This publication aims at ensuring easy accessibility to cases and materials on the right to health in Africa. The publication contains decisions, resolutions, declaration and cases by the AU or the African Commission dealing with the right to health under the African Human Rights system. It is aimed at assisting scholars, researchers, students, lawyers, judges and others who are interested in researching on the right to health, including sexual and reproductive health and rights, in Africa. Equally, regional human rights bodies such as the African Commission and national human rights institutions will find this publication useful to their work.

COMMUNITY LAW CENTRE
UNIVERSITY of the WESTERN CAPE

Compendium of documents and cases on the right to health under the African human rights system

COMMUNITY LAW CENTRE

Compendium of documents and cases on the right to health under the African human rights system

Edited by Ebenezer Durojaye & Gladys Mirugi-Mukundi

A place of quality,
a place to grow,
from hope to action
through knowledge

Compendium of

Documents and cases on the right to health under the African Human Rights System

2013

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Introduction

Africa is faced with different health challenges ranging from the devastating effects of the HIV/AIDS pandemic, high maternal mortality, deaths resulting from tuberculosis to incessant cases of malaria. Today, African remains the burden bearer of sexual and reproductive ill health. While the region accounts for about 15% of the world's population, it is home to about 70% of the total number of people living with HIV.[1] According to UNAIDS, about 23 million out of the 34 million people living with HIV worldwide are from Africa.[2] Moreover, the region accounted for about 70% (1.2 million) of the 1.7 million AIDS-related deaths in 2011. Worse still, a recent report by PLAN International indicates that ten of the worst places for a woman to give birth in the world are in Africa.[3]The maternal mortality rates in some countries such Chad and Somalia are about 1, 000 deaths to 100,000, live births.[4] Indeed, the lifetime risk of a woman giving birth in Africa is put at 1 in 39 compared to 1 in 3, 600 in a country such as Malta. In recent times, maternal death in the region has been exacerbated by the prevalence of HIV/AIDS. The maternal mortality situation in the region is appalling and many of the countries in the region may not meet the MDG 5 target to reduce maternal deaths from 1990 rates by 75% by 2015. Despite concerted efforts to address its menace, malaria remains threats to lives in the region and deaths resulting from tuberculosis continue to increase by leaps and bounds. Several factors militate against the realisation of the right to health in Africa. These include lack of political will, weak health care system, non-justiciability of the right to health at the national level, corruption and dearth of health care personnel.

These challenges are not insurmountable but deserve commitment and concerted efforts on the part of African leaders. Indeed, over the years African governments have shown commitment to realising the right to health of their people. Towards this end, the then Organization of African Unity (OAU), now African Union, adopted the African Charter on Human and People' Rights in 1986. The African Charter became the first regional human rights instrument to explicitly guarantee civil and political rights and socio-economic rights as enforceable rights. Article 16 of the African Charter guarantees the right to health by providing that every individual shall have the right to enjoy the highest attainable state of physical and mental health. It further provides that states shall take necessary measures to protect the right to health of their people. In 2003, the African Union took another giant step in the realisation of human rights when it adopted the Protocol to the African Charter on Human and People's Rights on the Rights of Women. The African Women's Protocol contains a number of ground-breaking provisions relating to the sexual reproductive health and rights of women. More particularly, article 14 of the African Women's Protocol requires states to "ensure that the right to health of women, including sexual and reproductive health of women, is respected and promoted". This important article further provides that states should respect and promote a woman's right to control her fertility, decide the number and spacing of her children choose any method of contraception, self-protection from sexually transmitted infections including HIV/AIDS, legal abortion in certain situations and family planning. By these radical provisions, the African Women's Protocol has become a pace-setter under international human rights law, as the first treaty that clearly recognizes women's reproductive health as human rights and contains specific provisions on women's protection in the context of HIV/AIDS.

In recent times, the African Commission, through its jurisprudence, has attempted to clarify the nature of states' obligations regarding socio-economic rights, including the right to health, under the African human rights system. Although few cases have come before the Commission specifically dealing on the violations of the right to health, nonetheless, the Commission has strived to give a purposive interpretation to the provision relating to the right to health in some of these cases. In addition, the African Union and the African Commission has issued a number of non-binding declarations, resolutions and General Comments, which are very relevant in advancing the right to health, including sexual and reproductive health and rights in the region. Experience has shown that most scholars, researchers, students, activists, legal practitioners and judges working in the area of the right to health are either not aware of these instruments or do not have access to them. This can serve as a barrier to the realisation of the right to health in the region. While books and monographs have been published focussing generally on cases and instruments under the African Human Rights System, none of these publications specifically relate to the right to health.[5] Also, an attempt to collate human rights instruments at sub-regional level does not include instruments dealing with the right to health.[6] Therefore, this publication essentially aims at filling the gaps by providing researchers, students, lawyers, judges and activists in the field of health with access to important information to towards the realisation of the right to health.

Against this backdrop, this publication aims at ensuring easy accessibility to cases, and materials relating to the right to health in Africa. The publication contains decisions, resolutions, declaration and cases by the AU or the African Commission dealing with the right to health under the African Human Rights system. It is aimed at assisting scholars, students, lawyers, judges and others who are interested in researching in the area of right to health in Africa. Equally, regional human rights bodies such as the African Commission on Human and People's Rights and national human rights institutions will find this publication useful to their work. The materials in this publication are by no means exhaustive; however, they serve as very useful resource for any one genuinely interested in research on the right to health under the African human rights system.

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Endnotes

1 UNAIDS *AIDS epidemic report* (2012)

2 *Ibid*

3 Save the Children *State of the World's Mother: Surviving the first day* (2013).

4 WHO (2010).

5 See C Heyns and M Kilander (eds) *Compendium of Key human rights instruments of the African union* (2013).

6 See S Ebobrah and A Tanon (eds) *Compendium of African sub-regional human rights documents* (2010).

A Human Rights Instruments

A1 African Charter on Human and Peoples' Rights (Banjul Charter) (1981)

Adopted June 27, 1981
OAU Doc. CAB/LEG/67/3 rev. 5,
21 I.L.M. 58 (1982)
Entered into force Oct. 21, 1986

Preamble

The African States members of the Organization of African Unity, parties to the present convention entitled "African Charter on Human and Peoples' Rights",

RECALLING Decision 115 (XVI) of the Assembly of Heads of State and Government at its Sixteenth Ordinary Session held in Monrovia, Liberia, from 17 to 20 July 1979 on the preparation of a "preliminary draft on an African Charter on Human and Peoples' Rights providing inter alia for the establishment of bodies to promote and protect human and peoples' rights";

CONSIDERING the Charter of the Organization of African Unity, which stipulates that "freedom, equality, justice and dignity are essential objectives for the achievement of the legitimate aspirations of the African peoples";

REAFFIRMING the pledge they solemnly made in Article 2 of the said Charter to eradicate all forms of colonialism from Africa, to coordinate and intensify their cooperation and efforts to achieve a better life for the peoples of Africa and to promote international cooperation having due regard to the Charter of the United Nations. and the Universal Declaration of Human Rights;

TAKING INTO CONSIDERATION the virtues of their historical tradition and the values of African civilization which should inspire and characterize their reflection on the concept of human and peoples' rights;

RECOGNIZING on the one hand, that fundamental human rights stem from the attributes of human beings which justifies their national and international protection and on the other hand that the reality and respect of peoples rights should necessarily guarantee human rights;

CONSIDERING that the enjoyment of rights and freedoms also implies the performance of duties on the part of everyone;

CONVINCED that it is henceforth essential to pay a particular attention to the right to development and that civil and political rights cannot be dissociated from economic, social and cultural rights in their conception as well as universality and that the satisfaction of economic, social and cultural rights ia a guarantee for the enjoyment of civil and political rights;

CONSCIOUS of their duty to achieve the total liberation of Africa, the peoples of which are still struggling for their dignity and genuine independence, and undertaking to eliminate colonialism, neo-colonialism, apartheid, zionism and to dismantle aggressive foreign military bases and all forms of discrimination, particularly those based on race, ethnic group, color, sex. language, religion or political opinions;

REAFFIRMING their adherence to the principles of human and peoples' rights and freedoms contained in the declarations, conventions and other instrument adopted by the Organization of African Unity, the Movement of Non-Aligned Countries and the United Nations;

FIRMLY CONVINCED of their duty to promote and protect human and people' rights and freedoms taking into account the importance traditionally attached to these rights and freedoms in Africa;

HAVE AGREED AS FOLLOWS:

Part I: Rights and Duties

Chapter I – Human and Peoples' Rights

Article 1

The Member States of the Organization of African Unity parties to the present Charter shall recognize the rights, duties and freedoms enshrined in this Chapter and shall undertake to adopt legislative or other measures to give effect to them.

Article 2

Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, color, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.

Article 3

1. Every individual shall be equal before the law.
2. Every individual shall be entitled to equal protection of the law.

Article 4

Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.

Article 5

Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

Article 6

Every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained.

Article 7

1. Every individual shall have the right to have his cause heard. This comprises:
   a. the right to an appeal to competent national organs against acts of violating his fundamental rights as recognized and guaranteed by conventions, laws, regulations and customs in force;
   b. the right to be presumed innocent until proved guilty by a competent court or tribunal;
   c. the right to defence, including the right to be defended by counsel of his choice;
   d. the right to be tried within a reasonable time by an impartial court or tribunal.
2. No one may be condemned for an act or omission which did not constitute a legally punishable offence at the time it was committed. No penalty may be inflicted for an offence for which no provision was made at the time it was committed. Punishment is personal and can be imposed only on the offender.

Article 8

Freedom of conscience, the profession and free practice of religion shall be guaranteed. No one may, subject to law and order, be submitted to measures restricting the exercise of these freedoms.

Article 9

1. Every individual shall have the right to receive information.
2. Every individual shall have the right to express and disseminate his opinions within the law.

Article 10

1. Every individual shall have the right to free association provided that he abides by the law.
2. Subject to the obligation of solidarity provided for in 29 no one may be compelled to join an association.

Article 11

Every individual shall have the right to assemble freely with others. The exercise of this right shall be subject only to necessary restrictions provided for by law in particular those enacted in the interest of national security, the safety, health, ethics and rights and freedoms of others.

Article 12

1. Every individual shall have the right to freedom of movement and residence within the borders of a State provided he abides by the law.
2. Every individual shall have the right to leave any country including his own, and to return to his country. This right may only be subject to restrictions, provided for by law for the protection of national security, law and order, public health or morality.
3. Every individual shall have the right, when persecuted, to seek and obtain asylum in other countries in accordance with laws of those countries and international conventions.
4. A non-national legally admitted in a territory of a State Party to the present Charter, may only be expelled from it by virtue of a decision taken in accordance with the law.
5. The mass expulsion of non-nationals shall be prohibited. Mass expulsion shall be that which is aimed at national, racial, ethnic or religious groups.

Article 13

1. Every citizen shall have the right to participate freely in the government of his country, either directly or through freely chosen representatives in accordance with the provisions of the law.
2. Every citizen shall have the right of equal access to the public service of his country.
3. Every individual shall have the right of access to public property and services in strict equality of all persons before the law.

Article 14

The right to property shall be guaranteed. It may only be encroached upon in the interest of public need or in the general interest of the community and in accordance with the provisions of appropriate laws.

Article 15

Every individual shall have the right to work under equitable and satisfactory conditions, and shall receive equal pay for equal work.

Article 16

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.

Article 17

1. Every individual shall have the right to education.
2. Every individual may freely, take part in the cultural life of his community.
3. The promotion and protection of morals and traditional values recognized by the community shall be the duty of the State.

Article 18

1. The family shall be the natural unit and basis of society. It shall be protected by the State which shall take care of its physical health and moral.
2. The State shall have the duty to assist the family which is the custodian or morals and traditional values recognized by the community.
3. The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.
4. The aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs.

Article 19

All peoples shall be equal; they shall enjoy the same respect and shall have the same rights. Nothing shall justify the domination of a people by another.

Article 20

1. All peoples shall have the right to existence. They shall have the unquestionable and inalienable right to self-determination. They shall freely determine their political status and shall pursue their economic and social development according to the policy they have freely chosen.
2. Colonized or oppressed peoples shall have the right to free themselves from the bonds of domination by resorting to any means recognized by the international community.
3. All peoples shall have the right to the assistance of the States parties to the present Charter in their liberation struggle against foreign domination, be it political, economic or cultural.

Article 21

1. All peoples shall freely dispose of their wealth and natural resources. This right shall be exercised in the exclusive interest of the people. In no case shall a people be deprived of it.
2. In case of spoliation the dispossessed people shall have the right to the lawful recovery of its property as well as to an adequate compensation.
3. The free disposal of wealth and natural resources shall be exercised without prejudice to the obligation of promoting international economic cooperation based on mutual respect, equitable exchange and the principles of international law.
4. States parties to the present Charter shall individually and collectively exercise the right to free disposal of their wealth and natural resources with a view to strengthening African unity and solidarity.
5. States parties to the present Charter shall undertake to eliminate all forms of foreign economic exploitation particularly that practiced by international monopolies so as to enable their peoples to fully benefit from the advantages derived from their national resources.

Article 22

1. All peoples shall have the right to their economic, social and cultural development with due regard to their freedom and identity and in the equal enjoyment of the common heritage of mankind.
2. States shall have the duty, individually or collectively, to ensure the exercise of the right to development.

Article 23

1. All peoples shall have the right to national and international peace and security. The principles of solidarity and friendly relations implicitly affirmed by the Charter of the United Nations and reaffirmed by that of the Organization of African Unity shall govern relations between States.
2. For the purpose of strengthening peace, solidarity and friendly relations, States parties to the present Charter shall ensure that:

a. any individual enjoying the right of asylum under 12 of the present Charter shall not engage in subversive activities against his country of origin or any other State party to the present Charter;
b. their territories shall not be used as bases for subversive or terrorist activities against the people of any other State party to the present Charter.

Article 24

All peoples shall have the right to a general satisfactory environment favorable to their development.

Article 25

States parties to the present Charter shall have the duty to promote and ensure through teaching, education and publication, the respect of the rights and freedoms contained in the present Charter and to see to it that these freedoms and rights as well as corresponding obligations and duties are understood.

Article 26

States parties to the present Charter shall have the duty to guarantee the independence of the Courts and shall allow the establishment and improvement of appropriate national institutions entrusted with the promotion and protection of the rights and freedoms guaranteed by the present Charter.

Chapter II - Duties

Article 27

1. Every individual shall have duties towards his family and society, the State and other legally recognized communities and the international community.
2. The rights and freedoms of each individual shall be exercised with due regard to the rights of others, collective security, morality and common interest.

Article 28

Every individual shall have the duty to respect and consider his fellow beings without discrimination, and to maintain relations aimed at promoting, safeguarding and reinforcing mutual respect and tolerance.

Article 29

The individual shall also have the duty:

1. To preserve the harmonious development of the family and to work for the cohesion and respect of the family; to respect his parents at all times, to maintain them in case of need;
2. To serve his national community by placing his physical and intellectual abilities at its service; 3. Not to compromise the security of the State whose national or resident he is;
3. To preserve and strengthen social and national solidarity, particularly when the latter is threatened;
4. To preserve and strengthen the national independence and the territorial integrity of his country and to contribute to its defence in accordance with the law;
5. To work to the best of his abilities and competence, and to pay taxes imposed by law in the interest of the society;
6. To preserve and strengthen positive African cultural values in his relations with other members of the society, in the spirit of tolerance, dialogue and consultation and, in general, to contribute to the promotion of the moral well being of society;
7. To contribute to the best of his abilities, at all times and at all levels, to the promotion and achievement of African unity.

Part II: Measures of Safeguard

Chapter I – Establishment and Organization of the African Commission on Human and Peoples' Rights

Article 30

An African Commission on Human and Peoples' Rights, hereinafter called "the Commission", shall be established within the Organization of African Unity to promote human and peoples' rights and ensure their protection in Africa.

Article 31

1. The Commission shall consist of eleven members chosen from amongst African personalities of the highest reputation, known for their high morality, integrity, impartiality and competence in matters of human and peoples' rights; particular consideration being given to persons having legal experience.
2. The members of the Commission shall serve in their personal capacity. . . .

Article 41

The Secretary General of the Organization of African Unity shall appoint the Secretary of the Commission. He shall also provide the staff and services necessary for the effective discharge of the duties of the Commission. The Organization of African Unity shall bear the costs of the staff and services. . . .

Chapter II – Mandate of the Commission

Article 45

The functions of the Commission shall be:

1. To promote Human and Peoples' Rights and in particular:
   a. to collect documents, undertake studies and researches on African problems in the field of human and peoples' rights, organize seminars, symposia and conferences, disseminate information, encourage national and local institutions concerned with human and peoples' rights, and should the case arise, give its views or make recommendations to Governments.
   b. to formulate and lay down, principles and rules aimed at solving legal problems relating to human and peoples' rights and fundamental freedoms upon which African Governments may base their legislations.
   c. co-operate with other African and international institutions concerned with the promotion and protection of human and peoples' rights.
2. Ensure the protection of human and peoples' rights under conditions laid down by the present Charter.
3. Interpret all the provisions of the present Charter at the request of a State party, an institution of the OAU or an African Organization recognized by the OAU.

4. Perform any other tasks which may be entrusted to it by the Assembly of Heads of State and Government.

Chapter III – Procedure of the Commission

Article 46

The Commission may resort to any appropriate method of investigation; it may hear from the Secretary General of the Organization of African Unity or any other person capable of enlightening it.

Communication From States

Article 47

If a State party to the present Charter has good reasons to believe that another State party to this Charter

has violated the provisions of the Charter, it may draw, by writtencommunication, the attention of that State to the matter. This communication shall also be addressed to the Secretary General of the OAU and to the Chairman of the Commission. Within three months of the receipt of the communication, the State to which the communication is addressed shall give the enquiring State, written explanation or statement elucidating the matter. This should include as much as possible relevant information relating to the laws and rules of procedure applied and applicable, and the redress already given or course of action available.

Article 48

If within three months from the date on which the original communication is received by the State to which it is addressed, the issue is not settled to the satisfaction of the two States involved through bilateral negotiation or by any other peaceful procedure, either State shall have the right to submit the matter to the Commission through the Chairman and shall notify the other States involved.

Article 49

Notwithstanding the provisions of 47, if a State party to the present Charter considers that another State party has violated the provisions of the Charter, it may refer the matter directly to the Commission by addressing a communication to the Chairman, to the Secretary General of the Organization of African Unity and the State concerned.

Article 50

The Commission can only deal with a matter submitted to it after making sure that all local remedies, if they exist, have been exhausted, unless it is obvious to the Commission that the procedure of achieving these remedies would be unduly prolonged.

Article 51

1. The Commission may ask the States concerned to provide it with all relevant information.
2. When the Commission is considering the matter, States concerned may be represented before it and submit written or oral representation.

Article 52

After having obtained from the States concerned and from other sources all the information it deems necessary and after having tried all appropriate means to reach an amicable solution based on the respect of Human and Peoples' Rights, the Commission shall prepare, within a reasonable period of time from the notification referred to in 48, a report stating the facts and its findings. This report shall be sent to the States concerned and communicated to the Assembly of Heads of State and Government.

Article 53

While transmitting its report, the Commission may make to the Assembly of Heads of State and Government such recommendations as it deems useful.

Article 54

The Commission shall submit to each ordinary Session of the Assembly of Heads of State and Government a report on its activities.

Other Communications

Article 55

1. Before each Session, the Secretary of the Commission shall make a list of the communications other than those of States parties to the present Charter and transmit them to the members of the Commission, who shall indicate which communications should be considered by the Commission.
2. A communication shall be considered by the Commission if a simple majority of its members so decide.

Article 56

Communications relating to human and peoples' rights referred to in 55 received by the Commission, shall be considered if they:

1. Indicate their authors even if the latter request anonymity,
2. Are compatible with the Charter of the Organization of African Unity or with the present Charter,
3. Are not written in disparaging or insulting language directed against the State concerned and its institutions or to the Organization of African Unity,
4. Are not based exclusively on news discriminated through the mass media,
5. Are sent after exhausting local remedies, if any, unless it is obvious that this procedure is unduly prolonged,
6. Are submitted within a reasonable period from the time local remedies are exhausted or from the date the Commission is seized of the matter, and
7. Do not deal with cases which have been settled by these States involved in accordance with the principles of the Charter of the United Nations, or the Charter of the Organization of African Unity or the provisions of the present Charter.

Article 57

Prior to any substantive consideration, all communications shall be brought to the knowledge of the State concerned by the Chairman of the Commission.

Article 58

1. When it appears after deliberations of the Commission that one or more communications apparently relate to special cases which reveal the existence of a series of serious or massive violations of human and peoples' rights, the Commission shall draw the attention of the Assembly of Heads of State and Government to these special cases.
2. The Assembly of Heads of State and Government may then request the Commission to undertake an in-depth study of these cases and make a factual report, accompanied by its findings and recommendations.
3. A case of emergency duly noticed by the Commission shall be submitted by the latter to the Chairman of the Assembly of Heads of State and Government who may request an in-depth study.

Article 59

1. All measures taken within the provisions of the present Chapter shall remain confidential until such a time as the Assembly of Heads of State and Government shall otherwise decide. . . .
2. The report on the activities of the Commission shall be published by its Chairman after it has been considered by the Assembly of Heads of State and Government.

Chapter IV – Applicable Principles

Article 60

The Commission shall draw inspiration from international law on human and peoples' rights, particularly from the provisions of various African instruments on human and peoples' rights, the Charter of the United Nations, the Charter of the Organization of African Unity, the Universal Declaration of Human Rights, other instruments adopted by the United Nations and by African countries in the field of human and peoples' rights as well as from the provisions of various instruments adopted within the Specialized Agencies of the United Nations of which the parties to the present Charter are members.

Article 61

The Commission shall also take into consideration, as subsidiary measures to determine the principles of law, other general or special international conventions, laying down rules expressly recognized by member states of the Organization of African Unity, African practices consistent with international norms on human and people's

rights, customs generally accepted as law, general principles of law recognized by African states as well as legal precedents and doctrine.

Article 62

Each state party shall undertake to submit every two years, from the date the present Charter comes into force, a report on the legislative or other measures taken with a view

to giving effect to the rights and freedoms recognized and guaranteed by the present Charter.

Article 63

1. The present Charter shall be open to signature, ratification or adherence of the member states of the Organization of African Unity.
2. The instruments of ratification or adherence to the present Charter shall be deposited with the Secretary General of the Organization of African Unity.
3. The present Charter shall come into force three months after the reception by the Secretary General of the instruments of ratification or adherence of a simple majority of the member states of the Organization of African Unity.

Part III: General Provisions

Article 64

1. After the coming into force of the present Charter, members of the Commission shall be elected in accordance with the relevant Articles of the present Charter.
2. The Secretary General of the Organization of African Unity shall convene the first meeting of the Commission at the Headquarters of the Organization within three months of the constitution of the Commission. Thereafter, the Commission shall be convened by its Chairman whenever necessary but at least once a year.

Article 65

For each of the States that will ratify or adhere to the present Charter after its coming into force, the Charter shall take effect three months after the date of the deposit by that State of its instrument of ratification or adherence.

Article 66

Special protocols or agreements may, if necessary, supplement the provisions of the present Charter.

Article 67

The Secretary General of the Organization of African Unity shall inform member states of the Organization of the deposit of each instrument of ratification or adherence.

Article 68

The present Charter may be amended if a State party makes a written request to that effect to the Secretary General of the Organization of African Unity. The Assembly of Heads of State and Government may only consider the draft amendment after all the States parties have been duly informed of it and the Commission has given its opinion on it at the request of the sponsoring State. The amendment shall be approved by a simple majority of the States parties. It shall come into force for each State which has accepted it in accordance with its constitutional procedure three months after the Secretary General has received notice of the acceptance.

A2 African Charter on the Rights and Welfare of the Child (1990)

OAU Doc. CAB/LEG/24.9/49 (1990),
entered into force Nov. 29, 1999.

Preamble

The African Member States of the Organization of African Unity, Parties to the present Charter entitled 'African Charter on the Rights and Welfare of the Child',

CONSIDERING that the Charter of the Organization of African Unity recognizes the paramountcy of Human Rights and the African Charter on Human and People's Rights proclaimed and agreed that everyone is entitled to all the rights and freedoms recognized and guaranteed therein, without distinction of any kind such as race, ethnic group, colour. sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status,

RECALLING the Declaration on the Rights and Welfare of the African Child (AHG/ST.4 Rev.l) adopted by the Assembly of Heads of State and Government of the Organization of African Unity, at its Sixteenth Ordinary Session in Monrovia, Liberia. from 17 to 20 July 1979, recognized the need to take appropriate measures to promote and protect the rights and welfare of the African Child,

NOTING WITH CONCERN that the situation of most African children, remains critical due to the unique factors of their socio-economic, cultural, traditional and developmental circumstances, natural disasters, armed conflicts, exploitation and hunger, and on account of the child's physical and mental immaturity he/she needs special safeguards and care,

RECOGNIZING that the child occupies a unique and privileged position in the African society and that for the full and harmonious development of his personality. the child should grow up in a family environment in an atmosphere of happiness, love and understanding,

RECOGNIZING that the child, due to the needs of his physical and mental development requires particular care with regard to health, physical, mental, moral and social development, and requires legal protection in conditions of freedom, dignity and security,

TAKING INTO CONSIDERATION the virtues of their cultural heritage, historical background and the values of the African civilization which should inspire and characterize their reflection on the concept of the rights and welfare of the child,

CONSIDERING that the promotion and protection of the rights and welfare of the child also implies the performance of duties on the part of everyone,

REAFFIRMING ADHERENCEto the principles of the rights and welfare of the child contained in the declaration, conventions and other instruments of the Organization of African Unity and in the United Nations and in particular the United Nations Convention on the Rights of the Child; and the OAU Heads of State and Government's Declaration on the Rights and Welfare of the African Child.

HAVE AGREED AS FOLLOWS:

Part 1: Rights and Duties

Chapter 1: Rights and Welfare of the Child

Article 1: Obligation of States Parties

1. Member States of the Organization of African Unity Parties to the present Charter shall recognize the rights, freedoms and duties enshrined in this Charter and shall undertake to the necessary steps, in accordance with their Constitutional processes and with the provisions of the present Charter, to adopt such legislative or other measures as may be necessary to give effect to the provisions of this Charter.

2. Nothing in this Charter shall affect any provisions that are more conductive to the realization of the rights and welfare of the child contained in the law of a State Party or in any other international Convention or agreement in force in that State.
3. Any custom, tradition, cultural or religious practice that is inconsistent with the rights, duties and obligations contained in the present Charter shall to the extent of such inconsistency be discouraged.

Article 2: Definition of a Child

For the purposes of this Charter. a child means every human being below the age of 18 years.

Article 3: Non-Discrimination

Every child shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in this Charter irrespective of the child's or his/her parents' or legal guardians' race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status.

Article 4: Best Interests of the Child

1. In all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration.
2. In all judicial or administrative proceedings affecting a child who is capable of communicating his/her own views, and opportunity shall be provided for the views of the child to be heard either directly or through an impartial representative as a party to the proceedings, and those views shall be taken into consideration by the relevant authority in accordance with the provisions of appropriate law.

Article 5: Survival and Development

1. Every child has an inherent right to life. This right shall be protected by law.
2. States Parties to the present Charter shall ensure, to the maximum extent possible, the survival, protection and development of the child.
3. Death sentence shall not be pronounced for crimes committed by children.

Article 6: Name and Nationality

1. Every child shall have the right from his birth to a name.
2. Every child shall be registered immediately after birth.
3. Every child has the right to acquire a nationality.
4. States Parties to the present Charter shall undertake to ensure that their Constitutional legislation recognize the principles according to which a child shall acquire the nationality of the State in the territory of which he has been born if, at the time of the child's birth, he is not granted nationality by any other State in accordance with its laws.

Article 7: Freedom of Expression

Every child who is capable of communicating his or her own views shall be assured the rights to express his opinions freely in all matters and to disseminate his opinions subject to such restrictions as are prescribed by laws.

Article 8: Freedom of Association

Every child shall have the right to free association and freedom of peaceful assembly in conformity with the law.

Article 9: Freedom of Thought, Conscience and Religion

1. Every child shall have the right to freedom of thought conscience and religion.
2. Parents, and where applicable, legal guardians shall have a duty to provide guidance and direction in the exercise of these rights having regard to the evolving capacities, and best interests of the child.

3. States Parties shall respect the duty of parents and where applicable, legal guardians to provide guidance and direction in the enjoyment of these rights subject to the national laws and policies.

Article 10: Protection of Privacy

No child shall be subject to arbitrary or unlawful interference with his privacy, family home or correspondence, or to the attacks upon his honour or reputation, provided that parents or legal guardians shall have the right to exercise reasonable supervision over the conduct of their children. The child has the right to the protection of the law against such interference or attacks.

Article 11: Education

1. Every child shall have the right to an education.
2. The education of the child shall be directed to:
   (a) the promotion and development of the child's personality, talents and mental and physical abilities to their fullest potential;
   (b) fostering respect for human rights and fundamental freedoms with particular reference to those set out in the provisions of various African instruments on human and peoples' rights and international human rights declarations and conventions;
   (c) the preservation and strengthening of positive African morals, traditional values and cultures;
   (d) the preparation of the child for responsible life in a free society, in the spirit of understanding tolerance, dialogue, mutual respect and friendship among all peoples ethnic, tribal and religious groups;
   (e) the preservation of national independence and territorial integrity;
   (f) the promotion and achievements of African Unity and Solidarity;
   (g) the development of respect for the environment and natural resources;
   (h) the promotion of the child's understanding of primary health care.
3. States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realization of this right and shall in particular:
   (a) provide free and compulsory basic education;
   (b) encourage the development of secondary education in its different forms and to progressively make it free and accessible to all;
   (c) make the higher education accessible to all on the basis of capacity and ability by every appropriate means;
   (d) take measures to encourage regular attendance at schools and the reduction of drop-out rates;
   (e) take special measures in respect of female, gifted and disadvantaged children, to ensure equal access to education for all sections of the community.
4. States Parties to the present Charter shall respect the rights and duties of parents, and where applicable, of legal guardians to choose for their children's schools, other than those established by public authorities, which conform to such minimum standards may be approved by the State, to ensure the religious and moral education of the child in a manner with the evolving capacities of the child.
5. States Parties to the present Charter shall take all appropriate measures to ensure that a child who is subjected to schools or parental discipline shall be treated with humanity and with respect for the inherent dignity of the child and in conformity with the present Charter.
6. States Parties to the present Charter shall have all appropriate measures to ensure that children who become pregnant before completing their education shall have an opportunity to continue with their education on the basis of their individual ability.
7. No part of this Article shall be construed as to interfere with the liberty of individuals and bodies to establish and direct educational institutions subject to the observance of the principles set out in paragraph I of this Article and the requirement teal the education given in such institutions shall conform to such minimum standards as may be laid down by the States.

Article 12: Leisure, Recreation and Cultural Activities

1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.
2. States Parties shall respect and promote the right of the child to fully participate in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

Article 13: Handicapped Children

1. Every child who is mentally or physically disabled shall have the right to special measures of protection in keeping with his physical and moral needs and under conditions which ensure his dignity, promote his self-reliance and active participation in the community.
2. States Parties to the present Charter shall ensure, subject to available resources, to a disabled child and to those responsible for his care, of assistance for which application is made and which is appropriate to the child's condition and in particular shall ensure that the disabled child has effective access to training, preparation for employment and recreation opportunities in a manner conducive to the child achieving the fullest possible social integration, individual development and his cultural and moral development.
3. The States Parties to the present Charter shall use their available resources with a view to achieving progressively the full convenience of the mentally and physically disabled person to movement and access to public highway buildings and other places to which the disabled may legitimately want to have access to.

Article 14: Health and Health Services

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures:
   (a) to reduce infant and child morality rate;
   (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
   (c) to ensure the provision of adequate nutrition and safe drinking water;
   (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;
   (e) to ensure appropriate health care for expectant and nursing mothers;
   (f) to develop preventive health care and family life education and provision of service;
   (g) to integrate basic health service programmes in national development plans;
   (h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;
   (i) to ensure the meaningful participation of non-governmental organizations, local communities and the beneficiary population in the planning and management of a basic service programme for children;

   (j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.

Article 15: Child Labour

1. Every child shall be protected from all forms of economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's physical, mental, spiritual, moral, or social development.
2. States Parties to the present Charter take all appropriate legislative and administrative measures to ensure the full implementation of this Article which covers both the formal and informal sectors of employment and having regard to the relevant provisions of the International Labour Organization's instruments relating to children, States Parties shall in particular:

(a) provide through legislation, minimum wages for admission to every employment;
(b) provide for appropriate regulation of hours and conditions of employment;
(c) provide for appropriate penalties or other sanctions to ensure the effective enforcement of this Article;
(d) promote the dissemination of information on the hazards of child labour to all sectors of the community.

Article 16: Protection Against Child Abuse and Torture

1. States Parties to the present Charter shall take specific legislative, administrative, social and educational measures to protect the child from all forms of torture, inhuman or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment including sexual abuse, while in the care of the child.
2. Protective measures under this Article shall include effective procedures for the establishment of special monitoring units to provide necessary support for the child and for those who have the care of the child, as well as other forms of prevention and for identification, reporting referral investigation, treatment, and follow-up of instances of child abuse and neglect.

Article 17: Administration of Juvenile Justice

1. Every child accused or found guilty of having infringed penal law shall have the right to special treatment in a manner consistent with the child's sense of dignity and worth and which reinforces the child's respect for human rights and fundamental freedoms of others.
2. States Parties to the present Charter shall in particular:
   (a) ensure that no child who is detained or imprisoned or otherwise deprived of his/her liberty is subjected to torture, inhuman or degrading treatment or punishment;
   (b) ensure that children are separated from adults in their place of detention or imprisonment;
   (c) ensure that every child accused in infringing the penal law:
      (i) shall be presumed innocent until duly recognized guilty;
      (ii) shall be informed promptly in a language that he understands and in detail of the charge against him, and shall be entitled to the assistance of an interpreter if he or she cannot understand the language used;
      (iii) shall be afforded legal and other appropriate assistance in the preparation and presentation of his defence;
      (iv) shall have the matter determined as speedily as possible by an impartial tribunal and if found guilty, be entitled to an appeal by a higher tribunal;
   (d) prohibit the press and the public from trial.
3. The essential aim of treatment of every child during the trial and also if found guilty of infringing the penal law shall be his or her reformation, re-integration into his or her family and social rehabilitation.
4. There shall be a minimum age below which children shall be presumed not to have the capacity to infringe the penal law.

Article 18: Protection of the Family

1. The family shall be the natural unit and basis of society. it shall enjoy the protection and support of the State for its establishment and development.
2. States Parties to the present Charter shall take appropriate steps to ensure equality of rights and responsibilities of spouses with regard to children during marriage and in the even of its dissolution. In case of the dissolution, provision shall be made for the necessary protection of the child.
3. No child shall be deprived of maintenance by reference to the parents' marital status.

Article 19: Parent Care and Protection

1. Every child shall be entitled to the enjoyment of parental care and protection and shall, whenever possible, have the right to reside with his or her parents. No child shall be separated from his parents against his will,

except when a judicial authority determines in accordance with the appropriate law, that such separation is in the best interest of the child.

2. Every child who is separated from one or both parents shall have the right to maintain personal relations and direct contact with both parents on a regular basis.
3. Where separation results from the action of a State Party, the State Party shall provide the child, or if appropriate, another member of the family with essential information concerning the whereabouts of the absent member or members of the family. States Parties shall also ensure that the submission of such a request shall not entail any adverse consequences for the person or persons in whose respect it is made.
4. Where a child is apprehended by a State Party, his parents or guardians shall, as soon as possible, be notified of such apprehension by that State Party.

Article 20: Parental Reponsibilities

1. Parents or other persons responsible for the child shall have the primary responsibility of the upbringing and development the child and shall have the duty:
   (a) to ensure that the best interests of the child are their basic concern at all times-
   (b) to secure, within their abilities and financial capacities, conditions of living necessary to the child's development; and
   (c) to ensure that domestic discipline is administered with humanity and in a manner consistent with the inherent dignity of the child.
2. States Parties to the present Charter shall in accordance with their means and national conditions the all appropriate measures;
   (a) to assist parents and other persons responsible for the child and in case of need provide material assistance and support programmes particularly with regard to nutrition, health, education, clothing and housing;
   (b) to assist parents and others responsible for the child in the performance of child-rearing and ensure the development of institutions responsible for providing care of children; and
   (c) to ensure that the children of working parents are provided with care services and facilities.

Article 21: Protection against Harmful Social and Cultural Practices

1. States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular:
   (a) those customs and practices prejudicial to the health or life of the child; and
   (b) those customs and practices discriminatory to the child on the grounds of sex or other status.
2. Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory.

Article 22: Armed Conflicts

1. States Parties to this Charter shall undertake to respect and ensure respect for rules of international humanitarian law applicable in armed conflicts which affect the child.
2. States Parties to the present Charter shall take all necessary measures to ensure that no child shall take a direct part in hostilities and refrain in particular, from recruiting any child.
3. States Parties to the present Charter shall, in accordance with their obligations under international humanitarian law, protect the civilian population in armed conflicts and shall take all feasible measures to ensure the protection and care of children who are affected by armed conflicts. Such rules shall also apply to children in situations of internal armed conflicts, tension and strife.

Article 23: Refugee Children

1. States Parties to the present Charter shall take all appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law shall, whether unaccompanied or accompanied by parents, legal guardians or close relatives, receive appropriate protection and humanitarian assistance in the enjoyment of the rights set out in this Charter and other international human rights and humanitarian instruments to which the States are Parties.
2. States Parties shall undertake to cooperate with existing international organizations which protect and assist refugees in their efforts to protect and assist such a child and to trace the parents or other close relatives or an unaccompanied refugee child in order to obtain information necessary for reunification with the family.
3. Where no parents, legal guardians or close relatives can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his family environment for any reason.
4. The provisions of this Article apply mutatis mutandis to internally displaced children whether through natural disaster, internal armed conflicts, civil strife, breakdown of economic and social order or howsoever caused.

Article 24: Adoption

States Parties which recognize the system of adoption shall ensure that the best interest of the child shall be the paramount consideration and they shall:

(a) establish competent authorities to determine matters of adoption and ensure that the adoption is carried out in conformity with applicable laws and procedures and on the basis of all relevant and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and guardians and that, if necessary, the appropriate persons concerned have given their informed consent to the adoption on the basis of appropriate counselling;
(b) recognize that inter-country adoption in those States who have ratified or adhered to the International Convention on the Rights of the Child or this Charter, may, as the last resort, be considered as an alternative means of a child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;
(c) ensure that the child affected by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;
(d) take all appropriate measures to ensure that in inter-country adoption, the placement does not result in trafficking or improper financial gain for those who try to adopt a child;
(e) promote, where appropriate, the objectives of this Article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework to ensure that the placement of the child in another country is carried out by competent authorities or organs;
(f) establish a machinery to monitor the well-being of the adopted child.

Article 25: Separation from Parents

1. Any child who is permanently or temporarily deprived of his family environment for any reason shall be entitled to special protection and assistance;
2. States Parties to the present Charter:

(a) shall ensure that a child who is parentless, or who is temporarily or permanently deprived of his or her family environment, or who in his or her best interest cannot be brought up or allowed to remain in that environment shall be provided with alternative family care, which could include, among others, foster placement, or placement in suitable institutions for the care of children;
(b) shall take all necessary measures to trace and re-unite children with parents or relatives where separation is caused by internal and external displacement arising from armed conflicts or natural disasters.

3. When considering alternative family care of the child and the best interests of the child, due regard shall be paid to the desirability of continuity in a child's up- bringing and to the child's ethnic, religious or linguistic background.

Article 26: Protection against Apartheid and Discrimination

1. States Parties to the present Charter shall individually and collectively undertake to accord the highest priority to the special needs of children living under Apartheid and in States subject to military destabilization by the Apartheid regime.
2. States Parties to the present Charter shall individually and collectively undertake to accord the highest priority to the special needs of children living under regimes practising racial, ethnic. religious or other forms of discrimination as well as in States subject to military destabilization.
3. States Parties shall undertake to provide whenever possible, material assistance to such children and to direct their efforts towards the elimination of all forms of discrimination and Apartheid on the African Continent.

Article 27: Sexual Exploitation

1. States Parties to the present Charter shall undertake to protect the child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent:

   (a) the inducement, coercion or encouragement of a child to engage in any sexual activity;
   (b) the use of children in prostitution or other sexual practices;
   (c) the use of children in pornographic activities, performances and materials.

Article 28: Drug Abuse

States Parties to the present Charter shall take all appropriate measures to protect the child from the use of narcotics and illicit use of psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the production and trafficking of such substances.

Article 29: Sale, Trafficking and Abduction

States Parties to the present Charter shall take appropriate measures to prevent:

(a) the abduction, the sale of, or traffick of children for any purpose or in any form, by any person including parents or legal guardians of the child;

(b) the use of children in all forms of begging.

Article 30: Children of Imprisoned Mothers

1. States Parties to the present Charter shall undertake to provide special treatment to expectant mothers and to mothers of infants and young children who have been accused or found guilty of infringing the penal law and shall in particular:

   (a) ensure that a non-custodial sentence will always be first considered when sentencing such mothers;
   (b) establish and promote measures alternative to institutional confinement for the treatment of such mothers;
   (c) establish special alternative institutions for holding such mothers;
   (d) ensure that a mother shall not be imprisoned with her child;
   (e) ensure that a death sentence shall not be imposed on such mothers;
   (f) the essential aim of the penitentiary system will be the reformation, the integration of the mother to the family and social rehabilitation.

Article 31: Responsibility of the Child

Every child shall have responsibilities towards his family and society, the State and other legally recognized communities and the international community. The child, subject to his age and ability, and such limitations as may be contained in the present Charter, shall have the duty;

(a) to work for the cohesion of the family, to respect his parents, superiors and elders at all times and to assist them in case of need;

(b) to serve his national community by placing his physical and intellectual abilities at its service;

(c) to preserve and strengthen social and national solidarity;

(d) to preserve and strengthen African cultural values in his relations with other members of the society, in the spirit of tolerance, dialogue and consultation and to contribute to the moral well-being of society;

(e) to preserve and strengthen the independence and the integrity of his country;

(f) to contribute to the best of his abilities, at all times and at all levels, to the promotion and achievement of African Unity.

Part II

Chapter Two: Establishment and Organization of the Committee on the Rights and Welfare of the Child

Article 32: The Committee

An African Committee of Experts on the Rights and Welfare of the Child hereinafter called `the Committee' shall be established within the Organization of African Unity to promote and protect the rights and welfare of the child.

Article 33: Composition

1. The Committee shall consist of 11 members of high moral standing, integrity, impartiality and competence in matters of the rights and welfare of the child.
2. The members of the Committee shall serve in their personal capacity.
3. The Committee shall not include more than one national of the same State.

Article 34: Election

As soon as this Charter shall enter into force the members of the Committee shall be elected by secret ballot by the Assembly of Heads of State and Government from a list of persons nominated by the States Parties to the present Charter.

Article 35: Candidates

Each State Party to the present Charter may nominate not more than two candidates. The candidates must have one of the nationalities of the States Parties to the present Charter. When two candidates are nominated by a State, one of them shall not be a national of that State.

Article 36

1. The Secretary-General of the Organization of African Unity shall invite States Parties to the present Charter to nominate candidates at least six months before the elections.
2. The Secretary-General of the Organization of African Unity shall draw up in alphabetical order, a list of persons nominated and communicate it to the Heads of State and Government at least two months before the elections.

Article 37: Term of Office

1. The members of the Committee shall be elected for a tenn of five years and may not be re-elected, however. the term of four of the members elected at the first election shall expire after two years and the term of six others, after four years.
2. Immediately after the first election, the Chairman of the Assembly of Heads of State and Government of the Organization of African Unity shall draw lots to determine the names of those members referred to in sub-paragraph 1 of this Article.
3. The Secretary-General of the Organization of African Unity shall convene the first meeting of Committee at the Headquarters of the Organization within six months of the election of the members of the Committee, and thereafter the Committee shall be convened by its Chairman whenever necessary, at least once a year.

Article 38: Bureau

1. The Committee shall establish its own Rules of Procedure.
2. The Committee shall elect its officers for a period of two years.
3. Seven Committee members shall form the quorum.
4. In case of an equality of votes, the Chairman shall have a casting vote.
5. The working languages of the Committee shall be the official languages of the OAU.

Article 39: Vacancy

If a member of the Committee vacates his office for any reason other than the nonmal expiration of a term, the State which nominated that member shall appoint another member from among its nationals to serve for the remainder of the term - subject to the approval of the Assembly.

Article 40: Secretariat

The Secretary-General of the Organization of African Unity shall appoint a Secretary for the Committee.

Article 41: Privileges and Immunities

In discharging their duties, members of the Committee shall enjoy the privileges and immunities provided for in the General Convention on the Privileges and Immunities of the Organization of African Unity.

Chapter Three: Mandate and Procedure of the Committee

Article 42: Mandate

The functions of the Committee shall be:

(a) To promote and protect the rights enshrined in this Charter and in particular to:
   (i) collect and document information, commission inter-disciplinary assessment of situations on African problems in the fields of the rights and welfare of the child, organize meetings, encourage national and local institutions concerned with the rights and welfare of the child, and where necessary give its views and make recommendations to Governments;
   (ii) formulate and lay down principles and rules aimed at protecting the rights and welfare of children in Africa;
   (iii) cooperate with other African, international and regional Institutions and organizations concerned with the promotion and protection of the rights and welfare of the child.

(b) To monitor the implementation and ensure protection of the rights enshrined in this Charter.

(c) To interpret the provisions of the present Charter at the request of a State Party, an Institution of the Organization of African Unity or any other person or Institution recognized by the Organization of African Unity, or any State Party.

(d) Perform such other task as may be entrusted to it by the Assembly of Heads of State and Government, Secretary-General of the OAU and any other organs of the OAU or the United Nations.

Article 43: Reporting Procedure

1. Every State Party to the present Charter shall undertake to submit to the Committee through the Secretary-General of the Organization of African Unity, reports on the measures they have adopted which give effect to the provisions of this Charter and on the progress made in the enjoyment of these rights:
   (a) within two years of the entry into force of the Charter for the State Party concerned: and
   (b) and thereafter, every three years.
2. Every report made under this Article shall:

(a) contain sufficient information on the implementation of the present Charter to provide the Committee with comprehensive understanding of the implementation of the Charter in the relevant country; and
(b) shall indicate factors and difficulties, if any, affecting the fullfilment of the obligations contained in the Charter.

3. A State Party which has submitted a comprehensive first report to the Committee need not, in its subsequent reports submitted in accordance with paragraph I (a) of this Article, repeat the basic information previously provided.

Article 44: Communications

1. The Committee may receive communication, from any person, group or non- governmental organization recognized by the Organization of African Unity, by a Member State, or the United Nations relating to any matter covered by this Charter.
2. Every communication to the Committee shall contain the name and address of the author and shall be treated in confidence.

Article 45: Investigations by the Committee

1. The Committee may, resort to any appropriate method of investigating any matter falling within the ambit of the present Charter, request from the States Parties any information relevant to the implementation of the Charter and may also resort to any appropriate method of investigating the measures the State Party has adopted to implement the Charter.
2. The Committee shall submit to each Ordinary Session of the Assembly of Heads of State and Govenrment every two years, a report on its activities and on any communication made under Article [44] of this Charter.
3. The Committee shall publish its report after it has been considered by the Assembly of Heads of State and Government.
4. States Parties shall make the Committee's reports widely available to the public in their own countries.

Chapter Four: Miscellaneous Provisions

Article 46: Sources of Inspiration

The Committee shall draw inspiration from International Law on Human Rights, particularly from the provisions of the African Charter on Human and Peoples' Rights, the Charter of the Organization of African Unity, the Universal Declaration on Human Rights, the International Convention on the Rights of the Child, and other instruments adopted by the United Nations and by African countries in the field of human rights, and from African values and traditions.

Article 47: Signature, Ratification or Adherence

1. The present Charter shall be open to signature by all the Member States of the Organization of African Unity.
2. The present Charter shall be subject to ratification or adherence by Member States of the Organization of African Unity. The instruments of ratification or adherence to the present Charter shall be deposited with the Secretary-General of the Organization of African Unity.
3. The present Charter shall come into force 30 days after the reception by the Secretary-General of the Organization of African Unity of the instruments of ratification or adherence of 15 Member States of the Organization of African Unity.

Article 48: Amendment and Revision of the Charter

1. The present Charter may be amended or revised if any State Party makes a written request to that effect to the Secretary-General of the Organization of African Unity, provided that the proposed amendment is not submitted to the Assembly of Heads of State and Government for consideration until all the States Parties have been duly notified of it and the Committee has given its opinion on the amendment.
2. An amendment shall be approved by a simple majority of the States Parties.

A3 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2003)

Adopted by the 2nd ordinary session of the African Union General Assembly in 2003 in Maputo, Mozambique, CAB/LEG/66.6 (2003) (entered into force 25 November 2005)

The States Parties to this Protocol,

CONSIDERING that Article 66 of the African Charter on Human and Peoples' Rights provides for special protocols or agreements, if necessary, to supplement the provisions of the African Charter, and that the Assembly of Heads of State and Government of the Organization of African Unity meeting in its Thirty-first Ordinary Session in Addis Ababa, Ethiopia, in June 1995, endorsed by resolution AHG/Res.240 (XXXI) the recommendation of the African Commission on Human and Peoples' Rights to elaborate a Protocol on the Rights of Women in Africa;

CONSIDERING that Article 2 of the African Charter on Human and Peoples' Rights enshrines the principle of non-discrimination on the grounds of race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status;

FURTHER CONSIDERING that Article 18 of the African Charter on Human and Peoples' Rights calls on all States Parties to eliminate every discrimination against women and to ensure the protection of the rights of women as stipulated in international declarations and conventions;

NOTING that Articles 60 and 61 of the African Charter on Human and Peoples' Rights recognise regional and international human rights instruments and African practices consistent with international norms on human and peoples' rights as being important reference points for the application and interpretation of the African Charter;

RECALLING that women's rights have been recognised and guaranteed in all international human rights instruments, notably the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women and its Optional Protocol, the African Charter on the Rights and Welfare of the Child, and all other international and regional conventions and covenants relating to the rights of women as being inalienable, interdependent and indivisible human rights;

NOTING that women's rights and women's essential role in development, have been reaffirmed in the United Nations Plans of Action on the Environment and Development in 1992, on Human Rights in 1993, on Population and Development in 1994 and on Social Development in 1995;

RECALLING ALSO United Nations Security Council's Resolution1325 (2000) on the role of Women in promoting peace and security;

REAFFIRMING the principle of promoting gender equality as enshrined in the Constitutive Act of the African Union as well as the New Partnership for Africa's Development, relevant Declarations, Resolutions and Decisions, which underline the commitment of the African States to ensure the full participation of African women as equal partners in Africa's development;

FURTHER NOTING that the African Platform for Action and the Dakar Declaration of 1994 and the Beijing Platform for Action of 1995 call on all Member States of the United Nations, which have made a solemn commitment to implement them, to take concrete steps to give greater attention to the human rights of women in order to eliminate all forms of discrimination and of gender-based violence against women;

RECOGNISING the crucial role of women in the preservation of African values based on the principles of equality, peace, freedom, dignity, justice, solidarity and democracy;

BEARING IN MIND related Resolutions, Declarations, Recommendations, Decisions, Conventions and other Regional and Sub-Regional Instruments aimed at eliminating all forms of discrimination and at promoting equality between women and men;

CONCERNED that despite the ratification of the African Charter on Human and Peoples' Rights and other international human rights instruments by the majority of States Parties, and their solemn commitment to eliminate all forms of discrimination and harmful practices against women, women in Africa still continue to be victims of discrimination and harmful practices;

FIRMLY CONVINCED that any practice that hinders or endangers the normal growth and affects the physical and psychological development of women and girls should be condemned and eliminated;

DETERMINED to ensure that the rights of women are promoted, realised and protected in order to enable them to enjoy fully all their human rights;

HAVE AGREED AS FOLLOWS:

Article 1: Definitions

For the purpose of the present Protocol:

a) "African Charter" means the African Charter on Human and Peoples' Rights;

b) "African Commission" means the African Commission on Human and Peoples' Rights;

c) "Assembly" means the Assembly of Heads of State and Government of the African Union;

d) "AU" means the African Union;

e) "Constitutive Act" means the Constitutive Act of the African Union;

f) "Discrimination against women" means any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their marital status, of human rights and fundamental freedoms in all spheres of life;

g) "Harmful Practices" means all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity;

h) "NEPAD" means the New Partnership for Africa's Development established by the Assembly;

i) "States Parties" means the States Parties to this Protocol;

j) "Violence against women" means all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war;

k) "Women" means persons of female gender, including girls;

Article 2: Elimination of Discrimination Against Women

1. States Parties shall combat all forms of discrimination against women through appropriate legislative, institutional and other measures. In this regard they shall:
   a) include in their national constitutions and other legislative instruments, if not already done, the principle of equality between women and men and ensure its effective application;
   b) enact and effectively implement appropriate legislative or regulatory measures, including those prohibiting and curbing all forms of discrimination particularly those harmful practices which endanger the health and general well-being of women;
   c) integrate a gender perspective in their policy decisions, legislation, development plans, programmes and activities and in all other spheres of life;
   d) take corrective and positive action in those areas where discrimination against women in law and in fact continues to exist;
   e) support the local, national, regional and continental initiatives directed at eradicating all forms of discrimination against women.
2. States Parties shall commit themselves to modify the social and cultural patterns of conduct of women and men through public education, information, education and communication strategies, with a view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men.

Article 3: Right to Dignity

1. Every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights;
2. Every woman shall have the right to respect as a person and to the free development of her personality;
3. States Parties shall adopt and implement appropriate measures to prohibit any exploitation or degradation of women;
4. States Parties shall adopt and implement appropriatemeasures to ensure the protection of every woman's right to respect for her dignity and protection of women from all forms of violence, particularly sexual and verbal violence.

Article 4:The Rights to Life, Integrity and Security of the Person

1. Every woman shall be entitled to respect for her life and the integrity and security of her person. All forms of exploitation, cruel, inhuman or degrading punishment and treatment shall be prohibited.
2. States Parties shall take appropriate and effective measures to:
   a) enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public;
   b) adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women;
   c) identify the causes and consequences of violence against women and take appropriate measures to prevent and eliminate such violence;
   d) actively promote peace education through curricula and social communication in order to eradicate elements in traditional and cultural beliefs, practices and stereotypes which legitimise and exacerbate the persistence and tolerance of violence against women;
   e) punish the perpetrators of violence against women and implement programmes for the rehabilitation of women victims;
   f) establish mechanisms and accessible services for effective information, rehabilitation and reparation for victims of violence against women;
   g) prevent and condemn trafficking in women, prosecute the perpetrators of such trafficking and protect those women most at risk;
   h) prohibit all medical or scientific experiments on women without their informed consent;
   i) provide adequate budgetary and other resources for the implementation and monitoring of actions aimed at preventing and eradicating violence against women;
   j) ensure that, in those countries where the death penalty still exists, not to carry out death sentences on pregnant or nursing women.
   k) ensure that women and men enjoy equal rights in terms of access to refugee status, determination procedures and that women refugees are accorded the full protection and benefits guaranteed under international refugee law, including their own identity and other documents;

Article 5: Elimination of Harmful Practices

States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including:

a) creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;

b) prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them;

c) provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicialsupport, emotional and psychological counselling as well as vocational training to make them self-supporting;

d) protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.

Article 6: Marriage

States Parties shall ensure that women and men enjoy equal rights and are regarded as equal partners in marriage. They shall enact appropriate national legislative measures to guarantee that:

a) no marriage shall take place without the free and full consent of both parties;

b) the minimum age of marriage for women shall be 18 years;

c) monogamy is encouraged as the preferred form of marriage and that the rights of women in marriage and family, including in polygamous marital relationships are promoted and protected;

d) every marriage shall be recorded in writing and registered in accordance with national laws, in order to be legally recognised;

e) the husband and wife shall, by mutual agreement, choose their matrimonial regime and place of residence;

f) a married woman shall have the right to retain her maiden name, to use it as she pleases, jointly or separately with her husband's surname;

g) a woman shall have the right to retain her nationality or to acquire the nationality of her husband;

h) a woman and a man shall have equal rights, with respect to the nationality of their children except where this is contrary to a provision in national legislation or is contrary to national security interests;

i) a woman and a man shall jointly contribute to safeguarding the interests of the family, protecting and educating their children;

j) during her marriage, a woman shall have the right to acquire her own property and to administer and manage it freely.

Article 7: Separation, Divorce and Annulment of Marriage

States Parties shall enact appropriate legislation to ensure that women and men enjoy the same rights in case of separation, divorce or annulment of marriage. In this regard, they shall ensure that:

a) separation, divorce or annulment of a marriage shall be effected by judicial order;
b) women and men shall have the same rights to seek separation, divorce or annulment of a marriage;
c) in case of separation, divorce or annulment of marriage, women and men shall have reciprocalrights and responsibilities towards their children. In any case, the interests of the children shall be given paramount importance;
d) in case of separation, divorce or annulment of marriage, women and menshall have the right to an equitable sharing of the joint property deriving from the marriage.

Article 8: Access to Justice and Equal Protection before the Law

Women and menare equal before the law and shall have the right to equal protection andbenefit of the law. States Parties shall take all appropriate measures to ensure:

a) effective access by women to judicial and legal services, including legal aid;

b) support to local, national, regional and continental initiatives directed at providing women access to legal services, including legal aid;

c) the establishment of adequate educational and other appropriate structures with particular attention to women and to sensitise everyone to the rights of women;

d) that law enforcement organs at all levels are equipped to effectively interpret and enforce gender equality rights;

e) that women are represented equally in the judiciary and law enforcement organs;

f) reform of existing discriminatory laws and practices in order to promote and protect the rights of women.

Article 9: Right to Participation in the Political and Decision-Making Process

1. States Parties shall take specific positive action to promote participative governance and the equal participation of women in the political life of their countries through affirmative action, enabling national legislation and other measures to ensure that:
   a) women participate without any discrimination in all elections;
   b) women are represented equally at all levels with men in all electoral processes;
   c) women are equal partners with men at all levels of development and implementation of State policies and development programmes.
2. States Parties shall ensure increased and effective representation and participation of women at all levels of decision-making.

Article 10: Right to Peace

1. Women have the right to a peaceful existence and the right to participate in the promotion and maintenance of peace.
2. States Parties shall take all appropriate measures to ensure the increased participation of women:
   a) in programmes of education for peace and a culture of peace;
   b) in the structures and processes for conflict prevention, management and resolution at local, national, regional, continental and international levels;
   c) in the local, national, regional, continental and international decision making structures to ensure physical, psychological, social and legal protection of asylum seekers, refugees, returnees and displaced persons, in particular women;
   d) in all levels of the structures established for the management of camps and settlements for asylum seekers, refugees, returnees and displaced persons, in particular, women;
   e) in all aspects of planning, formulation and implementation of post conflict reconstruction and rehabilitation.
3. States Parties shall take the necessary measures to reduce military expenditure significantly in favour of spending on social development in general, and the promotion of women in particular.

Article 11: Protection of Women in Armed Conflicts

1. State**s** Parties undertake to respect and ensure respect for the rules of international humanitarian law applicable in armed conflict situations which affect the population, particularly women.
2. State**s** Parties shall, in accordance with the obligations incumbent upon them under the international humanitarian law, protect civilians including women, irrespective of the population to which theybelong, in the event of armedconflict.
3. States Parties undertake to protect asylum seeking women, refugees, returnees and internally displaced persons, against all forms of violence, rape and other forms of sexual exploitation, and to ensure that such acts are considered war crimes, genocide and/or crimes against humanity and that their perpetrators are brought to justice before a competent criminal jurisdiction.
4. States Parties shall take all necessary measures to ensure that no child, especially girls under 18 years of age, take a direct part in hostilities and thatno child is recruited as a soldier.

Article 12: Right to Education and Training

1. States Parties shall take all appropriate measures to:
   a) eliminate all forms of discrimination against women and guarantee equal opportunity and access in the sphere of education and training;
   b) eliminate all stereotypes in textbooks, syllabuses and the media, that perpetuate such discrimination;
   c) protect women, especially the girl-child from all forms of abuse, including sexual harassment in schools and other educational institutions and provide for sanctions against the perpetrators of such practices;
   d) provide access to counselling and rehabilitation services to women who suffer abuses and sexual harassment;
   e) integrate gender sensitisation and human rights education at all levels of education curricula including teacher training.

2. States Parties shall take specific positive action to:
   a) promote literacy among women;
   b) promote education and training for women at all levels and in all disciplines, particularly in the fields of science and technology;
   c) promote the enrolment and retention of girls in schools and other training institutions and the organisation of programmes for women who leave school prematurely.

Article 13: Economic and Social Welfare Rights

1. States Parties shall adopt and enforce legislative and other measures to guarantee womenequal opportunities in work and career advancement and other economic opportunities. In this respect, they shall:
   a) promote equality of access to employment;
   b) promote the right to equal remuneration for jobs of equal value for women and men;
   c) ensure transparency in recruitment, promotion and dismissal of women and combat and punish sexual harassment in the workplace;
   d) guarantee women the freedom to choose their occupation, and protect them from exploitation by their employers violating and exploiting their fundamental rights as recognised and guaranteed by conventions, laws and regulations in force;
   e) create conditions to promote and support the occupations and economic activities of women, in particular, within the informal sector;
   f) establish a system of protection and social insurance for women working in the informal sector and sensitise them to adhere to it;
   g) introduce a minimum age for work and prohibit the employment of children below that age, and prohibit, combat and punish all forms of exploitation of children, especially the girl-child;
   h) take the necessary measures to recognise the economic value of the work of women in the home;
   i) guarantee adequate and paid pre and post-natal maternity leave in both the private and public sectors;
   j) ensure the equal application of taxation laws to women and men;
   k) recognise and enforce the right of salaried women to the same allowances and entitlements as those granted to salaried men for their spouses and children;
   l) recognise that both parents bear the primary responsibility for the upbringing and development of children and that this is a social function for which the State and the private sector have secondary responsibility;
   m) take effective legislative and administrative measures to prevent the exploitation and abuse of women in advertising and pornography.

Article 14: Health and Reproductive Rights

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:
   a) the right to control their fertility;
   b) the right to decide whether to have children, the number of children and the spacing of children;
   c) the right to choose any method of contraception;
   d) the right to selfprotection and to be protected against sexually transmitted infections, including HIV/AIDS;
   e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
   f) the right to have family planning education.
2. States Parties shall take all appropriate measures to:
   a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
   b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy andwhile they are breast-feeding;
   c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of themother or the foetus.

Article 15: Right to Food Security

States Parties shall ensure that women have the right to nutritious and adequate food. In this regard, they shall take appropriate measures to:

a) provide women with access to clean drinking water, sources of domestic fuel, land, and the means of producing nutritious food;

b) establish adequate systems of supply and storage to ensure food security.

Article 16: Right to Adequate Housing

Women shall have the right to equal access to housing and to acceptable living conditions in a healthy environment. To ensure this right, States Parties shall grant to women, whatever their marital status, access to adequate housing.

Article 17: Right to Positive Cultural Context

1. Women shall have the right to live in a positive cultural context and to participate at all levels in the determination of cultural policies.
2. States Parties shall take all appropriate measures to enhance the participation of women in the formulation of cultural policies at all levels.

Article 18: Right to a Healthy and Sustainable Environment

1. Women shall have the right to live in a healthy and sustainable environment.
2. States Parties shall take all appropriate measures to:
   a) ensure greater participation of women in the planning, management and preservation of the environment and the sustainable use of natural resources at all levels;
   b) promote research and investment in new and renewable energy sources and appropriate technologies, including information technologies and facilitate women's access to, and participation in their control;
   c) protect and enable the development of women's indigenous knowledge systems**;**
   d) regulate the management, processing, storage and disposal of domestic waste;
   e) ensure that proper standards are followed for the storage, transportation and disposal of toxic waste.

Article 19: Right to Sustainable Development

Women shall have the right to fully enjoy their right to sustainable development. In this connection, the States Parties shall take all appropriate measures to:

a) introduce the gender perspective in the national development planning procedures;

b) ensure participation of women at all levels in the conceptualisation, decision-making, implementation and evaluation of development policies and programmes;

c) promote women's access to and control over productive resources such as land and guarantee their right to property;

d) promote women's access to credit, training, skills development and extension services at rural and urban levels in order to provide women with a higher quality of life and reduce the level of poverty among women;

e) take into account indicators of human development specifically relating to women in the elaboration of development policies and programmes; and

f) ensure that the negative effects of globalisation and any adverse effects of the implementation of trade and economic policies and programmes are reduced to the minimum for women.

Article 20: Widows' Rights

States Parties shall take appropriate legal measures to ensure that widows enjoy all human rights through the implementation of the following provisions:

a) that widows are not subjected to inhuman, humiliating or degrading treatment;

b) a widow shall automatically become the guardian and custodian of her children, after the death of her husband, unless this is contrary to the interests and the welfare of the children;

c) a widow shall have the right to remarry, and in that event, to marry the person of her choice.

Article 21: Right to Inheritance

1. A widow shall have the right to an equitable share in the inheritance of the property of her husband. A widow shall have the right to continue to live in the matrimonial house. In case of remarriage, she shall retain this right if the house belongs to her or she has inherited it.
2. Women and men shall have the right to inherit, in equitable shares, their parents' properties.

Article 22: Special Protection of Elderly Women

The States Parties undertake to:

a) provide protection to elderly women and take specific measures commensurate with their physical, economic and social needs as well as their access to employment and professional training;

b) ensure the right of elderly women to freedom from violence, including sexual abuse, discrimination based on age and the right to be treated with dignity.

Article 23: Special Protection of Women with Disabilities

The States Parties undertake to:

a) ensure the protection of women with disabilities and take specific measures commensurate with their physical, economic and social needs to facilitate their access to employment, professional and vocational training as well as their participation in decision-making;

b) ensure the right of women with disabilities to freedom from violence, including sexual abuse, discrimination based on disability and the right to be treated with dignity.

Article 24: Special Protection of Women in Distress

The States Parties undertake to:

a) ensure the protection of poor women and women heads of families including women from marginalized population groups and provide the an environment suitable to their condition and their special physical, economic and social needs;

b) ensure the right of pregnant or nursing women or women in detention by providing them with an environment which is suitable to their condition and the right to be treated with dignity.

Article 25: Remedies

States Parties shall undertake to:

a) provide for appropriate remedies to any woman whose rights or freedoms, as herein recognised, have been violated;

b) ensure that such remedies are determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by law.

Article 26: Implementation and Monitoring

1. States Parties shall ensure the implementation of this Protocol at national level, and in their periodic reports submitted in accordance with Article 62 of the African Charter, indicate the legislative and other measures undertaken for the full realisation of the rights herein recognised.
2. States Parties undertake to adopt all necessary measures and in particular shall provide budgetary and other resources for the full and effective implementation of the rights herein recognised.

Article 27: Interpretation

The African Court on Human and Peoples' Rights shall be seized with matters of interpretation arising from the application or implementation of this Protocol.

Article 28: Signature, Ratification and Accession

1. This Protocol shall be open for signature, ratification and accession by the States Parties, in accordance with their respective constitutional procedures.
2. The instruments of ratification or accession shall be deposited with the Chairperson of the Commission of the AU.

Article 29: Entry into Force

1. This Protocol shall enter into force thirty (30) days after the deposit of the fifteenth (15) instrument of ratification.
2. For each State Party that accedes to this Protocol after its coming into force, the Protocol shall come into force on the date of deposit of the instrument of accession.
3. The Chairperson of the Commission of the AU shall notify all Member Statesof the coming into force of this Protocol.

Article 30: Amendment and Revision

1. Any State Party may submit proposals for the amendment or revision of this Protocol.
2. Proposals for amendment or revision shall be submitted, in writing, to the Chairperson of the Commission of the AU who shall transmit the same to the States Parties within thirty (30) days of receipt thereof.
3. The Assembly, upon advice of the African Commission, shall examine these proposals within a period of one (1) year following notification of States Parties, in accordance with the provisions of paragraph 2 of this article.
4. Amendments or revision shall be adopted by the Assembly by a simple majority.
5. The amendment shall come into force for each State Party, which has accepted it thirty (30) days after the Chairperson of the Commission of the AU has received notice of the acceptance.

Article 31: Status of the Present Protocol

None of the provisions of the present Protocol shall affect more favourable provisions for the realisation of the rights of women contained in the national legislation of States Parties or in any other regional, continental or international conventions, treaties or agreements applicable in these States Parties.

Article 32: Transitional Provisions

Pending the establishment of the African Court on Human and Peoples' Rights, the African Commission on Human and Peoples' Rights shall be the seized with matters of interpretation arising from the application and implementation of this Protocol.

Adopted by the 2nd Ordinary Session of the Assembly of the Union
Maputo, 11 July 2003

Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa

People's Democratic Republic of Algeria
Republic of Angola
Republic of Benin
Republc of Botswana
Burkina Faso
Republic of Burundi
Republic of Cameroon
Republic of Cape Verde
Central African Republic
Republic of Chat
Union of the Comoros
Republic of the Congo
Republic of the Côte d'Ivoire
Democratic Republic of Congo
Republic of the Djibouti
Arab Republic of the Egypt
State of Eritrea
Federal Democratic Republic of Ethiopia
Republic of the Equatorial Guinea
Republic of Gabon
Republic of the Gambia
Republic of Guinea
Republic of Guinea Bissau
Kingdom of Lesotho
Republic of Liberia
Great Socialist People's Libyan Arab Jamahiriya
Republic of Madagascar
Republic of Malawi
Republic of Mali
Republic of Mauritania
Republic of Mauritius
Republic of Mozambique
Republic of Namibia
Republic of Niger
Republic of Nigeria
Republic of Rwanda
Sahrawi Arab Democratic Republic
Republic of Sao Tome and Principe
Republic of Senegal
Republic of Seychelles
Republic of Sierra Leone
Republic of Somalia
Republic of South Africa
Republic of Sudan
Kingdom of Swaziland
United Republic of Tanzania
Republic of Togo
Republic of Tunisia
Republic of Uganda
Republic of Zambia
Republic of Zimbabwe

B

African Union Decisions, Resolutions and Declarations on Health

1 Resolution on Health, Sanitation and Nutrition (1963)

2 Resolution for Essential Medicines for Mothers and their Children (1988)

3 Resolution on the AIDS Epidemic in Africa Progress Report (1993)

4 Tunis Declaration on AIDS and the Child in Africa (1994)

5 Lome Declaration in HIV/AIDS in Africa (2000)

6 Decision on the Sixth Conference in Africa (2000)

7 Decision on Traditional Medicines in Africa (2001)

8 Abuja Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Diseases (2001)

9 Solemn Declaration on Gender Equality in Africa (2004)

10 Decision on AIDS Watch Africa (AWA) and the Implementation of the Abuja and Maputo Declarations on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in Africa (2004)

11 Decision on the Interim report on HIV/AIDS, Tuberculosis, Malaria and Polio (2005)

12 Abuja Call for Accelerated Action Towards Universal Access to HIV and Aids, Tuberculosis and Malaria Services in Africa (2006)

13 Sexual and Reproductive Health and Rights Continental Policy Framework (2006)

14 Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health Rights 2007–2010 (2007)

15 Africa Health Strategy: 2007–2015 (2007)

16 African Ministers Johannesburg Declaration (2007)

17 Call for Accelerated Action on the Implementation of the Plan of Action Towards Africa Fit for Children (2008-2012) (2007)

18 Johannesburg Declaration of the Sixth Ordinary Session of our General Assembly of the African Population Commission (2007)

19 Decision on the Progress Report on the Implementation of the Commitments of the May 2006 Abuja Special Summit on HIV/AIDS, Tuberculosis and Malaria (ATM) (2008)

20 Decision on the Report on the Promotion of Maternal, Infant and Child Health in Africa (2008)

21 Decision on Promotion of Maternal, Infant and Child Health and Development (2008)

22 Decision on the Report of the Implementation Status of Decision Assembly/AU/Dec.204 (XI) on Promotion of Maternal, Infant and Child Health and Development in Africa) (2009)

23 Five-Year Review of the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis, and Malaria Services by 2010: Progress Report (2006-2010) (2010)

24 Decision on the Support of a Draft Resolution at the Sixty Sixth Ordinary Session of the General Assembly of the United Nations to Ban Female Genital Mutilation in the World (2011)

25 Decision on Progress Report on Maternal New Born and Child Health (2012)

26 Declaration on the Report of AIDS Watch Africa (AWA) Action Committee of Heads of State and Government (2012)

27 The Road Map of the African Women's Decade 2010–2020

28 General Comments on Article 14 (1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2012)

29 Implementation of the Abuja Call for Accelerated Action Towards Universal Access to HIV/Aids, Tuberculosis and Malaria Services: Progress report 2010–2012

B1 Resolution on Health, Sanitation and Nutrition (1963)

Organisation of African Unity
Resolutions adopted by the First Conference of Independent African Heads of State and Government
held in Addis Ababa, Ethiopia, from 22 to 25 May 1963
CIAS/Plen.3

The Summit Conference of Independent African States meeting in Addis Ababa, Ethiopia, from 22 to 25 May 1963,

REALIZING the importance of health standard for the African peoples and the urgent need for raising such standard and improving sanitation and nutrition amongst the people,

CONSIDERING that the co-operation amongst the African States in health, sanitation and nutrition fields is vital and will contribute to the realization of stronger solidarity amongst their peoples,

DECIDES that a Committee of Experts be called to convene within three months, pending the setting up of the Commission on Health, Sanitation and Nutrition provided for in Article XX of the Charter of the Organization of African Unity, to submit a report to the above Commission:

With regard to health:

1. To conduct extensive studies on health problems facing the continent;
2. To lay down detailed programmes with a view to raising health standards among the peoples and to strengthen inter-African co-operation through:
   (a) The exchange of information about endemic and epidemic diseases and the means to control them;
   (b) The exchange of health legislations;
   (c) The exchange of doctors, technicians and nurses;
   (d) The reciprocal offer of scholarships for medical students and the establishment of training courses on health, sanitation and nutrition;
3. To conduct, research in all African States on sanitation and nutrition and to study ways and means to improve them.

B2 Resolution on the Programme of Essential Medicines for Children and their Mothers (1988)

CM/Res. 1164 (XLVIII) 1988

[Council]

CONSCIOUS of the fact that human resources in general, [and] mothers and children in particular constitute the main wealth of the continent,

CONVINCED of the need to ensure the welfare of mothers and children through effective and less expensive actions, with long lasting effects, so as to guarantee their active participation in the economic development efforts of African states:

1. **WELCOMES** Resolution No AFR/RC37/WP/05 adopted by the Regional Committee of the World Health Organization for Africa in support of the Bamako Initiative;
2. **EXPRESSES SATISFACTION** at the full support given the initiative by many African states;
3. **ENCOURAGES** those states which have already begun taking action to pursue their efforts and URGES those desirous of undertaking such actions to do so;
4. **PAYS TRIBUTE** to the World Health Organisation for its technical support for the initiative and to the Governing Council of the United Nations Children's Fund for having adopted a resolution in support of the immediate implementation of this initiative and for having mobilised substantial resources to support the efforts of those states which have begun to take actions or are desirous of doing so;
5. **CALLS UPON** member states to:
   (1) launch a large-scale campaign aimed at alerting a large number of people to the positive aspects of this initiative;
   (2) integrate elements of this initiatives into their countries' health policy on mother and child care by defining an appropriate policy for essential medicines;
   (3) mobilise to win the support of the donor and bilateral or multilateral bodies in favour of the extension of the system to the population in those countries which have opted for this initiative.
6. **REQUESTS** the WHO Regional Director and the Executive Director of UNICEF to do everything within their power to ensure the implementation of the programmes adopted, organise meetings among countries with a view to exchanging ideas and experiences on the issue, and to encourage bodies and agencies concerned to define and support plans of action.

B3 Resolution on the AIDS Epidemic in Africa: Progress Report and Guidelines for Action (1993)

AHG/Res. 223 (XXIX) 1993.
Also reprinted in
***African Yearbook of International Law* (1993) 322**

The Assembly …

CONSIDERING Document CM/1779 (LVIII) on the Report of the Secretary-General on the Six Point Action Agenda of the Declaration on the AIDS Epidemic in Africa: Progress Report and Guidelines for Action,

RECALLING Declaration AHG/Decl. 1 (XXVIII) on the AIDS Epidemic in Africa,

RECALLING FURTHER Declaration AHG/Decl. 3 (XXVII) on the Current African Health Crisis, Resolutions CM/Res. 1165 (XLVIII), CM/Res. 1302 (LII) of the Council of Ministers of 1988 and 1990 respectively and Resolutions CAMH/Res. 11 (II), CAMH/Res. 6 (IV) Rev 1 of the Conference of African Ministers of Health on AIDS in Africa.

ACKNOWLEDGING that among the many health problems facing the African continent AIDS is an additional burden,

CONCERNED, however, that unlike other diseases AIDS has no drugs or vaccines to prevent or cure it yet, that it is invariably fatal, widespread, and affects the reproductive population group 15 - 49 years, the backbone of socio-economic development of our continent,

CONCERNED FURTHER that by the year 2000 cumulatively about 14 million Africans will be infected with the deadly AIDS virus causing approximately one million deaths annually and resulting in ten to fifteen million orphans:

1. **COMMENDS** the efforts of the OAU Secretariat and its partners (notably the WHO) in putting together the guidelines for implementation of the Six Point Action Agenda and the Management Scheme;
2. **URGES** all member states to implement all the activities as set out in the guidelines within the targeted time frames;
3. **CALLS UPON** the international community to assist member states in their endeavours towards implementing the guidelines;
4. **URGES** the United Nations System and its specialised agencies, the ECA, the African Development Bank, bilateral and multilateral agencies, non-governmental and voluntary organisations to support the Africa-wide struggle against AIDS in conformity with Declaration AHG/Dec. 1 (XXVIII) on the AIDS Epidemic in Africa;
5. **REQUESTS** the OAU Secretary-General to monitor, in collaboration with WHO, the implementation of the Declaration on the AIDS Epidemic in Africa, AHG/Decl. 1 (XXVIII) and report bi-annually to this Assembly on progress.

B4 Tunis Declaration on AIDS and the Child in Africa (1994)

AHG/Decl. 1 (XXX) 1994.
Also reprinted in 3 *African Yearbook of International Law* (1995) 380

I. Background

[The Assembly]

RECOGNISING the devastating effect facing our African people, we adopted in Dakar in 1992 Declaration AHG/Decl. 1 (XXVIII) on the AIDS Epidemic in Africa as an integral part of our earlier Declaration AHG/Decl. 3 (XXVII) on the Current African Health Crisis adopted in Abuja in 1991,

HAVING REVIEWED Document CM/1780 (LVIII) on the Report of the Secretary-General on the Implementation of the Six Point Action Agenda of the Declaration of the AIDS Epidemic in Africa, we adopted in Cairo Resolution AHG/Res. 223 (XXIX),

INSPITE OF the above concerted actions we resolved to undertake, the magnitude of the problem of the HIV infection and AIDS in most of our countries is on the increase especially among the African children who are the most vulnerable sector of our population.

WE TAKE NOTE THAT:

1. Some 1 million infections occur annually in men, women and children and that by the year 2000, about twenty million Africans will be infected with the Human Immunodeficiency Virus (HIV);
2. The Acquired Immunodeficiency Syndrome (AIDS) causes sickness and despair, kills young and middle-aged adults who are parents, the mainstay of the family, the backbone of the work force, and the care givers to our young;
3. Children are infected by various modes of transmission and girls are particularly vulnerable to infection by adults through sexual intercourse;
4. The positive gains in the health status of children and women brought about by successful primary health care programmes of immunisation, and child survival efforts in most African states are being threatened and will actually be reversed by AIDS;
5. As a consequence of less-than-aggressive preventive efforts in the past, millions of children will die from AIDS or be orphaned over the coming decade and will require care and supportive efforts.

II. Commitment

(a) Prevention is the key to slowing the spread of AIDS in Africa and curtailing its ultimate impact; attention should also be given to care of HIV/AIDS patients including those with accompanying illness such as tuberculosis;

(b) Effective national HIV/AIDS programmes require broad-based, multisectoral support from all sectors of government; and we commit ourselves to undertake the following measures to protect our African children.

In the light of the foregoing we commit ourselves to:

1. Elaborate a "national policy framework" to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues.
   (a) We must recognise that an effective response to the needs of AIDS-affected children requires a multidisciplinary, multisectoral response effectively coordinated to avoid duplication of effort and encourage the rational use of resources.
   (b) We must recognise that the serious effect the AIDS epidemic is having on children must be seen as a national issue, not just the concern of the communities most directly affected.

(c) The largest group of AIDS-affected children are those whose parents have died in the epidemic. But in the hardest hit communities, nearly all children – not just those whose family members have died of AIDS – are adversely affected because of the loss of people they are close to, the trauma of watching their friends become orphaned, and the effects on the community of the loss of so many of its most productive members.
(d) The immediate policy responses should address issues related to food and nutrition, education, nurture of parentless children, medical care for the sick as well as addressing the psychosocial problems resulting from the loss of loved ones and security.
(e) Children who are not at present infected or affected may soon join this group as the epidemic is rapidly developing.
(f) The various actors include concerned ministries, national and international non-governmental organisations, donor organisations and, most importantly, the communities themselves. Communities have the capacity to convert rejection into acceptance and risk-taking into risk prevention. Moreover, the individual capacity to act can be reinforced by a supportive community.

2. Protect young children from HIV infection.
(a) We must recognise not only the vulnerability of young people to HIV infection, but that they provide a window of opportunity to eventually break the chain of transmission.
(b) We must therefore encourage and develop strong prevention strategies and interventions based on, among other things, moral and ethical values of our society, appropriate sex education in schools, and as a matter of urgency plans must be drawn up to reach out-of-school youth. Furthermore, young people must be given access to reproductive health care and the knowledge and skills to avoid sexual exploitation and unprotected sex.
(c) We must give particular attention to the prevention of transmission of infection by adults to young people, through legislation designed to regulate the age of consent and by the introduction of measures to improve the economic status of families.
(d) In addition, we must institute measures to prevent parenteral transmission through transfusion of infected blood or use of contaminated needles and syringes or traditional surgical manipulation made with inadequately sterilised equipment. We should intensify all efforts including social mobilisation and introduce legislation to discourage harmful traditional practices.
(e) Furthermore, to prevent perinatal transmission we must institute counselling services to advise HIV infected women.

3. Promote and support applied research.
(a) Promote research efforts based on African experience and tradition and support institutes of research in Africa working mainly in the field of determining the magnitude and extent of HIV infection among children and women and the underlying factors relating to HIV infection in order to orient our response aimed at preventing the spread of infection and alleviating its consequences on children and women.

4. Make definite and substantial budgetary provisions to meet the identified requirements for preventive programmes among children and for the care and support of those infected and/or affected by HIV/AIDS.
(a) Recognising the socio-economic constraints to which our countries are subject and the multisectoral impact of the AIDS epidemic, we shall draw on all possible resources, community, national, bilateral and international, to meet the needs of the programme.

5. Continuously monitor the epidemiological situation and the impact of the action programme and regularly evaluate its implementation in order to effect any necessary modifications or reorientation.

III. We commit outselves to follow closely the implementation of this declaration

B5 Lomé Declaration on HIV/AIDS in Africa (2000)

AHG/Decl.3 (XXXVI) 2000

[The Assembly]

HAVING DEVOTED a full session of our meeting to deliberate frankly and extensively on the epidemic of HIV/AIDS in our countries and **BEARING IN MIND** the daunting medical, socio-economic and political challenges posed by the HIV/AIDS scourge in our continent;

RECOGNISING that responding to those challenges requires inter-alia, intense awareness building campaigns and an expression of political will of an exceptional nature at the highest possible level in all countries of our continent;

RECALLING our previous Declaration AHG/Decl. (XXIII) on Health, as a Foundation for Socio-Economic Development, endorsed in 1987 in Addis Ababa, Ethiopia, as well as our Dakar (1992) and Tunis (1994) Declarations on HIV/AIDS in Africa in which we committed ourselves to mobilise all segments of the society in our countries, to fight against the HIV/AIDS pandemic;

GRAVELY CONCERNED about the rapid spread of HIV infection in our countries and the millions of deaths caused by AIDS throughout our continent in spite of the serious efforts being invested by our countries to combat this scourge, as well as infectious diseases, particularly sexually transmitted diseases (STDs);

FURTHER CONCERNED by the recurrence of diseases which had previously been eradicated from our continent, such as Tuberculosis, and the emergence of new diseases which have become prevalent in Africa, and are complicating the control of HIV/AIDS;

COMMENDING the efforts made by our respective individual national governments, our continental Organization, the United Nations and its Specialised Agencies, national and international NGOs, and some individuals, to sensitise our peoples to the threat of HIV/AIDS and **RECOGNISING** that progress made in this endeavour has remained largely limited, uneven, fragile and incomplete;

FURTHER RECOGNISING that the sacrifices, and ability of our people, mainly women, to cope with the tragic consequences of this pandemic at the individual, family, community and national levels, to confront and overcome the losses and threats of HIV/AIDS, need our greater attention and support;

SOLEMNLY DECIDE TO:

1. **RECOMMIT OURSELVES** and our governments to the principles and actions enunciated in our previous Declarations, Decisions and Recommendations on controlling the spread of HIV/AIDS on our continent;
2. **COMMIT OURSELVES** to take personal responsibility and provide leadership for the activities of the National AIDS Commissions/Councils where they exist and ensure that they are established where they do not exist;
3. **RESOLVE** to keep the question of HIV/AIDS high on the national agendas for health, social, cultural and economic activities and to make it a development issue;
4. **ENHANCE** capacities of our governments, particularly our Ministries of Health, to develop and enact national strategies to deal with HIV/AIDS as a priority within our national development plans;
5. **TO THAT EFFECT, WE RESOLVE TO ENDORSE:**
   - The Algiers Common Position and Plan of Action on Strategies to Support HIV/AIDS Orphans, Vulnerable Children and Children Infected with HIV/AIDS adopted by the OAU Labour and Social Affairs Commission;
   - The Algiers Appeal by the OAU Labour and Social Affairs Commission for the Intensification of the Fight Against AIDS in Africa;

- The Ouagadougou Commitment for Action for the Implementation of the Declarations, Decisions and Recommendations of the Heads of State and Government of the OAU aimed at strengthening HIV/AIDS Control in Africa;
- The Framework of the International Partnership on AIDS in Africa in order to intensify the health sector response to the HIV/AIDS epidemic;

6. **FURTHER COMMIT OURSELVES** and **PLEDGE TO TAKE** all necessary measures to facilitate the implementation of the above instruments and to allocate resources within the framework of our national budgets to HIV/AIDS activities, particularly the prevention and the epidemiological study of the HIV/AIDS epidemic, public education on HIV/AIDS and its prevention and care, taking due recognition of the needs of HIV positive people and people living with AIDS, and their rights and roles in the containment of the epidemic;

7. **REQUEST** the International Partnership against HIV/AIDS to collaborate with the OAU General Secretariat and our individual member states in order to mobilise necessary additional financial resources for the fight against the AIDS epidemic in Africa;

8. **MANDATE** our governments, with the assistance of international partners, to take all necessary measures in order to accelerate health sector reform with a focus on all pandemics in general and HIV/AIDS in particular, as a basis for improving the standard of living of our populations;

9. **FURTHER REQUEST** our Secretary-General in collaboration with international partners, to draw up a Plan of Action for acceleration of Health Sector Reform with a focus on epidemics such as HIV/AIDS, and malaria in our continent, particularly the establishment of research and training centres where African indigenous knowledge on health systems could be incorporated;

10. **ALSO REQUEST** our Secretary-General, in collaboration with WHO, UNAIDS, UNICEF and all other interested international partners, to follow-up on the implementation of this Declaration and report to our Assembly every year on progress achieved.

B6 Decision on the Report of the Sixth Conference of African Ministers of Health (CAMH 6) Held from 18–21 October 1999 in Cairo, Egypt (2000)

CM/Dec. 534 (LXXII) Rev 1 2000

Council

1. **TAKES NOTE** of the Report;

2. **RECALLS** the Addis Ababa (1987) Declaration on Health as a Foundation for Development, AHG/Decl.1 (XXIII) and other subsequent Declarations, Decisions and Resolutions on Health endorsed during the last decade;

3. **ENDORSES** the Recommendations of the Sixth Conference of African Ministers of Health (CAMH 6) which was held from 18–21 October 1999 in Cairo, Egypt;

4. **FURTHER ENDORSES**
   a) the Ouagadougou Commitment for Action for the Implementation of the Declarations, Decisions and Recommendations of the Heads of State and Government of the OAU aimed at strengthening HIV/AIDS Control in Africa;
   b) the Algiers Common Position and Plan of Action on Strategies to support HIV/AIDS Orphans, Vulnerable Children and Children Infected by HIV/AIDS ;
   c) the Algiers Appeal by the OAU Labour and Social Affairs Commission for the Intensification of the Fight Against AIDS in Africa;

5. **URGES** member states to accelerate Health Sector Reform with a focus on integrating strategies to prevent and control epidemics in Primary Health Care, and by promoting training standards and carrying out studies in order to establish an African Training Centre, to that effect, REQUESTS the Secretary-General, in collaboration with development partners to prepare a Plan of Action for Health Sector Reform in Africa together with a follow-up mechanism;

6. **CALLS UPON** the international community and all development partners to cancel in full the debt of African countries in order to release resources which should be targeted to financing Health Sector Reform;

7. **FURTHER REQUESTS** the Secretary-General to take necessary actions to that effect and report on the status of the progress made in this area to the Seventy-third Ordinary Session of Council.

B7 Decision on the Declaration of the Period 2001–2010 as the OAU Decade for African Traditional Medicine (2001)

AHG/Dec. 5 (XXXVII) 2001

The Assembly

1. **WELCOMES** the proposal by Uganda to declare the Decade 2001 – 2010 as the OAU Decade for African Traditional Medicine;

2. **RECOGNISES** the important role traditional medicine continues to play in African societies, as almost 85% of the African population resort to it for their health delivery services;

3. **RECOGNISES FURTHER** that member states and their governments need to acknowledge and build upon this traditional knowledge resource-base, thereby making the goal of health for all easier to achieve by mobilising and using these resources more effectively;

4. **ACKNOWLEDGES** that it is unlikely that social, technical or economic changes in member states over the next decade will reduce significantly the dependency of rural populations on medicinal plants, species and resources;

5. **ENDORSES** the Nairobi Declaration formally recognising Traditional Medicine as the most affordable and accessible form of healthcare system for the majority of the African rural population;

6. **REITERATES ITS COMMITMENT AND SUPPORT** for the on-going two processes initiated by the General Secretariat of elaborating:
   a) an African Model Law for the Protection of the Rights of Local Communities, Farmers and Breeders and for the Regulation of Access to Biological Resources;
   b) an African Biosafety Model Law and an Africa-wide Biosafety System.

7. **CALLS** for a speedy finalisations of these two processes and CALLS UPON member states to use these models as a basis for finalising their national legislation by adapting their provisions to the national context and within the framework of the WTO Negotiations;

8. **REQUESTS** the General Secretariat, in collaboration with relevant partners and stakeholders to also initiate a process to draw up the appropriate elements for national legislation in relation to compulsory licensing, parallel imports and other aspects to incorporate in national patent laws that are important to increase access to vitally-needed medicines, and thereafter, to draft a "National Model Law" or "Model elements to be incorporated into national patent laws" in Africa for this purpose;

9. **DECLARES** the period 2001-2010, the decade for African traditional medicine and REQUESTS the General Secretariat, in collaboration with WHO and other interested stakeholders to assist OAU member states to prepare a Plan of Action for implementation;

10. **FINALLY REQUESTS** the Secretary-General to report regularly to Assembly on progress made in the implementation of this Decision.

B8 Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases (2001)

African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, Abuja, Nigeria, 24–27 April 2001

1. **We, the Heads of State and Government of the Organisation of African Unity (OAU)** met in Abuja, Nigeria from 26-27 April 2001, at a Special Summit devoted specifically to address the exceptional challenges of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, at the invitation of H.E. President Olusegun Obasanjo of the Federal Republic of Nigeria and in accordance with the agreement reached at the Thirty-Sixth Ordinary Session of our Assembly in Lomé, Togo from 10 to 12 July 2000.
2. We gathered in Abuja to undertake a critical review and assessment of the situation and the consequences of these diseases in Africa, and to reflect further on new ways and means whereby we, the lea ders of our Continent, can take the lead in strengthening current successful interventions and developing new and more appropriate policies, practical strategies, effective implementation mechanisms and concrete monitoring structures at national, regional and continental levels with a view to ensuring adequate and effective control of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in our Continent.
3. We are deeply concerned about the rapid spread of HIV infection in our countries and the millions of deaths caused by AIDS, Tuberculosis and other related infectious diseases throughout the Continent, in spite of the serious efforts being made by our countries to control these diseases. Africa is exceptionally afflicted by the HIV/AIDS epidemic. This generalised epidemic is affecting a wide cross-section of our people, thus decimating the adult population, the most productive group, and leaving in its wake millions of orphans, and disrupted family structures.
4. We recognize the role played by poverty, poor nutritional conditions and underdevelopment in increasing vulnerability. We are concerned about the millions of African children who have died from AIDS and other preventable infectious diseases. We are equally concerned about the particular a nd severe impact that these diseases have on children and youth who represent the future of our continent, the plight of millions of children orphaned by AIDS and the impact on the social system in our countries.
5. We are particularly concerned about the high incidence of mother to child transmission, especially given the challenges of infant breastfeeding in the context of HIV infection on the continent.
6. We recognize that special efforts are required to ensure that Africa's children are protected from these pandemics and their consequences and that the full and effective participation of young people in prevention and control programmes is essential to their success.
7. We recognise that biologically, women and girls are particularly vulnerable to HIV infection. In addition, economic and social inequalities and traditionally accepted gender roles leave them in a subordinate position to men.
8. We appreciate the special needs and challenges of the HIV/AIDS pandemic for the youth that make them vulnerable to infection and adverse impacts of the epidemic.
9. We recognize that the practice of injectable drug abuse with sharing of contaminated needles in some African countries is a major concern. The abuse of alcohol, marijuana and other mind-altering drugs, which is on the increase among the youth further enhances their vulnerability to HIV infection.
10. We recognize the essential place that education, in its widest sense has played and will continue to play in the fight against HIV/AIDS in Africa. Education constitutes the most powerful, cost effective tool for reaching the largest number of people with information and personal development strategies that promote long-term behaviour change.
11. We acknowledge that forced migrations due to war, conflicts, natural disasters and economic factors including unilateral sanctions imposed on some African countries, lead to an increased vulnerability and the spread of the disease; we note that special attention should be given to migrants, mobile populations,

refugees and internally displaced persons in national and regional policies. We also note that special attention should be given to the problem trafficking in human beings and its impact on HIV/AIDS.

12. We are aware that stigma, silence, denial and discrim ination against people living with HIV/AIDS (PLWA) increase the impact of the epidemic and constitute a major barrier to an effective response to it. We recognize the importance of greater involvement of People Living with HIV/AIDS.
13. We recognise that the epidemic of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases constitute not only a major health crisis, but also an exceptional threat to Africa's development, social cohesion, political stability, food security as well as the greatest global threat to the survival and life expectancy of African peoples. These diseases, which are themselves exacerbated by poverty and conflict situations in our Continent, also entail a devastating economic burden, through the loss of human capital, reduced productivity and the diversion of human and financial resources to care and treatment.
14. We recognize the need to intensify our efforts in all areas of research such as traditional medicines and vaccine development.
15. We are fully convinced that containing and reversing the HIV/AIDS epidemic, tuberculosis and other infectious diseases should constitute our top priority for the first quarter of the 21st Century. We are equally convinced that tackling these epidemics should constitute an integral part of our continental Agenda for promoting poverty reduction, sustainable development and ensuring durable peace and political security and stability consistent with the Millennium African Recovery Programme.
16. We recognise and commend the efforts by our respective national Governments, our continental Organisation and its Regional Economic Communities (RECs), the national and international NGOs, the civil society, including youth, women, people with disability, religious organisations, sport organizations, Trade Unions, Employers organizations, Traditional Health Practitioners, Traditional Rulers, people living with HIV/AIDS and individuals, who care for, support and sensitise our people to the threat of HIV/AIDS and the associated opportunistic infections including Sexually Transmitted Infections (STIs).
17. We acknowledge the support that the international Community, including the United Nations System, its Specialised Agencies and programmes, bilateral agencies, private sector and other communities and stakeholders have provided in raising awareness about and combating the scourge of HIV/AIDS, Tuberculosis and other related infectious diseases in Africa.
18. We further acknowledge that, to successfully implement a comprehensive and multisectoral approach and campaign to overcome HIV/AIDS, tuberculosis and other related infectious diseases, there is a need to secure adequate financial and human resources at national and international levels.
19. We recognize the need to establish a sustainable source of income to fund HIV/AIDS programmes.
20. We recognise the importance of leadership at all levels in the fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in our Continent. We, therefore, acknowledge the special importance of the "African Consensus and Plan of Action: Leadership to overcome HIV/AIDS" adopted at the African Development Forum 2000 as the outcome of a wide-ranging process of consultation with all stakeholders.
21. In this regard, we recall and reaffirm our commitment to all relevant decisions, declarations and resolutions in the area of health and development and on HIV/AIDS, particularly the "Lomé Declaration on HIV/AIDS in Africa" (July 2000) and the "Decision on the adoption of the International Partnership against HIV/AIDS" (Algiers 1999).

WE SOLEMNLY DECLARE AS FOLLOWS:

22. We consider AIDS as a State of Emergency in the continent. To this end, all tariff and economic barriers to access to funding of AIDS-related activities should be lifted.
23. To place the fight against HIV/AIDS at the forefront and as the highest priority issue in our respective national development plans. To that end, **WE ARE RESOLVED**to consolidate the foundations for the prevention and control of the scourge of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases through a comprehensive multisectoral strategy which involves all appropriate development sectors of our governments as well as a broad mobilisation of our societies at all levels, including community level

organisations, civil society, NGOs, the private sector, trade unions, the media, religious organisations, schools, youth organisations, women organisations, people living with HIV/AIDS organizations and individuals who care for, support and sensitise our population to the threat of HIV/AIDS and associated opportunistic infections and also to protect those not yet infected, particularly the women, children and youth through appropriate and effective prevention programmes.

24. To that effect, **WE COMMIT OURSELVES TO TAKE PERSONAL RESPONSIBILITY AND PROVIDE LEADERSHIP** for the activities of the National AIDS Commissions/Councils. **WE THEREFORE RESOLVE** to lead from the front the battle against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases by personally ensuring that such bodies were properly convened in mobilizing our societies as a whole and providing focus for unified national policy-making and programme implementation, ensuring coordination of all sectors at all levels with a gender perspective and respect for human rights, particularly to ensure equal rights for people living with HIV/AIDS (PLWA).

25. **WE ALSO COMMIT OURSELVES TO ENSURE** that leadership role is exercised by everyone in his/her area of responsibility in the fight against HIV/AIDS and other related diseases. **WE THEREFORE ENDORSE** the "African Consensus and Plan of Action: Leadership to overcome HIV/AIDS" adopted during the Second African Development Forum on "AIDS: The Greatest Leadership Challenge" organised by the United Nations Economic Commission for Africa (UNECA) in collaboration with the OAU, UNAIDS and ILO (Addis Ababa, 3-7 December 2000).

26. **WE COMMIT OURSELVES** to take all necessary measures to ensure that the needed resources are made available from all sources and that they are efficiently and effectively utilized. In addition,WE PLEDGE to set a target of allocating at least 15% of our annual budget to the improvement of the health sector. WE ALSO PLEDGE to make available the necessary resources for the improvement of thecomprehensive multi-sectoral response, and that an appropriate and adequate portion of this amount is put at the disposal of the National Commissions/Councils for the fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.

27. **WE REQUEST** the OAU Secretariat, in collaboration with ADB, ECA, and all other partner institutions, especially WHO and UNAIDS, to assist Member States in formulating a continental-wide policy for an international assistance strategy for the mobilisation of additional financial resources.

28. **WE CALL UPON** Donor countries to complement our resources mobilization efforts to fight the scourge of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Bearing in mind that Africa cannot, from its weak resource base, provide the huge financial resources needed. In this regard, **WE URGE** those countries to, among others, fulfil the yet to be met target of 0.7% of their GNP as official Development Assistance (ODA) to developing countries.

29. We support the creation of a Global AIDS Fund capitalized by the donor community to the tune of US $5–10 billion accessible to all affected countries to enhance operationalization of Action Plans, including accessing Anti-retroviral programmes in favour of the populations of Africa.

30. **WE UNDERTAKE** to mobilize all the human, material and financial resources required to provide **CARE** and **SUPPORT** and quality treatment to our populations infected with HIV/AIDS,Tuberculosis and Other Related Infections, and to organize meetings to evaluate the status of implementation of the objective of access to care.

31. **WE RESOLVE** to enact and utilize appropriate legislation and international trade regulations to ensure the availability of drugs at affordable prices and technologies for treatment, care and prevention of HIV/AIDS, Tuberculosis and Other Infectious Diseases. **WE ALSO RESOLVE** to take immediate action to use tax exemption and other incentives to reduce the prices of drugs and all other inputs in health care services for accelerated improvement of the health of our populations.

32. **WE COMMIT OURSELVES** to explore and further develop the potential of traditional medicine and traditional health practitioners in the prevention, care and management of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.

33. **WE COMMIT OURSELVES** to support the development of effective affordable, accessible HIV vaccine relevant to Africa. We, therefore, support "The Africa; AIDS Vaccine Programme" (AAVP), its collaborative partners, International partners and Institutions committed to the facilitation of HIV vaccine research and testing in Africa.

34. **WE COMMIT OURSELVES** to documenting and sharing these successful and positive experiences with a view to sustaining and scaling them up for wider coverage; mindful that there are still challenges that confront us, particularly in the area of infant feeding.

35. **WE COMMIT OURSELVES** to scaling up the role of education and information in the fight against HIV/AIDS in recognition of the essential role education, in its widest sense plays as a cost-effective tool for reaching the largest number of people.

36. **WE COMMIT OURSELVES** to the strengthening and development of special youth programmes to ensure an AIDS-free generation.

37. **WE**, within the framework and spirit of our Sirte Declaration of 9 September 1999, **RENEW THE MANDATE** of our brothers, President Bouteflika of Algeria, President Mbeki of South Africa and President Obasanjo of Nigeria to continue discussion with our debt creditors, on our behalf, with the view to securing the total cancellation of Africa's external debt in favour of increased investment in the social sector.

38. **WE ENDORSE** the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases; and **WE PLEDGE** to promote advocacy at the national, regional and international levels; and WE ALSO PLEDGE to ensure massive participation of Heads of State and Government at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS slated for 25–27 June 2001 so as to ensure that the session comes up with concrete and urgent decisions for the fight against HIV/AIDS in Africa including the fight against poverty and deduction of Africa's debt.

39. **WE REQUEST** the OAU Secretary General, in collaboration with ECA, ADB, UNAIDS, WHO, UNICEF, UNDP, ILO, UNFPA, FAO, UNESCO, UNIFEM, IOM, UNDCP and other partners, to follow up on the implementation of the outcome of this Summit and submit a report to the Ordinary Sessions of our Assembly.

40. **WE MANDATE** the Government of the Federal Republic of Nigeria to submit a report on the outcome of this African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases to the next Ordinary OAU Summit, which will be held in Lusaka, Zambia in July 2001. Abuja, Federal Republic of Nigeria 27 April 2001.

B9 Solemn Declaration on Gender Equality in Africa (2004)

Assembly/AU/Decl.12 (III)

We, the Heads of State and Government of Member States of the African Union, meeting in the Third Ordinary Session of our Assembly in Addis Ababa, Ethiopia, from 6-8 July 2004:

REAFFIRMING our commitment to the principle of gender equality as enshrined in Article 4 (l) of the Constitutive Act of the African Union, as well as other existing commitments, principles, goals and actions set out in the various regional, continental and international instruments on human and women's rights, including the Dakar Platform for Action (1994), the Beijing Platform for Action (1995), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW - 1979), the African Plan of Action to Accelerate the Implementation of the Dakar and Beijing Platforms for Action for the Advancement of Women (1999); the Outcome Document of the Twenty- third Special Session of the United Nations General Assembly Special Session on the Implementation of the Beijing Platform for Action (2000); UN Resolution 1325 (2000) on Women, Peace and Security; and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003);

STANDING BY our Decision on gender parity taken at the Inaugural Session of the AU Assembly of Heads of State and Government in July 2002 in Durban, South Africa implemented during the Second Ordinary Session of the Assembly in Maputo, Mozambique, 2003 through the election of five female and five male Commissioners;

NOTING WITH SATISFACTION that our Decision on gender parity is a historic achievement that does not yet exist in any other continent or regional organizations;

RE-AFFIRMING our commitment to continue, expand and accelerate efforts to promote gender equality at all levels;

DETERMINED to build on the progress that we have achieved in addressing issues of major concern to the women of Africa;

TAKING COGNIZANCE of the landmark decision to adopt the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa during the Second Ordinary Session of the Assembly in Maputo, Mozambique, 2003;

NOTING THE DECISION of the Chairperson of the African Union Commission to transform the African Women's Committee on Peace and Development (AWCPD) into the African Union Women's Committee (AUWC), which will be located in the Gender Directorate and serve as an Advisory Body to the Chairperson on Gender and Development;

RECOGNISING that major challenges and obstacles to gender equality still remain and require concerted and collective leadership and efforts from all of us including networks working on gender and development;

DEEPLY CONCERNED about the status of women and the negative impacts on women of issues such the high incidence of HIV/AIDS among girls and women, conflict, poverty, harmful traditional practices, high population of refugee women and internally displaced women, violence against women, women's exclusion from politics and decision-making, and illiteracy, limited access of girls to education;

AWARE of the policies and programmes we have put in place to curb the spread of HIV/AIDS pandemic as well as the current challenges in this campaign;

CONCERNED that, while women and children bear the brunt of conflicts and internal displacement, including rapes and killings, they are largely excluded from conflict prevention, peace-negotiation, and peace-building processes in spite of African women's experience in peace-building;

AWARE of the fact that low levels of women's representation in social, economic and political decision-making structures and feminisation of poverty impact negatively on women's ability to derive full benefit from the economies of their countries and the democratization process;

AWARE of the digital divide between the North and the South, men and women and the role of information telecommunication technologies (ICTS) in the advancement of the gender issue as stated in the e-gender Forum Declaration of Tunis, May 2004 in preparation for the World Summit on Information Society (WSIS) 2005;

HEREBY AGREE TO:

1. **ACCELERATE** the implementation of gender specific economic, social, and legal measures aimed at combating the HIV/AIDS pandemic and effectively implement both Abuja and Maputo Declarations on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Disease. More specifically we will ensure that treatment and social services are available to women at the local level making it more responsive to the needs of families that are providing care; enact legislation to end discrimination against women living with HIV/AIDS and for the protection and care for people living with HIV/AIDS, particularly women; increase budgetary allocations in these sectors so as to alleviate women's burden of care;
2. **ENSURE** the full and effective participation and representation of women in peace process including the prevention, resolution, management of conflicts and post- conflict reconstruction in Africa as stipulated in UN Resolution 1325 (2000) and to also appoint women as Special Envoys and Special Representatives of the African Union;
3. **LAUNCH**, within the next one year, a campaign for systematic prohibition of the recruitment of child soldiers and abuse of girl children as wives and sex slaves in violation of their Rights as enshrined in the African Charter on Rights of the Child;
4. **INITIATE**, launch and engage within two years sustained public campaigns against gender based violence as well as the problem of trafficking in women and girls; Reinforce legal mechanisms that will protect women at the national level and end impunity of crimes committed against women in a manner that will change and positively alter the attitude and behaviour of the African society;
5. **EXPAND AND PROMOTE** the gender parity principle that we have adopted regarding the Commission of the African Union to all the other organs of the African Union, including its NEPAD programme, to the Regional Economic Communities, and to the national and local levels in collaboration with political parties and the National parliaments in our countries;
6. **ENSURE** the active promotion and protection of all human rights for women and girls including the right to development by raising awareness or by legislation where necessary;
7. **ACTIVELY** promote the implementation of legislation to guarantee women's land, property and inheritance rights including their rights to housing;
8. **TAKE SPECIFIC MEASURES** to ensure the education of girls and literacy of women, especially in the rural areas, to achieve the goal of "Education for All" (EFA);
9. **UNDERTAKE** to Sign and ratify the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa by the end of 2004 and to support the launching of public campaigns aimed at ensuring its entry into force by 2005 and usher in an era of domesticating and implementing the Protocol as well as other national, regional and international instruments on gender equality by all States Parties;
10. **ESTABLISH** AIDS Watch Africa as a unit within the Office of the Chairperson of the Commission who should render annual report on HIV/AIDS situation in the continent during annual Summits; and promote the local production of anti- retroviral drugs in our countries;
11. **ACCEPT** to establish an African Trust Fund for Women for the purpose of building the capacity of African women and further request the African Union Commission to work out the modalities for the operationalisation of the Fund with special focus on women in both urban and rural areas;

12. **COMMIT OURSELVES** to report annually on progress made in terms of gender mainstreaming and to support and champion all issues raised in this Declaration, both at the national and regional levels, and regularly provide each other with updates on progress made during our Ordinary Sessions;

13. **WE REQUEST** the chairperson of the African Union Commission to submit, for our consideration, an annual report, during our ordinary sessions, on measures taken to implement the principle of gender equality and gender mainstreaming, and all issues raised in this Declaration both at the national and regional levels.

B10 Decision on AIDS Watch Africa (AWA) and the Implementation of the Abuja and Maputo Declarations on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in Africa (2004)

Assembly/AU/Dec.42 (III) Rev.1

The Assembly:

1. **TAKES NOTE** of:
   - The presentation by the Representative of the Chairman of AIDS Watch Africa;
   - The presentation by the Commissioner for Social Affairs of the AU; and
   - The recommendations of the Executive Council as contained in the Decision EX.CL/Dec.104 (V).

2. **URGES** Member States to ensure effective implementation of their commitments in accordance with the 2000 Abuja Declaration and Plan of Action on Roll Back Malaria, the 2001 Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases as well as the 2003 Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in Africa and to report on progress made;

3. **DECIDES** to reposition AWA's Secretariat within the Social Affairs Department of the AU Commission for a more effective coordination of AWA's roles and activities;

4. **URGES** AWA to ensure that best practices amongst Member States in the prevention and control of HIV/AIDS, Tuberculosis, Malaria and Other Related Infectious Diseases are identified, propagated and adopted by all;

5. **REQUESTS** the Chairman of AWA to report on progress made to the next Ordinary Session of the Assembly.

B11 Decision on the Interim Report on HIV/AIDS, Tuberculosis, Malara and Polio (2005)

Assembly/AU/Dec.55 (IV)

The Assembly:

1. **TAKES NOTE** of the Interim Report;

2. **ALSO TAKES NOTE** with satisfaction, of the institutionalization of AIDS Watch Africa (AWA) at the AU Commission;

3. **ENDORSES** the detailed strategies on health systems development, reducing disease burden and promoting child survival considered by Assembly;

4. **COMMENDS** the Global Fund Against HIV/AIDS, Tuberculosis and Malaria for holding its Ninth Board Meeting in Africa from where a decision was taken to launch Round Five funding for projects against these diseases, and; **CALLS UPON** the international community, especially the rich industrialized countries, to fully fund the Global Fund in line with previous commitments made in this regard, and taking into account the magnitude of the health emergency presented by these diseases in Africa;

5. **FURTHER COMMENDS** the sustained national, continental and international efforts to combat these diseases and promote health and development in Africa;

6. **REAFFIRMS** its commitment to invest increased resources in health and to address internal obstacles impeding their utilization;

7. **URGES** Member States to:
   (a) Take the lead in TRIPs negotiations and in implementing measures identified for promoting access to affordable generic drugs;
   (b) Ensure that every child receives polio immunization in 2005;
   (c) Prepare inter-ministerial costed development and deployment plans to address the Human Resources for Health crisis;
   (d) Prepare health literacy strategies to achieve an energized continent-wide health promotion endeavour;

8. **URGES** Member States to intensify efforts towards more effective and well-coordinated implementation of national programmes to promote health systems development as well as improve access to prevention, treatment, care and support; along the "Three ones initiative"; the "3 by 5 Strategy" and Global "Child Survival Partnership";

9. **RESOLVES** to take all the necessary measures to produce with the support of the international community, quality generic drugs in Africa, supporting industrial development and making full use of the flexibility in international trade law and; **REQUESTS** the AU Commission within the framework of NEPAD to lead the development of a Pharmaceutical Manufacturing Plan for Africa;

10. **CALLS UPON** the International Community to match the US$19 billion gap in health financing which the WHO has determined that Africa is not in a position to self finance;

11. **REQUESTS** the AU to foster partnerships with the global community, the UN Agencies and RECs, and to coordinate a review of the MDGs and report to the next Assembly.

B12 Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (2006)

Special Summit of African Union on
HIV and AIDS, Tuberculosis and Malaria (ATM)
Abuja, Nigeria 2–4 May, 2006
Sp/Assembly/ATM/2 (I) Rev.3

I. Introduction

1. **WE, THE HEADS OF STATE AND GOVERNMENT OF THE AFRICAN UNION**, meeting in Abuja, Nigeria, from 2–4 May 2006 to review the progress made in implementing the Abuja Declaration and Plan of Action on Roll Back Malaria (RBM) of 2000, and the Abuja Declaration and Plan of Action on HIV and AIDS, Tuberculosis and Other Infectious Diseases (ORID) of 2001; focused our deliberations on the Theme: "Universal Access to HIV and AIDS, Tuberculosis and Malaria Services by a United Africa by 2010". We recall that the twelve priorities for our Abuja Plan of Action on HIV and AIDS, Tuberculosis and Other Related Infectious Diseases included Leadership at National, Regional and Continental Levels to mobilize the society as a whole; Resource Mobilization; Protection for Human Rights, Poverty, Health and Development; Strengthening Health Systems; Prevention of Primary and Secondary Infections; Improvement of Information, Education and Communication; Access to Treatment, Care and Support; Access to Affordable Drugs and Technologies; Research and Development on HIV and AIDS, Tuberculosis and ORID; Partnership; and Monitoring and Evaluation.
2. **WE ALSO RECALL** that at the same 2001 Abuja Summit Eight African Heads of State and Government deeply, concerned with the impact of the HIV and AIDS epidemic, created AIDS Watch Africa (AWA) as an advocacy platform at the Head of State and Government level and for monitoring the African response and to mobilize resources.

II. Africa's Progress towards the Achievement of the 2000 and 2001 Abuja Commitments in Declarations and Plans of Action

3. Marked progress has been also observed in the proportion of national budgets allocated to health as 33% of countries have allocated at least 10% of their national budget to health while one country has attained the target of 15%. Heads of State have engaged with the G8 countries for additional resources and debt relief.
4. **WE REALIZE** that the movements of people across and within borders spread diseases such as HIV and AIDS Tuberculosis and Malaria. In view of this, we take regional level actions and cooperation as vital to the fight against the HIV and AIDS epidemic in the continent. Accordingly, Regional Economic Communities (RECs) have integrated health and social issues in their development programmes. Some RECs are implementing HIV and AIDS strategies. With the coordination of RECs, cross border cooperation and delivery of services is enhanced.
5. **WE ARE AWARE** that the AU Commission developed and is implementing the AU Commission HIV and AIDS Strategic Plan 2005-2007, coordinating the implementation of the AIDS Watch Africa Strategic Framework; and is playing its advocacy role through the World AIDS Campaign, World TB Day and Africa Malaria Day campaigns, among other advocacy activities.
6. In 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was created as suggested by the OAU/AU Heads of States following the advice by their health ministers and then proposed to the UN Secretary General at the Abuja Special Summit in 2001 and endorsed by the UNGASS on AIDS. Since then, several African countries have been able to access funds from GFATM, and other sources, which include the World Bank Multi-country AIDS Programme (MAP), US President's Emergency Fund for HIV and AIDS Relief Programme (PEPFAR), the Commission for Africa, the initiative by France on air ticket levy and

other bilateral and multi-lateral sources. Despite the increased number of donors, the current annual global spending is less than half of the US$ 12 billion needed by 2005 and less than one-quarter of the amount needed in 2007. However, spending for Africa from this amount accounts for 6- 10% of the total AIDS expenditure. According to the Global Fund Observer 2003, Africa was able to secure 60 per cent of the resource of the Global Fund.

III. The Challenges and Obstacles

7. **WE HAVE IDENTIFIED** the following as the main challenges and obstacles to accelerated action towards universal access to HIV and AIDS, Tuberculosis and Malaria services in Africa:

- The triple burden of disease including non-communicable diseases and injuries;
- The difficulty in ensuring predictable and sustainable financing for HIV, tuberculosis and malaria services;
- Weak planning partly because of lack of institutional and human resource capacity at national level;
- The health crisis reflected in terms of weak health systems, infrastructures inadequate laboratory network for diagnosis of diseases, human resources in terms of numbers, mix of skills, motivation, and retention which have become major barrier to the implementation of disease control programmes in general and HIV and AIDS, TB and Malaria programmes in particular;
- Inadequate access to essential medicines, preventative commodities and technologies across much of the continent; inadequate global supply of long lasting Insecticide Treated Nets (ITNs) and Artemisinin-based Combination Therapy (ACTs) and indoor residual spraying (IRS) with effective insecticides;
- Lack of adequate policies and legislation protecting the human rights of PLWHA and TB by most countries;
- Failure to take into account the link between HIV and AIDS and sexual and reproductive health;
- Stigma, discrimination and gender inequity, which result in inadequate application of the human rights of people infected or affected by HIV and AIDS and directly hampers their ability to access services;
- Poor or inadequate coordination of regional and national and international partnerships;
- Weak monitoring and evaluation (M&E) systems and cumbersome M&E framework for the Abuja Declaration on HIV and AIDS and TB and ORID;
- Conflicts that result in mass displacement, violence, loss of livelihood and property as well as major breakdowns in essential services.
- Other cross-cutting issues such as ensuring good nutrition and food security, and internal and inter-country migration for reasons other than conflicts;
- Policy planning and programming for addressing health in national development frameworks by most countries which is reflected by inadequate health system development, low coverage and access to services for the three diseases;
- An increasing burden of disease and other development challenges

IV. Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services by 2010

Rededication by African Heads of State and Government

8. **WE STILL CONSIDER** AIDS, Tuberculosis and Malaria as a State of Emergency in our continent. They are major threats to our national and continental socioeconomic development, peace and security. We reaffirm the commitments contained in the 2000 and 2001 Abuja Declaration and Plans of Action, the MDGs and subsequent commitments;

9. After reviewing the progress made to date, the challenges confronted by individual and Member States, acknowledging progress made by member-states and the contributions of civil society and the international community, and bearing in mind that HIV, TB and Malaria are preventable and treatable while malaria and TB are curable, **WE RESOLVE TO** intensify the fight against HIV and AIDS, TB and malaria and to achieve the targets adopted by the Summit and other internationally agreed goals on health.

10. **WE THEREFORE**, individually and collectively rededicate ourselves and our countries to the following:

Leadership at National, Regional and continental Levels

◊ To intensify our practical leadership role at national, regional, and continental levels to mobilize society as a whole to fight HIV and AIDS, TB, and Malaria more effectively

Resource Mobilization

◊ To mobilize local resources for sustainable and predictable financing, including the implementation of the Abuja Declaration Call for 15% of the National Budget to health and strengthen our collaboration with national and international partners to mobilize adequate financial resources to fight the epidemics; and ensure that financial resources mobilized to fight all the three epidemics can actually be spent by the removal of the medium- term expenditure ceilings on public spending imposed on African countries by the International Financing Institutions.

◊ To negotiate for debt cancellation and the availability of grants at national and regional levels that would specifically be targeted at financing prevention, treatment, care and support of the three diseases.

◊ To undertake collective advocacy with multi-lateral and bilateral donors to end all conditionalities except normal fiduciary requirements;

Protection of Human Rights

◊ To continue promoting an enabling policy, legal and social environment that promotes human rights particularly for women, youth and children and ensure the protection of people infected and affected by HIV and AIDS, TB and Malaria and to reduce vulnerability and marginalization including conflict-affected and displaced persons, refugees and returnees;

◊ Adapting national legislation to take cognizance of HIV and AIDS and TB issues specifically discrimination and stigmatization and encourage Member States to ratify relevant International Conventions such as the Convention on Discrimination and Employment.

◊ To enact or repeal laws and policies related to gender and human rights in order to align them with AU frameworks including the Solemn Declaration on Gender Equality in Africa and the AU Protocol on Women.

Poverty Reduction, Health and Development

◊ To ensure the integration of HIV and AIDS, TB and Malaria programmes into Poverty Reduction Strategies and Programmes and country programmes; and thus ensure access to adequate nutrition and food security by pursuing the realization of an integrated African food production, storage and

distribution plan and other social protection measures including adequate social security schemes to address sustainability of treatment as well as treatment, care and support; ensuring community involvement and participation.

Strengthening Health Systems

- ◊ To strengthen health systems and building on existing structures (infrastructure, human resource, financing, supplies etc.) for scaling up and accelerating Universal Access to prevention, treatment, care and support for HIV and AIDS, TB and Malaria;
- ◊ To strengthen data management and surveillance;
- ◊ To meet WHO standards for doctors and nurses

Prevention, Treatment, Care and Support

- ◊ To invest heavily in evidence-based prevention as the most cost-effective intervention with focus on young people, women, girls and other vulnerable groups.
- ◊ To ensure access to a comprehensive package of prevention interventions for the prevention of primary and secondary infections with HIV and AIDS, and sexually transmitted infections (STIs) (including post-exposure prophylaxis following sexual violence), TB and malaria, reduction of vulnerability to HIV and AIDS, TB and malaria;
- ◊ To ensure the promotion and integration of access to prevention treatment, care and support in primary health care services, and in education institutions;
- ◊ To improve information, education and communication;
- ◊ To disseminate, correct, reader-friendly information on prevention, treatment, care and support on HIV and AIDS, malaria and tuberculosis
- ◊ To ensure universal access to male and female condoms for all sexually active persons.
- ◊ To integrate HIV and AIDS issues into ongoing immunization programmes and sexual and reproductive health programmes, and conversely sexually and reproductive health issues into HIV and AIDS programmes;
- ◊ Awaken traditional values on abstinence but continually increase condom use.

Access to Affordable Medicines and Technologies

- ◊ To enact and utilize appropriate legislation and international trade regulations and flexibilities, to ensure the availability of medicines and commodities at affordable prices as well as technologies for the treatment, care and prevention of HIV and AIDS, TB and malaria including vaccines, medicines and Anti-retrovirus Therapy (ART).
- ◊ To promote regional bulk purchase and local production of generic medicines and other commodities;
- ◊ Support work on regional local production of generic ARV drugs.

Research and Development

- ◊ To promote and support research and development of microbicides, vaccines, diagnostics and treatment for HIV and AIDS, TB and malaria, including traditional medicine;
- ◊ Monitoring of drug resistance in the treatment of HIV and AIDS, Tuberculosis and Malaria;
- ◊ Demographic and Health Surveys every five years;
- ◊ Research ethics including for HIV and AIDS;
- ◊ Conduct regular incidence surveys on HIV.

Implementation

- ◊ Enhance and support implementation of comprehensive strategic programmes at country and regional levels against HIV and AIDS, TB and malaria;
- ◊ Prevention of multi-drug resistant TB;
- ◊ Accelerate Malaria control programmes with a goal to eliminate malaria using all effective strategies such as indoor residual spraying, insecticide treated bed nets, Artemisenin Combination Therapy (ACTs) and Intermittent Presumptive Therapy (IPT);
- ◊ Implement the Three-Ones (one executing authority, one Plan of Action and one Monitoring and Evaluation Plan (for HIV and AIDS, Tuberculosis and Malaria).

Partnerships

- ◊ To further develop and support comprehensive frameworks and mechanisms of well-coordinated partnerships, particularly public, private, civil society, regional and international including donors, to promote universal access to prevention, treatment, care and support for HIV and AIDS, TB and Malaria;

Monitoring, Evaluation and Reporting

- ◊ To strengthen in collaboration with all relevant stakeholders particularly Civil Society partners affected by the three diseases, planning, monitoring and evaluation and generation of information for quality, sustainability and accountability of programmes, and for advocacy;
- ◊ To ensure networking and sharing of best practices and submit progress reports regularly to appropriate Organs of the AU;
- ◊ To undertake to strengthen implementation of NEPAD Health Strategy to fight poverty and under-development.

11. **WE REQUEST** Ministries of Health, National AIDS Councils or equivalent and Ministries of Finance and Economic Planning to coordinate the realization of a multi-sectoral and integrated approach to disease control, in collaboration with other Sectors, including the involvement of the community in the planning and implementation.

12. **FINALLY, WE COMMIT OURSELVES** to the implementation of the recommendations and action points enshrined in the in "Brazzaville Commitment on Scaling up Universal Access to HIV and AIDS Prevention, Treatment, Care and Support"; and to extend these to TB, Malaria and other prevailing diseases.

Call to Civil Society and the Private Sector

13. Recognizing and commending the progress made by Member States, the efforts and achievements of the Civil Society and Private Sector;

    WE CALL UPON the respective national, regional, continental and international partners including NGOs, and civil society, (including, youth, women, people with disability, religious organizations, trade unions, employers organizations, traditional health practitioners, traditional rulers, people living with HIV and AIDS and other Groups) to:

    - Intensify their efforts more than ever before for the fight against HIV and AIDS, Tuberculosis and malaria.
    - In this connection, they should develop and implement well- coordinated and harmonized frameworks which will provide concrete results.
    - Support the mobilization of additional resources for prevention, care and support and treatment-related activities;
    - Facilitate through enhancing their monitoring role, the operationalization of commitments at all levels.

Call to Regional Economic Communities (RECs)

14. **WE CALL UPON** Regional Economic Communities (RECs) and other Regional Groupings to:

- Intensify the implementation of inter-country and cross-border health initiatives
- Coordinate inter-country efforts and provide support to Member States
- Mobilize resources for HIV and AIDS, Tuberculosis and Malaria programmes in their respective regions.
- Report back to us through the AU Commission on the progress made in the implementation of this Call.
- accelerate the prevention and control of malaria, learning from best practices on the continent with the aim of eliminating malaria in Africa using all available control strategies including indoor residual spraying, use of insecticide-treated nets, ACT combination therapy and intermittent preventive therapy

Mandate the AU Commission and AU Organs

15. **WE REQUEST** the AU Commission and the AU Organs and Programmes to:

- Effectively implement the AU Commission HIV and AIDS Strategic Plan and AWA Strategic Framework 2005-2007;
- Promote regional integration and collaboration in the areas of Disease Control;
- Ensure that HIV and AIDS Tuberculosis and Malaria are catered for in the NEPAD Health Strategy;
- Ensure that malaria prevention and control is accelerated with the goal to eliminate malaria in Africa by 2010 using all available control strategies
- Coordinate in broad partnership with Civil Society and the private sector, the effective implementation of the Abuja Call and report annually to the AU Assembly.

16. **WE FURTHER REQUEST** the Pan-African Parliament Committee on Health, Labour and Social Affairs to provide oversight and accountability for the implementation of the commitments made towards universal access and the implementation of the Abuja Declaration.

17. **WE ALSO REQUEST** the Peace and Security Council (PSC), and Economic, Social and Cultural Council (ECOSOCC) of the AU, the NEPAD Programme, other AU Organs and National Parliamentarians to play an effective advocacy role and provide necessary support to Member States in the fight against these diseases.

Call to the International Community

18. **WE SOLEMNLY CALL UPON:**

◊ Development partners to continue to work closely with Member Sates, the AU Commission and the RECs to ensure long term, predictable financing commensurate with the burden of these diseases and to provide financial and technical support to our efforts in a coordinated, efficient and country and AU led manner.

◊ The UN Agencies and other Development Partners to provide technical, material and financial support and to facilitate follow up on the implementation of this Call.

◊ The Development partners to mobilize additional and adequate resources on long-term basis for the fight against HIV and AIDS, Tuberculosis and Malaria;

◊ The international community to reaffirm its commitment to strengthening the partnership with Africa for the fight against HIV and AIDS, Tuberculosis and malaria, other major causes of morbidity and mortality.

Follow up and Reporting

19. Recognizing and commending the lead role played by the Federal Government of Nigeria for the Abuja 2000, 2001 and 2006 commitments; **WE MANDATE** H.E President Olusegun Obasanjo, Head of State of the Federal Republic of Nigeria to report the outcome of this Special Summit on HIV and AIDS, TB and Malaria to the next Ordinary AU Assembly, and to continue to lead in the follow up on implementation of the Abuja Call.

20. Finally, **WE REQUEST** consultative reviews at two years (2008) and five years (2010) on the status of implementation of the 2006 Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services by 2010; and of the MDGs.

B13 Sexual and Reproductive Health and Rights: Continental Policy Framework (2006)

Foreword

This Sexual and Reproductive Health and Rights Continental Policy Framework was developed by in response to the call for the reduction of maternal and infant morbidity and mortality in the African continent. It was developed by the African Union Commission in collaboration with the United Nations Population Fund, the African Regional Office of the International Planned Parenthood Federation, and other development partners.

It started with the conducting of studies in the six Regions of the African Union and consideration of the issues that were identified at the review meetings at Expert and Ministerial levels in each of these Regions as the major factors contributing to the unnecessary deaths of women and children on the continent.

The Continental Policy Framework calls for mainstreaming of Sexual and Reproductive Health and Rights in primary health care so as to accelerate the achievement of health-related MDGs. It addresses the commonest causes of maternal and newborn child morbidity and mortality, and identifies the implementation of the Roadmap for the Acceleration of the Reduction of Maternal and Newborn Child morbidity and mortality as the strategy for improving reproductive health.

The Policy Framework also calls for strengthening of the health sector component in Poverty Reduction Strategy Papers, and Sexual and Reproductive Health and Rights in particular; by implementing the Abuja recommendation of the 2001 Summit of Heads of State and Government to increase resources to health sector thereby improve access to services. By extension the Framework calls for mainstreaming gender issues in socio-economic development programmes, by facilitating improved women's health thereby increasing their participation in national economic development. It also calls for the development of SRH Commodity Security by including SRH commodities in the Essential Drug Lists and thereby ensures that women do not die needlessly because of lack of basic medicines.

The Continental Policy Framework on Sexual and Reproductive Health and Rights was adopted by the African Ministers of Health at the 2nd African Union Conference of Health Ministers held in Gaborone, Botswana in October 2005 and endorsed by the Summit of the African Heads of State and Government in Khartoum, Sudan in January 2006.

It is our sincere hope that the effective implementation of this Policy Framework at regional and national levels will greatly reduce the high rate of maternal and child mortality and ensure that there is a better life for all.

Adv BIENCE GAWANAS
Commissioner of Social Affairs African Union

Acknowledgement

The African Union Commission wishes to express its appreciation to the UNFPA, the IPPF Africa Regional Office and other development partners for their technical and financial assistance in the elaboration of this Framework. The AU Commission further wishes to acknowledge the support by UNFPA in the printing and publishing of this booklet containing the Framework which will assist greatly in its wider dissemination.

Member States have also played an important role in the process through their valuable contribution in the Regional Workshops conducted to collect information, which eventually culminated, into this framework. The African Union Commission therefore wishes to acknowledge and appreciate the role they played and for the effective collaboration in making the elaboration of this Framework possible.

Introduction

The International Conference on Population and Development (ICPD), held in Cairo in September 1994 represented a major shift in international thinking about the relationship between population and development. The document, which was agreed by 179 governments, set a number of objectives to be implemented by 2015.

The experiences gained since the 1974 Bucharest Conference had shown the necessity to move from the narrow confines of demographic targets through contraceptive services to the wider area of sexual and reproductive health and rights, taking into serious account issues such as human rights, gender equality and informed choice.

Although some progress has been made in implementing the ICPD/ Programme of Action (PoA) as documented at various meetings (Cairo Plus 5, held in 1999 and ICPD at Ten, held in 2004), many government and international organizations' officials doubt whether the majority of developing countries would be able to achieve the Cairo objectives by 2015.

A number of constrains prevent many countries, especially in Africa, from attaining the ICPD/PoA and MDGs. Shortage of funds both from national budgets and from donor countries, the absence of an enabling legislative environment, administrative rigidity which prevents integration of reproductive health services and the lack of human and technical resources- all contribute to the slow progress in achieving the internationally agreed objectives.

Aware of the need to accelerate the implementation of the ICPD/PoA, the African Union (AU) and the International Planned Parenthood Federation, Africa Regional Office (IPPFARO), in collaboration with the United Nations Population Fund (UNFPA), sponsored sub-regional studies on the situation of reproductive health in Africa ten years after the Cairo Conference and joined their efforts to organize a number of sub-Regional consultations to discuss and recommend ways to accelerate the promotion of sexual and reproductive health and rights (SRHR) and develop a comprehensive Policy Framework for Sexual and Reproductive Health and Rights at the African Union Commission. The Department of Social Affairs has played a leading role in driving this process forward and taken an active part in many of the sub-regional meetings of experts and in ministerial meetings.

Accordingly to the six sub-regional meetings were held in Yaoundé (August 2004), Bamako (November 2004), Windhoek (February 2005), Abuja (June 2005) and Tunis (August 2005) and in Nairobi (September 2005). The main purpose of theses meetings was to review the issues relating to the status of reproductive health and rights in Africa with emphasis on sub-regional realities and to make recommendations which will guide the preparation of a Continental Policy Framework on SRHR, which will in turn be passed to appropriate organs of the Africa Union for consideration.

Therefore, the present document is based on the deliberations of the sub- regional meetings mentioned above. It reviews the position of Africa with regard to the international consensus regarding SRHR, the progress achieved so far in implementing the ICPD/PoA, the gaps and opportunities in the areas of SRHR issues and the challenges facing Africa. This review is followed by a draft Declaration and draft Plan of Action to guide policy formulation and/or actions at the level of respective member states. The draft Action emphasizes nine areas having a strategic Focus, Priority Actions and a Check List to help in monitoring progress.

Africa and the International Consensus on Sexual and Reproductive Health and Rights

After a number of decades during which the international community looked at the population issue from purely a demographic perspective, the International Conference on Population and Development (ICPD), held in Cairo in September 1994, represented a paradigm shift in dealing with the population and development issues facing humanity at the end of the second millennium. However, despite the pre-ICPD focus on demographic targets, many voices rose in developing countries in general and in Africa in particular to advocate the view that population and health problems go beyond the perspective of "human numbers". So, in a sense, ICPD and its Programme of Action (PoA) represented a victory for such voices.

The ICPD/PoA, shifted the attention of governments, inter-government agencies and the civil society from demographic targets and couple-year protection to issues that were considered important for the achievement of a balanced development. Such issues relate among others to reproductive and sexual health, reproductive rights, women's empowerment and youth reproductive health. In addition, the ICPD/PoA called upon governments and donor agencies to adopt an integrated approach to deal with these issues rather than continuing with the old practice of fragmented actions through uncoordinated projects.

This draft Policy Framework is to provide a model for the harmonization of national, sub-regional and continental efforts to promote "reproductive health" and "reproductive rights" as one of priority flagship programmes of the African Union Commission. Sexual and Reproductive Health and Rights are here defined as they were stated in the ICPD/ PoA.

Reproductive Health

> *"Reproductive health is a state of complete physical, mental and social well- being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".*

In line with the above definition of reproductive health, reproductive health care is defined as "The constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." (ICPD/ PoA. Chapter VII. sect. A. Paragraph 7.2)

Reproductive Rights

> *"Bearing in mind the definition of reproductive health above, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls, and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed"(Chapter .VII sect. A, Paragraph. 7.3).*

This holistic approach was reinforced through the deliberations and recommendations of the Fourth World Conference on Women (FWCW), held in Beijing in September 1995, which put emphasis on gender equity and equality and on reproductive rights and a rights-based approach to reproductive health.

The follow-up conferences: Cairo + 5 (1999), Cairo at Ten (2004) and Beijing + 5 (2000) while they reinforced the messages of ICPD and FWCW, they also drew the attention of stakeholders (governments,

UN Agencies, regional institutions and NGOs) that based on the achievements so far, there is a risk of not implementing the objectives of these conferences if reproductive health is not fully integrated in the various health strategies at various levels.

In order to consolidate the recommendations of the major UN conferences held in the 1990s, the Heads of State held the Millennium Summit in September 2000 and adopted the Millennium Declaration which was agreed by 189 countries and which led to the adoption by the UN of the Millennium Development Goals (MDGs) to be achieved by 2015.

The eight MDGs are:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health (Reduce maternal mortality)
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development.

Of the eight MDGs, the three highlighted above - improve maternal health, reduce child mortality and combat HIV/AIDS, Malaria and other diseases are directly linked to reproductive health, while the other four are closely related to health, including reproductive health.

However, the MDGs do not explicitly articulate the most important objective of the ICPD/PoA - universal access to reproductive health services by 2015. This led the UN Secretary General Kofi Annan to state at the Fifth Asian and Pacific Population Conference in Bangkok in December 2002 that "*The Millennium Development Goals, particularly the eradication of poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed*". This "lacuna" has been addressed by setting up a Reproductive Health Task Force advising the UN Secretary General with regard to the implementation of the MDGs.

In order to create a "mechanism" for implementing the MDGs, the UN General Assembly adopted at its Fifty-sixth Session in September 2001 a "Road Map towards the implementation of the United Nations Millennium Declaration". The Road Map contains both targets and indicators for each MDG and these will be partly used in developing the NEPAD's Implementation Plan.

Africa and ICPD: 10 Years After

In 2003 the UN Economic Commission for Africa (ECA) and the United Nations Population Fund (UNFPA) conducted two ICPD at Ten surveys to assess the degree of implementation of the ICPD/PoA by the African Governments. The surveys showed that most African countries have given priority to the implementation of comprehensive reproductive health programmes and that some progress has been achieved in several areas relating to the Cairo Programme of Action and to the MDGs.

However, a number of operational constraints have prevented the implementation of the ICPD/PoA. In a number of countries, the vertical organizational health systems, often inherited from the colonial era, constitute a major obstacle for a more integrated approach.

On the policy level, a number of countries have integrated population issues into the development, implementation and evaluation of various development programmes and in some cases in the Poverty Reduction Strategy Papers (PRSPs). In addition, a number of governments have integrated reproductive health services into their health care services. In the area of reducing maternal and child mortality, many governments introduced emergency obstetric care, assisted delivery, extension of immunization campaigns and programmes dealing with the complications resulting from unsafe abortion.

In the area of combating HIV/AIDS, following ICPD, the majority of African governments increased commitment to deal with this epidemic. This has been demonstrated through the fact that close to half of the African countries have established coordinating bodies, many of them at the level of the Presidents' office.

However, despite such a progress, only a small number of African countries have succeeded in the implementation of the ICPD objectives. A report presented at the ICPD at Ten meeting held in London in 2004 concluded that eight countries only made significant progress, seven made moderate progress and five made little or no progress.

Sexual and Reproductive Health and Rights in Africa: Issues and Challenges

The six Sub-Regional meetings held so far identified issues and challenges relating to the following areas of reproductive health:

Issues

Demographic Situation

Although there are some sub-regional variations, the continent is characterized by high birth and death rates. On average, there are 38 births and 14 deaths per 1,000 people respectively leading to a rate of natural increase of 2.4%. The number of births per 1,000 people ranges from a low of 16 in Mauritius to 51 in Malawi while the number of deaths per 1,000 people ranges from 4 in Algeria and Libya to 29 in Sierra Leone. The highest natural rate of increase is registered in Niger and Comoros (3.5%) while the lowest is registered in Botswana (0.1%). (Population Reference Bureau: 2004 World population Data Sheet).

The sub-regional meetings discussed the issue of high Total Fertility Rates (TFR), which is estimated at 5.1 with the lowest rate in Mauritius (1.9) and the highest in Niger (8). As far as the total population in Africa is concerned, it is now estimated at 885 million and is expected to reach 1,323 million in 2025 and 1,941 million in 2050. The projected population change between 2004 and 2050 is 119% in Africa in general and 132% in Sub-Saharan Africa.

Maternal Mortality and Morbidity

All the Sub-Regional meetings raised the issue of the high mortality rate that ravages a number of African countries. While the average is around 400 maternal deaths per 100,000 live births, this number is above 900 in certain countries.

The lifetime risk of death from maternal causes is 1 in 16 in Sub-Saharan Africa. WHO estimates that the major causes of maternal mortality are: bleeding after delivery, followed by infection, unsafe abortion, high blood pressure and obstructed labour. One of the contributing factors to maternal mortality in Africa is the lack of skilled personnel during delivery. While skilled health workers attended 33% of deliveries in 1985, the percentage increased to 41% by 2000 but remains far short on the demand for skilled attendants for prenatal, childbirth and postnatal care.

Infant And Child Mortality

In general, infant and child mortality rates have declined in many African countries, (infant mortality declined from 99 per 1,000 live births in the period 1990-95 to 88.5 in 2000-2004). The same trend has been witnessed with regard to child mortality from 163.6 in 1990-95 to 148.4 in 2000-2004. However, the region continues to have some of the highest mortality rates in the world. The average rate for infant mortality ranges between 16 and 177 per 1,000 live births (respectively in Mauritius and Sierra Leone) while the average is 89 (Africa) and 96 in Sub-Africa. As for under five mortality rates, it ranges from 52 per 1,000 live births among the richest fifth of the population of Ghana to 282 per 1,000 live births among the poorest fifth of the population of Niger.

It is estimated that 45 African countries have not met the goal of bringing child mortality rate to less than 70 death per 1,000 live births set for the year 2000.

Contraceptive Use

All the sub-regional studies reveal the phenomenon of low contraceptive prevalence in most countries. While the world average relating all methods (traditional and modern) is 59%, this average is 28% in Africa (21% in Sub- Saharan Africa) in terms of modern contraceptives. (Source: Population Reference Bureau: 2004 World population data sheet).

There are, however, some stark variations. The highest use of modern contraceptive is to be found in Mauritius (76%), Egypt (57%) and South Africa (55%) while the lowest is registered in Chad (2%) and DRC, Guinea, Guinea- Bissau and Rwanda (4%).

In general, Africa continues to have the world's lowest contraceptive prevalence rate. While the prevalence is low, the proportion of married women who need contraceptives but who are not using any methods is estimated to be 24% in sub-Saharan Africa and 18% in Northern Africa. However, this estimate is conservative as it deals only with married women.

Unsafe Abortion

All the sub-regional meetings reported high frequency of abortion. It was reported by the Central Africa meeting to reach 28% for the sub-region as a whole while the West Africa meeting estimated that abortion resulted in 13% of maternal death and as many as 40% in some countries such as Eritrea.

STDS And HIV/AIDS

All the sub-regional meetings draw attention to the unprecedented spread of HIV/AIDS. In the case of Central Africa, the prevalence rate ranges from 2% in Madagascar to 38% in Swaziland.

Despite the current political will and donors support for curative programmes, only 11% of those infected with AIDS in Africa have access to anti-retroviral therapy (as opposed to 62% in Latin America and 14% in Asia).

About twice as many young women as men are infected with HIV in sub-Saharan Africa. In 2001, it was estimated that 6% to 11% of young women were living with HIV/AIDS, compared 3% to 6% of young men.

Adolescent Reproductive Health

Adolescents and young people aged 15-19, who represent 20.3 % of the African population, are at risk of early and unwanted pregnancy leading to unsafe abortion, sexually transmitted diseases and dropping out of school.

In the majority of countries, young people lack relevant information on sexual and reproductive health and rights. The UN Population Division estimates that of the African girls who were sexually active by the age 20, 51% had initiated sexual activity before marriage. The corresponding proportion for males is 90%. As a result, the contribution to fertility of adolescents aged 15-19 is around 107 per 1,000 women 15-19 years old (ranging from 7 in Libya and Tunisia to 233 in Niger). In some sub-regions, the proportion of girls aged 15-19 with at least one child varies from 10% in the Congo to over 30% in the Cameroon.

Female Genital Mutilation (FGM)

Despite research revealing the harmful effects of this practice including physical pain, mental anguish and injuries and sometimes deaths during the procedure and during childbirth, there is a legal and legislative vacuum that needs to be addressed. The percentage of FGM ranges from 10% in the Democratic Republic of Congo to 89 % in Eritrea. It is also widely practiced in most ECOWAS and some African Arab countries. A frequency of 80 – 90% in common in these countries.

In 2003, the Afro-Arab Expert Consultation for the Prevention of Female Genital Mutilation issued the Cairo Declaration, which calls on all concerned Governments to adopt and implement appropriate laws to eradicate this "obsolete tradition not required by religion". Despite campaigns by some First

Ladies, efforts by The Inter-Africa Committee on Harmful Traditional Practices, and despite prohibition by some Governments, progress is painfully slow.

Sexual And Domestic Violence

While sexual and domestic violence is widespread in most African countries, the phenomenon is still poorly reported due to socio-cultural reasons and to the legal vacuum surrounding this issue.

Health Budget Allocation

Some sub-regional meetings decried the low budgetary allocations to health in general and to RH in particular. The inadequate budgetary allocation has its own impact on the promotion of health in general and on ensuring reproductive health in particular.

Challenges

In view of the various SRHR issues identified by the Sub-Regional consultations, the participants identified the following challenges that Africa has to face if the African countries are to successfully implement the ICPD Programme of Action as well as MDGs. These challenges relate to areas such as policy and legislation, infrastructures, services, human resource development and partnership.

Policy

While all African countries have subscribed to the ICPD/PoA andrenewed their commitment on the occasion of Cairo Plus 5 and Cairo at Ten, as well as in a number of regional instruments, especially those developed by the OUA and AU, many policies and laws fall far short of the expectations of all the stakeholders. One of the difficulties faced in the area of policy formulation is the absence of adequate human and technical capacity to monitor progress in the implementation of the ICPD objectives. This deficiency includes the areas of data collection and analysis and the absence of indicators and benchmarks and the quasi absence of SRH management information systems in many countries. It is therefore necessary to amend laws in order to match the commitments made, especially in the areas of SRHR, HIV/AIDS and adolescent and young people SRH. In addition, there is a need to build the capacity of health care providers for the successful implementation of these commitments.

Funding

Despite the commitments made by donors at the Cairo Conference, the level of Official Development Assistance (ODA) in general and the level of ODA devoted to health, the actual funding decreased between 1995 and 2001. It was only in 2002 that the decreasing trend of ODA has been checked and its amount returned to the pre-ICPD figure in 2003.

Infrastructures

Due to low budget allocations to health, in general and to reproductive health, in particular, the existing infrastructures, including facilities and equipment are not able to cope with the rising SRH demands, especially in remote and rural areas where the majority of the population lives.

Services

While the major ICPD /PoA components were agreed, their integration into the pre-existing services was not carried out in a systematic manner and this has rendered difficult the task of assessing progress in implementing the Cairo recommendations.

Human Resource Development

In the absence of adequate financial resources, many countries have failed to train staff in the additional areas of SRH which resulted from the Cairo agenda.

Partnership

Despite the positive discourse on partnership and cooperation, no systematic cooperation plans were put in place to exchange experiences and lessons learned and to set up a programme of South-South collaboration, be it in the field of training, contraceptive supplies or joint procurement.

OAU/AU's Response to Reproductive Health Challenges:

Gaps and Opportunities

The Constitutive Act of the African Union (AU), which entered into effect in May 2001, referred to health matters by stating in its Article 3(n) that the AU will work toward "the eradication of preventive diseases and the promotion of good health". In addition, Article 13(h) relating to the AU Institutions states that the Executive Council is responsible for the coordination and policy decision –making in education, culture, health and human resource development.

In order to tackle the issue of African development on amore solid basis, the African Heads of State adopted, in July 2001, the New Partnership for Africa's Development (NEPAD), which represents a strategic development framework for African countries in meeting the socio-economic challenges facing the continent. This Framework was ratified by the African Union Summit in July 2002.

However, the NEPAD Programme of Action did not sufficiently cover the other issues of sexual and reproductive health and rights despite the fact that almost all African countries subscribed to the recommendations of the ICPD and FWCW. The April 2003 meeting of the African Health Ministers held in Tripoli, Libya recognized this gap. The Ministers called for the inclusion of maternal and infant mortality reduction into the NEPAD health sector strategy document and drew the attention to the fact that the NEPAD Framework did not make adequate case for sexual and reproductive health and rights. It is the recognition of this gap that led the African Union in collaboration with the International Planned Parenthood Federation, Africa Regional Office (IPPFARO) and United Nations Fund for Population (UNFPA) to organize a number of sub-Regional consultations with the view to developing recommendations and Draft Policy Framework for reproductive health and rights to be considered by the competent authorities of the African Union.

As pointed out earlier, the objectives of the sub-Regional meetings are as follows:

- To make an inventory of the Sexual and Reproductive Health and Rights (SRH&R)–related implications of the various international conferences on population, gender and development;
- To define critical reproductive health challenges in Africa;
- To determine the place of SRH in the NEPAD Plan of Action;
- To recommend a comprehensive SRH component for incorporation into the NEPAD Framework;
- To advocate for the full institutionalization of SRH within the African
- Union structures.

Policy Statement

On the basis of the review of progress made by the African countries in implementing the objectives of the ICPD/PoA, of the current situation of reproductive health and in view of the continuing Sexual and Reproductive Health and Rights challenges facing Africa, the African Union Commission believes that it is time to act towards mainstreaming reproductive health programmes on the continent. This mainstreaming and harmonization of reproductive health issues into national, sub-Regional and continental development initiatives will surely speed up the process of implementing the ICPD/PoA and Millennium Development Goals (MDGs)

and will contribute generally to the alleviation of poverty in Africa since development is measured not in terms of quantitative growth in GDP but in terms of the quality of life enjoyed and the overall well-being of the population of a given country.

While all African countries have expressed concern over the worsening situation of SRHR in their respective countries, there is still a lot to be done to translate these commitments into action. Among others there is lack of harmonization, coordination and standards for monitoring and evaluation of efforts towards promoting sexual and reproductive health and rights on the continent. Moreover, there are also some legislative bottlenecks that need to be amended in order to facilitate actions in the RH programme. This policy framework is elaborated to assist member states fill this gap in the promotion of reproductive health and rights.

Due to the fact that policy formulation at the central level is only the beginning of socio-cultural change and that some of the socio-cultural values are deeply rooted in the mind of people, and in order to obtain the largest possible adherence to the new enabling legislation, it is imperative that all relevant institutions and representatives of the community participate in the discussions leading to this policy review and formulation. It is also important to sensitize authorities at the district and local levels to the need to implement the new policies and regulations.

However, all good legislation, regulations and programmes would remain alien to the community if they were not part of the policy-making and planning process and if messages are not communicated in their own African languages and dialects. In this regard, the implementing agencies of the Policy Framework should develop glossaries of various SRHR terms with translation into local languages in order to increase people's awareness about issues relating to their health.

Concerning the adoption, adaptation or integration of SRHR Policy Framework into the health programmes of the various African countries, it is imperative to put a special emphasis on a number of areas which are strategic in terms of their contribution to achieving the ICPD objectives and the MDGs and to providing an enabling environment for a healthy and decent life. These areas relate to core policy concerns, including maternal mortality, infant and child mortality, family planning services, unsafe abortion, STDs and HIV/AIDS, adolescent reproductive health, female genital mutilation and gender-based violence.

With regard to maternal mortality and morbidity, some progress has been achieved in many countries. However, in order to reduce maternal mortality by two-thirds by 2015, a systematic focus should be put on eliminating the major five women killers: post-partum haemorrhage, infection, unsafe abortion, high blood pressure and obstructed labour which account respectively for 25%, 15%, 13%, 12% and 8% of maternal mortality. A priority action is to increase the number of emergency obstetric services closer to the community. As the means are lacking to establish emergency obstetric facilities in all health structures, it is imperative that the public, private and NGO sectors collaborate with local communities to plan for emergency transportation to the nearest relevant health facility when required.

Africa still lags behind with regard to reducing infant and child morbidity and mortality. At a time when lives are ravaged by the HIV/AIDS epidemic, it is imperative to save the lives of infants and children under five. While the phenomenon of the under-five mortality is linked to a number of factors accounting for poverty, some priority actions can be taken in the short term: intensifying immunization of all infants under one year of age against measles and the generalized immunization of all children against other diseases.

Despite the efforts that governments and the civil society have exerted over the last forty years to expand family planning services, the contraceptive prevalence rate is still very low (average of 21%) in Africa. This is so despite the fact that the majority of African governments consider that the population growth in their countries is high and despite the fact the couples that would like to have access to contraceptives do not have access to family planning services. Indeed, an unmet family planning need is around 24% and the lack of access to services leads to unsafe sex, unwanted pregnancy and unsafe abortion, which often results in death. The supply of family planning methods should be one of the priorities of any minimum SRH package due to its impact on many other components of reproductive health. The successful experience of community-based services by NGOs should be replicated and scaled up and authorities across the African countries should facilitate the tasks of NGOs in this regard due to the cost effectiveness of NGO interventions.

The issue of abortion is certainly a sensitive one for a number of people. However, the solution is not to bury one's head in the sand and to hope the phenomenon will disappear. While programmes should aim at eliminating the reasons leading to abortion, it is important also to deal with the issue of unsafe abortion squarely. Policy makers and opinion leaders must encourage a healthy and unemotional debate about the issue

and about the ravages caused by unsafe abortion. Positive legislative change must be envisaged despite the ideological clouds surrounding this issue. In the final analysis, one has to recognize that unsafe abortion is the third cause of maternal death and ill-health. One cannot achieve the goal of reducing maternal mortality and morbidity without dealing with unsafe abortion.

The HIV/AIDS epidemic has hit Africa harder than any other continent. No family or community has been able to escape this modern plague. The success of some countries in dealing with this problem is an indication that it is possible to start tackling the issue. In this area more than any other, the exchange of experiences among African countries is of a primordial importance. This is one area where the new Policy Framework can be an important instrument to encourage such an exchange. In addition, a special effort is required by all African countries to expand the supply and use of anti-retroviral medicines.

Young people have been always regarded as the future of the continent. Yet, when it comes to their reproductive health a number of taboos blur the vision of society. Facts are strong-headed and they speak for themselves: 90% young men and 50% of young women have had sexual activities before they reach the age of twenty. However, neither families nor schools prepare them in terms of their sexual and reproductive health and rights. The result is that 20% of births are attributed to adolescents aged 15-19. Dealing with the issue of adolescent reproductive health is easy neither for families nor for schools. In fact, a number of African NGOs embarked on successful experiments relating to Youth Friendly Services where young people participated in the design and implementation of relevant SRHR programmes. This is one area where governments should encourage as well as provide meaningful support to young people's NGOs to promote health sexuality both in and out-of-school.

The experience of African and other developing countries since independence has shown that no success can be achieved without gender equality. And the same is even truer when it comes to SRHR. African women are exposed to poverty, ill health and illiteracy and are the victims of pregnancy- related morbidity and mortality and many of them lose their lives during delivery at the time there are giving life. It is essential to review all existing legislation and amend all provisions which discriminate against women or which restrict equality. In addition to suffering from the lack of gender equality, women throughout the continent are suffering in silence from gender-based violence. Domestic and sexual violence should not be tolerated and laws to punish the culprits should be enacted. Women should be empowered to decry domestic violence and young girls should be enabled to grow up with self- esteem.

Needless to say, African leaders, governments and civil society have been aware of the shortcomings in implementing the ICPD objectives. Among others, two factors have contributed to the lack of meaningful progress: lack of resources and the weight of bureaucracy.

With regard to resources, while donors promise to increase their support to reproductive health at the Cairo Conference, in actual fact, their contributions decreased during most of the decade following Cairo. The increase in Official Development Assistance (ODA) that began in 2002 is to be applauded although most donors are still far from reaching the 0.7% of GNP to ODA, which the UN General Assembly recommended in 1970. At a time when globalization, the decreasing prices of developing countries' commodities and the increasing oil prices are creating additional problems for most African economies. Africa calls upon its donors to increase support to African countries in order for them to be able to achieve the ICPD goals and the MDGs.

Internal additional resources should also be made available to health in general and SRHR in particular. The African Heads of State already pledged that 15% of the national budget be allocated to health. Now is the time to transform this pledge into a budgetary reality.

As for good governance, the war of turf between different sectors of the administration and the lack of cost effective management have resulted in maintaining vertical SRH programmes in place and not embarking on integrating their services. In order to give impetus to such an endeavour, it is important to establish a coordination mechanism at the top government level of each member state.

Annexes

Annex I: Declaration

RECOGNISING the critical linkages between population dynamics, poverty, productivity, health including sexual and reproductive health, human rights and gender and their resulting impact on sustainable development as articulated in the 1994 International Conference on Population and Development (ICPD) Programme of Action, the 1995 Beijing Platform for Action and the 2000 UN Millennium Declaration and noting that most of these agreements have not been satisfactorily implemented,

RECOGNISING that sexual and reproductive health is an important component in its own right of health, human rights and development programmes and that it is an integral part of the Millennium Development Goals (MDGs),

ACKNOWLEDGING the strong link between gender inequality, women's ill health, violence against women and the lack of access to reproductive health information and services and the need to overcome pervasive gender bias in bringing about more equitable and effective solutions to national development,

CONSIDERING the Convention on the Elimination of all Forms of Discrimination against Women (1979), the African Charter on Human and People's Rights (1981), the African Charter on the Rights and Welfare of the African Child (1990), the Dakar/Ngor Declaration on Population, Family and Sustainable Development (1992), the SADC Gender and Development Declaration (1997, 1998), the SADC Health Protocol (1999) and the Abuja, Maseru and Maputo Declarations (2001, 2003),

ACKNOWLEDGING that the New Partnership for Africa's Development (NEPAD) adopted by the African Union as a development strategy, constitutes a strong and shared commitment by all States to the urgent eradication of poverty and for the achievement of sustainable growth and development,

ENCOURAGED by the fact that the new Vision, Mission and Strategic Framework of the African Union has recognized the importance of sexual and reproductive health for the success of the African development agenda,

CONCERNED by the high rate of maternal mortality, the high prevalence of unsafe abortions, low contraceptive prevalence rate, the high HIV/AIDS prevalence rate,

CONSIDERING the African Union/WHO African Regional Office Roadmap to accelerate the reduction of maternal and infant mortality and morbidity and cognizant of our commitment in the Abuja Declaration of 2001 against Malaria, Tuberculosis and other related infectious diseases and the AU NEPAD Health strategy,

CONCERNED with the plight of adolescents and young adults who have limited access to SRH services although carrying the burden of sexually transmitted infections, including HIV and AIDS, sexual abuse and other life threatening challenges to their SRH&R,

RECOGNISING that programmes for young people are crucial to address their vulnerability to Sexually Transmitted Infections (STIs) and Human Immune-deficiency Virus (HIV) infections, unsafe abortions and unintended pregnancies and acknowledging the benefits of investing in young people's development and health, including their sexual and reproductive health,

ALARMED at the effects of the escalating pandemic of HIV/AIDS, recognizing that investment in sexual and reproductive health programmes and services are key points for entry for HIV prevention and aware of the need to scale up prevention of maternal to child transmission of HIV infection,

ALARMED at the increasing brain drain of trained skilled health personnel and the implication for the implementation of the various health strategies adopted and for the development targets we have set ourselves,

HAVING REVIEWED the SRH status in Africa and having considered the inadequate inclusion of SRH in the NEPAD Plan of Action as a whole, and in its health component in particular;

WE HEREBY REAFFIRM our strong and irrevocable commitment to work together towards the full enforcement of SHR into the AU NEPAD Health strategy and to take all the necessary key actions to speed up

the development of the relevant policies for its implementation in our countries including but not limited to the following:

- Work towards realising our commitment to allocate 15% of national budgets to health (Abuja Declaration, 2001);
- Scale up efforts to meet the Millennium Development Goals of reducing maternal and child mortality rates;
- Ensure that RH&R policies and actions follow a life-course approach that recognizes the continuum from birth through childhood, adolescence and adulthood;
- Ensure that the health needs of young girls, adolescents and women past reproductive age are not neglected;
- Involve adolescents in reproductive health programmes intended for them at all stages of development, implementation, monitoring and evaluation;
- Scale up efforts to meet the Millennium Development Goals of halting and beginning to reverse the spread of HIV and AIDS, malaria and tuberculosis by 2015;
- Increase the contraceptive prevalence rate by 30% by 2015;
- Address men both in terms of their own health needs and in terms of their shared responsibility as husbands, partners and fathers;
- Advocate for the inclusion of sexual and reproductive health and rights in all agreements entered into for socioeconomic development;
- Strengthen partnerships for improving SRH outcomes with communities, local government, youth networks, civil society, regional economic communities, member states, United Nations agencies and other development partners;
- Work with national stakeholders and regional and international partners to secure political, financial and material support for reproductive health projects and programmes;

Mainstream SRH&R, gender equity and youth empowerment initiatives within the structures of NEPAD and other relevant African institutions;

- Strengthen existing structures for promoting SRH&R, gender equity and youth empowerment within the African Union;
- Institute mechanisms for a harmonised, standardised database that enables better monitoring and evaluation of SRH&R policies and programmes across the sub-region;
- Support the exchange of South-to-South experience, expertise and best practice in the area of SRH&R;

WE ENDEAVOUR TO:

UNDERTAKE to harmonize existing policies into nationally relevant and specific 'road-maps' that address SRH issues in a coordinated manner with a view to facilitate mobilization of resources to ensure that the policies are underpinned by a gender analysis that is disaggregated by age and sex.

DEVELOP strong and equitable health systems to eliminate the current gaps in access to and use of reproductive health services, especially focusing on the needs of women and young people.

STRENGTHEN health systems to ensure universal access to basic health services including services to promote child and maternal health, support Sexual and Reproductive Health and control Tuberculosis and Malaria.

PROMOTE SRH&R policies, including policies to facilitate access to services for HIV and AIDS prevention, mitigation, treatment and care, family planning, maternal and newborn health and prevention of unsafe abortion among adults and young people in the sub-region.

COMMIT to ensuring a review of national laws so that they are gender and youth friendly and in line with relevant international agreements and AU protocols to ensure full realization of the sexual and reproductive health and rights of women and adolescents in order to ensure full gender equity for all our citizens.

CREATE an enabling environment for increased private and public investments and partnerships in the health system to adequately address human resource development, infrastructure and commodity supplies for effective delivery of health services.

STRENGTHEN coordination and partnership mechanisms with civil society including nongovernmental organizations, the broader community, religious organizations and the private sector covering all levels of administration (national, regional, district) in order to sustain development.

ENSURE the development and use of appropriate monitoring and evaluation frameworks including those related to the universal access to sexual reproductive health that measure progress towards the achievement of internationally agreed health development goals in order to determine cost- effective programmes and achieve better health and nutritional outcomes.

Annex II: Policy Framework[1]

1. Sexual and Reproductive Health Legislation into Primary Health Care

Considering the inadequacy of existing sexual and reproductive health and legislative frameworks member states should strengthen the existing laws, to adopt new sexual and reproductive laws taking into account African specificities and a better application of laws.

2. Integration of Sexual and Reproductive Health Services

In view of the acuteness of sexual and reproductive health issues, including very high maternal and infant mortality and unsafe abortion rates, African countries need to integrate sexual and reproductive health services in the minimum activity package at all levels of the health pyramid, with particular emphasis on family planning and emergency obstetric and infant care.

3. SRH Communication

It is important to note that language is a key and indispensable vehicle for effective and efficient communication, mainly in the fight against and prevention of diseases. In this regard, it is necessary to develop appropriate communication strategies sensitive to age, gender, religion and culture in all its manifestations. It is also essential to strengthen communication and advocacy systems, to mainstream local languages in behaviour change communication (BCC) strategies and programmes and to enable SRH programmes to have access to public mass media.

4. Budgeting of SRH Activities

Considering the importance of SRH for the well-being of people and families and its impact on development and poverty alleviation, countries should fulfil their commitment of allocating at least 15% of the budget for the health sector and to provide SRH programmes with adequate resources.

5. Mainstreaming Gender in Development Programmes

It is an established fact that there exists persistent disparities between men and women in Africa and their bearing on the use of services and access to sexual and reproductive health information is immense. It is therefore imperative to always work towards mainstreaming gender in all development programmes of respective member states

6. Youth Sexual and Reproductive Health

Given the persistence of adolescent and youth sexual and reproductive health problems and their harmful implications, it is essential to strengthen quality youth-friendly services and their access to information likely to

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1 Guidelines relating to the components of this Policy Framework are to be found in Appendix III, the operational plan.

meet their specific needs as well as to adopt enabling legislations for their development with emphasis on rural youth.

7. Mid-life concerns of both men and women

In the spirit of poverty reduction a continuum of care should be available to promote healthful living for both men and women. The objective is to promote healthy active living in old age thereby facilitate productivity and reduce reproductive health morbidity in both men and women by responding to concerns about menopause, andropause, sexual dysfunction and cancers involving the reproductive systems.

8. The Fight against HIV/AIDS Pandemic

The pervasive prevalence and rapid spread of the HIV/AIDS pandemic in Africa as well as the harmful bearing of the pandemic on Africa's development is felt by all sections of African society. Though previous efforts in curving the spread of the pandemic and alleviating its negative consequences are encouraging, a lot needs to be done to register success in meeting the MDGs and also implementing commitments by African leaders. In this regard, member states should develop affordable preventive and curative services including counselling, voluntary testing, mother-to-child HIV transmission, prevention services and access to treatment for infected people, especially for the most vulnerable groups of society: women, children, the elderly and persons living with disabilities. Finally, they should sensitize those who have not yet been infected to the danger of risky behaviour.

In view of the AUC's commitment towards promoting health in general and reproductive health in particular, as reflected in its Vision, Mission and strategic Framework, it is imperative to build and strengthen the Commission's capacity for effective coordination, advocacy, monitoring and evaluation of sexual and reproductive health programmes and action in Africa.

9. Strengthening of Sexual and Reproductive Health Programme of the AU

The importance of partnership has been underlined in a number of regional and international fora including the ICPD, MDGs and others. Africa has gained a considerable benefit from working hand-in-gloves with partners and will continue to do so since the challenges faced by the continent are too huge to be tackled single-handedly. More importantly the magnitude of unmet sexual and reproductive health need is very large and there is a great need to involve international partners, civil society organizations, the private sector and local communities in the resolution of sexual and reproductive health problems. It is therefore important to continue to build strong partnerships with all these bodies in order to ensure adequate funding of SRH services in Africa.

10. Establishment of an African Maternal and Infant Mortality Advocacy Day

Considering the very high maternal and infant morbidity and mortality rates and poor contraceptive prevalence rates in the region, we resolve to establish an African Maternal and Infant Mortality Advocacy Day.

11. Establishment of an African Adolescent and Youth Health Day

Africa is a youthful continent. Young people, however, represent the majority of the victims of SRH problems. Promoting adolescent and youth SRH is the cornerstone of sustainable development process. It is therefore necessary to establish an African brainstorming and orientation day on youth and adolescent health (Resolution of the 26th African Health Ministers Meeting in April 2003, Tripoli) as well as to establish a "Youth" Unit within the African Union and sub-regional organizations.

Annex III. Operational Plan

The following Operational Plan has been developed taking into account the review of the SRHR challenges, the draft Declaration and the draft Resolutions. The plan focuses on 10 strategic areas:

1. Increasing resources to SRHR programmes,
2. Translating ICPD commitments into national legislation,
3. Reducing maternal mortality,
4. Reducing infant and child mortality,
5. Young people's SRHR,
6. Combat HIV/AIDS,
7. Expand contraceptive use,
8. Reduce levels of unsafe abortion,
9. Female genital mutilation
10. Gender-based violence.

For each strategic area, a number of priority actions are proposed. This list is not exhaustive and can be enriched through the addition of successful actions, which have been launched throughout Africa.

Finally, selected checklists for monitoring progress are proposed. Some of these relate to internationally recognized indicators. Additional indicators may be added as per the specific conditions of every country.

Operational Plan Matrix

Strategic Focus: Increase Resources for Sexual and Reproductive Health and Rights

Major Issues:

- Low budget allocation to health in general and to Sexual and Reproductive Health and Rights, in particular.
- Many sub-Regional consultations recommended that the health allocations be increased by 15% and that allocations to SRHR are also increased. However, such an increase should not lead to vertical programmes.
- Donor countries have not fulfilled their pledge to bring their support to development to the level of 0.7% of their GNP

Strategic Focus	Priority actions	Check list for monitoring progress
1. Increase resources for Sexual and Reproductive Health and Rights	• Increase national health budget by 15% • Prioritise SRH in PRSPs to increase funding for SRH and thereby accelerate the achievement of MDGs • Set up a National SRHR Fund • Rationalize MOH expenditures with view to allocating additional funding to SRHR • Launch cost sharing schemes where appropriate • Support Civil Society NGOs to provide services • Enlist donor support through transparent accounting • Collaborate with donors to fulfil their pledge to devote 7% of their GNP to development • Request donors to harmonize their reporting requirements • Increase partnerships with both national and international stakeholders to mobilise resources for SRH	• Percentage of state budget allocated to health. • Annual health expenditure per capita. • Collaboration agreements with the private and NGO centres. • Audit Accounts published. • Propose to donors a single reporting systems on the basis of their needs • Establishment of and access to properly equipped and staffed referral facilities • Proportion of health budget allocated to contraceptives

Strategic Focus: Translation of ICPD commitments into programmes and actions

- Despite the approval by most African countries of the ICPD/PoA and other SRHR instruments, there was no systematic translation of these agreements and commitments into national legislation.
- The Roadmap to accelerate reduction of maternal and newborn mortality agreed by most African countries still to be followed systematically.
- Internationally agreed SRHR protocols have not been integrated in relevant regulations and procedures.
- Weak human and technical capacity to systematically collect and analyze data with the view to developing informed policy and regulations.
- Weak monitoring and evaluation capacity.

Strategic Focus	Priority actions	Check list for monitoring progress

2. Translation of ICPD commitments into national policies and regulations.	• Harmonize national RH policies at the level of the African Union.
	• Mobilize political will to do so.
	• Review current legislation with the view to:
	  • Amend laws and regulations that are in contradiction with commitments of ICPD/PoA and MDGs.
	  • Sensitise relevant authorities at national, regional and district levels to the need to implement the revised and new legislation.
	• Building capacity in the collection, analysis, and management of information.
		• Existence of a blue print for a RH policy at the level of the continent.
		• Review process in place.
		• New legislation and regulations approved
		• Awareness seminars and training launched
		• Monitoring and evaluation procedures in place.

Strategic Focus: Integration of Sexual and Reproductive Health and Rights in Relevant Health Care Services.

- Despite the call of the ICPD/PoA to integrate SRHR in all aspects of the health system, the structures of the health system still follow a vertical approach towards SRHR interventions.
- In many countries, the support given in pronouncements to SRHR has not been transformed into meaningful actions in terms of integration and increased funding.
- Only a small number of countries have reported the implementation of the ICPD objectives. Only eight African countries have made significant progress in this regard.

Strategic Focus	Priority actions	Check list for monitoring progress
3. Integration of SRHR in relevant programmes and services	Assemble all relevant data and indicators with the view to obtaining a realistic picture of the SHRR situation at national, regional and district levels and to developing a baseline survey to be used in assessing progress.	• Integration of HIV/AIDS services in RH services • Mainstreaming of gender issues in SRH • Inclusion of SRH in PRSPs • SRHR database in place.

Strategic Focus: Reduce Maternal Mortality and Morbidity.

- Maternal mortality rates in Africa are still high: an average of 400 maternal deaths per 100,000 live births. The rate reaches 900 in some countries.
- The lifetime risk of death from maternal causes is 1 in 16 in Sub-Saharan Africa.
- Lack of skilled health personnel during delivery is a contributing factor.
- Unsafe abortion is also a contributing factor.
- Lack of facilities and adequate transportation to deal with obstetric emergencies.

Strategic Focus	Priority actions	Check list for monitoring progress
4. Reduce maternal morbidity and mortality	Increase access to maternal health care services through strengthening collaboration between public, private and NGO health actors. • Safe pregnancy and childbirth: Train and retain skilled attendance during pregnancy, childbirth and the immediate postpartum period. • National Confidential Enquiry into maternal Deaths (CEMD): Setting up a mortality surveillance system to collect information on maternal mortality. • Standard Management of Obstetric conditions: Adhere to relevant international standards, and clinical protocols[1]. • Health System: Set up emergency obstetric care standards and facilities • Referral System: Provide emergency transportation and/or mobilize the community to plan for securing transportation in the case of life-threatening complications. • Reproductive Health Commodity Security (RHCS) Initiative: Include RH commodities in the Essential Drugs List to improve quality of care and reduce RH morbidity and mortality. Operationalize Roadmap for the Reduction of Maternal and Newborn morbidity and Mortality.	• Proportion of women attending health care centres for pre-natal and post-natal care. • Reduction of unwanted pregnancies and unsafe abortions. • Implementation of best practices in the care of pregnant women. • Reduction in stillbirths and neonatal mortality • Maternal mortality rate. • Proportion of births attended by skilled health personnel. • Collaboration agreements in place. • Number of newly established emergency obstetric facilities. • Number of emergency transportation equipment. • Reduction in unmet need for Family Planning. • Contraceptive Prevalence Rate • HIV Prevalence among women aged 15 – 24 years. • Condom use among population aged 15-24 years. • Caesarean section rate • RHCS implemented

1 Refer to WHO Pregnancy, Childbirth, Newborn Care and Postnatal Care manual

Strategic Focus: Reduce the under-five mortality rate by two-thirds by 2015.

- Infant and child mortality rates still high in Africa.
- Infant mortality rates range between 16 and 177 with an average of 88.5 per 1,000 live births.
- Child mortality rates range between 52 and 282 with an average of 89 per 1,000 live births.
- 45 countries have not met the goal of less than 70 deaths per 1,000 live births set for the year 2000.

Strategic Focus	Priority actions	Checklist for monitoring progress
5. Reduce the under-five mortality rate by two-thirds by 2015.	• Safe pregnancy and childbirth: Provide skilled attendance during pregnancy, childbirth and the immediate postpartum period. • Infant feeding: Promote exclusive breastfeeding during the 1st 6 months, thereafter supplemented breast-feeding plus vitamin A for the next 2 years. Promote complementary foods and feeding for under-5 children. • Immunization: Increase EPI coverage to over 80%; including vaccination against measles and tetanus. • Diarrhoea: Promote routine use of ORS, plus therapeautic zinc supplements and antibiotics for dysentery. • Pneumonia and sepsis: Promote integrated management of childhood pneumonia and neonatal sepsis with appropriate antibiotics at community and health facility levels. • Malaria: Promote use of Insecticide Treated mosquito bed Nets (ITNs), prompt treatment of malaria, during pregnancy and childhood, as well as intermittent preventive antimalarial treatment for pregnant women. • Prevention and Care of HIV/AIDS: Integrate the prevention and management of HIV/AIDS in SRH, including provision of PMTCT services, and treatment of opportunistic infections in ANC and childbirth routine • Neonatal mortality rate: Provide quality neonatal care services in all maternity units to deal with neonatal emergencies.	• Neonatal mortality rates • Prevalence of underweight children. • Under-five mortality rate. • Infant mortality rate. • Proportion of 1-year old children who have had full immunisation against communicable diseases including measles. • Safe motherhood campaign in place. • Progress in treating pneumonia, malaria and HIV/AIDS.

1 Refer to WHO Pregnancy, Childbirth, Newborn Care and Postnatal Care manual

Strategic Focus	Priority actions	Check list for monitoring progress
6 . Young People's SRHR • Young people aged 15-19 represent more than 20% of the African Population. • They are at risk of unwanted pregnancy and unsafe abortion. • Contribution of young women aged 15-19 to fertility is 107 per 1,000 women.	Introduce and/or strengthen sexuality education in and out-of-school activities. • Empower young women to say NO. • Enable young people to have access to SRH information, counselling and services. • Develop and expand youth friendly services ensuring they are affordable and accessible to all youth including the rural. • Involvement of the male child/youth in SRHR issues and services Advocate for legislation against harmful traditional practices and ensure its enforcement. Care, treatment and services for young people	• Sexuality education manuals in place. • Ratio of unwanted pregnancy. • Number of youth friendly services in place. • Fertility rate among women aged 15-19 years (births /1000 in the age group) • Legislation against THPs in place • Proportion of reported incidences of THPs prosecuted by year.
7 . Combat HIV/ AIDS Major issues: • Prevalence ranges from 2 to 38%. • Only 11% of infested people have access to anti-retroviral medicines. • 6 to 11 young women and 3 to 6% young men are infected with HIV in Sub- Saharan Africa. • Care, treatment and services	• Accelerate the integration of HIV/ AIDS prevention and care in SRH services at all levels of the health system. • Pay a special attention to pregnant women with the view to reducing mother-to-child HIV transmission. • Strengthen NGO capacity in dealing with HIV/AIDS prevention and care. • Increase the distribution of condoms. • Combat the negative campaigns against the condom. • Sensitise the community about the consequences of unsafe sex and integrate PEP into FP programs. • Sensitise health personnel to deal with people living with HIV/AIDS in a non-judgemental way. • Integrate HIV/AIDS management in SRH services and vice-versa. • Management of opportunistic infections	• Number of health facilities where integration has been achieved. • HIV prevalence among women in reproductive age. • Percentage of people living with HIV/AIDS. • Percentage of people with HIV using anti-retroviral medicines. • Condom use rate of the contraceptive prevalence rate. • Condom shortage. • Number of children orphaned by HIV/AIDS and those made vulnerable to HIV infection

Strategic Focus	Priority actions	Check list for monitoring progress
8 . Increase family planning services and contraceptive use. Major issues: • Low contraceptive prevalence rates • High unmet need for FP estimated at 24%.	• Repeal laws and regulations that constrain the provision and expansion of family planning services. • Promote men's responsibility in family planning. • Provide as a wide a choice of family planning methods. • Develop and expand CBD programmes to increase access to services. • Include RH commodities in the Essential Medicines List to promote routine delivery.	• Legislative action to facilitate access to FP services, • Contraceptive supply logistics in place. • Distribution of male and female condoms.
9 . Reduce levels of unsafe abortion Major issues: • Frequency of up to 28% in parts of Africa. • Unsafe abortion leading in 13% - 40% of maternal death.	• Review and amend laws and regulations with the view to creating an enabling environment for preventing unsafe abortion. • Encourage a responsible debate to demystify taboos about abortion. • Train health professionals to deal with abortion in a non-judgmental manner. • Promote the expansion of post-abortion care and the use of menstrual vacuum aspiration (MVA) techniques as part of public health care package. • Provide safe abortion services to the fullest extent of national laws, and where appropriate provide legal framework for safe abortion services.	• Positive legislation in place. • Mortality rate resulting from unsafe abortion • Sensitisation programmes in place.
10. Gender equality <u>Major issues:</u> • Widespread inequality.Commitments to equality not matched by legislative change. • Lack of data on un-equality in various fields of activities.	Review current legislation with the view to: - Amending legislation and regulations not favourable to gender equality. - Introducing constitutional and legal provisions instituting gender equality. - Removing gender discrimination relating to education, employment and opportunities. Disaggregate gender data in order to identify gender disparities and address them.	• Review process in place. • Amended legislation adopted.

11. Gender-Based Violence (GBV). Major issues: • While the problem is widespread, no data is available. • Existence of legal vacuum regarding GBV. • Phenomenon tolerated in some socio-cultural settings.	• Integrate sensitisation about GBV into SRHR programmes and services. • Include in the training g curricula aspects relating to GBV such as detecting cases of abuse, counselling, treatment and referral). • Empower women to bring cases of GBV into the open and to the court system. • Encourage research on GBV. • Advocate for legal protection of GBV and its enforcement in full.	• Counselling services in place. • Guidelines dealing with GBV developed and distributed. • Legal profession sensitised. • Laws dealing with GBV in place.
12. Promote male involvement in RH programmes	• Make SRH clinics male friendly • Increase availability of SRH male services • Promote male participation at ANC registration • Advocate for employers to allow men to accompany spouses to SRH clinic • Initiate and strengthen SRH education programmes at community level targeting males	• Range of SRH male services available • Male knowledge of SRH issues (Community surveys) • No. males accessing SRH services
13. Mid-life concerns of both men and women	• Integration of management of menopause, andropause and sexual dysfunction in reproductive health services. • Mass media campaigns to provide information on symptoms of menopause, andropause, sexual dysfunction and their management. • Community mobilization and sensitisation for utilization of services. • Screening for cancers of the reproductive systems for both males and females	• Information, education and communication services on symptoms and signs of menopause and andropause in place • Counselling services for management of symptoms and signs of menopause and andropause in place • Clinical services for screening and definitive treatment in place.

Annex IV. *Decision on the Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa (Doc. EX.CL/225 (VIII)

The Executive Council:

TAKES NOTE of the Report of the 2nd session of the Conference of African Ministers of Health;

ACKNOWLEDGES the efforts of various UN agencies, International Organizations, other development partners, and NGOs in assisting Member States in improving maternal and newborn health.

RECOGNIZES the role of Sexual and Reproductive Health and Rights in the attainment of Millennium Development Goals (MDGs) and the International Conference on Population and Development (ICPD) goals.

ENDORSES the Continental Policy Framework for the Promotion of Sexual and Reproductive Health (SRH) and Rights in Africa ;

URGES Member States to allocate adequate resources for the improvement of maternal and newborn child health;

ALSO URGES Member States to mainstream SRH in their National Health Programmes by developing linkages between SRH, HIV/AIDS and other primary health care programmes and to draw inspiration from the Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa;

APPEALS to the International Community to continue to provide assistance towards the attainment of the objectives contained in the Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa;

REQUESTS the Commission, in collaboration with UNFPA, WHO, UNAIDS, UNICEF and IPPF, to advocate for the implementation of the Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa and submit a progress report every two (2) years.

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* Reservations were entered by the delegations of Djibouti, Egypt, Libya, Somalia and the Sudan.

B14 Maputo Plan of Action for the Operationalistion of the Continental Policy Framework for Sexual and Reproductive Health Rights, 2007–2010 (2006)

Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa

Special Session of the
African Union Conference of Ministers of Health,
Maputo, Mozambique, 18–22 September 2006
Sp/MIN/CAMH/5(I)

Introduction

1. Recognizing that African countries are not likely to achieve the Millennium Development Goals (MDGs) without significant improvements in the sexual and reproductive health of the people of Africa which is crucial in addressing MDG 1 on poverty reduction, the 2nd Ordinary Session of the Conference of African Ministers of Health, meeting in Gaborone, Botswana, in October 2005, adopted the Continental Policy Framework on Sexual and Reproductive Health and Rights which was endorsed by AU Heads of State in January 2006.
2. The Continental Policy Framework on Sexual and Reproductive Health and Rights addresses the reproductive health and rights challenges faced by Africa. It also calls for strengthening the health sector component by increasing resource allocation to health, in order to improve access to services. Mainstreaming gender issues into socio-economic development programmes and SRH commodity security are also addressed. Moreover, the AU Ministers of Health recommended that SRH should be among the highest six priorities of the health sector. In harmony with this ministerial recommendation the outcome of the World Summit held in New York in September 2005 reiterated the need to attain universal access to services, including access to reproductive health care services.
3. The AU Health Ministers further called for a Special Session to discuss the issues associated with improving sexual and reproductive health and the need to develop a concrete, costed Plan of Action (POA) for implementing the Framework. This decision was endorsed by the Summit of the Heads of State and Government in Khartoum, Sudan, in January 2006.
4. The Gaborone Declaration on the Roadmap towards Universal Access to prevention, treatment and care, among other things, underlines the need for the development of an integrated health care delivery system based on essential health package and the preparation of costed health development plan.
5. This Maputo Plan of Action for the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015. It is a short term plan for the period up to 2010 built on nine action areas: Integration of sexual and reproductive health (SRH) services into PHC, repositioning family planning, developing and promoting youth-friendly services, unsafe abortion, quality safe motherhood, resource mobilization, commodity security and monitoring and evaluation. The Plan is premised on SRH in its fullest context as defined at ICPD/PoA 1994 taking into account the life cycle approach. These elements of SRHR includes Adolescent Sexual and Reproductive Health (ASRH); Safe Motherhood and newborn care; Abortion Care[1]; Family planning; Prevention and Management of Sexually Transmitted Infections including HIV/AIDS; Prevention and Management of Infertility; Prevention and Management of Cancers of the Reproductive System; Addressing mid-life concerns of men and women; Health and Development; the Reduction of Gender-based Violence; Interpersonal Communication and Counselling; and Health education.

1 Abortion as specified in para. 8.25,of ICPD/PoA, includes prevention of abortion, management of the consequences of abortion and safe abortion, where abortion is not against the law.

6. The Plan learns from best practices and cost-effective interventions and responds to vulnerability in all its forms, from gender inequality, to rural living and the youth, to specific vulnerable groups such as displaced persons, migrants and refugees. It recognizes the importance of creating an enabling environment and of community and women's empowerment and the role of men.

7. While recognizing the need for an emphasis on SRH the Plan recognizes that this must be built into and on an effective health system and sufficient financial and human resources and that SRH interventions will be impeded until the crisis in these is resolved. It is therefore essential to mobilize domestic resources to support health programmes including complying with the Abuja 2001 commitment to increase allocation of resources to the health sector to at least 15% of the national budget.

8. Recognizing the unique circumstances of each country, the Plan is specifically broad and flexible to allow for adaptation at the country level. It provides a core set of actions, but neither limits countries, nor requires those that already have strategies to start afresh; rather it encourages all countries to review their plans against this action plan to identify gaps and areas for improvement. At the same time, the Plan, although focused on country action, blends in niche roles in the eight action areas for the African Union, Regional Economic Communities and continental and international partners. It also recognizes the role of civil society and the private sector within the framework of national programs. The Plan sets indicators for monitoring progress at these different levels.

9. In addition to the Sexual and Reproductive Health Continental Policy Framework the plan has also recognised and drawn on the Gaborone Declaration on the Roadmap Towards Universal Access to Prevention, Treatment and Care, the Brazzaville Commitment on Scaling Up Towards Universal Access and the Abuja Call for Accelerated Action Towards Universal Access to STI/HIV/AIDS, Tuberculosis and Malaria Services in Africa.

Rationale

10. Reproductive health conditions are devastating the African Continent: 25 million Africans infected with HIV, 12 million children orphaned due to deaths related to AIDS. 2 million deaths from AIDS each year, women increasingly affected with the feminization of the epidemic; 1 million maternal and newborn deaths annually, an African woman having a 1 in16 chance of dying while giving birth; high unmet need for family planning with rapid population growth often outstripping economic growth and the growth of basic social services (education and health), thus contributing to the vicious cycle of poverty and ill-health. Addressing poverty (MDG1) and addressing SRHR are mutually reinforcing.

11. Today, by any measure, less than one third of Africans have access to reproductive health (RH). Under current trends and with business as usual, Africa will not reach universal access to RH. The challenge is one of scale, to redouble our efforts and to accelerate programmes towards rapid increases in access and coverage towards the ultimate goal of universal access to RH by 2015.

12. The March 2006 Brazzaville Commitment on Scaling Up Towards Universal Access, among other things, recognizes:

    i. The importance of building long-term infrastructure and systems strengthening and capacity building at all levels of the health care system for an exceptional response to STI/HIV/AIDS.
    ii. That basic medicines and other commodities are a human right and should be available and accessible to all who need them in Africa.

13. The Abuja Call for accelerated action towards Universal Access to STI/HIV/AIDS, Tuberculosis and Malaria services in Africa also calls for the strengthening of health systems and the promotion of an integration of STI/HIV/AIDS services in Primary Health Care. This call was supported at the UN General Assembly Special Session on STI/HIV/AIDS in 2006.

14. All the above are in harmony with the consensus reached at ICPD a decade ago and reaffirm the urgency of doubling efforts to ensure attainment of universal access.

15. The Plan of Action takes into account the growing shortage of health care personnel and the threats surrounding the production and availability of generic medicines. Consequently, a whole section is devoted to capacity building and another to the issue of availability of commodities.

Overarching Goal

16. The ultimate goal of this Maputo Plan of Action is for African Governments, civil society, the private sector and all development partners to join forces and redouble efforts, so that together the effective implementation of the continental policy including universal access to sexual and reproductive health by 2015 in all countries in Africa can be achieved

17. Key strategies for operationalisation of the SRH Policy framework:

    i. Integrating STI/HIV/AIDS, and SRHR programmes and services, including reproductive cancers, to maximize the effectiveness of resource utilization and to attain a synergetic complementary of the two strategies;
    ii. Repositioning family planning as an essential part of the attainment of health MDGs;
    iii. Addressing the sexual and reproductive health needs of adolescents and youth as a key SRH component;
    iv. Addressing unsafe abortion;
    v. Delivering quality and affordable services in order to promote Safe Motherhood, child survival, maternal, newborn and child health.
    vi. African and south-south co-operation for the attainment of ICPD and MDG goals in Africa

18. The strategy includes the crosscutting issues to:

    1. Increase domestic resources for sexual and reproductive health and rights including the addressing of the human resource crisis;
    2. Include males as an essential partner of SRHR programmes;
    3. Adopt a multisectoral approach to SRHR;
    4. Foster community involvement and participation;
    5. Strengthen SRH commodity security with emphasis on family planning and emergency obstetric care and referral;
    6. Put in place operational research for evidence based action and effective monitoring tools to track progress made on the implementation of this Plan of Action;
    7. Integration of nutrition in STI/HIV/AIDS, and SRHR especially for pregnant women, and children by incorporating nutrition in the school curriculum. fortification of food institutionalisation.
    8. Involvement of families and communities;
    9. Involvement of the Ministries of Health in conflict resolution;
    10. Rural-urban service delivery equity.

19. The cost estimates provided in this PoA is a global requirement for the delivery of affordable quality SRHR services in the continent during the 4-year period 2007 - 2010. This PoA will mainly be financed through domestic resources and the shortfall will have to be mobilised.

Priority Target Groups

20 Reproductive Health encompasses the whole life span of an individual from conception to old age as such SRH services shall be provided to all who need them. Emphasis will be on men and women of reproductive age, newborns, young people rural, mobile, and cross-border populations, displaced persons and other marginalized groups.

Expected Outcome

21 This Program of Action will provide a framework from which countries can draw inspiration. This will not require the elaboration of new strategies but simply the incorporation of elements of this strategy into the existing ones.

Costing the Plan of Action

22. Preliminary cost estimates have been made for the direct service delivery costs required to make progressive advancement to universal access to reproductive health services by 2015 (including family planning, safe motherhood, newborn health and sexually transmitted infection interventions). $3.5 billion is required for sexual and reproductive health services for Africa in 2007 and a total of $16billion through to 2010.

23. Review and updating of the preliminary cost estimates, incorporating national statistical inputs, is required. (See Annex). These are provisional results, conditional on the details in the appendix. The results also reveal that the savings in other maternal, newborn and child health interventions are significantly greater than the marginal increase in expenditures for higher family planning prevalence.

24. These estimates should be reviewed and further updated on the basis of the experience gained in the implementation of the programmes. However, what is most important is that national plans include detailed definitions of interventions appropriate to meeting national needs for sexual and reproductive health and that investments reflect and improve national capacity for their implementation and monitoring.

25. The principles of the current analysis, however, should be adhered to, including that: plans should be geared to achieving universal access to reproductive health by 2015, increased investment and action to improve human resources for health are required, such plans and estimates include resources to strengthen the health system including allocations for monitoring, supervision, basic public health functions, community action and other necessary support functions, that additional resources will be needed to address elements explicitly not included (such as capital investments) and that further investment will be needed in sectors other than health that support and advance progress towards health-related objectives, including those in the Millennium Development Goals. The current estimates are indicative of the scale of the required effort and should mobilize an appropriate response by governments, donors, civil society and the private sector.

POA for Implementing the Continental Sexual and Reproductive Health and Rights Policy Framework 2007–2010

Outputs	Strategic actions	Indicators for monitoring progress
1. HIV, STI, Malaria and SRH services integrated into primary health care		
1.1 Advocacy/ policy	1.1.1 Integrate SRHR and HIV/AIDS/STI and malaria in key national health policy documents and plans	1.1.1 # countries with integrated SRHR/ HIV/AIDS/STIs and Malaria policy documents and national plans
	1.1.2 Develop policies and legal frameworks for STI/HIV/AIDS prevention to support the provision of appropriate and comprehensive HIV/AIDS/STI and malaria prevention, care and treatment options for all including pregnant women, mothers, infants , families and PLWHA	1.1.2# countries with policies and legal frameworks in place to ensure access to comprehensive HIV/ AIDS/ STI and malaria prevention, care and treatment options for pregnant women, mothers, infants, families and PLWHA
	1.1.3 Develop and/or implement strategies to address Gender Based Violence (GBV) in collaboration with other relevant stakeholders.	1.1.3a# Countries strategies dealing with GBV developed and implemented. 1.1.3b Laws dealing with GBV in place
	1.1.4 Conduct Research and Develop and/or implement strategies to address early marriages and harmful traditional practices (HTP) such as Female Genital Mutilation (FGM)	1.1.4a # countries with programmes to address HTP 1.1.4b# countries conducting with research reports on HTP and FGM

	1.1.5 Incorporate health management of GBV in the training curricula of health workers and providers of legal services.	1.1.5 # countries with curricula for health workers and legal service providers that incorporate health related components of GBV
	1.1.6 Develop policies to ensure access to condoms especially among PLWHA	1.1.6 # countries with policies that ensure access to condoms especially for PLWHA
	1.1.7 Develop policies that promote involvement of civil society and private sector in SRHR service delivery within national programmes	1.1.7 # countries with policies on public private partnership on SRHR developed and implemented
	1.1.8 Advocate for multi-sectoral effort to create a supportive environment for promotion of national SRHR policies and programmes	1.1.8 # Countries with multi-sectoral plans supporting SRHR
1.2 Capacity building	1.2.1 Conduct comprehensive assessments of health care delivery systems to assess management, infrastructure and resource needs for effective integration of STI/HIV/AIDS into SRHR services	1.2.1 # SDPs providing integrated STI/HIV/AIDS and SRHR services
	1.2. 2 Review training curricula for service providers to incorporate integration of SRH with STI/HIV/AIDS and nutrition.	1.2.2 # Training institutions integrating STI/HIV/AIDS and nutrition with SRHR in their curricula
	1.2.3 Provide pre- and in-service training for health service providers in the provision of integrated SRHR STI/HIV/AIDS and malaria services	1.2.3 # Providers trained in integrated STI/HIV/AIDS, malaria and SRHR
	1.2.4 Refurbish structures and reorganise service provision to ensure effective provision of integrated services	1.2.4 # SDPs providing integrated services
	1.2.5 Develop a Human Resource plan for training various cadres for local consumption, distribution, utilisation, and retention of health workers at all levels	1.2.5 Proportion of health workers per population
1.3 Services	1.3.1 Ensure access to routine HIV counselling and testing in STI, family planning and maternal and newborn and reproductive cancer services	1.3.1 % Service Delivery Points (SDPs) offering routine HIV counselling and testing in STI, family planning and maternal and newborn and reproductive cancer services
	1.3.2 Integrate comprehensive HIV/STI prevention, management and treatment with SRHR, including dual protection	1.3.2 % SDPs offering integrated comprehensive HIV prevention, management and treatment
	1.3.3 Ensure access to services that address gender- based violence including management of sexual abuse, emergency contraception and HIV post- exposure prophylaxis and STI treatment in an integrated and co-ordinated manner	1.3.3 % SDPs offering STI, PEP and EC services for GBV victims

	1.3.4 Ensure integration of services for prevention and management of infertility	1.3.4 Prevalence of childlessness
	1.3.5 Provide appropriate information on the provision of integrated STI/HIV/AIDS and SRHR services	1.3.5 Wide availability of appropriate information on the provision of integrated STI/HIV/AIDS and SRHR services
	1.3.6 Provide services for the SRH needs of all persons including vulnerable groups and mobile populations especially migrant women, IDPs and those in conflict situations	1.3.6 Coverage for SRH services by target group
	1.3.7 Develop and implement a programme that ensures partnership with, support from and inclusion of men in SRHR services.	1.3.7 % Men with favourable attitude to SRHR (FP, assisted delivery)
	1.3.8 Provide screening and management services for cancers of the reproductive system	1.3.8 Proportion of SDPs offering screening and management services for cancers of the Reproductive system for both men and women
	1.3.9 Provide services for the management of mid-life concerns of both men and women, menopause and andropause	1.3.9Proportion of SDPs offering services for mid-life concerns of both men and women
	1.3.10 Integrate nutrition education and food supplementation programmes with SRHR and HIV/AIDS/STI services and training	1.3.10a Prevalence of underweight by age group 1.3.10b Prevalence of anaemia in pregnancy
	1.3.11 Develop and implement strategies for ensuring blood safely	1.3.11 # SDPs with blood screening facilities
2. Strengthened community-based STI/HIV/AIDS/STI and SRHR services		
	2.1.1 Build capacity of community structures and referral networks to provide a continuum of STI/HIV/AIDS services within SRHR SDPs	2.1.1 Sexual and Reproductive Health coverage statistics
	2.1.2 Build capacity of all categories of SRHR service providers (including nurses, traditional birth attendants [TBAs], community-based distributors [CBDs], etc.) to facilitate effective integration of STI/HIV/AIDS into SRHR service delivery	2.1.2 # countries with integrated STI/HIV/AIDS into SRHR service delivery
	2.1.3 Build capacity and empower communities to effectively partner with SRHR/STI/HIV/AIDS SDPs for enhanced community-based responses	2.1.3 # SDPs with community partnerships
	2.1.4 Develop and implement behaviour change communication strategy for community mobilisation and education on health promotion and utilisation of integrated SRH with STI/HIV/AIDS, malaria and nutrition.	2.1.4a # countries with comprehensive BCC strategy 2.1.4b Knowledge for integration of SRH with STI/HIV/AIDS, malaria and nutrition. Services

3. Family planning repositioned as key strategy for attainment of MDGs		
3.1 Advocacy/ policy	3.1.1 Mobilise political will and leadership for provision of quality family planning services.	3.1.1 Proportion of SRH budget allocated to family planning
	3.1.2 Develop and/or implement gender and culture sensitive policies/ legislation to ensure universal access to quality FP services	3.1.2 Supportive legislation, protocols and guidelines for family planning
3.2 Capacity building	3.2.1 Develop or implement structures and systems for increasing access to FP	3.2.1 # Countries with functional structures for FP service delivery
	3.2.2 Train health care providers for the delivery of a comprehensive range of FP services	3.2.2 Proportion of health workers trained in FP
3.3 Service delivery	.3.1.1 Develop gender and culture appropriate information to enhance FP knowledge in the target populations	3.3.1 Knowledge levels for FP for both men and women
	3.3.2 Develop systems to increase coverage for FP services, including community based distribution and alternative models of service delivery	3.3.2 Proportion of SDPs offering range of FP services
	3.3.3 Integrate and provide FP as a component of Maternal, New born and Child Health service package	3.3.3a CPR 3.3.3b Couple Year Protection (CYP) 3.3.3c Unmet need for FP 3.3.3d % of clients accessing FP through community based mechanisms and alternative models
4. Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and wellbeing		
4.1 Advocacy/ policy	4.1.1 Strengthen implementation and/or advocacy for policies that support the provision of SRHR services addressing the needs of young people	4.1.1 # countries that have developed policies to support SRH services for young people
	4.1.2 Cerebrate a day for the SRHR Services for young people	4.1.2 # countries cerebrating day of SRHR Services for young people
4.2 Capacity building	4.2.1a Develop and implement information and communication strategies that support both abstinence and condom use as effective strategies to prevent HIV/AIDS/STIs and unplanned pregnancies and link information to service delivery	4.2.1 # Countries with IEC/BCC strategies that promote abstinence and condom use
	4.2.2 Build capacity of SDPs and all levels of service providers to provide a comprehensive, gender sensitive package of care for young people	4.2.2 # countries with youth-friendly health services within their training curricula

	4.2.3 Develop and implement IEC strategies for parents and educators to communicate to young people.	4.2.3# Countries with IEC strategies for parent education for young people.
4.3 Service delivery	4.3.1 Assess and establish/ strengthen youth-friendly services at SDPs	4.3.1 # youth-friendly SDPs per population 3.2.1b % young people with knowledge about both abstinence and condom use
	4.3.2 Integrate provision of youth friendly services including promotion of abstinence and dual protection methods within existing services	4.3.2a % Condom use among young people 4.3.2b Teenage pregnancy rate
	4.3.3 Develop alternative service delivery mechanisms to reach young people including outreaches, peer education, CBD and social marketing.	4.3.3 Adolescent fertility as a proportion of total fertility
	4.3.4 Provide sexuality education for young people in and out of school	4.3.4 Age of sexual debut
	4.3.5 Support the meaningful participation of young people, including young PLWHA, and communities in the positioning and delivery of youth-friendly services	4.3.5 Level of involvement of young people including young PLWHA and communities in the positioning and delivery of youth-friendly services
5. Incidence of unsafe abortion reduced		
5.1 Advocacy/ policy	5.1.1a Compile and disseminate data on the magnitude and consequences of unsafe abortion,	5.1.1 # countries with status report on the magnitude and consequences of unsafe abortion.
	5.1.2a Enact policies and legal frameworks to reduce incidence of unsafe abortion	5.1.2 # countries with legislative/policy framework on abortion.
	5.1.3a Prepare and implement national plans of action to reduce incidence of unwanted pregnancies and unsafe abortion	5.1.3 # countries with action plans to reduce unwanted pregnancies and unsafe abortion
5.2 Capacity building	5.2.1a Train service providers in the provision of comprehensive safe abortion care services where national law allows	5.2.1 # Service providers trained in safe abortion care
	5.2.2 Refurbish and equip facilities for provision of comprehensive abortion care services	5.2.2 Proportion of SDPs providing PAC services
5.3 Service delivery	5.3.1a Provide safe abortion services to the fullest extent of the law	5.3.1a # facilities providing safe abortion care 5.3.1b Abortion related MMR
	5.3.2 Educate communities on available safe abortion services as allowed by national laws	5.3.2 # of countries with community awareness programmes on abortion issues.
	5.3.3 Train health providers in prevention and management of unsafe abortion	5.3.3 # countries with critical mass of trained providers in place

6. Access to quality Safe Motherhood and child survival services increased		
6.1 Advocacy	6.1.1 Develop and/or roll out the Road Map for the reduction of maternal and newborn morbidity and mortality.	6.1.1 # countries that have developed Roadmaps for the reduction of maternal and newborn morbidity and mortality
	6.1.2 Observe a Safe Motherhood Day	6.1.2 # countries that commemorate safe motherhood days
	6.1.3a Intensify maternal and neonatal tetanus vaccination campaigns	6.1.3 # Pregnant women and children vaccinated
6.2 Capacity Building	6.2.1 Develop and implement national strategies for rapid production, deployment and retention of midwives, including harmonisation and accreditation of curriculum at regional level	6.2.1a # midwives per population 6.2.1b Coverage for supervised delivery
	6.2.2 Incorporate Emergency Obstetric Care in pre- service training of health care providers	6.2.2 # countries that have pre-service curricula incorporating EmOC for all appropriate cadres
	6.2.3 Develop systems for rapid transport for women with obstetric and gynaecological complications including strengthening the referral system	6.2.3 # countries with functional referral system from community to health facility.
	6.2.4 Strengthen the production of mid-level staff production	6.2.4 # Mid level staff per population
	6.2.5 South-South Staff exchange	6.2.5 # Countries exchanging staff
6.3 Services	6.3.1 Scale up safe motherhood services through the implementation of the Road Map for the reduction of maternal and newborn morbidity and mortality	6.3.1a Maternal Mortality Ration (MMR) 6.3.1b Peri-natal mortality rate 6.3.1 # facilities per 500,000 population providing basic and comprehensive EmOC
	6.3.2 Scale up neonatal care services including the creation of neonatal resuscitation care in maternity units	6.3.2 Neonatal mortality rate
	6.3.3 Increase coverage of child survival services (expanded programme for immunization [EPI], oral rehydration solutions [ORS]), early initiation of breast feeding, and other appropriate nutritional intervention, 1st week consultations	6.3.3 Immunisation coverage at one year 6.3.3b Prevalence of under-weight children
	6.3.4 Adopt integrated management of childhood illnesses (IMCI)	6.3.4a Availability of IMCI protocols 6.3.4b IMR 6.3.4c U-5 mortality
	6.3.5 Develop a mechanism for provision of adequate safe blood supply	6.3.5 Proportion of EmOC sites with access to adequate supply of safe blood.
	6. 3.6 Integrate STI/HIV/AIDS, malaria and nutrition services into obstetric care	6.3.6 Prevalence of newborn HIV infections 6.3.6b Proportion of malaria cases managed with 24 hours.

7 . Resources for SRHR increased		
7.1 Advocacy/ poly	7.1.1 Implement the Abuja Heads of State Declaration on national budgetary allocation for health to at least 15% of the total national budget, with an appropriate proportion of that for SRHR	7.1.1a # countries with 15% of budget allocated to health 7.1.1b Proportion of health budget allocated for SRHR
	7.1.2 Advocate for prioritisation of SRHR in national poverty reduction strategy papers (PRSPs) and other national development plans	7.1.2a # countries with SRHR in their national PRSP or development plans 7.1.2b % national health budgets allocated to SRHR
	7.1.3a Advocate for increased support to SRHR programmes from donors and development partners	7.1.3 % of total SRHR budget, mobilized from donors/development partners.
7.2 Capacity building	7.2.1 Develop partnerships with local & international institutions, private sector and civil society organizations (CSO/) for technical and financial support, and for advancing the implementation of the Plan of Action.	7.2.1 # partnerships formed with each sector.
	7.2.2 Institutionalise National Health Accounts (NHA)	7.2.2 # No of countries with updated NHAs
	7.2.3a Develop and implement human resource strategy to orient and train, deploy and retain health system workers	7.2.3 Cadre of staff per 100,000 population
8. SRH commodity security strategies for all SRH components achieved		
8.1 Advocacy	8.1.1 Develop national/regional strategies and action plans for forecasting, procurement and distribution of RH commodities	8.1.1 # countries with plans for RHCS
	8.1.2 Establish a national and/or regional RHCS committee	8.1.2 # countries/regions with national/ regional RHCS committees
	8.1.3a Develop national and where appropriate regional RHCS strategy and action plans	8.1.3 Regional/national RH commodity security strategy and action plan(s) in place
	8.1.4 Revise essential medicines lists to include reproductive health commodities	8.1.4 # countries with RH commodities in essential medicines list

	8.1.5 Establish a budget line for SRH commodities	8.1.5a % health budget allocated to RH commodities 8.1.5b # countries with a national budget line for SRH commodity security
8.2 Capacity building	8.2.1 Develop and implement logistics management system (LMS) for RHCS	8.2.1 # countries maintaining and regularly updating statistics on commodities' stocks and flows.
	8.2.2 Train relevant staff in LMS for RHCS	8.2.2 # countries experiencing stockout
	8.2.3 Establish effective commodity management system for the full range of commodities	8.2.3 # countries with commodity management systems in place
	8.2.4a Develop capacity for bulk purchasing through pooling of purchase orders at national and regional levels	8.2.4 # countries with integrated systems of bulk purchasing and supply
	8.2.5 Provide training in commodity management	8.2.5 # persons trained in management logistic systems
9. Monitoring, evaluation and coordination mechanism for the Plan of Action established		
9.1 Advocacy/ policy	9.1.1 Advocate for allocation of national resources for conducting regular censuses, DHS, and annual maternal death reviews	9.1.1 # countries that regularly conduct censuses, DHS & annual maternal death reviews
9.2 Capacity building	9.2.1 Establish a continental monitoring and tracking system to aggregate, analyse and disseminate data received from the national level	9.2.1 Continental mechanism and database for monitoring the POA in place
9.3 Data collection and utilization	9.3.1 Institutionalise M&E at the public administration and NGOs levels and allocate adequate human and financial resources to support it.	9.3.1 # countries with institutionalised M&E systems.
	9.3.2 Collect, analyse and disseminate minimum national level information required for a continental database	9.3.2 # countries that make timely submission of information to the continental database
	9.3.3 Support operational research for evidence based action	9.3.3 # countries utilizing operational research in their planning.
	9. 3.4 Collaborate with UN and donor agencies in harmonizing data collection systems to ensure consistency	9.3.4 Harmonized data collection system in place
	9.3.5Put in place coordination mechanisms to monitor and evaluate the efficient allocation of resources and implementation of laws	9.3.5 # countries able to monitor & evaluate allocation of resources and implementation of laws
	9.3.6 Institutionalise exchange and sharing of best practices including south-south technical exchanges	9.3.6a # Institutions in formal strategic partnerships for technical exchange 9.3.6b Best practice web platform established and maintained

	9.3.7 Develop and/or implement coordination and supervisory structure and mechanism for implementation of SRHR at regional and national levels.	9.3.7a # countries with functional coordination structure and mechanism established 9.3.7b Regional coordination structure and mechanism established.

Role of Stakeholders

(a) The African Union

26. The African Union will, among other things, play advocacy role, resource mobilisation, monitoring and evaluation, dissemination of best practices and harmonisation of policies and strategies.

(b) Regional Economic Communities

27. Regional Economic Communities will, among other things, provide technical support to Member countries including training in the area of reproductive health, advocate for increased resources for sexual and reproductive health, harmonise the implementation of national Action Plans, monitor progress, identify and share best practices.

(c) Member States

29. Member States will adapt and implement the Action Plan for the operationalisation of the Continental SRHR Policy Framework. They will also put in place advocacy, resource mobilisation and budgetary provision as a demonstration of ownership and monitoring and evaluation. They will also invite civil society and the private sector to participate in national programs.

(d) Partners

28. In line with the Paris principle multi-lateral and bi-lateral organizations; international and national civil society organizations and other development partners will align their financial and technical assistance and cooperation plans with national and regional needs and priorities for implementation of the plan of action.

Conclusion

29. African leaders have a civic obligation to respond to the Sexual and Reproductive Health needs and Rights of their people. This Action Plan is a clear demonstration of their commitment to advance Sexual and Reproductive Health and Rights in Africa.

Annex:

Methodology and Results of Costing of SRHR Services

1. The principles of this costing estimate include the expectation that: plans should be geared to achieving universal access to reproductive health by 2015, increased investment and action to improve human resources for health are required, such plans and estimates include resources to strengthen the health system including allocations for monitoring, supervision, basic public health functions, community action and other necessary support functions, that additional resources will be needed to address elements explicitly not included (such as capital investments) and that further investment will be needed in sectors other than health that support and advance progress towards health-related objectives, including those in the Millennium Development Goals.

2. Estimates were conducted, using available information, on a national level and aggregated up to regional totals. These costs reflect direct service delivery requirements to reach coverage targets directed towards the universal access to reproductive health ICPD goal, which would also advance health related ICPD and MDG goals. These calculations propose that each country in Africa rapidly increase access to an essential package of integrated reproductive health services that would reduce by nearly half by 2010 their current gaps on the way to universal access by 2015. Countries with 40 per cent coverage in 2006 should aim to reach 66% coverage by 2010, those with 60 per cent should aim to exceed 75% and those with 75 per cent should aim for 85%. Additional adjustments are then made to the resulting direct costs.

3. These adjustments include a doubling of medical and paramedical salaries required to increase commitment, staff retention when supplemented with other non-monetary incentives, motivation and service quality: issues well recognized in both the prior and current African Union deliberations, as well as in other settings. The adjustments include a 37% adjustment comprised of the following elements added to total direct costs, including salaries: strengthening management systems (including financial management) at 20%; improving monitoring, evaluation, and quality assurance at 15%; and, building capacity for basic research and development at 2%. In addition, a 67% increment is required for general overhead (support staff, electricity, etc., and maintenance), public health functions (including community demand generation) and regulatory requirements. In toto, these additions reflect the effort required for direct service provision, health system development and several crucial supportive activities. Direct service inputs of salary and drug/equipment provision therefore account for less than half of the total estimate.

4. SRH-related prevention interventions were estimated by specifying the share of the UNAIDS-identified prevention activities that relate to SRHR. For example, all condom distribution and STI management, substantial shares of youth-based and special population interventions and small shares of harm exposure and blood safety interventions (in the latter case, proxied by an estimate of the proportion of transfusions needed for maternal hemorrhage) are included. These analyses, based on UNAIDS data, produce estimates for SRH-related prevention interventions increasing from $2.2 - $3.6 billion over the same period. Additional resources would be needed for the remaining proportions of prevention, treatment, care and support services.

5. Annex Table 1 reflects the estimated requirements for service delivery of SRH services, aggregated up from national level analyses, under two scenarios: (1) the United Nations Population Division Medium Variant projection of fertility decline during 1997-2010 and (2) fertility and contraceptive prevalence levels associated with progressively eliminating current unmet need for family planning before 2015. The results presented for this latter scenario capture the prevalence increase early in the sequence of progress.

6. The results suggests that delivery of sexual and reproductive health services for Africa under two scenarios will require in 2007 the expenditure of $3.5 billion and will increase to about $4.6 billion by 2010. The total SRH/HIV prevention costs for direct service provision, health system development and crucial supportive activities therefore total $5.8, $6.6, $7.4 and $8.3 billion, respectively in the years from 2007 to 2010. Family planning expenditures are higher in the unmet need scenario but total expenditures for other SRH interventions

7. The resulting totals for SRH and STI/HIV/AIDS prevention correspond to per capita expenditures increasing from $6.03 to $8.14 (of the $34 per capita recognized by the AU as needed for health) during

this period. In comparison, the 2005 direct expenditures for SRH are estimated at roughly $2 per capita (not including system investments).

8. Review and updating of the estimates, incorporating national statistical inputs, is required. These are provisional results, conditional on the details above. The results also reveal that the savings in other maternal, newborn and child health interventions are significantly greater than the marginal increase in expenditures for higher family planning prevalence.

Annex Table 1: Resource requirements for Reproductive, Maternal, Newborn Health Direct Service Delivery in Africa (2007-2010) Medium Variant and Unmet Need Met Projection Scenarios, with and without System adjustments (millions $US)

	2007	2008	2009	2010	2007–2010
MEDIUM VARIANT					
Personnel costs					
Family Planning	29.2	31.5	33.8	36.2	130.6
ANC and normal delivery	281.5	308.2	335.1	362.0	1,286.7
Added maternal/newborn*	156.0	178.1	198.5	217.8	750.5
STI	55.4	61.9	68.5	75.2	261.1
Total Personnel	522.2	579.7	635.9	691.2	2,429.0
Drug/supply costs					
Family Planning**	85.5	92.3	99.3	106.5	383.6
ANC and normal delivery	360.6	381.3	402.0	422.5	1,566.4
Added maternal/newborn*	216.7	252.3	286.2	319.2	1,074.4
STI	23.6	26.3	29.1	32.0	111.0
Total Drugs/supplies	686.3	752.2	816.6	880.2	3,135.4
Grand total (w salary adj.)	1,730.7	1,911.5	2,088.4	2,262.7	7,993.3
GRAND TOTAL (w system costs)	3,530.5	3,899.5	4,260.3	4,616.0	16,306.4
UNMET NEED					
Personnel costs					
Family Planning	30.4	33.3	36.3	39.5	139.5
ANC and normal delivery	279.4	303.5	327.4	350.9	1,261.3
Added maternal/newborn	155.0	175.8	194.7	212.2	737.7
STI	55.4	61.9	68.5	75.2	261.1
Total Personnel	520.2	574.6	627	677.8	2,399.6
Drug/supply costs					
Family Planning	88.3	97.2	106.4	116.0	407.9
ANC and normal delivery	358.0	375.8	393.1	410.0	1,536.9
Added maternal/newborn	215.3	248.9	280.6	310.8	1,055.6
STI	23.6	26.3	29.1	32.0	111.0
Total Drugs/supplies	685.1	748.2	809.2	868.8	3,111.4
Grand total (w salary adj.)	1,725.6	1,897.4	2,063.2	2,224.4	7,910.7
GRAND TOTAL (w system costs)	3,520.2	3,870.8	4,208.9	4,537.8	16,137.7

* Added maternal/newborn interventions include Emergency Obstetric Care, newborn health and additional maternal conditions.

** Additional condom costs for STI/HIV/AIDS are not included.

B15 Africa Health Strategy: 2007–2015 (2007)

Third Session of the African Union Conference of Ministers of Health
Johannesburg, South Africa, 9–13 April 2007
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1. Introduction

1. Africa has made significant strides in certain areas of social and economic development but has the potential to achieve even more if it can overcome the large burden of disease which continues to be a barrier to faster development. This ever increasing disease burden, despite good plans and strategies, is cause for concern to the policy makers. This has prompted the African Union Ministers of Health to harmonize all the existing health strategies by drawing this Africa Health Strategy which Regional Economic Communities (RECs) and other regional entities and Member States can use to enrich their strategies, depending on their peculiar challenges. The Strategy neither competes with nor negates other health strategies but seeks to complement other specific and detailed strategies by adding value from the unique perspective of the African Union. It provides a strategic direction to Africa's efforts in creating better health for all.
2. The Strategy recognises that Member States and regions and indeed the continent have previously set health goals in addition to the Millennium Development Goals that they have committed to. It explores some challenges that militate against the continent decreasing the burden of disease and improving development and also draws on existing opportunities. It highlights strategic directions that can be helpful if approached in a multi-sectoral fashion, adequately resourced, implemented and monitored accordingly.
3. The African Union, member states and the RECs will use this Strategy as the inspirational framework within which they will fulfil their roles. The Strategy provides a focus for all health initiatives to converge around. Ministers of Health are calling on multilateral agencies, bilateral development partners and other partners in Africa's development to build their health contribution around this Strategy. Such a co- ordinated response is critical to ensure maximum benefit from the resources mobilised and to prevent fragmentation and duplication. This Strategy thus provides an overarching framework to enable coherence within and between countries, civil society and the international community.
4. The strategy proposes strengthening of health systems with the goal of reducing disease burden through improved resources, systems, policies and management. This will contribute to equity through a system that reaches the poor and those most in need of health care. Investment in health will impact on poverty reduction and overall economic development.
5. Health sector should be at the forefront of efforts to advance women's rights and equality as women not only bear the greatest disease burden but are also primary care givers.

2. Situation Analysis

2.1 Disease Burden

6. The evidence of the impact of good investments and effective interventions on burden of disease and on economic indicators is becoming stronger. Nonetheless, the reality remains that Africa's people face a huge burden of preventable and treatable health problems whose solutions are known, proportionately far beyond Africa's share of the world's population. The triple burden from communicable and non-communicable diseases and injury and trauma, including the social impact of these, has adversely affected development in Africa. Africa is still not on track to meet the health Millennium Declaration targets and the prevailing population trends could undermine progress made. The maternal mortality rate will need to drop from between 500 and 1500 to 228 per 100 000 and Under 5 mortality from 171 to 61 per 1000 to reach their respective Millennium Development Goals. Life expectancy on the continent, already low, has been reduced further to an average of 52 years by many factors including structural adjustment programmes (SAPs) and the AIDS epidemic. Women and children carry a disproportionate share of Africa's heavy disease

burden, with 4.8 million children dying annually, mostly from preventable diseases. Women carry the major responsibility for care and poor education may add to their oppressed position.

7. AIDS, tuberculosis and malaria pose the greatest challenges. However, they should not overshadow the severe burden of other communicable diseases including pneumonia, diarrhoea and measles in children and other diseases that severely debilitate communities affected by them. These include Onchocerciasis, Trypanosomiasis, Schistosomiasis, Dracunculiasis (Guinea Worm) and Filariasis. Cholera, Meningitis, Ebola and Marburg outbreaks continue, while intermittent cases of Human Avian Influenza remind the continent of the pandemic threat that mutation poses.

8. The alarming rate of growth of the burden of both death and disability from non- communicable diseases in Africa is ever more recognised, with chronic diseases becoming ever more prevalent, linked to demographic, behavioral and social changes and urbanisation. Hypertension, stroke, diabetes, chronic respiratory disease and the consequences of tobacco use, alcohol abuse and illicit drugs, are growing as serious public health challenges. Injuries from violence, wars, traffic accidents and other mostly preventable causes result in widespread death and physical disability, while the impact of mental ill-health has previously been underestimated. Sickle Cell Disease is the most prominent genetic disorder, while the prevalence of specific cancers is extremely high in some parts of the continent.

9. Worsening protein energy and micronutrient malnutrition in many countries continues to contribute to elevated mortality, while dietary change and inactivity are factors driving the emergence of chronic diseases and obesity. Micronutrient deficiency including iron, zinc, iodine and vitamin A is widespread. About 60% of under-five mortality in some parts of Africa is attributable to malnutrition, which remains a major challenge to development and child survival in Africa.

2.2 Root causes

10. The economic growth in many Africa countries, decline in conflicts and important strides towards democracy and good governance are all contributing to health. Other wide ranging interventions are being implemented and important progress is being made in addressing the root causes of the disease burden in Africa. However, although the balance of reasons varies from country to country, the high disease burden continues because:

    a. Health systems are too weak and services too under-resourced to support targeted reduction in disease burden and achieve universal access
    b. Health interventions often do not match the scale of the problem
    c. People are not sufficiently empowered to improve their health nor adequately involved, while cultural factors play a role in health seeking behaviour.
    d. The benefits of health services do not equitably reach those with the greatest disease burden
    e. There is widespread poverty, marginalisation and displacement on the continent
    f. Insufficient action on the intersectoral factors impacting on health.
    g. Environmental factors and degradation are not sufficiently addressed

11. There have been commendable efforts towards addressing the inter-sectoral challenges affecting health, particularly since the advent of the African Union and its New Partnership for Africa's Development. Nonetheless, shortfalls in agriculture, low literacy and lack of safe water, adequate sanitation, electrification and infrastructure, and ongoing conflicts all drive up the disease burden. A vicious cycle remains in which poverty and its determinants drive up the burden of disease, while ill-health contributes to poverty. Investment in health could therefore contribute to economic development.

12. Health system factors that still undermine efforts to reduce the disease burden are:

    a. Insufficient sustainable financial resources and the efficient allocation and use thereof;
    b. Lack of social protection for the vulnerable groups especially those in catastrophic situations;
    c. A shortage of appropriately trained and motivated health workers;
    d. Poor commodity security and supply systems and unfair trade practices favouring the rich countries;
    e. Weak health systems operations;
    f. Marginalisation of African Traditional Medicine in national health systems;

g. Inadequate community involvement and empowerment;
h. Capacity of the private sector, including NGOs is not fully mobilised;
i. Paucity and inadequate use of available evidence and information to guide action including use of ICT;
j. Effective co-ordination with other sectors and harmony with partners not yet attained;
k. Lack of optimal intersectoral action and coordination;
l. Restrictive and disruptive global policies (e.g. structural adjustment programmes and unfair terms of trade), conditionalities and actions that adversely impact on Africa's health systems; and
m. Gaps in governance and effective leadership of the health sector.

13. The world is facing a global health work force crisis that is characterised by widespread shortages, mal-distribution between and within countries, poor working conditions and paucity of information and knowledge on best practice. Migration of health workers to rich nations is draining human resources for health in poor countries, which is exacerbated by insufficient training of adequate number of health workers. To compound this, Africa and the world face the emergence of new pandemics and resurgence of old diseases. While Africa has 10% of the world population, it bears 25% of the global disease burden and has only 3% of the global health work force. Of the four million estimated global shortage of health workers one million are immediately required in Africa. This crisis has developed as a result of long standing neglect, unfavourable international development policies and practices.

14. Subsequent to the Abuja Declarations, some countries have increased their health expenditure, while development partners have increased their development aid for health beyond US$10 billion per annum. However, health funding in most countries remains below what is required to achieve a functional basic health system, even if resources available were optimally used. Only two out of the 53 African countries have met the Abuja 2001 target of 15% of total government expenditure to be allocated to health.

2.3 Opportunities

15. At the same time as it faces challenges, Africa is at a time of unique opportunities to significantly impact on its disease burden, notably through ensuring adequate investments in health systems. There is increasing recognition that health creates wealth and advances GDP.

16. There is growing improvement in public sector performance including the health sector, with decentralization unfolding in many countries.

17. Pursuant to the Abuja Declaration, some countries have increased their budget allocation to health in real terms, now exceeding 10% of public budget, the vital importance of sufficient, motivated Human Resources for Health has been recognised by Africa's leaders.

18. There is progress in ensuring commodity supply, and the decision of the AU Heads of State at their Fourth Summit will enable Africa to realize the economic production at volume of quality generic medicines and other commodities (e.g. long lasting insecticides impregnated bed nets -LLITNs).

19. The African Union and its programmes provide an African-driven mechanism for ensuring a common platform and framework for avoiding duplication and fragmentation for countries / RECs and partners.

20. Development partners have increased their development aid for health in Africa beyond US$10 billion per annum and the move towards funding of core public health budgets based on national plans, such as through Sector Wide Approaches (SWAPS) integrated intersectorally, offers a major opportunity to move away from fragmented and inefficient vertical projects and programmes, which is supported by the international commitment on aid effectiveness as agreed at the High Level Forum in Paris in 2005. The benefit is enabled by alignment of donor funding with nationally determined plans and priorities. Funding opportunities such as Global AIDS Vaccine Initiative (GAVI) could also be utilized.

21. Independent research from large scale programmes is also providing evidence of what works and what does not work, especially in resource poor settings. This kind of evidence could be used to provide direction on cost-effective, high impact and sustainable interventions.

3. Vision and Mission, Principles, Goals and Objectives

22. Africa knows what its disease burden is and its consequences, Africa also knows that it is possible to and can change this legacy as well as the interventions required. Its Health Ministers are committed to leading and co-ordinating a committed effort to enhance the health of Africa.

3.1 Vision and Mission

23. The vision is an integrated and prosperous Africa free of its heavy burden of disease, disability and premature death.

24. The mission is to build an effective, African driven response to reduce the burden of disease and disability, through strengthened health systems, scaled-up health interventions, inter sectoral action and empowered communities.

3.2 Principles

25. This Strategy is underpinned by a set of principles:

- Health is a human right
- Health is a developmental concern requiring a multi-sectoral response
- Equity in health care is a foundation for all health systems
- Effectiveness and efficiency is central to realising the maximum benefits from available resources
- Evidence is the basis for sound public health policy and practice
- New initiatives will endeavour to set standards that go beyond those set previously
- Solidarity is a means of facilitating access for the poor
- Respect for culture and overcoming barriers to accessing services
- Prevention is the most cost-effective way to reduce the burden of disease
- Health is a productive sector
- Diseases know no borders and cross border cooperation in disease management and control is required.

3.3 Goals and Objectives

26. The goal of this Africa Health Strategy is to contribute to Africa's socio- economic development by improving the health of its people and by ensuring access to essential health care for all Africans, especially the poorest and most marginalised, by 2015.

27. The overall objective of this strategy is to strengthen health systems in order to reduce ill-health and accelerate progress towards attainment of the Millennium Development Goals in Africa; More specifically:

a. To facilitate the development of initiatives to strengthen national health systems in member states by 2009
b. To facilitate stronger collaboration between the health and other sectors to improve the socio-economic and political environment for improving health
c. To facilitate the scaling up of health interventions in member states including through regional and intergovernmental bodies.

4. Strategic Approaches

28. This Strategy presents an approach for addressing avoidable disease, disability and death in Africa and for strengthening Health Systems for equity and development, especially for the poorest, most marginalised and displaced people.

29. To achieve the goals of this Strategy, a number of strategic interventions need to be concurrently implemented towards achieving an effective and sustainable health sector, synchronised with an integrated focus on the major health burdens and vulnerable groups. The intention is to incorporate best practices for

promotion, prevention, care and rehabilitation into country health plans in line with national circumstances. There should be special attention to post-conflict countries and those caring for refugees and internally displaced persons. The Strategy must apply the life-cycle approach for cost-effective disease prevention.

4.1 Health Systems

30. For a country to deliver basic health care to its people, it requires a fully functional health system. There are many ingredients that make up a functional health system, including human resources for health, transport, ICT, facilities and medicines and supplies.

4.1.1 Governance

31. Health is a human right that is increasingly being recognised as enforceable. Governments have a responsibility for guaranteeing health care for all their citizens in an equitable manner and with clean and efficient governance, while using resources accountably. Governance includes providing stewardship, including vision and direction and providing transparent leadership.

32. There should be committed intersectoral action for health involving other ministries and levels of government. The Health Ministry's stewardship role goes beyond the Ministry of Health's leadership in the health sector (stewardship in health) and the strategic management of the health system (stewardship of health) to addressing the inter-sectoral, socio-political environment within which the health system operates (stewardship for health).

33. The move towards supporting one national plan, one governing framework and one monitoring and evaluation system should be accelerated.

4.1.1a Policies and legislation

34. Health policies will be reviewed regularly to ensure that they are an up to date reflection of government's vision and priorities, reflect best practice and take into account the realities and socio-cultural circumstances of the country. Policies should be geared towards guiding and supporting effective implementation and monitoring of programmes.

35. Legislation and consequent regulation are key tools in giving effect to policy. Countries should review their health legislation and promulgate new legislation and regulations as needed to ensure that their policy intent is supported and that legislative gaps are filled, creating an environment for effective delivery of affordable, appropriate, equitable, and accessible quality care for the entire population.

4.1.1b Organization and Management

36. This Strategy seeks to advocate and promote a coherent organisational framework that enhances efficiency and effectiveness through:

- Proper and adequate planning
- Strengthening and revitalizing a primary health care approach
- Reducing bureaucracy and enabling appropriately skilled and motivated management
- Increasing cost-effectiveness and evidence based decision making
- Improving efficiency through reorganizing services
- Introducing cost-effective, quality improvement programmes and services
- Allocating resources to effectively and equitably address health needs
- Determining the minimum package of core primary health care interventions that all citizens can access
- Decentralizing operational management of the health system
- Applying an effective multi-sectoral approach
- Providing an accessible, affordable and acceptable health care services.

37. Decentralisation provide for effective and transparent management. The basic unit of a well organised health system is the district, which needs to be strengthened and adequately resourced, in a balanced manner with the higher levels of health care. The essential features are the active involvement of local communities and stakeholders and flexibly adapting programmes to local circumstances. District managers should, within national guidelines and delegations, be able to allocate resources and modify approaches and introduce innovations. Each country should develop one or more learning sites to explore what it takes to develop an effective basic health system and to offer a demonstration opportunity to the country and even the region.

38. Integration of related and complementary programmes will be used to improve cost-effectiveness of the health system and convenience to the consumer, overcoming the problems of a vertical and fragmented approach.

4.1.1c Performance

39. Countries are committed to enhancing the performance of their health system to achieve the best value with the resources available. Each country will update and cost their national health plan, following a gap analysis between existing plans and this Strategy and other commitments, taking into account an agreed minimum package of core interventions. These National Health Plans will be the centre of health development in the country, and the basis for strengthening the health system, its implementation continuously monitored and its content regularly reviewed and updated.

40. National health care systems need to respond adequately to the expectations of their population and the changing health needs and there should be a clear mechanism for disseminating the expectations, enhancing community responsiveness and ownership and for improving performance and caring of health workers. There should be a commitment to transparency, accountability and reporting.

41. Countries should consider three possible resource availability scenarios; one at current or low growth levels, a second anticipating greater national commitment and delivery of international promises and the third for the resources required to make the impact desired – and then set targets commensurate with these resources. At the same time countries must constantly ask if the health outcomes justify the inputs, if resources are being optimally utilised and if health system improvements will achieve sustained positive change. These plans must include ways of bridging any possible resource gaps in the short, medium and long term.

42. Incorporating the new opportunities offered by advances in technology and developing and retaining human resources are critical to health systems performance and all elements should receive priority attention. Strategic interventions should value, motivate, proportionately compensate and equip all cadres of health workers.

Countries will update their National Health strategies and plans in line with this Africa Health Strategy and with the detailed commitments collectively made on specific issues by African Heads of State and Government and Ministers of Health. This will include a gap analysis and costing against different resource scenarios, taking into account the minimum package of core interventions.

Ministers of Health will drive efforts to strengthen health advocacy, governance and leadership, implement/strengthen the primary health care approach and make organisational changes to support efficiency, including strengthening of district health systems in line with the 1978 Alma Ata declaration.

4.1.2 Resources

43. Resources encompass key inputs such as fiscal provisions, human resources, physical capital, drugs and medical supplies and commodities. Ministries should generate and apply these resources optimally towards strengthening health systems for equity and development.

4.1.2a Financing, Resource Allocation and Purchasing of Health Services

44. Governments alone cannot assure the health of its population. Partnerships with communities, private sector, civil society organizations as well as development partners are essential to make an environment conducive to good health status as well as to deliver health services.

45. Countries are encouraged to target the US$34-40 per capita required to provide the essential package of health services.

46. Member states are urged to review current public and private health expenditure with a view to increasing the per capita expenditure so that a greater proportion of the population has access to the essential package of health services, with vulnerable sections of the population, especially women and children. This should focus on the major health challenges by using cost-effective measures, with adequate financing for primary health care.

47. Strategies that may be considered by Member States to increase the pool of funding available to the health sector include:

    (a) Increasing the efficiency of the public and private health care sector;
    (b) Advocating for greater donor support in line with the Paris Declaration;
    (c) Advocating for investment in health in line with the Commission of Macroeconomics and Health;
    (d) Exploring alternative sources of additional revenue for both public and private sector; including health insurance systems, while avoiding conflict of interest;
    (e) Elaborating national health accounts for better management of health expenditure.
    (f) Promoting public-private partnerships

48. Financing for health systems needs to be treated as an exceptional case. If basic essential health care is to be achieved then budget caps will need to be lifted, and time bound renewable employment contracts used. Development partners will need to move towards sector wide approaches to ensure absorptive capacity and reduce transaction costs. The health sector should receive suitable allocations from multi-donor budgetary support.

49. Member States are urged to allocate resources with due regard to redressing imbalances, including those between the rich and poor, the urban and rural communities and between men and women and children.

50. Member States must strengthen government's capacity and regularly review the practices and procedures to purchase health services, including tendering and contract management systems which must be accountable.

51. The African Union should engage global health initiatives to encourage them to fund the core health system and human resources requirements needed for their programmes

Countries should steadily increase their budget allocation for health to at least the 15% target set by Heads of State and prioritise primary health care.

The African Union should engage development partners to match the commitments they have made in international forums, with longer cycles of predictable, dependable and harmonised aid.

Countries should explore the use of contract posts (with benefits) for staff in the public sector using basket-funded development aid, the posts being renewable with new funding cycles.

The African Union should engage global health initiatives to encourage them to integrate with national health systems and to fund the core health system and human resources requirements needed for their programmes.

In exploring additional sources of revenue countries should work towards a solidarity model within a framework of equity, seeking to implement pre-payment systems to avoid user fees at the time that care needs to be sought.

Procurement systems should be transparent.

4.1.2b Social Protection

52. Social safety nets at country and community level as well as national health plans need to be encouraged and enhanced in a manner that meets the needs of the vulnerable and that is compatible with traditional and cultural norms and practices of the society. Measures for identifying people who fall through the cracks need to be put in place in a participatory manner. All social protection mechanisms should be mobilised, including social health insurance. There should be a review of user fees with a view to abolishing them as this is important in social protection.

53. National solidarity mechanisms for social protection should be put in place.

54. Enhanced inter sectoral action should provide for a continuum of care and it should be delivered as such. But, there are certain areas which are clearly the responsibility of the health sector and these should be included in National Health Plans or in social pensions.

55. Poverty reduction strategies rather than mere social welfare should be at the core of social protection.

> National Health Plans should include social protection for the vulnerable and a plan to protect families from the long term debt traps of catastrophic illness or injury.
>
> There should be a review of user fees with a view to abolishing them.

4.1.2c Human Resources

56. Health sector reforms must promote all aspects of human resources for health development and retention, addressing policies, strategic plans, information, training, recruitment, deployment and retention, administration, working and living conditions and the health of staff. In this regard, in line with the AU Heads of State and Government decision, Governments should:

    - Determine the categories of professional, auxiliary (mid-level) and community health workers that will provide an appropriate human resource mix for their needs.
    - Develop costed national human resources development and deployment plans, including revised packages and incentives, especially for working in disadvantaged areas.
    - Forward fund the establishment of the training capacity required to produce the desired number of health workers.
    - Build a cadre of multi-purpose trained staff as the nucleus of health care delivery.

    In addition, member states should:

    - Collectively lobby for the lifting of expenditure ceilings imposed by partners in health and other social services
    - Ensure that health workers trained are using public funds offer compulsory community service for a given time as a means of paying back to society
    - Explore additional sources for funding the development of human resources for health in Africa and especially how to reduce migration of health workers out of the continent. An endowment fund can be a possible starting point.
    - Advocate for western governments to also increase investments in the training of their own health care workers in order to address the gaps in their countries and thus reduce the pull factors in developed countries
    - Address the push factors by putting in place mechanism that value, respect, motivate, adequately compensate, professionally develop and equip the health workforce.

57. The African Union needs work towards ensuring ethical recruitment within the continent and by developed countries, by insisting on agreements that take into account the investment made by African countries as well as the rights and freedoms of individuals. Countries should address the causes of migration and conduct migration and retention studies of health workers and should also improve the conditions under which health professionals and other health workers operate. African countries should work together to produce the health workers we need and to develop a common African curriculum.

58. The continent has to implement most effective ways of developing, retaining and enhancing the human resource capital. The most fundamental issue to be ensured is whether the training of health care workers is appropriate and aligned to the needs of the continent. The decision by Africa to train mid level and multi-skilled health workers needs to be followed up by reviewing training curricula and sharing training resources and institutions of higher learning on the African continent. This must be coupled with updating personnel audits of various cadres of the health sector and determining causes of attrition, as well as reviews of career structures.

59. Countries policies and plans should provide for a balance of professional, auxiliary and community health workers to ensure suitable skills, continuous safety, cost-effectiveness and availability. Each country needs to have a comprehensive Training Needs Assessment, for basic and continuing education, supported by a plan of action. In scaling up training, one of the quickest measures is to increase the size and intake of existing institutions while bearing in mind the need to also increase the training and working environment infrastructure and appropriate staffing norms. Some may need upgrading of their facilities, all should have internet connectivity and curricula in some countries may need to be modernised to take account of the latest developments. As we scale up training, we should put in place mechanisms to absorb these staff into service. In this regard countries should support training needs assessment to help identify areas of most need for type, number and qualifications.

60. Countries should ensure effective management of human resources for health starting with updating their employment and deployment policies. Improvement in salaries and work conditions is a critical factor for success. To this should be added flexible career paths, supportive supervision and mentoring, continuing education, recognition of credit hours and continuing professional development and fostering motivation and retention strategies. Managers should demonstrate openly the value they place on their health workers and recognize their professional worth and the adverse circumstances under which many work. There should be effective registration and monitoring of health workers.

61. The severe rural – urban and formal – informal settlement imbalances require special attention. Financial and non-financial incentives e.g. housing, additional leave, further training opportunities should be used to entice/compensate staff. Community service (under supervision) is an important way for new graduates to offer something back to the society that has invested in affording them the opportunity to become a health professional.

62. Good performance of all health staff should be rewarded. Expertise in health management should be developed. All countries should establish National Health Workforce Observatories.

Countries should develop costed national human resources development and deployment plans, including revised packages and incentives, especially for working in disadvantaged areas and for clinical career paths.

Each country should determine the categories of professional, auxiliary (mid-level) and community health workers that will provide an appropriate human resource mix for their needs.

Countries should conduct migration and retention studies of health workers and explore the possibility of establishing networks for training health workers.

The African Union should facilitate a common African position on migration of health professionals and lead engagement with OECD countries to overcome the devastating impact this is having on Africa's health systems.

4.1.2d Commodity Security and Supply Systems

63. Important progress has been made globally and in Africa, but commodity security still lags behind in many countries. Increased resources need to be made available, national procurement systems need to be updated and other sources of commodities need to co-ordinate their efforts with those of government.

64. Universal access to essential health care must be supported with adequate supply of commodities including essential medicines, ARVs, contraceptives, condoms, vaccines and effective drugs and other supplies. They

should be part of the Essential Health Package. Essential medicines and supplies should be exempt from taxes and a special dispensation provided for landlocked countries.

65. Supply systems and logistics and human resource capacity need to be strengthened to ensure appropriate ordering, storage and distribution. As such Governments should promote bulk purchasing and ensure that local facilities have specific protected budgets to access supplies. Member States should be supported in use of available tools like the WHO Integrated Health Technology Package and the UNFPA Commodity Security tools to track commodity needs. Strong backing must be provided by quality assurance laboratories and control systems.

66. Following the decision of AU Heads of State and Government to develop and promote Local Pharmaceutical Manufacturing of Drugs, vaccines and health commodities in Africa, the AU Member States need to embark on local production of pharmaceuticals and other health commodities. Adequate preparation of infrastructure, Human resources training, resource Mobilisation and strategic partnerships for technology transfer in order to embark on the implementation of the Pharmaceutical Manufacturing Plan for Africa are critical and urgent. The AU Health Ministers should agree on a timeframe, scope, distribution, marketing and types of drugs and commodities to be manufactured in the continent.

Support should be given to the Pharmaceutical Manufacturing Plan for Africa which is aimed at realising the economic production at volume of quality generic medicines and other commodities, with countries showing solidarity and removing the tariff and non-tariff barriers to its success. The focus of the plan should be on ensuring a sustainable supply of affordable medicines, local production of generic medicines being but one of a range of ways to secure supply of affordable medicines. In this regard Ministers of health should encourage competition in the market while ensuring transparency in pricing of medicines to ensure affordability and access. Ministers of Health need to put in place medicine control laws and regulations for registration, use and distribution of medicines to ensure safety, quality and efficacy.

The African Union should engage with international partners to enable effective integration of global commodity strategies and systems with countries health needs and with the pharmaceutical industry and other stakeholders for accelerated development of need new commodities.

Countries should advance their logistics and supply systems towards ensuring continuous availability of commodities at health facilities.

4.1.3 Health Systems Operations

67. To be functional all parts of the health system need to be operational, work synchronously and guarantee accessibility in terms of distance. Thus, all elements should be developed simultaneously, focussing on making services widely accessible in terms of distance, cost and time.

68. Health facilities require water, power and working equipment maintained by a locally effective maintenance and repair system. Reliable communication is essential. The advances in telecommunication mean that no clinic should any longer be isolated. Access to laboratory tests, radiography, a safe blood supply and a suitable record system should back up patient care. The referral system should work both ways and be set up to cope with emergencies. Patient transport should be complemented by an effective logistics and supply system that, amongst others, ensures that drugs and other essentials are not out of stock.

69. While building the national health system, countries should consider developing one or more learning sites, as a pathfinder for strengthening their health system. Such integrated development will offer a working demonstration for the country of an effective basic health system.

70. Ensuring trained managers who can effectively mobilise, motivate and innovate as well as plan, organise and budget, and who stay in a district for a meaningful period of time is a top priority. This should be complemented by a cadre of staff with public health training. Each country should determine the qualifications and training they aspire their district, health programme and other managers to have and develop a plan for its attainment.

4.1.4 African Traditional Medicine

71. In declaring a Decade of African Traditional Medicine in 2001, Governments have recognized the wide use and hence importance of integrating traditional medicine into their national health systems and creating an enabling environment for optimising its contribution. The latter includes mobilizing and connecting all stakeholders. It is essential to strengthen structures of traditional medicine through analysis of the prevailing systems and with the involvement of traditional health practitioners and communities, focussing on strengthening the best practices of traditional medicine. Organizational requirements include the establishment of a national multidisciplinary body responsible for the coordination of traditional medicine; formulation of a policy and legal framework; allocation of adequate resources; development of regulations for the local production and rational use of traditional medicines and protection of intellectual property rights.

72. African Union Member States should consider establishing coordinating mechanisms at national and regional levels to facilitate the implementation of the Traditional Medicine Plan of Action. Research in Traditional Medicine should be promoted and funded to identify efficacious and safe traditional medicines and assist Traditional Health Practitioners patent their products.

73. In countries where ATM does not exist, other systems of TM should be considered.

Countries should integrate African Traditional Medicine or, where applicable, other forms of Traditional medicine into their health systems, recognising its strengths and limitations.

4.1.5 Participation

4.1.5a Community Participation and Empowerment

74. Community members are often perceived as consumers and yet are a potential resource that could be tapped into so as to strengthen health systems. Countries and the regions need to have strategies of empowering and involving communities to ensure ownership and sustainability of programmes. Community participation should not be limited to cost sharing only but should also include other aspects like report problems in the health systems.

75. Realising the full potential of community involvement is often a challenge. In scaling up community involvement there is a commitment to mobilize energy and voluntarism in a manner that is difficult for formal health services to match, and to achieve results in groups that formal services struggle to reach. Health ministries will therefore need to create an enabling environment for responsible and constructive community involvement, facilitate the emergence of local NGOs and CBOs and provide funding to initiate and facilitate efforts in underserved areas. However, such support should not detract from the independence and vibrancy of community involvement and there should be space for advocacy, which might coincide with or confront government efforts and also challenge other sectors to be supportive.

76. Innovative concepts on how buy-in by communities can be enhanced need to be employed. An example of this could be selling a stake of the health system, by outsourcing an income generating and self sustaining part of the system to communities, such that this results in a mutually beneficial relationship between the health system and the community it serves. Support and ancillary services in a health system lend themselves particularly well to this concept. The private sector has an important contribution to make through enabling the health of their labour force.

77. Countries should design and implement a plan for achieving health literacy, especially for women and girls, and community empowerment to realise the full benefit that this offers for health. The media have an important role to play in enhancing health and in reflecting community experience.

78. As situations vary from country to country, there is no single way of enabling community involvement. Each country should consider their local situation and incorporate a deliverable approach to community involvement in their counties health plan. The details may be different, but the aim is common to all

countries: to reach all sectors of society, especially the poorest and most marginalized, in a sustained programme of social mobilization in support of health.

Each country should plan their framework for community participation in the health system and create an enabling environment for this to take place.

Countries should design and implement a plan for achieving health literacy and community empowerment to realise the full benefit that this offers for health.

4.1.5b Strengthening Partnerships

79. There is generally unsystematic and uncoordinated partnership between donor and recipient countries resulting in conflicting focus in programme implementation. Countries need to adhere to the 3 ones principle and to establish organisational structures that ensure a single entry and review point for engaging with development partners. Successful implementation of the Africa Health Strategy will take more than defining the role and responsibilities of all contributors. Equally, for continent wide partnerships the AU should develop procedures for engagement with Africa.

80. Relationships based on government stewardship and mutual respect between government and its partners must be strengthened to ensure coordinated action aimed at strengthening health systems.

81. Ministries of Health must facilitate an environment that will deepen partnerships in health. Regional economic communities should build partnerships between countries and others.

82. As part of the global community, because they add value and because Africa does not have the fiscal space and is short of capacity in some areas, Multilaterals, Development partners and Global Health Initiatives offer valuable support. However, Health Ministers should ensure and facilitate consultation, establishment of donor forums and ensuring good corporate governance including longer term dependable funding systems. Foundations should continue to play a strategic role, moving rapidly and creatively to inspire new initiatives and learning. Multinational consulting and technical institutions should ensure that they are committed to building African capacity and not maintaining dependency. Countries should work with partners to assess the actions on commitments of both partners.

83. Multilaterals, which are predominantly in the United Nations system, play an important normative, developmental and technical role. Their expert views should continue to inform developments. All should be cognisant that that they are using funds which might otherwise have gone to countries and look carefully at their responsive to country accountability and the proportion of funds that are expended downstream.

84. The AU and its organs as well as RECs are urged to:

a. strengthen collaboration within Africa;
b. strengthen and expand south-south and North-South collaboration;
c. north-south collaboration;
d. work with donor partners to ensure that resources are mobilized to contribute to the attainment of the goals of this Strategy.

Innovative and effective partnerships are envisaged between government and health development stakeholders, anchored on mutual respect, leading to a harmonised and co-ordinated effort and a seamless health service for clients. Ministries of Health will provide an enabling framework for development partners to play their role.

4.1.6 Health Management Information and Research

85. Countries have been developing their essential national health research plans and their health information systems. Too often the latter is unsettled by the pressures to separately collect data on specific health challenges leading to a fragmented system. These need to be merged to in order to have an appropriate

health information system made up of locally generated and collected accurate data suitable to monitor progress, inform decision making and assure quality in the delivery of health care. The systems need to be readily accessible, user friendly and capable of synthesising data for use at any level of the health system (policy, planning, implementation, monitoring and evaluation), an imperative for running an effective and efficient health system. The information system should be simple and efficient so as to flow smoothly with the provision of care and be suitable for informed decision making. Government should publish official statistics on health.

86. Health information systems should be strengthened to guide and support decision-making at all levels. A standard package of information reflecting gender and age and based on a minimum package of interventions should be collected to monitor and evaluate health system performance. The district or hospital information systems should provide a framework of information for monitoring progress, identifying where interventions are required and evaluating success. The routine data will need to be supplemented by other information, such as from surveys.

87. Health Research provides the evidence for policy- and decision-makers at all levels to make efficient and effective decisions. This was reinforced and detailed direction on Health Research provided in the reports of the Abuja and Accra High Level Ministerial Meetings on Health Research. The content of research is critical and needs to go beyond determining prevalence to explore what social and psychological factors are behind health choices, and what factors lead to success of interventions. A continental position paper on health research in Africa should be developed.

88. The African continent must have locally driven and financed research which generates information to inform policy and plans. Empowerment of local researchers and resource allocation for research are critical factors for development of innovative approaches and interventions, which are sensitive to the peculiarities of Africa. Research in general, and operational health systems research specifically, is a necessity for improving health system performance. In consequence, countries should build research capacity and allocate at least 2% of national health expenditure and 5% of project and programme aid for research. They should prepare legislation governing research and establish or strengthen national health research systems and establish platforms for research to be presented so that it can indeed influence health policy and practice.

89. Multi-country collaborations will help to determine whether factors are specific to a country or locality or are broader predictors and determinants for a region or the continent. Countries should share their research findings among themselves and with the AU Commission. Clinical trials and research by international organisations should be regulated and be ethical.

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Countries should develop a simple, timely health information system that is suitable to monitor progress, inform decision making and assure quality in the delivery of health care.

Countries should allocate at least 2% of national health expenditure and 5% of project and programme aid for research. They should determine what their essential national health research needs are and establish platforms for such research to flourish.

4.1.6a Surveillance, Emergency Preparedness and Response

90. Member States and regional economic communities need to formulate, strengthen and periodically review their Surveillance and Emergency Preparedness plans for health disasters as well as natural disasters which have health consequences. Countries should prepare to implement the International Health Regulations.

91. Each country should have a community based, clinic and district hospital mechanism of monitoring and rapid reporting in place, which will ensure that outbreaks are identified and acted upon up the line as appropriate at the district, regional and national and continental levels. The response should be based on clinical suspicion followed by laboratory confirmation as quickly as possible. Countries should promptly call in expert support and pooled supplies, but their response should already be activated based on a national plan that incorporates operational details.

Ongoing surveillance of both diseases and vectors will be the basis of a high level of vigilance for outbreaks so that they are identified and acted upon early within a national plan, responses being based initially on clinical suspicion followed rapidly by laboratory confirmation.

4.2 Integrated Approach and Linkages

92. Each country, based on its specific circumstances, needs to define, cost and implement a basic health care package that address the major part of its disease burden through appropriate interventions using an integrated approach. The interventions would take care of the priority health problems both communicable and non-communicable disease and conditions, including neglected diseases, injuries and trauma. Joint planning with other sectors like water, education, agriculture, environment, social welfare and justice should be undertaken. National policies and plans should address the needs of the elderly, the disabled, women, children in school and other vulnerable groups. There should be a strong emphasis on behaviour change.

93. The interventions should be comprehensive addressing promotion, prevention, treatment and care, support and rehabilitation as may be required. The health sector needs to strengthen inter-sectoral collaboration to address other determinants of health.

94. AU Member States should fast track the implementation of the declarations, plans of action, strategies and policy frameworks that have already been adopted by the African Union in order to accelerate progress towards the attainment of MDGs. In line with the Charter of the Rights of Children countries need to strengthen or develop programmes to combat childhood illnesses, with particular emphasis on orphans and vulnerable children and their carers who in the case of AIDS orphans and vulnerable children are mainly older women caregivers.

95. The health system should prioritise actions to address maternal mortality, emphasise gender into health policy and seek elimination by law of all forms of violence against women. It should promote helpful traditional practices and by legislation, eliminate harmful traditional practices which are linked to Vesico Vaginal Fistulas, and female genital mutilation.

96. A broader women's health programme should be institutionalised including family planning repositioned into wider reproductive health programmes. There should be programmes to take care of sexually transmitted infections, and screening and treatment of reproductive cancers - including human papilloma virus vaccination, for managing infertility and for menopause. Recognising the morbidity and mortality from unsafe abortions especially for the poor, safe termination of pregnancy and post-abortion services should be included as far as country's law allow. The right of women to manage their own health and health seeking behaviour should be advocated. This should be built on a gender and sexuality education programme and youth and women friendly services, with a specific focus on reducing teenage pregnancies and sexually related disease as well as ensuring access to post exposure prophylaxis for victims of rape. The role of men, both as supporters and recipients of SRH services is imperative to develop.

97. With up to 40% of under-five deaths occurring in the first month of life and about 26% in the first week alone, reducing mortality and morbidity starts here. Efforts should be integrated with safer motherhood, which should have a specific neonatal care component to them.

98. The small number of major causes of under-5 mortality offers opportunities to make a major impact through focussed efforts. However, experience has shown that single disease efforts can be costly and lead to alternate mortality, making the case for integrated programmes, delivered at the family and community level by community health workers, scheduled interventions requiring auxiliary staff and clinical services requiring permanently available professional (ideally) staff. The package of interventions includes breast and child feeding including micronutrient supplementation, immunisation including the introduction of new vaccines such as pneumococcal and rotavirus, prevention of mother to child transmission of HIV and care of HIV, use of insecticide treated nets and intermittent presumptive treatment of malaria and management of common childhood illnesses within the strategy of Integrated Management of Childhood Illnesses. Countries may wish to implement these in packages of growing complexity and cost, but should maintain the link to wider health system strengthening and be cautious of cost estimates that emphasise only the

marginal costs of the drugs and supplies and do not sufficiently take into account the costs such as human resources, logistics and management.

99. Immunisation remains the most cost-effective public health intervention. Poliomyelitis has a special place in immunisation programmes. , not because it is still a cause of morbidity, but because of the potential of global eradication. At the same time experience has shown that diminishing the concentrated effort has resulted in importation of the polio virus to some areas.

There must be a focus on the key health challenges faced, but delivered within an integrated health system. A summary of the best practices for promotion, prevention, care and rehabilitation for each of these challenge, as elucidated in summary in this Strategy will be incorporated into country health plans in response to local circumstances. Universal access is the rallying point of the response to all health challenges.

4.3 Socio-economic and political context of health

100. Measures that reduce poverty, particularly for the poorest and most marginalised people of Africa, must be at the forefront of health interventions, while health interventions must be at the forefront of any poverty reduction strategy (PRS).

101. As health is influenced by interventions in many other sectors, a multi-sectoral approach is a cornerstone of any Health Strategy. Thus, the African Health Strategy recognizes and supports African commitments to address broader issues that are undermining health, including poverty, HIV/AIDS, marginalisation and displacement, poor governance, socio-political instability, economic underdevelopment, lack of infrastructure (energy, transport, water and sanitation), low educational levels, agricultural vulnerability, environmental degradation and gender inequality. The health sector will continuously engage with these other sectors to encourage decisions and actions that give the best return for health.

102. The link between the environment and health was strongly emphasised at the World Summit on Sustainable Development. The responsibility for obviating environmental health risks lies in many sectors and the health sector should encourage health friendly environmental decisions and contribute its insights into them. Beyond this there is a unique contribution of the health system to offsetting environmental health hazards. The focus has shifted from inspection to environmental health promotion. Especially in rural areas, environmental health workers, working hand in glove with other community health workers and advocating appropriate technologies should make an important contribution, guided by mid level health workers and professionals. Water filtration and chlorination, ventilated improved privies, fly traps and mud stoves all reduce disease. For example mud stoves with chimneys obviating the indoor air pollution of open cooking and heating fires has the potential dramatically impact on the mortality from childhood pneumonia. Removal of pooled stagnant water used by mosquitoes for breeding, while avoiding soda bottle storage of paraffin reduces accidental ingestion. Appropriate handling of livestock has become even more important with the threat of avian influenza. Urban informal settlements require major environmental health attention. This includes food vendor education about avoiding food poisoning and community education about measures to avoid refuse-related risks and accidental fires. Unlawful dumping of harmful substances in Africa should be addressed.

Ministers of Health will seek to participate in their countries poverty reduction strategy and economic empowerment processes to encourage health promoting options and development for the poorest and most marginalised people and will engage with other sectors to promote decisions and actions that work in favour of health.

5. Monitoring and Evaluation

103. Monitoring and evaluation of performance of the health system depends on the generation and use of sound data on health system inputs, processes, outputs and outcomes. The Health programmes must be responding to health problems. Countries must ensure that the data collected is accurate and timely as it will indicate both the performance of the system as well as the relevance of the programmes to health problems. The adequacy of a monitoring and evaluation system may be assessed by the regularity, completeness and quality of reports. Data should be disaggregated by gender and age to enable more focussed action. Community participation in monitoring health programmes should be encouraged.

104. While morbidity and mortality trends are important, the importance of health service operations monitoring should not be overlooked. Process and outcome data is particularly important. Surveys, including before and after intervention studies should be built in as part of the M&E system, as should qualitative perspectives, such as by community committees at clinics and hospitals and from focus group discussion. An ethos of using M&E to build a better health service, rather than a perspective of it as a policing tool should be nurtured and is likely to enhance the results.

105. Periodic reviews should be held at the regional and continental levels. This will help to share best practices, more effectively address obstacles, strengthen a partnership approach and accelerate progress in the implementation of this Health Strategy.

106. Quality Assurance should be an integral part in health programme implementation at all levels.

107. The African continent must agree on what areas to monitor and evaluate to assess progress in health; thus common indicators must be agreed upon and developed, based on the minimum package for health interventions. For this to happen, common and standard data sets, disaggregated by gender and age will have to be designed. This will necessitate collection of common data sets, across the continent, using the same design and methodologies, in order for scientifically sound analyses and comparisons to be made. Efforts should be concentrated on the improvement of the vital statistics registration systems, epidemiological surveillance, morbidity and mortality registration and resource management information systems. Health workforce monitoring should be an integral part of the information system.

6. Way forward

108. The Commission will print and disseminate the Strategy widely to all Member States, partners and all stakeholders. RECs and Member States should build their capacity for implementation of this strategy, as they will have to review their Health Plans to incorporate the essential elements from the Africa Health Strategy. There will be need to enhance the financial and human resources of the AU Commission, especially in monitoring and evaluation to ensure that it plays its role in the success implementation of this Strategy.

Role of Stakeholders

(a) The African Union

109. The African Union will, among other things, undertake advocacy, resource mobilisation and dissemination of best practices at continental level in support of the implementation of this Strategy. The Commission will assist RECs and member states to develop their own costed implementation plans and monitoring and evaluation frameworks. The AU should organise a meeting of stakeholders to develop an action plan for the overall implementation of this Strategy

(b) Regional Economic Communities

110. Regional Economic Communities will, among other things, provide technical support to Member countries including training in the area of health systems strengthening, advocate for increased resources for health

systems strengthening, harmonise the implementation of national Action Plans, monitor progress, identify and share best practices.

(c) Health Plans

111. Member States will review their Health Plans and will address issues of accountability within the health sector. They will also put in place advocacy, resource mobilisation and budgetary provision as a demonstration of ownership. They will also undertake monitoring and evaluation at country level and report to the RECs and AU Commission. They will also ensure participation of civil society and the private sector in the development and review of national health programs and create a conducive environment for this to happen. Member states will also harmonise their policies and strategies to ensure coherence.

Member States

(d) Partners

112. In line with the Paris principle multi-lateral and bi-lateral organizations, international and national civil society organizations and other development partners will align their financial and technical assistance and cooperation plans with national and regional needs and priorities for implementation of the Africa Health Strategy.

113. WHO, other UN agencies and International organizations should provide technical support for this Strategy

(e) Civil Society Organizations

114. These include NGOs, Faith Based Organizations (FBOs), CBOs, Traditional leaders and healers as well as media organizations. Civil society and the private sector must be included in national programs

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B16 African Ministers of Health Johannesburg Declaration (2007)

Johannesburg Declaration of the Third Ordinary Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa 9¬13 April 2007 CAMH/MIN/Draft/Decl.(III)

WE, MINISTERS OF HEALTH OF THE AFRICAN UNION, meeting at the 3rd Ordinary Session of our Conference in Johannesburg, South Africa, 9 -13 April 2007 under the theme "Strengthening of Health Systems for Equity and Development";

DEEPLY CONCERNED by the multitude of public health challenges faced by our continent owing to, among others: weak health systems including inadequate social protection, rising levels of communicable and non-communicable diseases, shortage of human resources for health aggravated by brain-drain, widespread poverty and the impact of armed conflicts and violence;

ACKNOWLEDGING existing national, regional and continental policies, programmes and partnerships as key for the promotion of health;

COGNIZANT that Africa has to make great strides to meet the Millennium Development Goals by 2015;

ALSO COGNIZANT that the health sector is not merely a consumer of scarce resources, but a great source of national wealth; and that investment in people's health is vital to sustainable socio-economic development;

AWARE of the cross-cutting nature of health and the importance of inter-sectoral collaboration in the promotion of universal and equitable access to health services and reduction of the disease burden;

FURTHER AWARE of the need to scale up the integration of traditional medicine into national health systems, including broadening the skill base of traditional health practitioners;

TAKING NOTE of the recommendations of the Inter-Ministerial Consultation on Health Work Force Development in Africa, Gaborone, 2-4 March 2007;

WELCOMING the launch of the Campaign to Accelerate HIV Prevention (11 April 2006), and of the Malaria Elimination Campaign (10 April 2007).

WE HEREBY:

1. **COMMIT** ourselves, in collaboration with our partners, to implementing the decisions and recommendations of the 3rd Session of our Conference, particularly those aimed at strengthening our health systems; and to providing periodic reports on the status of implementation to the AU Commission;
2. **ALSO COMMIT** ourselves to developing social protection systems, particularly for the poor and vulnerable groups in society, aimed at promoting greater access to health care services and protecting families from debt traps due to health emergencies;
3. **FURTHER COMMIT** ourselves to implementing the Continental Africa Malaria Elimination Campaign and to launching similar campaigns at national level on 25th April 2007, on the occasion of Africa Malaria Control Day;
4. **URGE** Member States to facilitate inter-ministerial collaboration for an integrated, well- coordinated, harmonized and comprehensive response to the health challenges facing Africa. In this regard, WE PLEDGE to implement the Africa Health Strategy in collaboration with the AU, RECs, Regional Health Organizations, UN Agencies, Private Sector, Development Partners and other International and Civil Society Organizations;

5. **ENDORSE** the proposal for urgently establishing a Technical Committee to facilitate the implementation and monitoring of the Pharmaceutical Manufacturing Plan for Africa;

6. **RESOLVE** to develop mechanisms to effectively implement the Plan of Action on Prevention of Violence in Africa, including in situations of civil strife and armed conflicts;

7. **ALSO RESOLVE** to make the necessary efforts to utilize the Monitoring, Follow Up and Reporting Framework on the Commitments of the 2006 Abuja Special Summit on HIV/AIDS, Tuberculosis and Malaria, in line with scaling up towards universal access to health services;

8. **UNDERTAKE** to implement a comprehensive program of action to address all the elements of the health workforce crisis in Africa, including achieving improved performance and effective deployment, tackling migration, scaling up production, securing sustainable financing, enhancing governance, stewardship and partnership, among others;

9. **CALL UPON** UN Agencies, Private Sector, Development Partners and other International and Civil Society Organizations to continue to collaborate with the Continent and provide support to its development agenda, in a well-coordinated and harmonized approach;

10. **REQUEST** the AU Commission and RECs, in collaboration with all stakeholders, to coordinate the mid-term review on the implementation of the Plan of Action for the Decade of African Traditional Medicine (2001-2010);

11. **FINALLY REQUEST** the AU Commission and RECs to promote and coordinate international partnerships, as well as follow up and report on the implementation of the outcomes of this meeting, in particular the Africa Health Strategy, at our next Ordinary Session.

Done in Johannesburg, South Africa, on 13 April 2007

B17 Call for Accelerated Action on the Implementation of the Plan of Action Towards Africa Fit for Children (2008–2012)

Second Pan-African Form on Children:
Mid-Term Review
29 October–2 November 2007
Cairo, Egypt
PANAF/FORUM/CHD/MIN/2(II)

I. Introduction

1. We, the Ministers of AU Member States responsible for promoting and safeguarding the rights and welfare of children in our respective countries, meeting in Cairo, Arab Republic of Egypt, from 29 October to 2 November 2007 considered and reviewed the progress made in implementing the 2001 Declaration and Plan of Action of Africa Fit for Children which constituted the African Common Position to the 2002 UN General Assembly Special Session on Children. We focussed our deliberations on the ten priorities set out in the Plan of Action, namely: Overall Framework; Enhancing Life Chances; Overcoming HIV/AIDS; Realising the Right to Education; Realising the Right to Protection; Participation of Youth and Children; Actions at all levels; International Partnership; Follow-up Actions and Monitoring; and Call to Action.
2. We reaffirm commitments made in making Africa Fit for Children, among others, in:
   - The African Charter on the Rights and Welfare of the Child (ACRWC) adopted by the African Heads of State and Government - July 1990;
   - The Declaration and Plan of Action on Africa Fit for Children adopted in 2001 which was also Africa's contribution to the UN General Assembly Special Session on Children held in New York - May 2002;
   - Plan of Action on African Decade on Persons with Disabilities – 2002;
   - The Declaration and Plan of Action on Employment and Poverty Alleviation in Africa adopted by the Third Extraordinary Summit of Heads of State and Government held in Ouagadougou, Burkina Faso in September 2004;
   - Plan of Action on the Family in Africa, 2004;
   - Decision - Assembly/AU/Dec.75(V) on Accelerating Action for Child Survival and Development in Africa to meet the MDGs, in particular MDG 4 on reducing child mortality and morbidity – Sirte, July 2005;
   - Decision - Assembly/AU/Dec.92(VI) on the Second Decade of Education in Africa (2006-2015) – January 2006;
   - The Policy Framework and Plan of Action on Sexual and Reproductive Health and Rights – January 2006;
   - The Abuja Call for Accelerated Action toward Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa - May 2006;
   - The African Youth Charter - July 2006;
   - Africa Health Strategy of 2007-2015.
3. We further reaffirm all other relevant declarations, decisions, resolutions, recommendations, and policy documents at all levels, including the UN Millennium Declaration and the MDGs on improving the livelihood and well-being of Africa's children.
4. We are concerned that the situation of children in Africa remains critical due to socio-economic, cultural, political challenges including conflicts, violence, abuse, neglect, exploitation, trafficking, natural disasters and generally preventable diseases, poverty, and harmful traditional practices.
5. We note with concern the special vulnerability of the girl child and children with disabilities; special attention needs to be accorded across all priority actions to help them access services and realize their rights with dignity.

6. We are aware that although a number of significant achievements have been made in Africa in the promotion of child survival, protection, development and participation, the progress has been slow and thus targets set in the Africa Fit for Children and the World Fit for Children are yet to be attained.
7. We recognize the need to strengthen mechanisms for accountability to ensure more consistent and comprehensive progress during the next five years.

II. Situation and Challenges

8. The well-being of Africa's children depends first and foremost on the well-being of their families and communities. Africa has among the highest levels of absolute poverty in the world. Government programmes and their outreach to eradicate poverty require considerable effort and support. This has major implications for the health, education and protection of the rights of children. As always, children pay the penalty for a situation over which they have no control or responsibility.

Enhancing Life Chances

9. The Declaration and Plan of Action of Africa Fit for Children sets out an ambitious series of measures to ensure that every child in Africa has a good start in life, can grow and develop in a child friendly, nurturing environment of love, acceptance, peace, security and dignity. Considerable progress has been made towards the achievement of these goals. Although new initiatives and developments since the declaration show some promise, the impact is not significant.
10. The life chances of Africa's children is amongst the lowest in the world. Almost 5 million African children die every year from preventable and treatable diseases. Since Africa Fit for Children was adopted in 2001, an estimated 28,800,000 African children have died of causes that are preventable.
11. Driven by this understanding, in 2007 the African Union Ministers of Health adopted the new Africa Health Strategy. As they noted, "While Africa has 10% of the world's population, it bears 25% of the global disease burden and has only 3% of the global health work force." The new strategy aims to strengthen health systems in a comprehensive manner. It deals with critical areas including reducing neonatal morbidity and mortality, combating malaria and malnutrition. It offers a clear set of directions for dealing with the conditions and diseases that are undermining the life chances of Africa's children.
12. At the same time, it is also understood that non-medical interventions such as clean drinking water and improved sanitation are crucial to the health and nutrition of children and their families.

Overcoming HIV and Aids

13. The Declaration and Plan of Acton of Africa Fit for Children called for reducing the incidence of HIV amongst young people aged 15-24 years by 25% by 2005 and preventing mother-to-child transmission (PMTCT) of HIV by 25% by the same year. In fact, PMTCT has indeed been reduced by 25% in several countries. Outside Southern and Eastern Africa, the incidence level of the virus among young people has largely remained low. At the same time, additional investment of millions of dollars is available and is being used to fight the pandemic on every front.
14. Still, the magnitude of the pandemic can hardly be exaggerated, especially in Southern and parts of Eastern Africa. In 2006, 2 million children had been infected as had 10 million youth between 15 and 24 years. Of these, three-fourths are female. Only a very small portion of young people who require treatment have access to the same.
15. In some parts of the continent, around one-third of pregnant women are infected and around one-third of the children born to these women will also be infected with the virus. Without treatment, more than half of these children will die before their second birthday. Mother-to-child transmission is the second most common mode of HIV transmission and can be reduced through timely anti-retroviral therapy. However, despite the progress noted above, the necessary drugs are not widely available and in some rural areas the access is very low.

16. One of the unanticipated consequences of the AIDS pandemic for Africa has been the emergence of a virtual nation of children who are orphaned, growing faster than the worst fears predicted. By 2010, it is estimated that the number of children without one of the parents will total 53 million.

17. In 2006, African Union Heads of State and Government, meeting in a special summit on HIV/AIDS, Tuberculosis and Malaria , adopted the Call for Accelerated Action toward Universal access to HIV and AIDS, Tuberculosis and Malaria services in Africa by 2010.. Clearly, these diseases remained, as they had been in 2001, the greatest survival issues affecting Africa's children and youth.

Realizing the Right to Education

18. The Declaration and Plan of Action on Africa Fit for Children reiterated the educational goals and commitments that had been emphasised in other Conferences and Summits of Heads of State and Government and Ministers of Education where they committed themselves to Education For All with an emphasis on provision of universal access to quality, free and compulsory basic education, and ensuring equal access to girls and boys. With the abolition of school fees by a number of countries, more African girls and boys now attend school than ever before. Progress towards Education For All has come closer to reality. Enrolments increased between 1990 and 2005 from 57% to 70%, and in some countries there is improvement in gender parity as well.

19. Nevertheless, educational challenges continue to be a major issue in Africa. An evaluation of the first Decade of Education for Africa (1997-2006) revealed that "most of the goals" were not achieved. Among the issues that urgently need to be tackled are the low completion and high drop out rates, access to education facilities and services for children with disabilities, low transition rates to post-primary education, teacher training, inadequate recreational and sports facilities in schools, technical and vocational training. as well as abuse of children especially adolescents and girls. The number of children out of school continues to rise in some countries. Early childhood development including pre-primary schooling also needs increased focus in order to enhance access. The education systems are still struggling with major resource constraints including, shortage of trained teachers.

20. Inadequate attention has been paid to higher education and research, as a source of human resources and new knowledge for the enrichment of all levels of education. The Ministers also identified the need for state of the art management information systems to facilitate knowledge-based educational planning, monitoring and follow-up.

21. In the face of these realities, African Ministers of Education have ushered in the Second Decade of Education in Africa, 2006-2015, with a comprehensive Plan of Action designed to meet the formidable challenges ahead.

Realizing the Right to Protection

22. The Declaration and Plan of Action of Africa Fit for Children commits state parties to protect children from all forms of abuse, neglect, exploitation and violence. There is inadequate data on most issues of child protection. This includes children affected by armed conflict, sexual exploitation of boys and girls, female genital mutilation, forced marriage and child marriage, child labour including worst forms of labour.

23. Although some progress has been made, it is still grossly inadequate. There is now an increasing awareness and recognition of violence against girls being a major problem at home, community and even schools. In recent years, considerable attention is being paid to female genital mutilation. Although, initial results are promising, a major continent-wide effort is needed for its elimination. Trafficking for purposes of prostitution, pornography and household servitude has grown rapidly across many African countries. Early and forced marriages remain a harsh reality for millions of young girls. Cultural traditions, customary laws and religious practices are often used to justify such unacceptable and destructive practices.

24. Despite the attention given to the issue, many African children are still affected by armed conflict. Children with disabilities are stigmatized and denied educational opportunities.

25. While some harmonization and domestication of laws have been accomplished, more remains to be done. Only 41 African countries have ratified the African Charter on the Rights and Welfare of the Child. Children's rights are seldom accorded the same priority that society does for adult's rights. Few children enjoy the rights that have been articulated in the ACRWC, UN Convention on the Rights of the Child (CRC) and do not have access to legal protection and remedial measures. Many UN protocols designed for the protection of children have not yet been ratified by some countries.

26. While the seriousness of these many injustices are widely recognized and while certain halting steps forward have been taken, the gap between policy and practice remains very considerable. Africa's children deserve from their governments protection from threats to life and respect for their human dignity.

Participation of Children and Youth

27. The Declaration and Plan of Action on Africa Fit for Children affirms "the right of youth and children to participate". Some preliminary initiatives have been launched in various parts of the continent to implement this goal. The African Youth Charter, 2006 provides, among others, the right of youth to participate in the development of the continent and in decision-making "at local, national, regional and continental levels of governance".

28. Despite the promises made, the reality is that meaningful participation of children in affairs of state, society, community and family is extremely rare. It should be recognised that a meaningful and well informed participation of children and adolescents not only leads to a better understanding and possible solution to the problems they face, but is also one of the most effective ways to enhance their social development, self esteem as well as respect for others and the need for responsible behaviour.

III. Call for Accelerated Action

29. We, the Ministers of AU Member States responsible for the promoting the rights and welfare of children, reaffirm our commitment in achieving the targets of the 2001 Plan of Action and commit to the following priority actions in each of the areas:

1. Legislative and Policy Framework

a) All AU Member States to ratify the African Charter on the Rights and Welfare of the Child, by end of 2008;
b) domesticate the Charter and enact appropriate laws or amend laws to bring them in line with the Charter by 2010;
c) accelerate legal reform to ensure all children are protected by comprehensive legislation in line with the African Charter and other international human rights standards;
d) harmonize existing laws on children at national level;
e) requests AU to develop an additional protocol to the ACRWC on elimination of involvement of children in armed conflict;
f) develop an appropriate policy framework within all Ministries dealing with children to accelerate actions for realizing the rights of children and achieve concrete results as noted in this Call for Action.

2. Institutional Framework

a) establish adequately resourced and mandated structure(s), such as national observatories, ombudspersons on child rights, that will include children as members;
b) establish appropriate structures to provide leadership, oversight and accountability for implementation of laws, policies and programmes for children;

c) set up functional mechanisms to coordinate the implementation of inter-sectoral programmes for children, that would involve all relevant Ministries and Departments as well as civil society, private sector and institutions represented and led by children themselves;
d) set up a joint task force drawn from the African members of the UN Committee on Rights of the Child and the Committee of Experts on the Rights and Welfare of the Child with adequate regional representation to examine the feasibility of harmonizing and simplifying reporting formats and to examine opportunities for mutual learning as well as options for adding value to each other's processes, when it comes to reporting and review of reports from countries in Africa.

3. Mobilizing and Leveraging Resources for Africa Fit for Children

a) allocate sufficient resources in the national plans, Poverty Reduction Strategies and the supporting Medium Term Expenditure Frameworks and budgets for implementing various elements of the Plan of Action of Africa Fit for Children with a focus on marginalized children, including those from poor families, vulnerable, children who are orphaned and children with disabilities;
b) enhance cooperation among stakeholders for learning lessons from good practices around resource mobilization and explore multi-country proposals for seeking funding from bilateral and international partners as well as from the private sector for accelerating the achievement of the goals in the Plan of Action of the Africa Fit for Children.
c) allocate adequate resources to strengthen social protection measures for children, especially the most vulnerable including children with special needs and those who are orphaned;
d) Allocate sufficient resources for structures created to address children's issues.

4. Enhancing Life Chances

a) strengthen health systems in order to provide good and quality maternal and child health services and develop health centres and hospitals that are child friendly, in line with the Africa Health Strategy;
b) scale up essential interventions to reduce maternal morbidity and mortality as well as reduce neonatal mortality;
c) scale up a minimum package of proven childhood interventions based on successful strategies such as Accelerated Child Survival and Development (ACSD) and Integrated Management of Childhood and Neonatal Illnesses (IMNCI) as part of national health policies and plans, poverty reduction strategies and health sector reforms, consistent with the Decision AU/Dec.75 (V) on Accelerating Action for Child Survival and Development in Africa to meet the MDGs;
d) support family and community based actions that enhance children's health, nutrition and well-being including safe drinking water, improved sanitation and hygiene as well as appropriate young child feeding practices and food security measures when needed.

5. Overcoming HIV and AIDS

a) scale up universal access to HIV and AIDS prevention, treatment, care and support (linking with other health measures on promoting reproductive health and reducing Tuberculosis, Malaria and other related diseases) with an emphasis on adolescents, young girls, women, children living with HIV and AIDS and the most vulnerable segments of the society;
b) scale up programmes for Prevention of Mother to Child Transmission of HIV and AIDS;
c) support measures that will assure primary prevention and protection as well as address the social context of HIV and AIDS that makes young girls, adolescents and children more vulnerable;
d) support initiatives to foster positive attitudes towards those affected, and address stigma and exclusion.

6. Realizing the Right to Education

a) implement the goals of the Second Decade of Education for Africa, 2006-2015;
b) ensure safety of boys and girls in schools, provide for quality child friendly schools that will ensure provision of safe drinking water, segregated toilet facilities for boys and girls and incorporate school health and school feeding, as well as guidance and counseling services, as measures that will enhance quality of learning and reduce drop outs of children.
c) ensure universal access to comprehensive quality basic education including early childhood care and education as well as preschool education, for both girls and boys with special attention to reducing disparities and addressing the rights of the marginalized children, including those from poor families, children on the streets, children with disabilities, children in situations of armed conflict and children out of school;
d) strengthen the Education Management Information System (EMIS) to include data on access, retention and achievement as well as educational processes, such as pedagogical techniques and learning outcomes;
e) develop and expand sports infrastructure at schools and promote extra-curricular activities for children.

7. Realizing the Right to Protection

a) ensure universal birth registration through comprehensive measures including campaigns and appropriately resourced systems;
b) put in place a comprehensive juvenile justice system that is consistent with the provisions of the ACRWC including rehabilitation and reintegration of children in conflict with the law;
c) promote and implement integrated national strategies comprising zero-tolerance, backed by appropriate amendment to criminal codes and relevant legislation enforcement and raising awareness to abandon harmful traditional practices such as female genital cutting/mutilation and early marriage;
d) promote and implement multi-sectoral programmes on ending violence against children, including neglect, abuse, sexual exploitation, child labour and trafficking guided by the findings and recommendations of the UN Study on Violence against Children as well as support activities such as lifelines and safe havens to rehabilitate and reintegrate children victims of abuse, sexual exploitation, rape and trafficking;
e) implement measures to prevent conflict through integrating peace education and promoting effective participation of children, consistent with international humanitarian law and the provisions of ACRWC , protect children from the impact of armed conflict and include children in post-conflict reconstruction and rehabilitation activities as well as implement the recommendations of the 10 years review of the Graca Machel study on .'Children in situations of Armed Conflict'

8. Realizing the Right to Child Participation

a) Promote the right to participation of all children (particularly those who are marginalized, children from poor families, children with disabilities and children who are orphaned and vulnerable) based on their evolving capacities through establishing appropriate consultative fora including child rights clubs, children's parliament, and associations;
b) create a safe and enabling environment for children's participation and provide them with access to appropriate and useful information, listen to their views and support them to participate in decision making and in search of solutions about issues affecting their lives through optimal use of social communication channels and interactive media;
c) provide for full and effective participation of children in all aspects of celebrating the Day of the African Child;
d) document good practices of child participation vis-à-vis how they enhance and accelerate achievement of results for children, for learning lessons and wider application;
e) promote children's participation in sports and cultural activities.

IV. Monitoring and Evaluation

30. The Declaration and the Plan of Action on Africa Fit for Children, 2001 suffered from lack of a monitoring and evaluation framework. The review, therefore requests:

Member States to:

a) use the framework for monitoring and evaluation through the national observatories and the coordinating mechanisms to review and track progress, identify gaps and find remedial measures on an annual basis;
b) submit biennial progress reports on status of implementation of the PoA and the Accelerated Call to the AU Organs through the African Union Commission.

AU Commission to:

a) develop a framework for monitoring and evaluation of this Call for Accelerated Action with appropriate baselines, targets and indicators for measuring progress at country level to allow inter-country comparisons, develop continental databases, include findings from research, share knowledge and good practices for scaling up interventions to achieve goals for children;
b) elaborate a "State of Africa's Children Report" every two years;
c) conduct a review on progress made in implementing this Call and the Plan of Action every five years;
d) strengthen the capacity of the ACERWC to follow up on the monitoring of key provisions of the Plan of Action and the Call;
e) use the information generated from the annual reports of Member States for ensuring the inclusion of children's issues in the African Peer Review Mechanism.

The African Committee of Experts on the Rights and Welfare of the Child to:

a) undertake country visits and also use the monitoring and evaluation framework of the Call for Accelerated Action as supplementary information to review the State Parties reports.

V. Roles and Responsibilities of Other Stakeholders

31. The AU Commission will ensure that all policy documents related to children on the continent are disseminated as widely as possible amongst all major stakeholders:

a) Regional Economic Communities (RECs) to:

i) establish a social development desk, where it does not exist, to coordinate all social issues including children's programmes;
ii) raise awareness on and promote the rights and welfare of the child in accordance with the African Charter on the Rights and Welfare of the Child and the Plan of Action on Africa Fit for Children;
iii) work closely with Member States, the African Committee of Experts on the Rights and Welfare of the Child and other stakeholders to implement the Declaration and Plan of Action on Children as well as other children's programmes;
iv) develop regional child policies in collaboration with partners and lead the agenda for children in the region;
v) collaborate and exchange information with the AU Commission on all matters related to children;
vi) take the Call and Africa Fit for Children as a regional issue and leverage resources to meet the additional needs identified for accelerating implementation of high impact interventions.

b) The African Committee of Experts on the Rights and Welfare of the Child (ACERWC) to:

i) advocate and lobby with Member States for the ratification of the African Charter on the Rights and Welfare of the Child;
ii) lead in advocacy towards implementing the African Charter on the Rights and Welfare of the Child, the Plan of Action on Children, as well as the Accelerated Call for Action;

iii) monitor and report cases of violation of children's rights, particularly in conflict and other emergency situations.

c) Other AU Organs (especially Pan-African Parliament, ECOSOCC, Peace and Security Council) to:

i) accord high priority to the Call for Accelerated Action and the Plan of Action on Africa Fit for Children on their agenda and play meaningful roles in implementing these commitments;
ii) include the promotion of children's rights and welfare in their specific programmes;
iii) work in collaboration with the Department of Social Affairs and the African Committee of Experts on the Rights and Welfare of the Child on child related activities.

d) Development Partners to:

i) provide technical and financial support to Governments to continue to implement the Declaration and Plan of Action on Africa Fit for Children as well as the Call for Accelerated Action;
ii) accord high priority to financing various elements for scaling up actions to achieve results for Africa fit for Children;
iii) collaborate with the AU Commission and Member States to promote, disseminate and implement the Plan of Action on Africa Fit for Children and the Call for Accelerated Action.

e) Civil Society to:

i) create network of civil society organizations to support the dissemination, implementation and monitoring of the Call for Accelerated Action and the 2001 Plan of Action;
ii) provide relevant information to the AU Commission to assist in compiling progress reports, and also the State of the Africa's Children report.

f) Children's Groups to:

i) participate in the implementation and monitoring of the Call for Accelerated Action and the 2001 Plan of Action;
ii) mobilize themselves to use all available fora to bring children's perspective in decisions and programmes that affect children.

Immediate Follow-up Actions

32. We hereby,

- Mandate the current Chairperson of the African Union to submit this Call for Accelerated Action as Africa's contribution towards the Mid-term Review of the World Fit for Children at the UN General Assembly Commemorative High-Level Plenary Meeting to be held in December 2007.
- Call for measures to be taken at all levels to implement the commitment made in the Plan of Action on Africa Fit for Children and the Accelerated Call for Action.
- Call for the dissemination of the Call for Accelerated Action as widely as possible.

Done in Cairo, Egypt on 2 November 2007

B18 Johannesburg Declaration of the Sixth Ordinary Session of Our General Assembly of the African Population Commission (2007)

ACP/Draft/Decl (VI)

WE, MEMBERS OF THE AFRICAN POPULATION COMMISSION, gathered at the Sandton Convention Centre in Johannesburg, South Africa from July 16 to17, 2007 on the occasion of the Sixth Ordinary Session of our General Assembly which focused on the theme "Policy Implications of the State of African Population Report 2006".

RECALLING:

1. The Millennium Declaration adopted by the United Nations General Assembly in the year 2000.
2. The Plan of Action of the 1994 International Conference on Population and Development and the Dakar/ Ngor Declaration on Population and Development.
3. The Continental Sexual and Reproductive Health Policy Framework (2005) and the Maputo Plan of Action for its operationalization (2006) of the African Union;
4. The Africa Health Strategy adopted by the AU Conference of Ministers of Health in April 2007 and endorsed by the Assembly.
5. The African Regional Nutrition Strategy
6. The Accra Communiqué on Safe Motherhood adopted in November 2006 during the West Africa Regional Forum.
7. The Mafikeng Declaration on Population and Development adopted during the Population and Development in Africa-Research and Policy Dialogue in Africa Conference in March 2007.
8. The African Common Position on Africa fit for children adopted in Cairo in 2001.
9. The African Youth Charter
10. Second Decade on Education Plan of Action

ACKNOWLEDGING that rapid population growth can undermine sustainable social and economic development in Africa

AWARE that:

a. The African population remains youthful which poses both opportunities and challenges.

b. Gender inequality persists in all spheres, particularly in the labour force participation and decision making.

c. As age dependency shrinks greater productivity and higher incomes are possible depending on social and economic policy responses of individual countries.

d. Aware that the demographic dividend concealed in Africa's youthful population is not automatic but depends on policy responses;

CONCERNED that:

1. Africa is not on track to attain the Millennium Development Goals almost half way through the target period;

2. Debate on population and development has been confined to population size and growth rate ignoring aspects of the age structure and the implications of population dynamics to socio-economic development and poverty reduction.
3. HIV and AIDS is having a devastating impact on political, social and economic development in the face of poverty and other challenges; and that both maternal and infant mortality in Africa remain high and that it is most likely that the MDG target of reducing maternal and infant mortality by 2015 will not be met.

We therefore, **COMMIT** ourselves to:

1. Increase investment in expanding and repositioning family planning as an integral part of sexual and reproductive health and socio-economic development in line with the Maputo Plan of Action on Sexual and Reproductive Health and Rights and the ICPD Plan of Action.
2. Integrate population variables in development planning in order to accelerate progress towards the attainment of the MDGs.
3. Increase investment in programmes that deal with the health of youth, women and children in line with the Africa Health Strategy and advocate for political, economic and social reforms that ensures the participation of youth in society.
4. Integrate and mainstream gender into population and development, women's empowerment including engagement to combat gender- based violence.
5. Put in place policies and programmes that keep youth and adolescents in school, with particular focus on the girl child since education for girls and women contributes to better health-seeking behaviour, improved uptake of family planning, reduces infant and maternal mortality rates and improves the living conditions of the family, in particular, and the society, in general .
6. Make primary education compulsory and free and that technical and professional training be developed to absorb those who are excluded from the general education system so as to give everyone the opportunity to be involved in economic development.
7. Advocate for the implementation of the Ouagadougou Declaration and Plan of Action on Employment and Poverty.
8. Promote south-south collaboration on population and development especially through regional networks, sharing of experiences and best practices;
9. Speed up progress on delivery of basic health services and interventions by renewing commitment to prioritize, allocate resources, and accelerating child survival efforts that incorporate several high- impact but standardized "packages" of health interventions within African countries.
10. Advocate for the central role of maternal health in Africa's development and commit to giving urgent priority to delivering affordable, high quality and accessible maternal health care services.
11. Scale up responses to HIV/AIDS, tuberculoses and malaria in line with the Abuja Call for Accelerated Action against these three diseases including the call of AU Heads of State on reduction of mortality.
12. Advocate for the implementation of the African Union Migration Policy Framework;
13. Address issues of social protection and social security especially for the elderly, orphans and vulnerable children.
14. Use African Union's united strong voice to work with developed countries to launch, by the year 2008, a group of "Quick Win" actions (especially in education and health sectors) to promote economic growth of the continent so as to save and improve the lives of millions of people.
15. Press for meaningful debt relief, debt cancellation, and more generous and predictable official development assistance (ODA). But more importantly, the African Union should press for favourable terms of trade and access to developed country markets. Only through fair trade and access to markets will Africa find real and long lasting answers to poverty eradication on the continent.

16. Strengthening the institutional capacity for coordination, monitoring and evaluation of the implementation of the national population policies including the collection, management and use of statistics;

17. Involve the civil society in active partnership for service delivery and advocacy

WE CALL UPON:

18. Member States to commit themselves to the strengthening of the APC by supporting activities and effective participation of its delegations to relevant meetings at the APC.

19. Member States to invest and address the causes of youth migration from the continent and its implications on the age structure and the overall plan for sustainable growth.

20. Development Partners to sustain their support to national, regional and continental efforts to promote population and development;

21. The African Union Commission in collaboration with the ECA, UNFPA and other partners, to coordinate the review of ICPD+15 and report to our next Session; ALSO REQUEST the Commission to facilitate the signing of the Sino-Africa Cooperation Agreement in the areas of population and sexual and reproductive health as well as ensure its operationalization.

22. The AU Commission in collaboration with Partners, to follow up the implementation of this Declaration and other recommendations of our Session and report to our next Session.

Sandton Convention Centre, Johannesburg, South Africa,
July 17, 2007

B19 Decision on the Progress Report on the Implementation of the Commitments of the May 2006 Abuja Special Summit on HIV/AIDS, Tuberculosis and Malaria (ATM) (2008)

Assembly of the African Union, Eleventh Ordinary Session
30 June–1 July 2008
Sharm El-Sheikh, EGYPT
Assembly/AU/Dec.194 (XI)

The Assembly:

1. **TAKES NOTE** of the Progress Report on the Implementation of the Commitments of the May 2006 Abuja Special Summit on HIV/AIDS, TB and Malaria (ATM);

2. **WELCOMES** the Malaria Initiative launched by the United Nations (UN) Secretary General and the appointment of a UN Special Envoy on Malaria; and **REQUESTS** the AU Commission to work closely with the Envoy in the implementation of the Malaria Elimination Campaign launched by the African Union;

3. **CONCERNED** that HIV/AIDS, Tuberculosis (TB) and Malaria remain major development challenges and thus require sustained political will and commitment in order to reverse their impact;

4. **DEPLORES** the high costs of medicines for these diseases, and **NOTES WITH CONCERN** the increasing challenges associated with resistance to the medicines and insecticides;

5. **ACKNOWLEDGES** the particular susceptibility of women, children and other vulnerable groups to HIV/AIDS, TB and Malaria;

6. **URGES** Member States to implement their pledge to devote at least fifteen percent (15%) of their national budget to health in order to adequately address health and development, especially HIV/AIDS, TB and Malaria;

7. **ALSO URGES** Member States to strengthen health systems in the framework of the Africa Health Strategy (2007-2015) as the best approach to promote universal access to HIV/AIDS, TB and Malaria services by 2010;

8. **FURTHER URGES** Member States to strengthen their respective disease surveillance capacities for effective monitoring and evaluation and to prepare progress reports to the AU organs and other constituencies;

9. **CALLS UPON** Regional and International partners to sustain efforts to support Member states in the implementation of the various commitments on HIV/AIDS, TB and Malaria (ATM);

10. **REQUESTS** the Commission to promote regional cooperation whilst coordinating and harmonizing follow-up on the response to HIV/AIDS, TB and Malaria;

11. **ALSO REQUESTS** the Commission in collaboration with development partners to monitor the implementation of this Decision and to prepare a review report in 2010 as requested by the Special Summit on ATM.

B20 Decision on the report on the Promotion of Maternal, Infant and Child Health and Development in Africa (2008)

Assembly of the African Union, Eleventh Ordinary Session
30 June–1 July 2008
Sharm El-Sheikh, EGYPT
Assembly/AU/Dec.195 (XI)

The Assembly:

1. **TAKES NOTE** of the Report of the Commission on the Promotion of Maternal, Infant and Child Health and Development in Africa;

2. **REAFFIRMS** the need to implement the Decision adopted by the Banjul Summit in 2006 on a legislation that regulates and respects social life in Africa, and URGES Member States to make contributions in this regard;

3. **REAFFIRMS** its commitment to intensify its leadership role and keep the Promotion of Maternal, Infant and Child Health high on the Continental agenda;

4. **URGES** Member States to take action to institutionalize enquiries into Maternal, Infant and Child deaths in Member States; to this effect periodic reports should be submitted to the Commission, Regional Economic Communities (RECs) and relevant partners for assessment and analysis of progress and sharing of best practices;

5. **ENDORSES** the nomination by the Special Session of the AU Conference of African Ministers of Health, on 17 May 2008 of Dr M. Tshabalala-Msimang, Minister of Health of the Republic of South Africa as Goodwill Ambassador to champion the Promotion of Maternal, Infant and Child Health in Africa;

6. **CALLS UPON** the United Nations (UN) Agencies and other International Partners to accelerate actions to improve maternal, infant and child health in order to achieve the Millennium Development Goals (MDGs) by 2015;

7. **REQUESTS** the Commission to speed up action for capacity building with the view to strengthening advocacy, resource mobilization, coordination and harmonization, monitoring and evaluation of progress made in the promotion of maternal, infant and child health in Africa;

8. **ALSO REQUESTS** the Commission to develop and disseminate a format to guide Member States with reporting, to enable it to update its statistical data;

9. **REITERATES** its previous Decision, requesting the Commission in collaboration with relevant Partners, to intensify advocacy and coordination efforts towards the attainment of MDGs 4, 5, and 6 in Africa and to submit progress reports to the next ordinary session of the Assembly, in January 2009.

B21 Decision on Promotion of Maternal, Infant and Child Health and Development – DOC. EX.CL/380 (XII) (2008)

Assembly of the African Union, Tenth Ordinary Session
31 January–2 February 2008
Addis Ababa, Ethiopia
Assembly/AU/Dec.176 (X)

The Assembly:

1. **TAKES NOTE** of the Report of the 2nd Pan-African Forum on Children: Mid-term Review, which was held in Cairo, Egypt from 29 October – 3 November 2007 and the Call for Accelerated Action on the Implementation of the Plan of Action on Towards Africa Fit for Children (2008-2012) which was adopted by the Forum;

2. **RECOGNISES** with concern that poor maternal, infant and child health remains a major challenges confronting the continent and undermining its development efforts;

3. **RECALLS** the Millennium Declaration and the Millennium Development Goals (MDGs), particularly No. 4: Reduce Child Mortality, No. 5: Improve Maternal Health, and No. 6: Combat HIV/AIDS, Malaria and other diseases, as vital indicators for monitoring socio-economic development of any country in Africa;

4. **ALSO RECALLS**, inter alia, the African Charter on the Rights and Welfare of the Child (1990); Sirte Assembly Decision on Accelerating Action for Child Survival and Development in Africa to meet the MDGs, in particular MDG 4 on reducing child mortality and morbidity (2005); Maputo Plan of Action on the Policy Framework on Sexual and Reproductive Health and Rights (2006); and the Africa Health Strategy (2007);

5. **WELCOMES WITH APPRECIATION** the world-wide support expressed through the numerous programmes and initiatives to mobilize resources to meet challenges related to the promotion of maternal, infant and child health, survival, protection, development and participation;

6. **REAFFIRMS** its previous commitments towards promotion of maternal, infant and child health, survival, protection, development and participation;

7. **REITERATES ITS COMMITMENT** to take responsibility and provide leadership to advance actions towards the implementation of the MDGs, particularly those related to the promotion of maternal, infant and child health, survival and development. In this regard, it will ensure that its statements at national, regional, continental and international levels (including the UN General Assembly) highlight the plight of women, infants and children in Africa, and the required action to rectify this related challenges;

8. **URGES** Member states, in collaboration with development partners and stakeholders, to effectively implement the commitments made to improve the rights and welfare of women, infants and children in Africa;

9. **CALLS UPON** development partners at all levels to intensify efforts to provide well-coordinated support, based on the respective needs and policies of affected communities and countries;

10. **MANDATES** the Chairperson of the African Union to undertake vigorous advocacy to mobilize resources and galvanise political will among the industrialized countries, at any available opportunity, including at such forums as the G8 Hokkaido Toyako Summit (2008), TICAD IV (2008), EU Summit (2008), to advance maternal, infant and child health and development in Africa;

11. **REQUESTS** the AU Commission to include the "Promotion of Maternal, Infant and Child Health and Development" on the Agenda of our 11th Ordinary Session in 2008;

12. **FURTHER REQUESTS** AU Commission to submit a progress report on the implementation of its commitments on children and progress towards achieving MDGs 4, 5 and 6 to the 12th Ordinary Session of the Assembly in 2009.

B22 Decision on the Report of the Implementation Status of Decision Assembly/AU/Dec.204 (XI) on Promotion of Maternal Infant and Child Health and Development in Africa – Doc. Assembly/ AU/6(XII)(2009)

Assembly of the African Union
Twelfth Ordinary Session
1–3 February 2009
Addis Ababa, Ethiopia
Assembly/AU/Dec.216(XII)

The Assembly:

1. **TAKES NOTE** of the Report of the implementation status of its previous decisions on Maternal, Infant and Child Health and Development in Africa;

2. **ALSO TAKES NOTE** of the initiatives of the Commission to advocate, harmonize and coordinate efforts geared towards the promotion of safe motherhood and survival and development of infants and children;

3. **REITERATES** its commitment to keeping maternal, infant and child health top on Africa's agenda for sustainable development through the implementation of all relevant national, regional, continental and global initiatives such as International Conference on Population and Development (ICPD) Programmes of Action, the Millennium Development Goals (MDGs) and the African Health Strategy as well as the Maputo Plan of Action on Sexual and Reproductive Health and Rights;

4. **TAKES NOTE** of the proposal by the Republic of Mozambique for the theme of the July 2010 Summit to be on Maternal, Infant and Child Health and Development in Africa;

5. **COMMENDS AND ENCOURAGES** Dr. Manto Tshabala-Msimang, Goodwill Ambassador for Maternal, Infant and Child Health, to utilize all avenues and platforms to promote maternal, infant and child health in Africa;

6. **REQUESTS** the Commission to continue to follow up on the implementation of the Assembly Decisions of January and July 2008 Sessions held in Addis Ababa, Ethiopia, and Sharm El Sheikh, Egypt, respectively on the issue of maternal, infant and child health and development;

7. **CALLS UPON** the World Health Organization (WHO), the United Nations Population Fund (UNFPA), other relevant United Nations Agencies and Africa's development partners, including the International Planned Parenthood Federation (IPPF), to support the Commission's efforts in the promotion of maternal, infant and child health;

8. **REQUESTS** the Commission to follow-up on the implementation of this decision and to report periodically to the Assembly.

B23 The Road Map for the African Women's Decade: 2010–2020 (2009)

Prepared by
Women, Gender and Development Directorate
African Union Commission
October 2009

1.0 Introduction

The United Nations has championed the global campaign for advancement since its creation in 1945, with creation of the Department of Advancement on Women (DAW) in 1946. Through DAW, women's participation and involvement in leadership and decision making has been a prominent agenda item in a series of United Nations International Conferences and Conventions. DAW was instrumental in organizing the four World Conferences on Women from Mexico City, through Copenhagen and Nairobi to Beijing, China, the Fourth World Conference on Women. In addition, the International Conference on Population and Development (ICPD), the International Conference on Human Rights held in Vienna in 1993 and the World Conference on Social Development held in Copenhagen in 1994 helped build momentum for Beijing Conference. While these conferences have produced frameworks aimed at promoting and achieving gender equality, the real work has been done by women themselves. Major outcomes of these efforts added momentum to the implementation of Beijing Platform for Action and Dakar PFAs and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

While the Beijing PFA promotes the concept of gender mainstreaming as central and critical to inclusive and participatory development; CEDAW on the other hand emphasizes the importance of equal participation of women and men in public life.

A common African position on effective promotion and the advancement of African women is expressed in the African Platform for Action, adopted by the Fifth Regional Conference on Women (Dakar 1994), which integrated regional views, priorities and agenda for the formulation of policies and implementation of concrete and sustainable programmes for the continent. This was developed in consonance with the Nairobi Forward-looking Strategies, the Kampala Action Plan and also in line with the Abuja Declaration on Participatory Development; The Role of Women in Africa in the 1990s, the Convention on the Elimination of All Forms of Discrimination against Women, and declarations at international and regional levels; these Platforms for Action aims to accelerate the social, economic and political empowerment of all women at all levels and at all stages of their lives.

This African Women's Decade presents a renewed opportunity for further realization and improvement of women's participation. It is now evident that the African women's contribution forms a critical part of the global women's movement. Africa women's brilliance, creativity, hard work, commitment and unwavering determination to shape their own destiny have made them visible globally. The increasing evidence that the inclusive participation in decision-making and exposure to gender related matters through capacity building, education and women's empowerment, among others, are necessary to achieving gender equality in Africa persuaded the Assembly of AU to declare 2010 -2020 as the African Women's Decade through African Union Assembly Declaration 229(XII).

The need for ownership, commitment and compliance with reporting requirements on cross-cutting gender issues resulted in the development of a new framework, operational strategies and road map for the advancement of gender equality and women empowerment in the continent.

The underlying conviction for this new process includes:

- The need for meaningful participation and increased collaboration of key stakeholders on women issues through capacity building, effective programming and movement building;
- Increased investment on gender equality for the Decade with corresponding improved participation of women in aid effectiveness;

- Demonstrable commitment by Member States through implementation of key regional and global agreements on women's rights and development;
- Need to develop and adopt required best practices for the enforcement of agreed protocol at all levels;
- Requirements for developing appropriate framework for tracking the performance and relevance of gender outputs, and results;
- Profound appreciation of poverty determinants and linkage with the grassroots through adoption of a holistic development approach;
- The need to strengthen key relevant regional organizations and international institutions such as the Regional Economic Communities (RECs), Africa Peer Review Mechanism (APRM) and the New Partnership for Africa's Development (NEPAD) for integration purposes; and
- Ownership and drive requirements for the implementation of the various gender policies developed by the AU as well as those of developed by other relevant Regional Economic Communities and AU Member States, with vital speed and commitment.

1.1 Goal of the Decade

The goal of the decade is to cascade, in concrete terms, the execution of commitments on gender equality and women's empowerment from the grass roots, national and regional to continental level.

1.2 Objectives of the Decade

The objectives of the Decade include the following:

- To preserve and build on the African women strength in the women movement and leverage on global and regional political goodwill for the advancement of African women;
- To usurp the opportunity for African women to provide leadership in rejuvenating the global women's movement, with a focus on youth and grassroots women; and
- To maintain the drive for empowering African women and marshal resources for the performance and relevance of the Decade.

2.1 Justification for the African Women's Decade

The idea of a Women's Decade was hatched by the United Nations at the Mexico City First World Conference on Women (1975). African women as key players in world global women's movement were actively involved in the United Nations Women's Decade finalized at the First World Conference on Women. They continued to participate and leverage on the Women's Decade and its mid-term reviews held in Nairobi, Kenya in 1985. With a robust history of global participation and local consultation on women's right and gender equality, African women have contributed to enriching discussions on women empowerment and gender equality for over three Decades. The highlights of participation during this period include the following:

- The First World Conference on Women (FWCW), Mexico City, Mexico (1975)
- Second World Conference on Women (SWCW), Copenhagen, Denmark (1980)
- Third World Conference on Women (TWCW), Nairobi, Kenya (1985)
- Fourth World Conference on Women , Beijing, China (1995)

Equally, the Assembly of Heads of States of the African Union has demonstrated consistent leadership in promoting and advancing gender equality in the continent. These efforts evidently visible in the development of the AU Gender Policy and its 10 year implementation plan have contributed robustly to reaching decisions on the implementation of vital gender equality instruments in Africa. Key decisions taken in the last few years

include those of Article 4 (1) of the Constitutive Act of the African Union as enshrined in the Parity Principle, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, and the Solemn Declaration on Gender Equality in Africa (SDGEA).

The AU Heads of States continue to promote international and regional agreements on gender equality and women development through states' support for efforts to domesticate various gender equality commitments such as the Beijing and Dakar Platforms for Action and the Millennium Development Goals (MDGs) with special consideration for achieving MDG 3 on Gender Equality and Women's Empowerment.

2.2 Justification for the Roadmap

The achievability of the African Women's Decade is dependent upon clear and specific guidelines carefully drafted on measurable and realistic terms that are capable of enhancing current interventions on gender equality as well as the advancement of the rights of women and girls.

However, in spite of African leadership best efforts at bridging the gender gap, lack of technical capability in tracking gender instrument performance and the diverse socio- cultural settings of the continent continue to serve as barriers to gender equality and women advancement.

Consequently, the decade will focus on utilising gender tools to influencing perception on cultural stereotypes, management and investment decisions, unfavourable gender power structure and tokenism. This will be actualised by taking prompt actions against the risk of gender policy evaporation in practice through actualisation of the decade's objectives.

Recognizing the barriers to achieving gender goals, the decade will be utilised to encourage inclusive participation of stakeholders to boost the performance of the decade by drawing on the experience, knowledge and creativity of men and women for developing innovative gender balancing strategies that will enhance gender equality and women development across the continent.

The commitment to gender equality is further embedded in the African Charter on Human and Peoples Rights, which is strengthened by the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, the AU Solemn Declaration on Gender Equality in Africa (SDGEA) and the Post Conflict Reconstruction and Development Policy agreed to by the AU Heads of State and Government in 2006.

To enhance equal socio-economic and political contribution of men and women, African Union Member States demonstrated their commitment to the UN international legal framework stressing the value of democratic principles and gender equality as signatories to international agreements such as the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW). Though this action acknowledges the role of men and women in development, it does not distinguish and calculate the specific contribution of women.

Also, in recent times, the UN Millennium Development Goals are considered across Africa as effective instrument to combating gender inequalities relating to poverty, health and the environment.

The African women's role through the various stages may have been as crucial as the different instrument utilised to measure progress in gender mainstreaming efforts, but gender equality agenda still remains largely under-achieved in Africa.

Some of the reasons for the lacuna, as earlier identified, are poor gender-based information and data management culture as evident in reporting processes. Others include limited capacity and other resources for the promotion of gender related issues, and lack of political support at the national level from the executive and the legislative arms of the government. In spite of the progress made at the continental level in terms of gender mainstreaming, especially with the introduction and adoption of gender equality principle, AU Member States are still very reluctant in integrating gender into the development and resource allocation process.

However, in order to reinforce its commitment to gender equality, the AU, in addition to making efforts to institutionalize gender mainstreaming through the creation of a functional Gender Management System (GMS) has also developed a Gender Policy for the African Union Member States. The Gender Policy is expected to be amplified by AU Member States and Regional Economic Communities (RECs).

The AU Gender Policy offers an opportunity for the advancement and achievement of gender equality between men and women as well as facilitates the inclusion of gender issues in the African agenda. The resultant effect of this Policy has been the increased awareness of the role of women in Africa's development and a demonstration of official commitment to recognizing gender related attributes in Africa. The Policy underlines the need to discover and utilize methods and processes that will assist in the restructuring of existing institutions to focus on gender equality as well as the creation of African Women's Trust Fund as a supportive mechanism in this regard.

The AU Gender Policy is a four-part document indicative of the historical background to gender issues in Africa, policy goals, objectives, principles, values, targets, and commitments as well as institutional framework for its implementation.

The Policy provides the basis for the eradication of obstacles to gender equality in African and for steering gender equality accomplishment through the execution of other global commitments on gender equality, such as CEDAW and the MDGs,

The AU Gender Policy commitments are hinged on the following premises:

- Fostering enabling and stable political environment that permits compliance with and enforcement of the AU 50/50 gender parity principle at all levels;
- Legislation and legal protection against discrimination for ensuring gender equality;
- Mobilizing and encouraging multi-stakeholder partnership process for the implementation of the AU Gender Policy;
- Integration and harmonization of gender policies and resources through the Regional Economic Communities (RECs) and related organs;
- Mobilizing and allocating resources for the implementation of the AU Gender Policy at regional, national and local levels;
- Building the capacities of key stakeholders for gender mainstreaming;
- Implement gender mainstreaming in all key-issues sectors of development and across institutional strata; and
- Promoting effective involvement and participation of women in peacekeeping and security and efforts aimed at reconciliation, reconstruction and development.

This policy instrument is deemed to be achievable through the creation of a Gender Management System (GMS), designed to ensure progress for gender equality through political will, effective stakeholder engagement and empowerment as well as monitoring of policy implementation. This stand informed the adoption of the Gender Policy by AU Member States.

3.1 Framework and Strategy for the Road Map

The aim of the Decade's Road Map is to advance gender equality by reinforcing equal partnership between men and women between 2010 and 2020. To achieve this, existing instruments will be strengthened and supported through an inclusive grassroots bottom-top approach. The proposed theme for the Decade "Gender Equality and Women's Empowerment (GEWE): A Bottom-Up Approach" aptly describes the focus of the Decade.

4.1. Framework

Following the extra-ordinary meeting of Ministers of Gender and Women Affairs in Maseru, Lesotho in December 2008, the AU Ministers for Women Affairs and Gender encouraged the AU to commence wider consultation engender to generate success for the African Women's Decade. The Ministers' call was further bolstered by the Assembly Dec. 487 (XIV) decision that declared 2010-2020 as African Women's Decade.

The course of action was further strengthened by a half day brainstorming roundtable held at the African Union Hall, New York on Sunday 01 March 2009, and by brainstorming opportunities provided for the Minister's meeting and African Women Leaders in New York on the decade's ideas and roll out by the 53rd CSW Session.

Subsequently, the African Group in New York deliberated on the African Women Decade to form their inputs into the Decade.

A set of guiding principles was developed for the decade and it includes the following:

1. Providing adequate resources allocation for programmes and activities during the Decade; this is against the background of inadequate resources and poor implementation of past commitments by member states
2. Reinforcing and safeguarding women's gains so far
3. Scaling up and ring fencing funding for gender equality and women empowerment programmes to prevent encroachment by current economic crises
4. Reinforcing benchmarks and mechanism to ensure implementation of decisions taken regarding the Decade
5. Building capacities, and developing adequate data and indicators for measuring the decades results.
6. Ensuring practical application of the gender parity principle
7. Providing opportunity for linkages with the grassroots
8. Focusing on the implementation of all policy documents (such as the SDGEA, the AU Protocol on Women and CEDAW) already adopted by Member States. This process also covers campaign to mobilize support and political will for the attainment of target by AU Heads of States commitment at global and regional levels.
9. Encouraging development partners to complement regional gender commitment
10. Recognizing the need on integration of NEPAD within the structure of the AU
11. Underlining and foregrounding the role of men
12. Championing the accelerated implementation of the AU Gender Policy and the Economic Communities as well as Member States Gender Policies.

The draft recommendation for implementation suggests the Decade will be implemented in phases, with the Phase 1 spanning the period 2010 – 2015. To demonstrate its commitment, the AU Experts' Meeting on the Status of Reporting and Implementation of the SDGEA and on the African Women's Decade 2010 – 2020 that was held in May 2009 in Banjul, the Gambia, also chose every 31st July as Pan African Women's Day to commemorate the Decade.

The Decade will focus on developing appropriate communication and advocacy strategy in-terms of the target audience, the methodology and procedure for achieving the following results:

- Improved advocacy mechanisms
- Increased level of lobbying
- Increased resource mobilization for the implementation of the Decade activities and
- Increased level of participation by young African Women's Movements

A variety of programmes to achieve the above results were identified and these include:

- Improved Advocacy Mechanisms To generate key messages, and create awareness as well as elicit understanding that will result in a change of beliefs on gender issues. Key outputs to determine improved advocacy mechanism have been identified to include:
  - Building information sharing forum
  - Simplification and translation of the SDGEA and other relevant instruments to local languages to stimulate participation of all stakeholders
  - Public consultation and awareness
  - Parliamentary Interactive Forum
  - Gender Based Social Responsibility Initiative Increased level of lobbying
  - Mapping of stakeholders

S/N	Time frame	Objective(s)	Activity	Tasks	Strategies	Responsible agents	Monitoring indicators
			Committee Consultation	Analysis of information		AU Experts and Technocrats	
			Forum Consultation	Identify discussions and set up groups	Organisation of workshops, technical sessions, online discussions, dialogues and meetings that will integrate the Decade's thematic areas		
			Consultation with AU member states - 2010 to 2020			AU Technocrats, AU Consultants, National Gender Policy makers and Experts	
			Community Engagement - Consultation with men and women on gender programme designs and financing options	Creating awareness and engendering participation	Set up gender equality and women empowerment clusters	National and local governments, NGOs, CBOs, FBOs	
			Analysis of information	Collect information at household level and community level on gender issues	Field visits to gather information on households and community gender relations		
			Utilize gender policy analysis to determine current status of gender issues locally	Raise awareness on gender and participation issues within the context of the enivronment	Developing modules for behavioural changes and training local leaders on mobilization and counselling strategies		
			Mobilize stakeholders participation including young women at national and local levels	Organise town hall meetings on gender and participation issues at the grassroots, utilizing a people-centred, contextual approach Organise rallies, match on context specific gender and participation issues Set up counseling, education and information centres at grassroots level for victims of rights abuse		National and local government and Ministries of Women Affairs	

S/N	Time frame	Objective(s)	Activity	Tasks	Strategies	Responsible agents	Monitoring indicators
		To facilitate legislation on gender issues at national and local levels	Creating Gender parliamentary interactive forum	Establish effective lobby groups across levels Facoilitate integration of international and regional gender protocols into national laws and statutes	Developing advocacy, lobbying and definitive communication processes to encourage mindset and behavioural changes	National and local governments, NGOs, CBOs, FBOs	Increased level of lobbying at MS Parliaments Improved advocacy mechanism
				Track formulation of legislative policy Facilitate the integration of gender in budgeting process Facilitate the development of legal and legislative framework for fund genderation			
7	2013-2020	To engender national and grass roots participation in the events of the decade	Launch and implement national grass roots projects Engage men and women at the grassroots in a participatory manner to understand gender issues, differences and similarities Organise discussions on emergent issues such as climate change, access to and management of natural resources (including water use), enentrepreneurship development, power relations, maternal and infant mortality, sustainable livelihoods, literacy, teenage pregnancy, schools drop outs, drug abuse, flooding	Explore grassroots particpants experience and views on gender Assess policy performance in terms of grassroots equitable impact Present translated versions of gender protocols and instrument to men and women in the grassroots to engender participation Develop issues-matrix locally by locality	Engage men and women at all levels in a participatory manner to understand gender issues, differences and similiarities using folklore theatre, puppet show, slogan writing, participatory videos, audio cassettes, distribution of pamphlets and manuals, small group meeting, march, bicycle rally, role play, simulation, participatory exercises etc.	Affected National Ministries and Agencies, NGOs, CBOs, FBOs, Community leaders, men, women and youth	Number of MS that launched national grassroots projects Type and number of grassroots initiatives Increased participation at the grass roots

S/N	Time frame	Objective(s)	Activity	Tasks	Strategies	Responsible agents	Monitoring indicators
			Facilitate the appointment of more women as extension rural workers and advocate for extension servicers to women farmers. Train grassroots men and women in gender and participation issues Train grassroots women, men, youth and leaders in community mobilization strategies on gender and participation Set up grassroots counselling units on rights, health and conflict issues Facilitate credit linkages for grassroots enterprises through community based organizations (CBOs) and FBOs				
8	Annually 2010-2010	To stimulate robust participation in resolving emergent gender issues	Declare and celebrate Africa's Gender Equality Day	Choose a thematic focus annually for discussion on emergent gender issues Produce and launch documentary /film on gender issues Print and distribute souvenirs to commemorate day Organise gender programmes across states to promote gender equality and women development in Africa Present medals / awards to deserving individuals / state / group on contribution to various categories on gender equality and women empowerment	Maintain and sustain visibility for the African Women's Decade	AUC and Line Ministries of member states	Increased level of participation The number of MS that celebrate the Gender Equality Day Outcome and Impact of the day on national gender policy and programmes

S/N	Time frame	Objective(s)	Activity	Tasks	Strategies	Responsible agents	Monitoring indicators
9	June 2011 to 2020	To mobilize resources To provide adequate funding for national gender apparatus	Creation of National Gender Equality Fund	Facilitate the creation of national gender equality fund Advocate for special policies to enable women to have access to credit	Developing recommendations Creating pool funds for specific activity / tasks Partnership / collaboration with multi-lateral donor agencies Lobbying of national government / line ministries for increased budgetary allocation for gender related programmes		Increased resources mobilized for the decades activities (volume of funds, number of programmes funded and amount, number of organisations / groups with access to funds etc.)
10	Jan 2010 - April 2010	To assess performance and relevance of indicators	Set up Monitoring and Evaluation system Develop strategy and content for sharing Conduct gender focused and disaggegated monitoring at national and grassroots levels	Develop common M and E standards Develop diverse range of assessment instrument Set up M and E task force Monitor utilization of gender equality fund Monitor existing Gender Monitoring System Develop capacity for monitoring Build capacity and skills for lobbying Develop leadership and self-assertiveness programme for in and out of school young women Set up mentoring programmes for the guidance of the less experienced by the more experienced on critical social, health, economic and political issues	Knowledge sharing and learning to boost M and E through electronic network Gather and analyse primary and secondary data Field, monthly, quarterly report and mid-term reviews		Increased number and frequency of M and E reports
		To build the capacity of gender team for reporting, data collection and monitoring	Training and capacity building at policy technical and operational levels				

S/N	Time frame	Objective(s)	Activity	Tasks	Strategies	Responsible agents	Monitoring indicators
11	Jan-Jun 2015	To encourage implementation across levels To generate feedback for 2nd phase programme design and management	Conduct Reviews	Assess national government compliance with existing international and regional agreements such as CEDAW, SDGEA Conduct mid-term review Conduct final evaluation of Decade Develop reporting process on deliverables and milestones	Roundtable discussions	AU Technocrats, AU Consultants, National Gender Policy makers and Exports, CSOs	Increased number of domesticated / decentralized protocols, instruments and agreements

4.4 Monitoring and evaluation

To achieve the overall objective(s) for the Decade, a localized monitoring and evaluation process should be established to track outputs and performance measures toward the achievement of results within a particular context. These indicators will be disaggregated by:

i. location
ii. type of institution
iii. age
iv. education
v. religion and
vi. gender where applicable.

The number of indicators to be measured should be defined prior to the commencement of the Decade.

A number of indicators highlighted for measuring results include the following:

a) Impact Indicators – these are indicators such as the number of stakeholders identified, the number of collaboration / partnerships, number of language translations of relevant protocol documents, number of programmes and participants (disaggregated by gender), number of gender focal points, number of persons provided technical training with types of training, number of public discourse and consultation programmes, number of gender sensitive financial laws/regulation per region, number of young women participation per region, volume of funds generated, number of award schemes, number of forums established for information sharing and experience sharing with number of participants etc

b) Process Indicators – existing institutional structures and mandate, linkages between international / regional gender agreements and implementation at national as well as local levels, system of reporting and frequency, current administrative and legislative framework that support linkage between organizational and gender machinery personnel performance, management and utilization of gender related information and data etc.

c) Assumption indicators – required for measuring essential conditions that may negatively impact the accomplishment of the Decades objectives and results

d) Milestones – will be utilized to track specific outputs relevant to the achievement of the programme cycle. Such activities may include the review of compliance level with existing gender equality instruments, assessment of country specific formulated strategy for the African Women Decade, develop short-term strategic plan, review mid-term strategic plan, prepare and evaluate life-of-programme targets.

The process will also generate baseline data from both primary and secondary sources for the monitoring of the performance and relevance of the Decade's activities.

Table 4-1: Details of Activities for the African Women's Decades

List of Activities	Description	Timing: Phase 1: 2010/2015 Mid-Term: 2015 Phase 2: 2016/2020	Indicative budget (US $)
Phase 1			
Development of communication strategies, plans and foundational issues with relevant stakeholders	Coordination meetings (20,000) between programme management team and policy makers	Phase 1 250,000.00	300,000.00
	Stakeholders' engagement to screen and scope processes for the determination of issues to be resolved	50,000.00	
Articulation of Pre-launch activities	Develop Media Plan - TV/Radio programme and publication of print materials and logistics plan	Phase 1 200,000.00	270,000.00
	Develop Community Engagement Plan	50,000.00	
	Generate debates focusing on the decade	20,000.00	
Sensitisation and popularization	Community consultation with men and women at the grassroots to gather inputs across levels and address issues of cultural taboos and repugnant traditional practices 53 x 100,00.00	Phase 1 to end of Decade 53 x 10,000.00	530,000.00
Six sub-regional consultations (including the Diaspora) closing with a launching conference at the regional level through a bottom-top approach to encourage inclusive participation	Inclusive participation of stakeholders	Phase 1 6 x 100,00.00	240,000.00
Launching of the African Women's Decade Day in October 2010 and featuring its themes on Pan African Women's Day (July 31)	Networking with individuals, corporations, groups and government on gender issues. Create gender awareness to promote gender equality and women development in Africa through organized event	Phase 1 53 x 40 x 2,000.00	2,122,000.00
Conduct benchmark survey on status of women at national level	Developing ToR for survey. Conducting gender sensitive research at the grassroots level	Phase 1 5 x 150,000.00	250,000.00
Mobilization of resources and creation of engagement mechanism at the national level for the Decade	Identification of sources of funds at the national, regional and continental level for effective implementation of the decade	Phase 1 200 x 50 x 5	200,000.00
Creation of African Women Trust Funds	This fund will be set up to support all activities that will promote gender equality at the national and sub-national level.	Phase 1 10,000.00	250,000.00
	Set up Coordinating Fund Management Framework	20,000.00	
	Defintion of Area of focus and activities to be covered by the Fund	10,000.00	
	Monitoring of Fund Utilisation and documentation of best practices	20,000.00	

List of Activities	Description	Timing: Phase 1: 2010/2015 Mid-Term: 2015 Phase 2: 2016/2020	Indicative budget (US $)
Introduction of Gender Based CSR Initiatives	This initiative will ensure that women and gender becomes the major focus of private sector organisation in the execution of their CSR projects manyof which are gender blind today.	Phase 2 50,000.00	100,000.00
	Re-engineering and Engagement with Organised Private Sector in Africa	50,000.00	
Linkage with Women Parliamentary Caucus	This forum will be created in all the MS of AU to serve both as advocacy platform that will provide gender related information legislative activities of national parliaments	Phase 2 250,000.00	250,000.00
Preparation and planning of Heads of State Gender Debate	This will essentially prepare the political actors especially the Heads for the planned in a manner that will guarantee and sustain their commitments towards gender equality in Africa	Phase 1 530,000.00 53 x 10,000	1,060,000.00
	Activities will include the setting up of lobby group with MS and HOs as well as the drafting of Debate Outcome which essentially should improve on the implementation status of SDGEA and the Protocol	530,000.00	
Launching of National Grass Root Gender Initiatives	These are set of programmes that translate policy to action programmes in the area of economic empowerment, rights empowerment, social and health empowerment, etc	Phase 1 530,000.00 53 x 10,000	530,000.00
Thematic focus - identification and selection of themes to reflect revival of intellectual ideas. Emergent issues to consider include HIV/AIDS, Climate Change, Water and Gender, Armed Conflict, Women's Rights, Partnership and Collaboration with men on gender equality. Mentoring of the less experienced by the more experienced on critical issues such as drug abuse, Poverty and livelihoods sustainability, Gender Parity Campaigns, Land availability/ownership - regarding cultivation at a commercial scale, women suffrage and participation in politics and governent, Gender role in decision making, Access to credit, Investment and management, Management and access to natural resources, ageing, drugs, reproductive health issues such as maternal infant mortality and malaria etc.	These are lists of issues that each of the stakeholders will be encouraged to focus during the decade. A variety of activities, programmes and initiatives are expected to drive their bearing from these thematic focus during the entire period of ten years and beyond	Phase 1 53 x 50,000	2,650,000.00

List of Activities	Description	Timing: Phase 1: 2010/2015 Mid-Term: 2015 Phase 2: 2016/2020	Indicative budget (US $)
Monitoring and Evaluation	The M&E will be based on agreed indicators. Activities will include:	Phase 1 100,000.00	350,000.00
	Organization of training resources to develop monitoring and evaluation capacity	100,000.00	
	Development of Performance Measurement Plan	50,000.00	
	Evaluation of existing gender equality protocols and instruments	50,000.00	
	Development of funding monitoring plans	50,000.00	
Mid-term review of the Decades programme outputs, etc	Performance and progress measurement for inputs to the design and management of Phase 2	Mid Term 53 x 5,000.00	265,000.00
Phase II - Continuation of implementation			
Thematic focus - Continuation of implementation of ongoing activities and identification of new activities under selected themes to include HIV/AIDs; Climate Change, Water and Gender, Armed Conflict, Women's Rights, Partnership and Collaboration with men on gender equality; Mentoring of the less experienced by the more experience on critical issues such as drug abuse; Poverty and livelihoods sustainability; Gender Parity Campaigns; Land availability / ownership – regarding cultivation at a commercial scale; women suffrage and participation in politics and governance; Gender role in decision making, Access to credit; investment and management, Management and access to natural resources; ageing, drugs, reproductive health issues such as maternal infant mortality and malaria etc	These are lists of issues that each of the stakeholders will be encouraged to focus during the decade. A variety of activites, programmes and initiatives are expected to drive their bearing from these thematic focus during the entire period of ten years and beyond	Phases 2	2,650,000.00
Monitoring and Evaluation	The M&E will be based on agreed indicators. Activities will include:	Phase 2 100,000.00	350,000.00
	Organization of training resources to develop monitoring and evaluation capacity	100,000.00	
	Development of Performance Measurement Plan	50,000.00	
	Evaluation of existing gender equality protocols and instruments	50,000.00	
	Development of funding monitoring plans	50,000.00	
Final review of the Decades programme outputs, etc	Performance and progress measurement for inputs to the design and management of Phase 2	Final evaluations	530,000.00

4.3 The Role of Stakeholders

Stakeholder consultation is regarded as an integral part of raising the visibility of gender issues and output of the Decade's programmes. This covers the development of creative strategies to achieve outcomes, which are consistent with the overall objective of gender equality and women empowerment for the Decade.

For the purposes of achieving successful outcome, it is needful to generate broad base support to cover stakeholders who are either impacted or may be interested in the Decade's programme. There is need to identify and communicate with appropriate policy makers and the wider population as awareness building and understanding can only be achieved through the adoption of a people centred approach that is capable of eliciting support and commitment to the movement. A map of the Decade's stakeholders have been provided below

Table 4-2 – Key Gender Stakeholders

Stakeholder Group	Component
Policy Makers	AU Assembly of Heads of States and Government / Executive Council Member States Parliamentarians
Civil Society Organisations	International and local NGOs, Community and faith based organisations, academic institutions, labour unions, individuals, lobbyists, men, women etc.
Media	International and local, print and electronic media
International Organisations	The United Nations (and all relevant organs)
Practitioners and Technocrats	Officials and staff of the United Nations System (and all relevant organs), NEPAD, Gender Management Team (GMT), AU Women, Gender and Development Directorate, National Gender Commissions, Expert Committees, Technical Working Groups, Gender Task Forces, Line Ministries and agencies such as Ministries of Women Affairs of national governments (national women and gender structures), Regional Economic Comminities (RECs), Ministries of National Planning and Statistics, etc.
Private Sector Operators	Multi-national Companies, Indigenous companies, professional associations and groups etc.

A two-way multiple communication strategy between stakeholders is required to enhance commitment, and measure progress in the delivery of all existing protocols on discrimination and other rights against women and girls. Subsequently, partnership and information sharing among international and local stakeholders are crucial to effective programming and response.

Multi-partnership approach, that encourages appropriate linkages between policy- making organisations with the desired political power and goodwill, and practitioners such as non-governmental organisations and technocrats with the relevant technical expertise as well as donor agencies possessing the required financial muscles will therefore, engender the achievement of the desired results for the Decade.

The high rate of poverty, especially among women, demands appropriate cost-efficient stakeholders engagement strategy to promote integration of the grassroots who constitute a large number of uninformed, impoverished, oppressed and conflict prone population.

To further boost stakeholder gender relationship, consistent and iterative efforts must be adopted to woo and enlist the involvement of men and women to elicit a gender based win-win negotiation approach to achieve the overall objective of gender equality and the advancement of women and girls.

The Decade is deemed to underscore the performance and relevance of existing policy documents, such as the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the SDGEA, to ensuring compliance with full development and advancement of women at all levels. It recognizes that any attempt to jettison existing instruments will amount to grave reputational, financial and time-cycle cost for the region.

Table 4-3 - Women's Decade: 2010 – 2020 Work Execution Plan

S/N	Time frame	Objective(s)	Activity	Tasks	Strategies	Responsible agents	Monitoring indicators
1	Sept 2009	To harmonize interest of key stakeholders on programme content and form for the decade	Internal Review of the roadmap	Set up Reivew Committee Collate / review materials	Tecnical Sessions within the AUC	Consultant and the AU Gender Directorate Technocrats	Improved and more acceptable Road map Document and gender mechanism
	Nov 2009	To maintain the drive for empowering African women and marshal resources for the perfomrance and relevance of the Decade	Set up a Women's Decade Coordinating Committee	Map and invite appropriate stakeholder Develop ToR for the committee	Experts' Meeting	AU Gender Directorate	Improved advocacy mechanism
		To supervise and coordinate the activities relating to the Decade for effective implementation					
		To maximize available expertise within the continent in an inclusive manner Internal Review of the roadmap					
2	Oct-Nov 2009	To create a variety of channels and products to target and attract specific stakeholders	Developing communication strategy	Screen and Scope gender issues Develop message and identify messaging processes Establish effective lobby groups across levels	Enhanced information sharing and communication processes through consultation, reporting, the web, media and partnership with relevant agencies such as the CSOs and other groups	Gender practitioners / technocrats, Consultants, African Union Member States and line ministries and agencies, the Media, Multi-lateral donor agencies, CSOs and other relevant stakeholders	Increased level of participation
		To stimulate participation of all stakeholders		Simplify and translate SDGEA and other relevant instruments ito local languages			
			Produce IEC materials, and prepare public consultation and disclosure strategy	Create disclosure tools and delivery centres Mobilize resources for public consultation and disclosure	Engagement of member states, national governments, sub-national authorities and grassroots organizations		

* Budget Estimate (to be decided in consultation with Gender Directorate)

S/N	Time frame	Objective(s)	Activity	Tasks	Strategies	Responsible agents	Monitoring indicators
3	Jan-Dec 2010	To support strategy and framework for the implementation of the Decade's programmes and recommendation	Gather information on current status of agreements, capacities and resources that will support the Decade	Conduct benchmark survey at national level	Developing appropriate stakeholder engagement mechanism	AU Technocrats, AU Consultants, National Gender Policy makers and Experts	Increased level of lobbying
		To determin the status of Member States on gender issues	Develop data bank from primary and secondary data sources				
4	Jan to Mar 2010	To preserve the role of the African woman in gender movement building and leverage on global and regional political goodwill for the advancement of women's rights	Pre-launch activities: Consultation on implementation process	Conduct field visits for consultation with relevant stakeholders Conduct media briefings	Meetings, Focus Group Discussions, establishing information centre, Field Visits, courtesy calls, press conferences	All stakeholders plus AU Gender ... plus Coordinating Committee	Increased level of lobbying
		To generate inclusive participation on programmes through consultation with national and local stakeholders		Develop logistics plan for launch Develop communication processes and messaging	Practitioners / Technocrats / CSOs representatives Online internet consultation for stakeholders		Increased participation
5	May 2010	To market and build awareness on programmes for the Decade To involve the participation of the general public	Launching	Develop Media Plan Plan and organize launching event Mobilize stakeholders participation	Documentation of media activities, types of media, target audience and timing Decentralize launching process Debates, Discussions, News report consultation and commemorative events	AUC, Member States, NGOs, National governments, multilateral donor organizations, CSOs	
6	2010-2020	To generate a bottom-up participation process across levels (Reports from these consultation will feed into the overall national report and implementation process	Develop procedure for consultation to generate information collection current gender status of policies, protocols and issues using online consultation and discussion groups	Create forum for information and experience sharing by stakeholders including young women		All stakeholders	Increased level of participation, number and types of consultation at the sub-national, national and regional levels on decade related activities

- Establishing effective lobby groups across levels (governments and organized groups)
- Building capacity and skills for lobbying
- Strengthening gender focal points in all institutions
- Male involvement and collaboration in the gender focal points at all levels Increased resource mobilization for the implementation of the Decade activities
- Integration of Gender into Budgeting process
- Gender budgeting creation in all institutions
- Gender Equality Fund
- Development of legal and legislative framework for fund generation e.g. monitoring of gender fund utilization.
- Increased level of participation by young African Women's Movement
- Young women mobilization at local and national levels
- Leadership and self-assertiveness programme for in and out of school young women
- Creation of competition and award schemes to motivate the participation of young women at community and national levels
- Establishment of forum for information and experience sharing by young women
- Launching and Implementation of National Grass Roots Projects

4.2. The Phases of Programme Activities

The details of the Decade's programme activities is provided below though it can accommodate additional activities based on the outcome of the mid-term review (2015) and the emerging issues.

The step-by-step procedure for Phased programmes of activities has been identified and reproduced below in table 4-1 below:

B24 Five-year Review of the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by 2010 Progress Report 2006–2010 (2010)

Special Session of the African Union Conference of Ministers of Health
Geneva, Switzerland
15 May 2010
MIN/Sp/AU/CAMH4/3

Abbreviations

ACT	Artemisinin-based combination therapy
AFRO	WHO Regional Office for Africa
AIDS	Acquired Immune Deficiency (or Immunodeficiency) Syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
AU	African Union
CAR	Central African Republic
CEMAC	Communauté Economique et Monétaire de l'Afrique Centrale
CPT	Cotrimoxazole preventive therapy
CSWs	Commercial sex workers
CTX	Cotrimoxazole
DOT	Directly observed treatment
DOTS	Directly observed treatment strategy
DRC	Democratic Republic of Congo
DST	Drug susceptibility testing
ECOWAS	Economic Community of West African States
GDF	Global drug facility for tuberculosis
GFATM	Global Fund to fight AIDS, Tuberculosis, and Malaria
GLC	WHO's green light committee
HHA	Harmonization in Health for Africa initiative
HIS	Health information systems
HIV	Human Immune-deficiency Virus
HIVDR	HIV drug resistance
HSSP	Health sector strategic plan
HTC	HIV Testing and Counseling
IDB	Islamic Development Bank
IPTp	Intermittent preventive treatment during pregnancy
ITNs	Insecticide treated nets
LLINs	Long-lasting insecticidal nets
MDGs	Millennium Development Goals
MDR-TB	Multi-drug resistant tuberculosis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PITC	Provider initiated HIV testing and counseling
PMI	United States President's Malaria initiative
PMTCT	Prevention of mother to child HIV transmission
RBM	Roll Back Malaria
RDTs	Regional directors' teams
SADC	Southern Africa Development Community
SME	Surveillance monitoring and evaluation systems
TB	Tuberculosis
TSS	Task shifting strategy
UA	Universal access
UNAIDS	United Nations Joint Program for AIDS
UNGASS	United Nations General Assembly's special session on HIV/AIDS
UNICEF	United Nations Children's' Fund
UNITAID	International facility for purchase of drugs for HIV/AIDS, tuberculosis, and malaria
VCT	Voluntary counseling and testing
WBB	World Bank booster program
WHO	World Health Organization
XDR-TB	Extremely drug resistant tuberculosis

Executive Summary

The primary objective of the 2000 and 2001 Abuja Declarations and Frameworks for Action adopted by AU Heads of State and Government on Malaria, and on HIV and AIDS, TB and Other Related Infectious Diseases respectively was to urge Member States to undertake action to arrest and reverse the staggering rate at which these diseases were eroding progress in socio-economic development in Africa at the turn of the century. The Abuja Declarations and subsequent commitments stimulated sharp increase in resource mobilization and the scale up of programs to fight these diseases in Africa. In early 2006, additional momentum was provided by the emerging international consensus on Universal Access as a means to attain Millennium Development Goal 6 and other health-related Millennium Development Goals (MDGs).

This culminated in the adoption of the "Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa" and related commitments at the Special Summit which was held in Abuja in May 2006 under the theme: "Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by 2010". The main objective of the Special Summit was to review the status of implementation of the Declarations and Plans of Action on the 2000 Abuja Summit on Roll Back Malaria (RBM) and the 2001 Abuja Summit on HIV/AIDS, TB and Other Related Infectious Diseases (ORID).

The combined burden and socio-economic impact of the HIV/AIDS, tuberculosis, and malaria epidemics in Africa has been massive. Tuberculosis (TB) is the leading cause of death in people living with HIV, due to the high HIV/TB co-infection. Malaria threatens a disproportionately high percentage of the population in Africa, with about 350 million episodes annually.

HIV/AIDS, tuberculosis and malaria undermine productive capacities of populations, perpetuate poverty, exacerbate social problems and overwhelm health services and contribute to a reversal in the health status of Africans, and threaten the development gains made in previous years.

Since 2006, significant progress has been made by Member States towards universal access to health services in general and HIV/AIDS, tuberculosis, and malaria in particular. There is clear continental and international political will and commitment to achieve universal access and the health-related Millennium Development Goals by 2015.

In spite of the commendable progress made, this is still insufficient to attain the Abuja target of universal access to HIV/AIDS, Tuberculosis and Malaria services by 2010. The 'final push' towards universal access should be advanced through intensified implementation of national programmes with the support of the UN system and international partners, further mobilization with more rational use of resources, and better harmonization and coordination of partnerships at national, regional and continental levels.

Reducing the impact of the three diseases would significantly propel efforts to achieve, not only MDG 6 and other health related MDGs, but also development goals related to women's and children's rights to health, education, nutrition and equality, as well as the reduction of extreme poverty.

This Report therefore represents a summary of the progress made by Member States since 2006 towards the implementation of the "Abuja Call", under its priority areas. (Moved from Para 2)

Introduction

Background

1. In the wake of the September 2000 Millennium Summit, the leaders of African Union Member States assembled in Abuja, Nigeria in 2000 and 2001, and adopted the Abuja Declarations and Frameworks for Action on Roll Back Malaria, and on HIV and AIDS, tuberculosis and other related infectious diseases. The primary objective of the Abuja Declarations and Frameworks was for Africa to collectively and individually work towards arresting and reversing the staggering rate at which these diseases were eroding prior progress made in socio-economic development. This high-level commitment marked a turning point in the continental response to these three diseases. The 2001 Declaration and Framework for Action also comprised Africa's Common Position to the 2001 United Nations General Assembly Special Session (UNGASS) on HIV and AIDS, which resulted in the landmark UN Declaration of Commitment on HIV and AIDS and also led to the establishment of the Global Fund to fight AIDS, Tuberculosis, and Malaria.

2. This commitment was reinforced on multiple occasions at the continental level:
    - The AU Conference of Ministers of Health adopted the Gaborone Declaration on Sustainable Access to Treatment and Care for the Achievement of the Millennium Development Goals (Gaborone, October 2005);
    - Ministers of Health of the WHO Regional Committee for Africa declared tuberculosis an emergency, and called upon Member States to implement "urgent and extraordinary actions" to bring tuberculosis under control (Maputo, August 2005);
    - AU Member States adopted the Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS prevention, treatment, care and support in Africa by 2010 (March 2006)
    - The AU, WHO, UNAIDS, UNICEF, ECA and other partners launched the campaign on: 2006 as the year for accelerating HIV prevention under the theme: "Step Up the Pace for HIV Prevention in Africa".
    - The AU Conference of Ministers of Health adopted the Johannesburg Declaration on Strengthening of Health Systems for Equity and Development in Africa" April 2006.
3. These commitments stimulated a sharp increase in resources and the scale up of programs to fight these diseases in Africa. However, it quickly became clear that much more needed to be done to achieve Millennium Development Goal 6. Momentum gathered towards an ambitious new target – universal access – that would pave the way to achieving Millennium Development Goal. In May 2006, the Special Summit on HIV and AIDS, Tuberculosis and Malaria in Abuja, reviewed continental progress towards the commitments made in the 2000 and 2001 Abuja Declarations and African leaders made a new collective commitment under the "Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa". Other commitments included Africa's Common Position to the UN General Assembly High Level Meeting on HIV and AIDS, which endorsed the target of universal access to HIV prevention, treatment, care and support services for all who need it by 2010.
4. The main objective of the 2006 Special Summit was to review the status of implementation of the Declarations and Plans of Action on the 2000 Abuja Summit on Roll Back Malaria (RBM) and the 2001 Abuja Summit on HIV/AIDS, TB and Other Related Infectious Diseases (ORID). The Abuja Call has the following priority areas to guide related action: Practical Leadership at National, Regional and Continental levels; Resource mobilization; Protection of Human Rights; Poverty Reduction, Health and Development; Strengthening Health Systems; Prevention, Treatment, Care and Support; Access to Affordable Medicine and Technologies; Research and Development; Implementation; Partnerships whereby the roles of each stakeholder were clearly spelt out; and Monitoring Evaluation and Reporting.
5. In accordance with the Abuja Call, regular progress reports on implementation are prepared and reviewed by the African Union policy organs. As requested the AU Commission, with the support of the United Nations, developed this five-year Progress Report on the Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa by 2010.

Mandate

6. In the "Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa" the African Union Commission was mandated in collaboration with Development Partners to:
    - Prepare a biennial Progress Report for consideration by Inter-Ministerial Committee Members of AU Member States;
    - Submit a biennial Progress Report on the status of implementation to the AU Executive Council and Assembly of Heads of State and Government.
    - Undertake consultative review at five years (2010) on the status of the implementation of the 2006 Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services by 2010; and of the MDGs.

Purpose

7. The purpose of this report is to present progress made by Member States since 2006 towards the implementation of the "Abuja Call". The report covers the progress for HIV and AIDS, Tuberculosis, and Malaria programs under the priority areas as identified in the Abuja Call. The report once adopted by the AU Ministers of Health, and endorsed by the Executive Council and the Assembly of Heads of State and Government, will be a framework for further continental efforts in the fight against these diseases. It will also contribute to Africa's Common Position to the United Nations Summit on the Millennium Development Goals in September 2010, review of the end-of-decade of Roll Back Malaria and other forums.

Methods

8. The primary sources of data for this report include:
    - 2008 and 2009 Progress Reports on the status of implementation on the Abuja Call to the AU organs, which were based on annual country reports on the three diseases.
    - Biennial country progress reports for the United Nations Declaration of Commitment on HIV and AIDS and annual country reports for monitoring the health sector response towards Universal Access for HIV prevention, care, and treatment from 52 African Union Member States. This data has been validated and reconciled with other global reporting mechanisms, such as PEPFAR, UNAIDS, and UNICEF databases.
    - For tuberculosis, WHO collects information on tuberculosis control program performance indicators from member countries using a standard tuberculosis data collection form on which countries voluntarily specify control policies and implementation of strategies, case finding activities, population coverage and access to services, and treatment outcomes for various forms and types of tuberculosis.
    - Apart from reporting on tuberculosis case details for the year under review, Member States also updated information for specified previous years where possible, which was used to produce this status report.
    - For malaria, the main sources of data are questionnaires received from 43 malaria-endemic countries whose data have contributed to the 2009 World Malaria Report, other published and unpublished reports as well as data that has been reviewed, summarized and synthesized to give an overall picture of the malaria situation in Africa, and that allows for comparison across AU Member States.
    - Global and regional reports on HIV and AIDS, tuberculosis, and malaria received from UNAIDS, WHO, the AFRO Region, the Stop TB Partnership, Rollback Malaria, and other partners, which are again based on country reports.

Situational Analysis

9. The combined burden and socio-economic impact of the HIV and AIDS, tuberculosis, and malaria epidemics in Africa has been massive. Tuberculosis is the leading cause of death in people living with HIV, due to the high HIV co-infection. Malaria threatens a disproportionately high percentage of the population in Africa, with about 350 million episodes annually.

10. HIV and AIDS reduce GDP growth in Africa by an estimated 0.5% and 2.6% annually. In countries with a high prevalence of tuberculosis, economic loss is estimated at between 4% and 7% of GDP annually. Due to the high prevalence of malaria in the past 30 years, Africa's GDP lost as much as USD 100 billion. HIV and AIDS, tuberculosis and malaria undermine countries' productive capacities, perpetuate poverty, exacerbate social problems and overwhelm health services. Together, they account for 75% of Disability Adjusted Life Years (DALYS) lost on the continent, contributing to a reversal in the health status of Africans and threatening to undermine the development gains made in previous years.

HIV and AIDS

11. Africa is the continent worst affected by HIV and AIDS, with the highest HIV prevalence concentrated in five countries in Southern Africa. In 2008, more than two million people in Africa became newly infected with HIV, bringing the total number of people living with HIV to over 22 million. While the rate of new HIV infections in most of Africa has slowly declined—with the number of new infections in 2008 approximately 25% lower than at the epidemic's peak in 1995—the number of people living with HIV in Africa increased slightly in 2008, in part due to increased longevity stemming from improved access to HIV treatment. North and West Africa have been least affected by HIV to date, although some countries in West Africa are experiencing rising HIV prevalence to as much as 5%. In 2008, an estimated 1.4 million AIDS-related deaths occurred in sub-Saharan, representing an 18% decline in annual HIV-related mortality since 2004. AIDS-related deaths in North Africa were estimated to be less than 20,000 in 2008. Since the epidemic began, more than 14 million children have lost one or both parents to AIDS. HIV and AIDS is the leading cause of maternal mortality in high prevalence countries. The epidemic has an enormous impact on households, communities, businesses, public services and national economies. Africa faces a triple challenge of scaling up prevention activities to reduce the number of new infections, providing adequate care and support to the growing population of people living with HIV, and ensuring adequate care for the millions of orphans and people affected by HIV.

Tuberculosis

12. In 2005, tuberculosis was declared an emergency across Africa in response to the rapid increase in new cases in recent years. Since 1990, the annual number of new cases has more than quadrupled in most African countries and continues to rise. Tuberculosis is the leading killer of people living with HIV in Africa. Although it has only 11% of the world's population, Africa accounts today for more than 25% of the global tuberculosis burden with an estimated 2.4 million tuberculosis cases and 540,000 tuberculosis deaths annually.
13. In Southern Africa in particular, weak health systems and poor tuberculosis control, compounded by a spiralling HIV epidemic and endemic poverty, has resulted in multi-drug resistant tuberculosis, which dramatically increases treatment costs, duration of treatment, and lowers the chances of treatment success. Tuberculosis is estimated to deprive the world's poorest countries of an estimated $1 to $3 trillion over the next 10 years. In some countries, loss of productivity attributable to tuberculosis has been estimated to be as high as 7% of GDP.

Malaria

14. The vast majority of global malaria deaths – around 767 or 89% of malaria mortality globally - occur in African countries south of the Sahara, and mostly in young children. Malaria is Africa's leading cause of under-five mortality (20%) and constitutes 10% of the continent's overall disease burden. Malaria accounts for 40% of public health expenditure, 30-50% of inpatient admissions, and up to 50% of outpatient visits in areas with high malaria transmission and is estimated to cost Africa more than USD 12 billion every year in lost GDP, although the disease could be controlled for a fraction of this amount. Despite commitments to eradicate malaria, most African nations lack the infrastructures and resources necessary to mount sustainable, effective campaigns.
15. One of the greatest challenges, in reaching RBM 2010 malaria control targets and MDGs faced by Member States today, is the effective containment of the spread of drug and insecticide resistance. Resistance to chloroquine, the cheapest and most widely used anti-malarial, is common throughout Africa. As a result, all malaria endemic many countries have changed their first line treatment policies to artemisinin-based combination therapies (ACTs). ACTs availability at no cost in public sector providers is increasing with funding from GFATM, UNITAID, World Bank Booster and the President's Malaria Initiative, albeit slowly; the Affordable Medicines Facility for malaria (AMFm) attempts to ensure availability of ACTs in private sector outlets at the price of chloroquine, a still widely available and consumed drug. But the appearance

of artemisinin resistance, as has been already documented in South-East Asia, could become a real threat to malaria treatment in Africa. The greatest threat to the development and spread of resistance to artemisinin is the use of oral artemisinin-based monotherapies for the treatment of malaria. Despite a World Health Assembly resolution in 2007 calling for halting the marketing and use of these medicines, 16 countries in Africa still provide marketing authorization for them.

16. Modern malaria vector control is thoroughly dependent on pyrethroids. They are the only class of insecticides currently available to treat nets. Pyrethroids are also used in large quantities for the indoor residual spraying of houses. However, various pyrethroid resistance mechanisms are now evolving in African malaria vectors. The impact of these on the effectiveness of vector control is not yet well understood, but the threat of resistance is real and threatens to cancel vector control gains made to-date as no new classes of insecticide currently exist for the treatment of bed nets.

Findings

Leadership at National, Regional and Continental Level

The primacy of national leadership and ownership as well as the alignment of development efforts around national priorities is enshrined in the provisions in the "Three ones Principles for Coordination and Harmonization of Programmes"; recommendations of the Global Task Team on Improving Coordination Among Multilateral Institutions and International Donors, and the 2005 Paris Declaration and Accra Plan of Action on Aid Effectiveness. This reaffirms the central role of sovereign nations in their development efforts and the primary responsibility of national governments for the welfare of their citizens. These national efforts are supported through sub-regional, regional and global forums, which act as catalysts for collective action.

17. The African Union Commission (AUC) and Regional Economic Communities (RECs), with support from national and international partner agencies and organizations, have led these catalytic efforts since the Abuja Call was adopted in 2006.

Continental Leadership

18. To better harmonize the continent's intensified efforts to combat HIV and AIDS, the African Union developed an HIV and AIDS Strategic Plan for 2005 – 2007, and the AIDS Watch Africa Strategic Framework, with four key objectives:

    - Building the African Union (AU) leadership, accountability and advocacy,
    - Promoting African and external stakeholder accountability to mitigate HIV/AIDS,
    - Facilitating the harmonization of HIV and AIDS policies at the continental, regional, and national levels, and
    - Mobilizing sustainable human and financial resources for a long-term AU response.

19. In 2007, the AU developed an implementation plan entitled "Accelerating Action and Responding to a Continental Emergency" for 2008 – 2010, in which the AUC committed to eight deliverables, including the development of a monitoring, evaluation and reporting framework, a process for coordinating and harmonizing efforts by RECs, Member States and partners, a campaign to address gender, youth, violence, and HIV, advocacy tools to improve access to services for vulnerable populations, the creation of an African Research Network for HIV and AIDS, tuberculosis and malaria, policy for regional cooperation on HIV and AIDS and conflict situations, a HIV and AIDS information and media strategy and an AU workplace program for mainstreaming of HIV and AIDS within the AUC.

20. In a further effort to assist Member States to harmonize their responses to combating diseases across the continent, the AU Conference of Ministers of Health adopted the Africa Health Strategy for 2007–2015, a framework whose goal is "to contribute to Africa's socio-economic development by improving the health of its people and by ensuring access to essential health care for all Africans, especially the poorest and most marginalized, by 2015." The overall objective of this strategy is to strengthen health systems in order to reduce morbidity and accelerate progress towards attainment of the Millennium Development Goals in

Africa. More specifically, it aims to assist in the strengthening of national health systems in Member States, to build stronger collaboration between health and other sectors to improve the socio-economic and political environment for improving health and to facilitate the scaling up of health interventions by Member States and through regional and intergovernmental bodies.

21. In April 2007 in Johannesburg, at the 3rd Session of the AU Conference of Ministers of Health, the Campaign for Malaria Elimination in Africa was launched to supplement the acceleration of Malaria control efforts. Furthermore, the MDG Malaria Summit was held in New York under the theme: "World Leaders Unite" and participants announced new funding in excess of USD 3 billion committed to eliminating malaria mortality by 2015.

22. In October 2008, the Department of Social Affairs of the African Union Commission held the 1st Session of the AU Conference of the Ministers in charge of Social Development in Windhoek, Namibia with the theme: "Towards a Sustainable Development Agenda for Africa". At this conference, the AU's Social Policy Framework for Africa was adopted aimed at providing an overarching policy structure to assist African Union Member states in the development of integrated national social policies to promote human empowerment and development and serving as a coordination tool.

23. At the 64th United Nations General Assembly in September 2009, the African Leaders Malaria Alliance (ALMA) was adopted by all African Heads of State and Government. Dedicated to ending malaria deaths in Africa, the purpose of the Alliance is not only to provide a forum for high level, collective advocacy to ensure: efficient procurement, distribution, and utilization of malaria control interventions; the sharing of most effective malaria control practices and ensuring that malaria remains high on the global policy agenda, but also seeks to help coordinate issues of joint importance, such as procurement to better leverage the collective buying power of ALMA members. In addition, the "United Against Malaria" campaign was launched in Addis Ababa in November 2009, with the slogan, "United, We Can Beat Malaria", to ensure that no one suffers from Malaria during the July 2010 Football World Cup in South Africa.

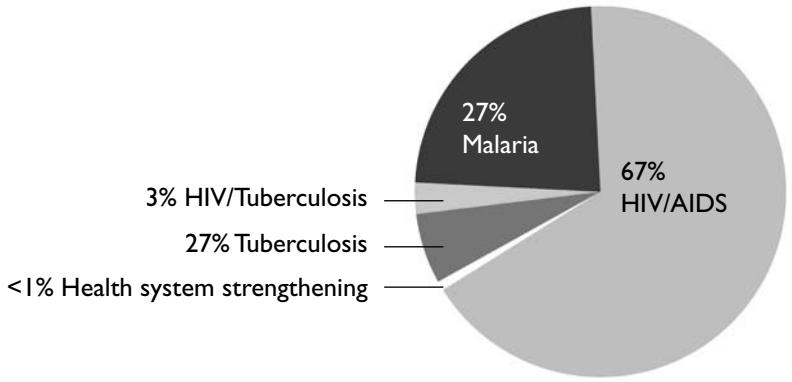
24. To improve coordination and harmonisation of partnerships at regional and continental levels, Inter-Agency Meetings on HIV/AIDS, TB and Malaria Strategies were held in 2006 (Addis Ababa), 2008 (Abuja) and 2009 (Addis Ababa), bringing together the AU, Regional Economic Communities (RECs), Regional Health Organisations (RHOs), UN Agencies, CSOs and other international partners. This operates under the AU/UN Regional Coordination Mechanism (RCM). The 2009 Inter-Agency Meeting was held under the theme - "Progress Towards Achievement of Abuja Call for Universal Access to HIV/AIDS, TB and Malaria Services by 2010: The Final Push for Action". Important recommendations to guide partnerships and follow-up action were adopted.

Regional and National Leadership

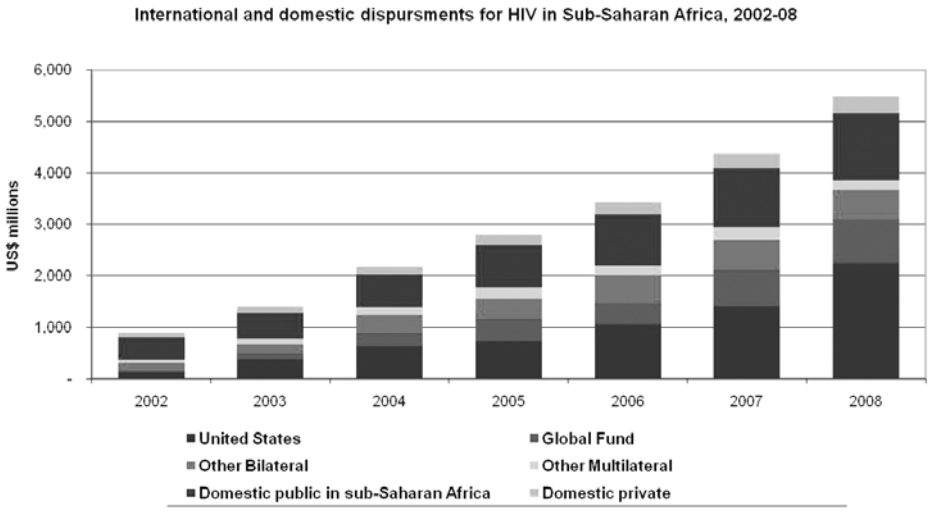
25. The East, Central, and Southern African Health Community (ECSA-HC) has contributed to the coordination and harmonization of policy, advocacy and program implementation to control HIV and AIDS, tuberculosis, and malaria among its Member States. Activities undertaken between 2005 and 2009 included strengthening policies, strategies and protocols across all countries, technical assistance for expansion of prevention and treatment services, advocacy for an integrated approach to HIV and tuberculosis, HIV and reproductive health, development of a regional pharmaceutical strategy and harmonized standardized treatment guidelines for all three diseases.

26. The Member States of the East African Community (EAC) are currently involved in coordinating drug regulatory and purchasing activities to resolve the challenges of high medicines prices, poor quality and other bottlenecks generally associated with the procurement and supply chains of essential medicines. The EAC Secretariat is building its capacity to support pooled regional procurement . In addition, countries within the EAC are also finalizing a common HIV Prevention and Management Bill to establish minimum standards for HIV and AIDS services. This is particularly significant in that it takes into consideration cross border movement and the need for a uniform response to the HIV epidemic. The legislation is intended to provide a basic legal framework in countries where no HIV laws exist and to address disparities in HIV and AIDS responses across this region. Under the EAC Treaty, regional law supersedes national law.

27. The Inter-Governmental Authority on Development (IGAD) Ministerial Committee on HIV and AIDS created the IGAD Regional HIV and AIDS Partnership Program (IRAPP) in 2007. Supported by the Africa Catalytic Growth Fund administered through the World Bank, with technical assistance from numerous UN agencies, this four year program aims to improve access to HIV and AIDS services for cross border and mobile populations and surrounding host communities, as well as to establish a common approach for scaling up of services and support to these populations amongst IGAD Member States. Preparatory activities took place in 2008, and activities to reach populations in need commenced in 2009. IGAD has added this year malaria to their agenda.



28. Heads of State of the Southern African Development Community (SADC) signed the Maseru Declaration on HIV and AIDS in July 2003, in which they reaffirmed the need to address HIV and AIDS as an urgent priority and committed to collective action through the multisectoral strategies reflected in the SADC HIV and AIDS Strategic Framework and Programme of Action. Progress has been regularly reviewed at subsequent summits, the latest being in Kinshasa, DRC in September 2009. The SADC Secretariat is now a Principal Recipient of a Round 9 Global Fund grant focused on HIV prevention and treatment services for mobile populations in the region.



29. SADC has also undertaken initiatives to combat the considerable burden placed on its Member States from endemic malaria and tuberculosis, including some of the first MDR-TB to be identified on the continent. The Directorate of Social and Human Development and Special Programs support the provision of essential, affordable, good quality and safe medicines for all three diseases, for urban and rural communities. The Directorate further seeks to promote and increase the coordinated and sustainable participation of all stakeholders, including the private sector, in the provision of services. In addition, SADC created a specific SADC malaria week.

30. In 2008, the Economic Community of West African States (ECOWAS),working jointly with UNAIDS and with funding from the Embassy of Norway, conducted an epidemiological analysis of its Member States to better understand the dynamics of and each country's governance of response to the HIV epidemic. Findings from this drove the development of a bold strategic plan on HIV to assist member States to improve their policies and strategies. ECOWAS also includes a support program on HIV and AIDS as one of its five priority programs in education. The program aims to foster sharing of experiences for those working in HIV and AIDS, promote learning at all levels of the educational system on life skills for HIV and AIDS, and to provide care for those affected by HIV and AIDS within the educational system. This

initiative has received considerable political support from Member States as well as financial and technical support from the UN and other international partners. ECOWAS issued a resolution on malaria in 2009.

31. The Community of Central African States (ECCAS) formed an HIV and AIDS and Health Committee to increase understanding of the growing HIV and AIDS problem in this region, as well as to accelerate a coordinated response to this situation. With technical assistance from a number of international agencies, 28 representatives of the nine Member States in Central Africa convened to determine the feasibility of implementing a regional surveillance and monitoring system to better inform future HIV interventions, and to begin to develop a system suitable for the region. The OCEAC, _ (Coordination Organization for the fight against endemic diseases in Central Africa) was mandated to develop and coordinate the implementation of the HIV and AIDS strategic plan 2006-2010, aimed at strengthening national AIDS responses within ECCAS.

32. Although the RECs have done a lot is the response to HIV/AIDS, they need to integrate Malaria and TB control together with general health and development programmes, especially where there are no corresponding RHOs.

Resource Mobilization

33. There has been a considerable increase in the available funding to fight HIV and AIDS, tuberculosis and malaria across Africa in the last five years. At the end of 2009, six AU Member States had reached the goal of allocating 15% or more of their national budgets to health as pledged in the 2001 Abuja Declaration, with just over half of all African countries reporting (26 out of 50), indicating that they had allocated 9% or more of their national budgets for health expenditures. Across these 50 Member States, national contributions to health as a percentage of total national expenditure averaged 8.7% in 2009, compared to nearly 15% and 17% in Europe and the Americas respectively. Average government per capita expenditure on health in Africa is only $27, far below the $1,250 to $1,350 per capita expenditures that occur in Europe and the Americas. Countries with higher government per capita expenditure on health alongside higher investment in initiatives such as clean water, sanitation and environment, nutrition, gender equity in health, and higher numbers of health workers distributed geographically utilize health resources more efficiently and have overall higher life expectancy. But higher per capita investment in health alone is not enough.

34. To reduce debt burden to a manageable level in many Africa countries, 29 Member States have successfully negotiated debt reduction packages through the "Heavily Indebted Poor Countries" Initiative jointly managed by the International Monetary Fund and the World Bank.

35. The Global Fund for HIV and AIDS, Tuberculosis, and Malaria (GFATM) has mobilized over USD 11.5 billion in funding for Africa since 2002, while the US government recently authorized almost USD 48 billion to be used over five years in the fight against HIV and AIDS, tuberculosis, and malaria, the majority of which will be spent on the African continent. Gains in resources across the continent are helping to scale up priority interventions, though a significantly larger amount of funding is needed to reach the Abuja targets.

HIV and AIDS

36. Since the adoption of the Abuja Call in 2006, significant increases in funding have been committed to the fight against HIV and AIDS in Africa. Domestic government spending in African countries south the Sahara has increased 32% from an estimated USD 986 million in 2006 to USD 1.3 billion in 2008. At the same time, domestic private spending has increased at a similar rate, from USD 247 million in 2006 to USD 327 million in 2008 .

37. Despite this laudable increase in domestic spending, external funding has accounted for an increasingly large portion of the financial resources for HIV and AIDS in Africa, accounting for 75% of the total funding for HIV and AIDS programs in 2008, compared to 69% in 2006. Overseas development assistance for HIV and AIDS programs in countries south of the Sahara increased by 75% from USD 2.2 billion in 2006 to USD 3.9 billion in 2008 . The US Government and the Global Fund to Fight AIDS, Tuberculosis and Malaria were the largest contributors to this cause, with the remaining funds coming from other bilateral and multilateral donors.

38. Initiated in 2003, the United State's President's Emergency Plan for AIDS Relief (PEPFAR) provides funding to fight HIV and AIDS in numerous countries, including 15 focus countries, most of which are African. In 2009, PEPFAR allocated almost USD 6.5 billion for combating HIV and AIDS, tuberculosis, and malaria compared to less than USD 2.5 billion in 2007. The World Bank Multi-Country HIV and AIDS Program for Africa has committed over USD 1.8 billion in 35 countries, including five regional projects addressing cross-border issues.

39. In 2010, an estimated USD 13 billion is needed to adequately fund HIV and AIDS interventions in Africa. Of the total investments required, one third is for activities addressing behavioral change, social drivers of the epidemic, social mitigation and other services that are managed outside of the health sector through multisectoral programs. Another one third is aimed at strengthening health systems. The remaining one third will go towards HIV specific health services, such as programs to reduce mother-to-child HIV transmission, blood safety, and provision of antiretroviral therapy for those in need.

Tuberculosis

40. Funding for prevention and treatment of tuberculosis in Africa in 2009 was estimated to be just over USD 500 million compared to approximately USD 400 million in 2008, an increase of 25%. While funding for tuberculosis has increased in recent years, and particularly in high burden countries in Africa, funding levels fall far short of what is required. Funding gaps reported by National Tuberculosis Programs (NTPs) since 2007 are larger than those reported during 2002–2006, as NTPs expand the range of interventions being planned in line with the Stop TB Strategy. In particular, funding for DOTS in Africa fell short of estimated need by about USD 200million in each year after 2007. Some countries continue to report funding gaps for first-line anti-tuberculosis drugs as well.

41. While the majority of available funding was used to support DOTS implementation, the share for MDR-TB has increased since 2007. A relatively small amount of funding has been reported for collaborative TB/HIV activities reflecting the fact that funding for most of these interventions is channeled through national HIV programs and nongovernmental organizations, rather than via NTPs. Financing from the Global Fund has become increasingly important since 2004, while other donor funding has and will continue to rise in 2010.

42. Greater support to tuberculosis programs is required to expand and strengthen laboratories services and improve community care to achieve and surpass the 70% target set for case detection rates in the Stop TB Plan, as well as to address the growing need for new medicines to fight drug resistant tuberculosis.

Malaria

43. Estimates for 2007 from the WHO World Malaria Report 2008 show that resources from endemic country governments in Africa account for 18% of the USD 622 million disbursed. The remaining disbursements came from international donors (notably The Global Fund 42%, the U.S. President's Malaria Initiative 20%, World Bank Booster Program 8%). Unfortunately, comparative data on household, government, and private institution spending on malaria in Africa remains insufficiently complete to allow a comprehensive analysis of trends. An important consideration however, is whether government financing for malaria remains stable, reduces or increases in the presence of large quantities of external financing. An analysis of 31 countries indicated that government expenditures had remained constant or slightly increased between 2004 and 2008. Member States are also taking steps to assure that out of pocket spending on malaria is money well spent and that malaria prevention becomes more affordable by reducing or abolishing taxes and tariffs on the insecticides, nets and the materials used in their manufacture.

44. Of the 43 malaria endemic countries in Africa, 40 (93%) received external funding between 2003-2009. During this interval, the total funding committed to malaria control in these countries reached almost USD 3.5 billion, the equivalent of USD 5.29 per person at risk in these countries. Over the past five years, the malaria control landscape in malaria-endemic African countries has changed dramatically. Since 2004, malaria funding from the Global Fund has increased almost threefold and new funding mechanisms such as the World Bank's Booster Program and the U.S. President's Malaria Initiative have provided much-needed funding and implementation support for commodities in 15 of 47 African countries.

45. In Africa, most of the malaria funding is directed to either prevention (42%) or treatment (38%) with the remaining 20% supporting program management and systems strengthening. Expenditures on LLIN and

malaria drugs for treatment make up two-thirds of all expenditures; of note, expenditures on diagnostics have been quite low (roughly 2% of treatment costs) in relationship to expenditures on drugs.

46. Scaling up malaria control to reach universal access enabling medium term elimination requires that national governments reach the 15% for health budget and retain their financial commitment, above and beyond time limited disease specific funding streams such as the global fund.

Protection of Human Rights

47. The AU Social Policy Framework adopted in 2008 states that HIV and AIDS, tuberculosis and malaria are symptomatic of deeper socio-economic and development problems and policies that seek to respond comprehensively to the pandemics through initiatives beyond the public health sector, such as the promotion of gender equality, should be of high priority. The AU Commission HIV and AIDS Workplace Policy issued in 2009, speaks directly to conditions at the work-place and provides a framework for enforcement of workers' rights and employers' responsibilities with respect to those living with HIV and AIDS.

48. There have been important efforts to reform the legal environment related to HIV in a number of African countries. These reforms have focused on non-discrimination in areas such as employment, education, housing, and access to health care. At the end of 2005, 16 of 29 reporting AU Member States (55%) had anti-discriminatory measures. Two years later, 28 of 42 reporting AU countries (67%) had such measures in place. Progress has been even greater regarding laws and regulations protecting most-at-risk and vulnerable populations. In 2005, only nine of 30 reporting AU countries (30%) had laws or regulations in place. By 2007, 33 of 43 reporting countries on the continent (77%) were providing legal or regulatory protection to at-risk groups.

49. Currently, four AU Member States still have some form of restriction on the entry, stay and residence of people living with HIV. Such restrictions have no public health rationale and constitute an inappropriate infringement of the rights to dignity, liberty, equality and non-discrimination. At a time of renewed global commitment to the elimination of restrictions on the entry, stay and residence of people living with HIV, it is urgent that these measures be lifted, and that AU members vigorously advocate for their removal.

50. In most countries, legislative endeavours have been insufficient to address the deep rooted causes of HIV-related vulnerability, stigma, and discrimination. As a result, the content, scope and scale of programs to address stigma and discrimination in most African countries are far from satisfactory. In 2007, 41 of 44 reporting AU countries reported the existence of restrictive measures targeting members of key populations, in particular, men who have sex with men and sex workers. More than 30 countries have laws prohibiting same-sex relations between consenting adults and the punishment for violations is often severe. In some countries, new legislation targeting members of key populations have been adopted or are being considered. These restrictive laws are known to negatively impact access to HIV-related services for members of key populations.

51. The insufficient focus on the HIV-related needs and rights of key populations, in particular sex workers, prisoners, men who have sex with men and people who inject drugs remains a challenge for the AIDS response. Effective HIV-related prevention, treatment, care and support addressing the specific needs and circumstances of these populations must be considered in all key national planning documents, and carried through the full planning process.

52. Tuberculosis (TB) prevention, care and control raise important ethical and policy issues that need to be adequately addressed. These concerns have been accentuated by the problem of multidrug-resistant TB (MDR-TB) and, most recently, by the emergence and spread of "extensively" drug-resistant TB (XDR-TB) which is especially difficult to detect and treat. In this regard, if a patient wilfully refuses treatment and, as a result, is a danger to the public, the serious threat posed by XDR-TB means that limiting that individual's human rights may be necessary to protect the wider public.

53. The important relationship between human rights and malaria has not received sufficient attention. The obligation to respect, protect and fulfill human rights provides a powerful impetus to control and, where possible, eliminate malaria in endemic countries. The scale-up and maintenance of malaria prevention and treatment now underway in many African countries contributes importantly to the fulfillment of the obligation of States to progressively realize for their people the Right to Health.

54. With the majority of the nearly one million deaths per year from malaria occurring in young African children, the right to life and the rights of the child are directly relevant to the fight against malaria .

55. Given the documented economic burden of malaria in malaria-endemic countries in Africa , the fight against malaria is a crucial component in the overall right to economic and social development. With loss of productivity and income, poor individuals and families face severe challenges to afford the higher costs of effective anti-malarial medicines, specifically ACTs. Seven African countries are participating in the first phase of the Affordable Medicines Facility- malaria, an innovative financing mechanism to expand access to ACTs designed by the Roll Back Malaria Partnership and hosted by GFATM. By subsidizing effective antimalarial medicines, this innovative financing mechanism helps to fulfill the human right to health, life and non-discrimination.

56. The introduction of universal access to treatment and prevention by all populations at risk was introduced through the RBM Global Strategic Plan in 2006. The introduction of the long term disease control target with subsequent possibility of attempting regional malaria transmission control requires that to-date, highly mobile cross border, IDPs and refugees become an important target population as national malaria control efforts hardly ever have the geographic reach to touch these populations. African Union RECs such as IGAD start addressing the needs of these marginal populations.

Poverty Reduction, Health and Development

57. Roughly 40% of Africa's population lives on less than a dollar a day. Low incomes reduce access to good nutrition, which further exacerbates the health problems of the very poor. While relatively inexpensive health commodities to prevent HIV and malaria transmission and affordable medicines to cure tuberculosis and malaria and treat HIV are increasingly available across Africa, poorer populations have more difficulty in accessing them. Economic growth in Africa, which had accelerated from 3.1% in 2000 to 6.1% in 2007, was projected to be only 1.7% for 2009 – down from the anticipated 6.4 percent, and far below the average growth rates of 5.3% posted by the continent's best 15 performing countries for more than a decade. This will slow progress toward the Millennium Development Goals, even for countries that were close to halving poverty by 2015.

58. Poverty Reduction Strategy Papers (PRSP) are prepared by Member States in collaboration with the World Bank, the International Monetary Fund, civil society and development partners. These documents describe the country's macroeconomic, structural and social policies and programs to promote growth and reduce poverty, as well as, associated external financing needs and major sources of financing. Thirty-six Member States have PRSPs, and continue to work alongside partners to improve these and their implementation .

59. The Africa Health Strategy emphasizes the need to provide social protection for the vulnerable. Furthermore, Member States are increasingly committed to Poverty Reduction Strategic Plans, the Highly Indebted Poor Countries initiative and other debt cancellation programs governed by the World Bank, the International Monetary Fund, and other international agencies. These macro-level approaches, if successful in reducing poverty and inequality, will eventually have a positive impact on the health of the poor in Africa.

HIV and AIDS

60. The social dimensions of HIV infection and the need for a multisectoral response that extends beyond the health sector has been well recognized by AU Member States, who are integrating AIDS responses into national development plans, including Poverty Reduction Strategies and UN Development Assistance Frameworks. In 2005, 28 of 32 reporting countries (88%) reported that HIV had been included in their development plans. By 2007, all 43 reporting countries (100%) said that HIV was included in their national poverty reduction strategic plans.

61. In the past five years, governments across Africa have shown growing insight and leadership in food security and nutrition as related to HIV and AIDS. In the highly affected Eastern and Southern African regions, 17 of 19 national strategic plans include food and nutrition related situation analysis and a broad spectrum of related intervention strategies. Food and nutrition are also an important component of national funding proposals, with just over half of awarded Global Fund proposals in Africa considered to be 'nutrition

aware'. However, more can be done to leverage financial and technical support to expand food and nutrition support across care and treatment programs.

Tuberculosis

62. Tuberculosis infection is transmitted more readily in the environmental conditions associated with poverty: overcrowding, inadequate ventilation and malnutrition. The poor are at higher risk of contracting the disease and also lack access to high-quality tuberculosis care due to financial and other access barriers. Strengthening policy and strategies to improve tuberculosis case detection and treatment efforts close to point of care is essential to provide maximum benefit to the poor and target scarce resources where the diseases burden is heaviest.

63. By 2008, 59% (27/46) of the member states had developed tuberculosis strategic plans aligned with national poverty reduction strategies.

Malaria

64. Malaria is understood to be both a consequence of poverty but at the same time a cause of poverty. Malaria has significant and measurable direct and indirect costs and has recently been shown to be a major constraint to economic development. In some countries with a heavy malaria burden, the disease may account for as much as 40% of public health expenditure, 30-50% of inpatient admissions, and up to 50% of outpatient visits. Annual economic growth in countries with high malaria transmission has historically been lower than in countries without malaria. Economists believe that malaria is responsible for a 'growth penalty' of up to 1.3% per year in some African countries.

65. Conscious of the drain on their economies, governments in Africa are now increasing resources for malaria control, in line with the resolutions made at the Abuja Summit of 2000. Malaria is also becoming an important topic within discussions of poverty reduction and debt relief.

Health Systems Strengthening

66. In April 2007, the 3rd Session of the AU Conference of Ministers of Health on "Strengthening of Health Systems for Equity and Development"was held in Johannesburg, South Africa and resulted in the adoption of the Africa Health Strategy. This document is a framework to facilitate Inter-Ministerial and Inter-Country collaboration for an integrated, coordinated, harmonized and comprehensive response to health challenges facing Africa. Between 2007 and 2009, major activities undertaken to address the need to strengthen health systems across the continent include, the development of the Social Policy Framework for Africa, the Africa Health Strategy (2007-2015), the Pharmaceutical Manufacturing Plan for Africa, the Development of Human Resources for Health and the Global Health Workforce Alliance, and the Declaration and Plan of Action on Africa Fit for Children.

67. In most of AU Member States, a mere 3% of the world's health workers combat 24% of the global disease burden. The World Health Organization (WHO) estimates that African regions face an acute shortage of more than 800,000 doctors, nurses, and midwives, and a shortfall of nearly 1.5 million health workers overall. Resolving this crisis would require African governments to more than double the size of their health workforce. Health system strengthening is currently under way, including health worker training conducted jointly by Ministries of Health and the African Medical & Research Foundation (AMREF) and the drive to capture reliable health data by the Health Metrics Network. AMREF is training a wide range of health workers in close to 40 African countries, including more than 10,000 community health workers each year in Africa's most marginalised communities.

68. Evidenced based information on human resources to be used for policy, planning and implementation is now available for 46 Member States. With technical support from WHO, fact sheets were compiled using data collected in a comprehensive human resources for health data collection exercise in 2005. Despite challenges in the completeness of the information, these fact sheets provide a strong foundation to guide Africa's strategies and activities to improve human resources for health.

69. In rural areas, the distance to the nearest health facility can be 10 kilometres or more, and often these

facilities are not equipped to provide essential health services. Many health facilities in Africa still lack basic infrastructure like clean water and a reliable supply of electricity. Where functioning health facilities exist, user fees often block access to essential health services. However where Member States have removed such fees, health facility attendance has shot up by as much as 50-100%. Insufficient health budgets compounded with logistical problems mean that many people cannot access even the most basic medicines. According to the latest available data from the World Health Organization, the majority of people in most African countries do not have sustainable access to affordable essential drugs or the basic equipment or tools needed to deliver adequate medical care.

70. In 2008, 46 Member States attended the International Conference on Primary Health Care and Health Systems co-organized by the United Nations, the African Development Bank and the World Bank and hosted by the Government of Burkina Faso, where the "Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium" was adopted, and a generic framework for implementation of this Declaration was prepared. To improve provision of essential health care services through an integrated primary health care approach, regional targets were set. The table below shows the targets for 2010 - 2011 and for the 6-year target for 2013:

Indicator	Basline	2010-2011	2013
#of of countries that increased or improved distribution of health facilities/service delivery per 10,000 population	7	15	36
#of countries that increased outpatient visits per 10,000 population per year by sex, age and rural/urban location	2	12	38
#of countries that have developed or updated a comprehensive national health policy and plan	20	27	46
#of countries that have conducted a regular evaluation of the implementation of their national health plans	10	15	40
#of countries that have established effective mechanisms for harmonization and alignment of partners	5	11	26

71. During the last four years there was a 47% increase in Member States - from 19 to28 countries - that have institutionalized an annual health sector review. However, up to 16 countries are yet to institutionalize health sector reviews. Standardization of this approach is in development to facilitate the process.

72. Alongside AU Member States commitment and progress towards increasing their national expenditure on health, foreign aid is also increasing to address this need. The United States passed the African Health Capacity Investment Act in 2007, which authorized $650 million over three years for training and retaining health workers in Africa, as well as to build basic infrastructure for health facilities. The Global Fund provides funds for funds to support health system strengthening activities, and to date, out of 36 eligible African countries, 22 countries have had their proposals approved for more than USD 300 million. In 2009, the World Bank launched its Health Systems for Outcomes, a new program to support 12 member States in the areas of health financing, human resources for health, pharmaceuticals and supply chains, governance and service delivery, infrastructure, and information and communication technology.

73. Malaria control activities have a significant impact on health system strengthening, at many levels. Malaria diagnostics have strengthened peripheral health centers by either deploying rapid diagnostic tests or enhancing the use of light microscopy. In both cases, substantial training capacities of health professionals are involved in this deployment, and confirmation or exclusion of other diseases, and thus management guidance, becomes also possible with the use of such tools. This implies a major accuracy gain in terms of the diagnosis of childhood illness in the context of the existing Integrated Management of Childhood Illness (IMCI) strategy. Malaria intermittent preventive treatment strategies have also contributed to the reinforcement of health systems during antenatal visits. Distribution of bednets in health centers have encouraged more clients to visits health centres. Some countries are starting community management of

malaria, a platform that can be used to improve treatment of common illnesses at the community level, including pneumonia and diarrhea. Malaria control is decreasing the burden on the health system and makes available human resources to address other health priorities.

Prevention

74. The African continent has witnessed significant results in reductions in disease transmission as a result of increased efforts to scale up proven prevention programs. Cumulatively, the number of adults and children newly infected with HIV has dropped by 17.4% between 2001 and 2008. Africa continues to record tuberculosis incidence, prevalence and mortality rates that are among the highest in the world, although these appear to have stabilized since 2004. The tuberculosis epidemic in Africa is driven by the spread of HIV; hence the leveling-off of the tuberculosis incidence rate in the region may be in part associated with the reported progress in reducing HIV incidence. There has been commendable progress in the widespread distribution of long-lasting insecticidal nets (LLINs), while the combined and comprehensive expansion of access to LLINs, insecticide spraying campaigns and preventive treatment in pregnant women, is showing impressive results in stemming the burden of malaria. Improvement in integration of these preventive efforts would increase impact further.

HIV and AIDS

75. HIV Testing and Counseling (HTC) is critical to the achievement of universal access to HIV prevention, care and treatment, as HTC serves as an essential gateway to HIV-related services. Across Africa, there was a vast increase both in the number of health facilities providing HTC and the number of tests conducted in recent years. Amongst Member States where the HIV burden is highest, the total number of health facilities providing HIV testing and counseling services increased by 50%, from 11,000 in 2007 to over 16,500 in 2008. As a result, in 2008, these facilities provided HTC to over 17 million people aged 15 years and above. Despite this increase in service provision, the median percentage of health facilities that provide HTC is 30%, indicating that access to HTC could still be greatly expanded. The scaling up of various models of HTC services, notably provider-initiated approaches in health care settings, has been a promising trend in Africa, though more work is needed.

76. Prevention of mother-to-child transmission (PMTCT) services have witnessed similar expansion, though there remains substantial unmet need. The percentage of pregnant women who received an HIV test in Eastern and Southern Africa increased substantially from 29% in 2007 to 43% in 2008 and from 7% to 16% in Western and Central Africa over the same period. In 2008, almost 580,000 HIV-positive pregnant women in Africa received anti-retroviral drugs (ARVs) for PMTCT purposes, representing a 24% increase from 2007 and a 93% increase since 2006. The 2008 figure represents approximately 45% of the total number of HIV-infected pregnant women in need of ARVs for PMTCT, compared to 34% coverage in 2007. The coverage of infant antiretroviral prophylaxis also increased, reaching 32% in 2008, up from 20% in 2007.

77. Access to PMTCT services is poorest in selected West and Central African countries. In 2008, it is estimated that 4,600 children in these areas became newly infected with HIV. Prevention coverage in antenatal settings in these regions remains virtually non-existent, with estimated coverage below 1% as of December 2008. .

78. Thirty out of the 44 countries, who reported on blood screening in 2007, reported screening 100% of donated blood for HIV. Still, a troubling nine countries reported testing less than 90% of donated blood.

79. Improved knowledge about correct and consistent condom use, delayed age of sexual debut, and the risk of multiple concurrent partnerships, alongside activities to combat stigma and discrimination, are critical to prevention of HIV, particularly among at risk populations. Evidence suggests that HIV prevention programs may be having an impact on sexual behaviors in some African countries. In southern Africa, a trend towards safer sexual behavior was observed among both young men and young women (15–24 years old) between 2000 and 2007. Though some individual countries report increases in condom use, rates of condom use still remain low in many high prevalence African countries. The age of sexual debut appears to be increasing, with 13% males and 14% females reporting sex before age 15 in 2007, down from 16% and 15% in 2005, though this might not hold true for all countries. Rates of concurrent sexual partnerships remain disturbingly high with 22% men and 6% women reporting multiple partners in 2007.

80. While progress has been made in many areas, prevention strategies often fail to address the key drivers of national epidemics. Even though a significant share of new infections in many African countries occurs among older heterosexual couples, relatively few prevention programs have specifically focused on older adults. Although sero-discordant couples account for a substantial percentage of new infections in some African countries, HIV testing and counseling programs are seldom geared specifically for sero-discordant couples. Many programs focused on adolescents and young people fail to address some of the key determinants of vulnerability, such as the high prevalence of intergenerational partnerships, youth unemployment, and gender inequality in many countries.

81. Across Africa, approximately 70% of sex workers had been reached with some HIV outreach and education, but only 36% of these sex workers possessed correct knowledge about HIV transmission and prevention. While only 42% of sex workers had been tested and knew their status in 2007, an impressive 81% of these sex workers reported consistently using condoms.

Tuberculosis

82. Prevention activities for tuberculosis have four main objectives: (a) To improve case detection and treatment adherence, (b) To combat stigma and discrimination, (c) To empower people affected by tuberculosis, and, (d) To mobilize political commitment and resources for tuberculosis. Improved detection and treatment of infected individuals and improved linkages with HIV services are the most effective tuberculosis prevention methods.

83. Across Africa, community involvement is a key mechanism to expanding access to high-quality tuberculosis care. There has been considerable progress in involving communities in tuberculosis care and prevention across the continent in recent years. In 2006, 65% of Member States reported community involvement. However, the available data does not shed much light on the specific activities that are being implemented at the community level, or on the contribution of communities to case detection and treatment success. More information, and indeed more emphasis, on these important activities are needed if Africa is to see a reduction in the burden of tuberculosis.

84. Given the very high rates of co-infection, HIV is the main reason for failure to meet tuberculosis control targets in high HIV settings. Of the African countries with a high HIV prevalence, 41% tested their notified tuberculosis cases for HIV in 2007, signaling important progress from the 14% tested in 2005. Conversely, among high prevalence HIV countries within Africa, 63% of people living with HIV were reported as tested for tuberculosis in 2007. Unfortunately, the number of HIV-positive tuberculosis patients who were given cotrimoxazole preventive therapy (CPT) and anti-retroviral treatment (ART) remains low in Africa and provision of isoniazid preventive therapy (IPT) for HIV-positive people without tuberculosis remains extremely limited.

Malaria

85. An increased focus on distribution of LLINs, indoor residual spraying (IRS), and intermittent preventive treatment (IPT) programs has produced impressive results: nine countries in Africa documented reductions in malaria cases of more than 50% in 2008 compared to 2000. In a number of countries, these reductions have been matched by similar drops in overall child mortality rates, suggesting that malaria control will be a critical element in achieving not only MDG 6, but also MDG 4.

86. In 2008, 23 countries in Africa had adopted the WHO recommendation to provide bed nets for all age groups at risk for malaria, not just women and children (universal coverage); this represents an increase of 13 countries since 2007. The distribution of over 140 million LLINs across Africa between 2006 and 2008 – primarily through integration with immunization campaigns and maternal and child health services - resulted in 31% of African households reporting owning at least one LLINs in 2008, nearly double the 17% reported in 2006. Household LLINs ownership reached more than 50% in 13 of 35 high burden African countries, while seven countries reached a household LLINs ownership rate of more than 60% by 2008. Increased emphasis on mass distribution programs of free or highly subsidized nets contributed heavily to this high uptake. A further 200 million more nets are expected to be delivered in 2010 and early 2011, to achieve universal coverage. For 2008, WHO estimates that coverage of households with at least one ITN had risen

from 1-2% in 2000 to 31% in 2008; it is expected based on LLIN procurements and distributions that this will be >40% at this time in 2010. While this is short of the universal coverage targets recently adopted, it does represent a remarkable increase across the continent. Similarly, in 27 countries with IPTp policies in place, coverage with IPTp has risen from ~1% in 2000 to ~22% of pregnant women in 2010 in these 27 countries. However, in two of four African countries in which repeated national surveys were carried out, household LLINs ownership decreased by 13% and 37% within 24–36 months of mass distribution, suggesting that strong programs for routine follow-up distribution of LLINs are needed.

87. ITN use at household level is consistently and significantly lower than net ownership. This implies a continued need for behavior change communication strategies that reach the community. While subsidized and free nets are largely targeted to those most at risk of malaria-related mortality, namely children under 5 and pregnant women, household use of these items does not always correspond to this goal. While net use varies widely across the five regions in Africa, on average, only 25% of children slept under an ITN in 2008. Although this is a considerable increase from the less than 10% estimated to use an ITN in previous years, it remains well below the WHO target of 80%. Use by pregnant women is lower yet; in 2006, only 5% of pregnant women were estimated to use ITNs, though this figure has increased substantially in recent years in countries with dedicated mass distribution programs.

88. Indoor residual spraying (IRS) with approved insecticides remains one of the main interventions for reducing and interrupting malaria transmission on the continent. In 2008, 19 Member States reported implementing IRS, and the number of persons protected by IRS nearly quadrupled between 2006 and 2008, from 15 to 59 million. Nevertheless, in the majority of African countries, IRS programs require increased focus as current data suggests that only 9% of the at-risk population is protected.

89. Intermittent preventive treatment (IPT) is recommended for pregnant women in areas of high transmission. Thirty-five African countries had adopted an IPT policy by 2009, though only 20 countries were implementing this policy countrywide, and the rest on a limited scale. IPT coverage remains low across Africa, with most countries reporting coverage of less than 15%. In 2007–2008, across nine high burden countries in Africa, 20% of pregnant women received two doses of IPT treatment. The potential for scaling up IPT in malaria-endemic countries is linked closely to the coverage and quality of antenatal care (ANC) services, as the two doses are generally administered in the second and third trimester of pregnancy.

Treatment, Care and Support

90. Remarkable achievements in increasing access to treatment, care and support programs are evident across the continent. Improvements in ART coverage are the most significant: in 2005, only 2% of people in need of ART had access to these; in 2008, the coverage rate of ART programs had grown to an impressive 43%, or nearly three million people. Still, over half of the population in need of ART have no access, and the growing numbers of people living with HIV present a formidable challenge in the future. While tuberculosis case detection remains a challenge at 46%, treatment success rate on the continent has made great progress, reaching 82% in 2008, just below the global Stop TB Plan target set for Africa of 85%. Despite the widespread adoption of policies for ACT as first-line treatment for malaria, access remains low across Africa, especially in rural areas where it is most needed. Greater attention to improvements in access to medicines for all three diseases is required.

HIV and AIDS

91. At the end of 2008, there were estimated to be nearly 7 million HIV-infected people in need of antiretroviral treatment (ART) in high burden countries in Africa, with coverage of 43% of those in need or 3 million people. The number of facilities providing anti-retroviral treatment, an important indicator of access, also increased by 51% between 2007 and 2008 in high-prevalence countries in Africa.

92. The greatest increase in ART occurred in Eastern and Southern Africa, reaching 2,395,000 people living with HIV in 2008, signifying 48% of those in need, and a 43% increase over the prior year. In West and Central Africa, 530,000 individuals received ARVs, representing 30% of those in need, and a 26% increase from 2007. Women represent 64% of adults receiving ARVs in countries south of the Sahara. In North Africa,

less than 10,000 people or 14% of those in need accessed ART, an increase from approximately 7,000 (11% of need) in 2007.

93. The number of health facilities providing ART increased by 51% in countries south of the Sahara in 2008, compared to 40% in North Africa. Progress was especially significant in the 26 sub-Saharan countries reporting comparable data, increasing by 264% from 1,440 health facilities in 2005 to 5,240 in 2008.

94. While overall ART coverage has increased across the continent, coverage of children under 15 years old remains low at less than 18%, or an estimated 35% of those in need. Regionally, this figure varies: ART coverage reached only 6% of children in North Africa and 15% in West and Central Africa, while coverage of children in East and Southern Africa reached 44% in 2008, up from 30% in 2007. Ongoing provision of ART for mothers is also critical to the survival of their children.

    Studies have shown that when mothers die, the survival of infants is reduced to less than two years. The development and implementation of national policies and recommendations specific to the use of co-trimoxazole prophylaxis for infants and children has started to improve the coverage and uptake of this important intervention in Africa. In Eastern and Southern Africa, coverage increased from 5% in 2007 to 9% in 2008. Increased efforts to introduce and/or scale up co-trimoxazole programs are needed across the continent.

95. Despite the impressive scale-up, considerable challenges and weaknesses in ART provision remain. More than half of all Africans in need are not on ART, and retention rates for those on ARVs remain a challenge. In high burden countries in Africa, the retention of people receiving ARVs was estimated at 75% at 12 months (22 countries reporting) and 67% at 24 months (13 countries reporting).

96. Furthermore, many people living with HIV in Africa continue to be diagnosed late, preventing timely initiation of antiretroviral therapy when its impact on survival would be greatest. Recent data shows that late access to antiretroviral therapy remains the most important threat to survival. Improved patient monitoring, expanding earlier access to HIV diagnosis and screening for treatment eligibility are required to improve retention rates and ultimately the impact of ART programs across the continent.

97. Among the most devastating effects of the AIDS epidemic in Africa is the rupturing of families and the orphaning of children. The cumulative number of African children orphaned or made vulnerable due to AIDS is estimated at 15.7 million in 2010. As the numbers of orphans and vulnerable children (OVCs) increase, so does the stress of traditional coping systems of extended families. Many Member States have begun to address this growing need through implementation of programs to support the needs of OVCs and their families and communities. The number of countries reporting on programs to provide care and support for OVCs increased substantially from only eight in 2005 to 26 in 2007, representing a considerable increase of coverage from 12% to 53%.

Tuberculosis

98. Tuberculosis treatment is largely measured by case detection and treatment success rates. While the case detection rate in Africa has increased over the past five years to 46%, it is still significantly below the 70% target. Similarly treatment success has been increasing progressively over the same period of time, reaching 79% in 2007, and 82% in 2008, just short of the 85% target. Some countries are doing better than others; 2009 country reports indicate that nine Member States achieved the goal of 70% case detection while ten countries reached the 85% treatment success rate target. Only four Member States achieved both targets. Despite much progress across the continent in tuberculosis control, North African countries lag behind other sub-regions in achieving the global targets for tuberculosis control.

99. Access to tuberculosis prevention, diagnosis, and treatment services for people living with HIV across Africa remains grossly inadequate; less than 1% of people living with HIV were screened for tuberculosis or started on isoniazid preventive therapy in 2007. Less than half of tuberculosis patients were tested for HIV in 2006 and 2007. Based on available data for these years, it is estimated that 50% of tuberculosis patients are co-infected with HIV. Of those testing positive, 37% were started on ART and between 75-90% were receiving cotrimoxazole preventive therapy (CPT). To improve on this, many countries with high HIV prevalence have established pilot projects for collaborative TB/HIV activities, or are scaling up TB/HIV activities nationally.

100. Although solid progress has been made in recent years to expand the DOTS program across the continent and which now covers 94% of Africa, those efforts have not translated into widespread success in reversing tuberculosis incidence and meeting Millennium Development and Stop TB goals. Forty-one of the 46 countries reporting in Africa have adopted DOTS as the national strategy for tuberculosis control, though some core elements of the strategy have not yet been implemented.

101. Drug resistant tuberculosis constitutes a silent and dangerous aspect of the tuberculosis epidemic in Africa. Although coverage of drug resistance surveillance is increasing across the continent, more work must done. In 2009, a total of 32 AU Member States reported at least one case of MDR-TB, while eight of these countries reported at least one case of XDR-TB. In 2007, 8,474 MDR-TB cases were identified from 28 Member States and 541 XDR-TB cases were reported in four of them. Twenty of the 32 African nations have structured treatment programs for MDR-TB, while 12 African countries are without local laboratory capability to diagnose MR-TB and ten countries still lack facilities for tuberculosis culture and drug susceptibility testing.

Malaria

102. Access to treatment, especially artemisinin-based combination therapy (ACT), is still low in Africa, despite the adoption in the recent years of policies which include ACTs as first line treatment for malaria in all but two malaria-endemic countries. At the end of 2007, no African country had begun implementing ACT use in home management of malaria except in a few pilot projects.

103. Still, in 11 of 13 countries surveyed in 2007-2008, fewer than 15% of children under 5 years of age with fever had received ACTs, well below the World Health Assembly (WHA) target of 80%. Other statistics are even more troubling: the median percentage of children with fever in the two weeks preceding the survey who received any anti-malarial was 48% in 2006, compared to just 33.5% in 2008. . Stock-outs of ACT at the national and health facility levels and inadequate monitoring of stocks using health information systems contributed to the inadequate performance

104. Most suspected malaria cases are not being tested for malaria. In 18 high-burden WHO African Region countries for which data were available, only 22% of the reported suspected malaria cases were confirmed with a parasite-based test in 2008. As of 2010, WHO recommends parasitological confirmation (either by light microscopy of with the use of a rapid diagnostic test) before the administration of any antimalarial drug, wherever this is possible. This strategy will limit the use of unnecessary antimalarials for non-malaria cases - potentially diminishing the spread of antimalarial drug resistance, and improve the treatment of non-malarial illnesses, and allow for timely and complete malaria surveillance.

105. The major constraints to scaling up of ACT in Africa are funding, since the medicines are considerably more expensive than their predecessors and inadequate supply chain management infrastructures. As a result, most fevers are still treated with less efficacious medicines, including chloroquine and artemisin-based mono-therapies. Resistance to artemisinin are a potential threat to the only currently effective treatment for falciparum malaria in most parts of the world. Efforts are underway to remove artemisinin-based mono-therapies from the market. Twenty one African countries have taken regulatory measures to withdraw oral artemisinin-based mono-therapies from the market and 11 countries have made commitments to take regulatory measures to withdraw artemisinin-based mono-therapies from the market, though they have not yet started. Sixteen countries in Africa still provide marketing authorization for these medicines.

Access to Affordable Medicines and Technology

106. At the third session of the African Union Conference of Ministers of Health in April 2007, Member States adopted the Pharmaceutical Manufacturing Plan for Africa to strengthen Africa's ability to locally manufacture and supply essential drugs and commodities to fight HIV and AIDS, tuberculosis, and malaria. This long-term approach aims to reduce Africa's dependence on external suppliers, as well as the financial burden of diagnosis, prevention and care, while simultaneously improving commodities supply. The political will to boost the African drug industry is further cemented by the adoption of the Global Strategy on Public Health, Innovation, and Intellectual Property at the World Health Assembly in May

2008. Sub-regional initiatives with EAC and SADC demonstrate further commitment to improving access to affordable medicines and technology on the continent.

HIV and AIDS

107. While approximately 80% of the 39 AU Member States reported having a national procurement and supply chain management system for HIV-related commodities (including ARVs and test kits) in 2008, 18 countries (46%) reported varying degrees of ARV stock outs in one or more facilities that provide anti-retroviral treatment. North Africa suffered considerably less stock outs in comparison to all other regions in Africa. This situation is further aggravated by increasing drug resistance and the need to shift treatment towards more effective – and more expensive - first line treatment regimes, such as tenofovir.

108. While improvements have been widely felt in the procurement and provision of condoms and HIV tests kits, challenges remain in provision of CD4 testing, especially as countries move towards policies to treat patients with higher CD4 counts. Similarly, many countries still lack the required technology for early diagnosis (before six months) of infant HIV infection.

109. During 2007 and 2008, in close collaboration with international partners, 15 high-prevalence countries in Africa evaluated their national procurement and supply management systems. The studies revealed inadequate coordination among national authorities and partners and a lack of adequately trained human resources. In response, nine countries are now participating in a regional project to establish harmonized procedures for procurement and supply management. In addition, a number of Member States are now working alongside the WHO to develop an early warning system to prevent drug stock-outs, treatment interruption and the emergence of drug resistance that result.

110. In 2008, the price of the most widely used first-line antiretroviral medicines (ARVs) ranged from USD 88 to USD 261 per person per year—more than 10% lower than the price in 2007. The price of a second line regimen has been reduced from USD 1,000/1,500 in 2007 to USD 579 in 2009 and for paediatric regimens, from USD 200 to USD 66 in 2009. The decline in drug prices between 2004 and 2008 is cumulatively estimated to be almost 50%. Factors contributing to such drastic reduction include: the sustained scaling up of treatment programs; growing transaction volumes and predictability of demand; competition between a growing number of products pre-qualified by WHO; regional bulk purchasing efforts, and favorable pricing policies by pharmaceutical companies.

111. Other activities are improving access to affordable commodities in Africa. Regional initiatives are also helping to lower the costs of commodities. The PPSAC (AIDS Prevention Project in Central Africa, collaboration between the Central African Economic and Monetary Community, KFW, and the UNFPA) aims to develop a regional grant for the procurement of male and female condoms at affordable prices.

112. Further reductions are expected to occur in coming years, as the ART scale-up effort reaches additional poor and disadvantaged populations and local production of ARVs increases. Currently, as many as six plants in Africa are producing generic ARVs mainly for local consumption, though some are prequalified for export to other countries.

Tuberculosis

113. In Africa, there is an increasing emergence of multi drug-resistant tuberculosis (MDR-TB), primarily improper treatment of standard tuberculosis, though resistant strains may also spread from person-to-person. MDR-TB is particularly difficult to diagnose and extremely costly to treat – factors which lead to a major treatment access gap. Of the 26 countries that reported at least one case of MDR or XDR-TB in 2007, only 17 countries had an established treatment program.

114. African Union Member States, working jointly with groups such as UNITAID, the Global Drug Facility (GDF) of the Stop TB Partnership, the Green Light Committee, and the Global Fund, are working to improve the global response to tuberculosis by: (a) helping expand access to quality-assured MDR-TB treatment and push for price reductions; (b) promoting the scale-up of MDR-TB diagnosis using new rapid diagnostic tests; (c) supporting the development of, and access to, child-friendly tuberculosis medicines; and (d) helping curb the emergence of resistant tuberculosis strains by ensuring that first-line tuberculosis treatment is readily accessible and available in countries.

115. The overall availability of first line anti-tuberculosis drugs has improved tremendously. By the end of December 2007, all 36 African countries that applied to the Global Drug Facility had secured three-year first-line anti-tuberculosis drug grants, including paediatric formulations for some countries. For the treatment of drug resistant tuberculosis, 16 countries had been approved for concessionary priced second line anti-tuberculosis drugs through the WHO Green Light Committee, while applications from four more countries were still under review, an increase from 11 countries at the end of 2008. Production capacity for high quality, second line drugs is being established in at least one Member State, however, with increasing incidence of drug resistant tuberculosis in Africa, the cost of such treatment poses a considerable challenge.

116. Development and supply of new child-friendly tuberculosis formulations is also anticipated by 2011. The first-ever pediatric tuberculosis medicine has already been prequalified by WHO. With increased number of manufacturers, price reductions for pediatric tuberculosis medicines of 18% have been achieved.

Malaria

117. Although in a number of countries ACTs are distributed free of charge or at low price in the public sector, they are very expensive in the private sector where many patients may initially seek treatment for malaria. Several initiatives across Africa have emerged in recent years to increase access to affordable malaria control commodities. The Rollback Malaria (RBM) Partnership was established in 1998. Consequently, all malaria endemic countries in Africa have established partnerships at the country level. Also, sub-regional RBM partnership networks have been established to bring together all key partners in the various malaria-endemic regions to consolidate support for malaria control in their respective countries.

118. The Affordable Medicines facility for Malaria (AMFm) was established to bring down the cost of artemisinin-based combination therapy (ACT) through subsidies and help phase out mono-therapies to avoid the development of resistance. Following a initial successful pilot project of this approach in East Africa, eight countries in Africa have submitted successful proposals to the Global Fund (through whom this program is managed) and the first co-paid drugs will be rolling out in June 2010. There will be an evaluation at the end to measure whether the objectives were met.

119. In further recognition of the need for affordable commodities to combat malaria, 74% of African nations have waived taxes on anti-malarials, 64% have removed taxes or introduced waivers on ITNs, while about half have waived taxes and tariffs on nets, netting materials and insecticides.

120. To ensure access to quality ACT in Africa, all ACT manufacturers must undergo a WHO-led stringent prequalification process before countries purchase the medicines. Compared to 2006, there are significantly more companies manufacturing ACT globally, one of them in Northern Africa.

121. In 2008, 42 of the 43 malaria endemic countries in Africa were distributing ACT for treatment of malaria, and in 23 of these countries, ACT was free of charge for children under 5 years old. The number of ACT distributed at country level increased significantly between 2004 and 2006, while the rate of increase in 2006–2008 was lower. . Data from manufacturers showed an 18% increase in ACT sales to the public sector in 2008 as compared with 2007. The Global Fund, working closely with many African countries and manufacturers, has moved to voluntary pooled procurement of commodities to reduce unit prices and enhance access to commodities whose accessibility was previously hampered by inefficient procurement and supply Chain management systems.

122. The number of rapid diagnostic tests (RDTs) delivered to and distributed across Africa increased rapidly in 2007 and 2008, from close to zero in 2005. The total number of RDTs distributed in 2008, however, corresponded to only 13% of all malaria cases in the 12 countries reporting, indicating a continuing gap in malaria diagnostic capacity. In 18 high-burden African countries for which data were available, only 22% of the reported suspected malaria cases were confirmed with a parasite-based test in 2008. The 2010 WHO recommendation for universal parasitological confirmation of malaria cases prior to antimalarial treatment, will likely contribute to a rapid increase in RDT procurement and distribution.

123. In 2003, as a result of technology transfer from the Sumitomo Corporation of Japan, the A to Z Textile Mill in Tanzania gained the ability to manufacture long lasting insecticide treated nets (LLINs). A to Z now

manufactures up to 10 million LLINs per year, a significant increase in local capacity. Global production of ITNs doubled from 30 million in 2004 to 63 million in 2006. This increase in production coupled with increased funding and new distribution channels for free or highly subsidized nets led to a steep rise in the number of nets reaching end-users, and ensured more equitable access to ITNs.

124. Challenges remain regarding the forecasting of needs and timely flow of information of these commodities, from producers and suppliers, to Government bodies, implementing agencies and consumers. Unless these factors are addressed, there is a risk of shortage of ACT and other essential commodities.

Research and Development

125. Increased focus on research to drive evidence-based decision making in policies and programs to combat HIV/AIDS, tuberculosis, and malaria are evident across Africa. Recent evidence of the protective effect of male circumcision for HIV prevention has led to the scaling up of its implementation in 13 Member States. Ongoing research is still required in the use of antiretroviral drugs for HIV prevention, pre-exposure prophylaxis and microbicides. With the emergence of extremely drug-resistant (XDR) tuberculosis in high-HIV-burden areas across Africa, the need for rapid culture confirmation of smear positive disease, rapid culture to detect smear negative disease, and rapid drug susceptibility testing (DST) and drug resistance surveillance (DRS) is moving to the top of the tuberculosis research agenda, along with the need for new anti-tuberculosis drugs active against MDR- and XDR-TB disease. Advancements in research for malaria vaccines, rapid diagnosis, and treatment are also underway.

HIV and AIDS

126. A number of informative research studies have been undertaken in recent years, and the findings and best practices documented and shared across the continent. The result has been an increase in evidence based policies and strategies to improve prevention, treatment and care for those living with HIV.

127. Recent studies have proven the sustained protective effect of male circumcision on HIV acquisition for at least 42 months. Three randomized controlled trials carried out in East and Southern Africa showed a strong protective effect, with an approximately 60% reduction in the risk of acquiring HIV. The consensus reached from these findings was that countries with HIV prevalence above 15%, generalized heterosexual HIV epidemics and low rates of male circumcision should consider urgently scaling up access to male circumcision services. As a result, all 13 priority countries with high rates of heterosexual HIV transmission and low rates of male circumcision have established policies and programs to scale up male circumcision to reduce the risk of heterosexually acquired HIV infection. A recent analysis determined that the scale-up of adult male circumcision in 14 African countries would require considerable funding (an estimated USD 919 million over five years) and substantial investments in human resources development, but that scale-up would save costs in the long run by altering the trajectory of national epidemics. Political commitment has been strong, with active political involvement at the highest levels. The successful engagement of traditional leaders and elders in selected countries supporting male circumcision has been pivotal, as has been the effective involvement of women's groups in others. Partnerships involving national and local governments, donors and technical support agencies – such as the Male Circumcision Consortium and the Male Circumcision Partnership – have been created to sustain and accelerate progress.

128. A number of studies have recently examined the potential for HIV prevention through reductions in concurrent sexual partnerships and use of microbicides. A recent analysis of household survey data from 18 countries in Africa found no significant correlation between prevalence of sexual concurrency and HIV prevalence at the country or community level. Similarly, a four-year clinical trial conducted in East and Southern Africa to determine the efficacy of a vaginal microbicide gel found it to be ineffective at preventing HIV infection.

129. Surveys in different settings across the African continent have demonstrated complex and variable in the relationship between HIV and income. In eight African countries where surveys have been conducted, HIV prevalence is higher among adults in the wealthiest quintile than among those in the poorest quintile. In five of six West African countries where survey data are available, women living in the wealthiest

households have higher HIV prevalence than other socioeconomic groups of women, but the relationship between wealth and HIV is less clear for African men.

130. Since 2001, national HIV surveys have been conducted in 31 high-prevalence countries in Africa, and eight of these countries have conducted more than one. Household surveys that include a component to assess HIV prevalence have been conducted in 28 African countries, nine of them in 2007 and 2008. While these surveys vary considerably in quality, they have provided more representative population-based estimates of HIV prevalence than was possible with previous extrapolations from sentinel surveillance of women attending antenatal clinics.

131. Recent research studies have modeled the effects of antiretroviral therapy on HIV prevention. In one study, researchers assessed the effect of expanding antiretroviral therapy coverage on the number of individuals testing newly positive for HIV and on related costs over the next 25 years. They estimated that expanding antiretroviral therapy can substantially reduce the growth of the epidemic and related costs. WHO also presented a model of the potential impact of universal voluntary HIV testing and counseling followed by immediate antiretroviral therapy, irrespective of clinical stage or CD4 count. Most remarkably, the results of the modeling exercise suggested that, in a generalized epidemic as severe as that in Southern Africa, HIV incidence may be reduced by 95% in 10 years and this approach may save money in the medium term.

132. Ongoing research is still required in the use of antiretroviral drugs for HIV prevention, pre-exposure prophylaxis and microbicides.

Tuberculosis

133. With the emergence of extremely drug-resistant (XDR) tuberculosis in high-HIV-burden areas across Africa, the need for rapid culture confirmation of smear positive disease, rapid culture to detect smear negative disease, and rapid drug susceptibility testing (DST) and drug resistance surveillance (DRS) is moving to the top of the tuberculosis research and development agenda, along with the need for new anti-tuberculosis drugs active against MDR- and XDR-TB disease.

134. Four countries in East and Southern Africa have undertaken pilot tests for rapid tests for the diagnosis of MDR-TB. Based on early results of these applied studies, South Africa is currently scaling up this approach through an increased number of laboratories to speed up identification of drug resistant tuberculosis forms. Eight more countries in Africa have also been earmarked to benefit from an expanded program to introduce this technology through a collaborative project between WHO and UNITAID.

Malaria

135. Ministries of Health have well-established mechanisms for developing and coordinating their priority research agenda in malaria-endemic countries in Africa. Across the continent, there is continuing collaboration aimed at the development of novel technologies and improving implementation Countries partner with WHO/TDR and other research initiatives such as the Malaria Vaccines Initiative and the Medicines Malaria Venture (MVI), the Medicines for Malaria Venture (MMV),the Innovative Vector Control Consortium (IVCC) and FIND for diagnostics, all supported, both by the Bill and Melinda Gates Foundation, to improve implementation and develop novel technologies. Examples of current activities include clinical trials with the most advanced malaria candidate vaccine RTS underway at 11 sites in seven African countries. Also, there is ongoing research aimed at improving access to malaria diagnostic tests and ensuring that effective treatment using ACTs is accessible at community level. There is also ongoing research aimed at improving access to malaria diagnostic tests and ensuring that effective treatment using ACT is accessible at community level. Finally, a global consultation during 2009 reviewed and defined the research agenda that will enable the global community to start working towards malaria eradication (malaria eradication research agenda - malERA).

Implementation

136. AU Member States committed in the Abuja Call to enhancing and supporting implementation of comprehensive strategic programs at country and regional levels against HIV and AIDS, tuberculosis, and malaria. Across all three disease areas, improvements in policies to promote better preventive measures, deliver more-effective medicines, and increase access to treatment and services has been significant. While it takes some time for new policies to be put in action and for measurable results to be seen, some notable achievements have been reached in the last five years.

HIV and AIDS

137. National AIDS coordinating authorities have been leading country-level efforts and aligning the efforts of major stakeholders around multisectoral strategic plans following the "Three Ones" principle adopted by Member States in 2003: (a) one agreed AIDS action framework that provides the basis for coordinating the work of all partners, (b) one national AIDS coordinating authority with a broad-based multisectoral mandate and (c) one agreed country level monitoring and evaluation system.

138. In 2005, 28 of 32 (87.5%) Member States reported having a national multisectoral strategy to combat AIDS. In 2007, all 44 reporting countries had a strategy in place. Of these, 43 out of 44 included formal program goals, and 42 out of 44 had clear targets or milestones indicated. Whereas 31 out of 32 African nations reported having one national coordinating authority in 2005, 44 of 44 countries reported having this in place in 2007.

139. Much work has been done in recent years by Member States to align monitoring and evaluation needs around indicators previously agreed to in the United Nations Declaration of Commitment on HIV and AIDS, with additional elements that emphasize performance and accountability.

140. In 2007, 39 of 42 reporting AU countries (93%) stated that the strategic and/or operational plan for the national AIDS response included a monitoring and evaluation framework. These plans appear to be increasingly harmonizing the efforts of major stakeholders in the response. In 2005, 19 of 31 reporting AU member states (61%) reported the existence of one harmonized M&E plan, increasing to 33 of 44 reporting countries (75%) in 2007. Civil society involvement in the development of these M&E plans remains high, with all 37 reporting indicating civil society involvement in 2007.

Tuberculosis

141. Since the Abuja Call, tuberculosis has been declared a national emergency or targeted for special action in 26 of 46 countries reporting. Ministers of Health from across Africa gathered in September 2007 in Brazzaville, Republic of Congo where they jointly adopted a regional strategy to combat the dual TB/HIV epidemic. More recently, in September 2009 at the 59thsession of the WHO Regional Committee for Africa, held in Kigali, Rwanda, Ministers of Health adopted a resolution to scale up efforts to attain the targets of the Maputo Declaration of 2005 and the May 2009 World Health Assembly commitment on drug-resistant tuberculosis control. Despite these repeated commitments and the development of regional strategies to fight tuberculosis, well-established national programs for diagnosis and treatment of MDR-TB are largely absent, with just 20 of the 32 Member States reporting cases of MDR-TB or XDR-TB having established programs to treat it.

142. The case detection rate in Africa for tuberculosis is the lowest in the world: countries with high HIV prevalence (48%) and low HIV prevalence (46%) were significantly behind 2007 milestones (69% and 63% respectively). The milestone for treatment success rate was achieved in 2007 by all African countries with a high HIV prevalence (average of 78%). African countries with a low HIV prevalence fell short of their target by an average of 14%. DOTS coverage now exceeds 90% in African countries with a high prevalence of HIV.

143. African countries with a high prevalence of HIV (accounting for approximately 75% of HIV-positive tuberculosis cases) tested 41% of their notified tuberculosis cases for HIV in 2007, signaling important progress from the 14% tested in 2005. While the proportion of tuberculosis patients who are HIV-positive in these countries has remained largely unchanged during the reporting period (at 42%), the estimated

mortality rate of HIV-positive tuberculosis patients in those countries has declined (from 66 per 100,000 population in 2005 to 59 per 100,000 in 2007).

Malaria

144. Since 2000, all malaria-endemic countries in Africa have established Roll Back Malaria (RBM) coordinating bodies and developed malaria strategic plans in line with WHO-recommended interventions and strategies. Globally, ACTs are the recommended first line treatment for uncomplicated malaria and as a result, all but two countries on the continent have adopted policies that introduce ACT as the first line treatment for malaria.

145. Country Strategic Plans (CSP) are all based on the four technical elements of Roll Back Malaria and the evidence-based interventions associated with them: Prompt access to effective treatment, promotion of ITNs and improved vector control, prevention and management of malaria in pregnancy, and improving the prevention of, and response to, malaria epidemics and malaria in complex emergencies. Countries are now working through local partnerships to develop the capacity to fully implement their CSPs using ongoing health sector reforms and linkages to other initiatives, such as Integrated Management of Childhood Illness and Making Pregnancy Safer, to improve access to key interventions. CSPs and political commitment to the fight against malaria have also resulted in increased funding, notably from the Global Fund.

146. Most AU Member States are moving towards universal access to malaria prevention and control among all at risk of malaria, a recent shift away from targeting only those most at risk (pregnant women and children under five-years old). Increasingly, countries in Africa are implementing a comprehensive package of interventions in the same geographical area for increased impact. Investment in highly effective interventions is leading to demonstrable progress in a number of countries. Reductions of more than 50% in the numbers of reported malaria cases and deaths were observed in five high burden African countries. Reductions of more than 50% were also observed in five low transmission African countries.

Partnerships

147. The New Partnership for Africa's Development (NEPAD), a program of the African Union, was established with the formal adoption of The NEPAD Strategic Framework at the 37th Summit of the Organization for African Unity (OAU) in July 2001. By their Decision Assembly/AU/Dec.283(XIV) in Jan 2010, Heads of State integrated NEPAD more closely into AU structures, replacing the NEPAD Secretariat with the NEPAD Planning and Coordinating Agency with the mandate to:

i. Facilitate and coordinate the implementation of the continental and regional priority programmes and projects;
ii. Mobilize resources and partners in support of the implementation of Africa's priority programmes and projects;
iii. Conduct and coordinate research and knowledge management;
iv. Monitor and evaluate the implementation of programmes and projects; and
v. Advocate on the AU and NEPAD vision, mission and core principles/values.

HIV and AIDS

148. In the Abuja Call, AU Member States committed to developing and supporting partnership mechanisms to coordinate the contributions of public, private, civil society, regional and international stakeholders in their efforts to achieve universal access to prevention, treatment, care and support for HIV, tuberculosis and malaria. In 2005, 30 of 32 countries reported the existence of such mechanisms, rising to 43 of 44 countries by 2007.

149. Alongside a number of critical global partnerships that have significantly scaled up financing and technical support in Africa, other partnerships are providing technical and other assistance to countries. For example, UNITAID's partnership with African countries leverages quality drug and diagnostic price reductions and accelerates the pace at which these are made available and has resulted in 44 Member States benefiting from price reductions of up to 40% for first and second line ARVs and diagnostic facilities.

Tuberculosis

150. To assist countries to coordinate their response to the increasing burden of tuberculosis in recent years, the Stop TB Partnership was established in 2001 with the strategy to assist African countries to design and implement recommended interventions to achieve the impact targets for global tuberculosis control. The Strategy has six major components:

151. UNITAID, along with the Global Drug Facility (GDF) of the Stop TB Partnership, the Green Light Committee and the Global Fund, are supporting Member States to improve the global response to tuberculosis by: (a) Helping expand access to quality-assured MDR-TB treatment and push for price reductions; (b) Promoting the scale-up of MDR-TB diagnosis using new rapid diagnostic tests; (c) Supporting the development of, and access to, child-friendly tuberculosis medicines; and (d) Helping curb the emergence of resistant tuberculosis strains by ensuring that first-line tuberculosis treatment is readily accessible and available in countries.

Malaria

152. Roll Back Malaria is a global partnership initiated by WHO, UNDP, UNICEF and the World Bank in 1998 that works with governments from malaria endemic and donor countries, multilateral development partners, NGOs, private sector, foundations and research & academia to reduce the human and socio-economic costs of malaria. All malaria endemic countries in Africa have established partnerships at the country level in support of achieving universal coverage targets. Sub-regional RBM partnership networks (SRNs) have been established in Eastern, Western, Central, and Southern Africa. The three primary task of these networks are i) the tracking of country roadmaps towards universal access, ii) the identification of implementation barriers that slow down roadmaps, and iii) the identification implementation support by mobilizing national / regional and global TA if and when required. RBM SRN has access to US $ 3 million PEPFAR TA funding annually for this purpose.

153. The Malaria Elimination Group (MEG) has catalyzed a Southern Africa Partnership known as the "E8", focussing on regional malaria elimination targets.

154. The Intergovernmental Agency for Development (IGAD), as a African Union Regional Economic Community (REC), has incorporated in its regional (7 countries) HIV/AIDS partnership programmes malaria prevention, diagnosis and treatment addressing needs of highly mobile cross border and internally displaced populations, refugees as well as for populations living in high transmission areas for HIV.

155. By working in partnership with national malaria control programs and non-governmental organizations, the AMP supports the development of appropriate and effective behaviors that lead to better prevention and management of malaria, particularly for young children and pregnant women.

156. The Intergovernmental Agency for Development (IGAD), as a African Union Regional Economic Community (REC), has incorporated in its regional (7 countries) HIV and AIDS partnership programmes malaria prevention, diagnosis and treatment addressing needs of highly mobile cross border and internally displaced populations, refugees as well as for populations living in high transmission areas for HIV.

Monitoring, Evaluation and Reporting

157. Strategic information systems provide country programs with three key elements: surveillance data to assess changes in disease burden (including incidence, prevalence, mortality rates and drug resistance) monitoring and evaluation of interventions and programs, and operational research. These three components provide vital information that drives the development of new strategies and policies, resource mobilization, and interventions.

HIV and AIDS

158. Forty-four countries in Africa reported having national monitoring and evaluation plans and submitted reporting forms in 2009 on the health sector response towards universal access for HIV prevention, care and treatment. Among 42 countries that submitted the reporting forms in 2008, 93% included surveillance

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B25 Decision on the Support of a Draft Resolution at the Sixty Sixth Ordinary Session of the General Assembly of the United Nations to Ban Female Genital Mutilation in the World (2011)

Doc. Assembly/AU/12(XVII) Add.5

Assembly of the Union
Seventeenth Ordinary Session
30 June -1 July 2011
Malabo, Equatorial Guinea
Assembly/AU/Dec.383(XVII)

The Assembly,

1. **TAKES NOTE** of the proposal by Burkina Faso for a resolution to be adopted at the Sixty Sixth Ordinary Session of the General Assembly of the United Nations to ban female genital Mutilation (FGM) in the world;

2. **RECOGNIZES** that female genital mutilation (FGM) is a gross violation of the fundamental human rights of women and girls, with serious repercussions on the lives of millions of people worldwide, especially women and girls in Africa;

3. **RECALLS** the African Charter on Human and Peoples' Rights adopted on 21 June 1981 by the Eighteenth Session of the Assembly of Heads of States and Governments of the Organization of African Unity held in Nairobi, Kenya;

4. **ALSO RECALLS** the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted on 11 July 2003 in Maputo, Mozambique which in its Article 5 requires State Parties to prohibit and condemn all forms of female genital mutilation through legislative measures enforced by sanctions;

5. **COMMENDS** Member States and African Union initiatives to ban FGM and efforts to pursue the necessary steps for full implementation of the Maputo Protocol. At the same time, **EXPRESSES DEEP CONCERN** at the continued practice of FGM in spite of numerous campaigns conducted over the last thirty (30) years;

6. **CALLS UPON** the United Nations (UN) General Assembly to adopt a resolution at its Sixty-sixth session to ban female genital mutilation worldwide, by harmonizing the actions of Member States and providing recommendations and guidelines for the development and strengthening of regional and international legal instruments and national legislations;

7. **URGES** all Member States to provide strong support for efforts to adopt a draft resolution to ban female genital mutilation worldwide, which draft will be submitted to the Sixty-sixth session of the General Assembly of the United Nations;

8. **INVITES** all Member States of the United Nations and other international organizations to support this initiative and contribute to its adoption after submission to the Sixty-sixth session of the UN General Assembly;

9. **REQUESTS** the Commission to report on the implementation of this Decision next Ordinary Session of the Assembly in January 2012.

B26 Decision on Progress Report on Maternal, New Born and Child Health (2012)

Doc. Assembly/AU/16(XIX)

Assembly of the Union
Nineteenth Ordinary Session
15-16 July 2012
Addis Ababa, Ethiopia
Assembly/AU/Dec.429 (XIX)

The Assembly,

1. **TAKES NOTE** of the Report: "Annual Status of Maternal, New born and Child Health in Africa, 2012";

2. **ACKNOWLEDGES** with appreciation that progress has been registered in improving maternal, new born and child health on the Continent and that 37 Member States have launched the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) as an advocacy strategy for the promotion of maternal, new born and child health, and urge other Member States that have not yet done so to launch CARMMA;

3. **URGES** Member States to accelerate implementation of actions adopted at the July 2010 Kampala Summit, including the institutionalization of maternal, new born and child mortality census;

4. **CALLS UPON** development partners and other stakeholders at national, regional and international levels to provide sustained support;

5. **REQUESTS** the Commission in collaboration with other Organs, RECs and partners to strengthen the implementation of the reporting system with aligned indicators as adopted by the Ministers of Health; and also urge Member States to provide the Commission with up-to-date information in this respect.

B27 Declaration on the Report of AIDS Watch Africa (AWA) Action Committee of Heads of State and Government (2012)

Assembly of the Union
Nineteenth Ordinary Session
15-16 July 2012
Addis Ababa, Ethiopia
Assembly/AU/Decl. 2(XIX)

WE, THE HEADS OF STATE AND GOVERNMENT OF THE AFRICAN UNION, meeting at our Nineteenth Ordinary Session in Addis Ababa, Ethiopia from 15 to 16 July 2012, following our consideration of the Report of AIDS Watch Africa (AWA) Action Committee of Heads of State and Government:

RECALLING Assembly Decision Assembly/AU/Dec.395 (XVIII) whereby AIDS Watch Africa (AWA) was revitalized as an African high level platform to advocate for action, accountability and resource mobilization for response to HIV/AIDS, TB, and Malaria in Africa; and Decision Assembly/AU/Dec.413(XVII) requesting the AU Commission, NEPAD and UNAIDS to work out a roadmap on shared responsibility for a viable response to AIDS, including health financing;

ALSO RECALLING the global and Abuja commitments on HIV/AIDS, TB and Malaria, as well as the Continental Policy Framework on Sexual and Reproductive Health and Rights; Africa Health Strategy, Pharmaceutical Manufacturing Plan for Africa, and African Plan Towards Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive;

ACKNOWLEDGING that efforts to implement these commitments should be redoubled by all stakeholders for Africa to achieve universal access to health services and the Millennium Development Goals (MDGs) by 2015;

ALSO ACKNOWLEDGING AND COMMENDING the role played by international development partners in the response to HIV/AIDS, TB and Malaria, particularly through availing the required financing and promotion of access to health services;

RECOGNIZING that the achievements of the last decade in promoting access to HIV/AIDS, TB and Malaria services depended largely on the political will and commitment by Africa's top leadership, increased financing as well as improved partnerships at all levels;

APPRECIATING the support of UNAIDS in the revitalization of AIDS Watch Africa;

DEEPLY CONCERNED that, in spite of these achievements, the challenge posed by HIV/AIDS, TB and Malaria on the continent remains immense.

Hereby declare as follows:

1. **RE-COMMIT** individually and collectively to continued implementation of all our previous commitments towards universal access to HIV/AIDS, TB and Malaria services in Africa including maternal and child health, equitable access to affordable and quality-assured medicines and health commodities, promotion of social protection and strengthening of health systems in the context of gender-equality and human rights;
2. **ALSO RE-COMMIT** to keeping the struggle against HIV/AIDS, TB and Malaria high on national, regional and continental agendas; and ensuring accountability for results and targets to be achieved in the response to these diseases, and for efficient utilization of resources budgeted for health;
3. **ENDORSE** the Report and recommendations on the Future Direction of AIDS Watch Africa (AWA) 2012-2015, and the "Shared Responsibility and Global Solidarity for AIDS, Tuberculosis (TB) and Malaria Response in Africa: Roadmap 2012-2015";

4. **DECIDE** to fully incorporate the AWA Secretariat into the structures and regular budget of the African Union Commission from 2013 onwards;

5. **ALSO DECIDE** that each AWA Action Committee Head of State and Government nominate an expert conversant with AIDS, TB and Malaria as his/her representative on the Consultative Experts Committee and the National Working Group on AWA;

6. **FURTHER DECIDE** to call for a parallel meeting on shared responsibility and Global Solidarity for the AIDS response on the sidelines of UN General Assembly in New York in September 2012 and URGED all AU Heads of State and Government to participate in the meeting;

7. **ENCOURAGE** all AU Heads of State and Government to join AIDS Watch Africa and, led by the AWA Action Committee, to champion the campaign against HIV/AIDS, TB and Malaria in Africa by 2015. To this end, we will lay emphasis on mobilizing increased domestic resources, improving value for money, enhancing planning and using existing resources more rationally;

8. **URGE** Member States to collaborate with people living with and affected by HIV and re-mobilize society as a whole for renewed response to AIDS, TB and Malaria in Africa through more innovative and sustainable mechanisms and well-coordinated partnerships. Focus should be on prevention of new HIV, TB and Malaria infections, ensuring good nutrition and more equitable access to affordable and quality-assured medicines and health-related commodities;

9. **CALL UPON** Development Partners to meet their previous commitments, sustain and coordinate their support for the fight against AIDS, TB and Malaria in the continent, in the spirit of promoting global solidarity, health and development;

10. **REQUEST** UN Agencies, Civil Society Organizations, the private sector and other international organizations and partnerships, to intensify and coordinate their support and collaboration at all levels;

11. **ALSO REQUEST** Regional Economic Communities and Regional Health Organizations, in collaboration with the AU and other partners, to redouble their efforts in the fight against HIV/AIDS, TB and Malaria in their respective regions;

12. **FINALLY REQUEST** the AU Commission to coordinate, follow up and report annually on the implementation of this Declaration; and the NEPAD Agency, African Peer Review Mechanism, the Pan-African Parliament and other relevant regional and continental bodies to fully incorporate HIV/AIDS, TB and Malaria control and accountability into their respective programmes and also report annually on related progress.

B28 Implementation of the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services (2013)

Progress Report 2010–2012

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Acronyms / Abbreviations

ACHPR	African Commission on Human and Peoples' Rights
ACT	Artemisinin Combination Therapies
AfDB	African Development Bank Group
AIDS	Acquired Immune Deficiency Syndrome
AMFm	Affordable Medicines Facility for Malaria Fund
ANDI	African Network for Drugs and Diagnostics
ART	Antiretroviral therapy
ARV	Antiretrovirals
AU	African Union
AUC	African Union Commission
AWA	AIDS Watch Africa
CSO	Civil Society Organisation
DOTS	Directly Observed Treatment Strategy
DRC	Democratic Republic of Congo
EAC	East African Community
ECA	United Nations Economic Commission for Africa
ECOWAS	Economic Community of West African States
ECSA-HC	East, Central and Southern Africa Health Community
GCHL	Global Commission on HIV and the Law
GFATM	Global Fund to Fight against AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IP	Intellectual Property
IPTp	Intermittent Preventive Treatment for pregnant women
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated mosquito Net
LLIN	Long Lasting Insecticidal Net
MDG	Millennium Development Goal MDR-TB Multidrug-Resistant Tuberculosis
MICS	Multiple Indicator Cluster Surveys
MMC	Medical Male Circumcision
PEPFAR	President's Emergency Plan For AIDS Relief
PMI	President's Malaria Initiative
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
REC	Regional Economic Communities
SADC	Southern African Development Community
TB	Tuberculosis
TDR	Tropical Diseases Research
TRIPS	Trade Related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly
UNICEF	United Nations Children's Fund
US	United States of America
WAHO	West African Health Organisation
WHO	World Health Organization
XDR-TB	Extensively Drug Resistant Tuberculosis

Executive Summary

Recognizing the devastating impact of HIV and AIDS, TB and Malaria and other related infectious diseases on population and development in Africa, the Heads of State and Governments of Africa adopted the 2000 and 2001 Abuja Declarations and Action Frameworks committing African Union Member States to take measures to halt and reverse the progression of these diseases in Africa. In 2006, the "Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa" renewed commitment amongst AU member states to effectively implement the Abuja Declarations and Action Frameworks, based on a vision of *"Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa by 2010"*. Additionally, to monitor progress in each country, a monitoring and reporting mechanism, including indicators, was developed and adopted by Member States, with countries committing to communicating results and progress in using of this mechanism.

In 2010, a five-year review of the Abuja Call recorded the progress made by AU Member States in the fight against HIV and AIDS, Tuberculosis and Malaria. It however, recommended, , the need to scale up efforts at several levels, particularly in terms of access to treatment, care and support, resource mobilization by countries and strengthening health systems.

Two years later, this 2010 to 2012 report on the review of progress by Member States towards the Abuja Call, commissioned by the AU Commission with the financial support of UNAIDS was conducted based on a literature review and indicators analysis.. A key limitation of the report was the limited number of countries submitting timely data to the AU Commission (12 out of 54 Member States) which consequently impacted on the report's ability to reflect findings as required by the adopted monitoring and evaluation mechanism. Therefore, data from other countries was supplemented by WHO, UNAIDS, RBM databases as well as other sources .

The report findings indicate that Member States have made substantial progress between 2010 and 2012 in certain areas, demonstrating willingness and political commitment at national, regional, continental and international levels to attain, by 2015, universal access and to achieve Millennium Development Goal 6. Significant efforts have been made by countries in preventing and treating HIV and AIDS, in particular through prevention of mother-to-child transmission programmes, testing of blood donations and providing antiretroviral treatment for those in need. Noteworthy achievements have also been made in tuberculosis treatment, with almost 100% Directly Observed Treatment Strategy coverage in several countries, and the reduction of malaria-related deaths. Important increases in health budgets in many countries is a positive sign, despite few (5) having reached the 15% threshold recommended by the Abuja Declaration. In addition, the development and strengthening of harmonized national, regional and continental strategies, policies, plans and laws to guide the response is step in the right direction.

Despite progress recorded challenges still abound and Member States may not be able to achieve the objectives of the Abuja Call and the MDGs by 2015. The burden of poverty in African countries continues to constraint country efforts, limiting access to health services. On the continent, only 54% of those eligible for antiretroviral treatment have access. Only 10.9% of children under 5 years were reported to have been timely treated according to national malaria guidelines. The emergence of multidrug-resistant tuberculosis is a major concern, given the significant costs of treatment. Health systems strengthening remains essential in almost all countries and can only be carried out with partners' renewed support in the context of good governance.

Finally, the low compliance with commitments to monitor, evaluate and communicate progress amongst Member States critically puts at risk efforts to measure progress and encourage continued commitment toward the Abuja Call.

In the light of progress made and ongoing challenges, the following recommendations are made for the African Union and its organs, Member States and technical and financial partners to strengthen efforts to achieve the MDGs by 2015:

- Improve good governance and co-ordination at all levels in order to ensure ownership and accountability for HIV and AIDS, TB and malaria.
- Share best practices on HIV and AIDS, TB and malaria across countries.

- Enhance advocacy and resource mobilization for health systems strengthening and achieving universal access to HIV and AIDS, TB and malaria services.
- Mobilize resources at national and international levels, to ensure predictable and sustainable long term financing in line with the Paris Declaration and Accra Agenda for Action.
- Ensure sound management of mobilized resources to ensure desired results are achieved and maintained and/or gain the trust partners.
- Establish innovative mechanisms for resource mobilization at national level with a strong involvement of the private sector.
- Continuous review of HIV-related laws and policies at national and regional level to strengthen rights-based protection for all vulnerable and key populations in the context of HIV.
- Implement effective and targeted poverty reduction strategies and social protection programmes that integrate HIV and AIDS, TB and malaria, for all populations, and in particular vulnerable populations.
- Strengthen health systems, with a particular focus on strengthening human resource capacity, health structures, health equipment and supply and purchase management systems to ensure constant availability of medicines and quality products at affordable prices for HIV and AIDS, TB and malaria.
- Implement the Pharmaceutical Manufacturing Plan for Africa Business Plan (PMPA BP) aimed at strengthening Africa's capacity to ensure sustainable supply of and access to quality, affordable Treatment, Technologies; Research and Development required to address these diseases that disproportionately affect this continent.
- Continue to promote access to prevention programmes for HIV and AIDS, TB and malaria.
- Implement the African Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive
- Improve collaboration between HIV and TB programmes
- Build capacity and put in place appropriate systems adequate facilities for the detection, treatment and monitoring of MDR and XDR-TB and make resources available to support detected cases
- Strengthen review, amend and adopt laws and measures to fully incorporate and where necessary utilize public health related TRIPS flexibilities and to avoid limits on the use of the transitioning period under the TRIPS Agreement and related TRIPS flexibilities.
- Explore and build on opportunities for South-South co-operation for pooled procurement and local pharmaceutical manufacturing.
- Mobilize more domestic and international resources and strengthen the capacity of AU Member States in the areas of biological, clinical and socio-cultural research.
- Strengthen country reporting on implementation of responses to address HIV and AIDS, Tuberculosis and Malaria in terms of the "Three-Ones" (one executing authority, one Plan of Action and one Monitoring and Evaluation Plan.
- Continue to strengthen collaboration with international partners as well as civil society and private sector partners to improve efforts to address HIV and AIDS, TB and malaria.
- Improve and strengthen the monitoring and evaluation systems of regional and continental initiatives in general and in the fight against the three diseases.
- Strengthen national, regional and continental monitoring and evaluation systems in order to better track the implementation of commitments under the Abuja Call and support the final assessment of progress in 2015, by communicating data to the AUC.
- Rethink the monitoring and evaluation system established under the Abuja Call at continental and national level to make it more operational.

Background

Africa remains one of the most affected regions in the world by HIV and AIDS, Tuberculosis (TB) and Malaria.

1. Of the 34 million people living with HIV across the world at the end of 2011, 69% live in Africa. Around 1 in 20 adults in Africa are living with HIV. Similarly, the World Health Organization (WHO) estimates that there were about 219 million cases of malaria in 2010 and about 90% of the estimated 660 000 deaths from malaria in that year occurred in Africa. Africa also carries a large burden of the TB disease with 30% of the approximately 9 million new TB cases each year and 9 of the 22 most affected countries coming from Africa.[1]
2. HIV and AIDS, TB and malaria are ranked amongst the most devastating contagious diseases in the world and the links between poverty, development, HIV and AIDS, TB and malaria are well recognized.[2] In Africa, where almost 50% of the continent's populations[3] continue to live in poverty, it is clear that health is not only a precondition for, but also an outcome and indicator of economic, social and environmental development. HIV and AIDS, TB and malaria affect many of the poorest and most marginalized, thriving in conditions of poverty, family displacement, violence, poor nutrition, overcrowding and situations of limited access to prevention, treatment, care and support services. In turn, they create barriers to economic development and bring about unnecessary suffering, disability and death amongst Africa's people.
3. The African Union (AU) has repeatedly declared the three diseases as a State of Emergency on the African continent, constituting major threats to national and continental socio-economic development, peace and security. In 2000 and 2001, the leaders of AU Member States adopted the Abuja Declarations and Action Frameworks on Roll Back Malaria (RBM) and on HIV and AIDS, TB and other infectious diseases.[4] The Declarations committed AU Member States to working individually and collectively to halt the spread HIV, AIDS, TB and malaria and to achieve the target set by Millennium Development Goal (MDG) 6.[5] This high- level commitment, reinforced on multiple occasions at the continental level over the years, marked a turning point in the continental response to the three diseases stimulating a sharp increase in resources and the scale up of programs to fight HIV and AIDS, TB and malaria.[6]
4. In May 2006, AU member states met at a Special Summit on HIV and AIDS, TB and Malaria to review the continent's achievements in terms of the Abuja Declarations and Plans of Action. Recognizing the need for accelerating the response to achieve MDG 6, African leaders made a new collective commitment under the Abuja Call for Accelerated Action towards Universal Access to HIV and
5. AIDS, Tuberculosis and Malaria Services in Africa ("the Abuja Call").[7] The Abuja Call identified twelve priority areas for action: Practical Leadership at National, Regional and Continental levels; Resource Mobilization; Protection of Human Rights; Poverty Reduction, Health and Development; Strengthening Health Systems; Prevention; Treatment, Care and Support; Access to Affordable Medicines and Technologies; Research and Development; Implementation; Partnerships and Monitoring, Evaluation and Reporting.
6. At the 2006 Special Summit, the African Union Commission (AUC) was entrusted with developing progress reports on the Abuja Call. This mandate included biennial Progress Reports for the AU Member States Interdepartmental Committee and AU Executive Council and Assembly of Heads of State and Government, as well as five year reports on the state of implementation of the Abuja Call, by 2010 and 2015, for review of the MDGs. This was further supported by the 2007 commitment by AU Ministers of Health to utilizing the monitoring and reporting mechanism, including clear targets and indicators, for monitoring the Abuja Call.[8]
7. In July 2010, on review of the five-year assessment report for 2006-2010,[9] Heads of State and Government mandated the AUC, in collaboration with other AU bodies, Regional Economic Communities (RECs) and partners to proceed with monitoring and implementation of the Abuja Call and to submit a progress report in 2013 (as well as a final report in 2015) to prepare for the review of the MDGs in 2015.
8. The purpose of this report is to present the progress made by AU Member States in priority areas identified by the Abuja Call for the period 2010 to 2012. After endorsement by the Assembly of Heads of State and Government, it will serve as a framework for identifying the successes, major challenges and priorities

for the continent in the continued fight against HIV, TB and malaria and the review of the MDGs post-2015.

9. The report looks at the extent to which the AU member states, at a national, regional and continental level, have addressed the twelve priority areas of the Abuja Call during the period 2010 to 2012. Of the 53 AU Member States, only 12 countries (namely Benin, Cameroon, Chad, Cote d'Ivoire, Guinea Republic, Liberia, Sudan, Mauritania, Mozambique, Rwanda, Togo and Zimbabwe) provided data to the AUC, as provided by the Monitoring and Reporting Mechanism. This scenario represents a major limitation to the report's findings. In order to produce the report, data was supplemented where possible from recent UN reports, reports prepared by other technical and financial partners on the basis of country data and data from surveys such as the Multiple Indicator Cluster Surveys (MICS) and Demographic & Health Surveys.

Findings

Leadership at National, Regional and Continental Level

10. Since the Abuja Declaration, there have been a number of efforts at continental, regional and national level to provide leadership and to support responses to HIV and AIDS, TB and malaria across Africa. These have included AU initiatives to develop continental policy frameworks, strategies, plans and campaigns, mobilize resources and consolidate partnerships around HIV and AIDS, TB and malaria as well as various initiatives by RECs and regional health organizations to mobilize, support and harmonize responses in law, policy and programmes within their regions for all the three diseases. At national level, AU Member States have set up national coordinating bodies for HIV, TB and malaria.[10]

11. The period 2010 to 2012 has seen signs of continued as well as renewed commitment to HIV and AIDS, TB and malaria at continental level. In 2012, AIDS Watch Africa (AWA) was revived as a platform for advocacy, resource mobilization and accountability of Heads of State and Government for HIV, TB and malaria[11] and the Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa was approved. All AU Member States are now members of AWA. The Action Committee of AWA, consisting of champions from Heads of State and Government and the President of the AUC, reiterated their commitment to the Abuja Call in July 2012 in Addis Ababa. The 4th Inter-Agency Meeting on HIV and AIDS, TB and Malaria in Addis Ababa in July 2012 to improve partnerships, coordination and harmonization at regional and continental levels, brought together the AU, RECs, regional health organizations, UN agencies, Civil Society Organizations (CSOs) and other partners to consider accountability for HIV, TB and malaria.

12. More recent regional leadership initiatives to galvanize responses to HIV during this period include the West African Health Organization (WAHO) regional program on *"Reproductive Health and HIV Prevention in the region of the Economic Community of West African States"* which included the development of a Regional Financing Facility for Reproductive Health Products and ongoing support for regular meetings of the Economic Community of West African States (ECOWAS) Health Ministers to discuss health programmes and access to treatment.[12] Similarly, in the East, Central and Southern Africa Health Community (ECSA-HC), ongoing activities to support health services include a project in collaboration with the United Nations Economic Commission for Africa to strengthen diagnosis, surveillance and research of TB (including Multi-Drug Resistant TB (MDR-TB)), support for the October 2012 regional medical experts' camp in Lesotho and support for regular meetings of ECSA-HC Health Ministers as well as Best Practice Forums to inform effective health responses in the region.[13]

13. A major challenge identified by the 2006-2010 Abuja Call Progress Report was the limited integration of TB and malaria control in health and development programmes at regional level. More recent regional leadership on malaria has seen the Intergovernmental Agency for Development incorporating the prevention, diagnosis and treatment of malaria in its regional HIV/AIDS Partnership programmes in 7 countries. The Malaria Elimination Group (MEG) has furthermore led to a partnership in Southern Africa known as the "E8", which focuses on malaria elimination targets at regional level.

Summary Recommendations:

- Improve governance and co-ordination at all levels in order to ensure ownership, good governance and accountability for HIV and AIDS, TB and malaria;
- Share best practices on HIV and AIDS, TB and malaria across countries.

Resource Mobilization

14. The Abuja Call commits Member States to mobilizing local resources for sustainable and predictable financing for HIV, AIDS, TB and malaria through various means. Recent years have seen two major events leading to a considerable increase in the available funding to fight HIV and AIDS, TB and malaria across Africa.

15. Firstly, domestic investments in health by low and middle-income countries, including AU Member States have, for the first time, exceeded global donations, reducing the global gap between resources available and those needed to address HIV, tuberculosis and malaria to around 30%.[14] Some 81 countries, including African countries, have increased their investments in national responses to HIV by more than 50% between 2006 and 2011. South Africa has increased its funding for health by 500% between 2006 and 2011, Kenya and Togo by 200% and Zambia by almost 50%.

16. Secondly, predictability of aid from international donors has been instrumental in improving efforts to respond to HIV and AIDS, TB and malaria. Several partners contributed financial support between 2010 and 2012 for responses to the three diseases.[15] Funding for malaria increased to US$2 billion in 2011. France has channeled the bulk of its aid towards multilateral organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), United Nations Joint Programme on HIV/AIDS (UNAIDS), WHO and UNITAID and is the 2nd largest contributor, after the United States (US) to the GFATM. The US President's Emergency Plan for AIDS Relief (PEPFAR) has contributed US$48 billion towards HIV, tuberculosis and malaria for the period from 2009 to 2013.

17. In short, resources for health have more than doubled over the past 5 years. However, resource mobilization remains an ongoing challenge in order to achieve the MDGs. The reliance on donor support in many African countries; the need for increased investment in basic prevention programmes and the costs of anti-retroviral treatment for HIV and AIDS; the serious lack of funding for TB prevention and treatment, especially with the emergence of resistant forms of TB which are expensive to treat, and the increased resources needed to achieve and maintain malaria targets are ongoing challenges. In order to effectively achieve MDG 6, Africa will require ongoing international investments; increased, cost-effective and efficient investments and national level and the consideration of new financing mechanisms.[16]

Summary Recommendations:

- Enhance advocacy and resource mobilization for universal access to HIV and AIDS, TB and malaria services;
- Mobilize resources at international level, to ensure predictable and sustainable long term financing, as well as at national level for priority interventions;
- Ensure sound management of mobilized resources to maintain and/or gain the trust of technical and financial partners;
- Establish innovative mechanisms for resource mobilization at national level with a strong involvement of the private sector.

Protection of Human Rights

18. The Abuja Call commits Member States to continue promoting an enabling policy, legal and social environment to reduce vulnerability and promotes human rights in the context of HIV and AIDS, in particular for vulnerable and key populations such as women, youth and children, conflict-affected and

displaced persons, refugees and returnees. There are several significant achievements during 2010-2012 that have strengthened legal and social environments in the context of HIV at continental, regional and national level.

19. At its 47th Ordinary Session held in Banjul in May 2010, the African Commission on Human and Peoples' Rights established a Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV. The Committee, comprising members of the African Commission and independent experts, is mandated to advance HIV and human rights in Africa.[17]

20. In 2011, the Global Commission on HIV and the Law (GCHL), supported by the United Nations Development Programme (UNDP), held an Africa Regional Dialogue on HIV and the Law, bringing together AU Member State leaders and civil society to discuss key HIV, law and human rights issues in Africa. The discussions and recommendations fed into the GCHL's 2012 report, *Risks, Rights & Health*[18] and has guided on-going efforts to strengthen legal and regulatory frameworks for HIV since that time.[19]

21. On 23 April 2012, the East African Legislative Assembly (EALA) passed the East African Community (EAC) HIV and AIDS Prevention and Management Bill 2012, providing a rights-based regional HIV law for the 5 countries of East Africa. It has since been assented to by 3 of the 5 Partner States, namely Kenya, Uganda and Burundi.

22. At national level, countries such as Namibia, Ghana, Malawi and Seychelles have assessed their legal and regulatory frameworks for HIV and have recommended strengthened rights-based protection in law and the repeal of punitive laws. Namibia has repealed its travel restrictions on people living with HIV and countries in West Africa, such as Senegal, Togo, Congo and Guinea, have narrowed criminalisation of HIV provisions in HIV law in accordance with UN guidance. Gabon recently rejected a proposal to criminalise HIV transmission; Mozambique and the Democratic Republic of Congo (DRC) have initiated efforts to review punitive provisions in existing HIV laws and Malawi and Ghana are currently reviewing draft HIV laws to protect rights.

23. Challenges noted in 2010 are still pertinent. The implementation and enforcement of the protections in law for people affected by HIV and vulnerable populations such as women, remains a challenge, as does limited provision in policy and restrictive laws targeting key populations at higher risk of exposure of HIV such as men who have sex with men, sex workers, people who inject drugs and prisoners. There is still an ongoing need to adequately address the relationship between TB, malaria and human rights.

Summary Recommendations:

24. Continuous review of HIV-related laws and policies in AU Member States to strengthen rights-based protection for all vulnerable and key populations in the context of HIV.

Poverty Reduction, Health and Development

25. Despite Africa's recent, rapid economic growth, over 45% of Africa's population, outside of North Africa, still lives in extreme poverty, surviving on less than US$1.25 per day. The current pace of poverty reduction will not enable Africa to reach the MDG target by 2015, even if it has accelerated relative to past trends.[20] Current projections estimate that 35.8% of people in sub-Saharan Africa will be living in extreme poverty in 2015.

26. AU Member States have recognized and committed to addressing the link between poverty, health and development in the Abuja Call by integrating HIV and AIDS, TB and malaria programmes into poverty reduction strategies and programmes. To date, 42 African countries have developed full or interim Poverty Reduction Strategy Papers and by 2013, 28 countries have benefited for debt relief under the Heavily Indebted Poor Countries Initiative. The 2006-2010 Progress Report noted that HIV and AIDS had been well integrated into Poverty Reduction Strategies and UN Development Assistance Frameworks in all AU Member States (43) reporting in 2007. Additionally, national strategic plans on HIV and AIDS in various countries include interventions to strengthen food security and nutrition. Integration of TB and malaria has been slower; by 2008, 59% of reporting states (27 of 46) had also

developed TB strategic plans aligned with national poverty reduction strategies and malaria was reported to be increasingly recognised as an important topic within discussions of poverty reduction and debt relief.[21] There is limited new information on the integration of HIV, TB and malaria into poverty reduction strategies for the period 2010-2012.

Summary Recommendations:

27. Implement effective and targeted poverty reduction strategies and social protection programmes that integrate HIV and AIDS, TB and malaria, for all populations, and in particular vulnerable populations.

Strengthening Health Systems

28. Africa bears 24% of the global burden of disease yet has only 3% of the world health workers;[22] the continent needs an estimated one million additional health workers to achieve the MDG targets.[23] Ongoing challenges include limited health facilities, particular in rural areas, as well as existing facilities that lack basic infrastructure (such as clean drinking water, electricity and beds) and regular access to medicines. User fees create further barriers to access for poor populations.[24] According to the latest WHO data, the majority of people in most African countries do not have sustainable access to affordable essential drugs or to the provision of appropriate medical care.

29. African leaders have recognised the strengthening health systems, including human resource capacity building, as critical to accelerating universal access to prevention, treatment, care and support for HIV and AIDS, TB and Malaria and have undertaken numerous initiatives over recent years to do so. In addition, both national expenditure and foreign aid increased to address health systems strengthening.[25]

30. The continued commitment through the Africa Health Strategy 2007-2015,[26] Global Health Workforce Alliance Strategy (now 2013-2016),[27] Call for Accelerated Action for the Implementation of the Plan of Action Towards Africa Fit for Children[28] and the African Health Initiative[29] have worked towards strengthening health systems. Additionally, since that time, the Business Plan for the Pharmaceutical Manufacturing Plan for Africa was adopted in July 2012 by AU Heads of State and Government to increase access to affordable medicines.[30] The 2009 World Bank Health Systems for Outcomes initiative has provided health systems strengthening assistance to 12 AU Member States.[31]

31. However, recent data from WHO still shows mixed progress towards strengthening health systems. Health statistics in 2012 reveal that while the number of doctors per 10 000 inhabitants increased by 0.2% from 2007, the number of nurses and midwives per 10,000 population decreased by 2%. The lack of sustainable health financing mechanisms, limited public health budgets and logistical challenges compound problems. National programmes by countries are positive signs to be built upon; however they vary widely; many initiatives are also reported to lack sustainability and potential for scale-up to national level.

Summary Recommendations:

- Strengthen health systems to ensure constant availability of medicines and quality products at affordable prices for HIV and AIDS, TB and malaria;
- Strengthen human resource capacity, health structures, health equipment and supply and purchase management systems in AU Member States.

Prevention

32. Prevention is recognised as a key, cost-effective response to HIV, TB and Malaria in the Abuja Call, and AU Member States have committed to increasing investments in evidence-based prevention, in particular for young people, women, girls and other vulnerable populations. In recent years, African countries have made significant progress in scaling up prevention of HIV, as well as TB and malaria.

33. Reports show increased prevention services and facilities for HIV in AU Member States as well as reduced rates of HIV infection. UNAIDS reports that 25 low and middle income countries, half of which are in Africa, have reduced rates of new HIV infection by 50% between 2001 and 2011. Significantly, in Southern Africa, with high HIV prevalence rates, the incidence of HIV fell by 73% in Malawi, 71% in Botswana, 68% in Namibia, 58% in Zambia, 50% in Zimbabwe, 41% in South Africa and 37% in Swaziland. In West and Central Africa, rates of new HIV infections fell by 66% in Ghana, 60% in Burkina Faso and 58% in Djibouti, with reductions of over 50% in Central African Republic, Gabon, Rwanda and Togo. Great strides have been made in 21 African countries covered by the Global Action Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive.[32] Around 59% of pregnant women with HIV have received ART during pregnancy and childbirth in 2011 and the rate of new HIV infections amongst children has fallen by 43% between 2003 and 2011, although there are strong variations between countries in achieving targets. An average of 36.8% of people across countries have comprehensive correct knowledge of HIV.[33]

34. Ongoing challenges include the fact that condom use is still well below target in most countries reporting, despite 5 countries, namely Algeria, Nigeria, Kenya, Swaziland and Côte d'Ivoire, reporting 50% of women and men 15 to 49 years with more than one partner using a condom during last sexual intercourse. In addition, the scale-up of medical male circumcision (MMC) services remains a challenge.[34]

35. WHO reports that the annual global number of new TB cases has been declining, albeit slowly, since 2006. In Africa, with 24% of the world's TB cases and the highest morbidity and mortality per capita, the number of new TB cases has been decreasing for several years and has fallen by about 2% between 2010 and 2011.[35] However, Africa is not yet on track to meet the goal of halving TB mortality from 1990 to 2015 and of particular concern is the slow progress towards diagnosis of MDR-TB.

36. Significant progress has been made to strengthen preventive measures against malaria during recent years, leading to remarkable changes in incidence rates from 2006. According to 2012 data, there is now an average incidence rate of 19 200 malaria cases per 100 000 inhabitants across the 54 AU Member States, down from over 23 000 cases per 100 000 inhabitants in 2010. During this time, the distribution of long-lasting insecticidal nets (LLINs) has increased through widespread distribution campaigns via routine health services and antenatal clinics, increasing the average proportion of households with a LLIN from 12% in 2007[36] to 49% in 2012, according to country data. The average percentage of children under 5 years who slept under an insecticide impregnated and/or treated mosquito net ranges greatly, from 1.5% in Swaziland to 76.5% in Madagascar.[37]

37. In 2011, 38 African countries[38] against 25 in 2008[39] recommended indoor residual spraying (IRS) to control malaria, increasing the number of people protected by IRS from 10 million in 2005 to 78 million in 2010. Thirty-six countries have now adopted intermittent preventive treatment in pregnant women (IPTp).[40] However, IPTp coverage is still well below target; based on data collected as part of this evaluation, the IPTp coverage varies from 0.3% in Burundi to 69.4% in Zambia, below the target of 80% adopted by countries.

Summary Recommendations:

- Continue to promote access to prevention for HIV and AIDS, TB and malaria;
- Implement the African Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive;
- Improve collaboration between HIV and TB programmes.

Treatment, Care and Support

38. AU Member States have committed to promoting and integrating access to treatment, care and support for HIV and AIDS, TB and malaria in the Abuja Call. Measurable progress has been made over the period 2010-2012 to increase access to antiretroviral therapy (ART) for HIV and AIDS.

39. UNAIDS reports that a record number of 2.3 million people have been integrated into treatment programmes over the past 2 years, indicating an increase of 59%.[41] A number of countries, such as South Africa, Zimbabwe and Kenya, have shown substantial increases in the numbers of people accessing ART and Ethiopia, Gambia, Benin, Rwanda and Swaziland have achieved ART coverage of 80%, of those in need, the current threshold for universal coverage. In addition, access to ART for children under 15 years of age has shown considerable improvement in Botswana (88%), Namibia (76%), Swaziland (60%) and South Africa (58%). However, huge efforts have to be made by other countries such as Angola, Ethiopia, Chad, Nigeria, Ghana, Cameroon, Côte d'Ivoire, where access to ART for children under 15 years is less than 20%. Notably, between 2005 and 2011, Africa has reduced the number of people who die from AIDS-related causes by 32%, with great progress particularly in high prevalence countries such as Botswana, South Africa, Namibia, Zambia, Zimbabwe, Kenya and the United Republic of Tanzania.[42]

40. TB detection and treatment rates have shown continued improvement, although they are still well below 2015 targets. TB targets in terms of MDG 6 and those set by the Stop TB Partnership, aim to achieve a TB detection rate of 84% and a treatment success rate of 87% by 2015. According to country reports, the TB detection rate has increased to 56.6% on average in 2010 across the 14 countries reporting. Furthermore, in 2010, 41 out of 46 African countries reporting, had adopted the Directly Observed Treatment Strategy (DOTS) as a national strategy to address TB. In terms of current data collected from 14 countries for the purpose of this report, countries have achieved an average treatment success rate of 73.9%, with only half of countries reporting have achieved treatment success rates greater than or equal to 80%, suggesting the need for improved treatment of detected TB cases to meet targets. Access to prevention, diagnosis and treatment of TB for people living with HIV remains a considerable challenge. A further major challenge identified by WHO[43] is the rise in the number of drug-resistant TB cases in AU Member States. In the case of MDR-TB, there is limited availability of medical equipment for effective screening, limited treatment options and the treatment is extensive, costly, not widely available and causes serious side-effects in patients. Extensively drug-resistant TB (XDR-TB) responds to even fewer available drugs, including the most effective second-line drugs.

41. Malaria treatment involves two key elements – diagnostic testing and access to recommended treatment. In 43 AU Member States, treatment requires combination therapy with the use of artemisinin derivatives (artemisinin combination therapies (ACT)) due to chloroquine-resistance and the risk of multi- resistance.

42. Treatment of malaria has made great strides, although challenges remain. By 2011, 41 AU Member States had adopted a policy to provide parasitological diagnosis for all age groups, against 39 countries in 2010. Strong support from international donors and partners, such as the GFATM, the World Bank, the (US) President's Malaria Initiative (PMI), the RBM Partnership and the United Nations Children's Fund (UNICEF) in recent years have increased the number of treatments of ACT delivered to public and private sectors in the world from 11 million in 2005 to 278 million in 2011, with a large quantity in Africa. However, access to ACT-based malaria treatment remains low in many AU Member States and data from household surveys in different countries report that, despite adopting ACT treatment policies, mono-therapies continue to be used in certain countries due to cost and poor supply management. Reports of treatment of children under 5 years for malaria remains well below targets; among the 33 countries for which information is available, around 10.9% of children are treated adequately; in 20 of 33 countries, less than 10% of children are treated appropriately.

43. WHO reports that by the end of 2011, 36 of 45 affected African countries had adopted IPTp as a national policy. In 25 of the 36 most affected countries adopting the policy and for which data is available, 44% of pregnant women received 2 doses of IPTp at antenatal care facilities.

Summary Recommendations:

- Strengthen access to HIV and AIDS, TB and malaria treatment, care and support services;
- Implement the African Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive;
- Build capacity and adequate facilities for the detection and monitoring of XDR-TB and make resources available to support detected cases.

Access to affordable medicines and technology

44. The Abuja Call commits AU Member States to developing measures to increase access to affordable medicines and technologies for HIV and AIDS, TB and malaria through appropriate legislation and international trade regulations and flexibilities. A critical enabler to a sustainable AIDS and tuberculosis response remains an intellectual property (IP) framework that is sensitive to public health objectives.

45. Treatment coverage for people living with HIV who are eligible for antiretroviral therapy was reported to be marginally higher in Africa (56%) than the global average of 54%,[44] with the large contributions of international actors like the GFATM and PEPFAR. Given the decline in multilateral AIDS funding in recent years,[45] sustainable financing is a key priority for African countries. Although the cost of treatment can often be reduce by using public health related trip flexibilities, many countries are yet to amend their national laws to incorporate and use flexibilities within the 1995 WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Countries that have not yet incorporate the TRIPS flexibilities in their national laws and refrain from adopting laws or measures that limit their ability to use TRIPS flexibilities. In Eastern and Southern Africa, proposed anti-counterfeit legislation, allegedly to fight substandard and falsified medicines, could end up impeding access to medicines.

46. The AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response is a strategy for African-sourced and sustainable action on HIV, malaria and tuberculosis, for 2012-2015. Complementary regional initiatives include the Southern African Development Community (SADC) Pharmaceutical Business Plan 2007-2013 which aims to enhance the capacities of Member States to increase access to quality medicines for priority diseases in the Region;[46] and the EAC Regional Pharmaceutical Manufacturing Plan of Action 2012-2016 which aims to build an effective regional pharmaceutical manufacturing industry to supply national, regional and international markets with medicines.[47] ECOWAS is formulating a charter to facilitate Public Private Partnerships for the local production of ARVs and other essential medicines.[48]

47. There are also examples of co-operation between South-South partners to increase access to treatment. For instance, Indian generic manufacturer, Cipla, is co-operating with the Ugandan government and a Ugandan pre-qualified pharmaceutical manufacturer to begin generic production of antiretrovirals (ARVs).[49] Brazil intends to invest U$23 million in an ARV production plant in Mozambique and to supply technology and training in the field of surveillance, inspection, certification and control of medication, and marketing, with active ingredients to be imported from India.[50]

48. Several initiatives have emerged in Africa in recent years to improve access to affordable malaria treatment. Supported by the AU, Member States have committed to increasing production of generic drugs, with concrete initiatives having been launched in Cameroon, Nigeria, South Africa and Tanzania. Other measures taken by countries to facilitate access to quality antimalarial medicines at affordable costs include through eliminating taxes on treatment and by establishing a strict pre-qualification process for producers, managed by WHO. The Affordable Medicines Facility for Malaria Fund (AMFm), established and managed by the GFATM with the support of UNITAID, the United Kingdom Department for International Development and other donors, aims to reduce the cost of ACT and gradually eliminate mono-therapy. Pilot projects in 7 African countries, Ghana, Kenya, Madagascar, Niger, Nigeria, Uganda and Tanzania, were followed up by implementation in several countries in 2010. An assessment carried out in 2012 indicates that AMFm subsidized nearly 320 million doses of ACT in Cambodia, Ghana, Kenya, Madagascar, Niger, Nigeria, Uganda and Tanzania and has helped to drive prices down.[51] Further evaluation of the AMFm strategy will be required in 2013.

49. Production of rapid diagnostic tests (RDTs) has increased from 45 million in 2008 to 88 million in 2010. Test quality has improved with over nearly 90% of RDTs purchased in 2011 showing detection scores over 75%, while only 23% of RDTs purchased in 2007 recorded such results.

Summary Recommendations:

- Strengthen review of laws and measures to fully incorporate and utilize all public health related TRIPS flexibilities and to avoid limits on the use of public health related TRIPS flexibilities..

- Explore and build on opportunities for South-South co-operation for local pharmaceutical manufacturing and pooled procurement.

Research and Development

50. The Abuja Call commits AU Member States to promoting ethical research and development for evidence-informed prevention, diagnosis, treatment and surveillance of HIV and AIDS, TB and malaria as well as to support monitoring of drug resistance. Though developing countries bear 90% of the global disease burden, only 10% of all health research funding is used to address these diseases.[52] Bridging this gap to deliver diagnostics for HIV and TB, drugs such as new fixed-dose combinations, pediatric formulations and more affordable second and third-line HIV treatments and possible vaccines to meet Africa's public health needs is critical to meeting the health related MDGs. In order to meet the access and innovation for needed health products[53] sstakeholders are re-examining current models and suggesting alternatives such as patent pools, public-private partnerships, prize funds, research incentives, tax breaks for some activities and tax levies for others, new donor relationships and strategies, and a global binding treaty to prioritize and ensure funding for research and development.

51. An important partnership initiative is the 2010 launch of the African Network for Drugs and Diagnostics (ANDI), initiated by the WHO's Department for Tropical Disease Research (TDR). ANDI seeks to create partnerships amongst African institutions to strengthen national capacity for research and development for affordable new tools, including those based on traditional medicines, to address local health needs.[54]

52. Significant research findings for HIV prevention during 2010 to 2012 include confirmation of the preventive possibilities of ARVs, making the prospect of a microbicide containing an antiretroviral drug an increasing reality for women in Africa, as well as further evidence on the protective role of male circumcision for HIV prevention, leading to strengthened implementation of MMC in 13 Member States.[55] Important findings for the treatment of mothers and children include a secondary analysis of the *Kisumu Breastfeeding Study* in Kenya showing that HIV-positive babies develop resistance to antiretroviral drugs via breastfeeding, and a randomized study, in Botswana showing that among pregnant women with HIV, ART including a protease inhibitor increases the risk of preterm delivery compared to treatment containing only nucleoside analogues.

53. Research to develop a test to diagnose TB and MDR-TB at the point of care is continuing and further diagnostic testing will soon be available. Innovative regimens to treat drug-susceptible TB and MDR-TB and shorten the duration of treatment have shown promising results in clinical trials.

54. Research linking malaria and economic development in the western region of Ghana may help to strengthen the integration of malaria in development strategies. The US National Institute of Allergy and Infectious Diseases has furthermore supported the establishment of international centers of excellence in research on malaria in endemic regions, especially in parts of Africa.

55. Research challenges for HIV include the need to improve understanding of the use of ARVs for HIV prevention, pre-exposure prophylaxis and microbicides. In the case of TB, the development of a preventive TB vaccine for adults, improved diagnostics and treatment of MDR and XDR-TB as well as monitoring of drug resistance remain a priority. The acute lack of funding for research and development in the field of tuberculosis remains a challenge. The development of a vaccine for malaria is an ongoing challenge, particularly given the various forms of the *Plasmodium* parasite.

Summary Recommendations:

56. Mobilize more domestic and international resources and strengthen the capacity of AU Member States in the areas of biological, clinical and socio-cultural research.

Implementation

57. In accordance with commitments made by states under the Abuja Call, AU Member States have committed to strengthen and support the implementation of generalized strategic programs against HIV and AIDS, tuberculosis and malaria at country and regional levels. Progress in general in relation to HIV and AIDS, TB and malaria, including the development of national strategic plans on HIV, TB and malaria; the acceleration of malaria control programmes and the prevention of MDR-TB, as well as the ongoing challenges, have been set out above in related sections of this report. Due to limited country reporting, in terms of the Abuja Call Monitoring and Reporting Mechanism, this report is unable to report further on the number of countries who have developed policies and multi-sectoral plans in accordance with the Principle of the "Three-Ones" (that is, one executing authority, one Plan of Action and one Monitoring and Evaluation Plan for HIV and AIDS, TB and malaria).

Summary Recommendations:

58. Strengthen country reporting on implementation of responses to address HIV and AIDS, Tuberculosis and Malaria in terms of the "Three-Ones" (one executing authority, one Plan of Action and one Monitoring and Evaluation Plan.

Partnerships

59. In the Abuja Call, AU Member States made the commitment to developing and supporting partnership mechanisms to coordinate the contributions of stakeholders, from public sector, private sector, civil society at regional and international levels, to achieve universal access to prevention, treatment, care and support for HIV and AIDS, TB and malaria. Although there is limited updated information on partnerships at national level, due to limited country reporting; global and regional partnerships for all three diseases have been important to efforts to address HIV and AIDS, TB and malaria.

60. At global level, critical partnership mechanisms which have helped to mobilize resources and accelerate progress in addressing HIV and AIDS, TB and malaria include the GFATM and PEPFAR.

61. More specifically, in the context of HIV and AIDS several continental and global partnerships are noteworthy, including PEPFAR, partnerships with WHO at state level to look at the integration of HIV and TB responses and UNITAID, an international drugs purchasing organization to increase access to affordable medicines for developing countries. Important sub-regional and national partnerships have been established in different countries such as the Esther Program and the Clinton Health Access Initiative. AWA has also fostered partnerships between African political leaders, CSOs, academics and development agencies through a high-level meeting in 2012, parallel to the UN General Assembly (UNGASS) meeting.

62. The Stop TB Partnership, established in 2001 to co-ordinate country responses to TB, continues to be an important partnership in the response to TB. UNITAID and the Global Drug Facility of the Stop TB Partnership, the Green Light Committee and the GFATM continue to support Member States to improve global responses to TB.

63. In the case of malaria, the RBM Partnership is a global partnership initiated by WHO, UNDP, UNICEF and the World Bank in 1998, enabling collaboration between governments of countries where malaria is endemic and donor countries, multilateral development partners, CSOs, the private sector, foundations, research and academia to reduce the human and socio-economic costs of malaria. African countries where malaria is endemic have furthermore established national partnerships to support universal access. The US PMI is a further important initiative to reduce malaria mortality by 50% in 15 countries heavily affected by malaria.

Summary Recommendations:

64. Continue to strengthen collaboration with international partners as well as civil society and private sector partners to improve efforts to address HIV and AIDS, TB and malaria.

Monitoring, Evaluation and Reporting

65. AU Member States have committed to strengthening monitoring and evaluation and reporting of the three diseases and a monitoring and reporting mechanism, including target indicators, has been developed for reporting in terms of the Abuja Call.[56] The limited reporting by countries (only 10 having reported) for the period 2010 to 2012, however, is a cause for concern, seriously undermining continental efforts to monitor progress and effectively respond to HIV and AIDS, TB and malaria. Of the 10 countries reporting for this period, only 3 indicated that they had a national monitoring and evaluation plan for each disease in place.

66. Data from other sources indicates that of 53 countries, 33 have monitored and provided information on HIV prevalence amongst young people aged 15-24 years and 64% of African countries have information on the number of infants born to pregnant women with HIV. However, fewer countries have data on other indicators such as the percentage of pregnant women attending antenatal clinics that were tested for HIV and know their results, the percentage of patients receiving HIV care and support who are tested for TB or the involvement of associations or networks of people living with HIV in national responses. No country has a system for monitoring access to HIV prevention programmes for vulnerable populations such as refugees and displaced populations.

67. Monitoring and evaluation of TB requires strengthening. The existence of a monitoring mechanism for TB in 94% of countries is encouraging; however other information is less widely available. Information on HIV prevalence among TB patients as well as the proportion of TB patients who receive HIV testing and counseling is available in almost 60% of countries. The detection rate of TB cases is provided by 13 countries and 6 countries provided information on DOTS coverage

68. Monitoring and evaluation of malaria has not progressed as well as in past years. Many countries are still struggling to measure various indicators related to malaria, reflected by the non-availability of information in a number of countries in 2012. Although 87% of countries are able to provide information on national malaria incidence rates, 46 countries provided information on malaria death rates and 72% were able to provide data on children under 5 years who had slept under an impregnated mosquito net the previous night, there is less available information on other indicators such as the number of children under 5 years with fever receiving treatment and the proportion of pregnant women receiving IPTp.

69. Overall, the system of monitoring and evaluation and reporting in African countries requires strengthening and renewed commitment from African leaders, as well as technical and financial support from international institutions and organizations.

Summary Recommendations:

- Share best practices on HIV and AIDS, TB and malaria across countries;
- Improve and strengthen the monitoring and evaluation systems of regional and continental initiatives in general and in the fight against the three diseases;
- Strengthen national monitoring and evaluation systems in order to better meet commitments under the Abuja Call and support the final assessment of progress in 2015, by communicating data to the AUC;
- Rethink the monitoring and evaluation system established under the Abuja Call at continental and national level to make it more operational.

Conclusions

70. The momentum of AU Member States to address HIV and AIDS, TB and malaria since the Abuja Declarations in 2000 and 2001 and the renewed commitments under the 2006 Abuja Call, continues to produce concrete results on the African continent. Progress varies across sectors and countries but remains substantial.

71. Broadly, countries have strengthened their interventions across many of the priority targets set by the Abuja Call. However, they continue to face constraints due in large part to the lack of financial, material, technical and human resources for addressing health needs. Despite substantial increases in funding from 2010 to 2012, unmet needs in terms of access to treatment and care persist on the continent. Increased access to ART for all those in need is an imperative. TB treatment in terms of DOTS has been implemented across all countries but the threat of MDR-TB and XDR-TB requires urgent, strengthened surveillance. Remarkable gains have been made in terms of policy commitments to prevent and treat malaria in accordance with WHO guidelines, but challenges remain in the implementation of diagnostic tests, antimalarial drugs and LLINs. The future of current initiatives at sub-regional, continental and international levels to improve access to medicines and technology at an affordable cost may provide critical impetus to country efforts.

72. In the light of progress to date, the realization of the Abuja Call objectives and the MDG health goals may elude AU Member States without strategic intervention to maintain current efforts and strengthen health systems. For AU Member States, accelerated action for Universal Access to HIV and AIDS, TB and malaria services should remain a priority. AU initiatives to mobilize additional resources, strengthen good governance at all levels, establish innovative funding mechanisms and strengthen partnerships are imperative to supporting Member States, and Africa as a whole, achieve the goal of halting and reversing the spread of HIV and AIDS, TB and malaria.

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C

Resolutions of the African Commission on Human and People's Rights on Health

1 53: Resolution on the HIV/AIDS Pandemic – Threat Against Human Rights and Humanity

2 110: Resolution on the Health and Reproductive Rights of Women in Africa

3 135: Resolution on Maternal Mortality in Africa

4 141: Resolution on Access to Health and Needed Medicines in Africa

5 163: Resolution on the Establishment of a Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV

6 172: Resolution on the Appointment of Members of the Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV

7 220: Resolution on the Extension of the Mandate of the Committee on the Protection of the Rights of People Living with HIV (PLWHIV), and Those at Risk, Vulnerable to and Affected by HIV in Africa

C1 53: Resolution on the HIV/AIDS Pandemic – Threat Against Human Rights and Humanity

Adopted at the 29th Ordinary Session of the African Commission held in Tripoli, Libya ACHPR Res.53/(XXIX) 01

The African Commission on Human and People's Rights, meeting at its 29th Ordinary Session in Tripoli, the Great Socialist Peoples' Libyan Arab Jamahiriya from 23rd April to 7th May 2001:

NOTING the rampant escalation of the HIV/AIDS pandemic in Africa especially in sub-Saharan Africa where estimates show that some 9 million people have died and within the next decade some 25 million people will become infected;

NOTING with satisfaction the convening of the Africa Summit on HIV/AIDS in Abuja, Nigeria, from 24th to 26th April 2001 where the crisis was declared and interventions of emergency proportions called for;

WELCOMING the statement of the Abuja Summit and the emergency measures declared there especially the announcement by the Secretary General of the UN on the establishment of a US$10 billion war chest to fight HIV/AIDS in Africa;

WELCOMING the forthcoming UN General Assembly Special Session on HIV/AIDS to be held in June 2001 and trusting that it will increase awareness of the need for international action to fight the pandemic and devise strategies by international co-operation against HIV/AIDS;

MINDFUL of the mandate of the Commission in terms of the Charter to "promote human and peoples' rights and ensure their protection in Africa" and especially in this regard allow the right of every individual to "enjoy the best attainable state of physical and mental health" (Article 16);

1. **DECLARES** that the HIV/AIDS pandemic is a human rights issue which is a threat against humanity;
2. **CALLS UPON** African Governments, State Parties to the Charter to allocate national resources that reflect a determination to fight the spread of HIV/AIDS, ensure human rights protection of those living with HIV/AIDS against discrimination, provide support to families for the care of those dying of AIDS, devise public health care programmes of education and carry out public awareness especially in view of free and voluntary HIV testing, as well as appropriate medical interventions;
3. **CALLS UPON** the international pharmaceutical industries to make affordable and comprehensive health care available to African governments for urgent action against HIV/AIDS and invites international aid agencies to provide vastly increased donor partnership programmes for Africa including funding of research and development projects.

Done in Tripoli, 7th May 2001.

C2 110: Resolution on the Health and Reproductive Rights of Women in Africa

Adopted at the 41st Ordinary Session in Accra, Ghana, from 16 to 30 May 2007

The African Commission on Human and Peoples' Rights (the African Commission), meeting at its 41st Ordinary Session in Accra, Ghana, from 16 to 30 May 2007:-

RECALLING the entry into force of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Protocol) on 25 November 2005,

NOTING that only twenty (20) State Parties to the African Charter on Human and Peoples' Rights have ratified the Protocol,

CONSIDERING the inherent difficulties in implementing the Protocol, notably those regarding its domestication, as well as harmonisation of national laws with its content,

RECALLING that Article 14 of the Protocol specifically protects the health and reproductive rights of women;

CONCERNED that female genital mutilation is a harmful practice which affects the reproductive health of women and continues to exist in some countries in spite of legislation outlawing it;

FURTHER CONCERNED about the disproportionate impact of the HIV and AIDS pandemic on women, especially on the African continent;

CONCERNED ALSO about the problems relating to reproductive health care and the quality of services available to women in Africa, including the inability of existing healthcare institutions to provide adequate pre post-natal care for mothers and babies (especially in cases of complications), the high rate of maternal mortality in a number of African countries, and the prohibition of abortion except where necessary to save the woman's life:

1. **CONGRATULATES** States which have ratified the Protocol, and urges them to take all the necessary measures to domesticate and harmonize their national laws in order to give full effect to the rights enshrined in the Protocol;
2. **URGES** States which have not yet ratified the Protocol to do so promptly and without reservations;
3. **FURTHER URGES** States to protect the health and reproductive rights of women as stipulated in the Protocol;
4. **CONGRATULATES** States which have adopted laws prohibiting female genital mutilation, and encourages them to implement specific programs to create awareness in all sectors of society and ensure eradication of this harmful traditional practice;
5. **URGES** those States that have not yet outlawed female genital mutilation to do so without delay;
6. **CALLS ON** States to take appropriate measures to protect women from sexually transmitted diseases, including HIV and AIDS;
7. **REQUESTS STATES** to reduce the maternal mortality rate and to take adequate measures to provide effective access for women to reproductive health services, including access to lawful medical abortion in accordance with the Protocol.

C3 135: Resolution on Maternal Mortality in Africa

ACHPR/Res 135 (XXXXIIII) 08

The African Commission on Human and Peoples' Rights Meeting at its 44th Ordinary session held in Abuja, Federal Republic of Nigeria, from 10 - 24 November 2008:

RECALLING that women's rights and the principle of non-discrimination have been recognised and guaranteed in all international human rights instruments, notably the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women and its Optional Protocol, and all other international and regional conventions and covenants such as the African Charter on Human and Peoples' Rights relating to the rights of women;

RECALLING that women's rights to maternal health have been recognised and reaffirmed by the United Nations Plans of Action on Population and Development in 1994 and on Social Development in 1995 and have been enshrined in the Beijing Declaration and Platform for Action in 1995;

RECOGNIZING that improving maternal and reproductive health is both a regional and international obligation enshrined in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa and the Millennium Development Goals;

FURTHER RECALLING the commitments of the Heads of State and Governments in the Solemn Declaration on Gender Equality in Africa adopted during the 3rd Ordinary Session held in Addis Ababa, Ethiopia from 6-8 July 2004;

NOTING the commitments of the Heads of State and Governments in the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases made during the African Summit on HIV/AIDS, Tuberculosis and Other Infectious Diseases in Abuja, Nigeria from 24-27 April 2001 to allocate 15% of their national budgets to health ;

STANDING BY our Declaration on Economic, Social and Cultural Rights in Pretoria during our 36th Session in December 2004 that lack of political will, privatisation of essential services, failure to allocate sufficient resources and brain drain amongst other factors are at the centre of the non-realisation of economic, social and cultural rights in Africa including the right to enjoy the best attainable state of physical and mental health;

DEEPLY DISTURBED that Africa currently has the worst records of maternal deaths in the world accounting for more than two hundred and fifty thousand deaths annually;

CONCERNED that most member states of the African Union are not making progress in reducing the maternal mortality rates in their respective countries;

NOTING with concern that maternal mortality destroys the very foundation of the African family which according to article 18 of the African Charter on Human and Peoples' Rights is the "natural unit and basis of the society" and "the custodian of morals and traditional values recognised by the community";

CONSIDERING that the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa makes provision in article 14 for health and reproductive rights and in particular, obliges states to " establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast - feeding";

APPRECIATING the great role women play in securing the future of the society and that pregnancy being a natural occurrence, every society should seek to protect the life of the mother and the child from conception, to delivery and beyond;

CONVINCED that preventable maternal mortality is a violation of the rights to life, health and dignity of women in Africa;

FIRMLY convinced that only through effective health institutions as well as strategic and sustained funding to the health sector that the problem of maternal mortality will be managed and finally reduced in Africa;

1. **DECLARES** that preventable maternal mortality in Africa is a violation of women's right to life, dignity and equality enshrined in the African Charter on Human and Peoples' Rights and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa;

2. **Calls upon** African Governments to individually and collectively address the issue of maternal mortality in accordance with the recommendations attached to this resolution.

Done in Abuja, Federal Republic of Nigeria on the 24th November 2008.

Recommendations on Addressing Maternal Mortality in Africa

The African Commission on Human and Peoples' Rights

In accordance with its Resolution on Maternal Mortality in Africa adopted during its 44 th Ordinary Session held from 10-24 November 2008 in Abuja, Federal Republic of Nigeria, hereby recommends that States parties to the African Charter on Human and Peoples' Rights:

1. Meet their obligations under the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. In particular, to:
    - Allocate 15% of their national budgets to the health sector in accordance with the Declaration;
    - Ensure that market based economic reforms including privatisation do not take away the responsibility of the state to fulfil the right to health;
    - Ensure that health reforms, policies and programmes should make adequate considerations of the right of poor and rural women to access basic healthcare as enshrined in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa;
    - Further ensure that access to ante natal and obstetric services as much as practicable be free, available and accessible;
2. Adopt human right based approaches in the formulation of country programs and strategies to reduce maternal mortality in Africa. In particular to:
    - Ensure participation of women and civil society in the formulation, implementation, monitoring and evaluation of policies and frameworks aimed at addressing maternal mortality;
    - Take all appropriate measures including positive discrimination in providing funds for specific programs and projects to secure maternal health;
    - Provide a well staffed and equipped maternity centres in rural areas;
    - Employ and retain skilled health personnel and birth attendants at rural and semi-urban areas;
    - Train and retain health workers in emergency obstetric care;
    - Develop community led emergency transport systems to cushion the effect of delays in getting medical attention;
    - Develop adaptive training curriculum for the education of women and girls on rights to reproductive health.
3. Include in their periodic reports under article 62 of the African Charter:
    - The general state of maternal health, including the level of mortality and morbidity and challenges faced in implementing related programs;
    - Policy and institutional measures taken to give effect to the provisions of article 14 of the African Charter on the right to the best attainable state of physical and mental health for women;
    - Budgetary and institutional measures dedicated to securing maternal health;
    - Other programs and activities undertaken to secure maternal health with results;
4. Consider the declaration on the state of maternal health in Africa as a continental emergency and to take appropriate regional actions;

5. To those member states of the African Union that have not already done so, to urgently ratify the Protocol to the Africa Charter on Human and Peoples' Rights on the Rights of Women in Africa;
6. To member states that have already ratified this protocol to immediately undertake measures for domestication, including the amendment of internal laws to conform with the provisions of the Protocol;
7. To develop programmes aimed at drawing attention to the negative impacts of maternal mortality on women in Africa and future generations of Africans;
8. To civil society organisations in Africa to work in collaboration and develop partnerships to:
    - Conduct research on maternal mortality in respective African countries;
    - Work in collaboration with governmental agencies to develop effective country strategies for securing the right to maternal health;
    - Ensure the participation of communities and women groups in the formulation of programs and activities aimed at reducing maternal mortality;
    - Monitor the implementation of programs aimed at reducing maternal mortality;
    - Advocate for accountability by governments to their respective obligations in reducing maternal mortality and securing the right to maternal health;
    - Advocate for the ratification and domestication by African states of the Protocol to the Africa Charter on Human and Peoples' Rights on the Rights of Women in Africa without reservations.

Done in Abuja, Federal Republic of Nigeria, the 24th November 2008

C4 141: Resolution on Access to Health and Needed Medicines in Africa

ACHPR/Res 141 (XXXXIIII) 08

The African Commission on Human and Peoples' Rights, meeting at its 44th Ordinary Session held in Abuja, Federal Republic of Nigeria, from the 10th to 24th November 2008:

REAFFIRMING that Article 16 of the African Charter on Human and Peoples' Rights guarantees the right to enjoy the best attainable state of physical and mental health and that States must ensure that everyone has access to medical care;

ALARMED that essential medicine, were available in only 38% of all public and private health care facilities in Africa between 2001 and 2007;

STRESSING that the right to health is not confined to a right to health care but embraces all underlying aspects of health;

RECOGNIZING that access to needed medicines for treatment, prevention and palliative care is a necessary condition for leading a healthy and dignified life;

RECOGNIZING that access to needed medicines is a fundamental component of the right to health and that States parties to the African Charter have an obligation to provide where appropriate needed medicines, or facilitate access to them;

RECOGNIZING FURTHER that the United Nations Special Rapporteur on the Right to Health has explained that "access to medicines forms an indispensable part of the right to the highest attainable standard of health" and that, therefore, the right to health mandates that State promote "the realization of the right to medicines for all";

URGES States to guarantee the full scope of access to needed medicines, including:

1. The availability in sufficient quantities of needed medicines, including existing medicines and the development of new medicines needed for the highest attainable level of health;
2. The accessibility of needed medicines to everyone without discrimination, including
   - Physical accessibility of needed medicines to all;
   - Economic accessibility (affordability) of needed medicines to all;
   - Information accessibility about the availability and efficacy of medicines;
3. The acceptability of medicine supplies, being respectful of cultural norms and medical ethics;
4. The quality of medicine supplies, ensuring that available medicines are safe, effective and medically appropriate;

CALLING on States to fulfill their duties with respect to access to medicines, in particular:

1. To promote access to medicines by refraining from measures that negatively affect access, such as:
   - denying or limiting equal access to medicines for marginalized individuals or communities;
   - prohibiting or impeding the use of traditional medicines and healing practices that are scientifically sound and medically appropriate;
   - interfering with the provision of humanitarian aid that facilitates the supply of necessary medicines;
   - implementing intellectual property policies that do not take full advantage of all flexibilities in the WTO Agreement on Trade Related Aspects of Intellectual Property that promote access to affordable medicines, including entering "TRIPS Plus" free trade agreements;
2. To protect access to needed medicines from actions by third parties through regulatory systems that:
   - ensure that only medicines that have met scientifically appropriate standards for quality, safety and efficacy are available;

- promote the rational use of medicines, through treatment guidelines based on the best available evidence;
- prevent unreasonably high prices for needed medicines in both the public and private sectors, through promotion of equity pricing in which the poor are not required to pay a disproportionate amount of their income for access;
- ensure that medical practitioners and patients have ready access to reliable, complete and unbiased information on the safety and efficacy of medicines;
- stimulate and Promote competition, intellectual property, consumer protection and other laws to promote access to medicines;

3. To fulfill access to medicines by adopting all necessary and appropriate positive measures to the maximum of its available resources to promote, provide and facilitate access to needed medicines, including:
   - immediately meeting the minimum core obligations of ensuring availability and affordability to all of essential medicines as defined by the country's essential medicines list and the WHO Action Programme on Essential Drugs;
   - immediately creating a national medicine strategy monitoring systems to ensure compliance with human rights obligations;
   - promoting meaningful participation by affected individuals and groups in decisions that affect access to medicines, including regulatory, pricing and patent decisions;
   - creating systems in which patent information and registration status for medicines is readily and publicly accessible;
   - expediting the regulatory review and registration of needed medicines and creating incentives for companies to register needed medicines expeditiously;
   - individually and together with other States and non-governmental entities, developing and implementing need-based research and development programmes to address currently neglected diseases and conditions;

MANDATES the Working Group on Economic, Social and Cultural Rights to further define State obligations related to access to medicines and to develop model monitoring and assessment guidelines.

Done in Abuja, Federal Republic of Nigeria, on 24th November 2008.

C5 163: Resolution on the Establishment of a Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV

Adopted at the 48th Ordinary Session held in Banjul, the Gambia 10–24 November 2008

The African Commission on Human and Peoples' Rights, meeting at its 47th Ordinary Session held in Banjul, The Gambia, from 12 to 26 May 2010:

RECOGNIZING that the African Commission on Human and Peoples' Rights has a fundamental role to protect the most vulnerable groups in Africa against human rights abuses;

RECOGNIZING also that a unique feature of the HIV pandemic is the overwhelming nature of the accompanying stigma;

NOTING THAT in circumstances where the rule of law and human rights are not respected as an integrated part of society, the most vulnerable groups within that society are often denied the level of protection they require and hence, are exposed to increased vulnerability;

RECOGNIZING that people living with HIV and those at risk are currently one of the most vulnerable groups exposed to serious violations of human rights in Africa.

RECALLING the Resolution on the HIV/AIDS Pandemic – Threat Against Human Rights and Humanity (2001) calling upon African governments, State Parties to the African Charter to allocate national resources that reflect a determination to fight the spread of HIV/AIDS, to ensure human rights protection of those living with HIV/AIDS against discrimination and to take appropriate actions so that international pharmaceutical industries make affordable and comprehensive health care available for African governments;

RECALLING commitments of the African Union Heads of State and Government in the Tunis Declaration on AIDS and the Child in Africa (1994); Grand Bay (Mauritius) Declaration and Plan of Action (1999); Lomé Declaration on HIV/AIDS in Africa (2000); Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infections Diseases (2001); Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Infections Diseases (2003); Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care (2005); Continental Framework for Harmonisation of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa (2005); Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006); Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (2006); and Africa's Common Position to the UN General Assembly Special Session on AIDS (2006);

NOTING with deep concern that of 33.4 million people living with HIV in the world, 22.4 million are living in Sub-Saharan Africa and of 2 million AIDS related deaths, 1.4 million occurred in Sub-Saharan Africa in 2008;

CONCERNED that AIDS related deaths result in an increase number of orphans and vulnerable children in Sub-Saharan Africa;

CONCERNED further that despite commitments undertaken by State Parties and regional bodies, PLHIV and those at risk continue to face serious violations of their basic human rights;

DEEPLY DISTURBED by the growing trend by various State Parties across Africa towards criminalisation and mandatory testing of PLHIV which leads to greater stigmatisation and discrimination;

DECIDES TO establish a Committee on the Protection of PLHIV and Those at Risk for a period of 2 years with the following mandate:

- To seek, request, receive, analyse and respond to reliable information from credible sources including individuals, community-based organisations, non-governmental organisations, specialised agencies, inter-governmental organisations, and State Parties, on the situation and rights of PLHIV and those at risk;
- To undertake fact-finding missions, where necessary, to investigate, verify and make conclusions and recommendations regarding allegations of human rights violations;
- To engage State Parties and non-state actors on their responsibilities to respect the rights of people living with HIV and those proven to be vulnerable to these infections;
- To engage State Parties on their responsibilities to respect, protect and fulfil the rights of people living with HIV and those at risk;
- To recommend concrete and effective strategies to better protect the rights of people living with HIV and those at risk;
- To integrate a gender perspective and give special attention to persons belonging to vulnerable groups, including women, children, sex workers, migrants, men having sex with men, intravenous drugs users and prisoners; and
- To report regularly to the African Commission on Human and Peoples' Rights.

Done in Banjul, The Gambia, 26th May 2010.

C6 172: Resolution on the Appointment of Members of the Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV

The African Commission on Human and Peoples' Rights (the African Commission), meeting at its 48th Ordinary Session held in Banjul, The Gambia, from 10¬24 November 2010:

RECALLING its mandate to promote human and peoples' rights and ensure their protection in Africa under the African Charter on Human and Peoples' Rights (the African Charter);

BEARING IN MIND its Resolution ACHPR/Res163 (XLVII) 2010 adopted at its 47th Ordinary Session on the Establishment of a Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV;

RECOGNIZING that the success of the Committee depends on the strong commitment of its members, including their expertise to carry out its specific milestones and address urgent issues falling within this mandate

DECIDES to appoint the following experts, as members of the Committee for a period of two years effective 24 November 2010:

M. Alain Patrick Le Doux Fogue Dzutue (Cameroun)

Mme Agnès Atim (HRDI)

M. Christian Garuka Nsabimana (Rwanda)

M. Tope Ebenezer Durojaye (Nigeria)

Mme Nicolette Naylor Merle (South Africa)

M. Patrick Eba Michel (UNAIDS)

Requests the Committee to present its activity report at each Ordinary Session.

Done in Banjul, The Gambia, 24 November 2010.

C7 220: Resolution on the Extension of the Mandate of the Committee on the Protection of the Rights of People Living with HIV (PLWHIV), and Those at Risk, Vulnerable to and Affected by HIV in Africa

Adopted at the 51st Ordinary Session held in Banjul, The Gambia 2 May 2012

The African Commission on Human and Peoples' Rights (African Commission) at its 51st Ordinary Session held from 18 April - 2 May 2012 in Banjul, The Gambia;

RECALLING its mandate to promote and protect human and peoples' rights in Africa under the African Charter on Human and Peoples' Rights (African Charter);

CONSIDERING that as part of fulfilling its mandate, the African Commission established various mechanisms for the promotion and protection of human and peoples' rights in Africa;

RECOGNIZING that the African Commission on Human and Peoples' Rights has the fundamental role to protect vulnerable groups in Africa from human rights violations;

FURTHER RECALLING its Resolution ACHPR/Res.163 (XLVII) 10, adopted at the 47th Ordinary Session of the African Commission on the establishment of a Committee on the Protection of the Rights of People Living with HIV (PLWHIV), and Those at Risk, Vulnerable to and Affected by HIV;

FURTHER RECALLING its Resolutions ACHPR/172 (XLVIII) 10 and ACHPR/Res.195 (L) 11 on the appointment of Members of the Committee and that of Commissioner Lucy Asuagbor as the Chairperson of the Committee on the Protection of the Rights of People Living with HIV (PLWHIV), and Those at Risk, Vulnerable to and Affected by HIV in Africa;

NOTING with satisfaction the work accomplished by the Committee on the Protection of the Rights of People Living with HIV (PLWHIV), and Those at Risk, Vulnerable to and Affected by HIV in Africa;

FURTHER NOTING that the mandate of the Committee on the Protection of the Rights of People Living with HIV, and Those at Risk, Vulnerable to and Affected by HIV/AIDS and that of its Members come to an end during this Session;

BEARING in mind the need for the Committee to continue with its activities and implement the action plan it adopted recently;

DECIDES to extend the mandate of the Committee and the following members for another term of two years with effect from 2 May 2012:

a) Commissioner members of the Committee:

1. Honourable Commissaire Lucy ASUAGBOR, the Chairperson;
2. Honourable Reine ALAPINI GANSOU, Member;
3. Honourable Soyata MAIGA, Member;

b) Experts Members of the Committee:

1. Mme Agnès ATIM APEA (Uganda);
2. M. Patrick Michael EBA (Côte d'Ivoire);
3. M. Patrick Le doux DUTZUE FOGUE (Cameroon);
4. M. Christian GARUKA NSABIMANA (Rwanda);
5. Mme Nicolette MERELE NAYLOR (South Africa);
6. M. Ebenezer TOPE DUROJAYIE (Nigeria);

Done in Banjul, The Gambia, 2 May 2012

C8 General Comments on Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2012)

Adopted at the 52nd Ordinary Session held in Cote d'Ivoire October 2012

Introduction

1. General Comments are used by human rights treaty bodies to interpret the provisions of relevant international legal instruments, with a view to assisting States to fulfil their obligations under such instruments. The competence of the African Commission on Human and Peoples' Rights (the African Commission) to adopt General Comments is derived from Article 45 (1) (b) of the African Charter on Human and Peoples' Rights (the African Charter), which authorises the African Commission to "formulate and lay down principles and rules aimed at solving legal problems relating to human and peoples' rights". As a complementary legal instrument to the African Charter, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Protocol) by necessary implications falls within the Commission's interpretative scope.
2. The Protocol was adopted by the African Union in 2003, and entered into force in 2005. It complements the African Charter by expanding the substantive protection of women's rights in Africa, including by explicitly providing for their health and reproductive rights. Under the Protocol, the term 'women' includes girls.
3. According to available data, women in Sub-Saharan Africa are at a disproportionate risk of HIV infection[1] Most recent figures indicate that women comprise 59% of people living with HIV in this region.[2] In Sub-Saharan Africa, young women aged 15 to 24 years are as much as eight times more likely than men to be living with HIV.[3] Given the susceptibility of women to HIV and related rights abuses in Africa, the African Commission recognises that the societal context based on gender inequalities, power imbalances and male dominance has to be addressed and transformed in order for women to meaningfully claim and enjoy freedom from violence, abuse, coercion and discrimination.
4. According to the African Commission there are multiple forms of discrimination based on various grounds such as: race, sex, sexuality, sexual orientation, age, pregnancy, marital status, HIV status, social and economic status, disability, harmful customary practices and/or religion. In addition, the African Commission recognises that these forms of discrimination, individually or collectively, prevent women from realising their right to self-protection and to be protected.
5. The African Commission recognises that women in Africa have the right to the highest attainable standard of health which includes sexual and reproductive health and rights. Amidst high prevalence and significant risk of HIV exposure and transmission, women are unable to fully enjoy these rights. Notably, the limitation of women's rights in the context of sexual and reproductive health increases the likelihood to HIV exposure and transmission. This is further compounded for women living with HIV whose access to these rights is severely limited or denied as a result of HIV-related discrimination, stigma, prejudices and harmful customary practices.
6. Addressing the issue of HIV for the first time in an international legally binding instrument, Article 14 (1) (d) and (e) of the Protocol specifically deals with HIV. While the African Commission welcomes the explicit mention of HIV, it notes that the provisions are framed in open-ended language and in broad terms, and that reference is made to international standards without stipulating their content. There is, therefore, a need to adopt these General Comments to guide States action in line with these provisions of the Protocol.
7. While these General Comments focus on Article 14 (1) (d) & (e), this article should not be read and understood in isolation from other provisions of the Protocol dealing with the intersecting aspects of women's human rights, such as gender inequality, gender-based violence, harmful customary practices, and access to socio-economic rights.

8. The African Commission welcomes the commitments made by African governments recognizing the need for enhanced efforts to promote and protect women's sexual and reproductive health rights such as the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja Declaration), the 2006 Continental Policy Framework on Sexual and Reproductive Health and Rights, and the Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights (Maputo Plan of Action) adopted in 2006.

9. Further, while Article 14 (1) (d) and (e) in focus refers to sexually transmitted infections, it must be noted that the focus on HIV in this document is deliberate in light of the disproportionate effect that HIV has on women's health in Africa. The aspects elaborated herein are also applicable to other sexually transmitted diseases.

Normative content

Article 14 (1)(d): The right to self-protection and the right to be protected from HIV and sexually transmitted infections

10. Although the Women's Rights Protocol distinguishes between the right to self-protection and the right to be protected from HIV in Article 14 (1) (d), this provision is interpreted to refer to States' overall obligation to create an enabling, supportive, legal and social environment that empowers women to be in a position to fully and freely realise their right to self-protection and to be protected.

11. The right to self-protection and to be protected includes women's rights to access information, education and sexual and reproductive health services. The right to self-protection and the right to be protected are also intrinsically linked to other women's rights including the right to equality and non-discrimination, life, dignity, health, self-determination, privacy and the right to be free from all forms of violence. The violations of these rights will impact on women's ability to claim and realise her right to self-protection.

Article 14 (1)(e): The right to be informed on one's health status and the health status of one's partner

12. Article 14 (1) (e) defines the right to sexual and reproductive health to include the right to be informed on one's health status and the health status of one's partner. Health status refers to the complete state of a person's physical, mental and social well-being and not merely the absence of disease or infirmity.[4]

13. The right to be informed on one's health status includes the rights of women to access adequate, reliable, non-discriminatory and comprehensive information about their health. This also involves access to procedures, technologies and services for the determination of their health status. In the context of HIV, this right includes, but is not limited to: access to HIV testing, CD4 count, viral-load, TB and cervical cancer screening.

14. Moreover, the right to be informed on one's health status must not only encompass knowing one's HIV status, but should also include pre-test counselling which enables women to make a decision based on informed consent before taking the test, as well as post-test counselling services on preventative measures or available treatment depending on the outcome of the HIV test.

15. The right to be informed on one's health status is applicable to all women irrespective of their marital status, including: young and adolescent women, older women, rural women, women who engage in sex work, women who use drugs, women living with HIV, migrant and refugee women, indigenous women, detained women, and women with physical and mental disabilities.

16. The right to be informed on the health status of one's partner is vital. It enables women to make informed decisions about their own health, especially where they may be exposed to a substantial risk of harm. Knowledge of a partner's health to help avoiding transmission of HIV and other sexually transmitted infections. Information on a partner's health status must be obtained with informed consent in line with international standards, without coercion, and should be primarily aimed at preventing harm to one's health.

17. Caution should be exercised in relation to the conditions and environments under which the right to be

informed on the health status of one's partner may be exercised, in particular, where the revealing of a partner's health status may result in negative consequences such as harassment, abandonment and violence.

18. Information about the health status of one's partner may be obtained through notification by a third party (usually a healthcare worker) or disclosure (for instance, by the person themselves). Disclosure of one's health status is not always explicit. It may take various forms, including coded and implicit actions, by the person concerned. Coded or implicit actions may include disclosure that allows for the communication of a person's health status in a manner other than direct verbal dialogue. States must ensure that all forms of disclosure are recognised.

19. While disclosure should be encouraged, there should be no requirement to reveal one's HIV status or other information related to one's health status. In the context of HIV, healthcare workers should be authorised, without being obliged to, decide, depending on the nature of the case and according to ethical considerations, whether to inform a patient's sexual partners of his or her HIV positive status. Such a decision should be made in line with international standards, in accordance with the following principles:[5]

    i. The HIV-positive person in question has been thoroughly counselled;
    ii. Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
    iii. The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
    iv. A real risk of HIV transmission to the partner(s) exists;
    v. The HIV positive person is given reasonable advance notice;
    vi. The identity of the person is not revealed to the partner (s), if practicable, otherwise identity is revealed;
    vii. Follow-up is provided to ensure support to those involved, as necessary; and
    viii. The person providing HIV treatment, care, or counselling services has ensured that the person living with HIV is not at risk of physical violence resulting from the notification.

The revealing of a person's health status by a third party outside the ambit of the abovementioned guidelines is unlawful and may lead to penal sanctions.

General State Obligations

Respect, protect, promote and fulfil

20. Article 14 (1) (d) and (e), like any other human rights provision, imposes four sets of general obligations on States Parties namely to respect, protect, promote and fulfil.

21. The obligation to respect in relation to Article 14 (1) (d) & (e) requires States to refrain from interfering directly or indirectly with the rights to self-protection, to be protected, and the right to be informed on one's health status and the health status of one's partner.

22. The obligation to protect in relation to Article 14 (1) (d) and (e) requires States to take measures that prevent third parties from interfering with these rights. Special attention, in the implementation of this obligation, should be given to action by third parties that may impact on the right to sexual and reproductive health of all women, including those mentioned under paragraph 14 above.

23. The obligation to promote in relation to Article 14 (1) (d) and (e) requires States to create the legal, social and economic conditions that enable women to exercise their rights in relation to sexual and reproductive health. This involves engaging in sensitisation activities, community mobilisation, training of healthcare workers, religious, traditional and political leaders on the importance of the right to protection and to be informed on one's status and that of one's partner.

24. The obligation to fulfil in relation to Article 14 (1) (d) and (e) requires States to adopt all the necessary measures, including allocation of adequate resources for the full realisation of the right to self-protection and to be protected and the right to be informed on one's health status and the health status of one's partner.

Specific State Obligations

25. The right to self-protection and to be protected against sexually transmitted infections, including HIV in Article 14(1)(d) of the Protocol entails the following:

Access to information and education

26. The African Commission wishes to emphasise the importance of information and education on HIV prevention for women, in particular adolescents and youths. States Parties must guarantee information and education on sex, sexuality, HIV, sexual and reproductive rights. The content must be evidence-based, facts-based, rights-based, non-judgemental and understandable in content and language. This information and education should address all taboos and misconceptions relating to sexual and reproductive health issues, deconstruct men and women's roles in society, and challenge conventional notions of masculinity and femininity which perpetuate stereotypes harmful to women's health and well-being. This should be pursued in line with the Maputo Plan of Action as well as articles 2 and 5 of the Protocol.

27. States Parties should provide educational programmes and access to information concerning HIV, including through sex education and public awareness campaigns, on available health services responsive to all women's realities in all contexts including those mentioned under paragraph 14 above. In addition, States Parties should ensure that educational institutions (primary and secondary schools), include HIV and human rights issues in their curricula. These should include HIV risk and transmission, prevention, testing, treatment, care and support and sexual and reproductive health and rights of women. States Parties must also ensure this education reaches women and girls in informal school systems including faith-based schools, as well as those out of school.

28. States Parties are obliged to provide appropriate pre-service and on-going in-service training for health providers and educators, including community based health care providers, on health and human rights.

Access to sexual and reproductive health services

29. Ensuring availability, accessibility, acceptability and quality sexual and reproductive health care services for women is crucial. Therefore, States Parties have the obligation to ensure comprehensive, integrated, rights-based, women-centred and youth friendly services that are free of coercion, discrimination and violence.

30. The African Commission is concerned about the limitations on and insufficient access to women's sexual and reproductive health services including access to prevention choices and methods, STI and HIV prevention skills, and access to treatment. States Parties must guarantee available, accessible, affordable, comprehensive and quality women-centred HIV prevention methods, which include female condoms, microbicides, prevention of mother-to-child transmission, and post-exposure prophylaxis to all women not based on a discriminatory assessment of risk.

31. States Parties should also ensure that health workers are not allowed, on the basis of religion or conscience, to deny access to sexual and reproductive health services to women as highlighted in this document.

32. States Parties should integrate women-centred prevention methods with other services, including family planning, reproductive health, primary health care services, HIV and STI testing, antiretroviral treatment programmes and antenatal care. More equitable availability and access to prevention methods such as female condoms should be promoted and ensured by having adequate and sustainable planning, funding and distribution, together with the provision of new prevention technologies or methods. To this end, States Parties should ensure on-going funding for research.

Enabling legal and policy framework

33. The African Commission recognises that an enabling legal and policy framework is intrinsically linked to women's right to equality, non-discrimination and self-protection. States Parties have an obligation to create an enabling supportive, legal and social environment to allowing to control their sexual and reproductive choices and thus to strengthen control over HIV prevention and protection choices.

34. States Parties should ensure implementation of laws and policies through establishment of accountability mechanisms, the development of implementing guidelines, a monitoring and evaluation framework, and the provision of timely and effective redress mechanisms where women's sexual and reproductive health rights have been violated.

35. The African Commission wishes to stress that, as the duty of States Parties includes ensuring that women are in the position to claim and exercise their right to self-protection in a non-discriminatory framework as articulated in Article 2 of the Protocol, States Parties should enact laws and policies to ensure women's access to health and legal services. In particular, States Parties should enact anti-discrimination legislation to address HIV- and other sexually transmitted infections, related discrimination, stigma, prejudices and practices that perpetuate and heighten women's risk to HIV and related rights abuses. Where discriminatory laws and policies exist, States must take immediate action to remove these legal and policy barriers that hinder women's access to sexual and reproductive health services.

36. The right to be informed on one's health status and the health status of one's partner in Article 14 (1) (e) of the Protocol entails the following:

Access to information and education

37. In realising their specific obligations under Article 14 (1) (e), the African Commission reiterates the importance of States Parties' obligations in relation to access to information and education as highlighted in paragraph 26 above.

38. In view of the serious nature of HIV testing and in order to maximise prevention and care, public health legislation should ensure that pre-and post-test counselling be provided in all cases. With the introduction of home-testing, States Parties should ensure quality control, and establish legal and support services for those who are the victims of misuse of such tests by others.

39. States Parties should ensure that information on one's health status held by authorities is subject to strict rules of data protection and confidentiality, and must be protected from unauthorised collection, use or disclosure.

Sexual and reproductive health procedures, technologies and services

40. States Parties are obliged to guarantee the availability, accessibility and affordability of comprehensive and quality procedures, evidence based technologies and services for the medical monitoring of one's sexual and reproductive health. These procedures, technologies and services should be evidence-based and should be appropriate to the specific needs and context of women. In the context of HIV, this should include: access to HIV testing, CD4 count, viral-load, TB and cervical cancer screening that may affect women's sexual and reproductive health.

41. States parties should provide training for healthcare workers on, amongst others, non-discrimination, confidentiality, respect for dignity, autonomy and informed consent in the context of sexual and reproductive health services for women.

42. States Parties must ensure that testing is not used as a condition for access to other health services, including treatment, contraception, abortion, medical examination, pre- and post-natal services, or any other reproductive health care. Furthermore, positive test results should not be a basis for coercive practices, or, the withholding of services.

43. States Parties should ensure that policies and programmes are sensitive to the needs of all women taking heed of the varying specificities of different groups of women highlighted in paragraph 14 above. These methods should include youth friendly services, and be part of a comprehensive package of care in the context of sexual and reproductive health.

44. The specific approaches mentioned in paragraph 39 above must ensure that these procedures, technologies and services are available in a manner that complies with ethical standards, is confidential, voluntary and obtained with informed consent.

45. States Parties should create safe and enabling conditions through legal, policy, regulatory and programmatic measures that create positive conditions for informed disclosure and lawful notification of one's health status and the health status of one's partner as enumerated in paragraphs 13 and 18 respectively.

Barriers to sexual and reproductive health rights

46. States Parties should take all appropriate measures, through policies, programmes and awareness-raising towards the elimination of all barriers to women and girls enjoyment of sexual and reproductive health. In particular, specific efforts should be made to address gender disparities, harmful traditional and cultural practices, patriarchal attitudes, discriminatory laws and policies in accordance with articles 2 and 5 of the Protocol. In this regard, States should collaborate with traditional and religious leaders, social movements, civil society, non-governmental organisations including women-centred NGOs, international organisations and development partners.

47. States should take all appropriate measures to eliminate economic and geographic barriers of women in accessing health services and thus bring such services closer to communities, particularly for women residing in rural communities.

Provision of financial resources

48. States Parties, in line with Article 26 (2) of the Protocol and paragraph 7 of the Maputo Plan of Action, should fund and empower public health authorities to provide a comprehensive range of services for the prevention and treatment of every person's sexual and reproductive health.

Redress for sexual and reproductive health violations

49. States shall ensure the availability and accessibility of redress and referral mechanisms such as legal and medical services in cases of violations of women sexual and reproductive rights, including non-discrimination, confidentiality, respect of autonomy and informed consent.

50. Failure by a State Party to comply with Article 14(1) (d) and (e) as clarified and enumerated in these General Comments will amount to a violation of the provisions of the said article.

51. The African Commission in deciding a communication and examining State reports relating to obligations under Article 14(1) (d) and (e) of the Protocol will be guided by these General Comments.

52. States are encouraged to submit timely periodic reports on measures taken to implement the African Women's Rights Protocol in line with Article 26 (1). Reports should include consideration of these General Comments and should respect the guidelines developed by the African Commission for this purpose.

Footnotes

[1] UNAIDS Progress Report 2011 p 19.

[2] As above, figures from 2010.

[3] UNAIDS Factsheet: Women, Girls and HIV (2012).

[4] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946 and entered into force on 7 April 1948.

[5] International Guidelines on HIV and Human Rights para 20(g) and SADC model law on HIV in Southern Africa.

D Decisions of the African Commission

1 25/89-47/90-56/91-100/93 : *Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine des Droits de l'Homme, Les Témoins de Jehovah / DRC* (1995)

2 137/94-139/94-154/96-161/97 : *International PEN, Constitutional Rights Project, Civil Liberties Organisation and Interights (on behalf of Ken Saro-Wiwa Jnr.) / Nigeria* (1998)

3 105/93-128/94-130/94-152/96 : *Media Rights Agenda, Constitutional Rights Project, Media Rights Agenda and Constitutional Rights Project / Nigeria* (1998)

4 54/91-61/91-96/93-98/93-164/97_196/97-210/98 : *Malawi African Association, Amnesty International, Ms Sarr Diop, Union interafricaine des droits de l'Homme and RADDHO, Collectif des veuves et ayants-Droit, Association mauritanienne des droits de l'Homme / Mauritania* (2000)

5 155/96 : *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) / Nigeria* (2001)

6 241/01 : *Purohit and Moore / Gambia (The)* (2003)

7 227/99 : *Democratic Republic of Congo / Burundi, Rwanda, Uganda* (2003)

8 279/03-296/05 : *Sudan Human Rights Organisation & Centre on Housing Rights and Evictions (COHRE) / Sudan* (2009)

D1 25/89-47/90-56/91-100/93:
Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine des Droits de l'Homme, Les Témoins de Jehovah / DRC (1995)

Summary of Facts

1. Communication 25/89 is filed by the Free Legal Assistance Group, the Austrian Committee against Torture, and the Centre haitien des droits et libertés, all members of the World Organization against Torture (OMCT). The submission of the Free Legal Assistance Group was dated 17th March 1989, that of the Austrian Committee against Torture dated 29th March 1989, that of the Centre Haitien dated 20th April 1989. The communication alleges the torture of 15 persons by a Military Unit, on or about 19th January 1989, at Kinsuka near the Zaire River. On 19th April 1989 when several people protested their treatment, they were detained and held indefinitely.
2. Communication 47/90, dated 16th October 1990 is filed by the Lawyers' Committee for Human Rights in New York. It alleges arbitrary arrests, arbitrary detentions, torture, extra-judicial executions, unfair trials, severe restrictions placed on the right to association and peaceful assembly, and suppression of the freedom of the Press.
3. Communication 56/91 is submitted by the Jehovah's Witnesses of Zaire and dated 27th March 1991. It alleges the persecution of the Jehovah's Witnesses, including arbitrary arrests, appropriation of church property, and exclusion from access to education.
4. Communication 100/93 is submitted by the Union interafricaine des droits de l'Homme and dated 20th March 1993. It makes allegations of torture, executions, arrests, detention, unfair trials, restrictions on freedom of association and freedom of the press. It also alleges that public finances were mismanaged; that the failure of the Government to provide basic services was degrading; that there was a shortage of medicines; that the universities and secondary schools had been closed for two years; that freedom of movement was violated; and that ethnic hatred was incited by the official media.
5. The African Commission, when it determined that the communications, taken together, evidenced a grave and massive violation of human rights in Zaire, brought the matter to the attention of the Assembly of the Heads of State of the Organisation of African Unity, in December 1995.
6. The Commission also requested that a mission consisting of two members of the Commission be received in that country, with the objective of discovering the extent and cause of human rights violations and endeavouring to help the government to ensure full respect for the African Charter. The government of Zaire has never responded to these requests for a mission.

Procedure

7. The Commission in June 1989 received communication 25/89. The Commission was seized of the communication at its 11th Session in October 1989 and the State of Zaire was notified on 14th March 1990.
8. Between 1990 and 1993, numerous reminders were sent by the Secretariat to the Government of Zaire, but no response was received.
9. The Secretariat also sent the Complainants regular updates on the status of the communications.
10. On 23rd September 1993, the Ministry of Justice of Zaire wrote that no copy of the communication had ever been received.
11. A copy was sent on 3rd March 1994 by registered post to the Embassy of Zaire in Dakar but no response was forthcoming.

12. At the 16th Session, held in April 1994, the Commission decided to send a mission to Zaire in order to create a dialogue.

13. At the 17th Session, held in March 1995, the Communications against Zaire were declared admissible.

14. The Government of Zaire was notified of this decision on 26th April 1995.

15. At the 18th Session, held in October 1995, the Commission decided to apply Article 58(1) of the Charter and to draw the attention of the Heads of State and Government to the serious and massive violations of human rights in Zaire.

16. On 12th January 1996, a Note Verbale was sent to the Ministry of Foreign Affairs of Zaire informing the Ministry of the proposed mission to Zaire to be undertaken by Commissioner Nguema and Ben Salem.

17. Communication No. 47/90 was received by the Commission in October 1990.

18. On 20th October 1990, at its 8th Ordinary Session in Banjul, the African Commission was seized of the communication and decided to notify the State of Zaire of the complaint and invite its written comments on the admissibility.

19. On 6th November 1990, the Secretariat of the Commission informed the Ministry of Zaire of this decision by registered post. No response was forthcoming.

20. At its 11th Ordinary Session, the Commission decided to send a reminder to Zaire. The Secretariat sent this reminder on 30th March 1992. No response was forthcoming.

21. At its 12th Ordinary Session, held in Banjul in October 1992, the Commission declared the communication admissible and decided that it would be examined on the merits.

22. The notice of this decision was sent on 16th November 1992. No response was forthcoming.

23. In 1993 and 1994, the Secretariat sent several reminders to the government of Zaire. No response was received.

24. From August 1994 to the present, the correspondence in respect of this communication is identical with that in the communication 25/89, above.

25. Communication No. 56/91 was received by the Commission in summer 1991.

26. The Commission was seized of the communication at its 10th Session in October 1991 and a notification was sent to the State on 14th November 1991. No response was forthcoming.

27. Two reminders were sent by the Secretariat to the Government of Zaire in 1992.

28. In a letter dated 14th September 1993, the Ministry of Justice of Zaire claimed that a copy of the communication had never been received.

29. A copy of the communication was sent 3rd March 1994 by registered post to the Embassy in Dakar,

but no response was received.

30. From August 1994, the correspondence in respect of this communication is identical with that in communication 25/89, given above.

31. Communication No. 100/93 was received by the Commission in April 1993.

32. The Commission was seized of the communication at its 13th Session in April 1993 and it was brought to the attention of the State on 12th April 1993. No response was forthcoming.

33. In 1993 and 1994, reminders were sent to the Government of Zaire but no response was forthcoming.

34. As from August 1994, the correspondence in respect of this communication is identical with that in communication 25/89, given above.1

Law

Admissibility

35. After deliberations, as envisioned by Article 58 of the African Charter, the Commission considered that communications 25/89, 47/90, 56/91 and 100/93 against Zaire reveal the existence of serious and massive violations of human rights.

36. Article 56 of the African Charter requires that Complainants exhaust local remedies before the Commission can take up a case, unless these remedies are as a practical matter unavailable or unduly prolonged. The requirement of exhaustion of local remedies is founded on the principle that a government should have notice of a human rights violation in order to have the opportunity to remedy such violations before being called before an international body. In this case, the government has had ample notice of the violation.

37. The Commission has never held the requirement of local remedies to apply literally in case where it is impractical or undesirable for the Complainant to seize the domestic courts in the case of each violation. This is the situation here, given the vast and varied scope of the violations alleged and the general situation prevailing in Zaire.

38. For the above reasons, the Commission declared the communications admissible.

Merits

39. The main goal of the communications procedure before the Commission is to initiate a positive dialogue, resulting in an amicable resolution between the complainant and the State concerned, which remedies the prejudice complained of. A pre-requisite for amicably remedying violations of the Charter is the good faith of the parties concerned, including their willingness to participate in a dialogue.

40. In the present case, there has been no substantive response from the Government of Zaire, despite the numerous notifications of the communications sent by the African Commission. The African Commission, in several previous decisions, has set out the principle that where allegations of human rights abuse go uncontested by the government concerned, even after repeated notifications, the Commission must decide on the facts provided by the Complainant and treat those facts as given. 2 This principle conforms with the practice of other international human rights adjudicatory bodies and the Commission's duty to protect human rights. Since the Government of Zaire does not wish to participate in a dialogue, the Commission must, regrettably, continue its consideration of the case on the basis of facts and opinions submitted by the Complainants alone.

41. Article 5 of the African Charter prohibits torture and inhuman or degrading treatment. The torture of 15 persons by a military unity at Kinsuka, near the Zaire River, as alleged in communication 25/89, constitutes a violation of this article.

42. Article 6 of the African Charter guarantees the right to liberty and security of person. The indefinite detention of those who protested against torture, as described in communication 25/89, violates Article 6.

43. Article 4 of the African Charter protects the rights to life. Communication 47/90, in addition to alleged arbitrary arrests, arbitrary detention and torture, alleges extrajudicial executions which are a violation of Article 4.

44. Article 7 of the African Charter specifies the right to have one's cause heard. The unfair trials described in communication 47/90 constitute a violation of this right.

45. Article 8 of the African Charter protects freedom of conscience. The harassment of the Jehovah's Witnesses, as described in communication 56/91, constitutes a violation of this article, since the government has presented no evidence that the practice of their religion in any way threatens law and order. The arbitrary arrests of believers of this religion likewise constitute a contravention of Article 6, above.

46. The torture, executions, arrests, detention, unfair trials, restrictions on freedom of association and freedom of the press described in communication 100/93 violate the above articles.

47. Article 16 of the African Charter states that every individual shall have the right to enjoy the best attainable state of physical and mental health, and that States Parties should take the necessary measures to protect the health of their people. 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.

48. Article 17 of the Charter guarantees the right to education. The closures of universities and secondary schools as described in communication 100/93 constitutes a violation of Article 17.

Holding

For these reasons, the Commission

Holds that the facts constitute serious and massive violations of the African Charter, namely of Articles 4, 5, 6, 7, 8, 16 and 17.

Taken at the 18th Ordinary Session, Praia, Cape Verde, October 1995.

Footnotes

1. The French language version is more detailed and contains more paragraphs (64 paragraphs) than the English language version (48 paragraphs in all).

2. See, e.g. the Commission's decisions in communications 59/91, 60/91, 87/93 and 101/93.

D2 137/94-139/94-154/96-161/97:
International PEN, Constitutional Rights Project, Civil Liberties Organisation and Interights (on behalf of Ken Saro-Wiwa Jnr.) / Nigeria (1998)

The Facts as submitted by the authors

1. These communications were submitted to the African Commission by International Pen, the Constitutional Rights Project, INTERIGHTS [and Civil Liberties Organisation] respectively. They were joined because they all concern the detention and trial of Kenule Beeson Saro-Wiwa, a writer and Ogoni activist, president of the Movement for the Survival of the Ogoni People. The communications 139/94 and 154/96 also complain of similar human rights violations suffered by Mr Saro-Wiwa's co-defendants, also Ogoni leaders.
2. The communications 137/94 and 139/94 were submitted in 1994 before any trial began. After the murder of four Ogoni leaders on 21st May 1994, following riot during a public meeting organised by Movement for the Survival of the Ogoni Peoples (MOSOP) representing the rights of those who lived in oil producing areas of Ogoni land, Saro-Wiwa and many hundreds of others were arrested, Saro-Wiwa himself on 22nd May 1994 and the vice-president of MOSOP, Ledum Mitee, shortly thereafter. Both communications allege that Mr Saro-Wiwa was severely beaten during the first days of his detention and was held for several days in leg irons and handcuffs. He was also denied access to his lawyer and the medicine he needed to control his blood pressure, at times prevented from seeing his family, and held in very poor conditions.
3. In its communication, submitted on 9th September 1994, the Constitutional Rights Project included a list of 16 other Ogonis who had been held without charge or bail for what was at that time over three months. Both communications alleged that Mr Saro-Wiwa had been detained because of his political work in relation to MOSOP. He had been detained five times for brief periods since the beginning of 1993, and released each time without charge, except on one occasion in mid-1993 where he was held for several weeks and charged with unlawful assembly.
4. The State Military Administrator declared that Mr Saro-Wiwa and his co-defendants had incited members of MOSOP to murder four rival Ogoni leaders, but no charges were brought until 28th January 1995. In the months between arrest and the beginning of the trial, the defendants were not allowed to meet with their lawyers, and no information on the charges was provided to the defence.
5. In February 1995 the trial of the defendants began before a tribunal established under the Civil Disturbances Act. The three members of this tribunal were appointed directly by General Abacha in November 1994, although counsel for the Rivers State Administrator argued in August that the cases were within the exclusive jurisdiction of the Rivers State High Court, since Rivers State is where the offences occurred.
6. In June 1995 the Constitutional Rights Project submitted a supplement to its communication, alleging irregularities in the conduct of the trial itself: harassment of defence counsel, a military officer's presence at what should have been confidential meetings between defendants and their counsel, bribery of witnesses, and evidence of bias on the part of the tribunal members themselves. In October 1995 PEN also copied to the Commission a letter it sent to General Abacha protesting the lack of concrete evidence and the unfair conduct of the trial.
7. On 30th and 31st October 1995, Ken Saro-Wiwa and eight of the co-defendants (Saturday Dobee, Felix Nuate, Nordu Eawo, Paul Levura, Daniel Gbokoo, Barinem Kiobel, John Kpunien and Baribor Bera) were sentenced to death, while six others including Mr Mitee were acquitted. The CRP submitted an emergency supplement to its communication on 2nd November 1995, asking the Commission to adopt provisional measures to prevent the executions.
8. The Secretariat of the Commission faxed a Note Verbale invoking interim measures under revised Rule 111 of the Commission's Rules of Procedure to the Ministry of Foreign Affairs of Nigeria, the Secretary General of the OAU, the Special Advisor (Legal) to the Head of State, the Ministry of Justice of Nigeria, and the Nigerian High Commission in The Gambia. The Note Verbale pointed out that as the case of Mr

Saro-Wiwa and the others was already before the Commission, and the government of Nigeria had invited the Commission to undertake a mission to that country, during which mission the communications would be discussed, the executions should be delayed until the Commission had discussed the case with the Nigerian authorities.

9. No response to this appeal was received before the executions were carried out.

10. On 7th November 1995 the Provisional Ruling Council (PRC) confirmed the sentences of death and on 10th November 1995 all the accused persons were executed in secret at the Port Harcourt Prison. By section 7 of the Civil Disturbances (Special Tribunals) Decree No. 2 of 1987, under which the executed persons were tried, the PRC are required to receive the records of the trial Tribunal before confirmation of the decision is possible. These records were not prepared by the Tribunal and so were not available for the PRC.

11. In 1996 the Secretariat received a communication from INTERIGHTS representing Ken Saro-Wiwa Jr. It alleged that the condemned persons had been detained arbitrarily prior to and during the trial and that they had been subjected to torture in the Army camp. Furthermore it alleged serious irregularities concerning the conduct of the trial: that the tribunals that convicted the accused persons were not independent; that there was no presumption of innocence; that the accused persons had not been given time or facilities in which to prepare their defence; that they had been denied legal representation by a counsel of their choice; that there was no right of appeal and that following the sentencing the persons were held incommunicado. INTERIGHTS asserted that they were tried, convicted and sentenced to death for the peaceful expression of their views and opinions on the violations of the rights of the Ogoni people.

12. In December 1996 the Secretariat received a communication from the Civil Liberties Organisation, alleging that the Civil Disturbances (Special Tribunal) Decree is invalid because it was made without participation of the people; that its composition with military officers and members of the Provisional Ruling Council meant that it could not be impartial; and that the lack of judicial review of the decisions of this tribunal amount to a violation of the right to appeal and fair trial. The communication alleges that the trial, conviction and sentencing of Ken Saro-Wiwa and others violated Articles 7(1) (b), 7(1) (c) and 7(1)(d) of the African Charter, and that the execution of these persons violates Article 4. The communication alleges that the arraignment of 19 more alleged suspects constitutes another potential violation of the Charter.

Complaint

13. The communications allege violation of Articles 1, 4, 5, 7, 9, 10, 11, 16 and 26 of the African Charter.

The State response and observations

14. The government argues that its actions were necessary to protect the rights of the citizens who had been murdered; that the tribunal which tried Saro-Wiwa was competent because two of its three members were lawyers; that the process of confirmation by a state government was an adequate appeal; that the Civil Disturbances Decree had not been protested upon its enactment in 1987 and that it had been set up to deal with a crisis situation.

Procedure before the Commission

15. Communication 137/94 is dated 28th September 1994 and was submitted by International Pen.

16. Communication 139/94 is submitted by Constitutional Rights Project and dated 9th September 1994.

17. The Commission was seized of the communications at its 16th Session in October 1994, but deferred its decision on admissibility pending notification and receipt of additional information from the Nigerian Government.

18. At the 16th session the Commission decided to merge the communications.

19. On 9th November 1994, a notification of the two communications was sent to the Nigerian Government and Rule 109 of the Rules of Procedure was invoked, requesting the Nigerian Government not to cause irreparable prejudice to Mr. Saro-Wiwa.

20. On 6th February 1995 a letter was received from International Pen stating that Mr Saro-Wiwa was being ill-treated and that he was facing the death penalty.

21. On 13th February a letter was sent to the Nigerian Government re-emphasising the need for Rule 109 to be applied.

22. On 22nd February 1995, a letter was received from Complainants stating that Ken Saro-Wiwa had been charged and was scheduled to appear before a three person tribunal from which there was no right of appeal. The tribunal members are chosen by General Abacha in violation of international fair trial standards. The complainant recognised that local remedies had yet to be exhausted and announced its intention to present an update of the case to the Commission once the trial was completed.

23. At the 17th Session the Commission declared the communications admissible. They were to be heard on their merits at the 18th Session.

24. On 20th April 1995, letters were sent to the Government of Nigeria and the complainants informing them of this.

25. On 28th June 1995 a letter was received from the Constitutional Rights Project describing developments in the case.

26. On 1st September 1995, a letter was sent to the government of Nigeria stating that the communication would be heard on the merits at the 18th Session of the Commission and inviting the government to send a representative.

27. At the 18th Session the Commission decided that the communications should be taken up by the mission planned for Nigeria.

28. On 9th October 1995 a letter was received from PEN American Centre expressing concern for the state of health of Mr Saro-Wiwa.

29. On 1st November 1995, upon hearing that a death sentence had been passed on Mr Saro-Wiwa and eight of his co-defendants, the Secretariat faxed a Note Verbale to the government of Nigeria, invoking the revised Rule 111 of Procedure (formerly 109) asking that the executions should be delayed until the Commission had taken its mission and spoken with the competent authorities. This Note Verbale was also faxed to the Secretary General of the OAU, the Nigerian High Commission in Banjul, and the Special Adviser (Legal) to the Head of State of Nigeria.

30. On 2nd November 1995 a letter was received from the Constitutional Rights Project notifying the Secretariat of the death sentences and requesting that provisional measures be invoked.

31. On 9th November 1995 Commissioner Dankwa, hearing that the death sentence had been confirmed, wrote to the Secretariat requesting such action. He was faxed a copy of the Note Verbale.

32. On 20th November 1995 the Secretariat received a Note Verbale from the Nigerian High Commissioner in Banjul, attempting to justify the executions.

33. On 21st November 1995 the Secretariat wrote a Note Verbale to the Nigerian High Commission in Banjul, requesting the official judgement in the Saro-Wiwa case, which had been mentioned in the Note Verbale.

34. On 30th November 1995 a letter was sent to the Complainants stating that the communications would be taken up by the Commission's mission to Nigeria.

35. On 13th December 1995, the Secretariat received a letter dated 13th November 1995 from the office of the Special Adviser to the Head of State, attempting to justify the executions.

36. On 18th and 19th December 1995, the Commission held an extraordinary session on Nigeria in Kampala.

37. On 26th January 1996 a letter was sent to the Constitutional Rights Project informing it of the interim measures taken with regard to Ken Saro-Wiwa.

38. At the 19th Session, held in March/April 1996 in Ouagadougou, Burkina Faso, the Commission heard statements from the government of Nigeria and the Complainants. Mr Chidi Anselm Odinkalu was

duly authorised to appear for the Complainants, and Mr Osah and Mr Bello appeared for the Nigerian Government. At the end of the hearing the Commission took a general view on the cases and deferred taking final decision in each case pending the accomplishment of its proposed mission to Nigeria. The Commission proposed May 1996 as the dates for the visit. The Nigerian delegation said they will communicate these dates to the Government of Nigeria for confirmation.

39. On 8th May 1996 the Commission wrote to the Nigerian Government, Constitutional Rights Project and International PEN informing them that a decision had been taken at the 19th Session to send a mission to the country where the cases would be taken up. At the 20th Session held in Grand Bay, Mauritius, October 1996, the Commission decided to postpone the final decision on the merits of the communications to the next session, awaiting the result of the planned mission to Nigeria. The Commission also decided to join communication 154/96 with these communications.

40. On 10th December 1996 the Secretariat sent letters to the Complainants informing them of the decisions of the Commission.

41. On 10th December 1996 the Secretariat sent a Note Verbale to the government informing it of the decisions of the Commission.

42. On 29th April, the Secretariat received a letter from Mr Olisa Agbakoba entitled 'Preliminary objections and observations to the Mission of the Commission which visited Nigeria from March 7th-14th 1997. The document was submitted on behalf of INTERIGTS with regard to 14 communications, including this one.

43. Among the objections raised and or observations made were: a) "the neutrality, credibility and relevance; and composition of the mission".

44. At its 21st Session held in April 1997, the Commission postponed taking decision on the Merits to the next session, pending the submission of scholarly article and court decisions by the complainants to assist it in its decision. The Commission also awaits further analysis of its report of the mission to Nigeria. It must be stated that Mr Chidi Odinkalu did send the article mentioned above.

45. On 22nd May, the Complainants were informed of the Commission's decision, while the State was informed on May 28th.

46. Communication 154/96 is dated 6th November 1995 and received at the Secretariat on 4th March 1996.

47. The communication requested the Commission to take interim measures to prevent the executions. A supplementary submission was sent with the communication informing the Commission that the executions had taken place on 10th November but that the communication was reaffirmed.

48. On 13th November 1995 the Nigerian Government wrote to the Commission informing it of the Government's view of the situation.

49. On 20th November 1995 the High Commission of Nigeria in The Gambia giving its opinion on the matter.

50. On 21st November 1995 the Commission wrote to the High Commission of Nigeria in The Gambia requesting a copy of the Justice's judgement in the case.

51. On 12th March 1996 a confirmation was sent to this effect by the Complainant.

52. At the 19th Session in March 1996 the communication was not considered, but the Commission took a general view of all the communications against Nigeria and deferred any decision on cases pending the accomplishment of its proposed mission to Nigeria.

53. On 13th August 1996 a complete copy of the communication was sent to the government of Nigeria.

54. On 13th August 1996 a letter was sent to the Complainant informing him of the status of the case.

55. On 4th February 1997, the Secretariat received a letter entitled supplementary submissions with respect to communication No. 154/96.

56. On 4th April, the Secretariat acknowledged receipt of the letter.

57. On 29th April, the Secretariat received a letter from Mr Olisa Agbakoba entitled 'Preliminary objections and observations' to the Mission of the Commission which visited Nigeria from March 7th-14th 1997. The document was submitted on behalf of INTERIGHTS with regard to 14 communications, including this one.

58. Among the objections raised and or observations made were: a) the neutrality, credibility and relevance; and composition of the mission.

59. At its 21st Session held in April 1997, the Commission postponed taking decision on the merits to the next session, pending the submission of scholarly articles and court case by the Complainants to assist it in its decision. The Commission also awaits further analysis of its report of the mission to Nigeria.

60. On 22nd May, the Complainants were informed of the Commission's decision, while the State was informed on May 28th.

61. On May 27th, the Secretariat received a letter from the Complainant entitled 'Additional Information on Ouster Clauses in Nigerian Law' in which he promised to furnish the Secretariat with the information requested by the Commission at its 21st Session "within the next three weeks".

62. From this day on the procedure is identical to communications 137/94 and 139/94.

63. Communication 161/97 was received on 10th January 1997.

64. On 14th January 1997 a Note Verbale with a copy of the communication was sent to the Ministry of External Affairs, copy to the Special Legal Adviser to the Head of State, the Nigerian High Commission, and the Embassy of Nigeria in Addis Ababa.

65. On 23rd January 1997 an acknowledgement of receipt was sent to the Complainant.

66. At its 21st Session held in April 1997, the Commission postponed taking decision on the merits to the next session, pending the submission of scholarly articles and court case by the Complainants to assist it in its decision. The Commission also awaits further analysis of its report of the mission to Nigeria.

67. On 22nd May, the Complainants were informed of the Commission's decision, while the State was informed on May 28th.

68. At the 22nd Ordinary Session, the Commission postponed taking a decision on the cases pending the discussion of the Nigerian Mission report.

69. At the 23rd Ordinary Session held in Banjul The Gambia, from 20th-29th April 1998, the Commission was unable to consider the communication due to lack of time.

70. On 25th June 1998, letters were sent from the Secretariat of the Commission to all parties concerned regarding the status of the communications.

Law

Admissibility

71. Article 56 of the African Charter reads:

Communications...shall be considered if they: ...5. Are sent after exhausting local remedies, if any, unless it is obvious that this procedure is unduly prolonged...

72. This is just one of the 7 conditions specified by Article 56, but it is that which usually requires the most attention. Because Article 56 is necessarily the first considered by the Commission, before any substantive consideration of communications, it has already been the subject of substantial interpretation; in the jurisprudence of the African Commission, there are several important precedents.

73. Specifically, in the four decisions the Commission has already taken concerning Nigeria, Article 56(5) is analysed in terms of the Nigerian context. Communication 60/91 (Decision ACHPR/60/91) concerned the Robbery and Firearms Tribunal; Communication 87/93 (Decision ACHPR/87/93) concerned the Civil Disturbances Tribunal; Communication 101/93 (Decision ACHPR/101/93) concerned the Legal Practitioners Decree; and Communication 129/94 (ACHPR/129/94) concerned the Constitution (Modification and Suspension) Decree and the Political Parties (Dissolution) Decree.

74. All of the Decrees in question in the above communications contain "ouster" clauses. In the case of the special tribunals, these clauses prevent the ordinary courts from taking up cases placed before the special

tribunals or from entertaining any appeals from the decisions of the special tribunals. (ACHPR/60/91:13 and ACHPR/87/93:13). The Legal Practitioners Decree specifies that it cannot not be challenged in the courts and that anyone attempting to do so commits a crime (ACHPR/129/94:14 and ACHPR/129/94:15). The Constitution Suspension and Modification legally prohibited their challenge in the Nigerian Courts (ACHPR/129/94:14 and ACHPR/129/94:15).

75. In all of the cases cited above, the Commission found that the ouster clauses render local remedies non-existent, ineffective or illusory. They create a legal situation in which the judiciary can provide no check on the executive branch of government. A few courts in the Lagos district have occasionally found that they have jurisdiction; in 1995 the Court of Appeal in Lagos, relying on common law, found that courts should examine some decrees notwithstanding ouster clauses, where the decree is "offensive and utterly hostile to rationality" (Reprinted in the Constitutional Rights Journal). It remains to be seen whether any Nigerian courts will be courageous enough to follow this holding, and whether the government will abide by their rulings should they do so.

76. In the present case, while the above reasoning was used in the initial decisions on admissibility, it is at the present time unnecessary. In light of the fact that the subjects of the communications are now deceased, it is evident that no domestic remedy can now give the complainants the satisfaction they seek. The communications are thus admissible.

Merits

77. Article 5 of the Charter reads:

Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

78. Article 5 prohibits not only torture, but also cruel, inhuman or degrading treatment. This includes not only actions which cause serious physical or psychological suffering, but which humiliate the individual or force him or her to act against his will or conscience.

79. International PEN alleges that Ken Saro-Wiwa was kept in leg irons and handcuffs and subjected to ill-treatment including beatings and being held in cells which were airless and dirty, then denied medical attention, during the first days of his arrest. There was no evidence of any violent action on his part or escape attempts that would justify holding him in irons. Communication 154/96 alleges that all the victims were manacled in their cells, beaten and chained to the walls in their cells.

80. The government has made no written submission in these cases, and has not refuted these allegations in its oral presentation. It is well-established jurisprudence of the Commission that where allegations go entirely unchallenged, it will proceed to decide on the facts presented (See, e.g., the Commission's decisions in communications 59/91, 60/91, 64/92, 68/92, 78/92, 87/93 and 101/93). Thus, the Commission holds a violation of Article 5 of the Charter.

81. Article 6 of the African Charter reads:

Every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained.

82. All the victims were arrested and kept in detention for a lengthy period under the State Security (Detention of Persons) Act of 1984 and State Security (Detention of Persons) Amended Decree No. 14 (1994), that stipulates that the government can detain people without charge for as long as three months in the first instance. The decree also states that the courts cannot question any such detention or in any other way intervene on behalf of the detainees. This decree allows the government to arbitrarily hold people critical of the government for up to 3 months without having to explain themselves and without any opportunity for the complainant to challenge the arrest and detention before a court of law. The decree therefore prima facie violates the right not to be arbitrarily arrested or detained protected in Article 6.

83. The government has made no defence of this decree, either for its general validity or its justice as applied in this case. Thus, the Commission holds a violation of Article 6.

84. Article 7 of the African Charter reads:

1. Every individual shall have the right to have his cause heard. This comprises:

- *the right to appeal to competent national organs against acts of violating his fundamental rights;*
- *the right to be presumed innocent until proved guilty by a competent court or tribunal; the right to defence, including the right to be defended by counsel of his choice;*
- *the right to be tried within a reasonable time by an impartial court or tribunal.*

85. As regards the conduct of the trial itself, it is unnecessary for the Commission to delve into the specific circumstances, because by the Commission's own precedent the tribunal was defective. As will be recalled, in its decision on Communication 87/93, the Commission considered that special tribunals established under the Civil Disturbances Act violate Article 7(1)(d) of the African Charter, because their composition is at the discretion of the executive branch. Removing cases from the jurisdiction of the ordinary courts and placing them before an extension of the executive branch necessarily compromises their impartiality, which is required by the African Charter. This violation of the impartiality of tribunals occurs in principle, regardless of the qualifications of the individuals chosen for a particular tribunal.

86. The Note Verbale of the Nigerian High Commissioner in The Gambia points out that the tribunal was not a military one, but was presided over by a judge of the Nigerian Court of Appeal, and that tribunals are properly constituted in the Nigerian judicial system to deal with specific issues and for speedier dispensation of justice. The Note Verbale makes other specific points on the conduct of the trial, arguing for its fairness: the placement of evidence, its conduct in public, and the fact that some of the defendants were ultimately acquitted.

87. In its oral presentation at the 19th Session, the government argued that the confirmation of sentence given by the state governors is an adequate appeal.

88. The Commission might cite opposing facts, casting doubt upon the fairness of the tribunal. For example, The Head of State personally chose its members consisting of three instead of the five persons required by the Civil Disturbances Act. When defence counsel wrote to the Chief Judge of the Federal High Court on 27th November 1994 for information on when the trial would begin, the judge responded, "This Court has nothing to do about the Tribunal. It is the responsibility of the Presidency".

89. There is a great deal of information available from Nigerian and international sources on the day-to-day conduct of the tribunal and the significance of its legal rulings. Yet in reaching its decision, the Commission need only rely upon its earlier holding, made in less politically charged circumstances, that the special tribunals established under the Civil Disturbances Act are in violation of the African Charter. As a result, it finds that Ken Saro-Wiwa and his co-defendants were denied the right to a fair trial, in violation of Article 7(1)(d).

90. Section 7 of the Civil Disturbances (Special Tribunals) Decree No. 2 of 1987 decides that the confirming authority of judgments given under the act is the PRC, that is the ruling council of the Federal Military government, the members of which are exclusively members of the armed forces.

91. Section 8(1) of the same Decree stipulates:

The validity of any decision, sentence, judgement, confirmation, direction, notice or order given or made, as the case may be, or any other thing whatsoever done under this Act shall not be inquired into by any court of law.

92. In this case, it is not safe to view the Provisional Ruling Council as impartial or independent. Section 8(1) effectively ousts all possibility of appeal to the ordinary courts. Thus, the accused persons had no possibility of appeal to a competent national organ, and the Commission finds a violation of Article 7(1)(a).

93. Article 26 of the African Charter reads:

States parties to the present Charter shall have the duty to guarantee the independence of the Courts...

94. As stated above, the Special Tribunal and the Provisional Ruling Council are not independent. The Commission also finds that there is a violation of Article 26 of the African Charter.

95. The government has not contradicted the allegations contained in communication 154/96 that at the conviction in October 1995 the Tribunal itself admitted that there was no direct evidence linking the

accused to the act of the murders, but held that they had each failed to establish that they did not commit the crime alleged. Communication 154/96 has also affirmed that prior to and during the trial, leading representatives of the government pronounced MOSOP and the accused guilty of the crimes at various press conferences and before the United Nations. As the allegations have not been contradicted, the Commission find a violation of the right to be presumed innocent, Article 7(1)(b).

96. Initially, the accused were defended by a team of lawyers of their own choice. According to Communication 154/96 and Communication 139/94, this team withdrew from the case because of harassment, both in the conduct of the trial and in their professional and private lives outside. Communication 154/96 alleges that two of the lawyers were seriously assaulted by soldiers claiming to be acting on the instruction of the military officer responsible for the trial. On three occasions defence lawyers were arrested and detained and two of the lawyers had their offices searched. When these lawyers withdrew from the case, the harassment subsided.

97. After the withdrawal of their chosen counsel, the accused were defended by a team assigned by the Tribunal. However, this team also resigned, complaining of harassment. After that, the accused declined to accept a new team appointed by the Tribunal, and the court proceedings were closed without the accused having legal representation for the duration.

98. Communication 154/96 also claims that the defence was denied access to the evidence on which the prosecution was based and that files and documents which were required by the accused for their defence were removed from their residences and offices when they were searched by security forces on different occasions during the trial.

99. The government claims that: "Their [the accused] defence team which comprised sly human rights activists such as Femi Falana and Gani Fawehinmi, known to be more disposed towards melodrama than the actual defence of their clients, inexplicably withdrew from the Special Tribunal at a crucial stage of the trial in order to either play to the gallery or delay and frustrate the process".

100. This statement does not contradict the allegations of Communication 154/96, that two different defence teams were harassed into quitting the defence of the accused persons; it merely attributed malicious motives to the defence. The government has not responded to the allegations of withholding evidence from the defence. The Commission therefore finds itself with no alternative but to conclude that a violation of Article 7(1)(c) has occurred.

101. Article 4 of the African Charter reads:

Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.

102. Given that the trial which ordered the executions itself violates Article 7, any subsequent implementation of sentences renders the resulting deprivation of life arbitrary and in violation of Article 4. The violation is compounded by the fact that there were pending communications before the African Commission at the time of the executions, and the Commission had requested the government to avoid causing any "irreparable prejudice" to the subjects of the communications before the Commission had concluded it consideration. Executions had been stayed in Nigeria in the past on the invocation by the Commission of its rule on provisional measures (Rule 109 now Rule 111) and the Commission had hoped that a similar situation will obtain in the case of Ken Saro-Wiwa and others. It is a matter of deep regret that this did not happen.

103. The protection of the right to life in Article 4 also includes a duty for the state not to purposefully let a person die while in its custody. Here at least one of the victims' lives was seriously endangered by the denial of medication during detention. Thus, there are multiple violations of Article 4.

104. Article 11 of the African Charter provides:

Every individual shall have the right to assemble freely with others...

105. Communication 154/96 alleges that Article 11 was violated because the murder trial directly followed public meetings of MOSOP. In its judgement, the Tribunal held that the condemned persons "created the fire that consumed the four Ogoni chiefs" by wrongfully organising election campaign rallies and permitting a large crowd of fanatical MOSOP and NYCOP youths to congregate. It appears that the

Tribunal holds the accused responsible for the murders because they organised the rally after which the murders took place, although Ken Saro-Wiwa for one was prevented by government officials from attending the rally. The Commission has considerable difficulty with this position as it can adversely affect the right to assembly.

106. Article 10(1) of the African Charter reads:

Every individual shall have the right to free association provided that he abides by the law.

107. Communication 154/96 alleges that Article 10(1) was violated because the victims were tried and convicted for their opinions, as expressed through their work in MOSOP. In its judgement, the Tribunal held that by their membership in MOSOP, the condemned persons were responsible for the murders, guilt by association, it would seem furthermore that, government officials at different times during the trial declared MOSOP and the accused guilty of the charges, without waiting for the official judgement. This demonstrates a clear prejudice against the organisation MOSOP, which the government has done nothing to defend or justify. Therefore the Commission finds a violation of Article 10(1).

108. Article 9(2) of the African Charter reads:

Every individual shall have the right to express and disseminate his opinions within the law.

109. There is a close relationship between the rights expressed in the Articles 9(2), 10(1) and 11. Communication 154 alleges that the actual reason for the trial and the ultimate death sentences was the peaceful expression of views by the accused persons. The victims were disseminating information and opinions on the rights of the people who live in the oil producing area of Ogoniland, through MOSOP and specifically a rally. These allegations have not been contradicted by the government, which has already been shown to be highly prejudiced against MOSOP, without giving concrete justifications. MOSOP was founded specifically for the expression of views of the people who live in the oil producing areas, and the rally was organised with this in view. The Government's actions is inconsistent with Article 9(2) implicit when it violated Articles 10(1) and 11.

110. Article 16 of the Charter reads:

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.*

111. The responsibility of the government is heightened in cases where an individual is in its custody and therefore someone whose integrity and well-being is completely dependent on the actions of the authorities. The State has a direct responsibility in this case. Despite requests for hospital treatment made by a qualified prison doctor, these were denied to Ken Saro-Wiwa, causing his health to suffer to the point where his life was endangered. The government has not denied this allegation in any way. This is a violation of Article16.

112. Nigeria has been a State Party to the African Charter for over a decade, and is thus bound by Article 1 of the African Charter.

113. The Commission assists States parties to implement their obligations under the Charter. Rule 111 of the Commission's Rules of Procedure (revised) aims at preventing irreparable damage being caused to a complainant before the Commission. Execution in the face of the invocation of Rule 111 defeats the purpose of this important rule. The Commission had hoped that the Government of Nigeria would respond positively to its request for a stay of execution pending the former's determination of the communication before it.

114. This is a blot on the legal system of Nigeria that will not be easy to erase. To have carried out the execution in the face of pleas to the contrary by the Commission and world opinion is something that we pray will never happen again. That it is a violation of the Charter is an understatement.

115. The Nigerian Government itself recognises that human rights are no longer solely a matter of domestic concern. The African Charter was drafted and acceded to voluntarily by African States wishing to ensure the respect of human rights on this continent. Once ratified, States Parties to the Charter are legally bound to its provisions. A state not wishing to abide by the African Charter might have refrained from ratification. Once legally bound, however, a state must abide by the law in the same way an individual must.

Holding

For the above reasons, the Commission

- Decides that there has been a violation of Articles 5 and 16 in relation to Ken Saro-Wiwa's detention in 1993 and his treatment in detention in 1994 and 1995;
- Decides that there has been a violation of Article 6 in relation to the detention of all the victims under the State Security (Detention of Persons) Act of 1984 and State Security (Detention of Persons) Amended Decree No. 14 (1994). The government therefore has the obligation to annul these Decrees;
- Reiterates its decision on communication 87/93 that there has been a violation of Article 7(1)(d) and with regard to the establishment of the Civil Disturbances Tribunal. In ignoring this decision, Nigeria has violation Article 1 of the Charter;
- Decides that there has been a violation of Article 4 and 7 (1) (a), (b) (c) and (d) in relation to the conduct of the trial and the execution of the victims;
- Holds that there has been a violation of Articles 9(2), 10(1) and 11, 26, 16;
- Holds that in ignoring its obligations to institute provisional measures, Nigeria has violated Article 1.

Banjul, 31st October 1998.

D3 105/93-128/94-130/94-152/96 :

Media Rights Agenda, Constitutional Rights Project, Media Rights Agenda and Constitutional Rights Project / Nigeria (1998)

The Facts as Submitted by the Complainant

1. Communications 105/93, 128/94 and 130/94, 152/96 state that after the annulment of the Nigerian elections of 12th June 1993, several decrees were issued by the government. These proscribed the publication of two magazines. State officials sealed the premises of the two magazines embarking upon frequent seizures of copies of magazines critical of its decisions and arrest of newspaper vendors selling such magazines.
2. By decree, the government also proscribed 10 newspapers published by four different media organisations. The Complainant alleges that the newspapers and their operators were not previously accused of any wrongdoing either publicly or before a court of law or given any opportunity to defend themselves before their premises were sealed up on July 22nd and they were subsequently outlawed by Decree 48 of 1993, which was released on 16th August 1993.
3. Constitution (Suspension and Modification) Decree no. 107 of 17th November 1993 Article 5 specifies: "No question as to the validity of this Decree or any other Decree made during the period 31st December 1983 to 26th August 1993 or made after the commencement of this Decree or of an Edict shall be entertained by a court of law in Nigeria."
4. On 16th August 1993, the Government also announced the promulgation of the Newspaper Decree No. 43 of 1993. By virtue of Section 7 of the Decree, it is an offence, punishable with either a fine of N250.000 or imprisonment for a term of 7 years or both for a person to own, publish or print a newspaper not registered under the Decree. The registration of existing newspapers under a previously subsisting law (the Newspaper Act) is extinguished by the Decree.
5. The decision whether or not to register a newspaper is vested exclusively in the Newspapers Registration Board set up under the Decree. Compliance with the formal pre-registration requirements stipulated in the Decree does not guarantee registration of a newspaper because the Newspaper Registration Board has total discretion to decide whether the registration of a newspaper is "justified having regard to the public interest". There are no procedures for challenging the Board's decision not to register a newspaper.
6. If the Board decides to register a newspaper, N100.000 must be paid as registration fee. Furthermore, N250.000 must be deposited into a fund to meet the amount of any penalty imposed on or damages awarded against the owner, printer, or publisher of the newspaper by a court of law in the future. Under the Newspapers Act (now repealed by Decree 43), a bond for N500 with sureties was sufficient security for possible penalties or damages which might be imposed on or awarded against a newspaper.
7. Although released by the Government on 16th August 1993, the Decree is given a retroactive commencement date to 23rd June 1993 and persons intending to own, print or publish newspapers in Nigeria are obliged to apply for registration within three weeks of the commencement of the Decree (i.e. by 14th July 1993) after complication with pre-registration requirements, thus making all newspapers in Nigeria immediately "illegal", and owners, printers and publishers liable to be arrested and detained.
8. Communications 128/94 and 130/94 deal specifically with the events of 2nd January 1994 when 50,000 copies of TELL magazine were seized by heavily armed policemen and other security officers on the printer's premises. In addition, twelve films and fourteen plates, used for processing, were also confiscated. TELL is a popular weekly magazine whose aim is to promote and protect human rights in Nigeria. That week's issue was entitled: "The Return of Tyranny - Abacha bares his fangs". The story involved a critical analysis of certain legislation enacted by the military government which ousts the jurisdiction of the courts.

The complainant stated that no remedies were available at the local level, the jurisdiction of the courts having been ousted in considering the validity of such actions.

9. Communication 152/96 was submitted by Constitutional Rights Project. It states that on 23rd December 1995 Mr Nosa Igiebor, the Editor in Chief of TELL Magazine was arrested and detained. The Constitutional Rights Project alleges that he was not told the reason for his arrest and that no charge has been made against him. Furthermore, Constitutional Rights Project alleges that he has been denied access to his family, doctors and lawyers and that he has received no medical help even though his health is deteriorating.

10. Constitutional Rights Project also claim that TELL Magazine was declared illegal and in violation of Decree No. 43 of 1993 which requires all newspapers to register with the Newspaper Registration Board and to pay a pre-registration fee of N250,000 and a non-refundable fee of N100,000. These payments would be put into a fund for payment of penalties from libel actions against the owner, publisher or printer. Constitutional Rights Project stated that Decree No. 43 of 1993 had been declared null and void by two different courts, namely the Ikeja High Court on 18th November 1993, and the Lagos High Court on 5th December 1993. The Nigerian Government did not appeal against these decisions.

11. In his oral arguments before the Commission, the Complainants' representative emphasised that the government's prerogative to make laws for peace and good government does not entitle it to evade its obligations under international law.

The State Party's Response and Observations

12. The government has made no written submissions in respect of this communication. At the 19th Session, held in March 1995 in Ouagadougou, Burkina Faso, the government sent a delegation of several persons. Mr Chris Osah, Assistant Director General of the Legal and Treaties Department at the Ministry of Foreign Affairs, made the following statements in his presentation on the communication.

13. He stated that "Decree No. 43 of 1993 was made to underscore not only the government's sovereign rights but also its policy of free enterprise. Registration fees are payable to an independent board. It is in the public interest that all newspaper providers or publishers should ensure registration of their enterprises. The government is convinced that such registration fees are reasonable and justifiable in any democratic society. In any case, many newspapers and magazines operate although they have not registered".

14. On ouster of the jurisdiction of the courts, the government stated that "there is nothing particularly new about this. It is the nature of military regimes to provide for ouster clauses, the reasons being that for a military administration which has come in, the resources of litigation become too cumbersome for the government to do what it wants to do".

15. As for retroactive effect, the government maintained that, although the decree technically did have retroactive effect, not a single newspaper was declared illegal or harassed for violating the decree.

Complaint

16. The communications allege violations of Articles 6, 7, 9, 14 and 16 of the Charter.

Procedure

16. Communication 105/93 is dated 1st September 1993. The Commission was seized of the communication at the 14th Session. The state concerned was notified on January 1994.

17. Communication 128/94 is not dated but was received at the Secretariat between January and April 1994. The Commission was seized of the communication at the 15th session. The text of the communication was sent to the state concerned on 29th July 1994.

18. Communication 130/94 is dated 5th January 1994. The Commission was seized of the communication at its 15th Session and the text was sent to the state on 29th July 1994. The procedure relating to these three cases is the same.

19. On 14th September 1994 a letter was sent to the Complainants concerning communications no. 105/93, 128/94 and 130/94, asking whether all domestic remedies had been exhausted and whether any further seizures of TELL Magazine has occurred since 2nd January 1994.

21. A reminder was sent by the Secretariat of the Commission to the government of Nigeria on 22nd September 1994.

22. At the 16th Session, held in October 1994 in Banjul, The Gambia, the Commission declared the communications admissible.

23. At the 17th Session, held in March 1995 in Lomé, Togo, it was decided to delay final decision on the cases so that they might be taken up with the Nigerian authorities when the Commission undertook its mission to that country. It was also declared that the chairman of the OAU should be informed of the situation in Nigeria.

24. On 20th April 1995, a letter was sent by the Secretariat of the Commission to the complainants stating that the communications were declared admissible, and that a mission would be sent to Nigeria, and that a decision on the merits would be taken at the 18th Session.

25. On 7th June 1995, a letter was sent by the Secretariat of the Commission to the government of Nigeria stating that the communications were declared admissible and that a mission would be sent to Nigeria.

26. On 1st September 1995, a letter was sent to the government of Nigeria stating that the communications would be heard on the merits at the 18th session of the Commission and inviting the government to send a representative.

27. At the 18th Session of the Commission it was decided that the communications would be taken up by the mission to Nigeria, and if the government did not facilitate the visit, the Commission would at the next session adopt a decision on the facts available.

28. On 30th November 1995 a letter was sent to the complainants reflecting this decision.

29. On 30th November 1995 a Note Verbale was sent to the government of Nigeria reflecting this decision.

30. At the 19th Session, the Commission heard Mr Chidi Anselm Odinkalu, who was duly instructed to appear for all the complainants in all cases against Nigeria, except that brought by International PEN. The Commission heard Mr Osah and Mr Bello for the Nigerian Government in reply. At the end of the hearing the Commission took a general view on the cases and deferred taking final decision in each case pending the accomplishment of its proposed mission to Nigeria.

31. On 9th May 1996 letters were send to the Nigerian Government, Constitutional Rights Project and Media Rights Agenda informing them of the Commission's renewed decision to take a mission to the country and that the three communications detailed above would be considered on their merits at the 20th Session in October 1996.

32. At the 20th Session held in Grand Bay, Mauritius, October 1996, the Commission decided to postpone the final decision on the merits of the communications to the 21st Session, awaiting the result of the planned mission to Nigeria.

33. On 10th December 1996 the Secretariat sent a Note Verbale to this effect to the government.

34. On 10th December 1996 the Secretariat sent letters to this effect to the Complainants.

35. Communication 152/96 is dated January, 1996.

36. On 5th February 1996 a letter was sent to the Complainant acknowledging receipt of the communication and that the admissibility of the case would be examined at the 20th Session in October 1996.

37. At the 19th Session the communication was not examined.

38. At the 20th Session held in Grand Bay, Mauritius October 1996, the Commission declared the communication admissible, and decided that it would be taken up with the relevant authorities by the

planned mission to Nigeria. At the same time it was joined with communications 105/93, 128/94 and 130/94.

39. On 29th April, the Secretariat received a letter from Mr Olisa Agbakoba entitled 'Preliminary objections and observations' to the Mission of the Commission which visited Nigeria from March 7th-14th 1997. The document was submitted on behalf of INTERIGHTS with regard to 14 communications including this one.

40. Among the objections raised and or observations made were on: "the neutrality, credibility and relevance; and, composition of the mission". 40. At its 21st Session held in April 1997, the Commission postponed taking decision on the merits to the next session, pending the submission of scholarly articles and court case by the Complainants to assist it in its decision. The Commission also awaits further analysis of its report of the mission to Nigeria.

41. On 22nd May, the Complainants were informed of the Commission's decision, while the State was informed on May 28th.

42. From this date on, the procedure in respect of the communication is identical to that in communication 105/93, 128/94 and 130/94, above.

43. At the 22nd Ordinary Session the Commission postponed taking a decision on the cases pending the discussion of the Nigerian Mission report.

44. At the 23rd ordinary Session held in Banjul, The Gambia, the Commission postponed consideration of the case to the next session due to lack of time.

46. On 25th June 1998, the Secretariat sent letters to the parties concerned informing them of the status of the case.

Law

Admissibility

47. Article 56 of the African Charter reads:

Communications...shall be considered if they:...Are sent after exhausting local remedies, if any, unless it is obvious that this procedure is unduly prolonged

48. Specifically, in the four decisions the Commission has already taken concerning Nigeria, Article 56(5) is analysed in terms of the Nigerian context. Communication 60/91 (Decision ACHPR/60/91) concerned the Robbery and Firearms Tribunal; Communication 87/93 (Decision ACHPR/87/93) concerned the Civil Disturbances Tribunal; Communication 101/93 (Decision ACHPR/101/93) concerned the Legal Practitioners Decree; and Communication 129/94 (ACHPR/129/94) concerned the Constitution (Modification and Suspension) Decree and the Political Parties (Dissolution) Decree.

49. All of the Decrees in question in the above communications contain "ouster" clauses. In the case of the special tribunals, these clauses prevent the ordinary courts from taking up cases placed before the special tribunals or from entertaining any appeals from the decisions of the special tribunals (ACHPR/60/91:13 and ACHPR/87/93:12). The Legal Practitioners Decree specifies that it cannot be challenged in the courts and that anyone attempting to do so commits a crime (ACHPR/101/93:14-15). The Constitution Suspension and Modification legal prohibited their challenge in the Nigerian Courts (ACHPR/129/94:14 and ACHPR/129/94:15).

50. In all of the cases cited above, the Commission found that the ouster clauses render local remedies non-existent, ineffective or illegal. They create a legal situation in which the judiciary can provide no check on the executive branch of government. A few courts in the Lagos district have occasionally found that they have jurisdiction; in 1995 the Court of Appeal in Lagos, relying on common law, found that courts should examine some decrees notwithstanding ouster clauses, where the decree is "offensive and utterly hostile to rationality" (Reprinted in the Constitutional Rights Journal). It remains to be seen whether any Nigerian courts will be courageous enough to follow this holding, and whether the government will abide by their rulings should they do so.

51. In communication 152/96 the Complainant states that Decree no. 43 has been declared null and void by two different courts, but these decisions have not been respected by the government. This is a dramatic illustration of the futility of seeking a remedy from the Nigerian courts.

52. For these reasons, consistent with its earlier decisions, the Commission declared the communications admissible.

Merits

53. Article 9 of the African Charter reads:

    1. Every individual shall have the right to receive information.
    2. Every individual shall have the right to express and disseminate his opinions within the law.

54. This article reflects the fact that freedom of expression is a basic human right, vital to an individual's personal development, his political consciousness, and participation in the conduct of public affairs in his country. The problem at hand is whether the decrees requiring the registration of newspapers, and prohibiting many of them, violate this article.

55. A payment of a registration fee and a pre-registration deposit for payment of penalty or damages is not in itself contrary to the right to the freedom of expression. The government has argued that these fees are "justifiable in any democratic society", and the Commission does not categorically disagree.

56. However, the amount of the registration fee should not be more than necessary to ensure administrative expenses of the registration, and the pre-registration fee should not exceed the amount necessary to secure against penalties or damages against the owner, printer or publisher of the newspaper. Excessively high fees are essentially a restriction on the publication of news media. In this case, the fees required for registration, while high, are not so clearly excessive that they constitute a serious restriction.

57. Of more concern is the total discretion and finality of the decision of the registration board, which effectively gives the government the power to prohibit publication of any newspapers or magazines they choose. This invites censorship and seriously endangers the rights of the public to receive information, protected by Article 9(1). There has thus been a violation of Article 9(1).

58. Also of serious concern is the retroactivity of the decree. The government bases its defence on the non-enforcement of this aspect of the decree. The government representative offered this defence: "Article 7(2) of the Charter is very specific: 'no one may be condemned', and we are saying that no one has been condemned. Second, it says 'no penalty may be inflicted' we are also submitting that there has been no penalty inflicted...We are even going further to say that more than 3/4 of the newspapers in Nigeria have registered and yet nobody has taken them to court."

59. While it is reassuring to hear that no one has suffered under the retroactivity clause of the Decree No. 43, the Commission must take a stand on the issue of justice underlying Article 7(2) and condemn the literal, minimalist interpretation of the Charter offered by the representative of Nigeria. Article 7(2) must be read to prohibit not only condemnation and infliction of punishment for acts which did not constitute crimes at the time they were committed, but retroactivity itself. It is expected that citizens must take the laws seriously. If laws change with retroactive effect, the rule of law is undermined since individuals cannot know at any moment if their actions are legal. For a law-abiding citizen, this is a terrible uncertainty, regardless of the likelihood of eventual punishment.

60. Furthermore, the Commission unfortunately cannot rest total confidence in the assurance that no one and no newspaper has yet suffered under the retroactivity of Decree 43. Potential prosecution is a serious threat. An unjust but un-enforced law undermines, as above, the sanctity in which the law should be held. The Commission must thus holds that Decree No. 43 violates Article 7(2).

61. Communication 152/96 states that two different courts have declared Decree No. 43 null and void, without any result.

62. This shows not only a shocking disrespect by the Nigerian government for the judgments of the courts, it is also a violation of Article 7(2). The right to have one's cause heard by competent and independent courts must naturally comprise the duty of everyone, including the state, to respect and follow these judgments.

63. Decree No. 48 proscribes approximately 10 newspapers published by four different media organisations without having subjected them to the due process of the law. Decree No. 48 likewise permitted the newspapers and their operators to have their premises sealed without being given any opportunity to defend themselves and without previously being accused of any wrongdoing before a court of law.

64. The Commission decided, in its decision on communication 101/93, with respect to freedom of association, that "competent authorities should not enact provisions which limit the exercise of this freedom. The competent authorities should not override constitutional provisions or undermine fundamental rights guaranteed by the Constitution and international human rights standards." (ACHPR\A\101/93:16).

65. With these words the Commission states a general principle that applies to all rights, not only freedom of expression. Governments should avoid restricting rights, and have special care with regard to those rights protected by constitutional or international human rights law. No situation justifies the wholesale violation of human rights. In fact, general restrictions on rights diminish public confidence in the rule of law and are often counter-productive.

66. According to Article 9(2) of the Charter, dissemination of opinions may be restricted by law. This does not mean that national law can set aside the right to express and disseminate one's opinions; this would make the protection of the right to express one's opinions ineffective. To allow national law to have precedent over the international law of the Charter would defeat the purpose of the rights and freedoms enshrined in the Charter. International human rights standards must always prevail over contradictory national law. Any limitation on the rights of the Charter must be in conformity with the provisions of the Charter.

67. In contrast to other international human rights instruments, the African Charter does not contain a derogation clause. Therefore limitations on the rights and freedoms enshrined in the Charter cannot be justified by emergencies or special circumstances.

68. The only legitimate reasons for limitations to the rights and freedoms of the African Charter are found in Article 27(2), that is, that the rights of the Charter "shall be exercised with due regard to the rights of others, collective security, morality and common interest."

69. The reasons for possible limitations must be founded in a legitimate State interest and the evils of limitations of rights must be strictly proportionate with and absolutely necessary for the advantages which are to be obtained.

70. Even more important, a limitation may never have as a consequence that the right itself becomes illusory.

71. The government has provided no evidence that the prohibition was for any of the above reasons given in Article 27(2). Given that Nigerian law contains all the traditional provisions for libel suits, so that individuals may defend themselves where the need arises, for the government to proscribe a particular publication, by name, is disproportionate and uncalled for. Laws made to apply specifically to one individual or legal personality raise the serious danger of discrimination and lack of equal treatment before the law, guaranteed by Article 3. The proscription of The News cannot therefore be said to be "within the law" and constitutes a violation of Article 9(2).

72. Communications 128/94 and 130/94 allege that 50,000 copies of TELL Magazine were seized without any possibility of having the decision judged by a court of law, because of an article critical of the government.

73. In the present case, the government has provided no evidence that seizure of the magazine was for any other reason than simple criticism of the government. The article in question might have caused some debate and criticism of the government, but there seems to have been no information threatening to, for example, national security or public order in it. All of the legislation criticized in the article was already known to members of the public information, as laws must be, in order to be effective.

74. The only person whose reputation was perhaps tarnished by the article was the head of state. However, in the lack of evidence to the contrary, it should be assumed that criticism of the government does not constitute an attack on the personal reputation of the head of state. People who assume highly visible public roles must necessarily face a higher degree of criticism than private citizens; otherwise public debate may be stifled altogether.

75. It is important for the conduct of public affairs that opinions critical of the government be judged according to whether they represent a real danger to national security. If the government thought that this particular article represented merely an insult towards it or the head of state, a libel action would have been more appropriate than the seizure of the whole edition of the magazine before publication. The seizure of the TELL therefore amounts to a violation of Article 9(2).

76. Article 14 of the Charter reads:

The right to property shall be guaranteed. It may only be encroached upon in the interest of public need or in the general interest of the community and in accordance with the provisions of appropriate laws.

77. The government did not offer any explanation for the sealing up of the premises of many publications. Those affected were not previously accused in a court of law, of any wrongdoing. The right to property necessarily includes a right to have access to property of one's own and the right not for one's property to be removed. The Decrees which enabled these premises to be sealed up and for publications to be seized cannot be said to be "appropriate" or in the interest of the public or the community in general. The Commission holds a violation of Article 14. In addition, the seizure of the magazines for reasons that have not been shown to be in the public need or interest also violates the right to property.

78. In his oral argument, the Complainant specifically raised the ouster of the court's jurisdiction over the decrees at issue here, denying the alleged victims the right to challenge the acts which affected them. The government offered the surprising defence that "[I]t is in the nature of military regimes to provide for ouster clauses", because without such clauses the volume of litigation would make it "too cumbersome for the government to do what it wants to do".

79. This argument rests on the assumption that ease of government action takes precedence over the right of citizens to challenge such action. It neglects the central fact that the courts are a critical monitor of the legality of government action, which no lawful government acting in good faith should seek to evade. The courts' ability to examine government actions and, if necessary, halt those that violate human rights or constitutional provisions, is an essential protection for all citizens.

80. It is true that if national tribunals are not deprived of their powers, they will almost certainly eventually pronounce on the legality of military government itself. The government representative's argument implicitly admits what the Commission has already said in its decision on communication 102/93, which is that military regimes rest on questionable legal ground. Government by force is in principle not compatible with the rights of peoples' to freely determine their political future.

81. A government that governs truly in the best interest of the people, however, should have no fears of an independent judiciary. The judiciary and the executive branch of government should be partners in the good ordering of society. For a government to oust the jurisdiction of the courts on a broad scale reflects a lack of confidence in the justifiability of its own actions, and a lack of confidence in the courts to act in accordance with the public interest and rule of law.

82. The Commission must therefore reject the defence of "the nature of military regimes" offered by the government's representative, and holds that the ouster of the court's jurisdiction violates the right to have one's cause heard, under Article 7(1).

83. Article 6 of the African Charter reads:

Every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained.

84. Communication 152/96 alleges that Mr Nosa Igiebor was arrested and detained without being told any reason and without any charges being made.

85. The government has offered no substantive response to this allegation.

86. The Commission, in several previous decisions, has set out the principle that where allegations of human rights abuses go uncontested by the government concerned, even after repeated notifications, the Commission must decide on the facts provided by the government at treat those facts as given (See, e.g., the Commission's decisions in communications 59/91, 60/91, 64/92, 68/92, 78/92, 87/93 and 101/93). Therefore the Commission finds that there has been a violation of Article 6.

87. Article 7(1)(c) of the African Charter reads:

1. Every individual shall have the right to have his cause heard. This comprises: .....(c) The right to defence, including the right to be defended by counsel of his own choice

88. Constitutional Rights Project alleges that Mr Nosa Igiebor was denied access to lawyers. The government has made no response to this allegation. Therefore the Commission must take a decision on the facts as presented by the Complainant. To be denied access to a lawyer is a violation of Article 7(1)(c) even if there were no charges against Mr Igiebor. People who are detained in violation of the Charter must not have lesser rights that those detained in conformity with the rules in Article 7.

89. Article 16 of the African Charter reads:

[#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 go their people and to ensure that they receive medical attention when they are sick.#]

90. Constitutional Rights Project alleges Mr Nosa Igiebor was denied access to doctors and that he received no medical help even though his health was deteriorating through his detention. The government has made no response to this allegation. Therefore the Commission must take a decision on the facts as presented by the Complainant.

91. The responsibility of the government is heightened in cases where the individual is in its custody and therefore someone whose integrity and well-being is completely dependent on the activities of the authorities. To deny a detainee access to doctors while his health is deteriorating is a violation of Article 16.

Holding

For these reasons, the Commission:

- Holds a violation of Articles 6, 9(1), 9 (2), 7 (1) (c), 7 (2), 14 and 16 of the African Charter;
- Requests that the Government of Nigeria take the necessary steps to bring its law into conformity with the Charter.

Banjul, 31st October 1998.

D4 54/91-61/91-96/93-98/93-164/97_196/97-210/98 : *Malawi African Association, Amnesty International, Ms Sarr Diop, Union interafricaine des droits de l'Homme and RADDHO, Collectif des veuves et ayants-Droit, Association mauritanienne des droits de l'Homme/Mauritania* (2000)

Summary of Facts

1. These communications relate to the situation prevailing in Mauritania between 1986 and 1992. The Mauritanian population, it should be remarked, is composed essentially of Moors (also known as 'Beidanes') who live in the North of the country, and various black ethnic groups, including the Soninke, Wolofs and the Hal-Pulaar in the South. The Haratines (freed slaves) are closely associated with the Moors, though they physically resemble the Black population of the South.
2. Following a coup d'état that took place in 1984, and which brought Colonel Maaouya Ould Sid Ahmed Taya to power, the government was criticised by members of the Black ethnic groups for marginalising Black Mauritanians. It was also criticised by a group of Beidanes who favoured closer ties with the Arab world.
3. Communication 61/91 alleges that in early September 1986, over 30 persons were arrested in the aftermath of the distribution of a document entitled "Le Manifeste des negro-mauritaniens opprimés" (Manifesto of the Oppressed Black Mauritanians). The document provided evidence of the racial discrimination to which the Black Mauritanians were subjected and demanded the opening of a dialogue with the government. Twenty-one persons were found guilty of holding unauthorised meetings and pasting and distributing publications that were injurious to the national interest, and of engaging in racial and ethnic propaganda. They were convicted and imprisoned, after series of trials that took place in September and October 1986. The accused had been held in custody for a period that was longer than provided for in Mauritanian law. They did not have access to their lawyers before the trials started. The lawyers, therefore, did not have time to prepare the cases, for which reason they withdrew, leaving the accused without defence counsel. The president of the tribunal considered that the refusal of the accused to defend themselves was tacit acknowledgement of their guilt. The trial was conducted in Arabic, even though only three of the accused were fluent in the language. The accused were thus found guilty on the basis of statements made to the police during their time in custody. They however pointed out to the tribunal that some of these statements had been given under duress. The sentences ranged from six months to five years imprisonment with fines, and five - ten years of house arrest.
4. The accused filed an appeal, claiming unfair trial, stating that they were not charged in due time; and that they did not have the opportunity to be defended. On 13 October 1986, the Court of Appeal upheld the sentences, even though the public prosecutor had not contested the appeal.
5. In September 1986, another trial against one Captain Abdoulaye Kébé took place before a special tribunal presided by a military officer; and no appeal was permitted. Captain Kébé was charged with violating military regulations by providing statistics on the racial composition of the army command, which were then quoted in the "Manifeste des negro-mauritaniens opprimés". He was held in solitary confinement before his trial, with no access to lawyers, and did not have sufficient time to prepare his defence. He was sentenced to two years imprisonment and twelve years house arrest.
6. In October 1986, a third trial relating to the Manifesto was brought against 15 persons. They were charged with belonging to a secret movement, holding unauthorised meetings and distributing tracts. Three of them were given suspended sentences and the others acquitted.
7. After the 1986 trial, there were protests against the conviction of the authors of the Manifesto. These brought about further arrests and trials.

8. In March 1987, 18 persons were charged before a criminal court for arson. They were not allowed family visits during the five months that their detention lasted. Many of them were alleged to be members of the support committee, established after the first trial relating to the Manifesto, to provide material and moral support to the families of the detainees. Most of the detainees were beaten during their detention. After the trial, nine accused were found guilty and sentenced to prison terms ranging from four to five years. The evidence was based almost exclusively on statements made to the police during their time in custody. They tried in court to retract these statements, arguing that they had been given under duress. Apparently, the tribunal did not try to clarify these facts.

9. At the end of April 1987, six persons were charged with distribution of tracts. Just before their trial, arson charges were added to the list of offences with which they were being accused. The lawyers, once again, did not have sufficient time to prepare the defence of their clients. All of the accused were found guilty by the court and sentenced to four years imprisonment. The Supreme Court later confirmed the sentences, regardless of the irregularities that occurred during the course of the trial.

10. On 28 October 1987, the Mauritanian Minister of Interior announced the discovery of a plot against the government. In reality, all those accused of taking part in this plot belonged to the Black ethnic groups from the South of the country. Over 50 persons were tried for conspiracy by the special tribunal presided by a senior army officer who was not known to have legal training. He was assisted by two assessors, both of them army officers. No appeal was provided for. The accused were kept in solitary confinement in military camps and deprived of sleep during their interrogation. They were charged with "endangering State security by participating in a plot aimed at deposing the government and provoking massacres and looting among the country's inhabitants". A special summary procedure was applied, under the pretext that they had been caught in flagrante delicto. This procedure provides for a trial without any prior investigation by an investigating magistrate. It restricts the rights of the defence as well as access to lawyers and allows the court to pass judgement without any obligation on the part of the judges to indicate the legal bases for their conclusions. Such a procedure is not normally applied in cases relating to a conspiracy or an attempted crime. It is applicable to an already consummated crime. Those who were convicted on 3 December 1987 did not have the right to file appeal. Three lieutenants were sentenced to death and executed three days [later]. The executions were reportedly stretched out in a manner as to subject the convicts to a slow and cruel death. To put an end to their suffering, they had to [beg] the executioners to kill them as quickly as possible. The other accused were sentenced to life imprisonment.

11. Some presumed members of the Ba'ath Arab Socialist Party were also imprisoned for a political cause. In September 1987, 17 supposed members of the party were arrested and charged with belonging to a criminal association, participating in unauthorised meetings and abduction of children. Seven of the accused were sentenced to a seven-month suspended term of imprisonment. On 10 September 1988, in another trial before the State Security Section of the special tribunal, 16 presumed Ba'athists were charged with disturbing the internal security of the State, having contacts with foreign powers and recruiting military personnel in a time of peace. Thirteen of them were found guilty, mainly on the basis of statements that they sought to withdraw during the trial, on the basis that they had been made under duress. The accused were held in solitary confinement in a police camp and did not have the right to consult their lawyers until three or four days before the trial. Communication 61/91 avers that the accused were arrested and imprisoned for their non-violent political opinions and activities.

12. Communication 61/91 also alleges that their conditions of detention were the worst and cites many examples to prove these allegations. Thus, from December 1987 to September 1988, those detained at Ouatala prison only received a small amount of rice per day, without any meat or salt. Some of them had to eat leaves and grass. The prisoners were forced to carry out very hard labour day and night and were chained up in pairs in windowless cells. They only received one set of clothes and lived in very bad conditions of hygiene. As from February 1988, their guards regularly beat them up. From the time of their arrival in the detention camp, they only received one visit. Only the guards and prison authorities were authorised to approach them. Between August and September 1988, four prisoners died of malnutrition and lack of medical attention. After the fourth death, the civilian prisoners in Ouatala were transferred to the Aïoun-el Atrouss prison, which had medical infrastructure. Some of them were so weak that they could only move on all fours. In the Nouakchott prisons, the cells were overcrowded. The prisoners slept on the floor without any blankets, even during the cold season. The cells were infested with lice, bedbugs and cockroaches, and nothing was done to ensure hygiene and provision of health care. The Black prisoners, from the South

of the country, complained of discrimination by the guards and security forces, who were mainly of the Beidane or Moorish ethnic group, supposedly Whites. They could not receive visits from their families, doctors or lawyers, except when the Ba'ath party supporters, all of them Beidanes, were in the same prison.

13. All these communications describe the events that took place in April 1989, simultaneously with the crisis that nearly caused a war between Senegal and Mauritania. The crisis was caused by Mauritania's expulsion of almost 50,000 people to Senegal and Mali. The government claimed that those expelled were Senegalese, while many of them were bearers of Mauritanian identity cards, which were torn up by the authorities when they were arrested or expelled. Some of them seemed to have been expelled mainly because of their relationship with the political prisoners or due to their political activities. Many of those who were not expelled were on the run to escape the massacres. Though the borders were later reopened, no security was assured those who desired to return, and they had no means by which to prove their Mauritanian citizenship. Many had been living in refugee camps since 1989, in extremely difficult conditions.

14. The main victims were Black Mauritanian government employees suspected of belonging to the Black opposition, and Black villagers from the South, mainly from the Hal-Pulaar or Peul ethnic group. The Haal-Pulaars traditionally live in the River Senegal valley where the land is fertile.

15. The complainants allege that thousands of people were arbitrarily detained. They state that the detentions were followed by expulsion, such as in the case of political opponents, people who had resisted the confiscation of their property, not to mention the cases that followed the incursions of [returning] refugee groups. This last category of arrests seems to have been carried out as a generalised reprisal, to the extent that there was no evidence of contacts between the detainees and the refugees who were returning to Mauritania. This type of retaliation and reprisal is contrary to Mauritanian law. Some of the detainees were released in early July 1990.

16. The communications allege also that there was daily persecution of villagers in the South between 1989 and 1990. There were many identity-card checkpoints where the Hal-Pulaar had to show their identity cards and prove that they were of Mauritanian origin. The security forces confiscated their livestock. Sometimes the villagers had to obtain military authorisation to take out their livestock to pasture, to go fishing or to work their fields. Nevertheless, such authorisation did not protect them from arrest.

17. The security forces are accused of surrounding the villages, confiscating land and livestock belonging to the Black Mauritanians and forcing the inhabitants to flee towards Senegal, leaving their property for the Haratines to take or to be destroyed. The Haratines who possessed the land of those who had been expelled were armed by the authorities and were expected to arrange their own defence. So they formed their own militia, which had no foundation in law, but which seemed to work in close collaboration or under the supervision of the army and internal security forces. Communication 96/93 provides a list of villages all or almost all of whose inhabitants were expelled to Senegal. Communication 98/93 provides a list of villages that were destroyed.

18. These communications also point to various incidents and extra-judicial executions of Black Mauritanians in the South of the country. Following the mass expulsions, some refugees in Senegal carried out incursions into the villages inhabited by the Haratines. Generally, after these raids, the Mauritanian army, the security forces and the Haratine militia would invade the villages reoccupied by the original inhabitants, and identified victims, generally Hal-Pulaar. The communications mention many cases of summary executions. On 10 and 20 April, for instance, military and Haratine patrols arrested 22 people. They were later found dead, with their arms tied up. Some of them had been shot, others had their skulls smashed with stones. On 7 May 1990, Dia Bocar Hamadi, for example, was killed while he was searching for livestock taken from him by Haratines. When his brothers protested to the police, they were arrested and detained until early July. On 12 April 1990, Thierno Saibatou Bâ, a religious leader, was shot dead, on his way to meet his pupils.

19. A curfew was imposed on all villages in the South. Anyone who broke it was shot at sight, even if there was not proof that they were engaged in acts that endangered the lives of other inhabitants. Communication 61/91 mentions a specific case where the victims were arrested, tied up, and taken to a location where they were executed. According to the complainants, the army, security forces and Haratines enjoy total impunity. Many villagers who were not expelled had to flee in order to escape the massacres.

20. Whenever the villagers protested, they were beaten and forced to flee to Senegal or simply killed. Many villagers were arrested and tortured. A common form of torture was known as "Jaguar". The victim's wrists are tied to his feet. He is then suspended from a bar and thus kept upside down, sometimes over a fire, and

is beaten on the soles of his feet. Other methods of torture involved beating the victims, burning them with cigarette stubs or with a hot metal. As for the women, they were simply raped.

21. In September 1990, a wave of arrests took place, ending between November and December 1990. Thousands of people were arrested. These were essentially Hal-Pulaar members of the armed forces or civil servants. All those arrested were from the South of the country. Later, the authorities alleged that there had been an attempt to unseat the government; but no proof was ever given. The accused were never put on trial, but were kept in what communication 96/93 describes as "death camps", in extremely harsh conditions.

22. Communication 61/91 contains a list of 339 persons believed to have died in detention. Some detainees were reportedly executed without trial. Thirty-three soldiers were hung, without trial, on 27th and 28th November 1990. Others were buried in sand to their necks and left to die a slow death. Many however died as a result of the torture they underwent. The methods used include the so-called 'Jaguar' mentioned above, electric shocks to the genital organs, as well as burns all over their bodies.

23. In February 1991, detainees in the J'Reida military camp were undressed, hands tied behind their backs, sprayed with cold water and beaten with iron bars. The 'Jaguar' torture was also utilised. The detainees were burned with coal embers, or they had some powder spread on their eyes, causing a terrible burning sensation. Their heads were plunged in dirty water to the point of suffocation; some were buried in sand to their necks. They were permanently chained in their cells, without toilet facilities. Some were kept in underground cells or dark cells where it got very cold at night.

24. In March 1991, the government announced the release of a number of political prisoners who had been convicted, as well as of other persons detained since November and December 1990. In April, other detainees were released, and President Maaouya Ould Taya announced that all those arrested had been released. However, there was never any response to the reports referring to people who had been killed in detention, nor on the unknown fate of many detainees. Communication 61/91 provides a list of 142 people whose deaths are confirmed, and another 197 who were not released and are probably dead.

25. According to communication 61/91, the government set up a commission of inquiry, but did not indicate either its prerogatives or the extent of its field of action. It [was] essentially composed of military men. And even if one were to believe that the commission has finished its work, no report ever made its conclusions public.

26. Communication 54/91 alleges that there are over 100,000 Black slaves serving in Beidane houses. And that though 300,000 had bought their freedom, they remain second-class citizens. Besides, Blacks do not have the right to speak their own languages. According to communication 98/93, a quarter of the population (500,000 out of 2,000,000 inhabitants in the country) are either slaves or Haratines (freed slaves). The freed slaves maintain many traditional and social links with their former masters, which constitutes a more subtle form of exploitation.

27. Amnesty International, Union Interafricaine des Droits de l'Homme and Rencontre africaine pour la défense des droits de l'Homme made statements at the 19th Session, reiterating the facts already presented. Amnesty International stated in writing that an amicable settlement could only be possible if the government set up an independent commission of inquiry to shed light on these violations, brought the authors to justice according to the internationally respected rules regarding fair trial, without using the death penalty; tried all other political prisoners according to international norms, and compensated the victims in a satisfactory manner.

The Government's Response

28. The government's response to these allegations was that Amnesty International had taken sides in the conflict between Senegal and Mauritania. The government admits that there had been what it calls "incidents" in late 1990, but that the "necessary measures had been taken to restore order as soon as possible and to limit the damage". It also declares that administrative sanctions were imposed on some army officers. The government maintains that a new pluralist Constitution was adopted, and that Mauritania is now a democratic State that respects the norms of the African Charter on Human and Peoples' Rights.

29. At the 19th Session of the Commission, the Mauritanian government representative in attendance did not contest the complainants' allegations, claiming that grave and massive human rights violations had been committed between 1989 and 1991. He expressed his governments wish to work together with the Commission to assist the victims, making it clear that the country's economy could not allow them all to be compensated. He further declared that it would be difficult to verify the situation of each victim prior to the 1989 events, which would make their resettlement impossible. He continued, saying that all those displaced could return to their native villages. Besides, the Mauritanian government representative categorically denied that the Black ethnic groups did not have the right to speak their languages. He reiterated his government's official position, that slavery had been abolished in Mauritania during French colonial days.

Provisions of the Charter alleged to have been violated

The communications allege violation of Articles 2, 4, 5, 6, 7, 9, 10, 11, 12, 14, 16, 18, 19 and 26 of the African Charter on Human and Peoples' Rights.

Procedure

30. Communication 54/91 is dated 16th July 1991 and was submitted by Malawi African Association, a non-governmental organisation.

31. The Commission was seized of it on 14th November 1991 and the Mauritanian government was notified and called upon to make its observations known. No response was received from it.

32. At the 19th Session held in March 1996, the Commission heard Mr Ahmed Motala, representative of Amnesty International, Mr Halidou Ouédraogo of UIDH, Mr Alioune Tine and Mr C. Faye of RADDHO, as well as the representative of the Mauritanian government. Mr Ahmed Motala then sent the Commission a letter dated 31st March 1996.

33. At the end of the hearings, the Commission held the view that the government did not seriously contest the allegations brought against it. The Mauritanian delegate admitted that human rights violations had indeed been committed. He did not try to explain the circumstances in which they had taken place. He requested the Commission to give its assistance in finding a solution to the problem. He further added that his government was ready to receive a delegation from the Commission to that end. Following this, the Commission reiterated its decision to send a mission to Mauritania to try and obtain an amicable settlement. It was also decided that the mission would be composed of the Chairman of the Commission and Commissioners Rezag-Bara and Ondziel-Gnelenga, as well as the Secretary to the Commission.

34. The mission was in Mauritania from 20th to 27th June 1996.

35. At the 20th Session held in Grand Bay, Mauritius, the Commission considered the mission's report and deferred the decisions on the communications to its 21st Session.

36. On 7th February 1997, the Secretariat wrote to the complainants explaining to them that the mission report would be sent to the government for its observations by the end of February and that they would subsequently have the chance to make comments on the said report.

37. At the 21st Session held in Nouakchott in April 1997, the Commission deferred its decision on this communication to the 22nd Session, pending its receipt of the Mauritanian government's reaction to the mission report.

38. Communication 61/91 was submitted by Amnesty International, on 21st August 1991.

39. The Commission was seized of it at its 10th Session, held in October 1991.

40. The Mauritanian government was notified of it by the Secretariat on 14th November 1991.

41. At the 15th Session, the Commission decided to compile all the communications filed against Mauritania.

42. From that date, the procedure for the present communication became identical to that for communication 54/91.

43. Communication 96/93 was submitted on 12th March 1993 by Ms. Sarr Diop, on behalf of the victims.

44. The Commission was seized of it at its 13th Session held in April 1993. Notification of it was sent to the accused state, asking it to forward its observations to the Secretariat. No response was received.

45. At the 15th Session held in March 1994, it was decided to combine all the communications filed against Mauritania.

46. From that date, the procedure for the present communication became identical to that for the above-mentioned communication 54/91.

47. Communication 98/93 was submitted on 30 March 1993 by two NGOs, Rencontre africaine pour la défense des droits de l'Homme (RADDHO, African Association for the Defence of Human Rights) and Union interafricaine des droits de l'Homme (UIDH, Inter-African Human Rights Union).

48. The Commission was seized of [it] at its 13th Session.

49. On 12 April 1993, notification of it was sent to the accused State, asking it to address its observations to the Secretariat of the Commission.

50. At the 15th Session held in March 1994, it was decided to combine all the communications filed against Mauritania.

51. From that date, the procedure for the present communication became identical to that for the above-mentioned communication 54/91.

52. At the 22nd Session held in Banjul, from 2-11 November 1997, the representative of Mauritania pointed out that his government was in the process of considering the mission report of the Commission and expected to have its observations ready before the 23rd Session. The Commission thus decided to defer consideration of all the communications filed against Mauritania to its following session, while bearing in mind that they had been pending before the Commission for quite a long time now.

53. At the 23rd Session held in Banjul (The Gambia), from 20-29th April 1998, the Commission decided to combine it with the procedure ongoing for communications 164/97 to 196/97 as well as communication 210/98. In addition, three Notes Verbales were addressed on 25th April and 9th and 10th July 1998, respectively, to the Mauritanian Ministry of Foreign Affairs, to inquire about the government's reaction. They have remained without reply to date.

54. Communications 164/97-196/97 allege that between September and December 1990, there was a wave of arrests in Mauritania directed at specific sectors of the population. Those arrested were mostly military men and public servants belonging to the Hal-Pulaar ethnic group and other ethnic groups from the South of the country. Sometime after this wave of arrests, the government announced, without providing any proof, that there had been an attempted coup d'état.

55. The accused were never brought before a court of law; according to communications 164/97-196/97, about a dozen of the accused were tortured and executed in the military camps of Inal, J'réida, Tiguint and Aleg between November and December 1990. Most remarkably, most of the communications allege that the victims were beaten to death.

56. The widows and mothers behind the present communications, have previously brought their complaints before the Mauritanian national authorities, both civilian and military, in particular the Minister of Interior, the head of the national army, the National Assembly, the Senate, the Special Court of Justice, the Nouakchott Criminal Court, the President and the Minister of National Defence. In all these cases they were either ignored or chased away.

57. On 14th June 1993, the Mauritanian government issued an enactment, No. 023 93, granting amnesty to those accused of perpetrating the series of murders for which the beneficiaries of the victims are hereby claiming compensation of injuries suffered.

Provisions of the Charter alleged to have been violated

58. The communications allege a series of grave and massive violations of Articles 2, 3, 4, 5, 6, 7, 16 and 26 of the African Charter.

59. Communications 164/97-196/97 were received by the Secretariat in April 1997. The beneficiaries of the alleged victims submitted them all.

60. On 6th October 1997, the Secretariat received a Note Verbale dated the 1st of the same month, with reference number 075/MAEC communicating the Mauritanian government's reaction to the accusations made against it. The gist was that Mauritania called on the Commission not to be seized of the said communications for the reason that they "deal with a naturally deplorable, but peculiar and exceptional situation [...] that has in any case since been surmounted... ".

61. On 9th October 1997, the Secretariat acknowledged receipt of the said note, pointing out that the fact that the Mauritanian state had paid compensation to the beneficiaries of the victim of the alleged violations (which are in any case not denied by the State) cannot invalidate the Commission's deliberations.

62. At the 23rd Session, the Commission adjudged on the admissibility of the communications and decided to combine the procedure followed for the present communications with those for communications 54/91, 61/91, 96/93, 98/93, 196/97 and 210/98. The Commission referred the dossiers for consideration as to the merits at its 24th Session.

63. Communication 210/98 was submitted by the Association mauritanienne des droits de l'Homme (AMDH, Mauritanian Human Rights Association), on behalf of the Collectif des rescapés, anciens détenus civils torturés (CRADPOCIT, Collective of Survivors, Ex-Civilian Detainees and the Tortured), against Mauritania. It alleges that during the bloody political events that troubled Mauritania between 1986 and 1991, those who have now joined together under the umbrella of CRADPOCIT were arrested, along with other Mauritanian citizens of black African stock and detained in the Nouakchott civil prison, and later transferred to various gaols where they were subjected to torture and other inhuman and degrading forms of treatment; this is alleged to have led to the death of some of their co-detainees.

64. After more than fifteen days of detention, some of them were released, while others were charged [in] court and held in the civilian prisons.

65. Following a number of court cases, some of those on remand were released and others were given suspended sentences, while yet others were sentenced to prison terms varying from three months to five years. These verdicts were aggravated with loss of civic rights, heavy fines and banishment after release.

66. In 1993, members of the armed forces who had been subjected to the same treatment as those who came together under CRADPOCIT were granted pension benefit coupons. Imbued with the hope raised by this measure, they addressed a letter to the President of the Republic on 3rd November 1993, in which they demanded their rehabilitation, in line with what had been provided to their compatriots of Arabo-Berber origin and the military personnel of black African origin. This move yielded no results.

67. Two years later, they addressed a second letter to the Head of State, with the same demands, without achieving any better results than in 1993. It was after this second failure that they decided to constitute themselves into a collective in order to better defend their rights. Application for the official recognition of the said collective (CRADPOCIT) was addressed to the Ministry of Interior. At the same time, its founding documents were sent to the Head of State, the Presidents of the Senate and the National Assembly, as well as the Mediator of the Republic, with the same demands annexed in all cases.

68. The complainant claims that as of the time of the arrest of the members of CRADPOCIT, the majority of them were civil servants who had each accumulated ten to twenty years of service. Furthermore, the complainant claims that at present they are subject to the most precarious living conditions, aggravated by unemployment and onerous family responsibilities. Some of them have even seen their homes broken following divorces that they were unable to prevent.

69. The communication was received by the Secretariat of the Commission on 26th January 1998.

70. At the 23rd Ordinary Session, held from 20-29th April 1998 in Banjul (The Gambia), the Commission decided:

1. to notify the Mauritanian government representative at the session of the communication (with signed acknowledgement);
2. to combine it with the ongoing procedure for communications 54/91, 61/91, 96/93, 98/93 and communication 164/97 to 196/97. It took the view that the reaction of the Mauritanian government to the various Notes Verbales from the Secretariat, as contained in Note No. 075/MAEC, dated 1 October 1997, was valid for the case under consideration.
3. to defer the communication to its 24th Session for consideration of its merits.

71. At the 24th Session held in Banjul, The Gambia, from 22-31st October 1998, it was decided that the members of the Commission who had undertaken the mission to Mauritania should consider the communications, taking into account the response of the Government of Mauritania to their mission report. Consideration of these communications was thus deferred to the 25th Session.

72. Members of CRADPOCIT are complaining of discriminatory practices on the part of the Mauritanian government, which they accuse of operating "a policy of double standards" , since the officials of Arabo-Berber origin who had been subjected to the same situation had been reintegrated into their various workplaces, while the members of the collective who are of Black African origin saw their pleas rejected.

73. They further point out that while they were in detention, in September 1987, when about fifteen pro-Iraqi Ba'athist Arabo-Berber military men (charged [with] belonging to a criminal organisation, participation in unauthorised meetings and kidnapping of children) joined them in the same prison, their arrival led to a notable improvement in their conditions of detention. They claim that they were then allowed to take walks within the prison courtyard, a "privilege" that was previously denied to them. However, they were still denied visits as a policy, while their Arabo-Berber compatriots had the right to receive anyone, including their spouses.

74. Immediately after the release of the Arabo-Berbers, the black Africans were thrust back to the difficult gaol conditions to which they had previously been subjected, which consisted, remarkably, of keeping them chained in pairs during the whole day, with all inconveniences arising from such a situation, hard labour, fetching water, etc. These inhuman prison conditions, coupled with poor nourishment and lack of hygiene are said to be the cause of the above-mentioned deaths of four of their co-detainees (two military and two civilians).

75. The Mauritanian Human Rights Association claims violation of the following provisions of the African Charter of Human and Peoples' Rights:

1. Article 2: *"Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status"*;
2. Article 4: *"Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right"*;
3. Article 5: *"Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited"*;
4. Article 15: *"Every individual shall have the right to work under equitable and satisfactory conditions, and shall receive equal pay for equal work"*;
5. Article 16: *"1. Every individual shall have the right to enjoy the best attainable state of physical and mental health; 2. "State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick"*;
6. Article 19: *"All peoples shall be equal; they shall enjoy the same respect and shall have the same rights. Nothing shall justify the domination of a people by another"*.

Law

Admissibility

76. Communications 54/91, 61/91, 98/93, 96/93, 164/97 - 196/97 and 210/98 allege cases of grave and massive violations of human rights attributed to the Mauritanian State.

77. In the African Charter on Human and Peoples' Rights, admissibility is governed by Article 56, which defines all the conditions that communications must meet in order to be considered. These criteria are applied with due regard to the specificity of each communication. The case under consideration, of which the Commission was seized through the present procedure, is a combination of four communications which it decided to consider together in view of the similarity of the facts related. The Commission had previously taken the same decision regarding communications submitted against Benin, Zaïre and Rwanda (Cf. decisions on communications 16/88, 17/88, 18/88, 25/89, 47/90, 56/91, 100/93 Legal Assistance Group/ Zaïre, and 27/89, 46/91, 49/91, 99/93 World Organisation against Torture, International Association of Democratic Jurists, International Commission of Jurists and Inter-African Human Rights Union / Rwanda). All these communications were submitted by non-governmental organisations and they all allege various violations that are inter-related and similar.

78. Article 56(1) of the Charter demands that anyone submitting communications to the Commission relating to human and peoples' rights must reveal their identity. They do not necessarily have to be the victims of such violations or members of their families. This characteristic of the African Charter reflects sensitivity to the practical difficulties that individuals can face in countries where human rights are violated. The national or international channels of remedy may not be accessible to the victims themselves or may be dangerous to pursue.

79. In the above-mentioned decisions, the Commission recognised that in a situation of grave and massive violations, it may be impossible to give a complete list of names of all the victims. It will be noted that article 56(1) demands simply that communications should indicate the names of those submitting and not those of all the victims of the alleged violations.

80. Article 56(5) of the Charter demands that the complainants must have exhausted internal remedies, where these exist, before the Commission can be seized of a communication. The Commission maintains that one of the justifications for this demand is that the accused state should be informed of the human rights violations it is being accused of, to provide it with an opportunity to redress them and save its reputation, which would be inevitably tarnished if it were brought before an international jurisdiction. This provision also enables the African Commission on Human and Peoples' Rights to avoid playing the role of a court of first instance, a role that it cannot under any circumstances arrogate to itself.

81. The Mauritanian state was informed of the worrying human rights situation prevailing in the country. Particular attention, both within the national and international communities, was paid to the events of 1989 and succeeding years. Even if it were to be assumed that the victims had instituted no internal judicial action, the government was sufficiently informed of the situation and its representative, on various occasions, stressed before the Commission that a law known as the "general amnesty" law, dealing with the facts arraigned was adopted by his country's parliament in 1993. The Mauritanian government justified the said law with the argument that "the civilians had benefited from an amnesty law in 1991, and consequently the military wanted to obtain the same benefits; especially as they had given up power after allowing the holding of presidential (1992) and legislative (1993) elections".

82. The Commission notes that the amnesty law adopted by the Mauritanian legislature had the effect of annulling the penal nature of the precise facts and violations of which the plaintiffs are complaining; and that the said law also had the effect of leading to the foreclosure of any judicial actions that may be brought before local jurisdictions by the victims of the alleged violations.

83. The Commission recalls that its role consists precisely in pronouncing on allegations of violations of the human rights protected by the Charter of which it is seized in conformity with the relevant provisions of that instrument. It is of the view that an amnesty law adopted with the aim of nullifying suits or other actions seeking redress that may be filed by the victims or their beneficiaries, while having force within

Mauritanian national territory, cannot shield that country from fulfilling its international obligations under the Charter.

84. Also, the Islamic Republic of Mauritania, being a party to the African Charter on Human and Peoples' Rights, has no basis to deny its citizens those rights that are guaranteed and protected by an international convention, which represents the minimum on which the State Parties agreed, to guarantee fundamental human freedoms. The entry into force of the Charter in Mauritania created for that country an obligation of consequence, deriving from the customary principle pact sunt servanda . It consequently has the duty to adjust its legislation to harmonise it with its international obligations. And, as this Commission has previously had to emphasise, "contrary to other human rights instruments, the African Charter does not allow for derogation from obligations due to emergency situations. Thus, even a situation of civil war [...] cannot be cited as justification for the violation by the State or its authority to violate the African Charter" (cf. communication 74/92, para. 36)1.

85. Finally, the Commission interprets the provisions of Article 56(5) in the light of its duty to protect human and peoples' rights as stipulated in the Charter. The Commission does not believe that the condition that internal remedies must have been exhausted can be applied literally to those cases in which it is "neither practicable nor desirable" for the complainants or the victims to pursue such internal channels of remedy in every case of violation of human rights. Such is the case where there are many victims. The gravity of the human rights situation in Mauritania and the great number of victims involved renders the channels of remedy unavailable in practical terms, and, according to the terms of the Charter, their process is "unduly prolonged". In addition, the amnesty law adopted by the Mauritanian parliament rendered obsolete all internal remedies.

For these reasons, the Commission declares the communications admissible.

Merits

86. In June 1996, the Commission sent a good-offices mission to Mauritania. The delegation met with members of the government and non-governmental organisations to discuss the overall human rights situation in the country.

87. The mission was undertaken at the initiative of the Commission in its capacity as promoter of human and peoples' rights. It was not an enquiry mission; and while it permitted the Commission to get a better grasp of the prevailing situation in Mauritania, the mission did not gather any additional specific information on the alleged violations, except on the issue of slavery. The present decision is therefore based on the written and oral declarations made before the Commission over the past six years.

88. In the case under consideration, no indication from the government, with the exception of the issue of slavery, seeks to refute the facts adduced in the communications. The representative of the government, who appeared before the Commission at the 19th Session and subsequent sessions, admitted that the communications of which the Commission was seized "deal with a naturally deplorable, but peculiar and exceptional situation [...] that has in any case since been surmounted... ". And according to the government, "most of the issues raised have already been resolved, others are in the process of being settled". It claims, as regards the ex-prisoner civil servants that "the démarches undertaken by those who have constituted themselves into a collective are the result of manipulations of the opposition..." with the aim of countering government action.

89. Though the above-mentioned declaration by the government representative could have constituted a basis for an amicable solution, such a solution could only take place with the agreement of the parties. However at least one of the complainants has clearly indicated that a resolution can only be reached on the basis of some specific conditions, of which none has so far been met to its satisfaction. While it appreciates the government's good will, and hopes to collaborate with it in future to ensure the effectiveness of the settlement of the damages suffered by all the victims of the events described above, the Commission has an obligation to adjudge on the clearly stated facts contained in the various communications. More so as it does not consider acceptable the position of the government that the atrocities and other assassinations committed within the military institution were "an internal affair of the army; that the army had conducted its own inquiry, following which appropriate sanctions were meted out to those military men who were found guilty".

90. Article 7 of the Charter stipulates that:

"Every individual shall have the right to have his cause heard. This comprises:
1. the right to an appeal to competent national organs against acts violating his fundamental rights...;
2. the right to be presumed innocent until proved guilty by a competent court or tribunal;
3. the right to defence, including the right to be defended by counsel of his choice;
4. the right to be tried within a reasonable time by an impartial court or tribunal."

91. Mauritania ratified the African Charter on 14th June 1986, and it came into force on 21st October 1986. The September trials, thus, took place prior to the entry into force of the Charter. These trials led to the imprisonment of various persons. The Commission can only consider a violation that took place prior to the entry into force of the Charter if such a violation continues or has effects which themselves constitute violations after the entry into force of the Charter (cf. decision taken on communication 59/91, p. 28) [sic]. The Commission should therefore have the competence to consider these trials with a view to ascertaining whether the incarcerations that resulted from them constitute a violation of Article 6 of the Charter.

92. The government did not give any substantial response to the allegations that the said trials were arbitrary. Consequently, in conformity with its well-established jurisprudence, the Commission (cf. decisions taken on communications 59/91, 60/91, 64/91, 87/93 and 101/93) shall adjudge based on the elements provided by the complainants.

93. The State Security Section of the Special Tribunal does not provide for any appeal procedure. Two specific cases mentioned in the communications took place in September and October 1987 (see para. 10 and 11) and no appeals were authorised. One of the trials ended in the execution of 3 army lieutenants.

94. Furthermore, even when an appeal was allowed, as in the first case in the "Manifesto" (para. 3 and 4), on 13th October 1986, the Court of Appeal confirmed the verdicts, even though the accused had contested the procedure of the initial trial, and the Public Prosecutor's office did not contest the complaints of the accused. From all indications, the Court of Appeal simply confirmed the sentences without considering all the elements of fact and law. Such a practice cannot be considered a genuine appeal procedure. For an appeal to be effective, the appellate jurisdiction must, objectively and impartially, consider both the elements of fact and law that are brought before it. Since this approach was not followed in the cases under consideration, the Commission considers, consequently, that there was a violation of Article 7(1)(a) of the Charter.

95. In the judgement of early September 1986 (para. 3), the presiding judge declared that the refusal of the accused persons to defend themselves was tantamount to an admission of guilt. In addition, the tribunal based itself, in reaching the verdicts it handed down, on the statements made by the accused during their detention in police cells, which statements were obtained from them by force. This constitutes a violation of Article 7(1)(b).

96. In most of the cases brought up in these communications (para. 3, 4, 5, 9, 10, 11), the accused either had no access or had restricted access to lawyers, and the latter had insufficient time to prepare the defence of their clients. This constitutes a violation of Article 7(1)(c) on the right to defence.

97. The right to defence should also be interpreted as including the right to understand the charges being brought against oneself. In the trial on the September Manifesto (para. 3), only 3 of the 21 accused persons spoke Arabic fluently, and this was the language used during the trial. This means that the 18 others did not have the right to defend themselves. This also constitutes a violation of Article 7(1)(c).

98. A senior military officer who is not required to have legal training, heads the section responsible for matters relating to state security in the Special Tribunal. Two assessors, both military men, assist him. The Special Tribunal is itself presided by an army officer. In the joint procedure on communications 139/94, 154/96 and 161/97 (International PEN, Constitutional Rights Project, Interights and Civil Liberties Organisation/ Nigeria), the Commission reached the conclusion that the "Special Military Tribunals...constituted a violation of Article 7(1)(d) of the Charter by the very virtue of their composition, which is reserved to the discretion of the executive organ". Withdrawing criminal procedure from the competence of the courts established within the judicial order and conferring onto an extension of the executive necessarily compromises the impartiality of the Courts, to which the African Charter refers. Independent of the qualities of the persons sitting in such jurisdictions, their very existence constitutes a violation of the principles of impartiality and independence of the judiciary and, thereby, of Article 7(1)(d).

99. Article 26 of the Charter states that:

"States Parties to the present Charter shall have the duty to guarantee the independence of the courts..."

100. By establishing a section responsible for matters relating to state security within the Special Tribunal, the Mauritanian State was reneging on its duty to guarantee the independence of the courts. The Commission therefore concludes that there has been violation of Article 26.

101. Article 9(2) of the Charter stipulates that:

"Every individual shall have the right to express and disseminate his opinions within the law."

102. Communication 61/91 alleges that the trials on the "Manifesto" (para. 3, 4, 5, 6) and the other related cases (para. 8 and 9) violate the right to freedom of expression and dissemination of one's opinions, to the extent that the accused were charged with distributing a manifesto which provided statistics on racial discrimination and were calling for a dialogue with the government. The expression "within the laws" must be interpreted as reference to the international norms. To the extent that the "Manifesto" did not contain any incitement to violence, it should be protected under international law.

103. Once again, the government did not contest the facts adduced by the complainants. In view of the foregoing, the Commission shall base its argument on the elements provided by the complainants (cf. Decisions 59/91 et al, cited in para. 89 [sic]).

104. Considering that the trials in question in paragraphs 3, 4 and 5 took place prior to the entry into force of the African Charter, the Commission finds no violation of Article 9(2)as regards these cases. However, if the indictments constituted a violation of the African Charter, the detentions that ensued from them would be arbitrary and violate Article 6. The Commission is of the view that these cases would have led to violation of Article 9(2) had they taken place after the entry into force of the Charter. Consequently, the detention of the accused would have been a violation of Article 6.

105. The cases mentioned in paragraphs 8, 9 and 10, which were heard after the entry into force of the Charter, are a violation of the rights stated and protected in Article 9(2).

106. Article 10(1) of the Charter stipulates:

"Every individual shall have the right to free association provided that he abides by the law..."

Some presumed supporters of the Ba'ath Arab Socialist Party were imprisoned for belonging to a criminal association. The accused in the third case relating to the "Manifesto" (para. 6) were charged [with] belonging to a secret movement. The government did not provide any argument to establish the criminal nature or character of these groups. The Commission is of the view that any law on associations should include an objective description that makes it possible to determine the criminal nature of a fact or organisation. In the case under consideration, the Commission considers that none of these simply rational requirements was met and that there was violation of Article 10(2).

107. Article 11 of the Charter stipulates:

"Every individual shall have the right to assemble freely with others. The exercise of this right shall be subject only to necessary restrictions provided for by law, in particular, those enacted in the interest of national security, the safety, health, ethics and rights and freedoms of others."

108. The accused in the Manifesto case were charged [with] holding unauthorised meetings (para. 3 and 6). The trial in question in paragraph 3 took place before the entry into force of the African Charter. Consequently, the Commission cannot consider that there was a violation of Article 11 as regards this particular case. However, had the indictments constituted a violation of Article 11, the detentions that ensued from them would have been a violation of Article 6, which prohibits arbitrary detention.

109. The presumed supporters of the Ba'ath Arab Socialist Party are equally accused of holding unauthorised meetings.

110. The government did not come up with any element to show that these accusations had any foundation in the "interest of national security, the safety, health, ethics and rights and freedoms of others" , as specified in Article 11. Consequently, the Commission considers that there was violation of Article 11 in the cases in question in paragraphs 3 and 11.

111. Article 6 of the Charter stipulates:

"Every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained."

112. There were recurring violations of Article 6. The indictments and trials of September 1986 (para. 3, 4 and 5) were not in conformity with the provisions of the Charter. All those who were incarcerated in its wake were denied their rights as guaranteed in Article 6. The imprisonment resulting from the other cases (para.. 6 and 8), and the two cases from November 1987 (para. 10) as well as the cases against the presumed members of the Ba'ath Arab Socialist Party (para. 11) are arbitrary, for the fact that they were not in conformity with international norms relating to fair trial.

113. The complainants allege that hundreds of people were detained in connection with the 1989 events (para. 15). They allege, further, that a wave of arrests at the end of 1990 resulted in the detention of hundreds of people without charge or trial. According to the complainants, some, and not all, of the detainees were released, adding however that the fate of many people remains unknown. The government did not deny that these arrests and detentions took place, but it maintained that such arbitrary detentions no longer exist. Even if that were the case, it would not annul the previous violations. The Commission considers, therefore, that there was massive violation of Article 6.

114. Article 5 of the African Charter prohibits torture, cruel, inhuman or degrading punishment and treatment. This article also stipulates: "Every individual shall have the right to the respect of the dignity inherent in a human being". All the communications detail instances of torture, and cruel, inhuman and degrading treatments. During their time in custody, the detainees were beaten (para. 8), they were forced to make statements (para. 8 and 11), and they were denied the opportunity of sleeping (para. 10). Both during the trial as well as the period of arbitrary detention, some of the prisoners were held in solitary confinement (para. 5, 8, 10, 11 and 12).

115. The conditions of detention were, at the very least, bad: the prisoners were not fed; they were kept in chains and locked up in overpopulated cells lacking hygiene and access to medical care (para. 12); some were burnt or buried in sand and left to die a slow death; electrical shocks were administered to their genital organs and they had weights tied on to them; their heads were plunged into water to the point of provoking suffocation; pepper was smeared on their eyes and some were permanently kept in small, dark (or underground) cells which got very cold at night (para. 23).

116. Both within and outside the prisons, the so-called "Jaguar" position was the form of torture utilised, (see para. 20 and 22). The prisoners were beaten (para. 12 and 20) and their bodies burnt using various instruments (para. 20 and 22). The women were raped (para. 20).

117. The government did not produce any argument to counter these facts. Taken together or in isolation, these acts are proof of widespread utilisation of torture and of cruel, inhuman and degrading forms of treatment and constitute a violation of Article 5. The fact that prisoners were left to die slow deaths (para

10) equally constitutes cruel, inhuman and degrading forms of treatment prohibited by Article 5 of the Charter.

118. Article 4 of the Charter stipulates that:

"Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right."

119. Following the November 1987 trial, which already violated the provisions of Article 7, three army lieutenants were sentenced to death and executed (para. 10). The trial itself constituted a violation of the African Charter. Furthermore, the Commission is of the view that the executions that followed the said trial constitute a violation of Article 4. Denying people food and medical attention, burning them in sand and subjecting them to torture to the point of death point to a shocking lack of respect for life, and constitutes a violation of Article 4 (see para. 12). Other communications provide evidence of various arbitrary executions that took place in the villages of the River Senegal valley (see para. 18 and 19) and stress that people were arbitrarily detained between September and December 1990 (see para. 22). The Commission considers that there were repeated violations of Article 4.

120. Article 16 of the Charter states that:

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

121. The State's responsibility in the event of detention is even more evident to the extent that detention centres are its exclusive preserve, hence the physical integrity and welfare of detainees is the responsibility of the competent public authorities. Some prisoners died as a result of the lack of medical attention. The general state of health of the prisoners deteriorated due to the lack of sufficient fool; they had neither blankets nor adequate hygiene. The Mauritanian state is directly responsible for this state of affairs and the government has not denied these facts. Consequently, the Commission considers that there was a violation of Article 16.

122. Article 18(1) states that:

    "The family shall be the natural unit and basis of society. It shall be protected by the State..."

123. Holding people in solitary confinement both before and during the trial, and during such detention, which is, on top of it all, arbitrary, (para. 5, 8, 10, 11 and 12) and depriving them of their right to a family life constitutes a violation of Article 18(1).

124. Article 12(1) states that:

    "Every individual shall have the right to freedom of movement and residence within the borders of a State provided he abides by the law."

125. Evicting Black Mauritanians from their houses and depriving them of their Mauritanian citizenship constitutes a violation of Article 12(1). The representative of the Mauritanian government described the efforts made to ensure the security of all those who returned to Mauritania after having been expelled. He claimed that all those who so desired could cross the border, or present themselves to the Mauritanian Embassy in Dakar and obtain authorisation to return to their village of birth. He affirmed that his government had established a department responsible for their resettlement. The Commission adopts the view that while these efforts are laudable, they do not annul the violation committed by the State.

126. Article 14 of the Charter reads as follows:

    "The right to property shall be guaranteed. It may only be encroached upon in the interest of public need or in the general interest of the community and in accordance with the provisions of appropriate laws."

127. The confiscation and looting of the property of Black Mauritanians and the expropriation or destruction of their land and houses before forcing them to go abroad constitute a violation of the right to property as guaranteed in Article 14.

128. Article 2 of the Charter states that:

    "Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour..."

129. The representative of the government as well as the authors of the communications declared that many Black Mauritanians were forced to flee or were detained, tortured or killed because of the colour of their skin, and that the situation in Mauritania became explosive due to the extreme positions adopted by the francophone and arabophone factions that were in opposition to each other in the country.

130. Article 2 of the Charter lays down a principle that is essential to the spirit of this convention, one of whose goals is the elimination of all forms of discrimination and to ensure equality among all human beings. The same objective under-pins the Declaration of the Rights of People Belonging to National, Ethnic, Religious or Linguistic Minorities adopted by the General Assembly of the United Nations in Resolution 47/135 of 18th December 1992. Article 1(1) of this document indeed stipulates: "States shall protect the existence and national or ethnic, cultural, religious or linguistic identity of the minorities within their respective territories and shall stimulate the establishment of conditions conducive to the promotion of such identity." From the foregoing, it is apparent that international human rights law and the community of States accord a certain importance to the eradication of discrimination in all its guises. Various texts adopted at the global and regional levels have indeed affirmed this repeatedly. Consequently, for a country to subject its own indigenes to discriminatory treatment only because of the colour of their skin is an

unacceptable discriminatory attitude and a violation of the very spirit of the African Charter and of the letter of its Article 2.

131. Article 5 of the Charter states that:

"All forms of exploitation and degradation of man particularly slavery ... shall be prohibited."

132. Communications 54/91 and 98/93 allege that a majority of the Mauritanian population is composed of slaves. The government states that slavery had been abolished under the French colonial regime. The communications also allege that freed slaves maintain traditional and close links with their former masters and that this constitutes another form of exploitation.

133. During its mission to Mauritania in June 1996, the Commission's delegation noted that it was still possible to find people considered as slaves in certain parts of the country. Though Edict Nº 81-234 of 9 November [1981] had officially abolished slavery in Mauritania, it was not followed by effective measures aimed at the eradication of the practice. This is why, in many cases, the descendants of slaves find themselves in the service of the masters, without any remuneration. This is due either to the lack of alternative opportunities or because they had not understood that they had been freed of all forms of servitude for many years. From all appearances, some freed slaves chose to return to their former masters. From the Commission's point of view, the State has the responsibility to ensure the effective application of the Edict and thus ensure the freedom of its citizens, to carry our inquiries and initiate judicial action against the perpetrators of violations of the national legislation.

134. Independently from the justification given, by the defendant State, the Commission considers, in line with the provisions of Article 23(3) *Everyone, without any discrimination, has the right to equal pay for equal work.* of the Universal Declaration of Human Rights, that everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection. These provisions are complemented by those of Article 7 of the International Covenant on Economic, Social and Cultural Rights . In view of the foregoing, the Commission deems that there was a violation of Article 5 of the Charter due to practices analogous to slavery, and emphasises that unremunerated work is tantamount to a violation of the right to respect for the dignity inherent in the human being. It furthermore considers that the conditions to which the descendants of slaves are subjected clearly constitute exploitation and degradation of man, both practices condemned by the African Charter. However, the African Commission cannot conclude that there is a practice of slavery based on the evidence before it.

135. Article 17 of the Charter stipulates that:

"2. Every individual may freely take part in the cultural life of his community.
3. The promotion and protection of morals and traditional values recognised by the community shall be the duty of the State...".

137. Language is an integral part of the structure of culture; it in fact constitutes its pillar and means of expression par excellence. Its usage enriches the individual and enables him to take an active part in the community and in its activities. To deprive a man of such participation amounts to depriving him of his identity.

138. The government made it known that there exists in the country an institute of national languages, for over ten years now, and that this institute teaches those languages. However, a persisting problem is the fact that many of these languages are exclusively spoken in small parts of the country and that they are not written. Communication 54/91 alleges the violation of linguistic rights but does not provide any further evidence as to how the government denies the black groups the right to speak their own languages. Information available to the Commission does not provide it a sufficient basis to determine if there has been a violation of Article 17.

139. Article23 of the Charter states: "All peoples shall have the right to national and international peace and security".

140. As advanced by the Mauritanian government, the conflict through which the country passed is the result of the actions of certain groups, for which it is not responsible. But in the case in question, it was indeed the Mauritanian public forces that attacked Mauritanian villages. And even if they were rebel forces, the responsibility for protection is incumbent on the Mauritanian State, which is a party to the Charter (cf.

Commission's decision in communication 74/92). The unprovoked attacks on villages constitute a denial of the right to live in peace and security.

141. Article 19 provides that:

"All peoples shall be equal; they shall enjoy the same respect and shall have the same rights. Nothing shall justify the domination of a people by another..."

142. At the heart of the abuses alleged in the different communications is the question of the domination of one section of the population by another. The resultant discrimination against Black Mauritanians is, according to the complainants (cf. especially communication 54/91), the result of a negation of the fundamental principle of the equality of peoples as stipulated in the African Charter and constitutes a violation of its Article 19. The Commission must however admit that the information made available to it do not allow it to establish with certainty that there has been a violation of Article 19 of the Charter along the lines alleged here. It has nevertheless identified and condemned the existence of discriminatory practices against certain sectors of the Mauritanian population (cf. especially para. 164).

Holding

For these reasons, the Commission

- Declares that, during the period 1989-1992, there were grave or massive violations of human rights as proclaimed in the African Charter; and in particular of articles 2, 4, 5 (constituting cruel, inhuman and degrading treatments), 6, 7(1)(a), 7(1)(b), 7(1)(c) and 7(1)(d), 9(2), 10(1), 11, 12(1), 14, 16(1)1 18(1), and 26.
- Recommends to the government:
  1. To arrange for the commencement of an independent enquiry in order to clarify the fate of persons considered as disappeared, and to identify and bring to book the authors of the violations perpetrated at the time of the facts arraigned.
  2. To take diligent measures to replace the national identity documents of those Mauritanian citizens, which were taken from them at the time of their expulsion and ensure their return without delay to Mauritania as well as the restitution of the belongings looted from them at the time of the said expulsion; and to take the necessary steps for the reparation for the deprivations of the victims of the above-cited events.
  3. To take appropriate measures to ensure payment of a compensatory benefit to the widows and beneficiaries of the victims of the above-cited violations.
  4. To reinstate the rights due to the unduly dismissed and/or forcibly retired workers, with all the legal consequences appertaining thereto.
  5. As regards the victims of degrading practices, to carry out an assessment of the status of such practices in the country with a view to identifying with precision the deep-rooted causes for their persistence and to put in place a strategy aimed at their total and definitive eradication.
  6. To take appropriate administrative measures for the effective enforcement of Ordinance No. 81-234 of 9 November 1981, on the abolition of slavery in Mauritania.

The Commission assures the Mauritanian State of its full cooperation and support in the application of the above-mentioned measures.

Algiers, Algeria, 11 May 2000.

Footnotes

1. Editor's note:The English language version of communication 74/92 is generally of shorter length (26 paragraphs in all) and is less detailed than the French language version (forty one paragraphs), and the paragraphs referenced here do not exist in the English language version.
2. Editor's note: Paragraph 122 of this decision says "Consequently, the Commission considers that there was a violation of Article 16.

D5 155/96:
Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) / Nigeria (2001)

Summary of Facts

1. The communication alleges that the military government of Nigeria has been directly involved in oil production through the State oil company, the Nigerian National Petroleum Company (NNPC), the majority shareholder in a consortium with Shell Petroleum Development Corporation (SPDC), and that these operations have caused environmental degradation and health problems resulting from the contamination of the environment among the Ogoni People.
2. The communication alleges that the oil consortium has exploited oil reserves in Ogoniland with no regard for the health or environment of the local communities, disposing toxic wastes into the environment and local waterways in violation of applicable international environmental standards. The consortium also neglected and/or failed to maintain its facilities causing numerous avoidable spills in the proximity of villages. The resulting contamination of water, soil and air has had serious short and long-term health impacts, including skin infections, gastrointestinal and respiratory ailments, and increased risk of cancers, and neurological and reproductive problems.
3. The communication alleges that the Nigerian Government has condoned and facilitated these violations by placing the legal and military powers of the state at the disposal of the oil companies. The communication contains a memo from the Rivers State Internal Security Task Force, calling for 'ruthless military operations'.
4. The communication alleges that the government has neither monitored operations of the oil companies nor required safety measures that are standard procedure within the industry. The government has withheld from Ogoni communities information on the dangers created by oil activities. Ogoni communities have not been involved in the decisions affecting the development of Ogoniland.
5. The government has not required oil companies or its own agencies to produce basic health and environmental impact studies regarding hazardous operations and materials relating to oil production, despite the obvious health and environmental crisis in Ogoniland. The government has even refused to permit scientists and environmental organisations from entering Ogoniland to undertake such studies. The government has also ignored the concerns of Ogoni communities regarding oil development, and has responded to protests with massive violence and executions of Ogoni leaders.
6. The communication alleges that the Nigerian government does not require oil companies to consult communities before beginning operations, even if the operations pose direct threats to community or individual lands.
7. The communication alleges that in the course of the last three years, Nigerian security forces have attacked, burned and destroyed several Ogoni villages and homes under the pretext of dislodging officials and supporters of the Movement of the Survival of Ogoni People (MOSOP). These attacks have come in response to MOSOP's non-violent campaign in opposition to the destruction of their environment by oil companies. Some of the attacks have involved uniformed combined forces of the police, the army, the air-force, and the navy, armed with armoured tanks and other sophisticated weapons. In other instances, the attacks have been conducted by unidentified gunmen, mostly at night. The military-type methods and the calibre of weapons used in such attacks strongly suggest the involvement of the Nigerian security forces. The complete failure of the Government of Nigeria to investigate these attacks, let alone punish the perpetrators, further implicates the Nigerian authorities.
8. The Nigerian Army has admitted its role in the ruthless operations which have left thousands of villagers homeless. The admission is recorded in several memos exchanged between officials of the SPDC and the Rivers State Internal Security Task Force, which has devoted itself to the suppression of the Ogoni campaign. One such memo calls for "ruthless military operations" and "wasting operations coupled with

psychological tactics of displacement". At a public meeting recorded on video, Major Okuntimo, head of the Task Force, described the repeated invasion of Ogoni villages by his troops, how unarmed villagers running from the troops were shot from behind, and the homes of suspected MOSOP activists were ransacked and destroyed. He stated his commitment to rid the communities of members and supporters of MOSOP.

9. The communication alleges that the Nigerian government has destroyed and threatened Ogoni food sources through a variety of means. The government has participated in irresponsible oil development that has poisoned much of the soil and water upon which Ogoni farming and fishing depended. In their raids on villages, Nigerian security forces have destroyed crops and killed farm animals. The security forces have created a state of terror and insecurity that has made it impossible for many Ogoni villagers to return to their fields and animals. The destruction of farmlands, rivers, crops and animals has created malnutrition and starvation among certain Ogoni communities.

Complaint

10. The communication alleges violations of Articles 2, 4, 14, 16, 18(1), 21, and 24 of the African Charter.

Procedure

11. The communication was received by the [African] Commission on 14th March 1996. The documents were sent with a video.

12. On 13th August 1996 letters acknowledging receipt of the communication were sent to both Complainants.

13. On 13th August 1996, a copy of the communication was sent to the Government of Nigeria.

14. At the 20th Ordinary Session held in Grand Bay, Mauritius in October 1996, the [African] Commission declared the communication admissible, and decided that it would be taken up with the relevant authorities by the planned mission to Nigeria.

15. On 10th December 1996, the Secretariat sent a Note Verbale and letters to this effect to the government and the Complainants respectively.

16. At its 21st Ordinary Session held in April 1997, the [African] Commission postponed taking decision on the merits to the next session, pending the receipt of written submissions from the Complainants to assist it in its decision. The [African] Commission also awaits further analysis of its report of the mission to Nigeria.

17. On 22nd May 1997, the Complainants were informed of the [African] Commission's decision, while the State was informed on 28th May 1997.

18. At the 22nd Ordinary Session, the [African] Commission postponed taking a decision on the case pending the discussion of the Nigerian mission report.

19. At the 23rd Ordinary Session held in Banjul, The Gambia, the [African] Commission postponed consideration of the case to the next session due to lack of time.

20. On 25th June 1998, the Secretariat of the [African] Commission sent letters to all parties concerned informing them of the status of the communication.

21. At the 24th Ordinary Session, the [African] Commission postponed consideration of the above communication to the next session.

22. On 26th November 1998, the parties were informed of the [African] Commission's decision.

23. At the 25th Ordinary Session of the [African] Commission held in Bujumbura, Burundi, the [African] Commission further postponed consideration of this communication to the 26th Ordinary Session.

24. The above decision was conveyed through separate letters of 11th May 1999 to the parties.

25. At its 26th Ordinary Session held in Kigali, Rwanda, the [African] Commission deferred taking a decision on the merits of the case to the next session.

26. This decision was communicated to the parties on 24th January 2000.

27. Following the request of the Nigerian authorities through a Note Verbale of 16th February 2000 on the status of pending communications, the Secretariat, among other things, informed the government that this communication was set down for a decision on the merits at the next session.

28. At the 27th Ordinary Session of the [African] Commission held in Algeria from 27th April to 11th May 2000, the [African] Commission deferred further consideration of the case to the 28th Ordinary Session.

29. The above decision was communicated to the parties on 12th July 2000.

30. At the 28th Ordinary Session of the [African] Commission held in Cotonou, Benin from 26th October to 6th November 2000, the [African] Commission deferred further consideration of the case to the next session. During that session, the Respondent State submitted a Note Verbale stating the actions taken by the Government of the Federal Republic of Nigeria in respect of all the communications filed against it, including the present one. In respect of the instant communication, the Note Verbale admitted the gravamen of the complaints but went on to state the remedial measures being taken by the new civilian administration and they included:

    - Establishing for the first time in the history of Nigeria, a Federal Ministry of Environment with adequate resources to address enviromental related issues prevalent in Nigeria and as a matter of priority in the Niger delta area;
    - Enacting into law the establishment of the Niger Delta Development Commission (NDDC) with adequate funding to address the environmental and social related problems of the Niger delta area and other oil producing areas of Nigeria;
    - Inaugurating the Judicial Commission of Inquiry to investigate the issues of human rights violations.

    In addition, the representatives of the Ogoni people have submitted petitions to the Commission of Inquiry on these issues and these are presently being reviewed in Nigeria as a top priority matter.

31. The above decision was communicated to the parties on 14th November 2000.

32. At the 29th Ordinary Session held in Tripoli, Libya from 23rd April to 7th May 2001, the [African] Commission decided to defer the final consideration of the case to the next session to be held in Banjul, the Gambia in October 2001.

33. The above decision was communicated to the parties on 6th June 2001.

34. At it 30th session held in Banjul, the Gambia from 13th to 27th October 2001, the African Commission reached a decision on the merits of this communication.

Law

Admissibility

35. Article 56 of the African Charter governs admissibility. All of the conditions of this Article are met by the present communication. Only the exhaustion of local remedies requires close scrutiny.

36. Article 56(5) requires that local remedies, if any, be exhausted, unless these are unduly prolonged.

37. One purpose of the exhaustion of local remedies requirement is to give the domestic courts an opportunity to decide upon cases before they are brought to an international forum, thus avoiding contradictory judgements of law at the national and international levels. Where a right is not well provided for in domestic law such that no case is likely to be heard, potential conflict does not arise. Similarly, if the right is not well provided for, there cannot be effective remedies, or any remedies at all.

38. Another rationale for the exhaustion requirement is that a government should have notice of a human rights violation in order to have the opportunity to remedy such violation, before being called to account by an international tribunal. (See the Commission's decision on Communications 25/89, 47/90, 56/91 and 100/93 World Organisation against Torture et al./Zaire: 53)[sic] [1]. The exhaustion of domestic remedies requirement should be properly understood as ensuring that the State concerned has ample opportunity to remedy the situation of which applicants complain. It is not necessary here to recount the international

attention that Ogoniland has received to argue that the Nigerian government has had ample notice and, over the past several decades, more than sufficient opportunity to give domestic remedies.

39. Requiring the exhaustion of local remedies also ensures that the African Commission does not become a tribunal of first instance for cases for which an effective domestic remedy exists.

40. The present communication does not contain any information on domestic court actions brought by the Complainants to halt the violations alleged. However, the [African] Commission on numerous occasions brought this complaint to the attention of the government at the time but no response was made to the [African] Commission's requests. In such cases the [African] Commission has held that in the absence of a substantive response from the Respondent State it must decide on the facts provided by the Complainants and treat them as given. (See communications 25/89, 47/90, 56/91, 100/93 World Organisation against Torture et al./Zaire [sic], communication 60/91 Constitutional Rights Project/Nigeria and communication 101/93 Civil Liberties Organisation/Nigeria).

41. The [African] Commission takes cognisance of the fact that the Federal Republic of Nigeria has incorporated the African Charter into its domestic law with the result that all the rights contained therein can be invoked in Nigerian courts including those violations alleged by the Complainants. However, the [African] Commission is aware that at the time of submitting this communication, the then Military government of Nigeria had enacted various decrees ousting the jurisdiction of the courts and thus depriving the people in Nigeria of the right to seek redress in the courts for acts of government that violate their fundamental human rights[2]. In such instances, and as in the instant communication, the [African] Commission is of the view that no adequate domestic remedies are existent (see communication 129/94 Civil Liberties Organisation/Nigeria).

42. It should also be noted that the new government in their Note Verbale referenced 127/2000 submitted at the 28th session of the [African] Commission held in Cotonou, Benin, admitted to the violations committed then by stating, "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".

The [African] Commission therefore declared the communication admissible.

Merits

43. The present communication alleges a concerted violation of a wide range of rights guaranteed under the African Charter. Before we venture into the inquiry whether the Government of Nigeria has violated the said rights as alleged in the complaint, it would be proper to establish what is generally expected of governments under the [African] Charter and more specifically vis-à-vis the rights themselves.

44. Internationally accepted ideas of the various obligations engendered by human rights indicate that all rights, both civil and political rights and social and economic, generate at least four levels of duties for a State that undertakes to adhere to a rights regime, namely the duty to respect, protect, promote, and fulfil these rights. These obligations universally apply to all rights and entail a combination of negative and positive duties. As a human rights instrument, the African Charter is not alien to these concepts and the order in which they are dealt with here is chosen as a matter of convenience and in no way should it imply the priority accorded to them. Each layer of obligation is equally relevant to the rights in question.[3]

45. At a primary level, the obligation to respect entails that the State should refrain from interfering in the enjoyment of all fundamental rights; it should respect right-holders, their freedoms, autonomy, resources, and liberty of their action.[4] With respect to socio economic rights, this means that the State is obliged to respect the free use of resources owned or at the disposal of the individual alone or in any form of association with others, including the household or the family, for the purpose of rights-related needs. And with regard to a collective group, the resources belonging to it should be respected, as it has to use the same resources to satisfy its needs.

46. At a secondary level, the State is obliged to protect right-holders against other subjects by legislation and provision of effective remedies.[5] This obligation requires the State to take measures to protect beneficiaries of the protected rights against political, economic and social interferences. Protection generally entails the creation and maintenance of an atmosphere or framework by an effective interplay of laws and regulations

so that individuals will be able to freely realize their rights and freedoms. This is very much intertwined with the tertiary obligation of the State to promote the enjoyment of all human rights. The State should make sure that individuals are able to exercise their rights and freedoms, for example, by promoting tolerance, raising awareness, and even building infrastructures.

47. The last layer of obligation requires the State to fulfil the rights and freedoms it freely undertook under the various human rights regimes. It is more of a positive expectation on the part of the State to move its machinery towards the actual realisation of the rights. This is also very much intertwined with the duty to promote mentioned in the preceding paragraph. It could consist in the direct provision of basic needs such as food or resources that can be used for food (direct food aid or social security).[6]

48. Thus, States are generally burdened with the above set of duties when they commit themselves under human rights instruments. Emphasising the all embracing nature of their obligations, the International Covenant on Economic, Social, and Cultural Rights , for instance, under Article 2(1) stipulates exemplarily that States "undertake to take steps...by all appropriate means, including particularly the adoption of legislative measures." Depending on the type of rights under consideration, the level of emphasis in the application of these duties varies. But sometimes, the need to meaningfully enjoy some of the rights demands a concerted action from the State in terms of more than one of the said duties. Whether the government of Nigeria has, by its conduct, violated the provisions of the African Charter as claimed by the Complainants is examined here below.

49. In accordance with Articles 60 and 61 of the African Charter, this communication is examined in the light of the provisions of the African Charter and the relevant international and regional human rights instruments and principles. The [African] Commission thanks the two human rights NGOs who brought the matter under its purview: the Social and Economic Rights Action Center (Nigeria) and the Center for Economic and Social Rights (USA). Such is a demonstration of the usefulness to the [African] Commission and individuals of actio popularis , which is wisely allowed under the African Charter. It is a matter of regret that the only written response from the Government of Nigeria is an admission of the gravamen of the complaints which is contained in a Note Verbale and which we have reproduced above at paragraph 30. In the circumstances, the [African] Commission is compelled to proceed with the examination of the matter on the basis of the uncontested allegations of the Complainants, which are consequently accepted by the [African] Commission.

50. The Complainants allege that the Nigerian Government violated the right to health and the right to clean environment as recognised under Articles 16 and 24 of the African Charter by failing to fulfill the minimum duties required by these rights. This, the Complainants allege, the government has done by:

- Directly participating in the contamination of air, water and soil and thereby harming the health of the Ogoni population;
- Failing to protect the Ogoni population from the harm caused by the NNPC Shell Consortium but instead using its security forces to facilitate the damage;
- Failing to provide or permit studies of potential or actual environmental and health risks caused by the oil operations.

Article 16 of the African Charter reads:

"(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."

Article 24 of the African Charter reads:

"All peoples shall have the right to a general satisfactory environment favourable to their development."

51. These rights recognise 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.[7] As has been rightly observed by Alexander Kiss, "an environment degraded by pollution and defaced by the destruction of all beauty and variety is as contrary to satisfactory living conditions and the development as the breakdown of the fundamental ecologic equilibria is harmful to physical and moral health."[8]

52. The right to a general satisfactory environment, as guaranteed under Article 24 of the African Charter or the right to a healthy environment, as it is widely known, therefore imposes clear obligations upon a government. It requires the state to take reasonable and other measures to prevent pollution and ecological degradation, to promote conservation, and to secure an ecologically sustainable development and use of natural resources. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) , to which Nigeria is a party, requires governments to take necessary steps for the improvement of all aspects of environmental and industrial hygiene. The right to enjoy the best attainable state of physical and mental health enunciated in Article 16(1) of the African Charter and the right to a general satisfactory environment favourable to development (Article 16 (3)[sic][9] already noted obligate governments to desist from directly threatening the health and environment of their citizens. The state is under an obligation to respect the just noted rights and this entails largely non-interventionist conduct from the state for example, not from carrying out, sponsoring or tolerating any practice, policy or legal measures violating the integrity of the individual.[10]

53. Government compliance with the spirit of Articles 16 and 24 of the African Charter must also include ordering or at least permitting independent scientific monitoring of threatened environments, requiring and publicising environmental and social impact studies prior to any major industrial development, undertaking appropriate monitoring and providing information to those communities exposed to hazardous materials and activities and providing meaningful opportunities for individuals to be heard and to participate in the development decisions affecting their communities.

54. We now examine the conduct of the Government of Nigeria in relation to Articles 16 and 24 of the African Charter. Undoubtedly and admittedly, the Government of Nigeria, through NNPC has the right to produce oil, the income from which will be used to fulfil the economic and social rights of Nigerians. But the care that should have been taken as outlined in the preceding paragraph and which would have protected the rights of the victims of the violations complained of was not taken. To exacerbate the situation, the security forces of the government engaged in conduct in violation of the rights of the Ogonis by attacking, burning and destroying several Ogoni villages and homes.

55. The Complainants also allege a violation of Article 21 of the African Charter by the Government of Nigeria. The Complainants allege that the Military government of Nigeria was involved in oil production and thus did not monitor or regulate the operations of the oil companies and in so doing paved a way for the Oil Consortiums to exploit oil reserves in Ogoniland. Furthermore, in all their dealings with the oil consortiums, the government did not involve the Ogoni communities in the decisions that affected the development of Ogoniland. The destructive and selfish role played by oil development in Ogoniland, closely tied with repressive tactics of the Nigerian Government, and the lack of material benefits accruing to the local population[11], may well be said to constitute a violation of Article 21.

    Article 21 provides:

    1. All peoples shall freely dispose of their wealth and natural resources. This right shall be exercised in the exclusive interest of the people. In no case shall a people be deprived of it.
    2. In case of spoliation the dispossessed people shall have the right to the lawful recovery of its property as well as to an adequate compensation.
    3. The free disposal of wealth and natural resources shall be exercised without prejudice to the obligation of promoting international economic co-operation based on mutual respect, equitable exchange and the principles of international law.
    4. States parties [sic] to the present Charter shall individually and collectively exercise the right to free disposal of their wealth and natural resources with a view to strengthening African unity and solidarity.
    5. States Parties [sic] to the present Charter shall undertake to eliminate all forms of foreign economic exploitation particularly that practised by international monopolies so as to enable their peoples to fully benefit from the advantages derived from their national resources.

56. The origin of this provision may be traced to colonialism, during which the human and material resources of Africa were largely exploited for the benefit of outside powers, creating tragedy for Africans themselves, depriving them of their birthright and alienating them from the land. The aftermath of colonial exploitation

has left Africa's precious resources and people still vulnerable to foreign misappropriation. The drafters of the [African] Charter obviously wanted to remind African governments of the continent's painful legacy and restore co-operative economic development to its traditional place at the heart of African Society.

57. Governments have a duty to protect their citizens, not only through appropriate legislation and effective enforcement but also by protecting them from damaging acts that may be perpetrated by private parties (see Union des jeunes avocats c/Chad [12]). This duty calls for positive action on [the] part of governments in fulfilling their obligation under human rights instruments. The practice before other tribunals also enhances this requirement as is evidenced in the case Velàsquez Rodríguez v. Honduras[13]. In this landmark judgment, the Inter-American Court of Human Rights held that when a state allows private persons or groups to act freely and with impunity to the detriment of the rights recognised, it would be in clear violation of its obligations to protect the human rights of its citizens. Similarly, this obligation of the state is further emphasised in the practice of the European Court of Human Rights, in X and Y v. Netherlands [14]. In that case, the [European] Court [of Human Rights] pronounced that there was an obligation on authorities to take steps to make sure that the enjoyment of the rights is not interfered with by any other private person.

58. The [African] Commission notes that in the present case, despite its obligation to protect persons against interferences in the enjoyment of their rights, the Government of Nigeria facilitated the destruction of Ogoniland. Contrary to its Charter obligations and despite such internationally established principles, the Nigerian Government has given the green light to private actors, and the oil companies in particular, to devastatingly affect the well-being of the Ogonis. By any measure of standards, its practice falls short of the minimum conduct expected of governments, and therefore, is in violation of Article 21 of the African Charter.

59. The Complainants also assert that the military government of Nigeria massively and systematically violated the right to adequate housing of members of the Ogoni community under Article 14, and implicitly recognised by Articles 16 and 18(1) of the African Charter.

Article 14 of the [African] Charter provides:

"The right to property shall be guaranteed. It may only be encroached upon in the interest of public need or in the general interest of the community and in accordance with the provisions of appropriate laws."

Article 18(1) provides:

"The family shall be the natural unit and basis of society. It shall be protected by the State..."

60. Although the right to housing or shelter is not explicitly provided for under the African Charter, the corollary of the combination of the provisions protecting the right to enjoy the best attainable state of mental and physical health, cited under Article 16 above, the right to property, and the protection accorded to the family forbids the wanton destruction of shelter because when housing is destroyed, property, health, and family life are adversely affected. It is thus noted that the combined effect of Articles 14, 16 and 18(1) reads into the [African] Charter a right to shelter or housing which the Nigerian Government has apparently violated.

61. At a very minimum, the right to shelter obliges the Nigerian Government not to destroy the housing of its citizens and not to obstruct efforts by individuals or communities to rebuild lost homes. The state's obligation to respect housing rights requires it, and thereby all of its organs and agents, to abstain from carrying out, sponsoring or tolerating any practice, policy or legal measure violating the integrity of the individual or infringing upon his or her freedom to use those material or other resources available to them in a way they find most appropriate to satisfy individual, family, household or community housing needs.[15] Its obligations to protect obliges it to prevent the violation of any individual's right to housing by any other individual or non-state actors like landlords, property developers, and land owners, and where such infringements occur, it should act to preclude further deprivations as well as guaranteeing access to legal remedies.[16] The right to shelter even goes further than a roof over one's head. It extends to embody the individual's right to be let alone and to live in peace, whether under a roof or not.

62. The protection of the rights guaranteed in Articles 14, 16 and 18(1) leads to the same conclusion. As regards the earlier right, and in the case of the Ogoni people, the Government of Nigeria has failed to fulfil these two minimum obligations. The government has destroyed Ogoni houses and villages and then, through its security forces, obstructed, harassed, beaten and, in some cases, shot and killed innocent citizens who have

attempted to return to rebuild their ruined homes. These actions constitute massive violations of the right to shelter, in violation of Articles 14, 16, and 18(1) of the African Charter.

63. The particular violation by the Nigerian Government of the right to adequate housing as implicitly protected in the Charter also encompasses the right to protection against forced evictions. The African Commission draws inspiration from the definition of the term "forced evictions" by the Committee on Economic Social and Cultural Rights which defines this term as "the permanent removal against their will of individuals, families and/or communities from the homes and/or which they occupy, without the provision of, and access to, appropriate forms of legal or other protection"[17]. Wherever and whenever they occur, forced evictions are extremely traumatic. They cause physical, psychological and emotional distress; they entail losses of means of economic sustenance and increase impoverishment. They can also cause physical injury and in some cases sporadic deaths.... Evictions break up families and increase existing levels of homelessness.[18] In this regard, General Comment No. 4 (1991) of the Committee on Economic, Social and Cultural Rights on the right to adequate housing states that "all persons should possess a degree of security of tenure which guarantees legal protection against forced eviction, harassment and other threats" (E/1992/23, annex III. Paragraph 8(a)). The conduct of the Nigerian Government clearly demonstrates a violation of this right enjoyed by the Ogonis as a collective right.

64. The communication argues that the right to food is implicit in the African Charter, in such provisions as the right to life (Article 4), the right to health (Article 16) and the right to economic, social and cultural development (Article 22). By its violation of these rights, the Nigerian Government trampled upon not only the explicitly protected rights but also upon the right to food implicitly guaranteed.

65. The right to food is inseparably linked to the dignity of human beings and is therefore essential for the enjoyment and fulfilment of such other rights as health, education, work and political participation. The African Charter and international law require and bind Nigeria to protect and improve existing food sources and to ensure access to adequate food for all citizens. Without touching on the duty to improve food production and to guarantee access, the minimum core of the right to food requires that the Nigerian Government should not destroy or contaminate food sources. It should not allow private parties to destroy or contaminate food sources, and prevent peoples' efforts to feed themselves.

66. The government's treatment of the Ogonis has violated all three minimum duties of the right to food. The government has destroyed food sources through its security forces and state oil company; has allowed private oil companies to destroy food sources; and, through terror, has created significant obstacles to Ogoni communities trying to feed themselves. The Nigerian Government has again fallen short of what is expected of it as under the provisions of the African Charter and international human rights standards, and hence, is in violation of the right to food of the Ogonis.

67. The Complainants also allege that the Nigerian Government has violated Article 4 of the [African] Charter which guarantees the inviolability of human beings and everyone's right to life and integrity of the person respected. Given the wide spread violations perpetrated by the Government of Nigeria and by private actors (be it following its clear blessing or not), the most fundamental of all human rights, the right to life has been violated. The security forces were given the green light to decisively deal with the Ogonis, which was illustrated by the wide spread terrorisations [sic] and killings. The pollution and environmental degradation to a level humanly unacceptable has made it living in the Ogoni land a nightmare. The survival of the Ogonis depended on their land and farms that were destroyed by the direct involvement of the government. These and similar brutalities not only persecuted individuals in Ogoniland but also the whole of the Ogoni community as a whole. They affected the life of the Ogoni society as a whole. The [African] Commission conducted a mission to Nigeria from the 7th to 14th March 1997 and witnessed first hand the deplorable situation in Ogoniland including the environmental degradation.

68. The uniqueness of the African situation and the special qualities of the African Charter imposes upon the African Commission an important task. International law and human rights must be responsive to African circumstances. Clearly, collective rights, environmental rights, and economic and social rights are essential elements of human rights in Africa. The African Commission will apply any of the diverse rights contained in the African Charter. It welcomes this opportunity to make clear that there is no right in the African Charter that cannot be made effective. As indicated in the preceding paragraphs, however, the Nigerian Government did not live up to the minimum expectations of the African Charter.

69. The [African] Commission does not wish to fault governments that are labouring under difficult circumstances to improve the lives of their people. The situation of the people of Ogoniland, however, requires, in the view of the [African] Commission, a reconsideration of the Government's attitude to the allegations contained in the instant communication. The intervention of multinational corporations may be a potentially positive force for development if the State and the people concerned are ever mindful of the common good and the sacred rights of individuals and communities. The [African] Commission however takes note of the efforts of the present civilian administration to redress the atrocities that were committed by the previous military administration as illustrated in the Note Verbale referred to in paragraph 30 of this decision.

Holding

For the above reasons, the [African] Commission,

- Finds the Federal Republic of Nigeria in violation of Articles 2, 4, 14, 16, 18(1), 21 and 24 of the African Charter;
- Appeals to the government of the Federal Republic of Nigeria to ensure protection of the environment, health and livelihood of the people of Ogoniland by:
    - Stopping all attacks on Ogoni communities and leaders by the Rivers State Internal Securities Task Force and permitting citizens and independent investigators free access to the territory;
    - Conducting an investigation into the human rights violations described above and prosecuting officials of the security forces, NNPC and relevant agencies involved in human rights violations;
    - Ensuring adequate compensation to victims of the human rights violations, including relief and resettlement assistance to victims of government sponsored raids, and undertaking a comprehensive cleanup of lands and rivers damaged by oil operations;
    - Ensuring that appropriate environmental and social impact assessments are prepared for any future oil development and that the safe operation of any further oil development is guaranteed through effective and independent oversight bodies for the petroleum industry; and
    - Providing information on health and environmental risks and meaningful access to regulatory and decision-making bodies to communities likely to be affected by oil operations.
- Urges the government of the Federal Republic of Nigeria to keep the African Commission informed of the outcome of the work of:
    - The Federal Ministry of Environment which was established to address environmental and environment related issues prevalent in Nigeria, and as a matter of priority, in the Niger Delta area including the Ogoniland;
    - The NDDC enacted into law to address the environmental and other social related problems in the Niger Delta area and other oil producing areas of Nigeria; and
    - The Judicial Commission of Inquiry inaugurated to investigate the issues of human rights violations.

Done at the 30thOrdinary session held in Banjul, The Gambia from 13th to 27th October 2001.

Footnotes

1. Editor's note: The French language version of Communications 25/89, 47/90, 56/91 and 100/93 is more detailed and contains more paragraphs (64 paragraphs) than the English language version (48 paragraphs in all). The paragraph referenced here should be paragraph 36, not paragraph 53
2. See The Constitution (Suspension and Modification) Decree 1993.
3. See generally, Asbjørn Eide, "Economic, Social and Cultural Rights As Human Rights" in Asbjørn Eide, Catarina Krause and Allan Rosas (eds.), Economic, Social, and Cultural Rights: A Textbook, Martinus Nijhoff Publishers, 1995, pp. 21-40.

4. Krzysztof Drzewicki, "Internationalization of Human Rights and Their Juridization" in Raija Hanski and Markku Suksi (eds.), Second Revised Edition, An Introduction to the International Protection of Human Rights: A Textbook, 1999, p. 31.
5. Drzewicki, ibid.
6. Eide, in Eide, Krause and Rosas, op cit., p. 38.
7. See also General Comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights .
8. Kathleen E. Mahoney and Paul Mahoney, "Human Rights in the Twenty-first Century: A Global Challenge"; Alexander Kiss "Concept and Possible Implications of the Right to Environment". p. 553.
9. Editor's note: Article 16 has only two subsections, the Article referenced here should be Article 24
10. See Scott Leckie "The Right to Housing" in Eide, Krause and Rosas, op. cit.
11. See a report by the Industry and Energy Operations Division West Central Africa Department "Defining an Environmental Development Strategy for the Niger Delta" , Volume 1, para. B(1.6 - 1.7), p. 2-3.
12. Communication 74/92 Commission Nationale des Droits de l'Homme et des Libertes/Chad.
13. See, Inter-American Court of Human Rights, Velàsquez Rodrígeuz (sic) case, judgment of July 19 1988, Series C, No. 4.
14. 91 ECHR (1985) (Ser. A) at 32.
15. Scott Leckie, "The Right to Housing" in Eide, Krause and Rosas, op cit., 107-123, at p. 113.
16. Ibid, pp. 113-114.
17. See General Comment No.7 (1997) on the right to adequate housing (Article 11(1)): Forced Evictions.
18. Ibid, p. 113.

D6 241/01: *Purohit and Moore/Gambia (The)* (2003)

Summary of Facts

1. The Complainants are mental health advocates, submitting the communication on behalf of patients detained at Campama, a Psychiatric Unit of the Royal Victoria Hospital, and existing and 'future' mental health patients detained under the Mental Health Acts of the Republic of The Gambia.
2. The complaint was sent by fax and received at the Secretariat on 7th March 2001.
3. The Complainants allege that legislation governing mental health in The Gambia is outdated.
4. It is alleged that within the Lunatics Detention Act [LDA], the principle instrument governing mental health) there is no definition of who a lunatic is, and that there are no provisions and requirements establishing safeguards during the diagnosis, certification and detention of the patient.
5. Further, the Complainants allege that there is overcrowding in the psychiatric unit, no requirement of consent to treatment or subsequent review of continued treatment.
6. The Complainants also state that there is no independent examination of administration, management and living conditions within the unit itself.
7. The Complainants also complain that patients detained in the psychiatric unit are not even allowed to vote.
8. The Complainants notify the African Commission that there is no provision for legal aid and the Act does not make provision for a patient to seek compensation if his/her rights have been violated.

Complaint

9. The Complainants allege a violation of Articles 2, 3, 5, 7(1)(a) and 7(1)(c), 13(1), 16 and 18(4) of the African Charter.

Procedue

10. Ms H. Purohit and Mr P. Moore presented the communication and it was received at the Secretariat on the 7th March 2001.
11. On 14th March 2001, the Secretariat wrote to the Complainants requesting that they furnish the names of the persons on whose behalf they were acting.
12. On the 4th April 2001, the Secretariat received the names of the persons on whose behalf Purohit and Moore were acting and it was stated clearly that those persons wished to remain anonymous.
13. At its 29th Ordinary Session from 23rd April to 7th May 2001 in Tripoli, Libya, the African Commission examined the complaint and decided to be seized of it.
14. On 23rd May 2001, the Secretariat conveyed the above decision to the parties and requested parties to furnish it with additional information on admissibility in accordance with Article 56 of the African Charter and forwarded a copy of the text of the complaint to the Respondent State. The Parties were requested to present their written submissions to the Secretariat within three months of notification of the decision.
15. During the 30th Ordinary Session held from 13th to 27th October 2001 in Banjul, The Gambia, the African Commission considered the complaint and the rapporteur of the communication addressed questions to the Representative of the Respondent State. The Representative stated that she was not in a position to provide satisfactory responses to the questions posed at the time but promised to do so soon after the 30th Session.

The African Commission decided to defer consideration of this communication to the 31st Ordinary Session pending receipt of the Respondent State's submissions.

16. On 9th November 2001, the Secretariat wrote to the Complainants informing them of the decision taken by the African Commission at its 31st Session and also forwarded them copies of the Respondent State's submissions that were received at the Secretariat on 11th October 2001. The Complainants were also reminded to forward exhaustive submissions on the question of admissibility of the complaint within two (2) months. On 9th November 2001, the Secretariat also forwarded a Note Verbale to the Respondent State informing it of the decision of the African Commission and reminding them to furnish the African Commission with responses to the questions raised by the African Commission at its 31st Session within two (2) months.

17. The Secretariat also on numerous occasions by telephone and in writing reminded the Solicitor General of the Respondent State to ensure that their written submissions on this matter are forwarded to the Secretariat.

18. At the 31st Ordinary Session held from 2nd to 16th May 2002 in Pretoria, South Africa, the African Commission considered the communication and it was declared admissible.

19. On 29th May 2002, the Secretariat informed the parties of the decision of the African Commission and requested them to transmit their written submissions on admissibility to the Secretariat within a period of three (3) months.

20. At its 32nd Ordinary Session held from 17th to 23rd October in Banjul, The Gambia, the African Commission decided to defer consideration of the communication on the merits and the parties were informed accordingly.

21. By a Note Verbale dated 30th October 2002, the Respondent State was reminded to forward its written submissions on the merits to the Secretariat of the African Commission within a period of two (2) months.

22. At its 33rd Ordinary Session held from 15th to 29th May 2003 in Niamey, Niger, the African Commission considered this communication and decided to deliver its decision on the merits.

Law

Admissibility

23. Article 56 of the African Charter governs admissibility of communications brought before the African Commission in accordance with Article 55 of the African Charter. All of the conditions of this Article are met by the present communication. Only Article 56(5), which requires that local remedies be exhausted, necessitates close scrutiny. Article 56(5) of the African Charter provides:

    "Communications ... received by the African Commission shall be considered if they: (5) are sent after exhausting local remedies, if any unless it is obvious that this procedure is unduly prolonged".

24. The rule requiring exhaustion of local remedies as a condition of the presentation of a complaint before the African Commission is premised on the principle that the Respondent State must first have an opportunity to redress by its own means within the framework of its own domestic legal system, the wrong alleged to have been done to the individual.

25. The Complainants submit that they could not exhaust local remedies because there are no provisions in the national laws of The Gambia allowing for the Complainants to seek remedies where a violation has occurred.

26. The Respondent State concedes that the [LDA] does not contain any provisions for the review or appeal against an order of detention or any remedy for detention made in error or wrong diagnosis or treatment. Neither do the patients have the legal right to challenge the two separate medical certificates, which constitute the legal basis of their detention.

27. The Respondent State submits that in practice patients found to be insane are informed that they have a right to ask for a review of their assessment. The Respondent State further states that there are legal provisions or procedures within the Gambia that such a vulnerable group of persons could have utilised for

their protection. Section 7(d) of the Constitution of The Gambia recognises that Common Law forms part of the laws of The Gambia. As such, Respondent State argues, the Complainants could seek remedies by bringing an action in tort for false imprisonment or negligence where a patient held at Campama Psychiatric Unit is wrongly diagnosed.

28. The Respondent State further submits that patients detained under the [LDA] have every right to challenge the Act in a Constitutional Court claiming that their detention under that Act deprives them of their right to freedom of movement and association as provided for under the Gambian Constitution

29. The concern raised in the present communication is that in The Gambia, there are no review or appeal procedures against determination or certification of one's mental state for both involuntary and voluntary mental patients. Thus the legislation does not allow for the correction of an error assuming a wrong certification or wrong diagnosis has been made, which presents a problem in this particular case where examination of the said mental patients is done by general practitioners and not psychiatrists. So if an error is made and there is no avenue to appeal or review the medical practitioners' assessment, there is a great likelihood that a person could be wrongfully detained in a mental institution.

30. Furthermore, the [LDA] does not lay out fixed periods of detention for those persons found to be of unsound mind, which, coupled with the absence of review or appeal procedures could lead into a situation where a mental patient is detained indefinitely.

31. The issue before the African Commission is whether or not there are domestic remedies available to the Complainants in this instance.

32. The Respondent State indicates that there are plans to amend the [LDA], which, in other words is an admission on part of the Respondent State that the Act is imperfect and would therefore not produce real substantive justice to the mental patients that would be detained.

33. The Respondent State further submits that even though the Act itself does not provide review or appeal procedures, there are legal procedures or provisions in terms of the Constitution that the Complainants could have used and thus sought remedies in court. However, the Respondent State has informed the African Commission that no legal assistance or aid is availed to vulnerable groups to enable them access the legal procedures in the country. Only persons charged with capital offences get legal assistance in accordance with the Poor Persons Defence (Capital Charge) Act.

34. In the present matter, the African Commission cannot help but look at the nature of people that would be detained as voluntary or involuntary patients under the [LDA] and ask itself whether or not these patients can access the legal procedures available (as stated by the Respondent State) without legal aid.

35. The African Commission believes that in this particular case, the general provisions in law that would permit anybody injured by another person's action are available to the wealthy and those that can afford the services of private counsel. However, it cannot be said that domestic remedies are absent as a general statement; the avenues for redress are there if you can afford it.

36. But the real question before this Commission is whether looking at this particular category of persons the existent remedies are realistic. The category of people being represented in the present communication are likely to be people picked up from the streets or people from poor backgrounds and as such it cannot be said that the remedies available in terms of the [Gambian] Constitution are realistic remedies for them in the absence of legal aid services.

37. If the African Commission were to literally interpret Article 56(5) of the African Charter, it might be more inclined to hold the communication inadmissible. However, the view is that, even as admitted by the Respondent State, the remedies in this particular instance are not realistic for this category of people and therefore not effective and for these reasons the

African Commission declares the communication admissible.

Merits

38. The present communication was declared admissible at the African Commission's 31st Ordinary Session in May 2002. The Respondent State has since been requested numerous times to forward their submissions on the merits but to no avail. On 29th April 2003, two weeks prior to the 33rd Ordinary Session, the Respondent State finally forwarded their written submissions to the Secretariat of the African Commission.

39. In coming to its decision, the African Commission will refer to the more recent written submissions on the merits as presented by the Respondent State as well the Respondent State's submissions on admissibility in particular where they address issues relating to the merits of this communication.

40. When States ratify or accede to international instruments like the African Charter, they do so voluntarily and very much awake to their responsibilities to implement the provisions of these instruments. It therefore troubles the African Commission to be forced to make several requests to the Respondent State for its submissions, which are pertinent to its consideration of communications. In the present communication, it is very much unfortunate that the African Commission was forced to take this path bearing in mind the fact that its headquarters is within the Respondent State. This situation not only seriously hampers the work of the African Commission but it also defeats the whole purpose of the African Charter, to which the Respondent States professes to be aligned with. The African Commission therefore hopes that in future the Respondent State will be forthcoming to its requests especially those relating to communications.

41. The Complainants submit that by ratifying the African Charter, the Respondent State undertook an obligation to bring its domestic laws and practice in conformity with the African Charter. This presupposes that any domestic law, which violates the African Charter, should as soon as the Respondent State ratifies or accedes to the African Charter be brought into conformity with articles provided for therein. 'As soon as' in this context would mean that States that are parties to the African Charter should take immediate steps, mindful of their obligations, to bring their legislation in line with the African Charter. The legislation in dispute in the present communication; the LDA was enacted in 1917 and the last amendment to this Act was effected in 1964. There is no doubt that since 1964, there have been many developments in the field of human rights, particularly addressing the rights of persons with disabilities. As such, the LDA should have long been amended to bring it in line with the changed circumstances.

42. In principle, where domestic laws that are meant to protect the rights of persons within a given country are alleged to be wanting, the African Commission holds the view that it is within its mandate to examine the extent to which such domestic law complies with the provisions of the African Charter 1. This is because when a State ratifies the African Charter it is obligated to uphold the fundamental human rights contained therein[2]. Otherwise if the reverse were true, the significance of ratifying a human rights treaty would be seriously defeated. This principle is in line with Article 14 of the Vienna Convention on the Law of Treaties of 1980.[3]

43. The Complainants submit that the provisions of the [LDA] condemning any person described as a 'lunatic' to automatic and indefinite institutionalisation are incompatible with and violate Articles 2 and 3 of the African Charter. Section 2 of the LDA defines a 'lunatic' as including 'an idiot or person of unsound mind'.

44. The Complainants argue further that to the extent that mental illness is a disability[4], the practice of detaining persons regarded as mentally ill indefinitely and without due process constitutes discrimination on the analogous ground of disability.

45. Article 2 of the African Charter provides:

"Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, or any other opinion, national or social origin, fortune, birth or other status."

Article 3 of the African Charter provides:

"1. Every individual shall be equal before the law Every individual shall be entitled to equal protection of the law."

46. In interpreting and applying the African Charter, the African Commission relies on its own jurisprudence, and as provided by Articles 60 and 61 of the African Charter, on appropriate and relevant international and regional human rights instruments, principles and standards.

47. The African Commission is, therefore, more than willing to accept legal arguments with the support of appropriate and relevant international and regional human rights instruments, principles, norms and standards taking into account the well recognised principle of universality which was established by the Vienna Declaration and Programme of Action of 1993 and which declares that "all human rights are universal, indivisible, interdependent, and interrelated."[5]

48. Articles 2 and 3 of the African Charter basically form the anti-discrimination and equal protection provisions of the African Charter. Article 2 lays down a principle that is essential to the spirit of the African Charter and is therefore necessary in eradicating discrimination in all its guises, while Article 3 is important because it guarantees fair and just treatment of individuals within a legal system of a given country. These provisions are non-derogable and therefore must be respected in all circumstances in order for anyone to enjoy all the other rights provided for under the African Charter.

49. In their submissions to the African Commission, the Respondent State conceded that under the LDA, persons declared 'lunatics' do not have the legal right to challenge the two separate medical certificates that constitute the legal basis of their detention. However, the Respondent State argued, that in practice patients found to be insane are informed that they have a right to ask for a review of their assessment. The Respondent State further argues that Section 7(d) of the Constitution of The Gambia recognises that Common Law forms part of the laws of The Gambia. Therefore, such a vulnerable group of persons are free to seek remedies by bringing a tort action for false imprisonment or negligence if they believe they have been wrongly diagnosed and as a result of such diagnosis been wrongly institutionalised.

50. Furthermore, the Respondent State submits that patients detained under the LDA have every right to challenge the Act in a Constitutional Court claiming that their detention under that Act deprives them of their right to freedom of movement and association as provided for under the Constitution of The Gambia.

51. In view of the Respondent State's submissions on the availability of legal redress, the African Commission questioned the Respondent State as to whether legal aid or assistance would be availed to such a vulnerable group of persons in order for them to access the legal procedures of in the country. The Respondent State informed the African Commission that only persons charged with capital offences are entitled to legal assistance in accordance with the Poor Persons Defence (Capital Charge) Act.

52. The category of persons that would be detained as voluntary or involuntary patients under the LDA are likely to be people picked up from the streets or people from poor backgrounds. In cases such as this, the African Commission believes that the general provisions in law that would permit anybody injured by another person's act can only be available to the wealthy and those that can afford the services of private counsel.

53. Clearly the situation presented above fails to meet the standards of anti-discrimination and equal protection of the law as laid down under the provisions of Articles 2 and 3 of the African Charter and Principle 1(4)[6] of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Illnesses and the Improvement of Mental Health Care.[7]

54. The Complainants further submit that the legislative scheme of the LDA, its implementation and the conditions under which persons detained under the Act are held, constitute separately and together violations of respect for human dignity in Article 5 of the African Charter and the prohibition against subjecting anybody to cruel, inhuman or degrading treatment as contained in the same Charter provision.

55. Article 5 of the African Charter provides:

"Every individual shall have the right to the respect of dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man, particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited."

56. Human dignity is an inherent basic right to which all human beings, regardless of their mental capabilities or disabilities as the case may be, are entitled to without discrimination. It is therefore an inherent right which every human being is obliged to respect by all means possible and on the other hand it confers a duty on every human being to respect this right.

57. In *Media Rights Agenda/Nigeria*,[8] the African Commission held that the term 'cruel, inhuman or degrading punishment and treatment' is to be interpreted so as to extend to the widest possible protection against abuses, whether physical or mental; furthermore, in John K. Modise/Botswana[9], the African Commission

stated that exposing victims to 'personal suffering and indignity' violates the right to human dignity. Personal suffering and indignity can take many forms, and will depend on the particular circumstances of each communication brought before the African Commission.

58. Under the LDA, persons with mental illness have been branded as 'lunatics' and 'idiots'. Terms, which without any doubt dehumanise and deny them any form of dignity in contravention of Article 5 of the African Charter.

59. In coming to this conclusion, the African Commission would like to draw inspiration from Principle 1(2) of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Care. Principle 1(2) requires that "all persons with mental illness, or who are being treated as such, shall be treated with humanity and respect for the inherent dignity of the human person."

60. The African Commission maintains that mentally disabled persons would like to share the same hopes, dreams and goals and have the same rights to pursue those hopes, dreams and goals just like any other human being[10]. Like any other human being, mentally disabled persons or persons suffering from mental illnesses have a right to enjoy a decent life, as normal and full as possible, a right which lies at the heart of the right to human dignity. This right should be zealously guarded and forcefully protected by all States party to the African Charter in accordance with the well established principle that all human beings are born free and equal in dignity and rights.[11]

61. The Complainants also submit that the automatic detention of persons considered 'lunatics' within the meaning of the LDA violates the right to personal liberty and the prohibition of arbitrary arrest and detention in terms of Article 6 of the African Charter.

62. Article 6 of the African Charter provides:

"Every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained."

63. Article 6 of the African Charter guarantees every individual, be they disabled or not, the right to liberty and security of the person. Deprivation of such liberty is only acceptable if it is authorised by law and is compatible with the obligations of States Parties under the African Charter [12]. However, the mere mention of the phrase 'except for reasons and conditions previously laid down by law' in Article 6 of the African Charter does not mean that any domestic law may justify the deprivation of such persons' freedom and neither can a State party to the African Charter avoid its responsibilities by recourse to the limitations and claw back clauses in the African Charter [13]. Therefore, any domestic law that purports to violate this right should conform to internationally laid down norms and standards.

64. Article 6 of the African Charter further states that no one may be arbitrarily arrested or detained. Prohibition against arbitrariness requires among other things that deprivation of liberty shall be under the authority and supervision of persons procedurally and substantively competent to certify it.

65. Section 3(1) of the LDA prescribes circumstances under which mentally disabled persons can be received into a place of detention and they are:

- On submission of 2 certificates by persons referred to under the LDA as "duly qualified medical practitioners";
- Upon an order being made by and signed by judge of the Supreme Court, a Magistrate or any two Justices of the Peace.

66. A duly qualified medical practitioner" under the LDA has been defined as "every person possessed of a qualification entitling him to be registered and practice medicine in The Gambia"[14].

67. By these provisions, the LDA authorises the detention of persons believed to be mentally ill or disabled on the basis of opinions of general medical practitioners. Although the LDA does not lay out fixed periods of detention for persons found to be mentally disabled, the Respondent State has submitted that in practice the length of time spent by patients in the unit ranges from two to four weeks and that it is only in exceptional circumstances that patients may be detained longer than this period. These exceptional circumstances apply to mainly schizophrenics, and vagrant psychotics without any family support and known addresses. The African Commission takes note of the fact that such general medical practitioners may not be actual experts in the field of mental health care and as such there is a possibility that they could make a wrong diagnosis

upon which certain persons may be institutionalised. Additionally, because the LDA does not provide for review or appeal procedures, persons institutionalised under such circumstances would not be able to challenge their institutionalisation in the event of an error or wrong diagnosis being made. Although this situation falls short of international standards and norms[15], the African Commission is of the view that it does not violate the provisions of 6 of the African Charter because Article 6 of the African Charter was not intended to cater for situations where persons in need of medical assistance or help are institutionalised.

68. The Complainants also allege that institutionalisation of detainees under the LDA who are not afforded any opportunity of being heard or represented prior to or after their detention violates Articles 7(1)(a) and 7(1)(c) of the African Charter.

69. Articles 7(1)(a) and 7(1)(c) of the African Charter provides:

"1. Every individual shall have the right to have his cause heard. This comprises: (a) The right to an appeal to competent national organs against acts of violating his fundamental rights as recognised and guaranteed by conventions, laws, regulations and customs in force;

(c) The right to defence, including the right to be defended by counsel of his choice."

70. It is evident that the LDA does not contain any provisions for the review or appeal against an order of detention or any remedy for detention made in error or wrong diagnosis or treatment. Neither do the patients have the legal right to challenge the two separate medical certificates, which constitute the legal basis of their detention. These omissions in the LDA clearly violate Articles 7(1)(a) and 7(1)(c) of the African Charter.

71. The guarantees in Article 7(1) extend beyond hearings in the normal context of judicial determinations or proceedings. Thus Article 7(1) necessitates that in circumstances where persons are to be detained, such persons should at the very least be presented with the opportunity to challenge the matter of their detention before the competent jurisdictions that should have ruled on their detention.[16] The entitlement of persons with mental illness or persons being treated as such to be heard and to be represented by Counsel in determinations affecting their lives, livelihood, liberty, property or status, is particularly recognised in Principles 16, 17 and 18 of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Care.

72. The Complainants submit that the failure of the Respondent State to provide for and enable the detainees under the LDA to exercise their civic rights and obligations, including the right to vote, violates Article 13(1) of the African Charter which provides:

"Every citizen shall have the right to participate freely in the government of his country, either directly or through freely chosen representatives in accordance with the provisions of the law."

73. In its earlier submissions, the Respondent State admits that persons detained at Campama are not allowed to vote because they believe that allowing mental health patients to vote would open the country's democratic elections to much controversy as to the mental ability of these patients to make an informed choice as to which candidate to vote for. Subsequently, the Respondent State in its more recent submissions suggests that there are limited rights for some mentally disabled persons to vote; however this has not been clearly explained.

74. The right provided for under Article 13(1) of the African Charter is extended to 'every citizen' and its denial can only be justified by reason of legal incapacity or that the individual is not a citizen of a particular State. Legal incapacity may not necessarily mean mental incapacity. For example a State may fix an age limit for the legibility of its own citizens to participate in its government. Legal incapacity, as a justification for denying the right under Article 13(1) can only come into play by invoking provisions of the law that conform to internationally acceptable norms and standards.

75. The provisions of Article 13(1) of the African Charter are similar in substance to those provided for under Article 25 of the International Covenant on Civil and Political Rights:

"Every citizen shall have the right and the opportunity, without any of the distinctions mentioned in article 2 and without unreasonable restrictions:

1. *To take part in the conduct of public affairs, directly or through freely chosen representatives;*
2. *To vote and to be elected at genuine periodic elections which shall be by universal and equal suffrage and shall be held by secret ballot, guaranteeing the free expression of the will of the electors;*
3. *To have access, on general terms of equality, to public service in his country.*

In interpreting Article 13(1) of the African Charter, the African Commission would like to endorse the clarification provided by the [UN] Human Rights Committee in relation to Article 25. The [UN] Human Rights Committee has expressed that any conditions applicable to the exercise of Article 25 rights should be based on objective and reasonable criteria established by law.[17] Besides the view held by the Respondent State questioning the mental ability of mentally disabled patients to make informed choices in relation to their civic duties and obligations, it is very clear that there are no objective bases within the legal system of the Respondent State to exclude mentally disabled persons from political participation.

76. The Complainants submit that the scheme and operation of the LDA both violate the right to health provided for in Article 16 of the African Charter when read with Article 18(4) of the African Charter.

77. Article 16 of the African Charter provides: [#"1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.

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

79. Article 18(4) of the African Charter which provides:

"The aged and disabled shall also have the right to special measures of protection in keeping with their physical or moral needs."

80. Enjoyment of the human right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind.

81. More so, as a result of their condition and by virtue of their disabilities, mental health patients should be accorded special treatment which would enable them not only attain but also sustain their optimum level of independence and performance in keeping with Article 18(4) of the African Charter and the standards applicable to the treatment of mentally ill persons as defined in the [UN] Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care.

82. Under the Principles, 'mental health care' includes analysis and diagnosis of person's mental condition and treatment, care and rehabilitation for a mental illness or suspected mental illness. The Principles envisage not just 'attainable standards', but the highest attainable standards of health care for the mentally ill at three levels. First, in the analysis and diagnosis of a person's mental condition; second, in the treatment of that mental condition, and third during the rehabilitation of a suspected or diagnosed person with mental health problems.

83. In the instant case, it is clear that the scheme of the LDA is lacking in terms of therapeutic objectives as well as provision of matching resources and programmes of treatment of persons with mental disabilities, a situation that the Respondent State does not deny but which nevertheless falls short of satisfying the requirements laid down in Articles 16 and 18(4) of the African Charter.

84. The African Commission would however like to state that it is aware that millions of people in Africa are not enjoying the right to health maximally because African countries are generally faced with the problem of poverty which renders them incapable to provide the necessary amenities, infrastructure and resources that facilitate the full enjoyment of this right. Therefore, having due regard to this depressing but real state of affairs, the African Commission would like to read into Article 16 the obligation on part of States party to the African Charter to take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind.

85. The African Commission commends the Respondent State's disclosure that there is no significant shortage of drug supplies at Campama and that in the event that there are drug shortages, all efforts are made to alleviate the problem. Furthermore, that it has taken steps to improve the nature of care given to mental health patients held at Campama. The Respondent State also informed the African Commission that it is fully aware of the outdated aspects of the LDA and has therefore long taken administrative steps to

complement and/or reform the archaic parts of the LDA. This is however not enough because the rights and freedoms of human beings are at stake. Persons with mental illnesses should never be denied their right to proper health care, which is crucial for their survival and their assimilation into and acceptance by the wider society.

Decision

For the above reasons, the African Commission,

- Finds the Republic of The Gambia in violation of Articles 2, 3, 5, 7(1)(a) and 7(1)(c), 13(1), 16 and 18(4) of the African Charter.
- Strongly urges the Government of The Gambia to:
  1. Repeal the [LDA] and replace it with a new legislative regime for mental health in The Gambia compatible with the African Charter and international standards and norms for the protection of mentally ill or disabled persons as soon as possible;
  2. Pending (a), create an expert body to review the cases of all persons detained under the [LDA] and make appropriate recommendations for their treatment or release;
  3. Provide adequate medical and material care for persons suffering from mental health problems in the territory of The Gambia.
- Requests the Government of The Gambia to report back to the African Commission when it submits its next periodic report in terms of Article 62 of the African Charter on measures taken to comply with the recommendations and directions of the African Commission in this decision.

Taken at the 33rd Ordinary Session of the African Commission held in Niamey, Niger, May 2003.

Footnotes

1. Communication 211/98 Legal Resources Foundation/Zambia.
2. In the case of the Attorney General v Unity Dow, 1994 6 BCLR 1 Per Ammisah JP, pp. 27-30 and Aguda J.A., pp. 43-47, The Botswana Appeal Court correctly observed that there is a presumption that when States sign or ratify treaties or human rights instruments, they signify their intention to be bound by and to adhere to the obligations arising from such treaties or human rights instruments even if they do not enact domestic legislation to effect domestic incorporation.
3. Article 14 of the Vienna Convention provides as follows:

   1. "The consent of a State to be bound by a treaty is expressed by ratification when:

   (a) the treaty provides for such consent to be expressed by means of ratification;
   (b) it is otherwise established that the negotiating States were agreed that ratification should be required;
   (c) the representative of the State has signed the treaty subject to ratification; or
   (d) the intention of the State to sign the treaty subject to ratification appears from the full powers of its representative or was expressed during the negotiation.
   (e)

   2. The consent of a State to be bound by a treaty is expressed by acceptance or approval under conditions similar to those which apply to ratification."

4. Paragraph 17 of the Introduction to the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (UN General Assembly Resolution 48/96 of 20th December 1993) provides that: "the term 'disability' summarises a great number of different functional limitations ...People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness..."
5. Vienna Declaration and Programme of Action, UN Doc A/CONF.157/23, para.5.
6. Principle 1(4) provides: "There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has an effect of nullifying or impairing equal enjoyment of rights."
7. General Assembly Resolution 46/119, 46 UN General Assembly ORSupp. (No. 49) at 189, UN Doc A/46/49 (1991).
8. Communication 224/98 Media Rights Agenda/Nigeria.

9. Communication 97/93 John K. Modise/Botswana, decision reached at the 27th Ordinary Session of the African Commission held in 2000.

10. Article 3 of the UN Declaration on the Rights of Disabled Persons, UNGA Resolution 3447(XXX) of 9th December 1975, provides that "Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and as full as possible."

11. Article 1 of the Universal Declaration of Human Rights of 1948

    All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

12. Consolidated communications 147/95, 149/95 [sic] Sir Dawda K. Jawara/The Gambia.

13. Communication 211/98 Legal Resources Foundation/Zambia.

14. Section 2 of the Lunatics Detention Act Cap 40:05, Laws of The Gambia.

15. See Principles 15, 16 and 17 of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Medical Care.

16. Communication 71/92 Rencontre Africaine pour la defense des droits de l'homme/Zambia; Communication 159/96 UIDH et al./ Angola.

17. Human Rights Committee, General Comment 25 (57), adopted by the Committee at its 1501th meeting, UN Doc. CCPR/C/21/Rev. 1/Add. 7 (1996), para. 4

    4. Any conditions which apply to the exercise of the rights protected by article 25 should be based on objective and reasonable criteria. For example, it may be reasonable to require a higher age for election or appointment to particular offices than for exercising the right to vote, which should be available to every adult citizen. The exercise of these rights by citizens may not be suspended or excluded except on grounds which are established by law and which are objective and reasonable. For example, established mental incapacity may be a ground for denying a person the right to vote or to hold office.

D7 227/99:
Democratic Republic of Congo / Burundi, Rwanda, Uganda
(2003)

Summary of facts

1. On 8 March 1999, the Secretariat of the African Commission on Human and Peoples' Rights received from Mr Léonard She Okitundu, Minister of Human Rights of the Democratic Republic of Congo, a letter with reference CABMIN/MDH/MM/201/MZ/99, dated 24 February 1999, a communication presented on behalf of the Congolese government based on the provisions of article 49 of the Charter.
2. The communication is filed against the Republics of Burundi, Rwanda and Uganda (hereinafter referred to, respectively, as 'Burundi', 'Rwanda' and 'Uganda'). It alleges grave and massive violations of human and peoples' rights committed by the armed forces of these three countries in the Congolese provinces where there have been rebel activities since 2 August 1998, and for which the Democratic Republic of Congo blames Burundi, Uganda and Rwanda. In support of its complaint the Democratic Republic of Congo states that the Ugandan and Rwandan governments have acknowledged the presence of their respective armed forces in the eastern provinces of the Democratic Republic of Congo under what it terms the 'fallacious pretext' of 'safeguarding their interests'. The complaint states, furthermore, that the Congolese government has 'sufficient and overwhelming evidence of Burundi's involvement'.
3. In particular, the Democratic Republic of Congo asserts that on Monday, 3 August 1998, 38 officers and about 100 men of the Congolese forces were assassinated, after being disarmed, at Kavumu airport, Bukavu, in the Congolese province of South Kivu. Relatedly, on Tuesday, 4 August 1998, over 50 corpses were buried in Bukavu, about twenty of them near the fuel station at the Nyamwera market, opposite Ibanda mosque. Other corpses (mostly civilians) were found at the military camp called 'SaÝo camp' in Bukavu. On 17 August 1998, the Rwandan and Ugandan forces that had been on Congolese territory for many weeks, besieged Inga hydroelectric dam, in Lower Congo province, a wholly civilian facility. The presence of these forces disrupted the lives of millions of people and the economic life of the Democratic Republic of Congo. It also caused the death of many patients including children in hospitals, due to the cutting off of electricity supply to incubators and other respiratory equipment.
4. On Monday, 24 August 1998, over 856 persons were massacred in Kasika, in Lwindi chiefdom, and Mwenga. The bodies found over a distance of 60 kilometres from Kilungutwe to Kasika (in South Kivu province) were mainly those of women and children. The women had been raped before being killed by their murderers, who slashed them open from the vagina up to the abdomen and cut them up with daggers. On 2 September 1998, in a bid to ambush the men of the Congolese army based in Kamituga, the Rwandan and Ugandan forces in Kitutu village massacred 13 people. On 6 October 1998, 48 civilians were killed in Lubarika village. In Uvira town, on the banks of Lake Tanganyika, a massacre of the population including intellectuals and other able-bodied persons took place. This was partly evidenced by the discovery of 326 bodies in Rushima river, near Luberizi. 547 bodies were also discovered buried in a mass grave at Bwegera, and 138 others were found in a butcher's shop in Luvingi village. From 30 December 1998 to 1 January 1999, 612 persons were massacred in Makobola, South Kivu province. All these atrocities were committed by the Rwandan and Ugandan forces which invaded territories of the Democratic Republic of Congo, according to the complaint of the Democratic Republic of Congo.
5. The Democratic Republic of Congo also claims that the forces of Rwanda and Uganda aimed at spreading sexually transmitted diseases and committing rape. To this end, about 2 000 AIDS suffering or HIV-positive Ugandan soldiers were sent to the front in the eastern province of Congo with the mission of raping girls and women so as to propagate an AIDS pandemic among the local population and, thereby, decimate it. The Democratic Republic of Congo notes that 75 per cent of the Ugandan army are suffering from AIDS. A white paper annexed to the communication enumerates many cases of rape of girls and women perpetrated by the forces of Rwanda and Uganda, particularly in South Kivu province. It further states that

on Monday, 5 October 1998, in Lumunba quarter, Babozo division, Bagira commune, under the instructions of a young Rwandan officer nicknamed 'Terminator', who was then commanding the Bagira military camp, several young Congolese girls were raped by soldiers based at the said camp. Similar cases of rape have been reported from Mwenga, Walungu, Shabunda and Idjwi.

6. The Democratic Republic of Congo avers that since the beginning of the war in its eastern provinces, the civilian population has been deported by the Rwandan and Ugandan armies to what it refers to as 'concentration camps' situated in Rwanda. It further states that other people are simply massacred and incinerated in crematories (especially in Bugusera, Rwanda). The goal of these operations is to make the indigenous people disappear from these regions and thus, to establish what it terms 'Tutsiland'.

7. The Democratic Republic of Congo also accuses Rwanda and Uganda of carrying out systematic looting of the underground riches of the regions controlled by their forces, just as the possessions of the civilian population are being hauled away to Burundi, Rwanda and Uganda. To substantiate its accusations, it states that on 4 September 1998, the contents of all the safes of the local branch of the Central Bank of Congo in Bukavu town were looted and the booty taken away to Rwanda. In Kalema, a town in Maniema province, all the minerals in the factory of the Sominiki firm were looted by the same forces. The Democratic Republic of Congo claims that between October and December 1998, the gold produced by the Okimo firm and by local diggers, yielding US$100 000 000 was carted to Rwanda. Still according to its estimation, the coffee produced in the region and in North Kivu yielded about US$70 000 000 to Uganda in the same period. As for the wood produced by the Amexbois firm based in Kisangani town, it is exported to Uganda. Rwanda and Uganda have also taken over control of the fiscal and customs revenue collected respectively by the Directorate General of Taxes. The plunder of the riches of the eastern provinces of Congo is also affecting endangered animal species such as okapis, mountain gorillas, rhinoceros, and elephants.

The Complaint

8. The Democratic Republic of Congo claims, among other things, that it is the victim of an armed aggression perpetrated by Burundi, Rwanda and Uganda; and that this is a violation of the fundamental principles that govern friendly relations between states, as stipulated in the Charters of the United Nations and the Organization of African Unity; in particular, the principles of non-recourse to force in international relations, the peaceful settlement of differences, respect for the sovereignty and territorial integrity of states and non-interference in the internal affairs of states. It emphasises that the massacres and other violations of human and peoples' rights that it accuses Burundi, Rwanda and Uganda of, are committed in violation of the provisions of articles 2, 4, 6, 12, 16, 17, 19, 20, 21, 22 and 23 of the African Charter on Human and Peoples' Rights.

9. It also claims violation of the provisions of the International Covenant on Civil and Political Rights, the Geneva Conventions of 12 August 1949 and of the Additional Protocol on the Protection of Victims of International Armed Conflicts (Protocol I) of 8 June 1977.

10. From the foregoing, the Democratic Republic of Congo, based on the facts presented and the law cited, requests the Commission to:

    Declare that the violations of the human rights of the civilian population of the eastern provinces of the Democratic Republic of Congo by Rwanda, Uganda and Burundi are in contravention of the relevant provisions of the African Charter on Human and Peoples' Rights cited above; andExamine the communication diligently, especially in the light of article 58(1) & (3) of the Charter with a view to producing a detailed, objective and impartial report on the grave and massive violations of human rights committed in the war-affected eastern provinces and to submit it to the Assembly of Heads of State and Government of the Organization of African Unity.

11. The Democratic Republic of Congo also requests the Commission to:

    Take due note of the violations of the relevant provisions of the Charters of the United Nations, the Organization of African Unity, and the one on Human and Peoples' Rights; Condemn the aggression against the Democratic Republic of Congo, which has generated grave violations of the human rights of peaceful peoples; Deploy an investigation mission with a view to observing in loco the accusations made

against Burundi, Rwanda and Uganda; Demand the unconditional withdrawal of the invading troops from Congolese territory in order to put an end to the grave and massive violations of human rights; Demand that the countries violating human and peoples' rights in the Democratic Republic of Congo pay just reparation for the damages caused and the acts of looting; and Indicate the appropriate measures to punish the authors of the war crimes or crimes against humanity, as the case may be, and the creation of an ad hoc tribunal to try the crimes committed against the Democratic Republic of Congo. The ad hoc tribunal may be created in collaboration with the United Nations.

The procedure

12. The communication was received at the Secretariat of the Commission on 8 March 1999. The same day, two letters were dispatched by fax, to the Ministry of Human Rights and the Ministry of Foreign Affairs of the Democratic Republic of Congo respectively, acknowledging receipt.

13. In compliance with the relevant provisions of the Charter and the Rules of Procedure, the Secretariat then submitted the communication to the Commission, meeting at its 25th ordinary session from 26 April to 5 May 1999, in Bujumbura (Burundi).

14. At its 25th ordinary session held in Bujumbura, Burundi, the Commission took a decision of seizure on the communication and requested the complainant state to forward an official copy of its complaint to the Secretary-General of the OAU.

15. On 28 May 1999, notes verbales together with a copy of the communication were each sent to the Ministries of External Affairs/External Relations of the respondent states informing them of the communication filed against them by the Democratic Republic of Congo.

16. On 2 June 1999, the Secretariat wrote to the authorities of the Democratic Republic of Congo informing them of the decision of seizure taken by the Commission and requesting them to comply with the provisions of article 49 of the Charter.

17. At the 26th session of the Commission held in Kigali, Rwanda, the communication was not examined, as the Commission considered it necessary to allow the respondent states more time to communicate their reactions.

18. On 14 December 1999, the Secretariat wrote to the various parties requesting their reactions regarding the issue of admissibility.

19. At the 27th ordinary session held from 27 April to 11 May 2000 in Algiers, Algeria, the Commission heard oral submissions on the admissibility of the case from representatives of the complainant state and from two respondent states (Rwanda and Uganda). The Commission, after examining the case according to the provisions of its Rules of Procedure, thereafter declared the communication admissible and requested parties to furnish it with arguments on the merits of the case.

20. The parties were accordingly informed of the above decision on 14 July 2000.

21. At the 28th session of the Commission held from 23 October to 6 November 2000 in Cotonou, Benin, the communication was not considered as the Commission had not received any response from respondent states on the request that was extended to them following the 27th session.

22. During the session, however, the delegation of Rwanda transmitted to the Secretariat of the Commission, a submission, which stated that the Commission should not have declared communication 227/99 admissible because the procedure followed by the Democratic Republic of Congo was not valid and that the Commission itself had not respected the provisions of its own Rules of Procedure. The submission further stated that the matters addressed by the communication were pending before competent authorities of the Organization of African Unity and other international bodies like the UN Security Council and ECOSOC. Finally, Rwanda refuted allegations of human rights violations made against it by the Democratic Republic of Congo and justified the presence of its troops in this country on grounds of security, while accusing the Democratic Republic of Congo of hosting groups hostile to Rwanda.

23. The submission of Rwanda was transmitted to all states concerned by communication 227/99.

24. In October 2000, the Secretariat of the Commission received from Uganda a submission on communication 227/99 in which the respondent state recognised and justified the presence of its troops in the Democratic Republic of Congo. The troops were said to be in the Democratic Republic of Congo to prevent Ugandan rebels from attacking the Ugandan territory.

25. Uganda stated in its submission that since the early 1990's the territory of the Democratic Republic of Congo (then the Republic of Zaire) has provided sanctuary to bands of armed rebel groups. These rebel groups, which Uganda claims support former dictator Idi Amin, have posed a significant danger for Uganda since 1996.

26. Uganda stated that supported by both Sudan and Mobutu's government in the Democratic Republic of Congo, these groups grew to 6 000, posing a serious security threat to Uganda and that therefore Ugandan troops were present in the Democratic Republic of Congo in order to prevent Ugandan rebels from attacking the Ugandan territory.

27. The submission further states that after Mobutu's overthrow in 1997, the Kabila government invited Uganda to enter eastern Congo to work together to stop the activities of the anti-Uganda rebels and that Ugandan armed forces remained in the Democratic Republic of Congo at the request of President Kabila, since his forces 'had no capability to exercise authority' in the remote eastern region. Uganda attached the Protocol between the Democratic Republic of Congo and the Republic of Uganda on Security along the Common Border to show that both sides recognised the problem of armed groups and decided to co-operate.

28. According to Uganda, President Kabila revoked the above-mentioned agreement in August 1998 as a new rebellion started in the Democratic Republic of Congo (when the coalition that had overthrown Mobutu disintegrated) and blamed this 'internal rebellion', on the invasion of Uganda and Rwanda. The Democratic Republic of Congo then started looking for allies in its struggle against the rebels and it turned to forces hostile to the governments of Rwanda and Uganda, specifically the Allied Democratic Force and pro-Idi Amin groups. Uganda said it therefore had no option but to keep its troops in the Democratic Republic of Congo, in order to deal with the threat of attacks posed by these foreign-sponsored rebel groups.

29. To support its actions, Uganda cited provisions of international instruments: article 51 of the UN Charter; article 3 of the UN General Assembly Resolution on the Definition of Aggression; The UN General Assembly Declaration of Principles of International Law Concerning Friendly Relations and Cooperation Among States; and article 23 of the African Charter on Human and Peoples' Rights.

30. In its submission, Uganda also points to the lack of evidence implicating it in the alleged human rights violations, stating for example that, Ugandan troops have never been in some places mentioned in the communication. The submission characterises the violations relating to HIV/AIDS as 'the most ridiculous allegation'. Referring to the joint case against itself, Rwanda, and Burundi, Uganda claims that '[t]here is never group responsibility for violations'. In addition, 'allegations of human rights violations must be verified by an independent body or by a fact-finding Commission.' Uganda contrasts the allegations it faces with evidence of the Democratic Republic of Congo government's involvement in violations in its eastern provinces.

31. As for the withdrawal of Ugandan troops from the Democratic Republic of Congo, the submission relies on the Democratic Republic of Congo's failed request to the International Court of Justice (ICJ) to order the unconditional withdrawal of Ugandan troops.

32. Regarding payment of reparations, Uganda points to the lack of documentation on this issue and, concerning the illegal exploitation of the Democratic Republic of Congo's natural resources, Uganda denied involvement and affirmed its 'unconditional support to the United Nation's efforts to set up a panel of experts [that the Democratic Republic of Congo has also approved] to investigate' the issue.

33. On the issue of investigation of human rights violations, while Uganda welcomed the Democratic Republic of Congo's call for independent investigation, it portrayed the Democratic Republic of Congo's uninvestigated allegations as 'disturbing'.

34. Uganda also noted that the Democratic Republic of Congo has accused Uganda in several other fora: the UN Security Council, the ICJ, the Lusaka Initiative, and the OAU. According to the respondent state, these actions 'present a dilemma to the conduct of international affairs ... and adjudication', undermining the credibility of these institutions and the Commission as divergent opinions may be reached.

35. In conclusion Uganda contends that 'there is no legal basis on which the African Commission can deal with the communication and declare any of the remedies sought by the Democratic Republic of Congo against Uganda'.

36. Copies of the submissions of Uganda on communication 227/99 were transmitted to all states concerned by the communication.

37. In December 2000, the Secretariat of the Commission received a set of five submissions from the Democratic Republic of Congo containing reports on alleged violations of human rights by armed forces of the respondent states and their alleged allies in the territory of the Democratic Republic of Congo. The submissions also stated that the foreign uninvited troops in the Democratic Republic of Congo were looting the resources of the country.

38. The Secretariat of the Commission transmitted these submissions to the respective parties to the communication.

39. At the 29th session, which was held from 23 April to 7 May 2001 in Tripoli, Libya, the communication was not considered because the Commission had still not received any submission from one of the respondent states, namely, Burundi. On that occasion, all relevant letters and submissions by the other states were transmitted to the delegations of all the respondent states including Burundi, for their consideration and reaction to the Commission.

40. In August 2001, the Secretariat of the Commission received a request from the Ministry of Human Rights of the Democratic Republic of Congo, which deplored the delays in the processing of communication 227/99 and invited the Commission to summon an extraordinary session in order to deal diligently with the communication.

41. By notes verbales ACHPR/COMM/044 sent to their respective Ministries of Foreign/External Affairs on 26 September 2001, the Secretariat of the Commission informed all states concerned by communication 227/99 that it was going to consider the said communication on the merits, at its 30th ordinary session scheduled from 13 to 27 October 2001 in Banjul, The Gambia.

42. In October 2001, the Secretariat of the Commission received a note verbale from Rwanda, which restated the objections raised in its submission of October 2000 concerning communication 227/99, adding that if Rwanda's arguments were not taken into account, it should not be called upon to present a defence.

43. At its 30th session, the Commission discussed the request by the Democratic Republic of Congo about organising an extraordinary session to deal with communication 227/99 and resolved to raise the issue with the relevant authorities of the Secretariat of the African Union. The Commission also heard oral statements by the delegations of Rwanda and Uganda on the issue, written copies of which were also handed over to its Secretariat

44. In its statement, the Rwandan delegation reiterated its arguments stated during the 28th session and objected to the proposed extraordinary session to deal with the communication on the grounds that the communication could be considered during an ordinary session and that an extraordinary session will have financial implication. Rwanda therefore recommended that the Commission deals with the communication during its 31st session scheduled for May 2002 in Pretoria, South Africa. The statement further justified the presence of Rwandan troops in the Democratic Republic of Congo by the assistance that the government of this country is granting elements hostile to the government of Kigali and concluded that as long as such a threat exists for Rwanda, it could not withdraw its troops from the Democratic Republic of Congo.

45. In its statement, the Ugandan delegation said that they had not received the documents sent to them on communication 227/99 and could not present their defence at that stage. The delegation further objected to the holding of an extraordinary session to deal with the communication and added that the facts complained of by the Democratic Republic of Congo are also pending before the International Court of Justice and that consideration of the communication by the Commission would prejudice the court hearing.

46. At the 31st session of the Commission, which was held from 2 to 16 May 2002 in Pretoria, South Africa, the Commission did not consider the Communication because there had been no response from the Organization of African Unity regarding the request from the Democratic Republic of Congo on the

holding of the extraordinary session on the communication. During that session, the Commission resolved to proceed as follows: the African Commission would hold the extraordinary session in case the Secretary General of the OAU agree to it, or (in case the OAU did not accept the idea of extraordinary session), the African Commission would arrange its agenda for the 32nd ordinary session in such a way as to have sufficient time to deal with the communication. That decision was communicated to the delegations of all the states concerned who were attending the session.

47. By note verbale ACHPR/COMM 227/99 of 11 June 2002, the Secretariat transmitted that decision to the states concerned by the communication.

48. A reminder was also sent to the same states by notes verbales ACHPR/COMM 227/99 on 8 October 2002.

49. During its 32nd ordinary session which took place from 17 to 23 October 2002 in Banjul, the Gambia, the Commission did not consider this communication because of the circumstances of the session [1] which did not provide enough time to deal with this important communication.

50. The Commission took a decision on the merits of the communication during its 33rd ordinary session, which was held from 15 to 29 May 2003 in Niamey, Niger.

Law

Admissiblity

51. The procedure for bringing inter-state communications before the Commission is governed by articles 47 to 49 of the Charter. At this stage, it is important to mention that this is the first inter-state communication brought before the African Commission on Human and Peoples' Rights.

52. It is to be noted that Burundi, [2] a respondent state was provided with all the relevant submissions relating to this communication, in conformity with article 57 of the African Charter. But neither did Burundi react to any of them nor did it make any oral submission before the Commission regarding the complaint.

53. The African Commission would like to emphasise that the absence of reaction from Burundi does not absolve the latter from the decision the African Commission may arrive at in the consideration of the communication. Burundi by ratifying the African Charter indicated its commitment to cooperate with the African Commission and to abide by all decisions taken by the latter.

54. In their oral arguments before the Commission at its 27th ordinary session held in Algeria (27 April - 11 May 2000), Rwanda and Uganda had argued that the decision of the complainant state to submit the communication directly to the Chairman of the Commission without first notifying them and the Secretary General of the OAU, is procedurally wrong and therefore fatal to the admissibility of the case.

55. Article 47 requires the complainant state to draw, by written communication, the attention of the violating state to the matter and the communication should also be addressed to the Secretary-General of the OAU and the Chairman of the Commission. The state to which the communication is addressed is to give written explanation or statement elucidating the matter within three months of the receipt of the communication.

56. By the provisions of article 48 of the Charter, if within three months from the date on which the original communication is received by the state to which it is addressed, the issue is not settled to the satisfaction of the two states involved through bilateral negotiation or by any other peaceful procedure, either state shall have the right to submit the matter to the Commission through the Chairman and to notify the other states involved.

57. The provisions of articles 47 and 48 read in conjunction with rules 88 to 92 of the Rules of Procedure of the Commission are geared towards the achievement of one of the essential objectives and fundamental principles of the Charter: conciliation.

58. The Commission is of the view that the procedure outlined in article 47 of the Charter is permissive and not mandatory. This is borne out by the use of the word 'may'. Witness the first sentence of this provision:

If a state party to the present Charter has good reasons to believe that another state party to this Charter has violated the provisions of the Charter, it may draw, by written communication, the attention of that state to the matter.

59. Moreover, where the dispute is not settled amicably, article 48 of the Charter requires either state to submit the matter to the Commission through the Chairman and to notify the other states involved. It does not, however, provide for its submission to the Secretary General of the OAU. Nevertheless, based on the decision of the Commission at its 25th ordinary session, requesting it to forward a copy of its complaint to the Secretary General of the OAU (see paragraph 14 above), the complainant state had done so.

60. Furthermore, it appears that the main reason why the Charter makes provision for the respondent state to be informed of such violations or notified of the submission of such a communication to the Commission, is to avoid a situation of springing surprises on the states involved. This procedure enables the respondent states to decide whether to settle the complaint amicably or not. The Commission is of the view that even if the complainant state had not abided by the said provision of the Charter, such omission is not fatal to the communication since after being seized of the case, a copy of the communication, as is the practice of the Commission, was forwarded to the respondent states for their observations (see paragraph 15 above).

61. Article 49 on the other hand, provides for a procedure where the complainant state directly seizes the Commission without passing through the conciliation phase. Accordingly, the complainant state may refer the matter directly to the Commission by addressing a communication to the Chairman, the Secretary General of the OAU and the state concerned. Such a process allows the requesting state to avoid making contacts with the respondent state in cases where such contacts will not be diplomatically either effective or desirable. In the Commission's considered opinion that seems to be the case here. Indeed, the situation of undeclared war prevailing between the Democratic Republic of Congo and its neighbours to the east did not favour the type of diplomatic contact that would have facilitated the application of the provisions of articles 47 and 48 of the Charter. It was also for this reason that the Commission took the view that article 52 did not apply to this communication.

62. The Commission is mindful of the requirement that it can consider or deal with a matter brought before it if the provisions of article 50 of the Charter and rule 97(c) of the Rules of Procedure are met, that is if all local remedies, if they exist, have been exhausted, unless such would be unduly prolonged.

63. The Commission takes note that the violations complained of are allegedly being perpetrated by the respondent states in the territory of the complainant state. In the circumstances, the Commission finds that local remedies do not exist, and the question of their exhaustion does not, therefore, arise.

64. The effect of the alleged activities of the rebels and armed forces of the respondent states parties to the Charter, which also back the rebels, fall not only within the province of humanitarian law, but also within the mandate of the Commission. The combined effect of articles 60 and 61 of the Charter compels this conclusion; and it is also buttressed by article 23 of the African Charter.

65. There is also authority, which does not exclude violations committed during armed conflict from the jurisdiction of the Commission. In communication 74/92, Commission Nationale des Droits de l'Homme et des Libertés v Chad [(2000) AHRLR 66 (ACHPR 1995) para 21], the Commission held that the African Charter,unlike other human rights instruments, does not allow for state parties to derogate from their treaty obligations during emergency situations. Thus, even ... war ... cannot be used as an excuse by the state violating or permitting violations of rights in the African Charter.

(See also communication 159/96, Union Interafricaine des Droits de l'Homme and Others v Angola [(2000) AHRLR 18 (ACHPR 1997)]). From the foregoing, the Commission declares the communication admissible.

The merits

66. The use of armed force by the respondent states, which the Democratic Republic of Congo complains of contravenes the well-established principle of international law that states shall settle their disputes by peaceful means in such a manner that international peace, security and justice are not endangered. Indeed, there cannot be both national and international peace and security guaranteed by the African Charter under the conditions created by the respondent states in the eastern provinces of the complainant state.

67. Rwanda and Uganda, in their oral arguments before the Commission at its 27th ordinary session held in Algeria had argued that the decision of the complainant state to submit the communication directly to the Chairman of the Commission without first notifying them and the Secretary-General of the OAU, is procedurally wrong and therefore fatal to the admissibility of the case. But the African Commission found otherwise.

68. The Commission finds the conduct of the respondent states inconsistent with the standard expected of them under the UN Declaration on Friendly Relations, which is implicitly affirmed by the Charters of the UN and OAU, and which the Commission is mandated by article 23 of the African Charter on Human and Peoples' Rights to uphold. Any doubt that this provision has been violated by the respondent states is resolved by recalling an injunction in the UN Declaration on Friendly Relations:

No state or group of states has the right to intervene, directly or indirectly, for any reason whatever, in the internal or external affairs of any other states. Consequently, armed intervention and all other forms of interference or attempted threats against the personality of the state or against its political, economic and cultural elements are in violation of international law ... Also no state shall organize, assist, foment, finance, incite or tolerate subversive, terrorist or armed activities directed towards the violent overthrow of the regime of another state or interfere in civil strife in another state.

The substance of the complaint of the Democratic Republic of Congo against the respondents is covered by the foregoing prohibition. The respondent states have therefore violated article 23 of the African Charter. The conduct of the respondent states also constitutes a flagrant violation of the right to the unquestionable and inalienable right of the peoples of the Democratic Republic of Congo to self-determination provided for by article 20 of the African Charter, especially clause 1 of this provision.

69. The complainant state alleges grave and massive violations of human and peoples' rights committed by the armed forces of the respondent states in its eastern provinces. It details series of massacres, rapes, mutilations, mass transfers of populations and looting of the peoples' possessions, as some of those violations. As noted earlier on, the series of violations alleged to have been committed by the armed forces of the respondent states fall within the province of humanitarian law, and therefore rightly covered by the four Geneva Conventions and the Protocols additional to them. And the Commission having found the alleged occupation of parts of the provinces of the complainant state by the respondents to be in violation of the Charter cannot turn a blind eye to the series of human rights violations attendants upon such occupation.

70. The combined effect of articles 60 and 61 of the African Charter enables the Commission to draw inspiration from international law on human and peoples' rights, the Charter of the United Nations, the Charter of the Organization of African Unity and also to take into consideration, as subsidiary measures to determine the principles of law, other general or special international conventions, laying down rules recognized by member states of the Organization of African Unity, general principles recognized by African states as well as legal precedents and doctrine. By virtue of articles 60 and 61 the Commission holds that the four Geneva Conventions and the two Additional Protocols covering armed conflicts constitute part of the general principles of law recognized by African states, and take same into consideration in the determination of this case.

71. It is noted that article 75(2) of the First Protocol of the Geneva Conventions of 1949, prohibits the following acts at any time and in all places whatsoever, whether committed by civilian or by military agents:

(a) violence to life, health, or physical or mental well-being of persons, in particular: i) murder; ii) torture of all kinds, whether physical or mental; iii) corporal punishment and iv) mutilation

(b) outrages upon personal dignity, in particular, humiliating and degrading treatment; enforced prostitution and any form of indecent assault.

72. The complainant state alleges the occupation of the eastern provinces of the country by the respondent states' armed forces. It alleges also that most parts of the affected provinces have been under the control of the rebels since 2 August 1998, with the assistance and support of the respondent states. In support of its claim, it states that the Ugandan and Rwandan governments have acknowledged the presence of their respective armed forces in the eastern provinces of the country under what it calls the 'fallacious pretext' of 'safeguarding their interests'. The Commission takes note that this claim is collaborated by the statements of the representatives of the respondent states during the 27th ordinary session held in Algeria.

73. Article 23 of the Charter guarantees to all peoples the right to national and international peace and security. It provides further that '[t]he principles of solidarity and friendly relations implicitly affirmed by the Charter of the United Nations and reaffirmed by that of the Organization of African Unity shall govern relations between states.' The principles of solidarity and friendly relations contained in the Declaration on Principles of International Law Concerning Friendly Relations and Co-operation among States in Accordance with the Charter of the United Nations (resolution 2625 (XXV), adopted by the UN General Assembly on 24 October 1970, prohibits threat or use of force by states in settling disputes. Principle 1 provides:

Every state has the duty to refrain in its international relations from the threat or use of force against the territorial integrity or political independence of any state, or in any other manner inconsistent with the purposes of the United Nations. Such a threat or use of force constitutes a violation of international law and the Charter of the United Nations and shall never be employed as a means of settling international issues.

74. In the same vein, article 33 of the United Nations Charter states that the parties to any dispute, the continuance of which is likely to endanger the maintenance of international peace and security shall first of all,seek a solution by negotiation, enquiry, mediation, conciliation, arbitration, judicial settlement, resort to regional agencies or arrangements, or other peaceful means of their own choice.Chapter VII of the same Charter outrightly prohibits threats to the peace, breaches of the peace and acts of aggression. Article 3 of the OAU Charter states:

The member states, in pursuit of the purposes stated in article 2, solemnly affirm and declare their adherence to the following principles: ... 2. Non-interference in the internal affairs of states; 3. Respect for the sovereignty and territorial integrity of each state and for its inalienable right to independent existence; 4. Peaceful settlement of disputes by negotiation, mediation, conciliation or arbitration.

75. It also contravenes the well-established principle of international law that states shall settle their disputes by peaceful means in such a manner that international peace and security and justice are not endangered. As noted in paragraph 66 above, there cannot be both national and international peace and security guaranteed by the Charter with the conduct of the respondent states in the eastern provinces of the complainant state.

76. The Commission therefore disapproves of the occupation of the complainant's territory by the armed forces of the respondent forces and finds it impermissible, even in the face of their argument of being in the complainant's territory in order to safeguard their national interests and therefore in contravention of article 23 of the Charter. The Commission is of the strong belief that such interests would better be protected within the confines of the territories of the respondent states.

77. It bears repeating that the Commission finds the conduct of the respondent states in occupying territories of the complainant state to be a flagrant violation of the rights of the peoples of the Democratic Republic of Congo to their unquestionable and inalienable right to self-determination provided for by article 20 of the African Charter.

78. As previously stated, the Commission is entitled, by virtue of articles 60 and 61 of the African Charter to

draw inspiration from international law on human and peoples' rights, ... the Charter of the United Nations, the Charter of the Organization of African Unity ... also take into consideration, as subsidiary measures to determine the principles of law, other general or special international conventions, laying down rules recognised by member states of the Organization of African Unity ... general principles recognised by African states, as well as legal precedents and doctrine.

Invoking these provisions, the Commission holds that the four Geneva Conventions and the two Additional Protocols covering armed conflicts, fall on all fours with the category of special international conventions, laying down rules recognised by member states of the Organization of African Unity and also constitute part of the general principles recognised by African states, and to take same into consideration in the determination of this case.

79. The Commission finds the killings, massacres, rapes, mutilations and other grave human rights abuses committed while the respondent states' armed forces were still in effective occupation of the eastern provinces of the complainant state reprehensible and also inconsistent with their obligations under part III of the Geneva Convention relative to the Protection of Civilian Persons in Time of War of 1949 and Protocol I to the Geneva Conventions.

80. They also constitute flagrant violations of article 2 of the African Charter, such acts being directed against the victims by virtue of their national origin; and article 4, which guarantees respect for life and the integrity of one's person and prohibits the arbitrary deprivation of rights.

81. The allegation of mass transfer of persons from the eastern provinces of the complainant state to camps in Rwanda, as alleged by the complainant and not refuted by the respondent, is inconstent with article 18(1) of the African Charter, which recognises the family as the natural unit and basis of society and guarantees it appropriate protection. It is also a breach of the right to freedom of movement, and the right to leave and to return to ones country guaranteed under article 12(1) and (2) of the African Charter respectively.

82. Article 56 of the First Protocol Additional to the Geneva Conventions of 1949 provides:

1. Works or installations containing dangerous forces, namely dams, dykes and nuclear electrical generating stations, shall not be made object of attack, even where these objects are military objectives, if such attack may cause the release of dangerous forces and consequent severe losses among the civilian population. ...
2. The special protection against attack provided by paragraph 1 shall cease: (a) for a dam or dyke only if it is used for other than its normal function and in regular, significant and direct support of military operations and if such attack is the only feasible way to terminate such support ...
3. In all cases, the civilian population and individual civilians shall remain entitled to all the protection accorded them by international law, including the protection of precautionary measures provided for in article 57.

83. As noted previously, taking article 56, quoted above into account, and by virtue of articles 60 and 61 of the African Charter, the Commission concludes that, in besieging the hydroelectric dam in Lower Congo province, the respondent states have violated the Charter.

84. The siege of the hydroelectric dam may also be brought within the prohibition contained in The Hague Convention (II) with Respect to the Laws and Customs of War on Land which provides in article 23 that '[b]esides the prohibitions provided by special conventions, it is especially prohibited ... to destroy or seize the enemy's property, unless such destruction or seizure be imperatively demanded by the necessities of war'. By parity of reason, and bearing in mind articles 60 and 61 of the Charter, the respondent states are in violation of the Charter with regard to the just noted article 23.

85. The case of Zejnil Delalic, Zdravko Mucic, Hazim Delic and Esad Landzo (the Celebici judgment, International Criminal Tribunal for the former Yugoslavia, 16 November 1998 at paragraph 587) is supportive of the Commission's stance. It states, inter alia, that

international law today imposes strict limitations on the measures which a party to an armed conflict may lawfully take in relation to the private and public property of an opposing party. The basic norms in this respect, which form part of customary international law ... [include] the fundamental principle ... that private property must be respected and cannot be confiscated ... [p]illage is formally forbidden.

86. The raping of women and girls, as alleged and not refuted by the respondent states, is prohibited under article 76 of the first Protocol Additional to the Geneva Conventions of 1949, which provides that '[w]omen shall be the object of special respect and shall be protected in particular against rape, forced prostitution and any other forms of indecent assault'. It also offends against both the African Charter and the Convention on the Elimination of All Forms of Discrimination Against Women; and on the basis of articles 60 and 61 of the African Charter find the respondent states in violation of the Charter.

87. The Commission condemns the indiscriminate dumping of, and / or mass burial of victims of the series of massacres and killings perpetrated against the peoples of the eastern province of the complainant state while the armed forces of the respondent states were in actual fact occupying the said provinces. The Commission further finds these acts barbaric and in reckless violation of Congolese peoples' rights to cultural development guaranteed by article 22 of the African Charter, and an affront on the noble virtues of the African historical tradition and values enunciated in the Preamble to the African Charter. Such acts are also forbidden under article 34 of the first Protocol Additional to the Geneva Conventions of 1949, which provides for respect for the remains of such peoples and their gravesites. In disregarding the last provision, the respondent states have violated the African Charter on the basis of articles 60 and 61 of this instrument.

88. The looting, killing, mass and indiscriminate transfers of civilian population, the siege and damage of the hydro-dam, stopping of essential services in the hospital, leading to deaths of patients and the general disruption of life and state of war that took place while the forces of the respondent states were occupying and in control of the eastern provinces of the complainant state are in violation of article 14 guaranteeing the right to property, articles 16 and 17 (all of the African Charter), which provide for the rights to the best attainable state of physical and mental health and education, respectively.

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

90. The complainant state alleges that between October and December 1998, the gold produced by the Okimo firm and by local diggers yielded US$ 100 000 000 to Rwanda. By its calculation, the coffee produced in the region and in North Kivu yielded about US$ 70 000 000 to Uganda in the same period. Furthermore, Rwanda and Uganda took over control of the fiscal and customs revenue collected respectively by the Directorate General of Taxes. The plunder of the riches of the eastern provinces of Congo is also affecting endangered animal species such as okapis, mountain gorillas, rhinoceros, and elephants.

91. Indeed, the respondent states, especially Uganda, has refuted these allegations, pretending for example that its troops never stepped in some of the regions [in which] they are accused of [having perpetrated] human rights violations and looting of the natural resources of the complainant state. However, the African Commission has evidence that some of these facts did take place and are imputable to the armies and agents of the respondent states. In fact, the United Nations have acknowledged that during the period when the armies of the respondent states were in effective control over parts of the territory of the complainant state, there were lootings of the natural resources of the complainant state. The United Nations set up a Panel of Experts to investigate this matter. [3]

92. The report of the Panel of Experts, submitted to the Security Council of the United Nations in April 2001 (under reference S/2001/357) identified all the respondent states among others actors, as involved in the conflict in the Democratic Republic of Congo. [4] The report profusely provides evidence of the involvement of the respondent states in the illegal exploitation of the natural resources of the complainant state. It is stated in paragraph 5 of the summary of the report: [5]

Mass-scale looting. During this first phase stockpiles of minerals, coffee, wood, livestock and money that were available in territories conquered by the armies of Burundi, Rwanda and Uganda were taken, and either transferred to those countries or exported to international markets by their forces and nationals.

93. Paragraph 25 of the reports further states:

The illegal exploitation of resources by Burundi, Rwanda and Uganda took different forms, including confiscation, extraction, forced monopoly and price-fixing. Of these, the first two reached proportions that made the war in the Democratic Republic of the Congo a very lucrative business.

94. The Commission therefore finds the illegal exploitation/looting of the natural resources of the complainant state in contravention of article 21 of the African Charter, which provides:

1. All peoples shall freely dispose of their wealth and natural resources. This right shall be exercised in the exclusive interest of the people. In no case shall a people be deprived of it. ...

4. State parties to the present Charter shall individually and collectively exercise the right to free disposal of their wealth and natural resources with a view to strengthening African unity and solidarity.

95. The deprivation of the right of the people of the Democratic Republic of Congo, in this case, to freely dispose of their wealth and natural resources, has also occasioned another violation - their right to their economic, social and cultural development and of the general duty of states to individually or collectively ensure the exercise of the right to development, guaranteed under article 22 of the African Charter.

96. For refusing to participate in any of the proceedings although duly informed and invited to respond to the allegations, Burundi admits the allegations made against it.

97. Equally, by refusing to take part in the proceedings beyond admissibility stage, Rwanda admits the allegations against it.

98. As in the case of Rwanda, Uganda is also found liable of the allegations made against it.

For the above reasons, the Commission:

- Finds the respondent states in violation of articles 2, 4, 5, 12(1) and (2), 14, 16, 17, 18(1) and (3), 19, 20, 21, 22, and 23 of the African Charter on Human and Peoples' Rights.
- Urges the respondent states to abide by their obligations under the Charters of the United Nations, the Organization of African Unity, the African Charter on Human and Peoples' Rights, the UN Declaration on Principles of International Law Concerning Friendly Relations and Co-operation Among States and other applicable international principles of law and withdraw its troops immediately from the complainant's territory.
- Takes note with satisfaction, of the positive developments that occurred in this matter, namely the withdrawal of the respondent states armed forces from the territory of the complainant state.
- Recommends that adequate reparations be paid, according to the appropriate ways to the complainant state for and on behalf of the victims of the human rights by the armed forces of the respondent states while the armed forces of the respondent states were in effective control of the provinces of the complainant state, which suffered these violations.

Footnotes

1. Financial constraints caused the 32nd Ordinary Session of the [African] Commission to last for only seven (7) days.
2. Burundi, a State Party to the African Charter, ratified the [African] Charter on 28th July 1989
3. See Resolution 1457 (2003) of the Security Council of the United Nations (UN) adopted on 24/01/2003 on the Panel of Experts on the illegal exploitation of the natural resources of the Democratic Republic of Congo. See also presidential statement dated 2nd June 2000 (S/PRST/2000/20), whereby the Security Council requested the Secretary General of the UN to establish a Panel of Experts on the Illegal Exploitation of Natural Resources and Other Forms of Wealth in the Democratic Republic of the Congo for a period of six months.
4. See Point 10a of the summary of the Report.

   Countries and other entities involved in the conflict in the Democratic Republic of the Congo, namely: Angola, Burundi, the Democratic Republic of the Congo, Namibia, Rwanda, Uganda, Zimbabwe, RCD-Goma and RCD-ML;
5. Also see para. 26, 27, 32, 55, 64 of the Report.

D8 279/03-296/05:
Sudan Human Rights Organisation & Centre on Housing Rights and Evictions (COHRE) / Sudan (2009)

Summary of facts

1. The first Communication, the *Sudan Human Rights Organisation et al/The Sudan* (the *SHRO Case*) is submitted by the Sudan Human Rights Organisation (London), the Sudan Human Rights Organisation (Canada), the Darfur Diaspora Association, the Sudanese Women Union in Canada and the Massaleit Diaspora Association (hereinafter called the Complainants).
2. The Complainants allege gross, massive and systematic violations of human rights by the Republic of Sudan (herein after called Respondent State) against the indigenous Black African tribes in the Darfur region (Western Sudan); in particular, members of the Fur, Marsalit and Zaghawa tribes.
3. The Complainants allege that violations being committed in the Darfur region include large-scale killings, the forced displacement of populations, the destruction of public facilities, properties and disruption of life through bombing by military fighter jets in densely populated areas.
4. The Complainants allege that the Darfur region has been under a state of emergency since the government of General Omar Al-Bashir seized power in 1989. They allege further that this situation has given security and paramilitary forces a free hand to arrest, detain torture and carry out extra-judicial executions of suspected insurgents.
5. The Complainants also allege that nomadic tribal gangs of Arab origin, alleged to be members of the militias known as the Murhaleen and the Janjaweed are supported by the Respondent State.
6. The Complainants allege further that an armed group known as the Sudan Liberation Movement/Army issued a political declaration on 13th March 2003 and clashed with Respondent State's Armed Forces. The Respondent State launched a succession of human rights violations against suspected insurgents, using methods such as extra-judicial executions, torture, rape of women and girls, arbitrary arrests and detentions.
7. The Complainants also contend that hundreds of people from the aforementioned indigenous African tribes have been summarily executed by the Respondent State's security forces and by allied militia, adding that detainees are usually tried by special military courts with little regard to international standards or legal protection.
8. The Complainants allege that the above said actions of the Respondent State violate Articles 2, 3, 4, 5, 6, 7(1), 9, 12(1), (2) and (3) and 13(1) and (2) of the African Charter on Human and Peoples' Rights.
9. The second communication, *Centre for Housing Rights and Evictions/The Sudan* (the *COHRE Case*), is submitted by an NGO based in Washington D.C. (the Complainant) against the Republic of Sudan (the Respondent State). The communication is based on almost similar allegations as in the SHRO Case.
10. The Complainant states that Darfur is the largest region in the Respondent State, divided into south, west and north administrative zones and covers an area of about 256,000 square kilometers in size and has an estimated population of five million (5,000,000) persons. That in February 2003 fighting intensified in the Darfur region following the emergence of two armed groups, the Sudan Liberation Army (SLA) and the Justice Equality Movement (JEM), which come primarily from the Fur, Zaghawa and Masaalit tribes. The two armed groups' political demand essentially is for the Respondent State to address the marginalisation and underdevelopment of the region.
11. The Complainant alleges that in response to the emergence of these groups and the armed rebellion, the Respondent State formed, armed and sponsored an Arab militia force known as the Janjaweed to help suppress the rebellion.
12. The Complainant alleges further that the Respondent State is involved at the highest level in the recruitment, arming and sponsoring of the Janjaweed militia. The Complainant cites a Directive dated 13th February 2004, from the office of the sublocality in North Darfur directing all Security units within the locality to

allow the activities of the Janjaweed under the command of Sheikh Musa Hilal to secure its "vital needs." The Complainant also claims that military helicopters from the Respondent State provide arms and supplies of food to the Janjaweed.

13. The Complainant alleges that in addition to attacking rebel targets, the Respondent State's campaign has targeted the civilian population, adding that villages, markets, and water wells have been raided and bombed by helicopter gunships and Antonov airplanes.

14. The Complainant claims that residents of hundreds of villages have been forcibly evicted, their homes and other structures totally or partially burned and destroyed. That thousands of civilians in Darfur have been killed in deliberate and indiscriminate attacks and more than a million people have been displaced.

Complaint and prayers

15. The Complainant in the COHRE Case alleges that the Respondent State has violated Articles 4, 5, 6 7, 12 (1), 14, 16, 18 (1) and 22 of the African Charter. It requests the African Commission to hold the Respondent State liable for the human rights violations in the Darfur region.

16. The Complainant also urges the African Commission to place the violations described in the communication, before the Assembly of Heads of State and Government of the African Union for consideration under 58 of the African Charter; that the African Commission, should undertake an in-depth study of the situation in Darfur and make a factual report with findings and recommendations as mandated in 2 of the African Charter; and that the African Commission should adopt provisional measures in view of the urgency required in this communication.

Procedure

17. The SHRO Case was received by post at the Secretariat of the African Commission (the Secretariat) on 18th September 2003.

18. On 10th October 2003, the Secretariat acknowledged receipt of the Complaint and indicated that it would be considered on seizure by the African Commission during its 34th Ordinary Session held from 6th - 20th November 2003, in Banjul, The Gambia.

19. During its 34th Ordinary Session, the African Commission examined the Communication and decided to be seized of it.

20. On 2nd December 2003, the Secretariat notified the Respondent State of this decision, sent a copy of the complaint, and requested it to send its arguments on admissibility within three months.

21. This decision was also conveyed to the Complainants by letter dated 2nd December 2003.

22. On 29th March 2004, the Respondent State informed the Secretariat that due to various reasons, it would not be able to present its submissions on admissibility and promised to send the said observations at the earliest time possible.

23. During its 35th Ordinary Session which was held in Banjul, The Gambia in May/June 2004, the African

Commission deferred consideration on the admissibility of the Communication to its 36th Ordinary Session at the Respondent State's request.

24. In the meantime, during the 35th Ordinary Session the Complainants delivered to the Secretariat documents containing supplementary information relevant to the complaint.

25. On 6th July 2004, the Secretariat informed both parties about its decision to defer the Communication and reminded the Respondent State to submit its arguments on admissibility. At the same time, the Secretariat conveyed the Complainants' supplementary submissions to the Respondent State, and also notified the Complainants about the Respondent State's request for a deferral of consideration on the admissibility.

26. Seizing the opportunity of a Commission's fact finding mission to the Respondent State, the Secretariat sent another set of the Communication documents to the Respondent State...

27. During its 36th Ordinary Session, held from 23rd November to 7th December 2004 in Dakar, Senegal,

the African Commission considered the Complaint and decided to defer its decision on admissibility to its 37th Ordinary Session. The Respondent State had submitted its arguments on admissibility during the said Session.

28. On 2nd December 2004, the Secretariat of the African Commission acknowledged receipt of the Respondent State's submissions.

29. On 23rd December 2004, the Secretariat informed the parties about the African Commission's decision.

30. During its 37th Ordinary Session, which took place from 27th April to 11th May 2005 in Banjul, The Gambia, the African Commission considered the complaint and, upon request from the Complainants, deferred its decision on admissibility to its 38th Ordinary Session.

31. During the 38th Ordinary Session held from 21st November to 5th December 2006, the African Commission considered the case and decided to postpone its consideration to the 39th Ordinary Session.

32. On 16th December 2005, the Secretariat of the African Commission notified this decision to the parties. The Complainants were requested to submit their rejoinder to the Respondent State's arguments.

33. During its 39th Ordinary Session held from 11th - 25th May 2006, in Banjul, The Gambia, the Commission considered the communication and declared it admissible. It further decided to consolidate the Communication with the COHRE Case.

34. By Note Verbale of 14th July 2006 and by letter of the same date, both parties were notified of the Commission's decision and requested to submit their arguments on the merits within two months.

35. The COHRE Case was received at the Secretariat of the African Commission by e-mail on 6th January 2005.

36. On 11th January 2005, the Secretariat wrote to the Complainant acknowledging receipt of the complaint and informing it that it will be considered on seizure at the Commission's 37th Ordinary Session.

37. At its 37th Ordinary Session held in Banjul, The Gambia from 27th April to 11th May 2005, the African Commission considered the Communication and decided to be seized thereof.

38. On 24th May 2005, the Secretariat sent a copy of the communication to the Respondent State, notified it of the decision of the Commission, and requested it to send its arguments on admissibility within three months of the notification. By letter of the same date, the Complainant was notified of the decision and asked to submit its arguments on admissibility within three months of notification.

39. By letter of 15th June 2005, the Complainant submitted its arguments on admissibility.

40. On 7th July 2005, the Secretariat acknowledged receipt of the Complainant's submission on admissibility and transmitted them to the Respondent State and requested the latter to submit its arguments before 24th August 2005.

41. By Note Verbale dated 2nd September 2005, the Respondent State was reminded to send its arguments on admissibility.

42. On 9th November 2005, the Secretariat received a Note Verbale from the Respondent State submitting its argument on admissibility.

43. By Note Verbale of 11th November, 2005, the Secretariat acknowledged receipt of the Respondent State's submission.

44. At its 38th Ordinary Session held from 21st November to 5th December 2005, the African Commission deferred consideration on the admissibility of the Communication to its 39th Ordinary Session.

45. By Note Verbale of 15th December 2005 and by letter of the same date, the Secretariat notified both parties of the African Commission's decision.

46. By letter of 9th March 2006, the Secretariat forwarded the arguments on admissibility of the State to the Complainant.

47. On 20th March 2006, the Secretariat received a supplementary submission on admissibility from the Complainant in response to the State's submission.

48. By letter of 27th March 2006, the Secretariat acknowledged receipt of the Complainant's supplementary submissions on admissibility.

49. By Note Verbale of 27th March 2006, the Secretariat transmitted the Complainant's supplementary submission on admissibility to the Respondent State and requested the latter to respond before 15th April 2006.

50. At its 39th Ordinary Session held from 11th - 25th May 2006, the African Commission considered the communication and declared it admissible. The Commission decided to consolidate the Communication with the SHRO case.

51. By Note Verbale dated 29th May 2006 and by letter of the same date, both parties were notified of the Commission's decision and requested to make submissions on the merits before 29th August 2006.

52. On 23rd August 2006, the Secretariat received the Complainant's submissions on the merits of the communication. On 1st October 2006, the Secretariat acknowledged receipt of the Complainant's submissions.

53. On 8th October 2006, the Secretariat forwarded the Complainant's submissions to the Respondent State and reminded the latter to make its submissions on the merits before 31st October 2006.

54. At its 40th Ordinary Session held in Banjul, The Gambia, from 15th - 29th November 2006, the African Commission considered the Communication and deferred it to its 41st Ordinary Session pending the Respondent State's response.

55. By Note Verbale of 4th January 2007 and by letter of the same date, both parties were notified of the Commission's decision.

56. By Note Verbale of 11th April 2007, the Secretariat reminded the Respondent State to submit its arguments on the merits.

57. On 25th May 2007, during the 41st Ordinary Session, the Secretariat received the State's submissions on the merits.

58. At its 41st Ordinary Session held in Accra, Ghana, the Commission considered the Communication and deferred it to its 42nd Ordinary Session to allow the Secretariat to translate the submissions and prepare a draft decision.

59. By Note Verbale of 10th July 2007 and letter of the same date both parties were notified of the Commission's decision.

60. At its 42nd Ordinary Session held from 15th-28th November 2007, in Brazzaville, Congo, the Commission considered the Communication and deferred it to its 43rd Ordinary Session because the Respondent State made additional submissions on the matter during the Session.

61. At its 43rd Ordinary Session held in Ezulwini, the Kingdom of Swaziland, the Commission deferred the communication to its 44th Ordinary Session to allow the Secretariat to prepare a draft decision

62. At its 44th Ordinary Session Abuja, Nigeria, the Commission considered the Communication and deferred further consideration to the 45th Ordinary Session due to time constraints.

Law

Submissions on admissibility

The SHRO Case

Complainants' submissions on admissibility

63. The Complainants submit that acts of violence were committed in a discriminatory manner against populations of Black African origin, in the Darfur region, namely the Fur, Massaleit and Zaggawa tribes.

64. They add that the Respondent State is "governed by a military regime, which does not attach the required importance to normal procedures under the Rule of law or respect for the country's institutions," hence citizens, groups and organizations cannot bring issues of human rights violations before independent and impartial Courts, because of the "inevitable harassment, threats, intimidations and disruption of normal life by State security agents".

65. The Complainants submit that the Respondent State continues to hold Mr Hassan El Turabi, leader of the political party National Popular Congress, in detention, in spite of the rulings by the Constitutional Court which gave instructions for his release. That the Darfur region has been placed under a state of emergency since the 1989 coup d'état, and that the situation is deteriorating very rapidly and in a highly dangerous manner in a country which is multi-denominational, multi-cultural and multi-ethnic.

The COHRE Case

66. The Complainant avers that the Respondent State has committed serious and massive violation of human rights. The Complainant argues that the violations are ongoing since 2003. It argues that the communication has been submitted to the African Commission within a reasonable period of time.

67. The Complainant argues further that the victims of forced evictions and other accompanying human rights violations in the Darfur Region cannot avail themselves of local remedies due to several reasons, including the fact that

    1. the victims are increasingly being displaced into remote regions or across international frontiers;
    2. the Respondent State has not created a climate of safety necessary for victims to avail themselves of local remedies; and
    3. the Respondent State is well aware of the series of serious and massive human rights violations occurring in Darfur and has taken little or no steps to remedy those violations. Consequently, these impediments render local remedies unavailable to the victims.

68. The Complainant therefore urges that the communication be declared admissible because domestic remedies are not available.

Respondent State's submissions on admissibility

69. The Respondent State denies all the allegations advanced by the Complainants in the SHRO Case. The Respondent State submits that the conflict in the Darfur region is a result of its geographical location. It argues that the instability in neighbouring countries has negative repercussions on the Respondent State.

70. The Respondent State admits that the conflict in Southern Sudan, which lasted for years had affected all the regions of the country at varying degrees. It states that South Darfur, which borders Southern Sudan, has been affected by armed operation and the massive exodus of the population running away from the fighting. That the three Darfur regions have also been affected by the situation in Chad, Central African Republic and the Democratic Republic of Congo through the introduction of arms from these countries and the influx of hundreds of tribes with kinship links in the Respondent State.

71. The Respondent State submits that armed conflicts in neighbouring States have contributed to the emergence of armed rebel groups which carry out plunder and theft. The Respondent State submits further that it has taken measures to restore stability, bring criminals to courts in accordance with the law and returned stolen property.

72. The Respondent State argues further that the Complainants have not exhausted local remedies. It states that there hasn't been any report/complaint to the police, the Courts, or the National Council or to the Human Rights Consultative Council. It submits further that the complaint does not conform to Articles 56(2) and 56(4) of the African Charter, because it is based on erroneous or imaginary facts which have nothing to do with the Respondent State.

73. The Respondent State claims that the Communication has been overtaken by events since several of the claims were addressed by the President of the Respondent State on 9th March 2004, when he granted general amnesty to those who surrendered their arms. That the Respondent State signed peace agreements at Abeche and N'djamena; launched the reconstruction of infrastructure destroyed by the rebels; allowed international aid organizations to intervene on the ground; and allowed the return of internally displaced persons. It created an independent Commission of Inquiry on the human rights violations, and convened a meeting for all Darfurians to discuss the restoration of peace in the region. In the light of the foregoing, the Respondent State denies all the allegations and declares them 'false and against the spirit of 56 of the African Charter'.

74. With respect to the COHRE Case, the Respondent State advances two main arguments: first, that local remedies have not been exhausted and secondly, that the Communication has been settled by other international mechanisms.

75. The Respondent State argues that the Complainant failed to resort to existing legal, judicial or administrative means within the Respondent State to address the allegations. It argues further that under its law, the protection of human rights is regulated by three main legislative norms:

    1. International and regional human rights as ratified by the Respondent State (considered to be an integral part of the Constitution),
    2. the Constitution, and
    3. State Legislation.

76. It submits that the Constitutional Court was established in 1998 and has jurisdiction to hear cases relating to the protection of human rights, guaranteed in the Constitution and other international instruments ratified. The Supreme Court, the Courts of Appeal, the General Courts and the Tribunals of 1st, 2nd and 3rd Appeals all have jurisdictions, depending on the location, to deal with specific issues. That the President of the Supreme Court can establish specialized courts to deal with specific situations and to hear cases on human rights violations in the three regions of Darfur.

77. The Respondent State argues that it had introduced legal and judicial procedures to punish perpetrators of alleged human rights abuses in Darfur. These mechanisms include: the National Commission of Enquiry on the violation of Human Rights in Darfur under the Chairmanship of the former Vice-President of the Supreme Court, comprised of human rights lawyers and activists. It adds further that the National Commission submitted its report to the President of the Republic in January 2005. Three Committees were established based on the recommendations of the report: namely, the Judiciary Committee of Enquiry to investigate violations, Committee for Compensation and Committee for the Settlement of priority cases of property ownership.

78. Therefore, the Respondent State submits that the communication does not comply with 5 of the African Charter.

79. The Respondent State submits further that the communication was submitted after being settled by UN mechanisms. It argues that the United Nations and the UN Security Council adopted resolutions 1590, 1591 and 1592 concerning the situation in Darfur, which are currently being implemented. In April 2005 the Commission on Human Rights of the UN Economic, Social and Cultural Council, also adopted a resolution concerning the human rights violations in Sudan. As a result, the Respondent State submits that a Special Rapporteur was assigned to look into the human rights situation. She recently visited Sudan, specifically the Darfur region.

80. The Respondent State argues therefore that, the communication is inadmissible under 7 of the African Charter.

Complainant's supplementary submission in response to Respondent State's submission on admissibility

81. In a supplementary brief on admissibility the Complainant submits that, taken together, the forced evictions and accompanying human rights violations amount to serious and massive violations of human rights protected by the African Charter.

82. Complainant cites a 2006 Report by the UN Special Rapporteur on the human rights situation in Sudan which found that "the human rights situation worsened from July 2005...and a comprehensive strategy responding to transitional justice has yet to be developed in the Sudan." The report adds that the cases prosecuted before the Special Criminal Court on the events in Darfur "did not reflect the major crimes committed during the height of the Darfur crisis" and "only one of the cases involved charges brought against a high-ranking official, and he was acquitted."

83. Consequently, the Complainant argues that, the domestic remedies, cited by the Respondent State, are not effective, nor sufficient, since they offer little prospect of success. They are incapable of redressing the complaints.

84. The Complainant submit that the Special Criminal Tribunals "may just be a tactic by the Sudanese government to avoid prosecution by the International Criminal Court." That such tribunals are "doomed to failure" because they lack "serious legal reforms ensuring independence of the judiciary." Hence, the Complainant submit, the Respondent State has failed to bring "...an end to the current climate of intimidation," thereby casting doubts about the effectiveness of domestic remedies.

85. It submits that even though the peace talks are likely to result in what could be considered injunctive relief by halting further human rights violations, they do not provide adequate remedies for the human rights violations.

86. The Complainant adds that the UN Human Rights Commission, in its Resolution 2005/82, found that these domestic remedies are ineffective and insufficient in preventing, halting or remedying the forced evictions and accompanying human rights violations in Darfur.

87. Consequently, it cannot be said that these claims have "been settled" as required by Article 56(7) of the African Charter.

88. The Complainant concludes that the present communication satisfies the requirements of 56 of the African Charter.

African Commission's decision on admissibility

89. Admissibility of communications under the African Charter is governed by the conditions set out in 56. The Complainants argue that the communication complies with all the requirements under 56 of the Charter. The Respondent State argues that the communications be declared inadmissible for not meeting the requirements of Article 56 (2), 56 (4), 56 (5) and 56(7) of the African Charter.

90. 2 requires communications to be compatible with the Constitutive Act or the African Charter. The Respondent State did not explain how the communication is incompatible with either instrument. The mere submission of a communication by a Complainant cannot be deemed an incompatibility under 2 of the African Charter.

91. Bringing communications against State Parties to the African Charter is a means of protecting human and peoples' rights. State Parties to the African Charter are duty bound to respect their obligations under both the Constitutive Act and the African Charter. Article 3(h)

(h) promote and protect human and peoples' rights in accordance with the African Charter on Human and Peoples' Rights and other relevant human rights instruments;

of the Constitutive Act enjoins African States to promote and protect human and peoples' rights in accordance with the African Charter. The African Commission does not consider the filing of complaints before it, an incompatibility with the Constitutive Act or the African Charter. It therefore finds that 2 has been complied with.

92. 4 stipulates that communications should not be based exclusively on news disseminated through the mass media. The present communications are supported by UN Reports as well as reports and press releases of international human rights organisations. These communications are not based exclusively on mass media reports. The Darfur crisis has attracted wide international media attention. It would be impractical to separate allegations contained in the communications from the media reports on the conflict and the alleged violations.

93. In its decision declaring *Sir Dawda Jawara v The Gambia* (the *Jawara Case*) [1] admissible, the Commission stated that "[w]hile it would be dangerous to rely exclusively on news disseminated from the mass media, it would be equally damaging if the Commission were to reject a communication because some aspects of it are based on news disseminated through the mass media. ... There is no doubt that the media remains the most important, if not the only source of information. It is common knowledge that information on human rights violation is always gotten from the media.....The issue therefore should not be whether the information was gotten from the media, but whether the information is correct...". The African Commission therefore finds further that the communications comply with 4.

94. With respect to 5, the Respondent State argues that no attempt was made to approach various internal remedies. The Complainants, on the other hand, argue that 5 does not apply to the communications due to the "serious, massive and systematic" nature of the alleged violations by the Respondent State. They submit that such violations are incapable of being remedied by domestic remedies.

95. 5 of the African Charter provides that communications relating to human and peoples' rights referred to in 55 received by the African Commission shall be considered if they "are sent after the exhaustion of local remedies, if any, unless it is obvious that this procedure is unduly prolonged".

96. The issue to be resolved is whether the local remedies were capable of addressing the violations alleged by the Complainants.

97. The African Commission has previously decided on the question of remedies with respect to cases of serious or massive violations of human rights. In the *Free Legal Assistance Group, Lawyers Committee for Human Rights, Union interafricaine des droits de l'Homme, Les témoins de Jehovah/ Zaire*, the Commission stated that: '[i] n the light of its duty to ensure the protection of human and peoples' rights...the Commission cannot hold the requirement of exhaustion of local remedies to apply literally in cases where it is impractical or undesirable for the complaint [s] to seize the domestic courts in the case of each individual complaint. This is the case where there are a large number of individual victims. Due to the seriousness of the human rights situation as well as the great number of people involved, such remedies as might theoretically exist in the domestic courts are as a practical matter unavailable'.[2]

98. The Respondent State argues that the remedies were not only available, but effective and sufficient, and that the Complainant didn't bother to access them to seek justice for the victims. The Complainants cite several reports which indicate various cases of intimidation, displacement, harassment, sexual and other kinds of violence, which according to the Complainant may not be dealt with appropriately through local remedies.

99. The African Commission has often stated that a local remedy must be available, effective and sufficient. All three criteria must be present for the local remedy envisaged in 5 to be considered worthy of pursuing. In the *Jawara Case*3 the African Commission held that a remedy is considered available if the petitioner can pursue it without impediment. It is deemed effective if it offers a prospect of success. It is found sufficient if it is capable of redressing the complaint.

100. In the present communication, the scale and nature of the alleged abuses, the number of persons involved ipso facto make local remedies unavailable, ineffective and insufficient. This Commission has held in *Malawi African Association and others v. Mauritania*[4] that it "does not believe that the condition that internal remedies must have been exhausted can be applied literally to those cases in which it is neither practicable nor desirable for the Complainants or the victims to pursue such internal channels of remedy in every case of violation of human rights. Such is the case where there are many victims. Due to the seriousness of the human rights situation and the large number of people involved, such remedies as might theoretically exist in the domestic courts are as a practical matter unavailable ..."[5].

101. Such is the case with the situation in the Darfur region, where tens of thousands of people have allegedly been forcibly evicted and their properties destroyed. It is impracticable and undesirable to expect these victims to exhaust the remedies claimed by the State to be available.

102. The African Commission, considering that the alleged violations prima facie constitute "serious and massive violations," finds that under the prevailing situation in the Darfur, it would be impractical to expect the complainants to avail themselves of domestic remedies, which, are in any event, ineffective. Had the domestic remedies been available and effective, the Respondent State would have prosecuted and punished the perpetrators of the alleged violations, which it has not done. The Commission finds that there were no remedies and therefore the criteria under 5 does sic not apply to the Complainants.

103. The Respondent State argued that the violations have been settled by other international mechanisms and cites 7 of the Charter.

104. The African Commission wishes to state that a matter shall be considered settled within the context of 7 of the African Charter, if it was settled by any of the UN human rights treaty bodies or any other international adjudication mechanism, with a human rights mandate. The Respondent State must demonstrate to the Commission the nature of remedies or relief granted by the international mechanism, such as to render the complaints res judicata, and the African Commission's intervention unnecessary.

105. The African Commission, while recognising the important role played by the United Nations Security Council, the Human Rights Council, (and its predecessor, the Commission on Human Rights,) and other UN organs and agencies on the Darfur crisis, is of the firm view that these organs are not the mechanisms envisaged under Article 56(7). The mechanisms envisaged under Article 56(7) of the Charter must be capable of granting declaratory or compensatory relief to victims, not mere political resolutions and declarations.

106. In the opinion of this Commission, the content of the current complaints were not submitted to any such bodies, by the Complainants, or any other individual or institution.

107. For these reasons, the African Commission declares both communications admissible.

Submissions on the merits

108. It should be noted that in spite of several reminders, neither the Complainants nor the Respondent State submitted in respect of the SHRO Case.

109. The other Complainant, COHRE, and the Respondent State made submissions on the merits with respect to the COHRE Case. The Commission will consider their submissions. 1995 Rules of Procedure of the African Commission on Human and Peoples' Rights,120 of the Rules of Procedure of the African Commission states that "[i]f the communication is admissible, the Commission shall consider it in the light of all the information that the individual and the State Party concerned has submitted in writing; it shall make known its observation on this issue...".

Complainant's submissions on the merits

110. The Complainant submits that since February 2003, following the emergence of an armed conflict in the Darfur region, the Respondent State has engaged in and continues to forcibly evict thousands of Black indigenous tribes, inhabitants of the Darfur from their homes, communities and villages. The alleged forced evictions and accompanying human rights abuses recorded in this communication constitute a violation of the rights guaranteed under the African Charter to which the Respondent State is a party.

111. It is submitted that the Respondent State failed to respect and protect the human rights of the Darfur people. Regarding the obligation to respect, it is submitted that government forces attacked villages, injuring and killing civilians, raping women and girls, and destroying homes. The State also failed to prevent the Janjaweed militiamen from killing, assaulting and raping villagers, hence failing in its obligation to protect the civilian population of Darfur. The communication also alleges that at times the Janjaweed and government forces conducted joint attacks on villages.

112. The Complainant argues further that attacks by militias prevented Darfurians from farming land, collecting fireweed for cooking, and collecting grass to feed livestock, which constitute a violation of their right to adequate food.

113. The Complainant submits that the forced eviction and the accompanying human rights abuses in the Darfur region tantamount to violations of the right to life, and the right to security of the person respectively protected under Articles 4 and 6 of the Charter, as thousands of people were killed, injured, and raped.

114. The Complainant submits further that attacks carried out by the Respondent State and the Janjaweed have forced thousands of people to flee their homes and habitual places of residence. According to the Complainant, those actions constitute a violation of the right to freedom of residence under 1 of the Charter.

115. The Complainant states that the forced evictions and destruction of housing and property in the Darfur region violated the right to property enshrined in 14 of the Charter. It is the Complainant's view that those attacks cannot be compared to a lawful dispossession as they have not been carried out "in accordance with the provisions of appropriate law..." and did not contribute to public need nor was it in the general interest of the community.

116. The communication recalls the decision of the Commission in the case of *Social and Economic Rights Action Centre and Centre for Economic and Social Rights v Nigeria* (the *SERAC Case*) [6] where the Commission found, inter alia, that forced evictions by government forces and private security forces is an infringement of 14 and the right to an adequate housing which is implicitly guaranteed by Articles 14, 16 and 18(1) of the Charter.

117. Regarding the right to adequate housing, the Complainant urges the Commission to draw inspiration from other international human rights law standards. It submits that the right to adequate housing is well-defined under international human rights law, including the Universal Declaration of Human Rights (Article 25(1)# Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.), and the International Covenant on Economic, Social and Cultural Rights (Article 11(1)The States Parties to the present Covenant recognise the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realisation of this right, recognising to this effect the essential importance of international co-operation based on free consent.), and other international human rights instruments.

118. The Complainant also submits that the Committee on Economic, Social and Cultural Rights gave a precise content to the right to housing in its General Comment No. 4 adopted on 12th December 1991, concerning the State's obligation to respect, protect and fulfil security of tenure. In its General Comment No. 7, the Committee defines and proscribes the practice of forced evictions.

119. The Complainant recalls that in General Comment No. 4, the Committee on Economic, Social Cultural Rights held that "many of the measures required to promote the right to housing would only require the abstention by the [Respondent State] from certain practices". Furthermore, in General Comment No.7, it is affirmed that: "The State itself must refrain from forced evictions and ensure that the law is enforced against its agents or third parties who carry out forced evictions."

120. The Complainant further invites the Commission to find the State in violation of 7 as it failed to "adequately investigate and prosecute" the authors of the forced evictions and destruction of housing.

121. The Complainant submits that the African Commission relied on international law to define the right to adequate housing implied by Articles 14, 16 and 18(1) of the Charter, in its decision on the SERAC Case.

122. The Complainant also relies on the jurisprudence of the *European Court of Human Rights in Akdivar and Others v. Turkey*[7], where, in a situation similar to the one prevailing in the Darfur, that is, destruction of housing in the context of a conflict between the government and rebel forces, the European Court of Human Rights ruled that Turkey was responsible for violations perpetrated by both its own forces and the rebel forces because it has the duty to both respect and protect human rights.

123. The Complainant submits that forced evictions and destruction of housing constitute cruel or inhuman treatment prohibited by 5 of the Charter, which is consistent with international human rights standards. It quotes the Concluding Observations on Israel in 2001 where the Committee against Torture (CAT) found that forced evictions and destruction of housing cause "indescribable suffering to the population".

Regarding forced evictions and destruction of housing carried out by non-state actors, the communication relies on the jurisprudence of the CAT in *Hijrizi v. Yugoslavia* [8] where the Committee ruled that the State is responsible for failing to protect the victims from such a violation of their human rights not to be subject to cruel, inhuman and degrading treatment or punishment under Article 16 of the Convention against Torture

1. Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in Article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in Articles 10, 11, 12 and 13 shall apply with the substitution for references to torture or references to other forms of cruel, inhuman or degrading treatment or punishment.

2. The provisions of this Convention are without prejudice to the provisions of any other international instrument or national law which prohibit cruel, inhuman or degrading treatment or punishment or which relate to extradition or expulsion.

124. The Complainant also submits that forced evictions and accompanying human rights violations constitute violations by the Respondent State of the right to adequate food and the right to water implicitly guaranteed under Articles 4, 16 and 22 of the Charter as informed by standards and principles of international human rights law.

125. The Complainant relies on the Committee on Economic, Social and Cultural Rights General Comment No. 12 of 1999, which obligates States to respect, protect and fulfil the right to adequate food, and General Comment No. 15 of 2003, where the Committee declares that "the human rights to water entitles everyone to sufficient, safe, acceptable, physically accessible and affordable water for personal domestic uses".

126. The Complainant invites the Commission to develop further its reasoning in the SERAC Case by holding that the right to water is also guaranteed by reading together Articles 4, 16, and 22, of the African Charter. It urges the Commission to find that the Respondent State has violated that right by "being complicit in looting and destroying foodstuffs, crops and livestock as well as poisoning wells and denying access to water sources in the Darfur region.

Respondent State's submissions on the merits

127. The Respondent State avers that it is addressing the alleged human rights violations through the framework of implementation of the Darfur Peace Agreement (DPA) adopted on 5th May 2006, containing a number of remedies on the situation in Darfur, including addressing the content of the present Communication. As a result of the Agreement, the Respondent State indicates that, it has taken a number of measures to implement the DPA and at the same time deal with the issues raised by the Complainant.

128. The Respondent State submits that following the signing of the Peace Agreement with the Major Armed Movements in Darfur, the signatory partners began to implement all the components of the Agreement (that is, power sharing, wealth sharing, the security arrangements, and the Darfur/Darfur Dialogue). Consequently, Presidential and States decrees and decisions to establish Commissions, development funds, appointing their heads and members, were issued in accordance with the provisions of the Darfur Peace Agreement.

129. The Respondent State submits further that, all the major organs stipulated in the Agreement were duly established, notably the Darfur Interim Authority. These organs have since begun to discharge their duties, since April 2007. In addition, the Respondent State argues that the official positions allocated to Darfurians in all the Organs, Commissions and Committees to a large extent have been occupied by them. The State added that a total of 87 posts have been filled and 16 posts, at lower levels, are yet to be filled.

130. The Respondent State further indicates that with regard to the core aspect of wealth sharing, specialized mechanisms and committees, such as the Darfur Fund for Re-construction and Development and the Compensation Fund for the War Victims, as well as the Rehabilitation Commission have been formed.

131. Regarding the establishment of the Darfur Joint Assessment Mission (DJAM) responsible for defining the development needs and services in Darfur, comprising the Government and the Movements representatives', donors and specialized International Agencies), the State submits that Committees have

conducted land surveys in Darfur with a view to defining the needs, adding that the process of data analysis and statistics in preparation for the anticipated International Conference on Development and Reconstruction of Darfur sponsored by Holland, is also being undertaken.

132. With respect to the security and military arrangements, the Respondent State submits that work was underway in earnest involving the Government and the Movements, as well as the AU Mission to consolidate the cease fire to which the concerned parties are committed, as well as to make the other security arrangements, notably the specification of military positions, re-integration and demobilisation work. The Respondent State added that it has presented disarmament plan regarding the Janjaweed/ Militias to the African Union in July 2006. The Respondent State added that a Joint Committee formed by the African Union and the Government was assigned to look into the implementation of the plan in accordance with the provision of the Darfur Peace Agreement.

133. The Respondent State submits further that the commitment of the parties to the Darfur Peace and Cease-fire Agreement has brought about a considerable improvement in the security situation, adding that the State of insecurity has now been confined to some pockets of North Darfur (only 6 localities in North Darfur out of a total of 34 localities which make up the three States of Darfur).

134. The Respondent State argues that it has improved the humanitarian situation and facilitated the flow of relief aid to internally displaced persons. Its fast track policy adopted in 2004, aims at removing all the administrative and procedural restrictions to the flow of relief. As such the level of coverage of relief supplies is 98% access by the needy leaving a balance of (2%) which was not covered due to insecurity in certain localities of North Darfur.

135. With respect to the voluntary repatriation of the refugees, the Respondent State indicates that it has embarked on the rehabilitation of a great number of the villages in Darfur by providing basic services such as water, health, education and housing, aimed at encouraging the return of internally displaced persons, (hereinafter, IDPs) and refugees to their villages and cities. Such efforts have resulted in the return of more than 100,000 IDPs and refugees to their villages in the 3 States of Darfur. The number includes returnees to 70 villages, in West Darfur, 22 villages in South Darfur and 10 villages in North Darfur, The State adds that, a number of major roads have been re-opened in order to facilitate the return of the refugees and the IDPs, including the Nyala-Quraidha-Bram Road, the Nyala-Labdu Road, the Nyala-Mohajiria Road, the Nyala-Dhuain Road and the Kalbas-Eljinaina Road.

136. The Respondent State submits that, following the signing of the Peace Agreement, a great number of the IDPs have begun to exercise pasturing and farming activities. In this regard, the Respondent State notes that, it has assisted in distributing agricultural inputs to the IDPs and those affected by the war. In the same context the efforts of social reconciliation have contributed to confidence building which, in turn, helped in the return of a high percentage of IDPs and the refugees to their villages.

137. The State avers that it has made contributions to humanitarian programmes in Darfur in 2006, to the tune of ($110,889,000 US Dollars) as follows:-

US Dollars

1. Food 42, 409, 000
2. Water 23, 015, 000
3. Health 36, 465, 000
4. Shelter 9, 000, 000

Total: 110, 889, 000

138. The Respondent State believes that "...the implementation of the Darfur Peace Agreement ... could indeed help in addressing all the humanitarian issues regarding the situation in Darfur, including the communication under reference. As stated in our previous memorandum..., the Sudanese government shall not be held responsible for the subject of the Communication but it will bear its consequences by virtue of the responsibility it has towards its citizens. The Sudanese Government shall in this regard, be enlightening the esteemed African Commission on all the developments regarding the Communication under reference".

African Commission's decision on the Merits

139. The Respondent State made a general denial of the allegations and stated that due to its geographical location, the security situation in the surrounding countries had a destablilising influence on the domestic situation in the country.

140. The Respondent State submits that further consideration of this communication is no longer relevant. It argues that several issues raised have been addressed by the President of the Republic. The State notes that on 9th March 2004, a general amnesty was granted to combatants who surrendered their arms, that the signing of the first peace agreement at Abeche and N'djamena, and the Abuja May 2006 Agreement, the launching of the reconstruction of infrastructure destroyed by the rebels to allow international aid organisations' assistance, the return of internally displaced persons, the creation of an independent Commission of Inquiry on the human rights violations, and the convening of a meeting for all Darfurians to discuss the restoration of peace, have all contributed to addressing the crisis in the Darfur.

141. The State notes that the commitment of the parties to the Darfur Peace and Cease-fire Agreement has brought about a considerable improvement in the security situation, adding that the State of insecurity has now been confined to some pockets of North Darfur.

142. From the above submissions, the Respondent State does not seem to be contesting the allegations made by the Complainants. Rather the State notes that following the signing of the Darfur Peace Agreement, measures have been put in place by the parties to the Agreement to ensure a resolution of the crisis in Darfur, and consequently address the grievances raised in the present communication.

143 Could it be said that by not contesting the allegations, the State has conceded to violating the provisions cited by the Complainants, that is, Articles 4, 5, 6, 7, 9, 12 (1), 14, 16, 18 (1) and 22.

144. It must be noted that the Respondent State has not conceded to the violations either. It simply informs the Commission that the grievances highlighted in the communications will be addressed by the political developments initiated, in particular, the Signing of the Darfur Peace Agreement. The African Commission will therefore have to address each and every allegation made by the Complainants to ascertain their veracity.

Alleged violation of Articles 4 and 5

145. With respect to allegations of violation of Articles 4 and 5 of the African Charter, the Complainants allege large-scale and indiscriminate killings, torture, poisoning of wells, rape, forced evictions and displacement, destruction of property, etc.

146. 4 of the Charter protects the right to life and provides that "Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of his right". The right to life is the supreme right of the human being. It is basic to all human rights and without it all other rights are without meaning. The term 'life' itself has been given a relatively broad interpretation by courts internationally, to include the right to dignity and the right to livelihood.

147. It is the duty of the State to protect human life against unwarranted or arbitrary actions by public authorities as well as by private persons. The duty of the State to protect the right to life has been interpreted broadly to include prohibition of arbitrary killing by agents of the State and to strictly control and limit the circumstances in which a person may be deprived of life by State authorities. These include the necessity to conduct effective official investigations when individuals have been killed as a result of the use of force by agents of the State, to secure the right to life by making effective provisions in criminal law to deter the commission of offences against the person, to establish law-enforcement machinery for the prevention, suppression, investigation and penalisation of breaches of criminal law. In addition to the foregoing, the State is duty bound to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual.[9] In *Article 19 v Eritrea* [10] this Commission noted that 'arbitrariness is not to be equated with against the law but must be interpreted more broadly to include elements of inappropriateness, injustice, lack of predictability and due process...'.

148. States as well as non-state actors, have been known to violate the right to life, but the State has duo legal obligations, to respect the right to life, by not violating that right itself, as well as to protect the right to life, by protecting persons within its jurisdiction from non-state actors. In *Zimbabwe Human Rights NGO Forum/ Zimbabwe* [11], the Commission noted that an act by a private individual or [non-state actor] and therefore not directly imputable to a State, can generate responsibility of the State, not because of the act itself, but because of the lack of due diligence on the part of the State to prevent the violation or for not taking the necessary steps to provide the victims with reparation.[12]

149. In the present communication, the State claims it has investigated some of the allegations of extra-judicial and summary executions. The Complainant submits that no effective official investigations were carried out to address cases of extrajudicial or summary executions.

150. To effectively discharge itself from responsibility, it is not enough to investigate. In *Amnesty International, Comite Loosli Bachel and Lawyers Committee for Human Rights, Association of Members of the Episcopal Conference of East Africa/Sudan*[13] the African Commission held that "investigations into extra-judicial executions must be carried out by entirely independent individuals, provided with the necessary resources, and their findings must be made public and prosecutions initiated in accordance with the information uncovered. In *Jordan v United Kingdom*[14] the European Court of Human Rights held that,

an effective official investigation must be carried out with promptness and reasonable expedition. The investigation must be carried out for the purpose of securing the effective implementation of domestic laws, which protect the right to life. The investigation or the result thereof must be open to public scrutiny in order to secure accountability. For an investigation into a summary execution carried out by a State agent to be effective, it may generally be regarded as necessary for the person responsible for the carrying out of the investigation to be independent from those implicated in the events. This means not only a lack of hierarchical or institutional connection but also a practical independence

In present communication, the State claims to have investigated the alleged abuses, put in place mechanisms to prevent further abuses and to provide remedies to victims. The question is - were all these initiatives done in accordance with international standards? Did they meet the test of effective official investigations under international human rights law?

151. The Fact-finding Report of the African Commission to the Darfur Region of Sudan [15] states that some women IDPs who were interviewed during the mission stated that

.....their villages were attacked by government forces, supported by men riding horses and camels. The attacks resulted in several deaths and injury of people. Some of these women who sustained injuries, showed their wounds to the Commission. The women furthermore stated that during the attacks, a number of cases of rape were committed, some of the raped women became pregnant. Complaints were lodged at the police but were yet to be investigated. They declared that the attackers came back at night to intimidate the villagers who had not fled, accusing them of supporting the opposition. Everyone had to run away from the villages.

The women indicated that they were traumatised by the violent nature of the attacks and said that they would not want to return to the villages as long as their security is not assured. They lamented lack of water and a school in the camp. The mission visited the police station to verify complaints and the level of progress made on the reported cases of rape and other offences, but the mission was unable to have access to the files as the officer in charge of the said cases was absent at the time. At one of its meetings in El Geneina, the mission was informed by the authorities of West Darfur State that even though cases of rapes were reported to the police, investigations could not be conducted because the victims could not identify their attackers. Therefore the files were closed for lack of identification of the perpetrators.

152. UN and Reports of International Human Rights Organisations attest to the fact that the Respondent State has fallen short of its responsibility. For instance, in her 2006 Report, the UN Special Rapporteur on the Human Rights Situation in The Sudan noted that, "the human rights situation worsened from July 2005... and a comprehensive strategy responding to transitional justice has yet to be developed in the Sudan." She added that the cases prosecuted before the Special Criminal Court on the events in Darfur "did not reflect the major crimes committed during the height of the crisis in Darfur" ... "only one of the cases involved charges brought against a high-ranking official, and he was acquitted".

153. The Special Rapporteur also found that "the Government has taken other justice initiatives, but they too have fallen short of producing accountability"[16] noting that "national laws ... effectively protect Sudanese

law enforcement officials from criminal prosecution [and that these laws] contribute to a climate of impunity in the Sudan." The fact that the abuses have persisted and are ongoing since the submission of the communications clearly demonstrates a weakness in the judicial system and lack of effectiveness to guarantee effective investigations and suppression of the said violations. In the opinion of the African Commission, lack of effective investigations in cases of arbitrary killings and extra-judicial executions amount to a violation of 4 of the African Charter.

154. Regarding the allegation of 5, the Complainants simply make a generalised allegation of human rights violations, adding that 'methods used included extra-judicial executions, torture, rape of women and girls and arbitrary arrests and detentions, evictions and burning of houses and property, etc.' 5 of the Charter provides that '[e]very individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man, particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited'.

155. 5 of the African Charter is aimed at the protection of both the dignity of the human person, and the physical and mental integrity of the individual. The African Charter does not define the meaning of the words, or the phrase "torture or degrading treatment or punishment.." However, Article 1 of the United Nations Convention against Torture [17] defines, the term 'torture' to mean "....any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity."

156. Torture thus constitutes the intentional and systematic infliction of physical or psychological pain and suffering in order to punish, intimidate or gather information. It is a tool for discriminatory treatment of persons or groups of person who are subjected to the torture by the State or non-state actors at the time of exercising control over such person or persons. The purpose of torture is to control populations by destroying individuals, their leaders and frightening entire communities.

157. The Complainant has submitted that the various incidences of armed attacks by the military forces of the Respondent State, using military helicopters and the Janjawid militia, on the civilian population, forced eviction of the population from their homes and villages, destruction of their properties, houses, water wells, food crops and livestock, and social infrastructure, the rape of women and girls and displacement internally and outside national borders of the Respondent State, constitute violation of the various cited articles of the African Charter, one of which is 5. The totality of the aforesaid violations amount to both psychological and physical torture, degrading and inhuman treatment, involving intimidation, coercion and violence.

158. In *Media Rights Agenda v Nigeria*[18], the Commission stated that the term 'cruel, inhuman and degrading punishment or treatment' is to be interpreted so as to extend the widest possible protection against abuse, whether physical or mental. In *John Modise v Botswana* [19], the Commission elaborated further and noted that 'exposing victims to personal sufferings and indignity violates the right to human dignity'. It went on to state that 'personal suffering and indignity can take many forms, and will depend on the particular circumstances of each communication brought before the African Commission'.

159. Based on the above reasoning, the African Commission agrees with the UN Committee Against Torture in *]Hijrizi v. Yugoslavia* [20] that forced evictions and destruction of housing carried out by non-state actors amounts to cruel, inhuman and degrading treatment or punishment, if the State fails to protect the victims from such a violation of their human rights. *Hijrizi v. Yugoslavia* involved the forced eviction and destruction of the Bozova Glavica settlement in the city of Danilovgrad by private residents who lived nearby. The settlement was destroyed by non-Roma residents under the watchful eye of the Police Department, which failed to provide protection to the Romani and their property, resulting in the entire settlement being leveled and all properties belonging to its Roma residents completely destroyed. Several days later the debris of Bozova Glavica was completely cleared away by municipal construction equipment, leaving no trace of the community.

160. The Committee against Torture found that the Police Department did not take any appropriate steps to

protect the residents of Bazova Glavica, thus implying acquiescence and that the burning and destruction of their homes constituted acts of cruel, inhuman or degrading treatment or punishment within the meaning of Article 16 of the Convention against Torture or other Cruel, Inhuman Degrading Treatment or Punishment.[21] Consequently, the Committee held that the Government of Serbia and Montenegro had violated Article 16 of CAT by not protecting the rights of the residents of Bozova Glavica.

161. In a similar case dealing with allegations that the applicants' property had been destroyed by Turkish security forces, the European Court of Human Rights arrived at the same conclusion, that the destruction of homes and property was cruel and inhuman treatment. In *Selçuk and Asker v Turkey*[22], the Complainants were both Turkish citizens of Kurdish origin living in the village of Islamköy. In the morning of 16th June 1993, a large force of gendarmes arrived in Islamköy and set fire to the houses and other properties of the said Complainants.

162. The Court held that "even in the most difficult of circumstances, such as the fight against organised terrorism and crime, the Convention prohibits in absolute terms torture or inhuman or degrading treatment or punishment." The Court concluded that the treatment suffered by the applicants in this case was so severe as to constitute a violation of Article 3[23], adding that "...bearing in mind in particular the manner in which the applicants' homes were destroyed ... and their personal circumstances, it is clear that they must have been caused suffering of sufficient severity for the acts of the security forces to be categorised as inhuman treatment within the meaning of Article 3".

163. Human dignity is an inherent basic right to which all human beings, regardless of their mental capabilities or disabilities are entitled to without discrimination. It is an inherent right which every State is obliged to respect and protect by all means possible.[24]

164. In the present communication, the Respondent State and its agents, the Janjawid militia, actively participated in the forced eviction of the civilian population from their homes and villages. It failed to protect the victims against the said violations. The Respondent State, while fighting the armed groups, targeted the civilian population, as part of its counter insurgence strategy. In the opinion of the Commission this kind of treatment was cruel and inhuman and threatened the very essence of human dignity.

165. The African Commission wishes to remind State Parties to the African Charter to respect human and peoples' rights at all times including in times of armed conflict. This was emphasised in *Constitutional Rights Project, et al/Nigeria* in which this Commission stated that:

[I]n contrast to other international human rights instruments, the African Charter does not contain a derogation clause. Therefore limitation on the rights and freedoms enshrined in the Charter cannot be justified by emergencies or special circumstances. The only legitimate reasons for limitation of the rights and freedoms of the African Charter are found in 2, that is, that the rights of the Charter "shall be exercised with due regard to the rights of others, collective security, morality and common interest".

166. The forced eviction of the civilian population cannot be considered permissible under 2 of the African Charter. Could the Respondent State legitimately argue that it forcefully evicted the Darfur civilian population from their homes, villages and other places of habitual residence, on grounds of collective security, or any other such grounds or justification, if any? For such reasons to be justifiable, the Darfurian population should have benefited from the collective security envisage under 2. To the contrary, the complaint has demonstrated that after eviction, the security of the IDP camps was not guaranteed. The deployment of peacekeeping forces from outside the country is proof that the Respondent State failed in its obligation to guarantee security to the IDPs and the civilian population in Darfur.

167. In its decision in the *Commission nationale des droits de l'Homme et libertés/Chad*[25], the Commission reiterated its position that; "[t]he African Charter, unlike other human rights instruments does not allow for states to derogate from their treaty obligations during emergency situations. Thus, even with a civil war in Chad [derogation] cannot be used as an excuse by the State violating or permitting violations of rights in the African Charter".

168. In view of the above, the African Commission finds that the Respondent State did not act diligently to protect the civilian population in Darfur against the violations perpetrated by its forces, or by third parties. It failed in its duty to provide immediate remedies to victims. The Commission therefore finds that the

Respondent State violated Articles 4 and 5 of the African Charter.

Alleged violation of Articles 6 and 7

169. The Complainant alleges arbitrary arrests and detentions of hundreds of Darfurians. It argues that the Respondent State has legal obligations pursuant to 6 of the African Charter to respect the right to liberty as well as to protect the right to security of the person, by protecting persons within its jurisdiction from non-state actors such as the Janjaweed militia.

170. 6 of the African Charter provides that "every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained". 6 of the Charter has two arms - the right to liberty and the right to security of the person.

171. The Complainant alleges that 6 has been violated. This presupposes that the victims of the Darfur conflict, have through the actions and omissions of the Respondent State, been subjected to among other violations, the loss of their right to liberty, arbitrary arrest and detention. Personal liberty is a fundamental condition, which everyone should generally enjoy. Its deprivation is something that is likely to have a direct and adverse effect on the enjoyment of other rights, ranging from the right to family and private life, through the right to freedom of assembly, association and expression, to the right to freedom of movement.

172. A simple understanding of the right to liberty is to define it as the right to be free. Liberty thus denotes freedom from restraint - the ability to do as one pleases, provided it is done in accordance with established law. In the *Purohit and Moore/The Gambia Case*, [26] the Commission held that prohibition against arbitrariness requires that deprivation of liberty 'shall be under the authority and supervision of persons procedurally and substantively competent to certify it'.

173. The second arm of 6 deals with the right to security of the person. This second arm, even though closely associated with the first arm, the right to liberty, is different from the latter.

174. Security of the person can be seen as an expansion of rights based on prohibitions of torture and cruel and unusual punishment. The right to security of person guards against less lethal conduct, and can be used in regard to prisoners' rights.[27] The right to security of the person includes, inter alia, national and individual security. National security examines how the State protects the physical integrity of its citizens from external threats, such as invasion, terrorism, and bio-security risks to human health.

175. Individual security on the other hand can be looked at in two angles - public and private security. By public security, the law examines how the State protects the physical integrity of its citizens from abuse by official authorities, and by private security, the law examines how the State protects the physical integrity of its citizens from abuse by other citizens (third parties or non-state actors).

176. The Complainant submits with respect to the present communication that the forced eviction, destruction of housing and property and accompanying human rights abuses amounted to a violation of 6 of the African Charter. The majority of the thousands of displaced civilians who were forcibly evicted from their homes and villages have not returned, in spite of the measures taken by the Respondent State. By its own account, the Respondent State admitted that only 100,000 IDPs [28] have returned to their villages. It submitted further that insecurity prevails in only 6 of the 34 Darfur localities. The numbers of needy IDPs camped in various relief centres remains high, notwithstanding the said improvements.

177. The Commission observes that IDPs and refugees can only return when security and safety is guaranteed and the Respondent State provides the protection in the areas of return. Voluntary return under situation of forced displacement must be in safety and dignity. The Commission believes that the right to liberty complements the right to freedom of movement under 12. If the IDPs or the refugees are not able to 16 move freely to their homes, because of insecurity, or because their homes have been destroyed, then their liberty and freedom is proscribed. Life in an IDP or refugee camp cannot be synonymous with the liberty enjoyed by a free person in normal society. The 2004 Mission of the African Commission to Darfur found that male IDPs could not venture outside the camps for fear of being killed. Women and girls who ventured outside the camps to fetch water and firewood were raped by the Janjawid militia.

178. Cases of sexual and gender based violence against women and girls in and outside IDP camps have been

a common feature of the Darfur conflict. The right to liberty and the security of the person, for women and girls, and other victims of the Darfur conflict has remained an illusion. The deployment of the African Union Mission in Sudan (AMIS) forces, could not guarantee the implementation of the Abuja Darfur Peace Agreement. The United Nations had to supplement the AU with the United Nations/African Union Mission to Darfur hybrid forces, (UNAMID) to provide protection to the civilian population.

179. In the present communication, the Respondent State, in spite all the information regarding the physical abuse the victims were enduring, has not demonstrated that it took appropriate measures to protect the physical integrity of its citizens from abuse either by official authorities or other citizens/third parties. By failing to take steps to protect the victims, the Respondent State violated 6 of the African Charter.

180. The Complainant argues that the victims' right guaranteed under 1 of the African Charter has been violated due to the failure by the Respondent State to investigate and prosecute its agents and the third parties responsible for the abuses. 1 of the Charter provides that 'Every individual shall have the right to have his cause heard. This comprises a) The right to an appeal to competent national organs against acts of violating his fundamental rights as recognised and guaranteed by conventions, laws, regulations and customs in force; b) The right to be presumed innocent until proved guilty by a competent court or tribunal; c) The right to defence, including the right to be defended by counsel of his choice; and d) The right to be tried within a reasonable time by an impartial court or tribunal'.

181. The right to be heard requires that the Complainants have unfettered access to a tribunal of competent jurisdiction to hear their case. A tribunal is competent having been given that power by law, it has jurisdiction over the subject matter and the person, and the trial is being conducted within any applicable time limit prescribed by law. Where the competent authorities put obstacles on the way which prevent victims from accessing the competent tribunals, they would be held liable.

182. Given the generalised fear perpetrated by constant bombing, violence, burning of houses and evictions, victims were forced to leave their normal places of residence. Under these circumstances, it would be an affront to common sense and justice to expect the victims to bring their plights to the courts of the Respondent State.

183. In *Rencontre africaine pour la defense des droits de l'Homme/Republic of Zambia*,[29] the African Commission held that the mass expulsions, particularly following arrest and subsequent detentions, deny victims the opportunity to establish the legality of these actions in the courts. Similarly, in *Zimbabwe Human Rights NGO Forum/ Zimbabwe*[30], the African Commission noted that the protection afforded by 7 is not limited to the protection of the rights of arrested and detained persons but encompasses the right of every individual to access the relevant judicial bodies competent to have their causes heard and be granted adequate relief. The Commission added that "If there appears to be any possibility of an alleged victim succeeding at a hearing, the applicant should be given the benefit of the doubt and allowed to have their matter heard."

184. To borrow from the Inter-American human rights system, the American Declaration of the Rights and Duties of Man[31] provides in Article XVIII that every person has the right to "resort to the courts to ensure respect for [their] legal rights," and to have access to a "simple, brief procedure whereby the courts" will protect him or her "from acts of the authority that ... violate any fundamental constitutional rights....".

185. In the present communication, the forced evictions, burning of houses, bombardments and violence perpetrated against the victims made access to competent national organs illusory and impractical. To this extent, the Respondent State is found to have violated 7 of the African Charter.

Alleged violation of 1

186. The Complainant alleges that the forced evictions constitute a violation of the right to freedom of movement and residence as guaranteed in 1 of the African Charter on Human and Peoples' Rights. The Complainant argues that the forceful displacement of thousands upon thousands of persons from their chosen and established places of residence clearly contravenes the right to residence.

187. Freedom of movement is a fundamental human right to all individuals within States. Freedom of

movement is a right which is stipulated in international human rights instruments, and the Constitutions of numerous States. It asserts that a citizen of a State, generally has the right to leave that State, and return at any time. Also (of equal or greater importance in this context) to travel to, reside in, and/or work in, any part of the State the citizen wishes, without interference from the State. Free movement is crucial for the protection and promotion of human rights and fundamental freedoms.

188. Freedom of movement and residence are two sides of the same coin. States therefore have a duty to ensure that the exercise of these rights is not subjected to arbitrary restrictions. Restrictions on the enjoyment of these rights should be proportionate and necessary to respond to a specific public need or pursue a legitimate aim.

    Under international law, it is the duty of States to take all measures to avoid conditions which might lead to displacement and thus impact the enjoyment of freedom of movement and residence. Principle 5 All authorities and international actors shall respect and ensure respect for their obligations under international law, including human rights and humanitarian law, in all circumstances, so as to prevent and avoid conditions that might lead to displacement of persons. of the Guiding Principles on Internal Displacement[32] requires States to adhere to international law so as to prevent or avoid situations that might lead to displacement.

189. The right to protection from displacement is derived from the right to freedom of movement and choice of residence contemplated in the African Charter and other international instruments. Displacement by force, and without legitimate or legal basis, as is the case in the present communication, is a denial of the right to freedom of movement and choice of residence.

190. The Complainant submitted that thousands of civilian were forcibly evicted from their homes to make-shift camps for internally displaced persons or fled to neighbouring countries as refugees. People in the Darfur region cannot move freely for fear of being killed by gunmen allegedly supported by the Respondent State. The Respondent State failed to prevent forced evictions or to take urgent steps to ensure displaced persons return to their homes. The Commission therefore finds that the Respondent State has violated 12 (1) of the African Charter.

Alleged violation of 14

191. The Complainants also alleged violation of 14 of the Charter which provides that '[t]he right to property shall be guaranteed. It may only be encroached upon in the interest of public need or in the general interest of the community and in accordance with the provisions of appropriate laws'.

192. The right to property is a traditional fundamental right in democratic and liberal societies. It is guaranteed in international human rights instruments as well as national constitutions, and has been established by the jurisprudence of the African Commission.[33] The role of the State is to respect and protect this right against any form of encroachment, and to regulate the exercise of this right in order for it to be accessible to everyone, taking public interest into due consideration.

193. The right to property encompasses two main principles. The first one is of a general nature. It provides for the principle of ownership and peaceful enjoyment of property. The second principle provides for the possibility, and conditions of deprivation of the right to property. 14 of the Charter recognises that States are in certain circumstances entitled, among other things, to control the use of property in accordance with the public or general interest, by enforcing such laws as they deem necessary for the purpose.

194. However, in the situation described by the present communication, the State has not taken and does not want to take possession of the victims' property. The property has been destroyed by its military forces and armed groups, acting on their own, or believed to be supported by the Respondent State. Could it be said that the victims have been deprived of their right to property? The answer to this is yes, and this is supported by international jurisprudence.

195. In *Dogan and others v Turkey*[34],the applicants allege that State security forces forcibly evicted them from their village, given the disturbances in the region at that time, and also destroyed their property.

196. The applicants complained to the European Court of Human Rights about their forced eviction from their

homes and the Turkish authorities' refusal to allow them to return. They relied on among other provisions, Article 1 (obligation to respect human rights), Article 6 (right to a fair hearing), Article 8 (right to respect for family life and home), and, Article 1 of Protocol No. 1 (protection of property).

197. The Court also recalled that the state of emergency at the time of the events complained of was characterised by violent confrontations between the security forces and members of the PKK which forced many people to flee their homes. The Turkish authorities had also evicted the inhabitants of a number of settlements to ensure the safety of the population in the region. In numerous similar cases the Court had found that security forces had deliberately destroyed the homes and property of applicants, depriving them of their livelihoods and forcing them to leave their villages.

198. The Court recognised that armed clashes, generalised violence and human rights violations, specifically within the context of the PKK insurgency, compelled the authorities to take extraordinary measures to maintain security in the state of emergency region. Those measures involved, among others, the restriction of access to several villages, including Boyda?, as well as the evacuation of some villages.

199. The Court noted that the applicants all lived in Boyda? village until 1994. Although they did not have registered property, they either had their own houses constructed on the lands of their ancestors or lived in houses owned by their fathers and cultivated their fathers' land. They also had unchallenged rights over the common lands in the village and earned their living from breeding livestock and tree-felling. Those economic resources and the revenue the applicants derived from them, according to the Court, qualified as "possessions" for the purposes of Article 1 of Protocol No. 1.

200. The Court found that the applicants had had to bear an individual and excessive burden which had upset the fair balance which should be struck between the requirements of the general interest and the protection of the right to the peaceful enjoyment of one's possessions. The Court made a finding that Article 1 of Protocol No. 1 had been violated[35].

201. The victims in the present communication, have been forced out of their normal places of residence by government military forces and militia forces believed to be supported by the Respondent State. Their homes and other possessions destroyed. The African Commission recognises that the Darfur Region has been engulfed in armed conflict and there has been widespread violence resulting in serious human rights violations. It is the primary duty and responsibility of the Respondent State to establish conditions, as well as provide the means, to ensure the protection of both life and property, during peace time and in times of disturbances and armed conflicts. The Respondent State also has the responsibility to ensure that persons who are in harm's way, as it seems the victims were, are resettled in safety and with dignity in another part of the country.

202. In *Akdivar and Others v. Turkey* case[36], a situation similar to the one prevailing in the Darfur, involving the destruction of housing in the context of a conflict between the government and rebel forces, the European Court of Human Rights held that the State is responsible for violations perpetrated by both its own forces and the rebel forces because it has the duty to respect and protect human rights.

203. The United Nations Sub-Commission on the Promotion and Protection of Human Rights on 11th August 2005 endorsed a set of guidelines, known as the Pinhero Principles, and recommended them to UN agencies, the international community, including States and civil society, as a guide to address the legal and technical issues concerning housing, and property restitution when the rights thereof are violated. Principle 5 addresses the right to protection from displacement. Paragraphs 5.3 and 5.4 of the Principles state the following;

"States shall prohibit forced eviction, demolition of houses and destruction of agricultural areas and the arbitrary confiscation or expropriation of lands as a punitive measure or as a means or methods of war"

"States shall take steps to ensure that no one is subjected to displacement by either State or non State actors. States shall also ensure that individuals, corporations, and other entities within their legal jurisdiction or effective control refrain from carrying out or otherwise participating in displacement"

204. The African Commission is aware that the Pinhero Principles are guidelines and do not have any force of law. They however reflect the emerging principles in international human rights jurisprudence. When these principles are read together with decisions of regional bodies, such as the cited European Court decisions, the African Commission finds great persuasive value in the said principles, albeit as a guide to interpret the

right to property under 14 of the African Charter.

205. In the present communication, the Respondent State has failed to show that it refrained from the eviction, or demolition of victims' houses and other property. It did not take steps to protect the victims from the constant attacks and bombings, and the rampaging attacks by the Janjaweed militia. It doesn't matter whether they had legal titles to the land, the fact that the victims cannot derive their livelihood from what they possessed for generations means they have been deprived of the use of their property under conditions which are not permitted by 14. The Commission therefore finds the Respondent State in violation of 14.

Alleged violation of 16

206. The Complainant also alleges violation of 16 of the African Charter. 16 provides that, '[e]very individual shall have the right to enjoy the best attainable state of physical and mental health... 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'.

207. The Complainant submits that the Respondent State was complicit in looting and destroying foodstuffs, crops and livestock as well as poisoning wells and denying access to water sources in the Darfur region.

208. In recent years, there have been considerable developments in international law with respect to the normative definition of the right to health, which includes both health care and healthy conditions. The right to health has been enshrined in numerous international and regional human rights instruments, including the African Charter.

209. In its General Comment No.14 on the right to health adopted in 2000, the UN Committee on Economic, Social and Cultural Rights sets out that, 'the right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as, access to safe and portable water, an adequate supply of safe food, nutrition, and housing...'. In terms of the General Comment, the right to health contains four elements: availability, accessibility, acceptability and quality, and impose three types of obligations on States - to respect, fulfill and protect the right. In terms of the duty to protect, the State must ensure that third parties (non-state actors) do not infringe upon the enjoyment of the right to health.

210. Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. According to General Comment 14 'states should also refrain from unlawfully polluting air, water and soil, ... during armed conflicts in violation of international humanitarian law... States should also ensure that third parties do not limit people's access to health-related information and services, and the failure to enact or enforce laws to prevent the pollution of water...[violates the right to health]'.

211. In its decision on *Free Legal Assistance Group and Others v. Zaire*[37] the Commission held that the failure of the Government to provide basic services such as safe drinking water and electricity and the shortage of medicine ... constitutes a violation of 16.

212. In the present communication, the destruction of homes, livestock and farms as well as the poisoning of water sources, such as wells exposed the victims to serious health risks and amounts to a violation of 16 of the Charter.

Alleged violation of Article 1

213. With respect to the alleged violation of 1, the Complainants argue that the destruction of homes and evictions of the victims constituted a violation of this sub-paragraph of 18. 18 (1) recognises that '[t]he family shall be the natural unit and basis of society'. It goes further to place a positive obligation on States, stating that '[t]he family shall be protected by the State which shall take care of its physical health and moral'. This provision thus establishes a prohibition on arbitrary or unlawful interference with the family.

214. In its General Comment No. 19, the Human Rights Committee stated that 'ensuring the protection provided for under Article 23 of the Covenant requires that States parties should adopt legislative, administrative or other measures...'. Ensuring protection of the family also requires that States refrain from

any action that will affect the family unit, including arbitrary separation of family members and involuntary displacement of families. In the Dogan case the European Court of Human Rights also held that the refusal of access to the applicants' homes and livelihood constituted a serious and unjustified interference with the right to respect for family life and home. The Court concluded that there had been a violation of Article 8 of 20 the European Convention, which protects the right to family, similar to 18 (1) of the African Charter.

215. In *Union inter africaine des droits de l'Homme, Fédération internationale des ligues des droits de l'Homme and others v. Angola* [38], the Commission found that massive forced expulsion [whether in peace time or war time] of population has a negative effect on the enjoyment of the right to family. In that Communication, it was alleged that between April and September 1996, the Angolan government rounded up and expelled West African nationals from its territory. These expulsions were preceded by acts of brutality committed against Senegalese, Malian, Gambian, Mauritanian and other nationals. The victims lost their belongings, and in some cases, families were separated. The African Commission held that mass expulsions of any category of persons, whether on the basis of nationality, religion, ethnic, racial or other considerations "constitute a special violation of human rights". The Commission added that 'by deporting the victims, thus separating some of them from their families, the Defendant State had violated and violates Article [18(1) of the Charter.

216. The Respondent State and its agents, the Janjaweed militia forcefully evicted the victims from their homes, some family members were killed, others fled to different places, inside and outside the territory of the Respondent State. This kind of scenario threatens the very foundation of the family and renders the enjoyment of the right to family life difficult. By not ensuring protection to the victims, thus allowing its forces or third parties to infringe on the rights of the victims, the Respondent State is held to have violated 18 (1) of the African Charter.

Alleged violation of 22

217. The Complainant alleges violation of 1 of the Charter. 1 provides that "[a]ll peoples shall have the right to their economic, social and cultural development with due regard to their freedom and identity and in the equal enjoyment of the common heritage of mankind. (2). States shall have the duty, individually or collectively, to ensure the exercise of the right to development".

218. The right to economic, social and cultural development envisaged in 22 is a collective right endowed on a people. To determine violation under this article, the Commission will first have to determine whether the victims constitute a "people" within the context of the African Charter.

219. The population in the Darfur Region, alleges the Complainant, is made up of three major tribes, namely the Zaghawa, the Fur, and the Marsalit. These tribes are described as being "people of black African origin". The Respondent State is the largest state in Africa. Part of its population is of Arab stock. A common feature shared between the people of Darfur and the population of the other parts of the Respondent State, except for Southern Sudan, is that they predominantly subscribe to the Islam religion and culture.

220. By attempting to interpret the content of a "peoples' right," the Commission is conscious that jurisprudence in that area is still very fluid. It believes, however, that in defining the content of the peoples' right, or the definition of "a people," it is making a contribution to Africa's acceptance of its diversity. An important aspect of this process of defining "a people" is the characteristics, which a particular people may use to identify themselves, through the principle of self identification, or be used by other people to identify them. These characteristics, include the language, religion, culture, the territory they occupy in a state, common history, ethno - anthropological factors, to mention but a few. In States with mixed racial composition, race becomes a determinant of groups of "peoples", just as ethnic identity can also be a factor. In some cases groups of "a people" might be a majority or a minority in a particular State. Such criteria should only help to identify such groups or sub groups in the larger context of a States' wholesome population.

221. It is unfortunate that Africa tends to deny the existence of the concept of a "people" because of its tragic history of racial and ethnic bigotry by the dominant racial groups during the colonial and apartheid rule. The Commission believes that racial and ethnic diversity on the continent contributes to the rich cultural

diversity which is a cause for celebration. Diversity should not be seen as a source of conflict. It is in that regard that the Commission was able to articulate the rights of indigenous people and communities in Africa.19 of the African Charter recognises the right of all people to equality, to enjoy same rights, and that nothing shall justify a domination of a people by another.

222. There is a school of thought, however, which believes that the "right of a people" in Africa can be asserted only vis-à-vis external aggression, oppression or colonisation. The Commission holds a different view, that the African Charter was enacted by African States to protect human and peoples' rights of the African peoples against both external and internal abuse.

223. In this regard it protects the rights of every individual and peoples of every race, ethnicity, religion and other social origins. 2 and 19 of the Charter are very explicit on that score. In addressing the violations committed against the people of Darfur, the Commission finds that the people of Darfur in their collective are "a people," as described under 19. They do not deserve to be dominated by a people of another race in the same state. Their claim for equal treatment arose from the alleged underdevelopment and marginalization. The response by the Respondent State, while fighting the armed conflict, targeted the civilian population, instead of the combatants. This in a way was a form of collective punishment, which is prohibited by international law. It is in that respect that the Commission views the alleged violation of 22.

224. The Complainant alleged that the violations were committed by government forces, and by an Arab militia, the Janjaweed, against victims of black African tribes. The attacks and forced displacement of Darfurian people denied them the opportunity to engage in economic, social and cultural activities. The displacement interfered with the right to education for their children and pursuit of other activities. Instead of deploying its resources to address the marginalisation in the Darfur, which was the main cause of the conflict, the Respondent State instead unleashed a punitive military campaign which constituted a massive violation of not only the economic social and cultural rights, but other individual rights of the Darfurian people. Based on the analysis hereinabove, concerning the nature and magnitude of the violations, the Commission finds that the Respondent State is in violation of 22 of the Africa Charter.

225. In Conclusion, the Commission would like to address the Complainant's prayer that the Commission draws the attention of the Assembly of the Africa Union to the serious and massive violations of human and peoples' rights in the Darfur, so that the Assembly may request an in-depth study of the situation. The Commission wishes to state that it undertook a fact finding mission to the Darfur suo motu, in July 2004. Its findings and recommendations were sent to the Respondent State and the African Union. The Commission has continued to monitor the human rights situation in the Darfur through its country and thematic rapporteurs and has presented reports on the same to each Ordinary Session of the Commission, which are in turn presented to the Assembly of the African Union.

226. The African Union has deployed its peacekeepers together with the United Nations under the UNAMID hybrid force. In the Commission view, these measures constitute what would most likely ensue, if an in-depth study were undertaken under 58. The request by the Complainant would have been appropriate had no action been taken by the African Commission or the organs of the African Union.

227. The African Commission concludes further that 1 of the African Charter imposes a general obligation on all State parties to recognise the rights enshrined therein and requires them to adopt measures to give effect to those rights. As such any finding of violation of those rights constitutes violation of 1.

Holding

228. Based on the above reasoning, the African Commission holds that the Respondent State, the Republic of The Sudan, has violated Articles 1, 4, 5, 6, 7(1), 12 (1) and (2), 14, 16, 18(1) and 22 of the African Charter.

229. The African Commission recommends that the Respondent State should take all necessary and urgent measures to ensure protection of victims of human rights violations in the Darfur Region, including to:

1. conduct effective official investigations into the abuses, committed by members of military forces, i.e. ground and air forces, armed groups and the Janjaweed militia for their role in the Darfur;
2. undertake major reforms of its legislative and judicial framework in order to handle cases of serious

and massive human rights violations;

3. take steps to prosecute those responsible for the human rights violations, including murder, rape, arson and destruction of property;
4. take measures to ensure that the victims of human rights abuses are given effective remedies, including restitution and compensation;
5. rehabilitate economic and social infrastructure, such as education, health, water, and agricultural services, in the Darfur provinces in order to provide conditions for return in safety and dignity for the IDPs and Refugees;
6. establish a National Reconciliation Forum to address the long-term sources of conflict, equitable allocation of national resources to the various provinces, including affirmative action for Darfur, resolve issues of land, grazing and water rights, including destocking of livestock;
7. desist from adopting amnesty laws for perpetrators of human rights abuses; and
8. consolidate and finalise pending Peace Agreements.

Adopted during the 45th Ordinary Session, held between 13 and 27 May 2009, Banjul, The Gambia.

Footnotes

1. See Communication 147/[95, 149/]96, 13th Annual Activity Report, 1999-2000
2. Communication 25/89, 47/90, 56/91, 100/93, (4 International Human Rights Law Report 89, 92), (1997).
3. See Footnote 2 above for reference.
4. Communications 54/91, 61/91, 98/93, 164/97, to 196/97 and 210/98, (2000).
5. See also *Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine des Droits de l'Homme, Les Témoins de Jehovah / Zaire* , African Comm. Hum. & Peoples' Rights. Communication No. 25/89, 47/90, 56/91, 100/93 cited above.
6. Communication 155/1996.
7. No. 21893/93, 1996-IV, no. 15.
8. Communication No. 161/2000: UN Doc CAT/C/29/D/161/2000 (2 December 2002).
9. See European Court judgments in *McCann v. United Kingdom* (1995) 21 EHRR 97 and *Tanrikulu v. Turkey* (1999) 30 EHRR 950.
10. Communication 275/2003.
11. Communication 245/2002.
12. In human rights jurisprudence this standard was first articulated by a regional court, the Inter-American Court of Human Rights, in looking at the obligations of the State of Honduras under the American Convention on Human Rights - Velasquez-Rodriguez, Ser. C., No.4, 9 Hum. Rts.I.J. 212 (1998). The standard of due diligence has been explicitly incorporated into United Nations standards, such as the Declaration on the Elimination of Violence against Women which says that states should 'exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the state or by private persons'. Increasingly, UN mechanisms monitoring the implementation of human rights treaties, the UN independent experts, and the Court systems at the national and regional level are using this concept of due diligence as their measure of review, particularly for assessing the compliance of States with their obligations to protect bodily integrity. 13. Communications 48/90-50/91-52/91-89/93]].
14. Application no. 24746/94 ((2003) 37 EHRR 2), Judgement of 4/8/2001.
15. The African Commission conducted a Fact Find[ing] Mission to the Darfur Region of Sudan between 8th to 18th July 2004. The Report of the Mission was adopted by the African Commission during the 3rd Extraordinary Session, held in Pretoria, South Africa, and was published in its Activity Report presented to the AU Executive Council. See para. 86, 87, and 88, at page 20.
16. Id. para 48.
17. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. res. 39/46, [annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984)], entered into force June 26, 1987.
18. Communication 224/1998 .
19. Communication 97/93 97/93.
20. Communication No. 161/2000: UN Doc. CAT/C/29/D/161/2000/ (2 December 2002).
21. Article 16 of the Convention Against Torture states in part that ... "Each State Party shall undertake to prevent in any territory

under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in Article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity".

22. European Court of Human Rights, Case of Selçuk and Asker v. Turkey, Judgement of 24 April 1998, Reports 1998, Reports 1998-II, p. 900, paras. 27-30.

23. Article 3 of the European Convention provides that 'No one shall be subjected to torture or inhuman or degrading treatment or punishment'.

24. See , Communication 241/2001.

25. Communication No 74/92 , 9th Annual Activity Report, 1995-1996 at paragraph 21.

26. Communication 241/01 published in the 16th Activity Report.

27. Rhona K.M. Smith, Textbook on International Human Rights, second edition, Oxford University Press, 2005, p. 245.

28. The figures given by UN and Non Governmental Humanitarian agencies operating in Darfur indicate that the number of IDPs have for the most part during the Darfur conflict ranged between 1,500,000.

29. Communication 71/1992.

30. Communication 245/2002.

31. American Declaration of the Rights and Duties of Man, O.A.S. Res. XXX, adopted by the Ninth International Conference of American States (1948), re printed in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc.6 rev. 1at 17 (1992).

32. OCHA/Brookings Institution on Internal Displacement, 1999 and Implementing the Collaborative Response to Situations of Internal Displacement, IASC, 2004.

33. See Communications 71/92 - *Rencontre africaine pour la défense des droits de l'Homme/Zambia*, Communication 292/2004 - *Institute for Human Rights and Development in Africa/Republic of Angola*, and Communication 159/1996 - *Union interafricaine des droits de l'Homme, Fédération internationale des ligues des droits de l'Homme and Others v. Angola*.

34. Applications nos. 8803-8811/02, 8813/02 and 8815-8819/02) 29 June 2004

35. Protocol to the Convention (European) for the Protection of Human Rights and Fundamental Freedoms, UNTS, Vol 213 No I-2889.

36. No. 21893/93, 1996-IV, no. 15.

37. Communications 25/89, 47/90, 56/91 and 100/93.

38. Communications 159/1996.