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Master of Laws Degree (LLM) in Human Rights Law

THE IMPLICATIONS OF THE RIGHT TO HEALTH FOR THE DEMOCRATIC REPUBLIC OF CONGO IN RELATION TO ACCESS TO MEDICAL SERVICE AND MEDICAL CARE

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DECLARATION

I hereby declare that I have read and understood the regulations governing the submission of Master of Laws dissertations, including those relating to length and plagiarism, as contained in the rules of this university, and that this dissertation conforms to those regulations.

Mumbanika Mbwisi Dady **Date**

DEDICATION

To my parents, Marc Mumbanika Musagu'i and Sophie Ngunza Sona for all their material, spiritual and moral support and unconditional love.

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ABBREVIATIONS

CESCR	Committee on Economic, Social and Cultural Rights
CRC	Committee on the Rights of the Child
DRC	Democratic Republic of Congo
ICESCR	International Covenant on Economic Social and Cultural Rights
UDHR	Universal Declaration of Human Rights
UNCRC	United Nations Convention on the Rights of the Child
UN	United Nations
WHO	World Health Organization

Chapter One

INTRODUCTION

1.1 Introduction

Ever since the existence of human beings, 'people tried to protect their health and treat diseases. Traditional practices, often integrated with spiritual counseling and providing both preventive and curative care, have existed for thousands of years and often co-exist today with modern medicine'.[1] This indicates that the need to challenge ill health is as old as the existence of human beings. Furthermore, within each modern State, one can observe an established health system whether or not in compliance with a given legal obligation which aims to address the health needs of its population. The Democratic Republic of Congo (DRC) does not constitute an exception to this. This is due to the fact that, currently health systems play a crucial role in people's lives than ever before in all countries whether rich or poor.[2] Indeed, since the creation of the United Nations in 1945, all State members are committed to taking joint and separate action in co-operation with the organization in order to promote solutions for health, and related problems.[3] It appears clear that health concerns fall within the jurisdiction of both the State and the international community.

It is for this reason that the DRC expressly reaffirms its commitment to comply with all its ratified international human rights instruments. Indeed, it is unequivocally stated in the Constitution of the Democratic Republic of Congo (the DRC Constitution) that 'once duly ratified, international treaties and agreements become part of the country's array of regulatory instruments. They take precedence over domestic laws, provided that those treaties are reciprocally applied'.[4] In other words, international treaties and agreements to which the DRC is signatory are part of its legal framework and must be analyzed in this manner.

In fact, the Constitutive Charters of the two main organizations to which the DRC belongs, namely the United Nations[5]and the African Union,[6] contain at least one provision

[1] Martyn Sama and Vinh-Kim Nguyen *Governing health systems in Africa* (2008) 3.
[2] Ibid.
[3] Charter of the United Nations (UN Charter) of June 26, 1945, entered into force 24 Oct. 1945, Art 55-56.
[4] Constitution de la République Démocratique du Congo du 18 Février 2006 telle que modifiée à nos jours, Art 215.
[5] UN Charter.
[6] Constitutive Act of the African Union, adopted on July 11, entered into force on 26 May 2001.

relating to human rights that each Member State has to give effect to within its domestic jurisdiction.[7] Accordingly, Article 60 of the DRC Constitution clearly states that 'the respect of all the human rights and fundamental freedoms contained in this Constitution is compulsory for both the State and all individuals.' This implies that as a sovereign State, the DRC also has its domestic system of human rights which must comply with international standards. From Article 60, two points must be highlighted. First, while it is internationally recognized that every human right gives rise to three different types of obligations on the State, namely the obligations to protect, respect and fulfil,[8] under the DRC Constitution all these obligations are encompassed into the obligation to respect. Secondly, in explicitly stating that individuals have to respect all rights and freedoms enshrined in it, the DRC Constitution holds private individuals to the same obligations as those of the State as far as the respect for human rights is concerned.

The right to health in particular has been recognized by several instruments adopted under the framework of the abovementioned two organizations. Illustrative of this is the fact that under the International Covenant on Economic, Social and Cultural Rights (ICESCR)[9] ratified by the DRC in 1976,[10] 'everyone is entitled to the enjoyment of the highest attainable standard of physical and mental health including access to medical services and medical attention.'[11] States parties are under an obligation to adopt legislative and other appropriate measures in order to give effect to this right.[12] Moreover, under the African Charter on Human and Peoples' Rights (the African Charter),[13] ratified by the DRC in 1987,[14] everyone is entitled to the enjoyment of the best attainable state of physical and mental health including medical attention, which States Parties have to realize through the adoption of legislative and other necessary measures.[15] The result of these provisions is that their implementation falls in the domestic jurisdiction of each Member State. The reason for this is that not only are these organizations created by States which adopt their respective constitutive instruments, but also

[7] See Arts 1 and 2 of the UN Charter and Art 3 of the Constitutive Act of the African Union.
[8] The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (1998) HRQ 20, 691-705, Art 6.
[9] International Covenant on Economic, Social and Cultural Rights, G.A .res. 2200A (XXI) of 16 December 1966, entered into force 3 January 1976, Art.12.
[10] Democratic Republic of Congo, Ministry of Human Rights: eighth, ninth and tenth periodic reports to the African Commission on Human and Peoples Rights, implementation of the African Charter on Human and Peoples Rights (Period from July 2003 to July 2007) 2007, Para 30.
[11] ICESCR Art 12.
[12] Ibid Art 2 (1).
[13] African (Banjul) Charter on Human and People Rights (Adopted 27 June 1981, OUA Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force 21 October 1986) Art 16.
[14] DRC report to the African Commission (note 10) Para 30.
[15] Arts 1 and 16 of the African Charter.

because it is the responsibility of states to give effect to their international obligations in the domestic level.[16]

At the domestic level, Article 47 of the DRC Constitution provides that 'the right to health and to food security is guaranteed. The Law establishes fundamental principles and organization rules relating to public health and food security.' Two main points may be drawn from this provision. First, the DRC Constitution uses the concept of the 'right to health' without explicitly mentioning health care or medical attention. The reason is that the concept of the 'right to health' is inclusive of both health care and other underlying health determinants.[17] Secondly, although there is no explicit mention of legislative and other appropriate or necessary measures to be adopted in order to give implement the right to health, these obligations are impliedly included in the obligation to 'guarantee'. For instance, subsequent to the constitutional obligation to 'guarantee the right to health' were adopted respectively a law on the protection of people living with HIV (the HIV Act),[18] the Strategy of Health System Reinforcement (the Health National Strategy)[19] on primary health care, the law on the protection of children (the Children's Act),[20] the National Policy on Reproductive Health (the Reproductive Health Policy)[21] and the National Plan of Action for Health Development (the Health Plan of Action)[22] on primary health care.

1.2 Statement of the Research

This paper seeks to answer the following issues. First, whether the DRC protects the right to health adequately? Secondly, whether the absence of the qualification 'progressive realization' and 'available resources' in respect of the right to health in the DRC Constitution indicates that this right must be immediately enjoyed by the Congolese people even though the State itself claims to be poor and heavily-indebted with one of the lowest rankings on the

[16] DM Chirwa 'The right to health in international law: its implications for the obligations of state and non-state actors in ensuring access to essential medicine' (2003) 19 (4) *SAJHR*, 541 at 542.
[17] Brigit CA Toebes *The right to health as a human right in international law* (1999) 17-18.
[18] Loi Portant Protection des Droits des Personnes Vivant avec le VIH/SIDA et des Personnes Affectées, 2008.
[19] Ministère de la Sante Publique de la RDC, Stratégie de Renforcement du System de Sante, 2006.
[20] Loi Portant Protection de l'Enfant, 2009.
[21] Ministère de la Santé Publique de la RDC, Politique Nationale de la Sante de Reproduction (2008).
[22] Ministère de la Sante Publique de la RDC, Plan National de Développement Sanitaire 2011-2015 (2010).

human development index in the world?[23] Thirdly, what is the consequence for the DRC of its ratification of the ICESCR, especially to right to health? Fourthly, has DRC taken adequate measures and policies to ensure medical services?

This study argues that the DRC Constitution has the potential adequately to deal with the right to health. However, certain factors impede the full enjoyment of the right to health by the Congolese people. First, the State's duties to implement human rights in general and the right to health in particular are not clearly defined. Secondly, inadequate measures have been taken to implement the right to health in the DRC. It will be argued that the full enjoyment of the right to health such as is provided by the Constitution and international treaties call for the elaboration of the State's obligations. Moreover, it will be argued that appropriate legislative and other necessary measures including policies and special measures of protection for the vulnerable groups of the society need to be adopted in order to give effect to the constitutional right to health. Otherwise, the right to health in the DRC will remain merely illusory.

1.3 Significance of Study

In 2006, the DRC adopted a new Constitution which provides for the right to health. While there is a lack of jurisprudence on the issue, this study will help understand what such recognition of the right to health means under the DRC Constitution. Furthermore, it will help understand whether the DRC obligations to implement the right to health are elaborated in light of international law and, look at what kind of measures have been adopted or must be adopted to give effect to this right.

Indeed, the right to health is a typical economic, social and cultural right[24] the contents and nature of which are controversial. Presently, this category of human rights gives rise to, among other topical and controversial questions, the debate between civil and political and socio-economic rights, the question regarding the applicability of human rights to private actors, and the concept of States' duties to ensure the progressive realization of socio-economic rights within their available resources. Regarding the first question, it has been

[23] Human Rights Council, Working on the Universal Periodic Review : National Report submitted in accordance with paragraph 15 (a) of the annex to Human Rights Council Resolution 5/1, Democratic Republic of Congo, 6th session, UN Doc A/HRC/WG.6/6/COD/1 (September 2009) Art124 (b).
[24] Chirwa 'The right to health' (note 16) at 555.

noted that generally, economic, social, and cultural rights are distinguished from civil and political rights.[25] As a result, economic, social and cultural rights are treated as aspirations that do not quite fit the notions of natural rights.[26] In respect of the applicability of human rights to private actors, while some argue that private actors should be directly accountable for human rights at both the international and domestic levels, others submit that only States can be held responsible for the protection of human rights.[27] With regard to the question concerning the progressive realization of socio-economic rights by States within their present capacity, it has been observed that, although the ICESCR acknowledges that States parties may have resource constraints, it nevertheless imposes on States parties various obligations which require immediate implementation.[28]

Therefore, throughout this study, some of the above questions will be directly or indirectly analyzed using the following approaches. First, the paper aims to reaffirm that all human rights and freedoms are interdependent, indivisible and interrelated[29] and then currently the right to health may be enforced at both the international[30] and domestic levels.

Secondly, the debates on civil and political rights and socio-economic rights, including the progressive realization of socio-economic rights, and the applicability of human rights to individuals, have been partially solved, at least on paper, by the DRC Constitution. Accordingly, the DRC Constitution puts all human rights on the same footing by avoiding the inclusion of the progressive realization clause and that concerning the limitation of States' socio-economic rights obligations only to the extent of the available resources. Moreover, it subjects individuals to the respect of all human rights.[31]

Thirdly, while according to the DRC Constitution all the State's obligations to implement the right to health are confined to the obligation to 'respect and guarantee the right to health',[32] this study will be a contribution not only to the clarification of the principle of

[25] Toebes (note 17) at 6.
[26] Zehra F Kabasakal Arat, 'Forging a global culture of human rights: origins and prospects of the International Bill of Rights' (2006) 28 (2) *Human Rights Quarterly*, 416 at 429.
[27] DM Chirwa 'The doctrine of state responsibility as a potential means of making private actors accountable for human rights' (2004) 1 at 3.
[28] CESCR, Substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment 14: The Right to the Highest Attainable standard of Health, UN ESCOR, 22end session, Agenda item 3, UN Doc E/C.12/2000/4 (11 August 2000) Para. 30.
[29] Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, G.A res A/RES/63/117, on 10 December 2008. See Preamble.
[30] Ibid Art 1.
[31] The DRC Constitution (note 4) Art 60.
[32] Ibid Arts 47 and 60.

interdependence, indivisibility and interrelatedness of all State duties,[33] but also to the clarification of all necessary steps for the full realization of the right to health.[34] Indeed, it has been argued that,

> [I]f a government focuses only on the duty to respect, but does not protect individuals from third party infringements; there is a greater chance that some individuals will be deprived of the enjoyment of the right. Hence, the duty to fulfil would be more burdensome for the State.[35]

Fourthly, the study aims to denounce and critique some Congolese legislation and regulations relating to the right to health which may be seen as inconsistent with the DRC Constitution and both the ICESCR and the African Charter. For instance, while the DRC Constitution binds individuals to respect all human rights herein contained, the Decree on the Exercise of Medicine (the 1952 Decree) in the DRC, explicitly states that its dispositions will not apply to indigenous peoples of Congo-Belgium who, in the customer areas, provide health care services or medicines in accordance with us and customs.[36] This Decree excludes traditional medicines practitioners from any kind of regulation. Furthermore, while the right to health must be enjoyed by everyone without discrimination, Article 41 of the Law on public servants (the Public Servants Act), [37] which provides for social benefits including health care for every public servant, explicitly states that, a married woman public servant will be entitled to such social benefits only if her husband does not exercise any gainful activity. Lastly, under Article 30 of the Decree on the Status of Physicians (the 2006 Decree),[38] which regulates social benefits including the provision of health care to all physicians, the State is under an obligation to pay medical fees for general health care only for a doctor, his wife and children. It follows from this Article that a married female doctor is excluded because there is no reference to her husband or her children.

[33] Magdalena Sepùlveda *The nature of the obligations under the International Covenant on Economic, Social and Cultural Rights* (2003) 170.
[34] General Comment 14 (note 28) Para 33.
[35] Sepùlveda (note 33) at 170-171.
[36] Décret Portant Art de Guérir au Congo -Belge, 1952, Art 15.
[37] Loi Portant Statut du Personnel de Carrière des Services Publics de l'Etat, Juillet 1981.
[38] Décret Portant Statut Spécifique Des Médecins des Services Publics de l'Etat, 2006.

1.4 Literature Review

There exists an important body of literature relating to States' duties to give effect to socio-economic rights, including the right to health such as are provided by international instruments, especially the ICESCR. However, this study is limited by the few publications on the right to health and access to medical service in the DRC. In her book, The Right to Health as a Human Right in International Law, Brigit Toebes rightly points out that due to the crucial importance of health for people's wellbeing and their dignity, the right to health has been recognized as a human right in several international human rights instruments.[39] She also argues that although States obviously cannot guarantee good health, they may nevertheless create certain basic conditions through which the health of the people may be protected.[40]

Magdalena Sepùlveda analyses States obligations under the ICESCR. She writes that 'States need to know what they are obliged to do in order to comply with the Covenant. Lawyers, advocates, potential victims and all bodies that are called upon to apply the Covenant need to have a clear understanding of the obligations assumed by the State in order to assess compliance.'[41] The author also stresses that the full protection of a given right contained in a human rights treaty cannot be achieved by relying merely on one or two of those obligations but must involve the performance of all levels of duties.[42]

Analyzing human rights such as those contained in the DRC Constitution, Mazyambo Makengo argues that this Constitution is the best that the country has had since its attainment of independence in 1960. Its human rights catalogue is closer to those found in international human rights instruments.[43] Further, he points out that an important number of both conventional and constitutional provisions relating to human rights call for the adoption of appropriate and applicable legislative measures for their full enjoyment by the people.[44] André Mbata thinks from the perspective of the supremacy of the Constitution, the

[39] Toebes (note 17) at 4.
[40] Ibid.
[41] Sepùlveda (note 33) at 4.
[42] Ibid at 170.
[43] Mazyambo Makengo 'Introduction aux droits de l'homme: théorie générale, instruments, mécanismes de protection' in Programme des Nations Unies pour le Développement (ed) *Mandats, rôles et fonctions des pouvoirs constitués dans le nouveau système politique de la République Démocratique du Congo. Journées d'information et de formation organisées à l'intention des parlementaires, députés provinciaux et des Hauts Cadres de l'administration* (2007) 225 at 259.
[44] Ibid at 277.

independence of the judiciary, and democratic governance in the DRC.[45] He advances the argument that reference to political, economic, social and cultural rights was equally a sign that Congolese people were not only committed to political democracy which is limited only to elections, multiparty and respect for civil and political rights. Rather, they adopted a maximalist conception of democracy as a government system where all human rights are interdependent and interrelated.[46] Furthermore, he writes that the judiciary headed by the Constitutional Court must ensure the effective protection of the Constitution, which is the supreme law of the land.[47]

On the other hand, Peter Persyn and Fabienne Ladriere, in their study 'The Miracle of Life in Kinshasa: New Approaches to Public Health' report that Kinshasa's main hospitals are a place of death. They reveal that the buildings themselves are in ruins, that plumbing and electricity are inadequate, and that the material and equipment are practically non-existent.[48] Moreover, they point out that 'for major surgery or sophisticated medical treatment, even elites must seek care abroad, usually in South Africa or Europe. For the vast majority of people, this is impossible; they have to accept poor quality healthcare and the steeply rising costs'.[49] Baudouin Wikha Tshibinda examines the obligations of State's institutions regarding the right to health, namely the President of the Republic, the Executive, the National Assembly and the Judiciary. He notes that the existing health legislation and regulation are outdated, unsuitable, inaccurate and even ambiguous.[50] He further reports that the inquiries carried out in the university clinics reveal that whenever a person is admitted to the hospital, he or she must pay the consultation fee in order to be able to be attended to by a teacher or a specialist, even in cases of emergency. After the consultation, the person is sent to the laboratory for Para-clinic tests with a laboratory sheet Subsequent to which the patient must pay the laboratory bills according to the different tests that the doctor has requested for. Whenever the person is admitted for a surgical operation or treatment, he must pay the

[45] Mbata Betukumesu Mangu 'Suprématie de la constitution, indépendance du pouvoir judiciaire et bonne gouvernance en République Démocratique du Congo' in Grégoire Bakandeja wa Mpungu et al (eds) *Participation et responsabilité des acteurs dans un contexte d'émergence démocratique en République Démocratique du Congo* (2007) 393 at 406.
[46] Ibid at 405.
[47] Ibid.
[48] Peter Persyn and Fabienne Ladriere 'The miracle of life in Kinshasa: new approaches to public health' in Theodore Trefon (ed) *Reinventing order in the Congo: How people respond to the state failure in Kinshasa* (2004) 66 at 66.
[49] Ibid at 72.
[50] Baudouin Wikha Tshibinda 'Guarantee mechanisms of ''rights-claims'' recognized by the constitution: right to health, state obligation' (President, Executive, National Assembly, Judiciary) (2010) Vol. 4 *African Law Study Library*, 1 at 14 and 18.

operation fees followed by those required for hospitalization, including medication for all the time spent in the hospital.[51]

The above outlined works are necessary in the completion of this study because they provide information on the relevance of the recognition of the right to health at the international level and the nature of State obligations in respect of the said right in general. Particularly, they deal with the recognition of socio-economic rights including the right to health in the DRC's domestic law such as provided by the DRC Constitution, with a focus on the manner in which people have access to health care services.

However, in only focusing on the national sphere of government (Legislature, Executive and Judiciary) specific works dealing with the DRC context seem to use a narrow understanding of the concept of State, excluding the relevant role to be played by provincial and local spheres of government. Furthermore, the assertion that all the existing legislation and regulation on health are outdated, unsuitable and inaccurate needs to be mitigated for the following reasons. First, although the framework regulation on the medical profession in the DRC consists mainly of the 1933 Ordinance on the practice of pharmacy (the 1933 Ordinance)[52] and the 1952 Decree, it is still relevant and has been supplemented by further laws and regulation. In addition, subsequent to the DRC Constitution new laws and policies have been adopted in order to protect the right to health. Lastly, ratified international human rights on health are part of the DRC legal system. Therefore, this study analyzes the nature of the DRC's obligations in respect of the right to health in the context of its monist legal system.

1.5 Methodology

The present paper will employ both primary and secondary sources. The primary sources include the DRC Constitution, the ICESCR, General Comments of the CESCR and the African Charter. These primary sources will be relied on to the extent that they provide a legal obligation on the DRC to implement the right to health. Other primary sources that will be used include relevant legislation, regulation and policies with a view to assess the DRC commitment to the implementation of its obligations in respect to the right to health.

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[51] Ibid at 21.
[52] Ordonnance No 27 bis Hyg. du 15 Mars 1933 sur l'Exercice de la Pharmacie au Congo-Belge.

On the other hand, secondary sources will include relevant literature, journal articles, and relevant online reports on the subject. These will be relied on to the extent that they provide important information on the topic and highlight States obligations in respect of the right to health or on the implementation of these obligations at the domestic level.

1.6 Outline of the Chapters

This chapter has defined the statement of the problem, which is the potential of the DRC Constitution to adequately protect socio-economic rights in general and the right to health in particular. It has further defined the significance of the study, which consists, in the absence of jurisprudence on the issue, of contributing to the understanding of the nature of the obligations the DRC has under international law and its on Constitution in relation to the right to health and the nature of the legislative and other policy reforms that are necessary for the DRC to comply with those obligations. The second chapter will discuss the recognition of health as human right in international law, with a focus on the nature of States' duties in respect of the right to health such as provided by the ICESCR and the African Charter. This is being carried out with a view to making a critical and objective assessment of these instruments, and to enhancing an understanding of this study at the domestic level. The third chapter deals with the DRC constitutional framework, especially the history of the DRC Constitution as it relates to the protection of human rights in general, and socio-economic rights including the right to health in particular. The fourth chapter will analyze and critique statutes and policies relevant to the right to health. The fifth chapter will conclude the study.

Chapter Two

HEALTH AS HUMAN RIGHT IN INTERNATIONAL LAW

2.1 Introduction

The present chapter discusses the recognition of the right to health in international law, with a specific focus on the ICESCR and the African Charter. Not only is the DRC party to those two international human rights instruments, also they constitute the main international and regional standards on the right to health. They will be used as a yardstick to assess DRC's commitment to the realization of this right within the domestic arena. The chapter will therefore provide a brief history of the concepts of health, the right to health and its content under the framework of the UN. It will further analyze the nature of State's obligations in respect of the right to health under both the ICESCR and the African Charter. Lastly, it will discuss both the minimum core obligation and the reasonableness approaches relating to the assessment of the State's commitment in implementing the right to health.

2.2 A brief history of the development of the concepts of health and the right to health under the UN

Diseases, air pollution, lack of public hygiene and poverty have always threatened the health of the populations since the earliest civilizations.[53] State's attempts to improve public health individually or through international action have gradually developed in accordance to the nature of the threats to the health of the people.[54] In the context of the UN in particular, the aftermath of the Second World War and the horrors of the holocaust were identified as new kinds of threats to public health and called for international action in order to tackle the issue of health.[55] For instance, it was reported that gross violations of human rights including enslavement and pseudo-medical experiments on victims of wars, were committed on a mass scale during the Second World War.[56] Subsequent to Nazi brutality in 1945, tens of thousands

[53] Toebes (note 17) at 3 and 8.
[54] Ibid at 8.
[55] Chirwa 'The right to health' (note 16) at 544.
[56] David P Forsythe *Human Rights in international relations* (2006) 39.

of Jews were weak and ill after being released from the concentration camps.[57] As a result, the mental and physical scars which resulted from such political persecution and brutality were to impact on them for the rest of their lives.[58]

It is within this context that, after the Second World War, the UN was committed to the realization of the right to health[59] and to save succeeding generations from the scourge of war.[60] During the United Nations Conference on International Organizations, the Brazilian delegation submitted a memorandum according to which medicine was one of the pillars of peace.[61] This interconnection between peace and health is reflected by the wording of article 55 of the UN Charter, which stipulates that the international promotion of health is crucial for peaceful and friendly relations among nations as well as for the creation of conditions of stability and well being of the people. Thus, the concept of 'health' was used for the first time in the UN Charter; although it is not defined therein. However, the Charter provides that the various specialized agencies, established by intergovernmental agreement and having wide international responsibilities, in economic, social, health, and related fields, shall be brought into relationship with the UN.[62]

Consequently, the first definition of the concept of health was provided by one of these specialized agencies, namely the World Health Organization (WHO).[63] It refers to health as, 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[64] According to this definition, Chapman observes that it provides a broader understanding of societal determinants of health than the narrow typical language of disease and disability.[65] However, this definition seems to be equating health with well-being[66] because it presupposes that the State may ensure the complete or good health of individuals.[67] On the other hand, it has been cautioned that the right to health is not

[57] Tony Kushner *The Holocaust and the Liberal imagination, a social and cultural history* (1994) 205.
[58] Ibid.
[59] Toebes (note 17) at 15.
[60] See Preamble to the UN Charter.
[61] Toebes (note 17) at 15.
[62] UN Charter Art 57.
[63] Constitutive Charter of the World Health Organization (WHO Charter), adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 and entered into effect on 22 July 1946.
[64] Ibid see preamble.
[65] Audrey R Chapman 'Core obligations related to the right to health' in Audrey Chapman and Sage Russell (eds) *core obligations: building a framework for economic, social, and cultural rights* (2002) 185 at 187.
[66] Ibid.
[67] Chirwa 'The right to health' (note 16) at 545.

the same as the right to be healthy, and that good health is determined by several factors, such as, an individual's biological make-up and socio-economic conditions.[68]

The WHO provides also a definition of the right to health. It stipulates that, 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'[69] It therefore becomes clear that WHO makes a distinction between health which is abstract and the enjoyment of the highest attainable standard of health which may be realistic. In other words, when the concept of 'right' is joined to 'health' it means the right to the enjoyment of the highest attainable standard of health. Therefore, the right to health refers to the enjoyment of a variety of goods, facilities, services and conditions necessary for its realization rather than an unconditional right to be healthy.[70]

In summary, the WHO Charter is the first international instrument under the UN, which provides the definition of both the concepts of 'health' and the 'right to the enjoyment of the highest attainable standard of health'. Subsequent human rights instruments interchangeably used expressions such as the right 'to a standard of living adequate for the health and well-being'[71], 'the enjoyment of the highest attainable standard of physical and mental health,'[72] the right 'to the best attainable state of physical and mental health,'[73] as well as the right 'to health'[74] in their various stipulations of health as a human right. Whatever the concept used to recognize health as a human right, its content reflects almost that of Article 25 of the UDHR which includes '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.' As pointed out by Chirwa,[75] most international and regional human rights instruments explicitly or implicitly converge on the point that the right to health, despite the differences in formulation, consists of both curative and preventive health care services, and the protection of the underlying determinants of health.

[68] WHO Fact Sheet 31 www.ohchr.org/documents/publications/**factsheet31**.pdf
[69] WHO Charter, see preamble.
[70] WHO Fact Sheet 31 (note 68).
[71] Universal Declaration of Human Rights (UDHR), adopted on 10 December 1948, Art 25.
[72] ICESCR Art 12.
[73] African Charter Art 16.
[74] The DRC Constitution (note 4) Art 47.
[75] Chirwa 'The right to health' (note 16) at 545.

2.3 The right to health under the ICESCR and the African Charter

The right to health is guaranteed by both the ICESCR and the African Charter. Under the ICESCR, the right to health is recognized in Article 12. It stipulates that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. It provides that the full realization of this right shall include taking necessary steps for the reduction of the stillbirth-rate and of infant mortality, and for the healthy development of the child as well as the improvement of all aspects of environmental and industrial hygiene. Moreover, it includes the prevention, treatment and control of epidemic, endemic, occupational and other diseases as well as the creation of conditions which ensure to all medical service and medical attention in the event of sickness.

The above definition indicates that the lack of hygiene and the presence of diseases constitute the main threats to human beings' health. On the other hand, this Article provides guidance regarding the action to be taken as soon as a human being's health is affected by disease. To sum up, it is worth mentioning that the right to health as has been provided by this Article is an inclusive right, which encompasses timely and appropriate health care and the underlying determinants of health.[76]

Under the African Charter, the right to health is recognized in Article 16. It entitles everyone to the enjoyment of the best attainable state of physical and mental health. The same Article enjoins the States Parties to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. Analogous to the concepts used by the ICESCR, the African Charter uses the concept of 'the best attainable or the highest attainable standard state of physical and mental health.' This is to stress that a State cannot provide for a good health of its people.

Moreover, unlike Article 12 of the ICESCR, which attempts to highlight different components of the right to health including medical services and medical attention in the event of sickness, the African Charter uses the concept of 'health' without defining it and that of medical attention only in the event of sickness. In other words, both Articles have in common the recognition of medical attention in the case of sickness, as one of the explicit components of the right to health.

[76]General Comment 14 (note 28) Para 11.

It is necessary to mention that, in fulfilling its duty of examining communications under Article 55 of the African Charter, the African Commission on Human and Peoples' Rights (African Commission) has interpreted Article 16 of the African Charter. Accordingly, it interprets it as an inclusive right encompassing not only the right to health facilities, access to good and services as well as adequate medical and material care[77] but also safe drinking water, electricity and medicines.[78] Hence, the right to health under the African Charter includes both the right to health care and the underlying determinants of health.

2.4 State obligations in respect to the right to health under the ICESCR and the African Charter

Both the ICESCR and the African Charter provide guidance on the nature of the State obligations in respect to the right to health. Accordingly, under the CESCR, States' duties concerning the right to health are outlined in both Articles 2 (1) and 12 of the Covenant. In respect of Article 2 (1) relating to general obligations, it reads as follows,

> [E]ach State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

Essentially, this Article sets out the general obligations and guidelines on what kind of steps States parties have to take, how they have to take them and the purposes for which these steps need to be taken.

As regards the nature of steps to be taken, the above Article enjoins the State to take steps by all means including legislative measures. In other words, States have the option to decide on which measures they have to adopt in order to comply with their obligations under the Covenant. These measures may include policies, judicial, administrative and financial

[77] African Commission on Human and Peoples' Rights, Communication No. 241/2001, Purohit and Moore v The Gambia (2001) Para 80 and 85.
[78] African Commission on Human and Peoples' Rights, Communications 25/89/, 47/90, 56/91, 100/93 World Organization Against Torture, Lawyers' Committee for Human Rights, Jehovah Witnesses, Inter-African Union for Human Rights/Zaire (Nineteenth Ordinary Session, March 1996), Para. 47.

measures.[79] These steps are supposed to be 'deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant.'[80]

In relation to how these steps must be adopted, the above Article suggests that States parties have to undertake steps individually and through international assistance and co-operation and to the maximum of available resources within the State party. This obligation clearly acknowledges the fact that the protection of human rights at domestic level falls into the State's sovereignty. However, in order to avoid that socio-economic rights remain unachievable in many countries due to resource constraints, resources include those existing within a State and those available from the international community through international cooperation and assistance.[81]

Lastly, the goal of all the steps undertaken is to progressively achieve the full realization of all the guaranteed rights. The emphasis on the progressive realization is due to the fact that generally socio-economic rights cannot be achieved in a short time because their full realization has to take account of the realities of the real world and difficulties involved for any country.[82]

With regards to State obligation in respect of the right to health, Article 12 of the ICESCR enjoins the States parties to take steps in order to achieve the full realization of the enjoyment of the highest attainable standard of physical and mental health by everyone. The same Article provides that these steps have to include those measures necessary for the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child. Lastly, they must be necessary for the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; the creation of conditions which would assure all medical service and medical attention in the event of sickness.

This Article does not explicitly mention the kind of steps to be taken; rather it stresses the goal that these steps have to achieve. Read in conjunction with Article 2 (1) of the ICESCR, this implies that it is the responsibility of the State to adopt all appropriate measures in order to progressively give effect to the right to health within its available resources.

[79] CESCR, General Comment 3, The nature of States parties' obligations (fifth session, 1990), U.N. Doc. E/1991/23, Para. 9.
[80] Ibid Para 2.
[81] Ibid Para 13 and 14.
[82] Ibid Para 9.

In general, State obligations under Article 12 may be interpreted as requiring the adoption of both preventive and curative measures in order to give effect to the right to health. Accordingly, one may hold that measures that aim to improve all aspects of environmental and industrial hygiene prevent and control diseases as well as those aiming to reduce infant mortality and stillbirth-rate, fall within the category of preventive measures.

Whereas, measures that aim to treat diseases as well as create conditions to assure everyone gets medical service and medical attention in the event of illness, fall within the category of curative measures. The relevance of a simultaneous implementation of both preventive and curative measures lies in the fact that they support and supplement each other. That is, where preventive measures fail or cannot apply, curative ones will supplement. Likewise, when preventive measures have succeeded, there will be no need for curative measures on the same issue.

On the other hand, like under the ICESCR, States parties to the African Charter are under complementary general and specific obligations with regard to the right to health.[83] Accordingly, Article 1 of the African Charter obligates Member States not only to recognize the rights, duties and freedoms enshrined therein, but also it enjoins them to undertake to adopt legislative or other measures in order to give effect to these rights.

It follows from this Article that like under the ICESCR, legislative measures must be supplemented by other necessary measures in order to achieve the realization of the right to health. Furthermore, unlike the ICESCR, the African Charter does not provide for a clause of progressive realisation of socio-economic rights, or that of the available resources. To this end, it has been argued that:

> [B]y sidestepping the differential treatment respecting civil and political rights on the one hand, and economic, social and cultural rights on the other, the African Charter falls within an unorthodox paradigm. This innovation enabled the Charter to transcend popular discourse and move the discussion beyond the artificial distinctions between the so-called categories of rights.[84]

In other words, the African Charter avoids providing preferential protection to any of the three classical categories of human rights namely civil and political rights, collective

[83] Thoko Kaime Beyond social programs: the right to health under the African Charter on Human and Peoples' Rights (2004) *East African Journal of Peace and Human Rights*, 192 at 198.
[84] Ibid at 193.

rights and socio-economic rights. This is made explicit by the wording of its preamble, which states that the right to development and civil and political rights cannot be dissociated from economic, social and cultural rights.[85] However, the criticism against Article 1 of the African Charter is that it binds the States with unqualified positive obligations without taking account of the widespread poverty on the African continent or that of acute resource constraints faced by African countries.[86] It is necessary to point out that the African Commission held that resource constraints have to be taken into account in the implementation of the right to health as protected by the African Charter.[87] Finally and unfortunately, unlike the ICESCR, the African Charter does not provide for regional assistance and cooperation in the implementation of all the rights contained therein including the right to health.

As regards State's specific obligations, Article 16 of the African Charter recognizes the right of everyone to the enjoyment of the best attainable state of physical and mental health. It further enjoins the Member Parties to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

As is clear, this Article, unlike Article 12 of the ICESCR, does not expressly indicate that States have to take necessary measures in order to achieve the enjoyment of the best attainable state of physical and mental health. Rather, it seems to suggest that this right will be achieved through the adoption of measures that aim to protect the health of the people and to ensure that they receive medical attention. However, once read in conjunction with Article 1 of the African Charter, it becomes clear that States have to adopt necessary measures in order to immediately give effect to the right to the enjoyment of the best attainable state of physical and mental health.

2.4.1 Minimum core obligations approach

The assessment of a State's compliance with its obligations depends on the clarity of the said obligations. In order to address the complexities of the normative content of Article 2 (1) of the ICESCR[88] and make explicit the vagueness of the Covenant's language regarding State's

[85] African Charter, see preamble.
[86] DM Chirwa 'African regional human rights system: The promise of recent jurisprudence on social rights' in Malcolm Langford (ed) *Social rights jurisprudence: Emerging trends in international and comparative law* (2008) 323 at 327 and 338.
[87] African Commission (note 77) at Para 84.
[88] Sepùlveda (note 33) at 427.

obligations in relation to the right to health,[89] the CESCR has elaborated the provision in both general comments 3[90] and 14.[91] In respect of the notion of a minimum core obligation in particular, it has been developed by General Comment 3 as follows:

> [T]he Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its raison d'être.[92]

It follows from the above quotation that, each right protected under the ICESCR contains minimum essential levels without which the right would lose its substance[93] and the Covenant its raison d'être. For instance, according to the General Comment 3, a State in which any significant number of individuals is deprived of essential primary health care may be seen as failing to comply with its obligations under the Covenant.[94] This implies that the notion of a minimum core obligation stresses the enjoyment of the minimum essential of the right by a significant number of individuals. However, while the ICESCR enjoins the State to fully give effect to all rights,[95] the General Comment 3 seems to confine the nature of State's obligation into the concept of a minimum core obligation. To this end, Toebes argues that the realization of the core content of rights is not enough and then States have to strive to fully give effect to all aspects of the said rights.[96] This is because, by complying with its core obligations, a State may consider the remainder of rights as unimportant.[97]

Any assessment of the State's compliance with its minimum core obligations cannot be made in isolation from resource constraints prevailing within its jurisdiction.[98] Consequently, a State may attribute its failure to comply with its minimum core obligations to a lack of available resources.[99] However, such justification is subject to three limitations. First, the State concerned has to show that it has made every effort to use all resources that

[89] Alicia Ely Yamin 'The future in the mirror: incorporating strategies for the defence and promotion of economic, social, and cultural rights into the mainstream human rights agenda' (2005) *HRQ*, 1202 at 1214.
[90] General Comment 3 (note 79).
[91] Yamin (note 89) at 124. See also General Comment 14 (note 28).
[92] General Comment 3 (note 79) Para 10.
[93] Sepùlveda (note 33) at 367.
[94] General Comment 3 (note 79) Para 10.
[95] ICESCR Art 2.
[96] Toebes (note 17) at 276.
[97] Ibid.
[98] General Comment 3 (note 79) Para 10.
[99] Ibid.

are at its disposal in order to give priority to its minimum core obligations.[100] Secondly, the State is still under a minimum obligation to strive to ensure the widest possible enjoyment of the relevant rights even where available resources are conceivably inadequate.[101] Lastly, the State has the obligation to protect the vulnerable members of society in times of severe resource constraints through the adoption of relatively low-cost targeted programmes.[102]

The minimum core approach has thus been developed in order to provide guidelines for a State with resource constraints to ensure access to a given right by everyone, especially the vulnerable groups of the society. However, the lack of clarity on the meaning of a minimum core is, led the South African Constitutional Court to develop the reasonableness test.[103]

2.4.2 The reasonableness test

The notion of a reasonableness test was developed by the Constitutional Court through the interpretation of section 26 (2) of the South African Constitution, which stipulates that, 'the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of the right to housing'. Accordingly, the Court held that section 26 (2) of the Constitution does not entitle the respondents[104] to claim shelter or housing immediately upon demand.[105] Rather, it obliges the State to devise and implement a coherent, co-ordinated program designed to meet its constitutional obligations.[106] The Court was further concerned that the existing program on housing fell short in complying with section 26 (2) of the Constitution in that it did not provide for any form of relief to those desperately in need of access to housing.[107] This decision was underpinned by the idea that not only has a reasonable program to include a significant segment of society, but also it has to respond to the needs of those most desperate through the provision of short, medium and

[100] Ibid.
[101] Ibid Para 11.
[102] Ibid Para 12.
[103] *Government of the Republic of South Africa and others v Grootboom and others* 2001 (1) SA 46 (CC) Para 30.
[104] In the Grootboom case respondents including children were evicted from informal homes and applied to Court for order requiring government to provide them with adequate basic shelter or housing until they obtain permanent accommodation.
[105] Ibid Para 95.
[106] Ibid.
[107] Ibid.

long term needs.[108] While the overall goal of such a program is to ensure that everyone has access to a given right, focus on a program providing for short term needs aims to take account of those in desperate needs.

Although, by virtue of the reasonableness test, a homeless person is entitled only to a reasonable policy rather than an immediate access to housing[109] or that he or she has the weight to prove that the State did not have a reasonable program,[110] the reasonableness approach may be given predilection[111] for the following reasons. First, it has been developed and tested by the Court at the domestic level. Therefore, it vests the courts with the power to participate within the parameters of the separation of powers in issues relating to policy-making and implementation.[112] Moreover, it helps enforce State's positive obligations and demonstrate in concrete terms failure for a State to comply with its obligations.[113] It is for this reason that the Protocol to the ICESC draws from the reasonableness test as developed by the South African jurisprudence.[114]

The Optional Protocol to the ICESCR refers to the reasonableness standard as follows,

> W]hen examining communications the Committee shall consider the reasonableness of the steps taken by the state party in accordance with part II of the Covenant and look at whether the state party has adopted a range of possible policy measures for the implementation of the rights set forth in the Covenant.[115]

It is clear from this provision that unlike the ICESCR which talks about the adoption of 'appropriate measures or steps,'[116] the Protocol to the ICESCR uses the concept of reasonableness of the steps to be adopted as developed by the Constitutional Court of South Africa. Furthermore, unlike the ICESCR which requires States to adopt all appropriate measures including legislative measures in particular, the Optional Protocol stresses the adoption of a range of possible policies without explicit reference to legislative measures. It

[108] Ibid Para 43-44.
[109] Danwood M Chirwa *Human rights under the Malawian Constitution* (2011) 277.
[110] Ibid.
[111] Ibid.
[112] Ibid.
[113] Ibid.
[114] Ibid at 278.
[115] Optional Protocol to the ICESCR (note 29) Art 8 (4).
[116] Art 2 (1) of the ICESCR.

seems premature to assess the reasonableness standard as elaborated under the Optional Protocol to the ICESCR, since it is not yet entered into effect.

2.5 Conclusion

The idea that the promotion of well-being, through the promotion of health is necessary for peaceful and friendly relations among nations, led to the recognition of 'health' as human right under the UN framework. The content of the right to health encompasses preventive and curative care, as well as other underlying determinants of health. Such a conception of the right to health has been adopted by both the ICESCR and the African Charter.

Although States parties to both the ICESCR and the African Charter are enjoined to give effect to the right to health at the domestic level, the nature of State's obligations in respect of the right to health remains nevertheless different. For instance, under the ICESCR, States are required to progressively implement the right to health individually and through international cooperation to the extent of their available resources. In contrast, under the African Charter it is the State's individual duty to immediately implement the right to health irrespective of its resources.

Two standards, namely the minimum core approach and the reasonableness test may be used in order to assess State's commitment to the right to health. Accordingly, a minimum core approach consists of providing progressively, a minimum essential level of the right to health to a significant number of individuals, especially the vulnerable groups of society through a lower-targeted program. Whereas, a reasonableness test requires that the State has to progressively achieve the right to health of a significant segment of society, including those that are desperate through a coordinated program providing for short, medium and long term needs.

Chapter Three

BACKGROUND TO THE CONSTITUTIONAL FRAMEWORK OF THE DRC

3.1 Introduction

This chapter provides the background to the constitutional framework of the DRC in relation to the promotion of human rights. It includes a history of the DRC Constitution with particular emphasis on the protection of human rights in general including the right to health, in particular from DRC's attainment of independence till today. Attention will also be placed on the relevance of international law in the DRC domestic legal framework. The chapter also provides an overview of the human rights provisions under the DRC Constitution and also discusses the nature of the protection of the right to health under this Constitution.

3.2 History of the DRC constitution with respect to the protection of human rights

The first Constitution that aimed to protect human rights in the DRC remains the 1908 Colonial Charter[117] governing the relationship between Belgium, the metropolis and the Belgian-Congo (currently DRC) and its colony from 1908 to 1960. Accordingly, chapter two of this Charter was devoted to 'the rights of Belgians, foreign and indigenous people.' However, the Colonial Charter did not detail any human rights. Instead, in addition the proclamation that the inhabitants of the colony had only few rights under certain provisions of the Belgian Constitution[118] it was provided that Belgians, the Congolese registered in the colony and foreigners enjoyed all civil rights recognized by the laws of the Belgian Congo, whereas the indigenous people were entitled to civil rights granted to them by the laws of the colony as well as their customs.[119]

[117] Charte Coloniale du 18 Octobre 1908 : Loi sur le Gouvernement du Congo Belge.
[118] Ibid Art 2.
[119] Ibid Art 4.

At its attainment of independence in 1960, the DRC adopted the 1960 Fundamental Law on the Structures of Congo.[120] This law was adopted and promulgated by the Belgian peoples. [121] Surprisingly, unlike the Colonial Charter, this Constitution made no reference to human rights. As a result, another Fundamental Law on Public Freedoms[122] was adopted one month later, which both together with the 1960 Fundamental Law mentioned above constituted the first Constitution of the independent DRC. Included in its 21 Articles dedicated to human rights were the rights to education, to property and to form and join trade unions as well as the right to work.[123] The general obligation on the State in respect of these guaranteed human rights had to be understood within the confines of the general aim of this Law, which was to define the rights of Congolese citizens and which the authorities were obliged to provide or facilitate the realization.[124] It should be noted, however, that Articles 12 and 15 of this Law relating to freedom of thought, conscience and religion as well as the right to express one's opinion contained a clause according to which their exercise was subject to protective measures necessary to the protection of among others, 'public health'. Although the link between the exercise of these rights and the protection of public health is hard to establish, this Law is the first to use the concept of 'public health' albeit in a manner which is confused and unclear.

In 1964, Congolese people adopted for the first time their own Constitution, which explicitly referred to the Universal Declaration of Human Rights.[125] A close analysis of its Bill of rights reveals that, out of 35 Articles dedicated to fundamental human rights,[126] seven Articles dealt with the rights to education, to property, to trade, and to form trade unions, the rights to practice art and scientific research as well as children's care and education.[127] However, the 1964 Constitution did not expressly provide for the right to health. In respect of State obligations, Article 12 provided that respect for human rights enshrined by the Constitution was compulsory for the executive, the legislature and the judiciary of the Republic and all provinces.

[120] La Loi Fondamentale du 19 Mai 1960 Relative aux Structures du Congo.
[121] Mbata (note 45) at 393.
[122] La Loi Fondamentale du 17 Juin 1960 Relative aux Libertés Publiques.
[123] Ibid Arts 13, 14, 16 and 17.
[124] Ibid Art 1.
[125] Constitution de la République Démocratique du Congo du 1er Aout, 1964, see preamble.
[126] Ibid Titre II.
[127] Ibid Arts 14, 28, 33, 38, 43, and 44.

The 1964 Constitution had a short span. In November 1965, a military coup led by Colonel Joseph Desire Mobutu[128] suspended the 1964 Constitution. Consequently, the country was ruled by a mere proclamation which acknowledged the existence of the 1964 Constitution[129] until the establishment of another Constitution in 1967.[130] The socio-economic rights protected under this Constitution included the rights to education, property and work.[131] There is no general or specific obligation on the State to give effect to these rights. From 1965 to 1997, the country went through a long period of dictatorship under the rule of President Mobutu.

In 1990, the transitional process to democracy began and led to the elaboration of a transition Constitution in 1994.[132] As regards the protection of human rights, out of 28 Articles dedicated to human rights and fundamental freedoms,[133] one can identify among guaranteed socio-economic rights, the rights to education, property, and to the practice of commerce and industry, to work and the right to strike.[134] Under Article 30 in particular, it is stated that, 'everyone has the right to a healthy environment and has the duty to defend it. The State shall protect the environment and public health'. This Article stresses the interconnection between the environment and public health.

It must be noted that, in accordance with the 1994 Constitution, the transition duration was 15 months and was supposed to end up in August 1995.[135] However, it was only in 1997 when another rebellion led by Laurent Desire Kabila had succeeded to get into power that President Mobutu gave up the power.

From 1997 to 2003, the DRC had a one-paged Constitution[136] of 15 Articles.[137] Under its Article 2, the only one which mentioned human rights, it was stated that 'the exercise of individual and collective rights and freedoms is guaranteed on the condition of

[128] Djoli Eseng'Ekeli 'Problématique de l'opposition politique en Afrique noire post-coloniale. Cas de la République Démocratique du Congo: Mythe ou réalité.' in Grégoire Bakandeja wa Mpungu et al (eds) *Participation et responsabilité des acteurs dans un contexte d'émergence démocratique en République Démocratique du Congo* (2007) 84 at 95.
[129] Ibid at 96.
[130] Constitution de la République Démocratique du Congo du 24 Juin 1967 (the 1967 Constitution).
[131] Ibid Articles 13, 14, 17 and 18.
[132] Acte Constitutionnel de la Transition de la République du Zaïre, Avril 1994 (the 1994 Constitution).
[133] Ibid Arts 9-36.
[134] Ibid Arts 21, 22, 25, 28 and 29.
[135] Ibid Art 117.
[136] Djoli (note 128) at 98.
[137] Décret Loi Constitutionnel Relatif a l'Organisation et l'Exercice du Pouvoir en République Démocratique du Congo, 1997.

respect of the law, public order as well as good mores'. This Constitution did not enumerate the specific individual or collective rights it alluded to. The dictatorship of President Laurent Kabila came to an abrupt end with his assassination in 2001.

This led to two years of political negotiations, which culminated in the adoption of a transition Constitution in 2003.[138] This Constitution contained 48 Articles on the protection of human rights in general,[139] including, the rights to property, to work, to strike and to create and join association, to education, and the right to protect the youth against any harmful practice to their health.[140] Also included were the rights to culture, freedom of intellectual and artistic creation, and freedom of scientific research.[141] As regards the right to health particularly, Article 50 of this Constitution provided that: 'the State has the obligation to ensure the wellbeing and food security of the consumers. The law will establish general principles relating to public health and food security'. As is clear, this Constitution enjoined the State for the first time to explicitly ensure the wellbeing of consumers. However, the concept of 'consumers' which is used in reference to the Congolese citizen is not appropriate.

As regards the State's obligation to implement the rights, Article 61 stated that: respect for human rights and fundamental freedoms enshrined in this Constitution are applicable to all citizens and public authorities. This provision subjects explicitly for the first time individuals to the respect of human rights. Due to the temporary character of this Constitution,[142] another Constitution was adopted in 2006 (the DRC Constitution) which is the current Constitution.

3.3 Overview of human rights under the DRC Constitution

3.3.1 Categorization of human rights

Human rights in the DRC Constitution are explicitly divided into three categories, namely, civil and political rights,[143] economic, social and cultural rights,[144] and collective rights.[145]

[138] Constitution de la Transition de la République Démocratique du Congo du 4 Avril 2003 (the 2003 Constitution).
[139] Ibid Arts 15 to 62.
[140] Ibid Arts 36, 37, 39, 40, 41, 42, 45 and 46.
[141] Ibid Art 49.
[142] Article 205 of the 2003 Constitution provides that the transitional Constitution ceases to have effect upon the entry into force of the Constitution to be adopted at the end of the transition.
[143] The DRC Constitution (note 4) Chap (1).

Accordingly, chapter one of the DRC Constitution, civil and political rights include, among others, the rights to human dignity, equality before the law, freedom from gender discrimination, freedom from sexual violence, the right to life as well as freedom of movement. Furthermore, it includes the rights of arrested, detained and accused persons, access to information, peaceful unarmed assembly, to demonstrate, and freedom of association.

Chapter two of the DRC Constitution protects socio-economic rights. They include the right to private property, to work, to freedom of association, freedom of syndicalism, to strike, to marry as well as the rights of the child.[146] It also contains the rights to education, to health, to housing as well as the rights of vulnerable groups. As regards the right to education, primary education school is compulsory and free of charge within public establishments.[147]

Lastly, chapter three on collective rights includes, the protection of rights and interests of Congolese people living abroad, the right to peaceful and harmonious coexistence of all ethnic groups in the country, the right to peace and security, and the right to a healthy and conducive environment, the right to enjoy the natural resources of the country as well as the right to development.[148] It is noteworthy that a legislative measure relating to the environment has been enacted[149] to supplement the Constitution.

Interestingly, although human rights are divided into categories, they are all subject to Article 60 of the Constitution, which provides that 'respect of human rights and fundamental freedoms enshrined in the Constitution is compulsory for both the State and individuals'. In other words, all human rights including economic, social and cultural rights in general and the right to health in particular enjoy the same status under the DRC Constitution.

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[144] Ibid Chap (2).
[145] Ibid Chap (3).
[146] Children's rights include the right to receive education and care from their parents with the assistance of the State, the right to know their parents, protection from violence and exploitation, the right to education and protection from any attack on the child's integral development.
[147] Ibid Arts 43, 47, 48 and 49.
[148] Ibid Arts 50, 51, 52, 53, 58.
[149] Loi Portant Principes Fondamentaux Relatifs à la Protection de l'Environnement, 2011.

3.3.2 The nature of the protection of the right to health under the DRC Constitution in the light of ICESCR and the African Charter

Under the DRC Constitution, the right to health is protected by Article 47 which stipulates that: 'the right to health and to food security is guaranteed. The Law will establish fundamental principles and rules regulating public health and food security'. It follows that in using the concept of the 'right to health', Article 47 of the DRC Constitution opts for a broad and holistic protection of the right to health. This is because, the concept of the right to health includes,

> [T]imely and appropriate health care, underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health as well as the participation of the population in all health-related decision making at the community.[150]

It is necessary to mention that in addition to their implicit protection in the concept of the 'right to health,' most underlying determinants of the right to health are protected as autonomous rights by the DRC Constitution. These include the right to food, housing, and access to safe drinking water and electricity, as well as the right to an environment which is safe for health.[151] Furthermore, conditions for building of factories, storage, handling, and toxic waste disposal from industrial or artisanal units installed on the national territory, are regulated by law[152] in order to protect public health.

The State's obligation to 'guarantee the right to health' is to be understood in its broad sense. This implies that, the State is under an obligation to adopt adequate and complementary measures including legislative, judicial, and budgetary and policies in order to make the right to health in all its aspects available, accessible, and acceptable and of good quality.[153] An example of such complementary approach includes the State's obligation to adopt a law on public health, which will consist of protecting, promoting and restoring the people's health through health-related activities in order to reduce the amount of diseases,

[150] General Comment 14 (note 28) Para 11.
[151] The DRC Constitution (note 4) arts 47, 48 and 53.
[152] Ibid Art 54.
[153] General Comment 14 (note 28) Para 12.

premature deaths and reduce discomfort and disability in the population.[154] Furthermore, under Article 60 of the DRC Constitution, both the State and individuals have to respect all human rights protected by the Constitution. According to the Constitution, the concept of 'State' includes national, provincial and local spheres of the government.[155] Consequently, each sphere of government within its jurisdiction is under an obligation to adopt measures that protect the right to health. Lastly, it is clear that individuals including private health care providers are compelled to respect the constitutional right to health.

It is necessary to compare Article 47 under consideration with Article 50 of the 2003 Constitution, the ICESCR and the African Charter. With regards to Article 50 of the 2003 Constitution, it reads as follows: 'the State has the obligation to ensure the wellbeing of health and food security of the consumers. The law will establish general principles relating to public health and food security'.

It follows that, unlike Article 47, which entails the obligation to guarantee the right to health for everyone, Article 50 sought to ensure the wellbeing of the consumers rather than of citizens. As a result, one may assume that while the concept of consumers may refer to health users, the protection of this wellbeing is likely to be reduced to the supply of health care services only. Furthermore, both provisions call for the adoption of law on public health in order to supplement the right to health. In summary, Article 47 of the DRC Constitution provides greater protection of the right to health than did Article 50 of the 2003 Constitution.

In relation to the ICESCR, the nature of the right to health is provided by Article 12 of the ICESCR through the concept of the right to the enjoyment of 'the highest attainable standard of physical and mental health'. Its full realisation consists of reducing stillbirth-rates, infant mortality and providing for the healthy development of the child. It further requires improving all aspects of environmental and industrial hygiene, preventing, controlling and treating all diseases, including the provision of medical service and medical attention in the event of sickness. States parties are enjoined by Articles 2 (a) and 12 of the ICESCR to adopt individually and through international assistance, to the maximum of their available resources, all means and legislative measures, with a view to achieving the full progressive realization of this right.

[154] Southern African Development Community Protocol on Health, adopted on 1999, entered into force on 14 August 2004, Art 1.
[155] The DRC Constitution (note 4) Arts 3 and 68.

With regards to the African Charter, the right to health is protected by Article 16 of the African Charter, which guarantees the right to enjoy the best attainable state of physical and mental health. Its explicit components include the protection of health of the people and the provision of medical attention in the event of sickness. States parties are, by virtue of both Articles 1 and 16 of the African Charter, under the obligation to individually and immediately achieve this right through the adoption of legislative and other necessary measures.

Taken together, the following points need to be made. First, it follows that, the nature of the right to health under the DRC Constitution as discussed above is broad enough to include all aspects guaranteed by both the ICESCR and the African Charter. Moreover, unlike both the ICESCR and the African Charter, which explicitly provide for the adoption of legislative and other necessary measures in order to give effect to the right to health, under the DRC Constitution these obligations are implied in the State's obligations to 'guarantee and to respect the right to health' through a combined reading of Articles 47 and 60 of the Constitution.

Furthermore, unlike the ICESCR, both the African Charter and the DRC Constitution do not subject the implementation of the right to health either to the qualification of progressive realization or to that of resources availability. Such unqualified State's obligations are challenged as being unrealistic. To this end, Chirwa rightly observes that considering the many socio-economic problems and human, infrastructural and financial resource constraints that African states face, it is unrealistic to expect an immediate the implementation of socio-economic rights guaranteed under the African Charter.[156] This is also true with the DRC, which is now seen as one of the poorest nations in the world despite its wealth in human and natural resources.[157]

Interestingly, unlike the African Charter and the DRC Constitution, the ICESCR subjects the implementation of the right to health not only to the progressive realization and the availability of resources, but also to the international assistance and co-operation. This implies that the ICESCR takes account of the fact that the achievement of the right to health in all its aspects cannot be implemented overnight. It further implies that the availability of resources including from international community is relevant for an adequate implementation of the right to health.

[156] Chirwa 'African human rights' (note 86) at 327.
[157] Jacques Bahati *Evaluating peace and stability in the Democratic Republic of Congo and the United States policy in the Great Lakes Region* (2009) 5.

Finally, unlike the ICESCR and the African Charter, the DRC Constitution explicitly subjects individuals to the obligation to respect human rights herein contained including the right to health. This obligation may be seen as taking account of the emerging novel idea of the horizontal application of human rights,[158] according to which constitutional rights are not only those rights against the State, but also against other individuals including private health care providers.[159] In other words, private individuals may be bound by the provisions of human rights in appropriate circumstances.

3.3.3 Relevance of International law to the DRC and the Domestication of international treaties

This section examines how the DRC incorporates international human rights instruments into its legal system with an emphasis on the ICESCR as well as the African Charter. It also discuses the ways in which international treaties serve as source of law or as interpretative standards for the courts.[160]

With regards to the incorporation of international law at the domestic level, it has been argued that the relationship between international law and national law is not easy to establish.[161] This is because once a treaty has entered into effect for a State it does not necessarily mean that such a treaty is in force in that State.[162] Instead, it is an attribute of sovereignty for each State to decide on how a treaty should be given effect in domestic law. Consequently, there are two general theories, namely dualism and monism, which govern the way in which treaties are given effect at the domestic law.[163] According to the dualist theory, 'international law and national law represent two separate legal systems given that they differ so greatly with regard to their sources, contents, and the relationships they govern'.[164] In contrast, the monist theory claims that the international legal system and the national system

[158] Chirwa 'The right to health' (note 16) at 564.
[159] Mattias Kumm and Victor Ferreres Comella 'What is so special about constitutional rights in private litigation? A comparative analysis of the function of state action requirements and indirect horizontal effect in Andras Sajo and Renata Uitz (eds) *the constitution in private relations expanding constitutionalism* (2005) 241 at 242.
[160] Committee on Economic, Social and Cultural Rights, Substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights, General comment 9: The domestic application of the Covenant (Nineteenth session), E/C.12/1998/24, CESCR/3 December 1998, Para. 13.
[161] John C Mubangizi *The protection of human rights in South Africa* (2004) 32.
[162] Anthony Aust *Modern Treaty Law and Practice* (2007) 178.
[163] Ibid at 181.
[164] Mubangizi (note 161) at 32.

constitute one legal order within which the national legal systems take a subordinate position.[165] The essence of this approach lies in that a treaty may, without legislation, become part of domestic law once it has been concluded in accordance with the Constitution and has entered into force for the State.[166]

As far as the DRC is concerned, it has adopted the monist approach. To this end, Article 215 of the DRC Constitution provides: 'treaties and international agreements duly concluded have, upon publication, precedence over domestic laws, subject, with respect to each agreement or treaty, to its application by the other party.' With a view to highlighting its commitment to apply ratified international human rights at the domestic level, the DRC's report to the Human Rights Council, stated that:

> [F]or a number of years now, Congolese courts have been basing their decisions on international human rights treaties. For example, in refusing to conduct criminal proceedings against a child aged 17, the Magistrate' s court of Kinshasa/Assossa cited Articles 2 and 17 of the African Charter on the Rights and Welfare of the Child, which establishes 18 years as the minimum age of criminal liability.[167]

The above quotation indicates that ratified international treaties do not need the adoption of further legislation for their application in the DRC. Such treaties include among others, the ICESCR ratified in 1976 and the African Charter in 1987 and, which can be enforced directly by the Congolese courts[168] without any further particular formality.[169] As regards the protection of the right to health in particular, the monist approach implies that any gaps or omission in the Constitution relating to the nature of the State obligations or the content of the right to health will be filled in by a direct application of both the ICESCR and the African Charter.[170]

Some observers argue that international instruments were to prevail over the laws of the Republic other than the Constitution[171] given that the place of international treaties within

[165] Ibid at 32.
[166] Aust note (162) at 183.
[167] DRC Report to the Human Rights Council (note 23) Para 20.
[168] Mbata B Mangu 'The conflict in the Democratic Republic of Congo and the protection of rights under the African Charter' (2003) 3 (25) African Human Rights Law Journal, 235 at 236, 251 and 255.
[169] Mazyambo (note 43) at 242-3.
[170] Chirwa 'Malawian Constitution' (note 109) at 30.
[171] Mbata (note 168) at 255.

the hierarchy of norms in the Congolese legal system is subject to many dispositions.[172] Such a position is untenable for the following reasons. First, the precedence of international treaties over domestic law must include the Constitution[173] because the Constitution itself is part of domestic law, which is that law in force within a State.[174] Secondly, as a rule in French legal system, the higher normative status of a treaty over the Constitution requires that the ratification of any treaty containing a clause contrary to the Constitution must occur only after the amendment of the latter.[175] This assertion is acknowledged by Article 216 of the DRC Constitution which provides:

> [I]f the Constitutional Court consulted by the President of the Republic, the Prime Minister, the President of the National Assembly and the President of the Senate or by one tenth of the Members of National Assembly or Senators, declares that a treaty or international agreement contains a clause, which is contrary to the Constitution, the ratification or approval of such a treaty may be made only after the revision of the Constitution.

It follows that, the underpinning idea of the constitutional revision is to make the Constitution consistent with the international treaty to be ratified. However, frequent application of this provision has potential to undermine the stability of the Constitution because it allows the constitutional revision whenever such kind of international treaty is to be ratified. It must be nevertheless stressed that given that no State is under a compulsory obligation to ratify a treaty, the government has the latitude to choose between preserving the stability of the Constitution and the ratification of an international treaty, which contains a clause contrary to the Constitution.

In relation to the application of international treaties as source of law, Article 153 of the DRC Constitution provides that: 'Courts and Tribunals must apply international instruments duly ratified, laws, regulations and custom provided that it is not inconsistent with public order'. The direct implication of the above provision is that in any litigation regarding the protection of the right to health in the DRC, courts and tribunals are entitled to directly apply all the ratified treaties including the ICESCR and the African Charter. In other

[172] JM Kumbu, B Kabamba and Esambo Kangashe 'La constitution de la République Démocratique du Congo' in Programme des Nations Unies pour le Développement (ed) *Mandats, rôles et fonctions des pouvoirs constitués dans le nouveau système politique de la République Démocratique du Congo. Journées d'information et de formation organisées à l'intention des parlementaires, députés provinciaux et des Hauts Cadres de l'administration* (2007) 16 at 27-28.
[173] Ministère de la Sante Publique de la RDC, Atelier de consensus national sur l'avant projet de loi cadre sur la santé publique, Rapport final (2010) at 28.
[174] Aust (note 162) at 178.
[175] Andrew West, Yvon Desdevises, Alain Fenet et al *The French legal system* (1998) 44.

words, international treaties constitute a powerful tool in the protection of the right to health given that they supplement the Constitution in filling any gaps in the bill of rights.[176]

Lastly, with regards to the application of international treaties as an interpretative aid, the Constitution does not expressly mention that courts and tribunals have to interpret the Bill of Rights in light of international treaties or international law. Rather, the Constitution enjoins the courts and tribunals to 'apply ratified international instruments'. This impliedly mean that in applying ratified international treaties in any matter relating to the right to health as guaranteed by the Constitution, courts and tribunals must use them as interpretative aid. Therefore, the fact that international treaties have precedence over domestic law coupled with the fact that the Constitution must first be amended before the ratification of a treaty containing a clause contrary to it, leads one to claim that the constitutional right to health is supposed to be given an interpretation, which would enables the DRC to comply with its international obligation.[177]

3.3.4 The justiciability of the right to health under the DRC Constitution

The justiciability of the right to health implies the possibility adjudication by the courts.[178] Accordingly, it has been suggested that as soon as any socio-economic right including the right to health has been given constitutional recognition and the provisions of the Covenant incorporated into national law, such rights can be seen as justiciable and therefore able to be invoked before the courts.[179]

The above conditions adequately apply to the DRC Constitution, which protects the right to health, acknowledges ratified international treaties including the ICESCR and the African Charter as source of domestic law and empowers courts and tribunals to ensure the guarantee of individual freedoms and fundamental rights herein enshrined.[180] Put differently, one can claim that the right to health as provided by the DRC Constitution can be invoked before the Courts and Tribunals. This assertion is supported by the wording of Article 60 of the DRC Constitution, which stipulates that the respect of all the rights and fundamental freedom contained by the Constitution is compulsory for both the State and all individuals.

[176] Chirwa 'Malawian Constitution' (note 109) at 28.
[177] General Comment 9 (note 160) Para 15.
[178] Ibid Para 10.
[179] General Comment 3 (note 79) Para 6.
[180] The DRC Constitution (note 4) Arts 47, 150 and 215.

3.3.5 Analysis of some Tribunal decisions

One point must be mentioned throughout this analysis: all the cases to be discussed dealt with criminal matters by Congolese Tribunals. However, they will be assessed to the extent that they do explicitly or implicitly impact on the right to health for the following reasons. First, all defendants were medical professionals who committed offences through the supply of bad medical services. Secondly, given that most of these offences caused the death of patients, the protection of the right to health implicitly implies that of the right to life.[181] Lastly, these cases show that, in the DRC bad medical practices may result in the prosecution of the medical service providers.

Accordingly, the first case related to blood transfusion, which entailed the death of the patient.[182] The patient, Musitu Pierre, was of the blood group ORh+ while the defendant, Doctor Kosi Mambula, transfused into him the blood of group AB Rh+. The Tribunal held that transfusing the patient with the blood which was incompatible with his group and which resulted in death, constituted a medical error, and therefore the crime of involuntary homicide had been proven. The Tribunal condemned the defendant to 12 months of imprisonment and a fine of $55.[183] Also, the defendant as well as the hospital that he worked for had to pay to the family of the victim an amount of $7500 as reparations.

Indeed, this case shows that the right of access to medical care, as impliedly protected by the right to life, does not only require the provision of scientifically and medically appropriate health care services but also skilled medical personnel capable to provide them.[184] Unfortunately, although the Tribunal referred to the concept of medical error, it did not mention explicitly the violation of the right to health and did not hold that the lack of skilled medical personnel was a violation of the right to health and entailed that of life.

[181] Evelyn A Ankumah *The African Commission on Human and People's Rights, practice and procedures* (1996) 147.
[182] R.P 11. 406/IV du 21 Novembre 2011, Jugement rendu par le Tribunal de Grande Instance de Kinshasa Njili dans l'affaire Ministère Public contre les prévenus Kosi Mambula et MAtondo Muzekila, page 8.
[183] Ibid page 9.
[184] General Comment 14 (note 28) Para 12 (2).

The second case related to the injection of penicillin to a patient who was allergic to it and died from it.[185] The Tribunal held that it was up to the defendant to get informed about his patient before all treatment, given that Congolese health institutions do not provide allergic certificate for patients.[186] As a result, the defendant was found guilty of involuntary homicide and sentenced to six months of imprisonment with the sentence suspended for one year, as well as to the civil reparation of $ 12500.[187]

From this case, it follows that, the defendant did not take into consideration the element of information accessibility which includes, the right to seek, receive and impart information and ideas concerning health issues.[188] In other words, it was the right of the patient to receive information concerning medicines he had to take.

The third case related to the abortion.[189] The defendant, Mandeke Kashinji Richard, a nurse, was accused of causing the abortion of a pregnant woman by administering medicines in hotel room. He claimed to have made the mistake of prescribing some abortion medicines.[190] The Tribunal held that the defendant made a mistake of prescribing abortion medicines to a pregnant woman and that the transformation of a hotel room into a medical facility was unacceptable. In mitigation of sentence, which consisted of 12 months of imprisonment with the sentence suspended for 12 months, the Tribunal held that it took into consideration the fact that not only was the defendant a third year undergraduate student of nursing sciences, but also a medical assistant.[191]

As is clear the defendant, a health care provider, is interchangeably referred to as 'nurse', 'undergraduate student in nursing sciences' as well as 'medical assistant.' It must be mentioned that the profession of nurse and medical assistance are not the same and are regulated by the 1952 Decree.[192] Consequently, being a student in nursing sciences does not constitute one of those conditions to perform as nurse or medical assistant.

[185] RMP. 0616/Pr/BWL du 22 Décembre 2001, Jugement rendu par le Tribunal de Paix de Kikwit dans l'affaire Ministère Public et Partie Civile Sefu Mafunina contre Maninga Christophe.
[186] Ibid Page 2.
[187] Ibid Page 3.
[188] General Comment 14 (note 28) Para 12 (b) (iv).
[189] R.P 4077 du 16 Décembre 2011, Jugement rendu par le Tribunal de Grande Instance de Kikwit dans l'affaire Ministère Public et Partie civile Buhika contre le Prévenu MandekeKashinji Richard.
[190] Ibid page 2.
[191] Ibid page 4.
[192] The 1952 Decree (note 36) Arts 3 and 4.

3.4 Conclusion

This chapter has highlighted the constitutional protection of human rights with a focus on socio-economic rights in general and the right to health in particular in the DRC from the colonial era to the present. It has been shown that unlike during the colonial rule, all the Constitutions that the DRC had had after its independence contained at least some provisions relating to human rights in general and some socio-economic rights in particular. However, the protection of the right to health was not adequately implemented. This was due to the fact that from 1960 to 2006, the DRC experienced recurrent political crises including despotic regimes and wars.[193] This adversely impacted on both the constitutional and judicial protection of socio-economic rights, which cannot be understood in isolation from the 'political and economic contexts, within which such protections evolve, function and mutate'.[194]

Fortunately, in 2006, the DRC adopted a new Constitution, which is the first in the constitutional history of the country to have the potential to adequately protect the right to health. Not only does the current Constitution guarantee the right to health in its broadest sense encompassing access to health care services and other underlying determinants of health, it also accords all human rights the same legal status. This Constitution further states that international treaties form part of domestic legal system and have precedence over domestic laws. As a result, the DRC is under an obligation to adopt adequate and necessary measures such as laws, policies, and budgetary measures in order to give effect to the constitutional right to health. This also enables the Congolese people to claim their right to health as protected by the ICESCR, the African Charter and the Constitution before the courts.

Any assessment of the DRC's compliance with its constitutional and international obligations must take account of the fact that while the Constitution protects the right to health broadly, the DRC is one of the poorest countries. Such approach is also advised for the implementation of the African Charter, by the African Commission, which held that,

> [M]illions of people in Africa are not enjoying the right to health maximally because African countries including DRC are generally faced with the problem of poverty which renders them

[193] See the Memorandum to the DRC Constitution.
[194] Ran Hirschland and Evan Rosevear 'Constitutional law meets comparative politics: socio-economic rights and political realities' in Tom Campbell et al (eds) *the legal protection of human rights: Sceptical essays* (2010) 207 at 207.

incapable to provide the necessary amenities, infrastructure and resources that facilitate the full realization 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 realized in all its aspects.[195]

[195] African Commission (note 77) Para 84.

Chapter Four

CRITICAL ANALYSIS OF STATUTES AND POLICIES RELEVANT TO THE RIGHT TO HEALTH IN THE DRC

4.1 Introduction

This chapter looks at whether adequate laws and policies on the right to health have been adopted by the DRC in the light of both its conventional and constitutional obligations. It first discusses existing framework regulating the medical profession, namely the 1952 Decree on the practice of medicine, and the 1933 Ordinance on the practice of pharmacy. Although these Statutes are older than the ICESCR, the African Charter and the DRC Constitution, the fact that the 1991 Ordinance-Law establishing a National Broad of Pharmacists (the 1991 Ordinance-Law),[196] adopted 58 years after their enactment, is legally based on them proves that they are still relevant. Therefore, they will be read together with subsequent laws and regulations that supplement them such as the 1968 Ordinance-law establishing a National Broad of Physicians (the 1968 Ordinance-Law),[197] the 1991 Ordinance-law, and the 2006 Decree on the status of public physicians. The chapter further analyzes some legislation and regulations providing for access to health care services for some people. It will further discuss some policies that aim to ensure access to health care for everyone. Lastly, it will discuss access to health care services in the DRC.

4.2 Framework regulation of medical profession

The DRC is under conventional and constitutional obligation to provide health care services of good quality, which requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment.[198] By virtue of both Articles 47 and 60 of the DRC Constitution, the DRC has to regulate the medical profession in order to ensure that health care services provided by both public and private health care institutions are of good quality.

[196] Ordonnance-Loi Portant Création d'un Ordre des Pharmaciens en République du Zaïre, 1991. See preamble and Art 43.
[197] Ordonnance-Loi 68-070 du 1er mars 1968 créant l'Ordre des Médecins.
[198] See General Comment 14 (note 28) Para 12 and Art 47 of the DRC Constitution.

In the DRC, the 1952 Decree is still regarded as the framework law for the health sector not only because it has the nature of a legislative measure[199] but also because it regulates almost all the categories of medical personnel including nurses, dentists and medical assistants, physicians and pharmacists.[200] It further recognizes the provision of health care services by traditional healers.[201] Its content may be summarized and analyzed into four categories, including conditions to perform as physicians or other medical professionals, pharmacists, traditional medicine practitioners and sanctions against non-compliance with these conditions.

4.2.1 Regulation of physicians, medical assistants, nurses, midwives and dentists

The practice of medicine and any other medical profession in the DRC is subject to a set of conditions. According to the 1952 Decree, 'no one may perform the role of doctor, dentist, nurse, health worker, medical personnel, as well as pharmacist if he or she does not hold a diploma, which allows him or her to practice the same profession in Belgium or an equivalent diploma.'[202] In other words, one has to first be capable of practicing these functions in Belgium before practicing it in the DRC. This was due to the fact that, although medical studies were inaugurated in Kinshasa in 1954, there were no Congolese medical school graduates at independence in 1960.[203] However, except for the profession of physician, dentist and pharmacist, Article 7 of the 1952 Decree empowered the General Governor of the DRC to determine by Ordinance the terms on which, some Congolese people trained in one of the government's schools or any recognized school, had to perform as medical assistants, nurses and midwives.

In respect of physicians, the 1968 Ordinance-Law requires that all physicians have to be accredited by the Congolese National Council of Physicians, resident in the DRC and be holders of diplomas and certificates required by the law to this end.[204] As is clear, both the 1952 Decree and the 1968 Ordinance-Law do not stress the element of nationality, but that of

[199] John H Crabb *The legal system of Congo-Kinshasa* (1970) 45. See also Article 7 of the Colonial Charter (note 117).
[200] The 1952 Decree (note 36), titles I, II, III, IV, V, VI and VII.
[201] Ibid Art 15.
[202] Ibid titles I, II, III, IV, V and Art.9.
[203] Persyn et al (note 48) at 68.
[204] The 1968 Ordinance Law (note 197) Arts 1 and 8.

qualification. It was only in 2006, that the 2006 Decree[205] explicitly stated that one has to be a Congolese before practicing as a physician in DRC; tough foreigners may also be allowed to practice this profession.[206] It must be mentioned, however, that the 2006 Decree is a mere regulation.[207] Therefore, as a matter of general knowledge, it cannot amend the 1952 Decree to which it is legally subordinate.

4.2.2 Regulation of pharmacists

The 1933 Ordinance as supplemented by the 1952 Decree remains the primary regulation on the practice of pharmacy in the DRC. Basically, it deals with these main topics: the practice of pharmacy, its control and inspection, and penalties in case of contravention.

With regards to the practice of pharmacy, the 1933 Ordinance states that only a pharmacist with the exception of a doctor and veterinary surgeon may proceed to the delivery and sale of drugs or other pharmaceutical products.[208] Read together with the 1952 Decree, it implies that one has to be first qualified to perform this profession in Belgium before practicing it in the DRC. However, by virtue of the 1991 Ordinance-Law, Congolese citizens, who are holders of a degree conferred by one of the Congolese universities are entitled to practice as pharmacists on condition they are accredited to either the National or Provincial Board of Pharmacists.[209] It further allows foreign pharmacists to practice in accordance with bilateral or multilateral conventions.[210]

In respect of the control and inspection of the practice of pharmacy, the General Governor of the DRC is vested with the duty to regulate the establishment of pharmacies, the detention of drugs or medicines, and the sale, offering for sale, import and export of all pharmaceutical products in order to preserve public health and hygiene.[211] The idea of regulating medicines and drugs with a view to prevent harm on the population has to be encouraged.

[205] Although the 2006 Decree does not expressly refer to the 1952 Decree, it is under the 1952 Decree, which is the supreme law on physicians that it has been adopted.
[206] The 2006 Decree (note 38) Arts 1 and 5.
[207] The 2003 Constitution (note 138) Art 71.
[208] The 1933 Ordinance (note 52) Arts 9, 10 and 15.
[209] Ibid Arts 2, 3, 40 and 78.
[210] Ibid Art 40.
[211] The 1952 Decree (note 36) Art 10.

Interestingly, Article 7 of the 1933 Ordinance prohibits and outlaws the sale or delivery of any altered, falsified and corrupted drugs. This provision is very crucial in the enjoyment of the right to health of everyone in respect of access to medicine. It may be interpreted as giving effect to the principle that, medicines have to be safe, effective and of good quality[212] for them to adequately contribute to the enjoyment of the right to health. However, it has been observed that due to the lack of provision of essential medicines within health institutions in DRC, patients have to buy medicines from unauthorized dealers on the streets, and these medicines are often outdated and counterfeit.[213]

Lastly, Article 62 of the 1933 Ordinance enjoins the physician in chief, the chief pharmacist and provincial pharmacists as well as the head of medical service of the nearest locality in which pharmaceutical establishments have been implanted to ensure their control. As is clear from this provision, the Ordinance vests the power to control pharmaceutical establishments in medical professionals who have high knowledge in the field of medicine. As regards the pharmacist in chief, provincial pharmacists and physician in chef particularly, they are currently meant to include the head of the National Council of Pharmacists and all the members of the Provincial Council of Pharmacists[214] as well as the head of the National Council of Physicians.[215]

4.2.3 The specific status of traditional healers

The 1952 Decree neither prohibits the practice of traditional medicine nor does it regulate it. Article 15 of the 1952 Decree says that the provisions of the Decree will not apply to persons indigenous to Congo-Belgium who, in the customary areas, provide health care or administer medicines in accordance with customs consistent with public order. This provision may be seen as legal foundation of the recognition of the practice of medicine by private individuals in general and traditional healers in particular. However, the Article explicitly excludes traditional healers, the only explicitly mentioned category of private health care providers, from any kind of regulation.

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[212] Human Rights Council, Access to medicine in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/RES/12/24, Twelfth session, 12 October 2009, Para 2.
[213] Persyn et al (note 48) at 66.
[214] The 1991 Ordinance-Law (note 196) Arts 16 and 18.
[215] The 1968 Ordinance-Law (note 197) Art 49.

Indeed, the regulation of the private health sector including traditional medicine is relevant to the enjoyment of the right to health for a number of reasons. First, in providing health care services including through traditional medicines, individuals perform a part of the State's sovereignty.[216] Therefore, it is the responsibility of the State to regulate the exercise of one of its attributes by individuals. Secondly, the DRC is under both a conventional and constitutional obligation to regulate the private health sector. For instance, independent and sovereign African countries including the DRC have resolved to recognize the use and relevance of integrating traditional medicine into their national health systems in order to create an enabling environment for optimizing its contribution.[217] Furthermore, the DRC has a duty to protect the right to health of its people in ensuring that privatization of the health sector does not constitute a threat to the enjoyment of the right to health.[218] Lastly, under Article 60 of the DRC Constitution, all individuals including traditional healers are bound to respect the right to health.

Taken together, the DRC government has to adopt necessary measures in order to control the marketing of medical equipment and medicines by third parties, and to ensure that private health care providers including traditional healers have skills and adequate standards of education.[219] It is for this reason that the National Health Strategy[220] is committed to tackle the issue of bad health services provided by private actors, filling in therefore the gap of the 1952 Decree on traditional healers.

4.2.4 Sanctions against non-compliance with regulation on medical profession

Any contravention of the conditions to the practice of the medical profession gives rise to sanctions. According to the 1952 Decree and the 1933 Ordinance, these sanctions include imprisonment, the closing down of the relevant establishment, and the prohibition of practicing as well as the confiscation of used materials, which must be pronounced by the tribunal.[221] In particular, sanctions consisting of closing down the establishment, prohibition from practicing, as well as the confiscation of used materials, have the merit of preventing

[216] Chirwa 'The right to health' (note 16) at 561-2.
[217] African Health Strategy http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf .
[218] General Comment 14 (note 28) Para 35.
[219] Ibid.
[220] The National Health Strategy (note 19) at 26.
[221] The 1952 Decree (note 36) Arts 17 and18. See also the 1933 Ordinance (note 52) Art 64.

harm from befalling most citizens who come into contact with the health sector, as patients or clients through using hospitals, clinics, or pharmacies.[222] As far as pharmacists and physicians are concerned, they are further subject to disciplinary sanctions.[223] Lastly, all medical personnel including traditional medicine providers are exposed to criminal sanctions if their actions amount to an offense and to civil reparation according to the law of negligence,[224] if their actions cause any grief to the patients.

In summary, the law governing the regulation of the medical profession in the DRC is rigorous and strict and aims to ensure that health care services are provided by skilled medical personnel. The above sanctions are underpinned by the idea that medical professionals must have the required skills and qualification for the performance of their different professions.

4.3 Statutes providing for access to health care services

The DRC has conventional and constitutional obligations to guarantee access to health care services to all the citizens on the basis of the principle of equality or non- discrimination.[225] The principle of equality is reinforced by that of equity,[226] which requires the adoption of specific measures of protection[227] for the vulnerable groups[228] of the society. The underpinning idea of the principle of equity is that there is no international human rights instrument which stipulates that health care services must be provided free of charge.[229] This section discusses statutes providing for access to health care services for some groups of people, namely public servants and public physicians, people living with or affected by HIV as well as children.

[222] Kent Buse, Nicolas Mays and Gill Walt *Making health policy* (2005) 5.
[223] See Art 43 of the 1991 Ordinance-law (note 196) and Arts 68 and 69 of the 2006 Decree (note 38).
[224] Décret du 30 Juillet 1888 Portant Code des Obligations et des Contrats tel que modifie et complété à nos jours, Art 258.
[225] See Art 2 of the African Charter, Art 2 (2) of the ICESCR and Art 13 of the DRC Constitution.
[226] The principle of equity requires that poorer households or vulnerable groups of the society 'should not be disproportionately burdened with health expenses as compared to richer households. See General Comment 14 Para 12.
[227] A combined reading of both Arts 49 and 51 of the DRC Constitution suggests that elderly, disabled people and minorities groups as well as all other vulnerable groups have the right to specific measures of protection in keeping with their physical, mental or moral state.
[228] Under international law vulnerable groups include ethnic minorities, indigenous populations, women and children, older persons, disabled persons, and persons with HIV/AIDS. See General Comment 14 Para 12 (b) (iii).
[229] Toebes (note 17) at 249.

4.3.1 Health related benefits for public servants and public physicians

As employees of the government, access to health care services of public servants and public physicians is covered by both the Public Servants Act[230] and the 2006 Decree on public physicians.[231] The Public Servants Act and the 2006 Decree deal respectively with the status of public servants and required conditions relating to the profession of physicians in the DRC. However, they contain some provisions relating to access to health care for both public servants and public physicians in terms of social benefits. These granted benefits, including medical expenses and health care, are also extended to family members of public servants[232] and public physicians.[233] For instance, Article 42 of the Public Servants Act stipulates that:

> [M]edical costs, health care, surgical, dental and obstetric hospital and the drugs and devices of orthopedics and prosthetics necessitated by the health status of the agent, his wife and children in accordance with rules regulating the granting of family allowances, are in charge of the Public Treasury.

Article 30 of the 2006 Decree states that: 'the government takes the charge of medical care, surgeries, dental and hospitalization as well as medicines, orthopedic and prostheses, necessary to the health state of the agent, his spouse and children'.

With regards to the agent or physician's children[234] particularly, both Articles 41 of the Public Servants Act and 29 of the 2006 Decree provide that they are taken into consideration until the age of 18 years. Moreover, unlike Article 41 of the Public Servants Act which covers access to health care of the agent's children until the age of 25 years if they are continuing with their studies or they are physically or mentally disabled, under Article 29 of the 2006 Decree, children are taken into consideration for the granting of family benefits until the age of 30 years if they continue studying, while disabled children enjoy such a guarantee as long as their physical or mental state persists.

[230] The Public Servants Act (note 37).
[231] The 2006 Decree (note 38).
[232] The Public Servants Act (note 37) Arts 39 (2), 41 and 42.
[233] The 2006 Decree (note 38), Arts 28 and 30.
[234] They include the agent or physician's children, adopted children, and children under the custody or guardianship of the agent or the physician.

It is necessary to mention that the terms for granting benefits are set by an administrative regulation[235] in accordance with the rank of the public servant[236] or physician.[237] According to access to health care services in particular, the public servant or the physician is supposed to pay all medical expenses whether provided at the public or private health institution and will be refunded by the government.[238] He or she has to submit a request to the Ministry of Public Health including all the proof of payment, which will be in turn submitted to the Ministry of Budget for refund.[239] Another alternative process consists of allowing health institutions that provided health care to the public servant or physician, to submit their invoices with other evidence to the Ministry of Health for payment.[240]

However, both the Public Servants Act and the 2006 Decree seem discriminatory because they do not adequately deal with cases where the concerned public servant or physician is a married woman. For instance, while Article 41 of the Public Servants Act explicitly states that 'a female public servant will be granted these benefits only if her husband does not exercise any gainful activity', the 2006 Decree does not mention the enjoyment of these health facilities by married women physicians. However, the fact that the 2006 Decree is a regulation, which is legally based on the Public Servants Act coupled with the fact that physicians are entitled to all social benefits due to public servants,[241] may lead one to claim by implication that the enjoyment of these benefits by a married woman physician is subject to the same condition than that of a married female public servant. The exclusion of married women physicians or public servants whose husbands exercise any gainful activity by these two Acts, leads one to question the nature and the purpose of these benefits when they may be granted in isolation from the work that one performs. It is contrary to the principle of non-discrimination against women in the enjoyment of their right to health provided by the DRC Constitution,[242] the ICESCR[243] and the African Charter.[244]

[235] See Arts 39 of the Public Servants Act and 27 of the 2006 Decree.
[236] Art 45 of the Public Servants Act.
[237] Art 26 of The 2006 Decree.
[238] Circulaire N°001 /CAB/MIN/BUDGET/2012 du 2 Aout Contenant les Instructions Relatives a l'Exécution de la Loi de Finances N°12/002 du 20 Juillet 2012, Para IV.1.4.10.1.
[239] Ibid.
[240] Ibid Para IV.1.4.10.2.
[241] See the preamble to the 2006 Decree and its Art 26 (note 38).
[242] The DRC Constitution (note 4) Arts 11, 12, 13 et 14.
[243] ICESCR Arts 2 (2) and 3.
[244] Arts 2 and 3 of the African Charter.

In summary, by providing for access to health care of more than 360, 558 public servants[245] and about 5,000 physicians[246] as well as their family members, both the Public Servant Act and the 2006 Decree facilitate the enjoyment of medical services of a considerable portion of Congolese people.

4.3.2 Health care services for people living with and affected by HIV

In implementing the right to health as protected under international law, States are urged to give a wider interpretation of the right to health as including new identified obstacles for health such as the HIV/AIDS.[247] This observation has been taken into account by the DRC Constitution, which provides for a wider protection of the right to health under Article 47.

Moreover, in order to protect public health, which is one of the preconditions for safeguarding the rights of individuals, the DRC is committed to tackle the issue of the emerging HIV/AIDS in a specific way.[248] It is in this context that subsequent to the right to health guaranteed in the DRC Constitution, the HIV Act was adopted in 2008 in order to protect the rights of people living with or affected by HIV/AIDS.[249]

In relation with its content, the HIV Act states that the State has the responsibility to ensure free access to preventive and curative cares of people living with HIV/AIDS within both public and private health institutions.[250] This provision seems revolutionary compared to the ICESCR, the African Charter and the DRC Constitution which do not provide for free access to health care services including for vulnerable groups. The State also provides psychological, social, educational and legal support to persons living with HIV/AIDS and affected.[251] The State is further under the obligation to make accessible (economically and

[245] The DRC government launched the process of biometric census of the public servants in 2005. The above number was partially published in 2011 after the completion of the census in 7 provinces out of 11. It does not include the four other provinces directly or indirectly affected by armed conflicts in which the census process is ongoing, namely, Kivu, Equateur, Province Orientale and Katanga. See Publication du rapport partiel du recensement biométrique des fonctionnaires de l'Etat, available at http://radiookapi.net/emissions-audio/dialogue-entre-congolais/2011/07/19/publication-du-rapport-partiel-du-recensement-biometrique-des-fonctionnaires-de-l%E2%80%99etat/ (Accessed on 19 July, 2011).
[246] Although there are 11,000 physicians enrolled to the National Board of physicians, the number of identified physicians working in public health administration is estimated at about 5,000 and 40, 000 other medical personnel. See the National Health Plan of Action (note 22) at 36.
[247] General Comment 14 (note 28) Para 10.
[248] See Preamble to the HIV Act (note 18).
[249] These persons include children, youth, men, women and sex workers, homosexual persons, refugees and displaced people. See Arts 1, 2 (5) and 2 (10) of the HIV Act.
[250] Ibid Art 11.
[251] Ibid.

geographically) antiretroviral and drugs against opportunistic infections and cancers associated with HIV.[252]

Furthermore, the State has to define the policy, outline the main directions and elaborate programs to prevent, support, and attenuate the negative impact of HIV/Aids.[253] Moreover, with a view to give substance to these rights, the State has to allocate an appropriate budget for this purpose.[254] It follows from this Article that the implementation of the HIV Act must be supported by a policy as well as budgetary measures.

Lastly, under Article 6 of the HIV Act, the State sets up a national multi-sectorial framework for coordinating the fight against HIV/AIDS, which must be headed by the Prime Minister. It has further to adopt a national plan and set up a system of provincial execution, monitoring and evaluation. The State is urged to ensure the equitable distribution of funds allocated to the fight against HIV / AIDS through the provinces.

It follows from this above Article that the idea of establishing a multi-sectoral framework[255] implies that all the ministries of the government, including the ministry of health, must be involved in the implementation of the HIV Act. Moreover, the involvement of provinces in the implementation, monitoring and evaluation of such a multi-sectoral framework in the fight against the pandemic of HIV falls within their constitutional mandate in the field of health. Indeed, provinces are empowered to deal with the implementation of development programs and sanitation campaigns against endemic and epidemic diseases in light of the national program, the organization of curative medicine services, and the organization and promotion of primary health care.[256] To give substance to this constitutional obligation, they enjoy a financial autonomy consisting of 40% of funds allocated to them by virtue of article 175 of the DRC Constitution.

Furthermore, Article 6 of the HIV involves all the decentralized entities. Indeed by virtue of the Law on decentralization[257] city, town, sector and the leadership have at least one jurisdiction on the field of health. It consists of organizing and managing health services,

[252] Ibid Art 12.
[253] Ibid Art 5.
[254] Ibid.
[255] A Presidential Ordinance adopted in 2011 set up a national multi-sectorial program for coordinating the fight against HIV/aids. See Ordonnance No 11/023 du 18 Mars 2011 Modifiant et complétant le Décret No 04/029 du 17 Mars 2004 Portant Création et Organisation du Programme National Multisectoriel de Lutte Contre le Sida.
[256] The DRC Constitution (note 4) Art 204 (18).
[257] Loi Organique Portant Composition, Organisation et Fonctionnement des Entités Territoriales Décentralisées et leurs rapports avec l'Etat et les Provinces, 2008 (the 2008 Law).

promoting the fight against HIV/AIDS and endemic diseases.[258] This is based on the fact that, as representative of the central government, local executive authorities have the duty to implement laws, edits as well as national and provincial regulations and ensure public order.[259]

In summary, the adoption of the HIV Act proves that the DRC Constitution provides for a broad protection of the right to health. It is further supplemented by a national program for fight against HIV/AIDS,[260] which aims to ensure access to health care services of about 1,185, 464 people living with HIV, 1, 042, 124 children orphaned by HIV[261] as well as those suffering from the collateral effects of HIV/AIDS.

4.3.3 Children's health

The physical and mental immaturity of the child, his or her vulnerability as well as dependence on the environment necessitates that special care and protection is given to the child.[262] In relation to the child's right to health in particular, the DRC has to adopt necessary measures in order to give effect to the right to health of the child, which includes health care services, provision for the reduction of the stillbirth-rate and infant mortality and for the healthy development of the child.[263] The preamble to the Children Act acknowledges that despite the DRC's commitment to the protection of the child, many children are still deprived of their rights and are victims of several abuses.[264] It is for this reason that the Children's Act was adopted in 2009 with a view to providing a specific protection to every person under the age of 18 years living within the jurisdiction of the DRC.[265]

In respect of the child's right to health in particular, Article 21 of the Children's Act provides:

[258] Ibid Arts 11, 50, 73 and 91.
[259] Ibid. See preamble.
[260] According to the national program for the fight against HIV/AIDS about 53,554 people living with HIV had access to free health care services in 2011. See Programme National Multisectoriel de Lutte Contre le Sida: Rapport d'activité sur la riposte au VIH/Sida (2012) at 31.
[261] Health Plan of Action (note 22) at 24.
[262] United Nations Convention on the Rights of the Child (UN CRC) GA Res 44/25, annex, 44 UN GAOR Supp (No 49) at 167, UN Doc A/44/49 (1989), entered into force 2 September 1990, see preamble.
[263] See Art 12 (2) of ICESC and Arts 47 and 123 (16) of the DRC Constitution.
[264] Many Congolese children live in the streets, are victims of social exclusion, economic exploitation and sexual abuse as well as armed conflicts.
[265] Art 3 of the Children's Act.

> [E]very child has the right to enjoy the best health status possible. This right includes health care, breastfeeding and a healthy, adequate, and balanced and varied diet. The state shall develop and implement effective strategies that aim to reducing infant morbidity and mortality.

It follows from this provision that in addition to health care, the child's right to health includes other underlying determinants of health namely breastfeeding and a healthy, adequate and balanced diet. Furthermore, according to international law, the reduction of infant morbidity and mortality implies that a range of other rights will be provided for the children.[266] Lastly, strategies to be adopted are supposed to be adequately resourced in both human and financial terms and set up achievable targets in order to ensure the full realization of the child's right to health.[267]

In addition, Article 42 of the Children's Act provides for the specific protection of disabled children. It reads as follows: 'children living with physical or mental disability are entitled to a special protection and specific health care in order to enable them to live a full and decent life. The State has to support parents in the implementation of this right.' This Article implies that, disabled children, as a particular category of vulnerable children, have a right to a specific protection and treatment.[268] Therefore, they cannot be subject to a discriminatory treatment which has been interpreted to include, any exclusion or any arbitrary distinction in the enjoyment of rights guaranteed by this law, based on health, physical disability of the child or any familial consideration.[269] The State's obligation to support parents in the implementation of this right is also acknowledged in international law.[270] However, assistance for a disabled child may be free of charge, whenever possible, taking account of the financial resources of the parents.[271] As a result, the DRC government is urged

[266] Children's rights have to be implemented through an holistic approach based on the principles of indivisibility and interdependence of human rights. See CRC General Comment 5 (2003) General measures of Implementation of the Convention on the Rights of the Child (arts 4, 42 and 44, Para 6), CRC/GC/2003/5, 27 November 2003, Para 17 and 18.
[267] Ibid Para 32.
[268] According to Art 42 of the Children's Act, disabled children have the right to specific education, training, and reeducation and to recreational activities as well as the right to preparation for employment in order to participate within their community.
[269] The Children's Act (note 20) Art 1 (10).
[270] UN CRC (note 262) Art 23 (2).
[271] Ibid Art 23 (3).

to adopt further specific and necessary measures in order to ensure health care of disabled children.[272]

In summary, the Children's Act deals with an important aspect of the right to health, namely the child's health. Its implementation will be supplemented by further strategies.[273] In so doing, the Children's Act will cover access to health care of 54% of the Congolese people, which consists of people under the age of 18.[274]

4.4 Policies

The DRC is under both conventional[275] and constitutional[276] obligation to adopt appropriate and necessary measures including policies in order to give effect to the right to health. These policies are subsequent to the constitutional protection of the right to health and deal respectively with the reorganization of health system in order to provide appropriate primary health care and reproductive health. They include two general policies, namely the National Health Strategy and the Health Plan of Action as well as a specific policy, which is the Reproductive Health policy.

4.4.1 National Health Strategy

The DRC has subscribed to the strategy of primary health care since 1978.[277] However, the health system was not based on the health district, which is regarded as an operational unit of the implementation of health policy on primary health care.[278] Instead, there was a development of a series of intermediate structures such as community outreach, health post and health center offering questionable health care services, harmful to the population.[279] It

[272] Committee on the Rights of the Child (CRC), Consideration of reports submitted by States parties under Article 44 of the Convention, concluding observations: Democratic Republic of Congo (Fiftieth session) CRC/C/COD/CO/2, 10 February 2009, Para 52 (a) and (b).
[273] The Children's Act is not yet supported by a comprehensive national plan of action on the protection of the rights of the child or by the issuance of appropriate decrees for implementation. Ibid. Para 10 and 14.
[274] WHO, Mental Health Atlas 2011: Democratic Republic of Congo, http://www.who.int/mental_health/evidence/atlas/profiles/cod_mh_profile.pdf.
[275] Arts 2 (1) and 12 of the ICESCR and Arts 1 and 16 of the African Charter.
[276] Art 47 of the DRC Constitution (note 4).
[277] The National Health Strategy (note 19) at 8.
[278] Ibid.
[279] Ibid at 9.

is for this reason that, the Ministry of Public Health with the technical support from the WHO adopted in 2006, the present Strategy of Strengthening the Health System in the DRC.[280]

The purpose of the National Strategy includes the reorganization of the whole health system with a view not only to cover the entire population through health structures that may provide global, efficient and effective basic health care, but also, to tackle the issue of health care services of doubtful quality provided by private actors whose activities are not coordinated.[281] It follows that the National Strategy is committed to reorganize the health system in the DRC. This is made explicit by the DRC determination to deal with the issue of bad health care services provided by private actors in order to improve public health, which is the responsibility of the government. To this end, the government has to set forth clear directions and guidelines on the activities of health care personnel, to ensure the regular supply of essential medicines, adequate equipment and regular maintenance of health care institutions as well as a periodical training of medical personnel.[282] As is clear, these initiatives of the government aim to ensure that health care services to be provided are of good quality. In order to achieve these goals, the Strategy opted to revitalize health districts, which have been identified as a unit of implementation of the strategy of primary health care.[283] This revitalization is crucial in the DRC context where the higher mortality rate of the whole population is due to the lack of access to basic health care services, namely primary health care.[284] In focusing on the revitalization of the role to be played by health districts, the National Health Strategy aims to ensure that every Congolese has access to primary health care.[285]

Due to the lack of financial and technical resources, the National Health Strategy opted to progressively develop health districts.[286] This consists of choosing within a province the health zones and within a zone, the health centers, as a starting point of the strategy.[287]

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[280] Ibid.
[281] Ibid at 26.
[282] Ibid at 31.
[283] Ibid at 28.
[284] The mortality rate for the whole of the Congolese population is 57% higher than the average for the sub-Saharan countries. See WHO Health Compendium consolidated appealed process 2012 http://www.who.int/hac/about/donorinfo/cap_drc_2012.pdf
[285] Primary health care refers to essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country may afford to maintain at every stage of their development in the spirit of self-reliance and self –determination. See Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, Para VI.
[286] The National Health Strategy (note 19) at 28.
[287] Ibid.

Such approach attempts to strike a balance between constitutional commitments and political and economic realities.[288] This is because; the prospects for advancing socio-economic rights in a given polity cannot be analyzed in isolation from the 'concrete fiscal realities, political interests, and legacies of welfare provision.'[289] Consequently, the government decides either to establish new health infrastructure or to improve both existing public and private structures, in order to facilitate access to health care.[290] The idea of improving health care provided by private actors must be welcomed for two raisons. First, it is consistent with Article 60 of the DRC Constitution which binds private health care providers to respect the right to health. Secondly, it takes account of the relevance of government partnership with communities as well as the private sector in delivering health care services.[291] The National Health Strategy has been supplemented by the Health Plan of Action.

4.4.2 Health Plan of Action

The need for the DRC government to adopt a document of reference regarding the health sector goes back to 1999.[292] However due to political context prevailing in that time, namely armed conflicts experienced by the country, no policy on health was adopted by the government.[293] In 2006, the government adopted the National Health Strategy, which constitutes the foundation of a new policy of the country in the health sector.[294] The Health Plan of Action, thus, was adopted in 2010, as a tool of its consolidation and implementation.[295]

The Health Plan of Action has both general and sectoral objectives.[296] Its general objective includes contributing to the amelioration of the health of the Congolese people in the context of the fight against poverty, while the sectoral goal is to ensure primary health care of good quality to the entire population, especially vulnerable groups. The development of zones of health is the fundamental strategy of the Plan given that the zone of health

[288] Hirschland and al (note 194) at 217.
[289] Ibid at 228.
[290] National Health Strategy (note 19) at 31.
[291] African Health Strategy (note 217).
[292] Health Plan of Action (note 22) at 30.
[293] Ibid.
[294] Ibid.
[295] Ibid.
[296] Ibid at 68-9.

constitutes the appropriate place where people are provided with primary health care[297] in the DRC.

To reinforce the development of zones of health, some strategies will be implemented, namely the adjustment of the pharmaceutical field; the reform of health financing; and the construction or rehabilitation of health infrastructures.[298] The aim of those strategies is to ensure that primary health care is provided by available and skilled medical personnel through available and acceptable infrastructures as well as health facilities of a good quality.[299]

The Health Plan of Action is further committed to progressively put an end to health care fees, through health mutual, medical insurance, the implementation of equity funds, the subvention of some medical care and the support to the implementation of health structures.[300] The implementation of these strategies has the potential to reinforce the principle of equity in the provision of health care services so that resource constraints may not constitute an impediment to the access to health care services, especially for vulnerable groups. The DRC has also adopted a specific policy on reproductive health.

4.4.3 The Reproductive Health Policy

Reproductive health constitutes an important aspect of the right to health not only as an autonomous right, but also for the enjoyment of other aspects of the right to health. For instance, an adequate commitment to reduce stillbirth rate and infant mortality and to improve the healthy development of the child requires the improvement of both child and maternal health through the provision of sexual and reproductive health services which include access to family planning, pre and post-natal care, emergency obstetric services, and safe motherhood, particularly in rural areas.[301] This aspect of the right to health is embodied under Article 47 of the DRC Constitution relating to the protection of the right to health.

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[297] Primary health care includes, *inter alia*, health education, maternal and infantile protection, vaccination, prevention and treatment of diseases as well as provision of medicines. Ibid at 70.
[298] Ibid at 77.
[299] Ibid.
[300] Ibid at 79.
[301] General Comment 14 (note 28) Para 14 and 36.

The first Reproductive Health Policy in the DRC was adopted in 1998.[302] However, it did not prevent from recording a number of 1.289 women who died in childbirth, 408 cases of infant juvenile mortality out of 1000 births [303] and 126 cases of infant mortality out of 1000 live births in the following years.[304] It is within this context that the Ministry of Public Health adopted the National Reproductive Health Policy in 2008 with a view of performing its duty to provide reproductive health care and services of good quality to the entire Congolese population as argued by Article 47 of the DRC Constitution, the National Health Strategy and international instruments.[305]

Its stated objectives are both general and specific. General objectives consist of improving the quality of life of individuals, couples, and families, communities for all aspects of reproductive health.[306] Specific objectives aim to reducing morbidity and maternal, infant and child mortality, as well as to promoting good health and sexual reproduction based on equity, gender equality and human rights approach.[307] They also consist of eliminating practices that undermine the human body in the field of sexuality and reproduction including poverty, sexual violence and HIV/AIDS.[308]

Briefly, in acknowledging reproductive health as a fundamental human right, the Reproductive Health Policy is committed to ensuring that the birth of any child is desired and that he or she should not die from preventable causes, that women should not lose or have their lives threatened by preventable diseases, pregnancy-related or at childbirth, and that everyone enjoys a good quality of sexual health free from sexually transmitted infections and HIV/AIDS.[309] The policy further aims to assure women, infants, children and men of reproductive health care services, which are of good quality, accessible, integrated and acceptable as well as effective in a no discriminatory basis.[310] These services include *inter alia*, reliable information and advice on problems relating to reproductive health, youth friendly services and community-based services which are quality, affordable and accessible and acceptable.[311]

[302] Reproductive Health Policy (note 21) at 5.
[303] Health Plan of Action (note 22) at 20 and 22.
[304] Reproductive Health Policy (note 21) at 14.
[305] Ibid see preamble and page 10.
[306] Ibid at 19.
[307] Ibid.
[308] Ibid.
[309] Ibid at 17.
[310] Ibid.
[311] Ibid.

In order to give effect to its content and goals, the policy calls for the availability of resources which include not only qualified health personnel, recycled material, drugs and contraceptive secure, but also material and financial resources as well as adequate infrastructure.[312] Furthermore, it subjects its implementation to the passing of the law on reproductive health in the DRC. [313] Meanwhile, recent statics report the maternal mortality ration of 670 (per 100, 000), under five-mortality rate 199 (per 1000) [314] and the infant mortality is of 97 (per 1000).[315]

To sum up, by adopting the above policies, the DRC aims to comply with its conventional and constitutional obligations to guarantee the right to health. Once enacted, the implementation law for both the Health Plan of Action[316] and the Reproductive Health Policy[317] will cover different aspects of the right to health for everyone namely, primary health care and reproductive health.

4.5 Access to health care services and medical attention in practice

The DRC government is under conventional and constitutional obligations to ensure that health care services[318] whether provided by public or private health care institutions are available in sufficient quantity and of good quality.[319] This requires the adoption of appropriate budgetary, promotional and other measures.[320] Furthermore, the DRC is under an obligation to ensure that all citizens including the vulnerable groups of the society have access to health care services without discrimination of any kind.[321] In order to avoid the financial constraints that constitute an impediment in the enjoyment of the right to health by the vulnerable groups and to reinforce the principle of equality, the DRC is under a special

[312] Ibid at 16.
[313] Ibid at 17.
[314] United Nations Population Fund state world's midwifery 2011: DRC country profile http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_DRC_SoWMy_Profile.pdf.
[315] World Bank 2011: *Congo, Democratic Republic of - Additional Financing for the Primary Health Care Project*, available at http://documents.worldbank.org/curated/en/2011/11/15493478/congo-democratic-republic-of-drc-additional-financing-primary-health-care-congo-democratic-republic-additional-financing-primary-health-care-project (Accessed on 23 November, 2011).
[316] Health Plan of Action (note 22) at 81.
[317] Reproductive Health Policy (note 21) at 17.
[318] Health care services must include at least hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs. See General Comment 14 (note 28) Para 12.
[319] Ibid. See also Articles 47 and 60 of the DRC Constitution.
[320] General Comment 14 (note 28) Para 33.
[321] Ibid Para 19. See also Art 13 of the DRC Constitution.

obligation to provide them with the necessary health insurance and health-care facilities,[322] including through the adoption of relatively low-cost targeted programmes.[323] This section discusses the DRC's commitment to health system as well as the applicability of the principle of equality in the provision of health care services.

4.5.1 The health care system in the DRC: health infrastructure, financing and human resources

The DRC government undertakes to facilitate access to health care services and medical attention of all its 67,827,495 citizens,[324] of which 69, 6% live in rural areas[325] and 59% live under $1, 25 per day.[326] These health care services are provided by both public and private health institutions.

As regards public health infrastructures, they consist of about 8,126 health centers and 421 general hospitals for the whole country[327] and other assets such as subsidized pharmaceuticals. [328] However, it has been reported that out of existing health centers, only 1,006 were built using durable materials, while less than 25% of existing 421 general hospitals have 100 beds.[329] Furthermore, most of public health institutions are ill equipped with a shortage of medicines.[330] The dilapidation of health infrastructure and equipment exposes the population to various health risks.[331]

In respect of human resources, they consist of about 5,000 physicians and 40,000 other medical personnel of all categories.[332] As is clear, the 45,000 medical personnel for an estimated population of 67, 827,495 are not enough. This shortage of human resources is partially due to the fact that Congolese medical personnel are in a continuous search for

[322] General Comment 14 (note 28) Para 19.
[323] General Comment 3 (note 79) Para 12.
[324] WHO Mental Health Atlas (note 274).
[325] Ministère de la Santé Publique, Rapport narratif : profil pharmaceutique de la République Démocratique du Congo (2011) at 10.
[326] World Bank (note 316).
[327] Health Plan of Action (note 22) at 58 and 59.
[328] DRC Report to the Human Rights Council (note 23) Para 58 and 62.
[329] Health Plan of Action (note 22) at 58 and 62.
[330] Ibid at 125, 14, 103, and 203. See also Ministère de la Santé Publique, Programme du Gouvernement (2007-2011) secteur de la santé, rapport de suivi (2007) at 10.
[331] WHO Compendium (note 284).
[332] Health Plan of Action (note 22) at 36.

better living and working conditions[333] either within international organizations or abroad.[334] It is necessary to mention that these human resources are unequally distributed between provinces and between urban and rural areas. For instance, although Kinshasa has the seventh highest population, out of the country's 11 provinces, it has the highest density of physicians per 10, 000 inhabitants.[335] In relation to birth deliveries in rural areas, four out of 10 births take place at home without the assistance of trained medical personnel.[336]

As regards the budgetary measures, from 2006 to 2010, 4, 41%, 3, 62%, 3%, 5, 29%,[337] and 5% [338] of the general budget was allocated to the health sector. It is clear that the portion of the budget allocated to the health sector has always been less than 15% of the general budget as suggested by the Abuja Declaration to which the DRC has been party to since 2001.[339] Moreover, due to the lack of financial autonomy of provinces, all the major decisions regarding the execution of expenditure on medical equipment or supplies are taken by the national government.[340] This is due partially to the lack of political will from the national government to enable provinces to administer the 40% of funds allocated to them by virtue of Article 175 of the DRC Constitution.[341] As a result, provinces may not be expected to adequately perform their constitutional obligations relating to the right to health.

On the other hand, private health institutions consist of among others, traditional healers,[342] agreed medical center[343] health institutions held by religious confessions, Non-governmental organizations and wholesalers of medicines and pharmacists.[344] The private health sector makes a significant contribution to the delivery of health services especially the Catholic network, which owns 40% of the health infrastructure.[345] However, due to a lack of

[333] Public Physicians have a salary of 56,500 Fc ($ 60) and a risk bonus of 500 000 Fc ($ 600). See Hélène Sodi, Rd Congo : les médecins en grève pour obtenir une bonne rémunération available at: http://www.infobascongo.net/beta/?p=9274 (Accessed on 2 Avril 2012).
[334] For instance, in 2006 there were more than 2,000 Congolese physicians in the South African Broad of Physicians. See Health Plan of Action (note 22) at 39.
[335] These seventh provinces are: Bandundu, Bas-Congo, Equateur, Kasaï Occidental, Kasaï Oriental, Katanga and Kinshasa. However, the density of physicians per 10 000 inhabitants is higher (1, 8) in Kinshasa than in other provinces such as Bandundu (0, 4) and Equateur (0, 2). See Health Plan of Action note 22 at 14 and 40.
[336] Ibid 24.
[337] Ibid at 47.
[338] La tribune de l'OMS http://www.who.int/hac/crises/cod/niger_la_tribune_de_loms_8_31mai2010.pdf.
[339] Ibid at 54. See also the National Reproductive Health Policy (note 21) preamble.
[340] Health Plan of Action (note 22) at 49.
[341] Mbata (note 46) at 403-404.
[342] The 1952 Decree (note 36) Art 15.
[343] The 2006 Decree (note 38) Art 31.
[344] Health Plan of Action (note 22) at 34.
[345] Ibid.

appropriate regulation and coordination, most private health institutions provide health care of poor quality.[346]

Through this section, it has been shown that the DRC's commitment to the health system, as a whole, is limited by resource constraints. The lack of available and sufficient health services, shortage of human resources, and the inadequacy of the budget allocated to the health sector may adversely impact on the accessibility to health care services by most of the Congolese citizens.

4.5.2 People's access to health institutions

Congolese people resort to both public and private health institutions in the event of illness in two ways. The first consists of attending a medical institution where a patient may have medical consultation which includes the attention of the medical personnel, laboratory or para-clinic tests, hospitalization or a medical prescription.[347] The patient pays fees relating to each medical treatment[348] regardless of the emergency,[349] or her or his income or social status. With respect to the price of medicines, it varies according to the quality of medicines or the places in which they are sold.[350] The price is high when it deals with some specialty and relatively low for generic drugs and depends on the quality of the health institution which provides such drugs.[351]

The second way is used as an alternative if one has financial constraints.[352] Accordingly, patients practice self-medication thanks to the free and illegal prescriptions of medicines by wholesalers or the sale of medicines without prescription.[353] This often happens in the private health sector.

Taken together, it follows that a part from people living or affected by HIV whose access to health care is free of charge, the DRC falls short to adequately deal with the principle of equality and equity in the provision of health care services for most of vulnerable

[346] Ibid at 36.
[347] Tshibinda (note 50) at 21.
[348] This may include consultation fees ($10), medical ordinance fees ($5) and about $ 70 for being admitted in the hospital for a maximum of one week.
[349] Ibid.
[350] Ministère de la Sante (note 330) at 26 and 28.
[351] For instance, when it is prescribed by medical personnel within a health institution, in addition to consultation and medical ordinance fees ($15), speciality for treating malaria costs about $15 and $10 for generic drugs. Whereas, once it is sold in public places without medical ordinance, speciality for treating malaria costs about $5 and $3 for generic drugs.
[352] Ministère de la Sante (note 325) at 28.
[353] Ibid at 30.

groups including women in the rural areas.[354] The lack of special measures of protection for vulnerable groups coupled with the poverty of most of Congolese people does not allow them to access formal health care services.[355]

4.6 Conclusion

This chapter has shown that the DRC has adopted laws and policies in order to protect the right to health in accordance with its conventional and constitutional obligations. For instance, in subjecting every medical personnel to required conditions and sanctions for non compliance, the law regulating the medical profession reinforces the DRC's commitment to ensure that health care services are provided by qualified and skilled medical personnel. Moreover, subsequent to the constitutional guarantee of the right to health, the HIV Act was adopted in 2008 and ensures free access to health care services of people living with or affected by HIV. In 2009, the Children's Act was passed in order to ensure the child's right to health. Lastly, three main policies namely the National Health Strategy on the reorganization of health system, the Health Plan of Action on primary health care and the Reproductive Health Policy on reproductive health were adopted respectively in 2006, 2008 and 2010.

However, apart from the HIV Act, the implementation law for both the Health Plan of Action and the Reproductive Health Policy as well as the implementation measures for the Children's Act has never been adopted. In addition to both the Public Servants Act and the 2006 Decree that discriminate against a married female public servant or physician whose the husband has a regular income, the principle of equality in the provision of health care services is infringed by the lack of special measures of protection such as medical insurance for most of the vulnerable groups.

[354] For instance, in Masi-manimba, a township within Bandundu province, when a woman gives birth, maternity expenses depend on the case: 25,000 FC ($25) if the child is a boy, 22000FC ($22) if the child is a girl and 120, 000FC ($120) for cesarean birth.
[355] Health Plan of Action (note 22) at 54.

Chapter Five

CONCLUSION AND SUGGESTIONS

Throughout this thesis, the nature of the obligations which the DRC has under international law and its own Constitution in relation to the right to health has been discussed. In particular, the main focus has been on access to medical services and medical attention.

It has been shown that the DRC Constitution protects the right to health in a more meaningful way than its predecessors. Indeed, not only does the Constitution protect the right to health in its broadest sense including health care and other underlying determinants of health, it also protects all the rights herein contained with the same status. Furthermore, the Constitution binds both the State and individuals including private health care providers to the Bill of Rights. Moreover, ratified international instruments including the ICESCR and the African Charter are part of the domestic legal system of the DRC that the Courts and Tribunals must apply. This implies that in applying international treaties, the courts and tribunals may hold the DRC government responsible for violating one or more aspects of the right to health, which are not specifically provided for in the Constitution.[356]

In addition, in order to give effect to the constitutional right to health, subsequent laws and policies have been adopted following the promulgation of the Constitution in 2006. These include the National Health Strategy in 2006, the HIV Act and the National Reproductive Health Policy in 2008, the Children's Act in 2009 and the Health Plan of Action in 2010. These laws and policies protect different aspects of the right to health including primary health care, reproductive health, the child's health and fight against the HIV/AIDS. They further cover all the categories of people such as children, people living with or affected by HIV/AIDS, women, men and all vulnerable groups. Furthermore, with a view to ensuring that health care services are of good quality and are provided by skilled personnel, the medical profession is strictly and rigorously regulated. Most importantly, although the DRC is under no obligation to ensure unqualified free access to health care including for vulnerable groups such as people living or affected by HIV, the HIV Act provides free access to health care services for those it covers.

[356] Chirwa ' Malawian Constitution' (note 109) at 28.

However, on a practical level, most of these adopted laws and policies on the right to health are not yet adequately implemented. Indeed, apart from the HIV Act, which is supplemented by a national multi-sectorial program of fight against HIV/AIDS,[357] implementation measures including appropriate strategies or a plan of action for the Children's Act,[358] and the law of implementation for both the Health Plan of Action[359] and the Reproductive Health Policy[360] have never been adopted. As a result, the child's right to health, the right of everyone including the vulnerable groups to primary health care and reproductive health such as respectively guaranteed by the Children's Act, the Health Plan of Action and the Reproductive Health Policy remain a mere statement of intent.

Notwithstanding the above identified impediments to the implementation of the right to health in the DRC, an optimistic viewer observes that:

> [T]he 2006 elections, the first in 40 years, were another crucial juncture in the history of the DRC. The new democratic dispensation that has allowed the Congo to put in place the institution that make up a modern state could mark a new beginning for the Congolese people, a prosperous future for which they have so long dreamt.[361]

For such dream to be translated into reality, two main steps have to be taken concurrently. The first step draws from the assertion that, constitutional recognition of socio-economic rights enables civil society, individuals and other interested persons not only to challenge legislation and policies that do not adequately implement these rights, but also to request for the adoption of new legislation and policies.[362] Thus the first step is twofold: the adoption of new legislation and new policies.

In respect of new legislation, the Congolese parliament needs to enact framework legislation on access to health care services. This option is explicitly recommended by Article 2 (1) of the ICESCR and Article 1 of the African Charter, though they do also acknowledge the relevance of other appropriate measures. As pointed out by Paula Proudlock,[363] the primary enabling law plays four key roles in the realization of each socio-economic right

[357] See (note 261).
[358] According to Art 21 of the Children's Act, the enjoyment of the right to health of the child is subject to the adoption of appropriate national strategies.
[359] Health Plan of Action (note 22) at 81.
[360] Reproductive Health Policy (note 21) at 17.
[361] Muzongo Kodi *Corruption and governance in the DRC during the transition period 2003-2006* (2008) 90.
[362] Danwood M Chirwa 'Combating child poverty: the role of economic, social and cultural rights' in Julia Sloth-Nielsen (ed) *Children rights in Africa: a legal perspective* (2008) 91 at 102.
[363] Paula Proudlock "Children's socio-economic rights" in Trynie Boezaart (ed) *Child law in South Africa* (2009) 91 at 296-97.

including the right to health. Accordingly, it places a statutory obligation on the executive arm of government to provide the services, programmes, human resources, and infrastructure that is needed to give effect to the right. Moreover, it creates a statutory entitlement to the relevant service. Furthermore, it plays an important role of clarifying the roles and responsibilities of each sphere of government in the delivery of services. Lastly, it provides for the regulation of the service or programmes to ensure that service is of good quality and is delivered properly. In the DRC context, in addition to allowing for the implementation of the right to health by all the three spheres of government and ensuring an equal repartition of resources between provinces and between rural and urban areas, such a primary enabling law will give effect to primary health care and reproductive health of everyone including special measures of protection for the vulnerable groups[364] as guaranteed by the Health Plan of Action and the Reproductive Health Policy. Moreover, it will help to amend some provisions of the Public Servants Act and the 2006 Decree on public physicians that discriminate against a married female public servant or physician on the one hand, and tackle the issue of private health care providers including traditional healers on the other hand.

In relation to the adoption of new policies, the government is urged to adopt appropriate implementation measures including appropriate decrees or ordinances, a national plan of action[365] and a range of strategies in order to fully and adequately give effect to the Children's Act, which protects the right to health of children that constitute the majority of the Congolese population.

The second and last step is the role to be played by the international organisations to which the DRC is member of, especially the United Nations and the WHO. To this end it has been suggested that states parties to both the UN and WHO have a joint and individual responsibility to cooperate in times of emergency so that priority in the provision of international medical and financial aid should be given to the most vulnerable or marginalized groups of the population.[366] Furthermore, the economically developed states have a particular responsibility to assist the poorest developing States in this regard.[367] To this end, the DRC calls for appropriate technical assistance from the international community

[364] These special measures of protection include health mutual, medical insurance, the implementation of equity funds, and the subvention of some medical care. See the Health Plan of Action (note 22) at 79.
[365] CRC (note 272) Para 14 and 15.
[366] General Comment 14 (note 28) Para 40.
[367] Ibid.

in order to help it find ways of lowering the cost of providing medical attention and support for the poor and indigent.[368]

[368] DRC Report to the Human Rights Council (note 23) Para 126.

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