ABHANDLUNGEN / ARTICLES

Traditional Medicine as Part of the Human Right to Health in the Democratic Republic of the Congo

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Abstract: Applicable law protecting the right to health in the Democratic Republic of the Congo (DRC) consists of ratified human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the African Charter on Human and Peoples' Rights (African Charter), and domestic laws. However, none of these legal instruments explicitly mention traditional medicine (TM). Nevertheless, their provisions are broad enough to include TM. The Committee on Economic, Social, and Cultural Rights and the African Commission on Human and Peoples' Rights have interpreted the right to health under the ICESCR and the African Charter to cover TM. Moreover, in implementing the right to health, the DRC has taken legislation, policies, and programs that regulate and protect TM. In addition to discouraging some bad practices associated with TM, regulation protects people from eventual violation of the right to health by Traditional Health Practitioners (THPs). Furthermore, the protection of medicinal natural resources contributes to the availability and accessibility of TM products. However, like in the colonial period, TM in the DRC continues to be marginalized compared to modern medicine. Therefore, several factors limit access to TM of good quality that is available and accessible. These include, among others, failure for public health facilities to provide TM, lack of provisions covering explicitly TM under the existing social security law, the absence of an adequate control mechanism, and the lack of appropriate criminal sanction regime.

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A. Introduction

All people worldwide have used and continue to use traditional medicine (TM), albeit to various degrees.[1] The Democratic Republic of the Congo (DRC) is no exception. TM is the oldest of all the existing therapeutic systems in African societies.[2] Ever before the import of biomedical medicine in Africa by European missionaries and colonialists,[3] African people relied on TM as the solely available health system[4] to meet their health needs. Thus, like conventional medicines, TM controls, prevents, treats, or heals diseases,[5] contributing to the enjoyment of the human right to health.

However, in their mission of propagating Western culture and civilization, colonial masters had engaged to replace TM with imported conventional medicine[6] [7] by, among others, providing legal limitations to the use of TM. In the DRC, colonial authorities adopted the 1952 Decree relating to the art of healing,[8] which explicitly states that "the provisions of this decree do not apply to the natives of the Belgian Congo who provide care or administer remedies in the customary areas according to the habits and customs without disturbing the public order." The 1952 Decree refers to TM as "care or remedies administered in customary areas following the habits and customs." It does not explicitly regulate the practice of TM in urban areas. Instead, the Decree under discussion relegates the use of TM in rural areas while excluding it from any regulation. In refraining from regulating the exercise of TM by Traditional Health Practitioners (THPs) on the same legal footing as modern medical professionals,[9] the 1952 Decree explicitly assigns an inferior status to TM and consecrates its legal marginalization.

Despite the marginalization of TM under the 1952 Decree, the Congolese government, which attained its independence on 30 June 1960, remains committed to protecting TM at both international and domestic levels through ratifying human rights treaties and taking

1 *Kamgoui Kuitche*, Médecine traditionnelle et droit de la santé pour une intégration du droit dans le système traditionnel, Paris, 2017, p. 24.

2 *Fawzi Mahomoodally*, Traditional medicines in Africa: An appraisal of ten potent African medicinal plants, Evidence-Based Complementary and Alternative Medicine, 2013, p. 2.

3 *Danwood M. Chirwa*, Access to medicines and health care in Sub-Saharan African: A historical perspective, Md. J. Int'IL 31 (2016), p. 26, and *Bruce Fetter*, Health care in twentieth century Africa: Statistics, theories, and policies, Africa Today 40 (1993), p. 12.

4 *Sekaya Yahaya / Warren Aryeija / Unice Bitwari*, Traditional medicine in Uganda: historical perspective, challenges and advances, IK Notes 67 (2004), p. 2. See also *Ali Abdullahi*, Trends and challenges of traditional medicine in Africa, Afr J Tradit Complement Altern Med 8 (2011), p. 120.

5 WHO General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine, 2000 (hereinafter WHO Guidelines 2000), p. 1.

6 European Christians missionaries and colonizers imported biomedicine to ensure their survival in tropical African. *Fetter*, note 3, p.12.

7 *Chirwa*, note 3, pp. 25 and 28.

8 Décret du 19 mars 1952 relatif à l'exercice de l'art de guérir (henceforth 1952 Decree).

9 Other health professionals covered in the 1952 Decree include physicians, dentists, nurses, birth attendants, health workers, and pharmacists.

domestic laws. At the international level, for instance, the DRC is a signatory to the leading human rights treaties[10] that protect the right to health. As an illustration, article 12 of the International Covenant on Economic, Social, and Cultural Rights[11] (ICESCR) protects everyone's right to enjoy the highest attainable standard of physical and mental health, without explicit mention of TM or modern medicine. The Committee on Economic, Social, and Cultural Rights (CESCR) interprets the right to health under article 12 of the ICESCR to include access to traditional preventive care, healing practices, and medicines for indigenous.[12] The CESCR further calls for the protection of vital medicinal plants, animals, and minerals necessary to the full enjoyment indigenous' right to health.[13] At the same time, the CESCR reads the State's obligation to respect the right to health as refraining from prohibiting or impeding traditional preventive care, healing practices, and medicines.[14] Finally, like other State parties, the DRC has to discourage the continued observance of harmful traditional medical practices.[15] It is worth recalling that, in implementing the Covenant' right to health, State parties have adopted legislation, programs, and policies dealing with various aspects of TM.[16]

Like the ICESCR, article 16 of the African Charter on Human and Peoples' Rights[17] (African Charter) on every individual's right to enjoy the best attainable state of physical and mental health does not explicitly distinguish between modern medicines and TM. The

10 Ratified human rights treaties include, among others, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1981, art 12, the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), 1969, art 5 (e) (iv), the Convention on the Rights of the Child, 1990, art 24, African Charter on the Rights and Welfare of the Child, 1999, art 14, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2005, art 14.

11 Adopted in 1966, the ICESCR came into force in 1976. The Democratic Republic of the Congo (DRC) ratified the ICESCR on 1 November 1976. See Democratic Republic of the Congo: Implementation of the International Covenant on Economic, Social and Cultural Rights, Combined second, third, fourth and fifth periodic reports submitted by States parties under articles 16 and 17, (14 August 2007).

12 Committee on Economic, Social and Cultural Rights General Comment No. 14: The Right to the Highest Attainable Standard of Health (art 12), 2000 (hereinafter General Comment 14), para 27.

13 Ibid.

14 Ibid. para 34.

15 Ibid. para 51.

16 See Republic of Uganda: Initial reports submitted by State parties under articles 16 and 17 of the Covenant, 2012 (hereinafter Uganda Report under the Covenant), para 141, Republic of South Africa: Initial reports submitted by State parties under articles 16 and 17 of the Covenant, 2017 (hereinafter South Africa Report under the Covenant), para 116, Republic of Zambia: Initial reports submitted by State parties under articles 16 and 17 of the Covenant, 2003, (hereinafter Zambia Report under the Covenant), para 214, Namibia: Initial reports submitted by State parties under articles 16 and 17 of the Covenant, 2012, (Namibia Report under the Covenant), para 337, and Republic of Zimbabwe: Initial reports submitted by State parties under articles 16 and 17 of the Covenant, 1995 (Zimbabwe Report under the Covenant), para 180.

17 African Charter on Human and Peoples' Rights, 1986.

African Commission on Human and Peoples' Rights (African Commission) has interpreted article 16 at hand to entail the State's obligation to refrain from prohibiting or impeding the use of TM and healing practices that are scientifically sound and medically appropriate.[18] In their efforts to give effect to article 16 of the Charter, State parties report on adopted implementation measures dealing with various aspects of TM.[19]

At the domestic level, the DRC has taken several legal instruments and policies which explicitly or implicitly deal with various aspects of TM. To begin with, the Constitution of the DRC,[20] like ratified human rights treaties, protects everyone's right to health, without distinguishing between conventional and traditional medicine. Thus, the constitutional right to health also can be interpreted to comprise TM. The Public Health Law confirms this assertion.[21] Implementing the constitutional right to health, the Public Health Law explicitly recognizes TM and TM facilities.[22] More importantly, the Congolese government further adopted laws and regulations on protecting TM products as part of the rights to health and natural resources and regulating the practice of TM. For instance, the Forest Code[23]expressly entitles individuals to use medicinal plants for domestic needs. Furthermore, in its efforts to integrate TM into the national health system, the government adopted two Decrees dealing respectively with the practice of TM[24] and the establishment of the National Programme on TM.[25] In addition to ensuring accessibility to and availability of TM, the

18 141 Resolution on Access to health and Needed Medicines in Africa, ACHPR/Res.141 (XXXXII-II)08, 2008, (hereinafter Resolution 141).

19 See, for instance, the United Republic of Tanzania: Report to the African Commission on Human and Peoples' Rights, 2006, para. 26, Republic of South Africa: Combined second periodic report under the African Charter on Human and Peoples' Rights and initial report under the Protocol to the African Charter on the Rights of Women in Africa, 2015, (hereinafter South Africa Report under the Charter), para 286, Republic of Zimbabwe: 7th, 8th, 9th and 10th combined report submitted to the African Commission on Human and Peoples' Rights, 2006 (hereinafter Zimbabwe Report under the Charter), Republic of Zimbabwe: second and third reports in terms of article 62 of the African Charter on Human and Peoples' Rights, 1997, (hereinafter Zimbabwe 1997 Report under the Charter), 23, Burkina Faso: Periodic Report within the framework of the implementation of article 62 of the African Charter on Human and Peoples' Rights, 2015, (hereinafter Burkina Faso Report under the Charter), paras 185-186.

20 Constitution de la République Démocratique du Congo du 18 Février 2006 telle que modifiée à ce jour (hereinafter DRC Constitution), art 47.

21 Loi n° 18/035 fixant les principes fondamentaux relatifs à l'organisation de la santé publique, 2018 (hereinafter Public Health Law), arts 12 (5) and 59.

22 Ibid. arts 12 (5) and 59.

23 Loi N°11/2002 portant Code Forestier, 2002 (hereinafter Forest Code) arts 36 and 39.

24 Arrêté Ministériel N° 1250/ CAB/MIN/S/CJ/KIZ/32/2002 portant organisation de l'exercice de la profession de praticien de la médecine traditionnelle, 2002 (hereinafter TM Decree).

25 Arrêté Ministériel N° 1250/ CAB/MIN/S/AJ/DJK/12/2002 portant création et organisation d'un programme national de promotion de la médecine traditionnelle et des plantes médicinales, 2002 (hereinafter Decree on the National Program for Traditional Medicine).

regulation aims to tackle some bad practices associated with TM, such as charlatanism, poor quality of TM products, and lack of education for some THPs.[26]

However, despite the above legal framework, TM in the DRC is still marginalized compared to conventional medicine from many perspectives. Consequently, several factors limit access to available good-quality TM. These include mainly the lack of provision for TM by public health facilities, including hospitals, health centres, and clinics, the omission by social security laws, including health insurance legislation, to cover TM services explicitly,[27] and the relegation of TM practice to rural areas. Other factors include the lack of an appropriate criminal sanction regime in case of non-compliance with the established standards and the lack of specific regulatory authority in charge of control quality for TM. All these concerns affect, to some extent, the State's obligation to make TM of good quality available and accessible.

Using treaty provisions on the right to health, the works of treaty bodies, including the CESCR and African Commission, States' reports and domestic laws and regulations, the present study argues that DRC is under the legal obligation to protect and regulate TM to make TM services of good quality available and accessible. Further, it is the Congolese government's duty to bring existing measures dealing with TM in conformity with the constitution, ratified human rights treaties, and the Public Health Law. In addition to the present introduction (A), the study comprises four parts. Part two discusses the concept of TM (B). Part three deals with TM under the ratified human rights treaties by the DRC (C). Part four deals with the protection and regulation of TM under the domestic laws of the DRC (D). Part five concludes the study by providing some recommendations (E).

B. Concept of TM

The present section discusses the definition of TM (I) and concerns about evaluating TM's safety, efficacy, and quality (II).

I. What is TM?

Human rights treaties providing the right to health, including the ICESC and the African Charter, do not define TM. Further, like the ICESCR and the African Charter, General Comment 14 and Resolution 141, which expressly use the concept of TM, remain silent on its definition. The same observation applies to the DRC Constitution, the Public Health

26 WHO Traditional Medicine Strategy 2014-2023, Geneva 2013 (hereinafter WHO Strategy 2014-2023), p.31. See also *Emmanuel Kabengele Mpinga* et al., Traditional/alternative medicines and the right to health: key elements for a convention on global health, Health and Human Rights 15, N°1, (2013), p. 50.

27 Loi N° 16/009 fixant les règles relatives au régime général de la sécurité sociale, 2016 (hereinafter Social Security Law) and Décret N° 06/130 Portant statut spécifique des médecins des services publics de l'Etat, 2006, art 30 (hereinafter Public Physicians Decree).

Law, the 1952 Decree, and the decree on THPs, which do not describe TM. Due to the absence of a universal definition for TM, the present work uses the description of TM provided by the World Health Organization, as

> *"the sum total of the knowledge, skills, and practices based on theories, beliefs and experiences indigenous to different cultures, whether explicable or not, which has been used for centuries to maintain health, prevent, diagnose, improve or treat physical and mental illnesses."*[28]

It follows that TM consists of knowledge, skills, and practices, which like conventional medicine, are used in maintaining health, and preventing, diagnosing, or treating physical and mental illnesses. Moreover, such knowledge, skills, and practices are based on theories, beliefs, and experiences original to each culture, which in turn are explainable or not. However, the definition under discussion does not determine the content of the above knowledge, skills, and practices, nor mentions the possessors of such skills and knowledge. The WHO Strategy 2014-2023 fills in the gap by stating that TM involves three interrelated components, namely TM products, practices, and practitioners.[29] TM products are referred to as traditional medicines, preventive care, or vital medicinal plants, animals, and minerals.[30] TM products consist of two main categories. The first category comprises medication therapies and involves the use of herbal medicines, animal parts, and minerals.[31] The second category consists of non-medication therapies, which are based on manual and spiritual therapies, such as acupuncture.[32]

TM practices are traditional healing practices[33] or approaches. They are associated with TM products. TM practices under the domestic laws of the DRC are numerous and various. They include, among others, religious and spiritual methods, prayers, and ritual acts provided or not by a liturgy, dance formulas, and other ritual acts.[34]

According to the Congolese legislation, THPs are individuals who usually advise on methods of preserving or improving health and deal with human, mental and physical illnesses by virtue of faith and spiritual guidance or by means traditionally used in the community to heal by helping or stimulating nature.[35] Following the diseases they treat and used healing methods in that regard, THPs in DRC exercise their profession as spiritualists,

28 WHO Guidelines, 2000.

29 WHO Strategy 2014-2023, p. 25.

30 General Comment 14, para 27. See also Resolution 141.

31 WHO traditional medicine strategy 2002-2005, Geneva 2002 (henceforth WHO Strategy 2002-2005).

32 Ibid.

33 General Comment 14, para 34.

34 TM Decree.

35 Ibid.

exorcists, ritualists, or herbalists, as the case may be.[36] Thus, like biomedical health professionals, THPs play a crucial role in the providing primary health care.[37]

II. Evaluating TM's safety, efficacy and quality: by whom and how?

The essence of TM rests in its therapeutic properties to prevent, diagnose, and improve or treat physical, social, and mental illnesses. The recognition of TM and recommendation for its use by some human rights treaty bodies[38] and other official documents[39] indicate that TM is medically sound. Resolution 141 significantly reaffirms the assertion that TM healing practices that are scientifically sound and medically appropriate form part of the right to health under the African Charter.[40] Contrary to allopathic medicine, which is based on Western culture following a scientific approach, TM has been mainly influenced by the culture and historical conditions within which it first evolved.[41] Therefore, using the scientific approach as a starting point, it is submitted that the quantity and quality of the safety and efficacy data on TM are far from sufficient to meet the criteria needed to support its use worldwide.[42] Conventional investigation methods can be used to scientifically study and analyse physical ingredients used in TM,[43]mainly traditional medication therapies that involve herbal medicines, animal parts, and minerals.[44] Some critics, however, warn that conventional and traditional medicine's conceptions of safety and efficacy may not be equivalent. [45] Unlike in biomedical systems where clinical trials demonstrate the safety and efficacy of medicines, the safety and efficacy of TM are mainly determined by its prolonged history use.[46] Furthermore, the spiritual realm of TM makes it difficult for modern scientists to fully assess the efficacy and effectiveness of some TM's aspects.[47] As a result, biomedical researchers may encounter limitations in assessing the safety of non-medication therapies and other traditional healing practices, such as manual and spiritual therapies, prayers, or dance formulas. Thus, there are some aspects of TM which are

36 TM Decree.

37 International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, para. VII

38 See CESCR's General Comment 14, and the African Commission Resolution 141.

39 See for instance, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 2006, para 50.

40 Resolution 141.

41 WHO Strategy 2002-2005.

42 Ibid.

43 *Kabengele* et al., note 26, p.119.

44 WHO Strategy 2014-2023.

45 *Carlos Bouso / Constanza Sánchez-avilés*, Traditional Healing Practices Involving Psychoactive Plants and the Global Mental Health Agenda, Health and Human Rights 22 (2020), pp. 146-147.

46 Ibid.

47 *Kabengele* et al*.,* note 26, p.119.

not science-based. These limitations are inherent to the definition of TM, which is based on beliefs, theories, and experiences that are explicable or not. Assessing TM's quality and efficacy becomes complex with the lack of adequate and accepted research methodology for evaluating TM.[48]

All in all, like conventional medicines, TM can become harmful when it is associated with bad practices linked to TM products, practitioners, and practices, such as the use of poor-quality products, unqualified practitioners, misdiagnosis, and delayed diagnosis.[49]Therefore, the government remains under the legal obligation to take appropriate measures to regulate TM products,[50] practices,[51] and practitioners[52]to ensure the safety and quality of TM.

C. TM under the ratified human rights treaties by the DRC

Ratified human rights treaties form part of the DRC's domestic legal arena. According to article 215 of the DRC Constitution, duly ratified international treaties and conventions have, upon their publication, supremacy over domestic laws. The present section examines the protection of TM through the right to health (I) and the human right to natural resources (II) under the ratified human rights treaties by the DRC, focusing on the ICESCR and the African Charter.

I. TM as part of the right to health

The DRC is a party to the ICESCR and the African Charter, which protect the human right to health. The present sub-section shows that the right to health covered in articles 12 of the ICESCR and 16 of the African Charter is broad enough to include TM.

1. TM as part of article 12 of the ICESCR

Article 12 of the ICESCR on everyone's right to health does not explicitly mention TM or conventional medicine.[53] Instead, it obligates State parties to take steps to reduce the

48 Ibid.

49 Further risks include exposure to misleading or unreliable information, side effects or unwanted treatment interactions. WHO Strategy: 2014-2023, p. 31.

50 To address this issue, Member States and regulatory agencies are increasingly cooperating and learning from each other's experiences. Some regional bodies have been working on harmonizing regulations on herbal medicines and other herbal products within their region. Ibid. p. 32.

51 National health authorities must develop policies and strategies that reflect their specific needs in dealing with the most popular forms of TM practised in their country. Ibid.

52 The State's responsibility is to regulate how THPs obtain their knowledge and skills, including through official education/training programme, university-level programmes, and oral transmission from generation to generation. Ibid. p. 33.

53 *Kabengele* et al., note 26, p. 49.

stillbirth rate and infant mortality, prevent, treat, and control diseases, and create conditions that assure all medical services and medical attention in the event of sickness. It is worth stressing that Article 12 uses the word "steps" without enumerating them. Read together with the State's general obligation to undertake steps to implement all rights to the maximum of its available resources,[54] one can argue that the use of TM in preventing, treating, and controlling diseases constitutes one of the measures that realize the right to health. States' reports and the CESCR's interpretation of article 12 of the ICESC reinforce and confirm this assertion.

a) TM and the DRC's reports under article 12 of the ICESCR

Article 16 (1) of the ICESCR requires State parties to report on the measures they have adopted and the progress made in achieving the observance of the rights recognized herein. It is worth recalling that none of the reports submitted by the DRC in application to article 12 of the ICESCR mention TM.[55]Despite its existing legal framework on TM, the Congolese government enjoys a kind of latitude regarding the content of the State's report about adopted implementation measures for the right to health. One can also lament the fact that in some of its issued concluding observations to the DRC, the CESCR does not address issues of TM.[56]

Unlike the DRC, many State parties expressly mention adopted measures on various aspects of TM. These include, among others, the recognition of THPs as one of the health personals categories,[57] the adoption of legislation dealing with TM,[58] and the relevance and contribution of TM regarding birth attendants[59] and mental health.[60] In Zimbabwe, where TM is acceptable to a large section of the population, the government has established the Zimbabwe National Traditional Healers Association.[61] Moreover, to reduce the stillbirth rate and infant mortality, and to provide for the child's healthy development, Zimbabwe ensures the training of midwives, both traditional and conventional, and the upgrading of

54 ICESCR, art 2 (1).

55 Democratic Republic of the Congo: Implementation of the International Covenant on Economic, Social and Cultural Rights, Combined second, third, fourth and fifth periodic reports submitted by States parties under articles 16 and 17, (14 August 2007). See also Sixth periodic report submitted by the Democratic Republic of the Congo under articles 16 and 17 of the Covenant, due in 2013 [Date received: 13 August 2019]

56 Committee on Economic, Social and Cultural Rights, concluding observations: Democratic Republic of the Congo, 2009.

57 Uganda Report under the Covenant, para 141.

58 South Africa Report under the Covenant, para 116.

59 Zambia Report under the Covenant, para 214.

60 Namibia Report under the Covenant, para 337.

61 Zimbabwe Report under the Covenant, para 180.

all traditional midwives.[62] In sum, these State's reports on implementing article 12 of the ICESCR reaffirm the view that TM forms part of the right to health.

b) The CESCR's General Comment 14 interprets article 12 of the ICESCR to include TM

At the outset, it is worth recalling that none of the CESCR's concluding observations or views on article 12 of the ICESCR address TM. Nevertheless, in General Comment 14, the CESCR interprets the content of the right to health and the nature of the State's obligations concerning TM. To begin with, the CESCR states that all health goods and services must be respectful of the culture of individuals, minorities, peoples, and communities.[63] One of the striking features of TM is its cultural acceptability.[64] The CESCR further interprets article 12 to include indigenous peoples' right to health services that consider traditional preventive care, healing practices, and medicines and calls for protecting vital medicinal plants, animals, and minerals necessary to the enjoyment of the said right.[65] However, this CESCR's interpretation gives rise to two main criticisms. The first criticism is that in only referring to indigenous people, the CESCR takes a reductionist view, which does not consider TM's use by everybody.[66] The counter-argument is that the CESCR has dealt with indigenous people as one of the special topics of broad application.[67] Furthermore, the CESCR has interpreted the State's obligation to respect the right to health to refrain from prohibiting or impeding traditional preventive care, healing practices, and medicines.[68] This obligation is of general application. The second criticism is that the above CESCR's interpretation is in tension with paragraph 51 of General Comment 14, which erects State's failure to discourage the continued observance of harmful traditional medical or cultural practices into the violation of the obligation to protect the right to health.[69] Against this criticism, one can argue that paragraph 51 only prohibits "harmful traditional medical practices" that can hinder the efficacy and safety of TM, such as practices that interfere with access to pre-and post-natal care and family planning.[70] Thus, State parties are under the obligation to promote good or positive TM practices through the abolishment of harmful practices and the dissemination of appropriate information in that regard.[71]

62 Ibid.

63 General Comment 14, para 12 (c).

64 WHO Regional Committee for Africa, Promoting the role of traditional medicine in health systems: a strategy for the African Region, 2000, para 9.

65 General Comment 14, para 27.

66 *Kabengele* et al., note 26, p. 49.

67 General Comment 14, paras 24-27.

68 Ibid, para 34.

69 *Maria Stuttaford* et al., The right to traditional, complementary, and alternative health care, Global Health Action 7 (2014), p. 3.

70 General Comment 14, paras 22 and 35.

71 Ibid. paras 22 and 37.

2. TM under Article 16 of the African Charter

Article 16 (1) of the African Charter entitles every individual to the right to enjoy the best attainable state of physical and mental health. Like article 12 of the ICESCR, Article 16 (1) does not explicitly mention TM. The absence of an explicit reference to TM in the African context gives rise to some concerns for some reasons. First, TM plays a crucial role in the African population's access to health delivery services.[72] Secondly, the preamble to the African Charter expressly claims to eradicate all forms of colonialism from Africa. As discussed earlier, African TM is one of the areas that has been negatively affected and impacted by colonialism.[73] Thirdly, the African Charter's preamble expressly considers the virtues of African States' historical tradition and African civilization's values, which inspire and characterize their reflection on the concept of human and peoples' rights. Thus, article 16 falls short by not explicitly mentioning TM, a fundamental part of African people's culture and integral to the African health care system since time immemorial.[74] However, the necessary measures that State parties take to protect people's health and ensure that they receive medical attention when they are sick[75] are broad enough to include the protection of TM, as discussed below.

a) States' reports and TM under article 16 of the African Charter

According to article 62 of the African Charter, State parties submit a report on the legislative or other measures taken to give effect to the rights and freedoms recognized by the Charter. Like under the ICESCR, the DRC's reports in the African Charter do not mention its legal framework on TM.[76] It is worth stressing that, unlike the DRC, some States parties explicitly report on legislative and other measures adopted concerning TM. For instance, in its report, the United Republic of Tanzania[77] expressly refers to the role of TM and alternative healing systems in national health policy. More importantly, the report mentions the adoption in 2002 of the Traditional Medicine Act, which governs the practices

72 OAU Assembly of Heads of State and Government, Decision on the declaration of the period 2001-2010 as the OAU decade for African traditional medicine, Zambia, 2001 (hereinafter OAU Declaration on TM), para 2.

73 *Sekaya et al*, note 4, p. 2, *Chirwa*, note 3, pp. 27, 28, and 43.

74 *Mahomoodally*, note 2, p. 9.

75 African Charter, art 16 (2).

76 Report to the African Commission on Human and Peoples' Rights, Initial report of the Democratic Republic of Congo (Congo-Kinshasa) under the provisions of the African Charter on Human and Peoples' Rights (mainly covering the period may 1997 to December 2001), 2003, Democratic republic of Congo: 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), 2010, and Report to the African Commission on Human and Peoples' Rights on the implementation of the African Charter on Human and Peoples' Rights from 2008 to 2015 (11th, 12th and 13th periodic reports), 2017.

77 URT Report under the African Charter, para. 26.

and issues of research regarding TM and alternative healing systems. Legislations on TM also appear in the reports submitted by the Republic of South Africa[78] and the Republic of Zimbabwe.[79] Further information from Zimbabwe includes the establishment of the Zimbabwe National Traditional Healers Association,[80] the upgrading skill of more than 30 000 traditional midwives,[81] and the interdiction for TMPs to sell their medicines from unhygienic premises.[82] Furthermore, Burkina Faso's report provides information about the recognition, development, efficiency, modernization, and integration of TM into its public healthcare system.[83] The same report reveals that following the OAU Declaration on TM, Burkina Faso has included TM in the 2001-2010 and 2011-2020 National Health Development Plans.[84]

In sum, these States' reports indicate that TM forms an integral part of the right to health under article 16 of the African Charter. However, the reports also reveal that State parties deal with TM according to their population's health needs from different perspectives.

b) TM in the decisions of the African Court on Human and Peoples' Rights and the African Commission under article 16 of the African Charter

In fulfilling its contentious and advisory jurisdictions,[85] the African Court on Human and Peoples' Rights (African Court) has not yet made a judgment or advisory opinion interpreting TM as part of article 16 of the African Charter. The same observation also applies to the already issued views[86] and concluding observations[87] by the African Commission. However, unlike the African Court, the African Commission has adopted Resolution 141 on

78 South Africa Report under the Charter, para 286.

79 Zimbabwe Report under the Charter.

80 Zimbabwe 1997 Report under the Charter, 23.

81 Ibid.

82 Zimbabwe Report under the Charter.

83 Burkina Faso Report under the Charter, paras 185-186.

84 Ibid.

85 Protocol to the African Charter on Human and Peoples` Rights on the establishment of an African Court on Human and Peoples` Rights, 2004 (hereinafter the African Court Protocol), arts 4 (1) and 5.

86 Communication 25/89, 47/90, 56/91, 100/93: Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine des Droits de l'Homme, les Témoins de Jehovah/Zaïre, 1993, Communication: 54/91-61/91-96/93-98/93-164/97_196/97-210/98: Malawi African Association and others vs. Mauritania, 2000, and Communication 155/96: Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) vs. Nigeria, 1996.

87 African Commission on Human and Peoples' Rights, Concluding observations and recommendations on the consolidated 2nd to 10th periodic report of the United Republic of Tanzania, 2008 (hereinafter African Commission concluding observations to URT, 2008).

access to health and needed medicines in Africa.[88] Accordingly, TM forms part of article 16 of the African Charter. Following Resolution 141, State parties have to promote access to medicines by refraining from measures that negatively affect access, such as prohibiting or impeding the use of TM and healing practices that are scientifically sound and medically appropriate.[89] The African Commission emphasizes TM's positive aspects. However, it does not determine how one should assess TM's safety.

It is worth noting that, unlike General Comment 14, which addresses some aspects of TM with explicit reference to indigenous peoples, Resolution 141 does not. However, in contrast to General Comment 14, Resolution 141 falls short in not explicitly dealing with protecting vital medicinal plants, animals, and minerals necessary to enjoy the right to TM. Further, Resolution 141 does not adequately reflect the African States' commitment to TM's protection as expressed in the OAU Declaration on TM. Entirely and exclusively dedicated to TM, the OAU Declaration on TM urges Member States to acknowledge and build upon traditional knowledge resource-base to make the goal of health for all easier to achieve through effective mobilization and use of TM.[90] Progress made so far by some African countries during the period from 2001 to 2010 includes, among others, the facilitation of the collaboration between THPs and conventional health practitioners, research on TM for malaria, HIV/AIDS, diabetes, and hypertension, and the inclusion of TM in their national essential medicines lists.[91] It is submitted that progress on the implementation of the OAU Declaration on TM through regulatory frameworks of TM in Africa is slow.[92] Other challenges faced by African countries in the performance of the Plan of Action to the OAU Declaration of TM include limited financial and human resources, weak regulatory capacity, insufficient scientific data on the safety, efficacy, and quality of TM, and unfavourable regulatory environments for local production of TM.[93] With due regards to these challenges, the AU conference of African ministers of health has renewed the decade from 2011 to 2020.[94]

88 Resolution 141.

89 Ibid.

90 OAU Declaration on TM, para 3.

91 WHO regional office for Africa, Progress Report on decade of traditional medicine in the African region, 2011 (hereinafter Progress Report on decade of TM), paras 7-14.

92 *Amber L. Abrams / Torkel Falkenberg / Christa Rautenbach* et al., Legislative landscape for traditional health practitioners in Southern African development community countries: a scoping review, BMJ Open 10 (2020), p. 2.

93 Progress Report on decade of TM, para 15.

94 Ibid.

II. Protection of TM through the human right to natural resources

TM products are collected in the wild,[95] mainly without State investment.[96] Located within the tropical and subtropical climate, Africa is full of fauna and flora that constitute an inexhaustible source of therapies for various ailments.[97] It contains about 45,000 species of plants with a potential for development and out of which 5,000 species serve medicinal purposes.[98] The DRC is one of the hotspots of plant biodiversity globally, with the potential role in developing new medicines from its flora.[99]

1. Natural resources and TM under the ICESCR

Article 1 (2) of the ICESCR grants all peoples the right to freely dispose of their natural wealth and resources. It further prescribes that one cannot deprive people of their means of subsistence. Without filling in their content, the treaty provision under discussion identifies natural wealth and resources as people's means of subsistence. One can legitimately argue that medicinal plants, animals, and minerals that serve TM constitute an essential part of natural wealth and resources. Therefore, their use for medical purposes meets the criteria of people's means of subsistence.

In giving effect to article 1 (2) of the ICESCR, the DRC mentions the constitutional provision on the right to enjoy national resources and adopted legislation, such as the law governing land ownership, the Mining Code, the Forestry Code, and other regulations.[100] The report does not explicitly refer to TM. However, as will be seen later, some laws entitle people to use natural resources for medicinal purposes.

The CESCR emphasizes the link between natural resources and TM through its General Comment 14 and concluding observations. According to General Comment 14, protecting vital medicinal plants, animals, and minerals is necessary for indigenous peoples' health.[101] Therefore, the forced displacement of indigenous peoples from their traditional territories negatively impacts their health.[102] Moreover, in its concluding observations to the DRC, the CESCR observed that abusive exploitation of the country's forests undermines indigenous

95 *Andrew Kaniki / Kutu Mphahlele*, Indigenous knowledge for the benefit of all: can knowledge management principles be used effectively?, South African Journal of Library & Information Science 68 (2002), p. 4.

96 *Kabengele* et al., note 26, p. 50. See also WHO Strategy 2014-2023.

97 *Mahomoodally*, note 2, p. 2.

98 Ibid. p. 9.

99 *Koto-te-Nyiwa Ngbolua et al.,* Medicinal plants from Democratic Republic of the Congo as sources of anticancer drugs, Journal of Advanced Botany and Zoology (2018), p. 1.

100 Combined second to fifth periodic reports submitted by the Democratic Republic of the Congo under articles 16 and 17 of the Covenant (hereinafter DRC's Report to the CESCR, 2007), paras 40-42.

101 General Comment 14, para 27.

102 Ibid.

peoples' rights to manage their forests according to their traditional practice and amounts to the violation of article 1 (2) of the ICESCR.[103] Although the CESCR talks only about indigenous populations, article 1 (2) protects everyone's right to natural resources. Therefore, one can argue that protecting medicinal plants, animals, and minerals is necessary for everyone's right to health.

2. Natural resources and TM under the African Charter

Article 21 of the African Charter on the protection of natural resources provides, among others, that

> *"all peoples shall freely dispose of their wealth and natural resources and that States parties shall undertake to eliminate all forms of foreign economic exploitation to enable their peoples to benefit from the advantages derived from their national resources fully."*

This Charter's provision does not explicitly say that natural resources shall serve as TM. However, "fully benefit from the advantages derived from national resources" is broad enough to include peoples' well-being[104]and TM. It is worth recalling that the Charter's provision under discussion has a historical foundation. It aims to heal the wounds of colonial times, where outside powers have exploited African material resources to the detriment of African peoples, depriving them of their birth right and alienating them from the land.[105]

In one of the cases against the Republic of Kenya before the African Court, the applicant contended that the Kenyan authorities had violated the rights of the Ogieks to freely dispose of their wealth and natural resources by evicting them from the Mau Forest and denying them access to the vital resources therein.[106] In response, the African Court ruled that the respondent State had violated Ogieks people's right to freely dispose of the abundance of food produced by their ancestral lands,[107]including their means of survival, such as animals, honey, and TM[108] as argued under article 21 of the African Charter. In sum, using TM constitutes one of the advantages that derive from the enjoyment of national resources, of which natural resources are essential.

103 Committee on Economic, Social and Cultural Rights, concluding observations: Democratic Republic of the Congo, 2009, paras 13-14.

104 Communication 155/96: Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) vs. Nigeria, 1996 (hereinafter Ogoni case), para 58.

105 Ibid. para 56.

106 Application 006/2012: African Commission on Human and Peoples´ Rights vs. Republic of Kenya, 2012 (hereinafter Ogieks Case), para 191.

107 Ibid. para 201.

108 Ibid. paras 179-183.

D. Protection, regulation of, and access to TM under the domestic laws of DRC

The present section discusses the protection (I) and regulation of TM (II) under the domestic laws of the DRC. It further discusses access to TM (III) and provides some concluding observations regarding the survival of the impact of colonial legislation on the existing implementation measures for TM (IV).

I. Protection of TM

Expressly intended official reasons for the use of TM in the DRC are manifold. They include improving health care coverage through the development of TM, harmonizing partnerships between modern and traditional medicines, integrating medicinal plants into the national pharmacopeia, and integrating TM into the national health system.[109]To this end, the Congolese government protects TM through the rights to health and natural resources.

1. The right to health and TM

Article 47 of the DRC Constitution provides that "the right to health and food safety is guaranteed. The law lays down the fundamental principles and rules for the organization of public health and food safety." The constitutional provision on the right to health does not explicitly refer to modern medicines or TM. However, it is worth noting that the Public Health Law implementing article 47 of the constitution recognizes TM. Accordingly, it mentions TM facilities among the components of public health service[110]and recognizes TM throughout the country[111] without restriction. Further, the Public Health Law subjects the exercise of TM to respect of laws and public policy.[112] It also vests the national health minister with the power to set out the conditions for the practice of TM and the rights and obligations of THPs.[113]The national health ministry is further competent to organize, regulate and promote TM, including traditional pharmacopeia and medicinal plants.[114]

Pending the implementation measures by the national health ministry as prescribed under the Public Health Law, the TM sector is governed by two principal decrees adopted in 2002, namely the TM Decree and the Decree on National Program for Traditional Medicine. Dealing exclusively with the practice of TM, the TM Decree implements the government's commitment to improving health care coverage through the development of TM and the harmonization of partnerships between modern conventional medicine and

109 Decree on the National Program for Traditional Medicine, and TM Decree.

110 Public Health Law, art 12 (5).

111 Ibid. art 59.

112 Ibid. art 60.

113 Ibid.

114 Ordonnance N° 20/017 fixant les attributions des ministères, 2020, art 24.

TM.[115] For its part, the Decree on the National Program for Traditional Medicine explicitly integrates TM into the national health system.[116]

2. Protection of TM products through natural resources

Article 58 of the DRC Constitution grants all Congolese the right to enjoy national resources while obligating the State to redistribute national resources equitably. The constitutional provision under discussion implicitly protects natural resources as part of national resources. Following the law on the conservation of nature,[117] natural resources include products provided by nature that serve as a means of people's livelihood, including land resources, water resources, forest resources, air, and wildlife species. It results from this provision that medicinal plants, animals, and minerals, essential components of natural resources, constitute livelihood for the Congolese people.

Along with the constitutional protection of national resources, several legal instruments explicitly deal with protecting medicinal natural resources. Under the Public Health Law, for instance, medicinal plants comprise any terrestrial or aquatic plant owning at its natural state active ingredients with healing or preventive properties for human or animal diseases.[118] This definition stresses the healing and preventive assets of medicinal plants, which are an essential component of natural resources. To make medicinal plants available, the Public Health Law creates a national service for medicinal plants within the national health ministry, the organization and operation of which are subject to the Prime Minister's Decree.[119] Pending the attributions of the above national service for medicinal plants, the Decree on the National Program for Traditional Medicine establishes and vests the National Program for the Promotion of Traditional Medicine and Medicinal Plants[120] with the power to organize and coordinate research on medicinal plants, promote the cultivation of medicinal plants, and carry out the inventory of all the Congolese medicinal plants.[121] In addition, the Program is also responsible for the protecting animals and plants based-medicines.[122]

Under the Forest Code,[123] people living in or near the forest estate have to use rights to harvest forest resources to satisfy their domestic needs by gathering fruits, food, or medicinal plants. The exercise of these rights for domestic purposes is free of charge.[124]

115 TM Decree.

116 Decree on the National Program for Traditional Medicine.

117 Loi N° 14/003 relative à la conservation de la nature, 2014 (hereinafter the Conservation of Nature Law), art 1 (42)

118 Public Health Law, art 58.

119 Ibid. art 57.

120 Decree on the National Program for Traditional Medicine, art 2.

121 Ibid, arts 2 and 3.

122 Ibid. art 3.

123 Forest Code, arts 36 and 39.

124 Ibid. art 43.

It is worth recalling that, in addition to being used in their raw state, TM products can be accessible in dosage forms, such as tablets, syrups, capsules, creams, lotion, or solutions. These are known as ameliorated traditional medicines (ATMs).[125] According to the Decree on the registration of pharmaceuticals, ATMs are traditional remedies based on traditionally known recipes prepared by the pharmacist by making them undergo modifications to improve the presentation, taste, packaging, and modalities of use while maintaining efficiency.[126] The National Program for the Promotion of Traditional Medicine and Medicinal Plants is responsible for promoting local production of ATMs.[127]

II. Regulation of TM

Regulation on TM in the DRC dates back to the colonial period. The 1952 Decree sets the conditions to exercise the art of healing for all health professionals, including physicians, dentists, nurses, birth attendants, health workers, and pharmacists. The Decree at hand does not explicitly use the word TM. Instead, it contains provisions that can be interpreted to include TM. Accordingly, article 15 of the 1952 Decree provides that,

> *"the provisions of the present decree do not apply to the natives of the Belgian Congo or those of the bordering African territories who provide care or administer remedies in the customary areas according to the habits and customs without disturbing the public order."*

Article 15, under discussion, refers to TM as "care or remedies administered according to the habits and customs." Moreover, "natives of the Belgian Congo" means to include THPs. However, the 1952 Decree does not set out qualification conditions for THPs. In relegating the practice of TM to the customary areas only, the 1952 Decree reflects the discriminatory character of colonial health legislation, which did not allow the coexistence of conventional medicines and TM in urban areas. It is submitted that colonial authorities saw TM as a manifestation of witchcraft, the practice of which was contrary to both colonial religion and Western medicine ideals.[128] Further, the sanction regime of the 1952 Decree does not apply to those providing TM services without regard to public order. The 1952 Decree is silent about TM services within public hospitals.

The TM Decree supplements the 1952 Decree's shortcomings in the definition of THP. Accordingly, a THP is any individual who usually advises on methods to preserve or improve health and treats human, physical, and mental diseases through faith and spiritual

125 Arrêté ministériel 1250/CAB/MIN/SP/011/CPH/OBF/2015 modifiant et complétant l'arrêté ministériel N°1250/CAB/MIN/S/AJ/MS/013/2001 portant dispositions relatives à l'enregistrement et à l'autorisation de mise sur le marché des produits pharmaceutiques, 2015 (hereinafter Decree on the Registration of Pharmaceuticals), art 2.

126 Ibid. art 1 (20).

127 Ibid, arts 2 - 3.

128 *Abdullahi*, note 4, p. 116, and *Yahaya / Aryeija / Bitwari*, note 4, p. 2.

guidance or by means traditionally used in the community and which can heal by helping or stimulating nature.[129] Interestingly, TM Decree classifies THPs into naturalists, spiritualists, exorcists, ritualists, herbalists, or traditional birth attendants.[130] Like the 1952 Decree, the TM Decree reiterates the view that TM is mainly exercised in rural areas.[131] Such provision conflicts with the Public Health Law, which does not explicitly distinguish between rural and urban regions regarding the exercise of TM. However, unlike the 1952 Decree, the TM Decree also allows the practice of TM in urban areas under some prescribed conditions.[132]

THPs who want to provide their health services within a modern health facility apply for and sign a partnership agreement with the concerned conventional health institution.[133] However, it would be recommendable that the government decides without ambiguity on the provision of TM by public hospitals.

In rural areas, THPs exercise their profession in conformity with public order and after registration. In contrast, those performing in urban regions need a license, a permit, or a collaboration agreement.[134] Furthermore, all THPs must observe the duty of integrity and honesty and respect human life and their patients' physical and moral integrity. Finally, they must keep their health facilities clean and respect hygiene rules.[135] All these provisions aim to ensure that qualified and skilled THPs administer TM in good conditions. However, the TM Decree falls short in two aspects. First, it does not expressly provide a regulatory authority responsible for the quality control of TM products, health facilities, and THPs. Secondly, like the 1952 Decree, the TM Decree remains silent about applicable sanctions in case of non-compliance with its relevant provisions.

The Decree on the Registration of Pharmaceuticals partially fills in the TM Decree's gap regarding the quality of ATMs in two ways. First, it subjects ATMs to the same registration procedure as modern medicines.[136] Secondly, non-compliance with the Decree on the Registration of Pharmaceuticals is subject to the sanction regime provided in article 64 of the 1933 Ordinance. This sanction regime's intended goal is to discourage lousy practices associated with ATMs. But unfortunately, the 1933 Ordinance, the Decree under discussion refers to, has already been repealed.[137] As a result, non-compliance with the provisions regulating TM under all these Decrees remains unpunished. Consequently, the absence of an appropriate sanction regime amounts to the State's failure to protect people's

129 TM Decree, art 1.

130 Ibid. art 2.

131 Ibid. art 9.

132 Ibid.

133 Ibid. art 7.

134 Ibid. arts 10-11.

135 Ibid. art 20.

136 Decree on the Registration of Pharmaceuticals, arts 1 (20) and 2.

137 Ordonnance 72-359 du 14 septembre 1972 portant mesures d'exécution de l'ordonnance-loi 72-046 du 14 septembre 1972 sur l'exercice de la pharmacie, art 171.

health from third parties, namely THPs, who can provide their services without qualification[138] or with no regard for good manufacturing practices and distribution.[139]

Thus, article 15 of the 1952 Decree, the TM Decree's silence on the applicable sanctions, including its provisions on the practice of TM in rural and urban areas, and the sanction regime under the Decree on the Registration of Pharmaceuticals, are contrary to the Public Health Law. As discussed earlier, the Public Health Law, which precedes over the above provisions, protects TM without limitation. Consequently, the Public Health Law repeals the specific provisions of these Decrees contrary to both its letter and spirit.[140] Furthermore, one can argue that the practice of TM, in contravention of the existing regulations, amounts to the illegal practice of the healing art, which falls within the criminal sanction regime of the Congolese Criminal Code.[141]

It derives from the above development that, in protecting and regulating TM within the framework of the right to health, the Congolese government defines and establishes the legal regime of TM in a restrictive manner. It determines the different categories of existing TMPs and prescribes the methods or approaches used in TM and different health issues that fall within their competencies. One of the essential points remains the recognition of TMPs by their communities as being able to provide traditional health care within their health domains.

III. Access to TM

An in-depth analysis of the above legal framework on TM reveals that, people in the DRC can access TM in three main ways. Firstly, individuals can directly use medicinal plants or parts of animals known for their therapeutic properties in the community. Secondly, people can get TM through "Traditional Medicine Care Centres," which are the legal premises for the delivery of TM services by TMPs.[142] Thirdly, people can access TM services provided by TMPs within modern healthcare facilities. As indicated earlier, TMPs are entitled to develop partnerships or sign collaboration agreements with conventional health institutions, including hospitals and pharmacies, whether public or private, to practice or provide TM.[143] In these collaboration agreements, TM practitioners' intellectual rights and fair remuneration from their traditional services, must be protected and guaranteed.[144] However, several factors still limit access to TM, as discussed in the following subsection.

138 Ministère de la Santé Publique : Plan National de Développement Sanitaire 2016-2020 : vers la couverture sanitaire universelle, 2016.

139 *Starmans Bofoe Lokangu*, La criminalité pharmaceutique en République Démocratique du Congo. Une véritable menace au droit à la santé, Paris 2019, p. 30.

140 Public Health Law, art 143.

141 Ibid. art 30.

142 TM Decree.

143 TM Decree, arts 6 and 7.

144 Ibid. art 6.

IV. Limited access to TM due to the survival of the impact of colonial legislation on existing protection and regulation for TM

The DRC adopted an impressive number of legal measures dealing with TM since the country's independence in 1960. However, existing implementation measures on the regulation and protection of TM seem similar to the 1952 Decree in many respects, reflecting, therefore, the survival of colonial legislation's impact on the current legal marginalization of TM. Consequently, they still contain some shortfalls that limit access to good-quality TM, which is available and accessible, as illustrated under the present subsection. These shortfalls relate to the availability and accessibility of TM (1) and its quality (2).

1. Factors impeding availability and accessibility to TM

Factors limiting the availability and accessibility to TM relate to the divide between rural and urban areas (a), the failure of modern public health institutions to provide TM (b), and the omission of TM services by social security laws (c).

a) The divide between rural-urban areas in the provision of TM

As part of the right to health protected under the ratified human rights treaties, the DRC Constitution, and other domestic laws, TM must be available and accessible within the country's jurisdiction without geographical limitation. However, like the 1952 Decree, the TM Decree reiterates the view that TM is mainly practiced in rural areas. This provision has the potential to limit access to TM in urban areas. It is worth recalling that, unlike the 1952 Decree, the TM Decree contains provisions allowing the practice of TM in urban regions under some circumstances. Further, the Public Health Law does not distinguish between rural and urban areas regarding TM.

b) Lack of provision for TM by modern public health institutions

To make medicines available and accessible within their jurisdictions, governments resort mainly to their provider and regulatory functions.[145] The provider function allows States to provide medicines within their public health institutions, including hospitals, clinics, pharmacies, and dispensaries. However, like the 1952 Decree, subsequently adopted legislation and regulations on TM do not expressly provide for the provision of TM by public health hospitals and clinics. Instead, they mainly consider TM as an exclusive realm of private TMPs. However, as indicated earlier, the TM Decree contains a progressive and advanced provision that allows the provision of TM by TMPs within a modern public

145 *Dady Mumbanika Mbwisi*, Access to medicines in the Democratic Republic of the Congo and the United Republic of Tanzania from a least developed country perspective, Berlin 2022, pp 119-120.

health institution, under their responsibility, and after the conclusion of a collaboration contract with the said health facility.

Without such an agreement, people cannot access TM within public health facilities. It is worth recalling that the present study maintains that treaty provisions on the right to health are broad enough to cover all modern, traditional,[146] and complementary medicines.[147] The same affirmation applies to the constitutional and legislative provisions dealing with the right to health in the DRC.[148] Therefore, the DRC is under the treaty,[149] constitutional[150] and legislative[151] obligations to give effect to TM. These obligations to respect, protect and fulfil TM as part of the right to health, should aim to make TM of good quality, including ameliorated traditional medicines (ATM),[152] available and accessible within public health institutions.[153] Regarding the obligation to fulfil in particular, it requires among others, the provision of health care and that of a sufficient number of hospitals, clinics and other health-related facilities by State parties.[154] In addition to complying with the duty to create conditions that assure to all medical service and medical attention in the event of sickness, the provision of TM within and by public hospitals is also consistent with the duty to prevent, treat or control diseases.[155] Thus, the State's failure to provide TM at public health institutions is inconsistent with the specific duty to fulfil, which consists of taking all the necessary steps to realize TM as a particular form of the right to health.[156]

c) Failure by social security laws to explicitly cover TM

The Public Health Law entitles all the universal health coverage system beneficiaries to the consumption of quality health care and services at an affordable cost,[157] without limitation.

146 *Mumbanika*, note 146, pp. 179-180.

147 *Angela Doolan / Greg Carne*, "Evolution and Complementarity? Traditional and Complementary Medicine as Part of the International Human Rights Law Right to Health", Bond Law Review 32 (2020), p. 70.

148 *Mumbanika*, note 146, pp. 200-201.

149 Treaty general and specific obligations to implement TM as part of the right to health consist of, among others, articles 2 (1) and 12 of the ICESCR and 1 and 16 of the African Charter.

150 DRC Constitution, arts 47 and 60.

151 Public Health Law, arts 59 and 60.

152 Decree on the Registration of Pharmaceuticals), art 2.

153 General Comment 14, para 12.

154 Ibid. Para 36.

155 ICESCR, art 12 (2) (c) (d), and art 16 of the African Charter. See also Angela Doolan and Greg Carne, 69.

156 General Comment 14, para 52.

157 Public Health Law, art 41 and 43.

However, legislation and regulations that cover medical costs as part of health insurance[158] or social benefits[159] do not make provisions for reimbursement of medical expenses for TM health services. Instead, they only cover medical expenses for healthcare services provided in official hospitals, preselected healthcare facilities, or accredited healthcare providers without express reference to TM facilities. As a result, the above laws and regulations impede their beneficiaries from accessing TM without explicit and justified grounds. Besides, they infringe on insured people's freedom to resort to health services of their choice. It is submitted that in countries with insurance systems, reimbursement for traditional therapies depends on the evidence of their therapeutic effectiveness.[160] However, it is unclear whether the burden of providing proof of TM's efficacy rests with insured persons or THPs. Further, justification based on the effectiveness of TM cannot stand in the context of DRC since it conflicts with the country's commitment to the legal recognition and protection of TM.

It is worth noting that, in allowing public physicians and insured persons to resort to "other medical means" or "health services provided by non-selected medical facilities" in the event of absolute necessity or force majeure, articles 31 of the Public Physicians Decree and 69 of the Social Security Law, can be broadly interpreted to include health care received in TM facilities. These exceptions emphasize the relevance of ensuring an appropriate collaboration of modern and traditional health systems to provide patients with a wide choice of healthcare providers.[161]

2. Factors limiting access to TM of good quality

Factors that can limit access to TM of good quality are related to the sanction regime (a) and control mechanism (b).

a) Lack of an appropriate sanction regime

The obligation to protect the right to health, including TM, entails the State's duty to ensure that privatization of the health sector does not threaten the availability, accessibility, and quality of health facilities, goods, and services.[162] The State is further under the obligation to control the marketing of medical equipment and medicines by third parties and to ensure that medical practitioners and other health professionals meet appropriate standards of

158 Décret n° 22/13 du 09 avril 2022 portant organisation et fonctionnement d'un Etablissement public dénommé Fonds de Solidarité de Santé « FSS » en sigle, art 3.

159 Social Security Law, art 69 and Public Physicians Decree, art 31.

160 *Kabengele* et al., note 20, p. 51.

161 *Gebremichael Habtom*, Perceptions and attitudes of modern and traditional medical practitioners about traditional medical practice in Eritrea, Int J Complement Alt Med 11 (2018), p. 17.

162 General Comment 14, para 35.

education, skill, and ethical codes of conduct.[163] To State must provide appropriate penal sanctions to ensure compliance with these provisions. However, like the 1952 Decree, existing legislation and regulation do not provide appropriate sanctions against individuals who can exercise TM without regard to the prescribed standards. The failure to punish bad practices associated with TM's provision and use amounts to the State's violation to protect people' health from third parties.[164] The absence of appropriate criminal sanctions contradicts the State's duty to discourage continued observance and practice of harmful traditional medical activities.

b) The absence of a specific supervisory body in charge of TM

An essential aspect of the obligation to protect the right to health is the establishment of appropriate control quality mechanisms, which ensure control of TMPs, used premises, materials, and products following the established standards of education, skill, and ethical codes of conduct. In the United Republic of Tanzania, for instance, the Traditional and Alternative Health Practice Council supervises and controls the practice of TM and protects the society from its eventual abuse,[165] while the Tanzania Food and Drugs Authority (TFDA) is the regulatory organ for modern medicines.[166] In DRC, the regulatory authority for medicines is vested with "Autorité Congolaise de Règlementation Pharmaceutique" (ACOREP).[167] However, except for the ACOREP's mission to authorize and control the sale of herbal medicines, the Decree establishing ACOREP does not explicitly empower it to ensure control quality for TM.[168]

E. Conclusion and recommendations

The protection and regulation of TM in DRC are justified by a combination of internal and external factors. Internal factors include accessibility to medicinal plants, animals, and minerals and people's use of TM since immemorial. Whereas external factors comprise the influence of the African Charter, the ICESCR, and the AOU Declaration on TM, the provisions cover TM as part of the rights to health and natural resources. However, existing implementation measures on TM do still contain some gaps, which limit access to TM of

163 Ibid.

164 Ibid. Para 51.

165 In carrying out its functions, the Council inspects and scrutinizes practitioners' practicing premises and terminates or suspends operations, permits, or professional certificates to practice as an aid or THP. See Traditional and Alternative Medicines Act, 2002, arts 4, 6, and 7.

166 Tanzania Food, Drugs and Cosmetics Act, 2003, arts 4 and 5.

167 Décret n° 20/002 du 05 mars 2020 portant création, organisation et fonctionnement d'un Etablissement public dénommé Autorité congolaise de Règlementation Pharmaceutique, en sigle " ACOREP, arts 1 et 4.

168 Ibid.

good quality, such as the failure of public health institutions to provide TM, the omission by social security laws to cover TM services explicitly, and the view that TM should be mainly practiced in rural areas. Further legal obstacles include the absence of an explicit and appropriate sanction in case of non-compliance with the existing regulation on TM and the lack of a body vested with the power to control and supervise the practice of TM. Therefore, the following recommendations are made to tackle the above- identified legal impediments to accessing TM in DRC.

First, the Congolese government is under the legal obligation to make TM available and accessible throughout the country without limitation. Actions to be taken in that regard should include the provision of TM by and within public health hospitals and clinics, the suppression of the condition that TM is mainly exercised in rural areas, and explicit consideration of TM services by social security laws and health insurance laws. Further actions should include provisions for transfer systems between TM facilities and between the latter and modern hospitals. Secondly, the government should ensure the quality of TM through implementation measures that provide, among others, appropriate control quality mechanisms and adequate penal sanction regimes. Furthermore, as part of its obligations to fulfil and protect the right to health, the DRC must disseminate appropriate information relating to harmful traditional practices and discourage the continued observance of harmful traditional medical practices.[169]

169 General Comment 14, paras 37 and 51.