nadar, *'Going through the Fire with Eyes Wide Open': African Women's Perspectives on*

that end, this culture, coupled with peer influence tacitly coerces men to have multiple sexual partners.[68] This pattern is likely to lead to the spread of HIV.[69] Thus, in seeking to contain the spread of STDs, and to be exact, HIV, it is key to also accentuate the protection of men during intimate interactions with their partners.[70] Bearing these textual deficits in mind, the paper now turns to examine the fulfillment, or lack thereof, of health right on the ground.

III. The Health of Africa

Despite the African Charter's explicit guarantee of health rights in the region, post-colonial Africa is riddled with a high mortality rate, marked by a string of non-communicable diseases.[71] While there has been scientific advancement and techniques for averting some of these

Indigenous Knowledge, Patriarchy and Sexuality, J. STUDY RELIGION 5, 6 (2009) (using gender justice concept to engage 'African cultural practices' such as polygamy and patriarchy). Also see Lorraine Bowan, *Polygamy and Patriarchy: An Intimate Look at Marriage in Ghana Through a Human Rights Lens,* 1 CONTEMP. J. AFR. STUD. 46, 50 ("Polygamy and patriarchy have long been comfortable bedfellows, and the rights of women had always been subordinated to the larger freedoms enjoyed by men and to the patriarchal perception of the good of the community.").

68. *See id.* at 49 (outlining the history and cultural attitudes towards polygamy).

69. *See* Seth C. Kalichman et al., *Recent Multiple Sexual Partners and HIV Transmission Risks Among People Living with HIV/AIDS in Botsawana*, 83 SEXUALLY TRANSMITTED INFECTIONS 371, 371 (2007) ("Although sexual concurrency is not the only factor propelling the African AIDS crisis,10 multiple concurrent sex partners clearly have the potential to accelerate the spread of HIV beyond serial monogamous relationships.").

70. *See id.* at 374 (noting that condom use was generally high among people with HIV in a study).

71. *See* Erin A. Mordecai et al., *Climate Change Could Shift Disease Burden from Malaria to Arboviruses in Africa*, 4 LANCET PLANETARY HEALTH e416, e416 (2020) (highlighting that apart from malaria placing major mortality and morbidity burden on the region, other vector-borne diseases such as o'nyong'nyong, trypanosomiasis, chikungunya, and Zika are also rife in the continent).

ailments, medical access remains limited.[72] With a rising population, and 98% of its medications produced overseas, it is perceptible that a growing number of the continent's demography are cut off from affordable medicines.[73] This trend underscores the estimated 1.6 million deaths recorded in Africa from treatable diseases such as HIV, malaria, and TB.[74]

Whereas rural-urban disparity plays an important role in income distribution, it appears the fate of rural valetudinarians is no different from their urban counterparts. At the rural hospitals, patients are informed the required medications can only be assessed at main hospitals in towns.[75] Given that some may not have the means of transport to follow through with this advice, others may succumb to their illnesses *en route* to distant health facilities.[76]

In urban centers, hospitals are far from safe havens.[77] The health systems in these communities have not been updated to catch up with new viruses, population explosion,

72. *See* Tefo Pheage, *Dying From Lack of Medicines*, 30 AFR. RENEWAL, Mar. 13, 2017, at 24, 24–25 (discussing the insufficient access to medication in Africa and coexisting vulnerabilities—for example, less than 2% of drugs consumed in Africa are made on the continent).

73. *See id*. (noting that with insufficient access to medications, communities are vulnerable to grave illnesses such as HIV/AIDS, TB, and malaria and are prescribed pain-killers as a general solution).

74. *See id*. (arguing that the rate of mortality could be averted with access to relevant drugs, vaccines, and healthcare).

75. *See* Eric Maimela et al., *The Perceptions and Perspectives of Patients and Health Care Providers on Chronic Diseases Management in Rural South Africa: A Qualitative Study*, 15 BMC HEALTH SERVS. RSCH., 2015, at 8 (noting that patients who are increasingly referred to main hospitals where due to lack of means, many default on treatment due to a lack of resources).

76. *See* Kwamboka Oyaro, *Taking Health Services to Remote Areas*, 30 AFR. RENEWAL, Mar. 13, 2017, at 22, 22–23 (describing the potential life-saving impact of innovative transportation solutions from remote areas to hospitals).

77. *See* MARIO J. AZEVEDO, HISTORICAL PERSPECTIVES ON THE STATE OF HEALTH AND HEALTH SYSTEMS IN AFRICA, VOLUME II: THE MODERN ERA (AFRICAN HISTORIES AND MODERNITIES) 1 (1st ed. 2017) (endorsing the restrengthening of a health care system by revamping the institutions to be responsive to the real health needs of all people).

and mass rural-urban migration.[78] With a considerable proportion of persons in low- and middle-income societies dependent on public facilities, the lack of critical medications and staff continues to undermine the health of urban residents.[79] Naturally, the continent's perennial workforce shortage continues to stifle its health sector.[80] Of the fifty-four African countries, fifty fall short of the health-worker-to-population ratio.[81] Even in Seychelles with the highest staff, the ratio is nine health workers per 100 people.[82] In contrast, Niger with the lowest ratio in the region has less than one staff person per 1000 people in the country.[83]

Then again, having a good governance architecture in the health system enhances effective service delivery.[84] Bearing this in mind, delegates of African countries converged in Burkina Faso approximately 15 years ago to adopt the Ouagadougou Declaration.[85] Sponsored by the African branch of the World Health Organization ("WHO"), the

78. *See id.* at 2 (describing measures needed to bring health systems in Africa up to date).

79. *See* Cynthia Modisakeng et al., *Medicine Shortages and Challenges with the Procurement Process Among Public Sector Hospitals in South Africa; Findings and Implications*, BMC HEALTH SERS. RSCH., Mar. 19, 2020, at 2 (2020) (arguing that aside from those coerced through out-of-pocket payment for medication, an inefficient procurement system for the purchase of pharmaceutical supplies has resulted in medicine shortages in many hospitals).

80. *See Chronic Staff Shortfalls Stifle Africa's Health Systems: WHO Study*, WHO AFR. REGION (June 22, 2022) ("A serious shortage of health workers in Africa is undermining access to and provision of health services even though countries in the region have made efforts to bolster the workforce . . . .") [perma.cc/ZJU7-57Z2].

81. *See id.* ("Only four countries (Mauritius, Namibia, Seychelles and South Africa) have surpassed the WHO health worker-to-population ratio.").

82. *Id.*

83. *See id.* (identifying Niger as the least compliant with the global threshold of approximately 5 health workers per 1000 people).

84. *See id.* (To reinforce Africa's health system, it is critical to address the persistent shortages and poor distribution of the health workforce.).

85. International Conference on Primary Health Care and Systems in Africa, *Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium*, art. III (Apr. 30, 2008).

declaration outlines specific interventions for revamping health systems throughout the continent.[86] The document entreats signatory states to prioritize specific key areas of the health system, to be exact: (i) foster awareness creation around healthy behaviors; (ii) promote health research; (iii) build collaboration with civil societies for improving healthcare; (iv) invest in health technologies; (v) facilitate skills development in health information systems; (vi) involve the community in the framing and operationalization of health policies; (vii) increase health funding; (viii) recruit and retain skilled workforce; (x) ensure quality and speedy access to health services; and (xi) ensure good governance and leadership in the administration of health service.[87] While these measures are resounding and have the potential of improving some of the perennial problems in the continent's health structures, the content of the document has faced a similar tragedy to others before it: lack of implementation.[88]

Then again, the inability or unwillingness of rulers to institutionalize these principles has manifested in wanton corruption in the provision of health treatment, inadequate ambulances for emergency services, poor surgical treatments leading to infestations, and unacceptable behaviors of nurses towards patients.[89] Significantly, whereas the Ouagadougou Declaration outlines progressive steps for rehabilitating

86. *See id.* at art. V (listing updating national health policies and using priority health interventions as methods to improve health systems).

87. *See id.* (identifying specific steps Member States should take to improve public health).

88. *See, e.g.*, Claire Bryan, *The Health System in Malawi*, BORGEN PROJECT (July 5, 2019) (noting the consistently high numbers of deaths resulting from HIV/AIDS, acute respiratory infections, and Malaria despite the Declaration's goals).

89. *See* Olawale Olonade et al., *Maternal Mortality and Maternal Health Care in Nigeria: Implications For Socio-Economic Development*, 7 OPEN ACCESS MACED. J. MED. SCI. 849, 851–53 (2019) (noting that poor healthcare systems, which spring from poor social structures, are mainly responsible for many pregnancy-related deaths).

healthcare, the continent continues to be plagued with rising deaths from treatable diseases.[90]

Moreover, the departure from the Ouagadougou Declaration is evident in the general poor health infrastructure, corruption in the procurement systems, and siphoning of medications to private pharmacies.[91] Noticeably, the kickback in the procurement systems has unintended circumstances of inflating the prices of medications at local hospitals that results in medical supplies and technologies mainly within the domain of the affluent.[92] With hundreds of Africans living on less than a dollar a day, it is not far-fetched to hint that more than half do not have access to the required healthcare.[93]

Besides, with the dominance of out-of-pocket payments, the upper class is prioritized in local clinics, even if their condition is not terminal.[94] These barriers have, in tandem,

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90. *See id*. (commenting that inadequate access to healthcare facilities gravely contributes to pre- and post-natal complications and maternal morbidity).

91. *See id.* at 851 ("It is therefore imperative that the healthcare delivery system needs a transformation that will address the inherent corruption that syphon resources meant to lead to efficient and effective delivery of services within the sector.").

92. *See id.* at 854 (highlighting Nigeria as an example of a nation where "a high percentage of women do not receive adequate care; this is as a result of lack of services in the residence they live, or inability to afford the services because they are too expensive."); *see also* Modisakeng, *supra* note 79, at 9–10 (emphasizing wide-spread procurement issues as a major contributor to medicine shortages).

93. *See* Khanyi Mlaba, *1 in 5 South Africans Are Living in Extreme Poverty: UN Report*, GLOB. CITIZEN (Dec. 23, 2020) ("The report notes that 18.9% of the population — about 11 million South Africans — live on less than R28 ($1.90) a day, which is around R800 ($55) per month.") [perma.cc/D5YM-2U4R]; Kerry Cullinan, *Universal Health Coverage: Only Half of Africans Have Access to Health Care*, HEALTH POL'Y WATCH (Mar. 8, 2021) (commenting that even with approximately half of the population having access to healthcare, the quality of the care is poor, especially with regards to the sexual and reproductive healthcare for women) [perma.cc/WLL6-WPVW].

94. *See* Abigail Nyarko Codjoe Derkyi-Kwarteng et al., *A Narrative Synthesis Review of Out-Of-Pocket Payments For Health Services Under Insurance Regimes: A Policy Implementation Gap Hindering Universal Health Coverage in Sub-Saharan Africa*, 10 INT'L J. OF HEALTH POL'Y & MGMT. 443, 444 (2021) (recognizing that the out-of-pocket payments

translated into cutting off a growing population of the impoverished yet infirm from accessing essential doses of medicine and life-saving treatment.[95]

More positively, some countries have progressed in the introduction and distribution of contemporary technologies to some major hospitals.[96] These digital solutions have gradually gained momentum as providing cutting-edge diagnostic and C-sections.[97] Yet, these computerized clinical systems have merely become aesthetic displays, rather than for diagnosing and treatment of diseases.[98] This trend persists in light of the dearth of knowledge among physicians, nurses, and midwives on the use of these medical technologies.[99] The paucity of computer knowledge and skills largely emanates from insufficient training in information and communication technologies ("ICT") in health colleges.[100]

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prevalent in Africa may potentially cause catastrophic health expenditure for the poor, thereby alienating them from accessing required medical needs).

95. *See id.* (referencing a review of studies in low and middle income countries that showed that out-of-pocket payments, regardless of context, decreased access to health services and increased catastrophic health expenditures).

96. *See* Tobias Broger et al., *Novel Lipoarabinomannan Point-Of-Care Tuberculosis Test for People with HIV: A Diagnostic Accuracy Study*, 19 LANCET INFECTIOUS DISEASES 852, 853 (2019) (outlining the launch and benefits of the AlereLAM and FujiLAM assays for early detection of TB to avert deaths among persons with HIV).

97. *See* Magdaline Saya, *Kenya Unveils Latest Innovations to Diagnose and Treat TB*, STAR (Jul. 7, 2022) (praising Kenya as one of the seven countries to implement Computer-Aided Detection technology that uses artificial intelligence to identify signs of TB in chest x-rays) [perma.cc/LV3J-PCCN].

98. See Thokozani Bvumbwe & Ntombifikile Mtshali, *Nursing Education Challenges and Solutions in Sub Saharan Africa: An Integrative Review*, 17 BMC NURSING at 4 (Jan. 31, 2018) (encouraging nursing education to take advantage of advancing technology).

99. *See id.* at 2 (highlighting that the majority of countries within Sub Saharan Africa are experiencing common challenges ranging from strained training institutions due to increased enrolments, inadequate faculty capacity, lack of infrastructure and resources, and high demand for clinical training sites).

100. *See* Ebenezer Toyin Megbowon & Oladipo Olalekan David, *Information and Communication Technology Development and Health Gap Nexus in Africa*, 11 FRONTIERS PUB. HEALTH at 4 (Mar. 30, 2023)

This challenge could be as well traced back to medical and nursing schools' overemphasis on theory, rather than providing these future professionals with practical training on the use of advanced medical technologies.[101]

Further, with limited state support for on-the-job and periodic ICT training, a disproportionate percentage of health practitioners continue to lack the technical skills for the use of digital solutions for accurate detection of mental and physical diseases.[102] As a result, the conventional approach of treating health complications remains, with often inaccurate prescriptions, coupled with unwarranted surgical procedures.[103]

Considering these challenges, the next part of the paper turns to engage the oversight role of the African Commission in safeguarding vulnerable communities from these health challenges. Whereas access to primary healthcare will be the focus of the analysis, the assessment will be complemented with barriers that impede the Commission's effort in this regard.

IV. The Commission

The African Commission on Human and Peoples' Rights is a supranational entity set up to act as a check and balance on the powers of African rulers.[104] The activities of the

(explaining the significance of Information Communication Technology and the negative impacts of insufficient training on it in Africa).

101. *See* Bvumbwe, *supra* note 9899, at 8 ("Effective academic practice partnerships can reduce the theory practice-gap thereby improving patient safety, reducing medical errors, strengthening practice setting and cushioning faculty shortage.").

102. *See* Megbowon, *supra* note 100100, at 1 ("The findings . . . suggest that ICT does act as an indispensable stimulator for Africa to significantly exceed the international health target of life expectancy at birth of 60 years.")

103. *See* Alemayehu B. Mekonnen et al., *Adverse Drug Events and Medication Errors in African Hospitals: A Systematic Review*, Drugs – Real World Outcome, Nov. 14, 2017, at 19 (noting that African hospitals have a higher rate of medication error than those in wealthier countries).

104. *See* Jamil Ddamulira Mujuzi, *The Rule of Law: Approaches of the African Commission on Human and People's Rights and Selected African States,* 12 AFR. HUM. RTS. L. J. 89, 110 (2012) (discussing how the African

Commission are aided by a Secretariat headquartered in Banjul-Gambia.[105] In line with Article 31 of the African Charter, it is composed of eleven members.[106] Elected by the AU General Assembly through a secret ballot, commissioners serve on a part-time basis and in their personal capacities.[107] To be eligible, it is expected that one ought to possess the highest competence in human rights issues, be with high integrity, morality, and an enviable reputation.[108] With a six-year renewable tenure,[109] members perform two key roles – promotional and protective. Understanding the contribution of the Commission to the right to health calls for one to be abreast with the unique features of these twofold competencies.

A. Promotional mandate

The promotional mandate, as its name connotes, provides the Commission with the leverage to rehabilitate and advocate for the rights in the Charter.[110] Article 45 sets out the list of activities to be pursued by the Commission,

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Charter on Human and Peoples' Rights uses different mechanisms to give itself the "role of law" without using that phrase).

105. *See About*, AFR. COMM'N H.P.R. ("The Commission's Secretariat has subsequently been located in Banjul, The Gambia.") [perma.cc/DJ27-KG9E].

106. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 31 ("The Commission shall consist of eleven members . . . .").

107. *See* AMNESTY INTERNATIONAL, A GUIDE TO THE AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS 6 (2007) (explaining the selection process and capacity of African Commission members).

108. *See id.* ("These independent experts are chosen from among African personalities of the highest reputation, known for their high morality, integrity, impartiality and competence in matters of human and peoples' rights and serve in their personal capacity.") (internal quotations omitted).

109. *See id.* ("Commissioners serve six-year terms in their personal capacity and are eligible for re-election.").

110. *See* Ebenezer Durojaye, *An Analysis of the Contribution of the African Human Rights System to the Understanding of the Right to Health*, 21 AFR. HUM. RTS. L. J. 751, 758 (2021) (expanding on the African Commission's attempts to promote the right to health, including General Comments, resolutions, decisions, and state reporting).

inter alia, increasing the visibility of the Charter and entreating states to domesticate its provisions.[111] This function may be grouped into three sects: (1) partnership, (2) information dissemination, and (3) guidelines.

1. Partnership

Partnership includes collaborating with other supranational entities, either at the regional or international levels, to foster the culture of human rights in the continent.[112] The entities under consideration may include UN human rights monitoring bodies, regional bodies, and sub-regional organizations.[113] The collaboration may extend to jointly solving or interpreting legal problems that affect a number of people, yet there is no specific guidelines for averting them.[114]

2. Information dissemination

Dissemination of information encompasses broad range of activities, including understanding the nature of human rights situation and diagnosing remedies.[115] This agenda may be attained through rigorous desk-top or on-site visits,

111. *See African Charter on Human and Peoples' Rights*, *supra* note 8, at art. 45 (mandating the Commission to promote and protect human and peoples' rights through cooperation "with other African and international institutions").

112. *See, e.g., Africa-EU Partnership*, EUR. COMM'N. (illustrating an example of a partnership between African and another international entity, European Union) [perma.cc/RKV2-J9W4].

113. *See UN Human Rights in West Africa*, U.N. HUM. RTS.: OFF. HIGH COMM'R. (Dec. 2020) (listing partners of the West African Regional Office of the UN High Commissioner for Human Rights, including other UN bodies, national governments, and international organizations). [perma.cc/7G3M-RE9T].

114. *See id.* (highlighting achievements in responding to human rights violations).

115. *See* U.N. HUM. RTS.: OFF. HIGH COMM'R., HUMAN RIGHTS INDICATORS: A GUIDE TO MEASUREMENT AND IMPLEMENTATION 46–70 (2012) (describing various types of human rights information and discussing the importance of its dissemination).

disseminating research findings.[116] The body may use existing or new channels to complete this task.[117] Apart from organizing conferences, symposia and seminars, it may utilize other innovative approaches to either create awareness, or liaise with the national ombudsman to empower their indigenes with knowledge of their rights.[118]

3. Setting Guidelines

Guidelines allow for introspection setting general rules for the advancement of rights in the Charter.[119] This role is often discharged through the issuance of resolutions addressing complex socioeconomic or civil/political issues.[120]

In terms of the latter, the Commission recently invited stakeholders to share their comments on a draft Resolution on the right to health and its continental financing.[121] The Resolution was inspired by the underlying structural barriers that became evident in the wake of the Covid-19 crisis.[122] The content of the Resolution and the invitation for

116. *See* Thomas Buergenthal, *The Evolving International Human Rights System*, 100 THE AM. J. OF INT'L L. 783, 798 (2006) (referencing the African Commission's power to perform on-site country visits).

117. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 46 (permitting the Commission to use any method appropriate in its investigations).

118. *See id.* at art. 45(1),(2) (outlining the avenues by which the Commission may achieve its goal to promote human rights).

119. *See id.* at art. 61 (determining that the Committee is responsible for interpreting provisions and setting rules of the Charter in accordance with its goals).

120. *See, e.g.,* Afr. Comm'n H.P.R. Res. 567(LXXVI) (Aug. 19, 2023) (responding to human rights violations in Senegal); Afr. Comm'n H.P.R. Res. 564(LXXVI) (Aug. 4, 2023) (addressing unconstitutional changes of governments).

121. *See Call for Comments Study on the Right to Health and its Financing in Africa: "End Epidemics and Strengthen Systems that Uphold the Right to Health for All,"* AFR. COMM'N H.P.R. (Mar. 28, 2023) [hereinafter *Call for Comments*] (mentioning the draft resolution which proposed a study on the right to health and country financing) [perma.cc/5KBK-A265].

122. *See id.* (acknowledging that the COVID-19 pandemic exposed several infrastructural weaknesses).

responses have five merits. First, this request could enable civil societies and individuals with interest in the topic to bring forth to the Commission three key concerns: (i) hotspots of fragile health care systems; (ii) possible antidotes for staving off diversion of medical resources; and (iii) barriers faced by health workers.[123] Second, based on this feedback, the Commission could solicit invitations from the concerned government to conduct country visits.[124] The on-site tour will enable relevant rapporteur(s) to ascertain the nature of the health condition, and if need be, persuade the state to institute measures to ameliorate the crisis.[125] Third, in instances where such diplomatic talks fail to trigger a positive response, the publication of the country report by the Secretariat could exert moral and political persuasions on the state to act.[126] This approach may be useful as rights think tanks could use the report as a tool for naming and shaming the government at local and international fora.[127] Fourth, it is likely to receive constructive feedback and suggestions on overcoming the continental barriers bedeviling mental and physical well-being.[128] Fifth, in opposition to the onerous red tapping typifying the Commission's contentious jurisdiction, this avenue could be a quicker approach to inspiring healthcare compliance at the state level.[129] As opposed to the

123. *See id.* (highlighting the Commission's main concerns about the healthcare system that arose from the COVID-19 pandemic).

124. *See* Buergenthal, *supra* note 116, at 798 (mentioning the African Commission's ability to perform on-site visits to investigate potential human rights violations).

125. *See id.* (referencing the Commission's ability to call upon states to remedy human rights violations).

126. *See id.* (discussing the political impact that on-site country visits have on political leaders to abide by the Charter's protection of human rights).

127. *See* Makau wa Mutua, *The African Human Rights System: A Critical Evaluation*, DIGIT. COMMONS UNIV. BUFF. SCH. L., 2000, at 30 (referring to shaming tactics used by the African Human Rights Court to achieve state compliance).

128. *See Call for Comments*, *supra* note 121 (inviting stakeholders to submit input and comments on a draft study).

129. *See* UNAIDS & Afr. Comm'n H.P.R., Right to Health and Its Financing in Africa: End Epidemics and Strengthen Systems that Uphold the Right to Health for All 27 (Mar. 8, 2023) (draft study) (discussing

Commission's merits-based competence, that could take months or years before one could exhaust domestic remedies, the country visit and publication of reports could be attained within a reasonable time.[130] Thus, the timely response to addressing healthcare challenges somewhat makes the Commission's promotional mandate quite appealing, as compared to its protective mandate, which is a shorthand for case-based petitions.[131] Perhaps it might be despotic to jump to such a hasty conclusion without first understanding the processes of the Commission's contentious jurisdiction.

B. Protective mandate

Article 30 of the African Charter entrusted it with monitoring the compliance of member states with its provisions.[132] For that reason, Article 55 opens the floodgate for its contentious jurisdiction, the submission of complaints for rights violation.[133] Counter to other monitoring mechanisms of the AU, the Commission is a viable platform for protecting health rights due to its: (i) universal ratification by all African states; and (ii) it keeps an open door for individuals and NGOs to submit communications.[134] It is important to underscore that the submission of such an

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short term remedies on the state level to effectuate change in healthcare) [**perma.cc/PQV8-5GUJ]**.

130. *See* Henry Onoria, *The African Commission on Human and Peoples' Rights and the Exhaustion of Local Remedies under the African Charter*, 3 AFR. HUM. RTS. L. J. 1, 18 (2003) (discussing the unduly prolonged length of time it can take to exhaust local and domestic remedies).

131. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 45 (delineating the difference between the Commission's protective and promotional mandates).

132. *See id.* at art. 30 (granting the Commission the jurisdiction to enforce and protect human rights amongst the treaty's signatories).

133. *See id.* at art. 55 (outlining the requirements of communication submitted to the Commission).

134. *See Basic Information*, AFR. CT. ON HUM. & PEOPLES' RTS. (referencing the ability of NGOs and individuals to directly submit claims to the Commission) **[**perma.cc/4FA4-6CFE**].**

application ought to meet three cardinal benchmarks: (1) procedural; (2) jurisdictional and (3) substantive.[135]

1. Procedural

One of the central tenets governing the Commission's admissibility processes is the exhaustion of domestic remedies.[136] The principle implies that one ought to first seek local judicial intervention, if available, before ascending to regional organs.[137] It may not be a fallacy to reason that the rule was set out to: (i) provide direct judicial access to victims; (ii) as a political trade-off to entice rulers to ratify the treaty.[138] It was a compromise to assure leaders that they will have the right of first arbitration, and as such, retain their territorial integrity over domestic issues; (iii) respect the sovereignty of national courts to adjudicate on cases in their agora; and (iv) limit the horde of cases that might flood the gates of the Commission.[139]

Due to the political capture of the judiciary by the executive arm, the latter may be the dominant rationale for the insertion of the principle under Article 50 of the African Charter. In some cases, the appointment of national judges

135. *See* Misha Ariana Plagis, JURISDICTION AND ADMISSIBILITY: AFRICAN COURT ON HUMAN AND PEOPLES' RIGHTS (ACTHPR) §§ 1, 5 (2021) (emphasizing the importance of meeting the African Commission's procedural, substantive, and jurisdictional benchmarks).

136. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at arts. 50, 56(5) (discussing the necessity of the exhaustion of domestic remedies rule).

137. *See id.* (outlining the requirement of the Commission to first exhaust local remedies before pursuing further relief).

138. *See African Commission on Human and Peoples' Rights: Communication Procedure,* CONSCIENTIOUS OBJECTOR'S GUIDE TO INT'L HUM. RTS. SYS. (highlighting the implications the exhaustive domestic remedies rule has on allowing remedies for individuals and incentivizing the State to take provisional measures) [perma.cc/5L2S-N4EB].

139. *See Exhaustion of Domestic Remedies*, STOP VIOLENCE AGAINST WOMEN (listing the benefits the exhaustion of domestic remedies rule provides) [perma.cc/QNB2-JAPF].

by the executive somewhat water down their abilities to remain impartial in cases against their patrons.[140]

2. Jurisdiction

The primary concern under this discussion is whether the Commission has the competence to entertain a claim emanating from a specific geographic enclave.[141] Given that virtually all African states are parties to the Charter,[142] the body is empowered to receive claims from individuals and NGOs across the continent, on violations of the rights in the treaty.[143] But the same cannot be said of the Maputo Protocol. With 42 states having ratified the treaty, a provision of the Protocol can only be evoked in a case relating to a state that has ratified the instrument.[144] Additionally, given that the Charter and the Protocol are, by their natures and contents

140. *See* Lovemore Madhuku, *Constitutional Protection of the Independence of the Judiciary: A Survey of the Position in Southern Africa*, 46 J. AFR. LAW 232, 243 (2002) (positing that judges who obtain and retain their appointment through executive discretion, a custom prevalent in Africa and beyond, are overtly or tacitly pressured by the latter to return the favor, thereby undermining judicial independence).

141. *See* Magnus Killander, *Communications Before the African Commission on Human and Peoples' Rights 1988-2002*, 10 L., DEMOCRACY, & DEV. 101, 104 (2006) (illustrating that the general principle of individual communication is that complaints can be submitted directly by the victim or on behalf of the victim(s)). Also, in cases where the infringement affects a large section of the population (mass violation), a relevant civil society organization may also be permitted (locus standi) to submit a complaint for, and on behalf, of the victims. *Id.*

142. *See State Parties to the African Charter*, AFR. COMM'N H.P.R. (listing the 54 states that have ratified the African Charter) [perma.cc/R87U-YWXQ].

143. *See* Killander, *supra* note 141141, at 101–06 (laying out the framework for claims submitted to the African Commission on Human and People's Rights.).

144. *See* AFRICAN UNION, *List of Countries which have Signed, Ratified/Acceded to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (2019) (listing the 13 African countries that have not ratified the Protocol as Botswana, Burundi, Central African Rep., Chad, Egypt, Eritrea, Madagascar, Morocco, Niger, Sahrawi Arab Democratic Rep, Somalia, South Sudan, and Sudan) [perma.cc/JKA6-7PJQ].

not retrospective, the Commission restricts itself in the application of the treaties to infringements that transpired after their adoptions or ratifications by the concerned state.[145]

3. Substantive

Since the Commission draws its competence from the Charter, the content of the application or the infringement that the aggrieved wishes to remedy must fall within the remit of the Charter.[146] That is, in framing a breach or non-fulfillment of one's health right, it is important to frame the petition within the context of Article 16.[147] In other words, without explicit reference to relevant provisions of the Charter, likely, the Commission will not consider such a breach admissible.[148]

At present, the Commission's website does not display a register of pending petitions, but it is reasonably to postulate that with the gradual evolution of civil societies across the continent and the Commission's growing jurisprudence around the right to health, the inventory of health applications being submitted to the Commission will grow.[149]

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145. *See The Maputo Protocol: Protecting African Women's Rights*, EQUAL. NOW (noting that countries that have signed and ratified the protocol are now held to its standards for women's rights) [perma.cc/62SQ-RHHT].

146. *See History*, AFR. COMM'N H.P.R. (describing the mandate of the commission, which is specifically grounded in the African Charter) [perma.cc/H52A-3TA2].

147. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 16 ("Every individual shall have the right to enjoy the best attainable state of physical and mental health . . . .").

148. *See* Sabelo Gumedze, *Bringing Communications Before the African Commission on Human and Peoples' Rights*, 3 AFR. HUM. RTS. L. J. 118, 129–130 (2003) ("Litigants must ensure that their communications are in line with the provisions of the Charter and those of the OAU Charter.").

149. There has been an increase in scholarly attention on the right to health, which coupled with the Commission's increased attention provides opportunity for the health applications being submitted to increase. *See* Ebenezer Durojaye, *The Approaches of the African Commission to the Right to Health under the African Charter*, 17 L.,

If this projection holds, then so will the Commission's archive of jurisprudence on this thematic area.

The seminal petition that provided the platform for the Commission to comment on an individual's right to health was the *International Pen and Others (On behalf of Ken SaroWiwa) v. Nigeria*.[150] In the communication, filed by a group of NGOs, the complainants alleged the failure of the respondent to provide healthcare for the victim during incarceration.[151] The Commission reasoned that the threshold for sustaining the well-being of citizens is raised particularly under circumstances where the state restricts their right to movement.[152] This opinion was echoed in a different application relating to the statutory detention of psychiatric patients in a neighboring country, The Gambia.[153] In this petition, the applicants bemoaned the arbitrary detention of citizens into mental facilities without prior assessment of their mental condition.[154] The Commission acknowledged that the forceful detention was in breach of the victim's right to dignity.[155] It further observed that since the right to health is a prerequisite to the attainment of all others, the state ought to ensure that the

DEMOCRACY & DEV. 393, 394 (2013) (recognizing landmark decisions, General Comments and resolutions of the Commission regarding the right to health).

150. *See Int'l Pen & Others ex rel.* Saro-Wiwa *v. Nigeria,* Decision 37/94, 139/94, 154/96, 161/97, African Commission on Human and Peoples' Rights [Afr. Comm'n H.P.R.], ¶ 110 (Oct. 31, 1998) (applying the Charter's Article 16 guarantee to health to find Nigeria in violation of the Charter).

151. *See id.* (examining the allegations laid out in the complaint).

152. *See id.* (exploring the heightened care that the State should provide to citizen inmates).

153. *See* Purohit & Moore v. Gambia, Commc'n, No. 241/2001, African Commission on Human and Peoples' Rights [Afr. Comm'n H.P.R.], ¶¶ 81–82 (2003) (emphasizing the necessity for nations to strive towards the standards set out in the African Charter).

154. *See id.* ¶ 62 (alleging a violation of the "right to personal liberty and the prohibition of arbitrary arrest and detention in terms of Article 6 of the African Charter").

155. *See id.* ¶¶ 54, 57 (agreeing with the Complainants regarding the inherit right to dignity).

victims are accorded equal access to healthcare, including medicines and treatment without discrimination.[156]

It is interesting to note that two years later, a similar pronouncement was made by the IACHR.[157] In the *Pivaral* case, it opined that one of the cardinal principles that foreground the victims' application was the citing of discrimination in the provision of healthcare.[158] In a separate decision, and referencing Article XI of the American Declaration of the Rights and Duties of Man, the IACHR reaffirmed that negligence in the provision of medical care for persons in detention is a grave threat to their physical and mental well-being.[159] This determination was made following the demise of an inmate from cholera.[160] Despite being a curable illness, the lack of medication and timely treatment aggravated the condition, leading to the untimely demise of the detainee.[161] To avert future occurrences, the IACHR recommended in a subsequent case that states ought to provide the required medical attention necessary for those being detained, as these necessities are crucial for the sustenance of their mental and physical being.[162] Thus,

156. *See id.* ¶¶ 81, 85 ("Persons with mental illnesses should never be denied their right to proper health care . . . .").

157. *See* Cuscul Pivaral et al. v. Guatemala, Case 12.484, Inter-Am. Comm'n H.R., Judgment of 23 August 2018. Series C No. 359, ¶ 23 (including a right to health in the discussion of economic, social, and cultural rights).

158. *See id.* ("The first is that of non-discrimination, in the sense that the State cannot guarantee the right to health in a discriminatory manner.").

159. *See* Hernández Lima v. Guatemala, Case 11.297, Inter-Am. Comm'n. H.R., Report No. 28/96, OEA/Ser.L/V/II.95, doc. 7 rev. 406, ¶ 53 (1997) (responding to the petitioners' claim that the Government was negligent in its medical care which contributed to the inmate's death).

160. *See id.* ¶ 4 ("While confined in the Zone 8 Preventive Detention Center, Mr. Hernández died on May 2, 1993. The apparent cause of death was a cerebral edema and an attack of cholera.").

161. *See id.* ("According to the petitioners, the medical treatment provided by the staff in charge of medical care at the detention center was inadequate. The Director in charge authorized Mr. Hernández' transfer to a hospital, but the transfer never took place.").

162. *See* Victor Rosario Congo v. Ecuador, Case 11.427, Inter-Am. Comm'n. Hum. Rts. No. 63/99 OEA/Ser.L/V/II.95 Doc. 7 rev., ¶ 98 (1998) (recommending that Ecuador "provide medical and psychiatric care for

drawing from the IACHR, one could justify that the pursuit of timely healthcare for persons is not simply an African virtue, but a shared global hankering.

In the realm of group rights, the African Commission reconstrued environmental justice as a means of advancing health right. The *Social Economic Rights Action Centre and another v. Nigeria*[163] has remained a celebrated case-law over the last two decades. At the outset, it ought to be acknowledged that the dispute was not a specific right to health issue. Rather, it was framed to contest the arbitrary exploration of oil and its implications on the natural environment.[164] The applicants alleged that the government was complicit in the violation of the rights of the Ogoni people.[165] The infringement was linked to the unregulated oil exploration in the Niger Delta.[166] The petitioners argue that the non-disclosure of the environmental impact assessment reports by the oil company endangered the rights to life (Article 4), health (Article 16), and environment (Article 24) of the indigenes.[167] From a correlative stance, the Commission read that a sound body and mind are dependent on a clean environment.[168] In other words, it expanded the ambit of Article 16 by articulating that the health right

persons suffering from mental illness and confined in penitentiary facilities.").

163. Soc. Econ. Rts. Action Ctr. v. Nigeria, Communication 155/96, African Commission on Human and Peoples' Rights [Afr. Comm'n H.P.R.] (2001).

164. *See id.* ¶¶ 1–9 (outlining the plaintiffs' allegations regarding the Nigerian government's involvement in oil production and its impacts on local communities and the environment).

165. *See id.* ¶ 67 (considering the petitioners' allegation that the Nigerian government violated Article 4 of the African Charter).

166. *See id.* ¶ 42 (noting the new Nigerian government had stated 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.").

167. *See id.* ¶ 10 ("The communication alleges violations of Articles . . . 4, . . . 16, . . . and 24 of the African Charter.").

168. *See id.* ¶ 51 ("These rights recogni[z]e the importance of a clean and safe environment that is closely linked to economic and social rights in so far as the environment affects the quality of life and safety of the individual.").

transcends the simple provision of expedient medication and treatment of infections.[169] Distilling from this decision, it is discernible that air quality, humidity, and temperature impact people's health, productivity, and general well-being.

Akin to the individual right discussed, it is important to underscore that the generous interpretation adopted in this case is not unique to the African Commission. The IACHR has harnessed a similar strategy to provide a safety net for indigenous communities threatened by extractive industries.[170] As early as 1985, a petition alleged that a Yanomami tribal group has occupied a previously deserted native land for years.[171] Yet, following the discovery of natural resources on the land, the state authorized the construction of a highway through the region for extractive purposes.[172] Ineluctably, the influx of outsiders triggered the spread of infectious diseases among the native Indians, without access to essential medical care.[173] Consequently, the IACHR found the government of Brazil in violation of the health right enshrined in Article XI of the American Declaration.[174] Again finding in favor of a violation of the

169. *See* Sudan Hum. Rts. Org. v. Sudan, Communication 279/03–296/05, African Commission on Human and Peoples' Rights [Afr. Comm'n H.P.R], ¶¶ 205, 212, 216, 223 (2009) (including damage to property and water sources, as well as the destruction of family units within the scope of Article 16).

170. *See* Coulter v. Brazil, Case 7615, Inter-Am. Comm'n H.R., Report No. 12/85, OEA/Ser.L/V/II.66, doc. 10 rev. 1, ¶ 12 (1985) (recommending that States take special care when undergoing environmental projects that impact indigenous peoples).

171. *See id.* ¶ 2(a) ("Between 10,000 and 12,000 Yanomami Indians live in the State of Amazonas and the Territory of Roraima, on the border of Venezuela.").

172. *See id.* ¶ 2(f) ("In 1973 construction began on highway BR-210 (the Northern Circumferential Highway), which, when it passed through the territory of the Yanomami Indians, compelled them to abandon their habitat and seek refuge in other places.").

173. *See id.* ¶ 3(a) (summarizing the petitioners' allegation that the State's action "resulted in many deaths, caused by epidemics of influenza, tuberculosis, measles, venereal diseases, and others").

174. *See id.* ¶ 17 (finding that the failure of the Government to "take timely and effective measures [on] behalf of the Yanomami Indians" resulted in the violation of the right to the preservation of health and to well-being).

right to health and well-being, the IACHR recommended that Paraguay adopt a vigorous intervention to provide effective protection for the attainment of the right to preservation of health and well-being of the Aché tribe.[175] The petition stemmed from the onset of epidemics in the native Indian tribe due to poor working conditions, coupled with the withholding of medication by the state.[176]

While the focus of this discussion is on the Commission, the Inter-American Court of Human Rights has made one beguiling pronouncement that is quite difficult to resist. In *Villagran-Morales et al v. Guatemala*, the bench observed that the failure to provide the necessities of life was in breach of the right to health of street children.[177] Ultimately, this strategy was adopted when the Court inferred a violation of health right from the state's indifference to the physiological needs of children.[178] To the judges, state parties ought to safeguard the right of every child to an adequate standard of living through the provision of material assistance, including nutritious meals, shelter.[179] To a great extent, this

175. *See* Aché People v. Paraguay, Case 1802, Inter-Am. Comm'n H R., OEA/Ser.L/V/II.43 doc. 21 corr. 1, ¶¶ 2–3 (1977) (citing Article XI of the American Declaration of the Rights and Duties of Man, the Commission recommended that the Government "adopt vigorous measures to provide effective protection for the rights of the Aché tribe").

176. *See id.* (referencing the communication that contained allegations of the persecution of the tribe).

177. *See* Villagran-Morales v. Guatemala, Merits, Am. Ct. H.R. (ser. C) No. 63, ¶¶ 137–147 (Nov. 19, 1999) ("[T]he conduct of the State not only violated the express provision of Article 4 of the American Convention, but also numerous international instruments, that devolve to the State the obligation to adopt special measures of protection and assistance for the children within its jurisdiction.").

178. *See id.* ¶ 30 (noting the Commission's recommendation to "institute appropriate measures so that violations of the human rights" of children are protected).

179. *See, e.g.* Free Legal Assistance Grp. v. Zaire, Communications 25/89, 47/90, 56/91, 100/93, African Commission on Human & Peoples' Rights [Afr. Comm'n. H.P.R.], ¶ 47 (1995) ("The failure of the Government to provide basic services such as safe drinking water and electricity and the shortage of medicine as alleged in communication 100/93 constitutes a violation of Article 16."). *See* Villagran-Morales v. Guatemala, *supra* note 177 at ¶ 195 (citing Article 27 of the Convention on the Rights of the

interpretation is faithful to, and recognizes the basic needs of populations whose health is often shaped by a range of socioeconomic conditions, including the environment. In essence, without a parallel interpretation of health rights, along with other civil or socioeconomic rights, the psychological and physical wellbeing of the poor are unlikely to be realized. With a disproportionate percentage of people in the Global South living under impoverished conditions, this broad interpretation is worthwhile.[180] By way of explanation, this legal construct could serve as an impetus for local arbiters to hold rulers accountable for poor socioeconomic amenities, *inter alia*, clean water, power supply, and sanitation.

At this point, it ought to be highlighted that the adoption of this approach (corresponding interpretation) by the African Commission (to advance the right to health) provide two corresponding, yet conflicting outcomes. On the one hand, the strategy is creative and deserves commendation. This is more so, as it provides leverage for guaranteeing rights that are not justiciable in the Charter. This approach may be useful, particularly for several states where the right to health is shrouded in the Directive Principles of State Policy (DPSP).[181] Under such regimes, the persuasive reading of health right into other civil and political rights such as life, dignity, and equality becomes inevitable.

On the other hand, the quest for ingenious interpretation is superfluous if not misplaced. Such interpretation becomes imminent if a specific right is non-justiciable. But that cannot be said of the right under discussion. Unlike in some national

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Child, the Court understood children's right to adequate standard of living as consisting of mental, moral, physical and social development.

180. *See* Marta Schoch et al., *Half of the Global Population Lives on Less than US$6.85 Per Person Per Day*, WORLD BANK BLOGS (Dec. 8, 2022) (describing global poverty as being concentrated in South Asia, Sub-Saharan Africa) [perma.cc/24PH-8V8N].

181. *See* Jo Vearey et al., *Migrants' Rights to Health: A Legislative and Policy Review for Southern Africa,* INT'L ORG. MIGRATION, 2022, at 33 (discussing one such state, the Kingdom of Eswatini, where the right to health cannot be enforced by the courts because it is classified as a non-justiciable directive principle of state policy).

Constitutions where the right to health is not codified, in the African Charter, the right is firmly grounded.[182] Simply put, it is directly enforceable.[183] Consequently, rather than skirting around the inextricable relationship of all rights, it could have simply hammered out the content of Article 16, setting out clear benchmarks, and channels for attaining that end. For future applications, it will be prudent if the African Commission could make the right to health the central focus of its contentious competence. Since the African Charter is evasive about the content of state responsibility in this arena, it ought to pay considerable attention to setting out the details on what precautionary measures states ought to operationalize to foster the mental and physical health of citizens. Thus, the need for parallel interpretation may be necessary only if the invocation of subsequent rights will breathe fresh air into the health jurisprudence of the African Commission.

Nonetheless, given its groundbreaking jurisprudence on this theme, the African Commission has still not been able to provide specific guidelines on how states ought to advance the health of their people.[184] Relatedly, the Commission lacks specific guidelines in which to measure the -compliance of states in terms of Article 16.[185] These shortfalls are unsettling given that it is the engine of the African human rights system. It is, therefore, imperative that the body

182. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 16 ("Every individual shall have the right to enjoy the best attainable state of physical and mental health.").

183. *See* Julia Swanson, *The Emergence of New Rights in the African Charter*, 12 N.Y.L. SCH. J. OF INT'L & COMPAR. L. 307, 331–332 (1991) (describing international versus national enforceability of the right to health).

184. *See African Rights Commission's Work More Important Than Ever*, HUM. RTS. WATCH (Nov. 2, 2022) (describing guidelines set forth by the African Commission in other areas, such as kidnapping) [perma.cc/3J3Q-72N7].

185. *See* Zahara Nampewo et al., *Respecting, Protecting and Fulfilling the Human Right to Health*, INT'L J. EQUITY HEALTH, Mar. 2022, at 9 (discussing the difficulty of measuring the performance of the Nigerian government in ensuring the right to health because the right has not been domesticated into the Nigerian Constitution).

commences a process of introspection as a means of reorienting its competence and effectiveness in the years ahead. This suggestion is offered against the backdrop of Africa being the epicenter of new viruses, such as Ebola, Covid-19, and HIV amidst weak infrastructure.[186]

In this regard, the next part will explore in depth some of the recommendations that can enhance the Commission's ambition of fostering a right to health. These suggestions will take into account existing barriers to the Commission's daily operations.

V. The Way Forward

The central discursive question staring us in the face is: how can the African Commission effectively advance the right to health? To surmise that the Commission will, by itself, foster health rights across the 55 African countries will be a fallacy of hasty conclusion. The potential of the institution to achieve this end may be tied to a series of conditions at the grassroots level, stretching from: (i) insufficient infrastructure to contain epidemics; (ii) long-standing alienation of certain ethnic groups from health-related decision-making processes; (iii) biases of local assemblies in the allocation of medical facilities; (iv) failure to translate into local languages pamphlets on a healthy lifestyle; and (v) in some cases, non-compliance of states with recommendations of the Commission.[187]

Arguably, the un-willingness of states to comply with the decision of a supranational entity may hinge on the

186. *See* Olivier Uwishema et al., *Viral Infections Amidst COVID-19 in Africa: Implications and Recommendations*, 93 J. MED. VIROLOGY 6798, 6800 (2021) ("Africa is a high-risk area for the spread of viral diseases mainly due to overpopulation, poverty, under-resourced health care system, inadequate healthcare workforce, low testing capacities, and poor surveillance system present in the region.").

187. *See* Frans Viljoen & Lirette Louw, *The Status of the Findings of the African Commission: From Moral Persuasion to Legal Obligation*, 48 J. AFR. LAW 1, 1 (2004) (identifying the protective mandate of the African Commission as yielding positive decisions).

reputation that the organization has carved for itself.[188] In the realm of human rights, one's credibility may be measured by proficiency.[189] The proficiency of an institution may be gauged by its ability to perform its assigned duties promptly.[190] This is particularly so when one's health, and by extension one's life hangs in the balance. While the admissibility procedure of the Commission is itself prolonged, due to backlogs and the exhaustion of domestic remedies, consideration of the merits of cases takes months to be concluded.[191] While the mounting pileup may be linked to the perennial human rights abuses across the continent, there is also the question of logistical constraints. First, there is a limited number of officials at the Secretariat to process the ever-growing amount of cases.[192] Second, the commission only meets four times a year in ordinary sessions, and with 11 members, there is only so much it can achieve within this

188. *See* Sfiso Benard Nxumalo, *A Culture of Non-Compliance? A Challenge to the African Commission and African Court*, AFR. L. MATTERS (June 9, 2022) ("The Commission was charged with being 'a façade, a yoke that African leaders have put around our necks.'") [perma.cc/L6J8-AF5T]. *Cf.* Oona A. Hathaway, *Between Power and Principle: An Integrated Theory of International Law*, 72 UNIV. CHI. L. REV. 469, 533 (2005) (discussing the impact of reputation on States' international decision-making).

189. *See* Nxumalo, *supra* note 188 (connecting a lack of compliance to the Commission's lack of follow-through).

190. *See id.* ("One of the chief reasons for [the culture of non-compliance] . . . is the lack of funding. The Commission has complained that it lacks the requisite funding to establish and develop mechanisms to assist it with reporting, following up, gathering information and enforcing its recommendations.").

191. *See* Trésor Muhindo Makunya, *Decisions of the African Court on Human and Peoples' Rights during 2020: Trends and Lessons*, 21 AFR. HUM. RTS. L. J. 1230, 1242 (2021) (referencing cases where the Commission took three to five years to make a judgement on the merits).

192. *See* Magnus Killander, *Confidentiality Versus Publicity: Interpreting Article 59 of the African Charter on Human and Peoples' Rights: Recent Developments*, 6 AFR. HUM. RTS. L. J. 572, 572 (2006) (acknowledging the lack of visibility and difficult circumstances that are engulfing the operations of the Commission, including dire financial and human resources constraints which equally undercut the functions of the Secretariat and Commission).

limited timeframe.[193] In a democratic regime where there are frequent elections, the delay implies that the perpetrator regime could leave office before the application is concluded. Under such a circumstance, a new regime may be apprehensive about inheriting such debt.[194]

Eliminating the heap of cases will call for novel approaches. It is against this backdrop that the paper seeks to explore some novel strategies that might facilitate the swift operations of the Commission towards the advancement of the right to health. Seven tactics are outlined.

A. The 'Isolator'

The chief layer of mounting application backlogs is often tied to the admissibility procedure.[195] This is the stage where a case may be declared admissible or inadmissible after nearly a year.[196] The pace could be quickened if the commissioners resort to the isolator tactic. To begin with, the Isolator was a helmet designed and popularized by Hugo Gernsback in the early 20th century.[197] The instrument aided

193. *See 75th Ordinary Session of the African Commission on Human and Peoples' Rights [ACHPR]*, AFR. UNION (May 3,2023) ("The ACHPR meets four times a year in Ordinary Sessions and may hold Extra-Ordinary Sessions. Since its inception, the ACHPR has held seventy-two (72) Ordinary Sessions and thirty-five (35) Extraordinary Sessions.") ¶¶ 2-4[perma.cc/FR5A-S3RH].

194. *See* Stanley Cohen, *State Crimes of Previous Regimes: Knowledge, Accountability, and the Policing of the Past*, 20 LAW & SOCIAL INQUIRY 7, 15 (1995) (noting that a new regime may resist the temptation of acknowledging the terrible wrongs of the past as they may have 'colluded in them by their silence').

195. *See* Rules of Procedure of the African Commission on Human & Peoples' Rights, at Rules 93, 102, 110–112, 116–119, 131 (Mar. 4, 2020) [hereinafter ACHPR Rules of Procedure] (laying out the procedures associated with determining admissibility of communications).

196. *See id.* at Rules 102, 110, 116, (outlining the timeline the admissibility determination process, which includes windows of 60 and 90 days for various responses from parties).

197. *See* Hugo Gernsback, *The Isolator*, 13 SCI. & INVENTION, July 1925, at 214, 214 (depicting the inventor wearing a mask that obscures the entire head, leaving only hones for eyes and oxygen).

his authorship by blocking all outside interferences and noise that prey on the mind.[198] In essence, he could focus on the specific theme without undue external interference. This strategy could prove useful to the contemporary operators of the Commission. In the preliminary assessment of individual communication, each commissioner ought to be assigned a number of dockets and tasked to determine their respective admissibility. To deter external influence, s/he/they will have little or no meaningful contact with other commissioners. Additionally, to guarantee impartiality, commissioners may not be assigned cases from their region. In the submission of their findings, they may be obliged to provide a brief reason for declaring an intricate application inadmissible or be excused from providing such a reason if the case is plainly (*prima facie*) outside the competence of the Commission. The downside of this strategy, however, is: (i) it remains unknown whether such a preliminary solitary approach will still cement fairness, a standard which the Commission aspires to; and (ii) whether states will be amenable to this radical reform.

B. Joint venture

This phase embodies mobilizing resources to revamp the Secretariat's staff. Nipping the communication backlogs in the bud requires hiring and retraining of officials to be capable of synchronizing applications. The suggestion is inspired by the IACHR's approach of merging individual petitions into a single folder for assessment.[199] The merit of this strategy is that it lowers the cost of litigation for victims while speeding the processing of cases at the level of the Commission. The demerit, however, is that with two or more

198. *See id.* (describing a helmet that enables concentrated thinking or flow of thought by shutting out external distractions).

199. *See* Rules of Procedure of the Inter-American Commission on Human Rights, at art. 29 (Aug. 1, 2013) [hereinafter IACHR Rules of Procedure] (allowing the Commission merge petitions that "address similar facts, involve the same persons, or reveal the same pattern of conduct" into the same file).

cases (from different contexts) merged, some complainants may be discontent with the outcome, regardless of how positive it might be. A generalized order that is not tailored to remedy a unique violation, or to forestall future occurrences of a specific infringement may not be gratifying to some applicants. Moreso, contrary to a single case which might be straightforward, the assessment of a multifaceted docket will merit a careful consideration of the different elements before deciding. This could cycle the Commission back to its initial setback of prolonging its assessment. Even more, the generalized nature of the recommendation is likely to further complicate the domestication of the decision. This is anticipated as some recommendations may already be in existence in some regions, or be applicable in some territories, or perhaps affront to some communities. This is the quagmire with joint venturing.

C. Partnership

The operations of the African Commission are crippled by insufficient resources.[200] The Commission, thus, has a mundane mandate of aspiring to promote the health rights of those living in deplorable conditions, while it waddles in limited human capital. For it to effectively perform its promotional role, there will be a need for considerable human and fiscal resources. In addressing this setback, the Commission ought to intensify partnership with vibrant civil society organizations (CSOs).[201] The cooperation could be tailored towards raising funds from external actors to

200. *See* Press Release, Amnesty Int'l, Africa: Regional Human Rights Bodies Struggle to Uphold Rights Amid Political Headwinds (Oct. 21, 2020) "[A]frican governments are grossly undermining regional human rights bodies by failing to comply with their decisions, ignoring their urgent appeals, neglecting to report to them on national human rights situations and starving them of resources they desperately need for operations.").

201. *See* André-Michel Essoungou, *The Rise of Civil Society Groups in Africa*, AFR. RENEWAL, Dec. 2013, at 10, 11 (describing CSO's grassroots mobilization and protests surrounding government and private corruption).

support and bolster its health advocacy. While one cannot foretell outcome of this union, it may be seen as innovative as it will enhance the future autonomy and financial projection of the organ.

D. Full-time commissioners

Arguably, it is high time the AU considered the appointment of full-time commissioners. To fast-track cases and effectively promote health rights across the 55 African countries, it will be essential to consider the appointment of commissioners on full-time contracts.[202] Akin to their peers at the national level,[203] such tenure will: (i) enable members to hold regular meetings on the subject at hand; (ii) conduct frequent country visits to assess health conditions on the ground; (iii) dedicate their attention to in-depth consideration of relevant applications; and ultimately (iv) provide feasible guidelines on the fulfillment of health rights. A carefully thought-out benchmark is likely to ring a bell with the concerned government and the local community.

E. Amicable settlement

One of the essential elements of the African Commission which could enable it to quickly dispose of some cases is its friendly settlement mechanism. At any stage during the processing or consideration of a complaint, the Commission may, at the behest of the victim, the state, or of its own volition, initiate a dialogue between the parties.[204] The aim

202. *See* Kennedy Kariseb, *Understanding the Nature, Scope and Standard Operating Procedures of the African Commission's Special Procedure Mechanisms*, 21 AFR. HUM. RTS. L. J. 149, 166 (2021) (noting that commissioners' part-time schedule compromises the effective execution of their mandates'.

203. *See, e.g.*, *Office of the Commissioners*, S. AFR. HUM. RTS. COMM'N (describing the duties of commission members) [perma.cc/QHU4-97VZ]; *Overview*, NIGERIAN NAT'L HUM. RTS. COMM'N (same) [perma.cc/PUA7-SMEH].

204. *See* IACHR Rules of Procedure, *supra* note 199199, at art. 40 ("On its own initiative or at the request of any of the parties, the Commission

of brokering such a talk is to hammer out opportunities through the consent of both parties, on what interventions ought to be operationalized to remedy the violation. The intervention may span from individual compensation to broad-based impact in society. Unfortunately, this approach has rarely been used by the Commission in recent times.[205] On the negative side, settlements are likely to perpetuate health violations as it gives states the impression that no harm was triggered.[206] Also, with some victims lacking the intellectual capacity to barter fair terms with the state, the former will likely get the shorter end of the stick.[207] It is for this very reason that commissioners with an in-depth understanding of the nature and content of rights are well-situated to decide on such matters. But, on the positive side: (i) the direct participation of victims in the negotiation opens doors for them to influence the outcome of the decision, as opposed to a decision being imposed by commissioners; (ii) it has the added merit of cutting attorney fees and fast-tracking the legal process; (iii) ultimately, as settlement implies 'no-fault', there is a prospect of building a cordial relationship between the state and the victim going forward. This is more so as conciliation eliminates the antagonistic element of contentious litigation; and (iv) with the parties reaching an

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shall place itself at the disposal of the parties concerned . . . with a view to reaching a friendly settlement . . . ."); *see also* Organization of American States, American Convention on Human Rights, Nov. 22, 1969, at art. 48(1)(f), O.A.S.T.S. No. 36, 1144 U.N.T.S. 123 ("The Commission shall place itself at the disposal of the parties concerned with a view to reaching a friendly settlement of the matter on the basis of respect for the human rights recognized in this convention.").

205. *See* Victor Oluwasina Ayeni & Tajudeen Ojo Ibraheem, *Amicable Settlement of Disputes and Proactive Remediation of Violations Under the African Human Rights System*, 10 BEIJING L. REV. 406, 409 (2019) ("Despite the universal existence and acceptance of the friendly settlement, the procedure has not been used frequently by regional human rights tribunals in Africa.").

206. *See id.* at 408 (noting the concern that the settlement process may be perceived as the government "paying off victims or buying their way out of a finding of violation").

207. *See id.* ("The procedure may, however, be criticized for the imbalance of powers created by the nature of the dispute and the identity of the parties.").

accord, the state is likely to comply with the outcome as it was involved in drafting the final agreement.

F. Reporting procedures

Another important resource of the Commission that has remained under-utilized is its state reporting procedures.[208] In its future sessions, it ought to consider expanding its benchmark for state reporting. Apart from following the conventional structure and content of the report, it may entreat states to dedicate a section of their narrative to the interventions operationalized to promote the mental and physical welfare of their citizens. Upon completion of its assessment, it may provide elaborate recommendations to each state on how to further foster their mitigation and adaptive capacities to health concerns. The reasoning can be useful in setting a benchmark for holding African countries accountable for non-compliance.

G. Piecemeal recommendation

At the regional level, the barrier of non-compliance with the Commission's recommendations is the most concerning.[209] To the ordinary eye, while partial compliance may signal the inability of the government to fully comply, total non-compliance may be interpreted as a non-recognition of the authority of the oversight body.[210] While states are

208. *See* African Charter on Human and Peoples' Rights, *supra* note 8, at art. 62 (requiring states to submit reports on "measures taken with a view to giving effect to the rights and freedoms recogni[z]ed and guaranteed by the present Charter").

209. *See* Sfiso Benard Nxumalo, *A Culture of Non-Compliance? A Challenge to the African Commission and African Court*, AFR. L. MATTERS (June 9, 2022) ("However, States have tended to ignore or not comply with the recommendations of the African Commission. There is generally a lack of a political will to implement these recommendations.") [perma.cc/L6J8-AF5T].

210. *See id*. (describing the view of the African Commission as "a feeble institution, lacking any real power to make any meaningful contribution to human rights").

often the culprit, one ought to ask, do the nature and contents of the recommendations inspire compliance? If one takes a quick scan of the suggestions offered by the body, they are often general.[211] As a result, it becomes conspicuous that some will take years to be complied with, or to be fully realized.[212] This is likely in the many cases that the Commission has called for major structural reforms, *inter alia*, amending or nullifying existing legislations, establishing facilities in the concerned locality to address the issue at hand, and providing education and technical skills to officials on the subject matter.[213] These suggestions, at one level, are commendable. In effect, their operationalization will address systemic inequality and translate to fulfilling the rights of a collective rather than an individual. Yet, such broad reforms have often resulted in partial conformity or complete flouting by states.[214] Looking ahead, the Commission could address this setback by providing recommendations in piecemeal, spiced with best practices on how states could mobilize internal and external resources to act upon its well-intended suggestions.

VI. Conclusion

The Article observes that the attainment of mental and physical health remains a challenge in Africa. It argued that although the African Charter lacks clear guidelines on what

211. *See, e.g.*, Soc. Econ. Rts. Action Ctr. v. Nigeria, Communication 155/96, African Commission on Human and Peoples' Rights [Afr. Comm'n H.P.R.], ¶ 69 (2001) (urging the Nigerian government to generally protect the environment and the Ogoni people).

212. *See* ACHPR Rules of Procedure, *supra* note 195195, at Rule 125 (outlining the recommended procedure for follow-up on the Commission's recommendations).

213. *See, e.g.*, Soc. Econ. Rts. Action Ctr., Communication 155/96, at ¶ 69 (recommending a major shift in how the Nigerian government treats the environment).

214. *See* Frans Viljoen & Lirette Louw, *State Compliance with the Recommendations of the African Commission on Human and Peoples' Rights, 1994-2004*, 101 AM. J. INT'L L. 1, 5–6 (2007) (finding that States were in "full compliance" in approximately 14% of communications, "noncompliance" in 30% of cases, and "partial" or "situational" or "unclear" compliance in the remaining cases).

steps ought to be operationalized by states to avert and contain diseases, the oversight role of the Commission could remedy the poor treatments received by vulnerable groups in public health facilities.

Given its mandate as the overarching regional human rights responder, the African Commission could nudge the 55 African states to act upon their legal obligation to foster health rights. Among others, the Commission's role may entail setting out practical guidelines on the fulfillment of this duty. These benchmarks could be launching pads for the empowerment of disempowered populations or concerned civil societies to press for the health rights of marginalized groups. But this potential is undercut by a string of barriers. Its inability to quickly dispose of the mounting application backlogs, coupled with a lack of compliance with its decisions hinder its effective operation.

In coping with the lack of political will to act upon its decisions, this Article argued for further exploration of diplomatic talks as a means of fast-tracking commitments to issues at the national level. At the brink of staff shortfalls amidst resource constraints, this Article highlighted building stronger collaborations with health rights organizations. This collaboration could be a gateway to seeking external funding to boost the operations of commissioners, and the Secretariat more broadly.

In sum, the Commission has the potential of advancing the right to health in Africa. But to achieve this object, it ought to reflect on (i) its credibility; (ii) the isolator principle; (iii) joint venturing; (iv) foster CSOs partnership; (v) lobby for full-time commissioners; (vi) reactivate amicable settlement; (vii) rethink its reporting procedures; and (viii) provide feasible recommendations.