

Southern African Development Community, African Regional Bodies

Protocol on Health in the Southern African Development Community

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Protocol on Health in the Southern African Development Community
 Contents

Article 1 – Definitions and abbreviations 2

 Subdivision – Definitions 2

 Subdivision – Abbreviations 3

Article 2 – Principles 3

 Subparagraph a) 3

 Subparagraph b) 3

 Subparagraph c) 3

 Subparagraph d) 3

 Subparagraph e) 3

Article 3 – Objectives 3

 Subparagraph a) 3

 Subparagraph b) 3

 Subparagraph c) 3

 Subparagraph d) 3

 Subparagraph e) 3

 Subparagraph f) 3

 Subparagraph g) 4

 Subparagraph h) 4

 Subparagraph i) 4

Article 4 – Institutional mechanisms 4

 Subdivision – The Health Sector 4

 Paragraph 1. 4

 Subparagraph (a) 4

 Subparagraph (b) 4

 Subparagraph (c) 4

 Subparagraph (d) 4

 Subdivision – Health Sector Co-ordinating Unit 4

 Paragraph 2. 4

 Paragraph 3. 4

 Paragraph 4. 4

 Subparagraph a) 4

 Subparagraph b) 4

 Subparagraph c) 4

 Subparagraph d) 4

Subparagraph e)	4
Subparagraph f)	4
Subparagraph g)	4
Subparagraph h)	4
Subdivision – Health Sector Committee of Ministers	4
Paragraph 5.	4
Paragraph 6.	5
Subparagraph a)	5
Subparagraph b)	5
Subparagraph c)	5
Subparagraph d)	5
Subparagraph e)	5
Subdivision – Health Sector Committee of Senior Officials	5
Paragraph 7.	5
Paragraph 8.	5
Paragraph 9.	5
Paragraph 10.	5
Subparagraph a)	5
Subparagraph b)	5
Subparagraph c)	5
Subparagraph d)	5
Subparagraph e)	5
Subdivision – Technical committees	5
Paragraph 11.	5
Paragraph 12.	5
Article 5 – Financial provisions	5
Paragraph 1.	5
Paragraph 2.	5
Paragraph 3.	6
Paragraph 4.	6
Paragraph 5.	6
Article 6 – Health systems research and surveillance	6
Subparagraph a)	6
Subparagraph b)	6
Subparagraph c)	6

Article 7 – Health information systems	6
Subparagraph a)	6
Subparagraph b)	6
Subparagraph c)	6
Subparagraph d)	6
Subparagraph e)	6
Article 8 – Health promotion and education	6
Subparagraph a)	6
Subparagraph b)	6
Subparagraph (i)	6
Subparagraph (ii)	6
Subparagraph (iii)	6
Article 9 – Communicable disease control	6
Paragraph 1.	6
Subparagraph a)	6
Subparagraph b)	6
Subparagraph c)	7
Subparagraph d)	7
Subparagraph (i)	7
Subparagraph (ii)	7
Subparagraph (iii)	7
Paragraph 2.	7
Article 10 – HIV/AIDS and sexually transmitted diseases	7
Article 11 – Malaria control	7
Paragraph 1.	7
Paragraph 2.	7
Subparagraph a)	7
Subparagraph b)	7
Subparagraph c)	7
Article 12 – Tuberculosis control	7
Subparagraph a)	7
Subparagraph b)	7
Article 13 – Non-communicable disease control	7
Subparagraph a)	7
Subparagraph b)	7

Article 14 – Chronic diseases and conditions of older persons	7
Subparagraph a)	7
Subparagraph b)	8
Article 15 – Disabilities	8
Subparagraph a)	8
Subparagraph b)	8
Subparagraph c)	8
Article 16 – Reproductive health	8
Subparagraph a)	8
Subparagraph b)	8
Subparagraph c)	8
Subparagraph d)	8
Article 17 – Childhood and adolescent health	8
Subparagraph a)	8
Subparagraph b)	8
Subparagraph c)	8
Article 18 – Health human resources development	8
Subparagraph a)	8
Subparagraph b)	8
Subparagraph c)	8
Subparagraph d)	8
Subparagraph e)	8
Article 19 – Health care resources	9
Subparagraph a)	9
Subparagraph b)	9
Article 20 – Traditional health practitioners	9
Article 21 – Prevention and treatment of trauma	9
Subparagraph a)	9
Subparagraph b)	9
Subparagraph c)	9
Subparagraph d)	9
Article 22 – Mental health	9
Subparagraph a)	9
Subparagraph b)	9
Subparagraph c)	9

Subparagraph d)	9
Subparagraph e)	9
Article 23 – Environmental health	9
Article 24 – Occupational health	9
Article 25 – Emergency health services and disaster management	10
Subparagraph a)	10
Subparagraph b)	10
Subparagraph c)	10
Article 26 – Health laboratory services	10
Subparagraph a)	10
Subparagraph b)	10
Article 27 – Health technology and equipment	10
Subparagraph a)	10
Subparagraph b)	10
Subparagraph c)	10
Subparagraph d)	10
Article 28 – Referral systems	10
Subparagraph a)	10
Subparagraph b)	10
Subparagraph c)	10
Article 29 – Pharmaceuticals	10
Subparagraph a)	10
Subparagraph b)	10
Subparagraph c)	10
Subparagraph d)	10
Subparagraph e)	11
Subparagraph f)	11
Article 30 – Settlement of disputes	11
Article 31 – Sanctions	11
Paragraph 1.	11
Subparagraph a)	11
Subparagraph b)	11
Paragraph 2.	11
Article 32 – Signature	11
Article 33 – Ratification	11

Article 34 – Accession	11
Article 35 – Entry into force	11
Article 36 – Withdrawal	11
Paragraph 1.	11
Paragraph 2.	11
Article 37 – Depositary	12
Paragraph 1.	12
Paragraph 2.	12
Article 38 – Annexes	12
Paragraph 1.	12
Paragraph 2.	12
Article 39 – Amendment	12
Paragraph 1.	12

Southern African Development Community

Protocol on Health in the Southern African Development Community

Published

Commenced in full on 14 August 2004

[This is the version of this document at 18 August 1999.]

Preamble

WE, the Heads of State or Government of:

The Republic of Angola

The Republic of Botswana

The Democratic Republic of Congo

The Kingdom of Lesotho

The Republic of Malawi

The Republic of Mauritius

The Republic of Mozambique

The Republic of Namibia

The Republic of Seychelles

The Republic of South Africa

The Kingdom of Swaziland

The United Republic of Tanzania

The Republic of Zambia and

The Republic of Zimbabwe

CONSIDERING Article 21 and 22 of the Treaty, which respectively provide for areas of co-operation and the conclusion of Protocols in the areas of co-operation;

MINDFUL that Member States agreed on a policy framework document adopted by the Council in Grand Baie, Mauritius in September, 1998, which forms the basis for co-operation under this Protocol;

AWARE that a healthy population is a prerequisite for sustainable human development and increased productivity in Member States;

RECOGNISING that close co-operation in the area of health is essential for the effective control of communicable diseases, non-communicable diseases and for addressing common health concerns in the Region;

ASPIRING to offer a full range of cost effective and quality integrated health services through regional co-operation;

CONVINCED that rendering co-ordinated and comprehensive health services in a concerted manner is a prerequisite for the improved health status of people of the Region in the 21st century and beyond; and

DESIROUS of realising the aspirations of regional co-operation and integration in the area of health;

HEREBY AGREE as follows:

Article 1 – Definitions and abbreviations

Definitions

In this Protocol, terms and expressions defined in Article 1 of the Treaty shall bear the same meaning unless the context otherwise requires.

In this Protocol, unless the context otherwise requires—

“**Adolescence**” means the age from ten to nineteen years;

“**Chronic Diseases**” means diseases having a long course;

“**Director**” means the Head of the Health Sector Co-ordinating Unit;

“**Disability**” means any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being;

“**Expanded response to HIV/AIDS**” means the response that goes beyond the Health Sector involving all other sectors as equal partners;

“**Health Promotion**” means the process of enabling people to increase control over, and to improve their health;

“**Health Sector**” means the body duly constituted as provided for in the Treaty;

“**Health Sector Committee of Ministers**” means the Committee of Ministers set forth in Article 4 of this Protocol;

“**Health Sector Committee of Senior Officials**” means the Committee of Officials set forth in Article 4 of this Protocol;

“**Health Sector Co--ordinating Unit**” means the executing organ for the purpose of co-ordinating the activities of the Health Sector;

“**Mental Health**” means a state of mental well-being;

“**Older Person**” means a person aged 65 years or above;

“**Primary Health Care**” means essential health care based on appropriate, acceptable methods and technology, made universally accessible through community participation;

“**Public Health**” means the effort of society to protect, promote and restore the people’s health through health-related activities in order to reduce the amount of diseases, premature death, and reduce discomfort and disability in the population;

“**Reproductive Health**” means the state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity, in all matters related to the reproductive system and to its functions and processes;

“**Senior Official**” means a Permanent Secretary or person of equivalent rank appointed to the Health Sector Committee of Senior Officials by each Member State;

“**Signatory**” means a Member State of SADC which is signatory to this Protocol;

“**State Party**” means a Member State that ratifies or accedes to this Protocol;

“**Technical Sub-Committee**” means the committee set forth in Article 4 of this Protocol;

“**Tele-Health**” means telemedicine together with distance learning;

“**Telemedicine**” means the use of information and telecommunication technologies to provide health services and medical information at a distance;

“**Traditional Health Practitioners**” means people who use the total combination of knowledge and practices, whether explicable or not, in diagnosing, preventing or eliminating a physical, mental or social disease and in this respect may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing, while bearing in mind the original concept of nature which included the material world, the sociological environment whether living or dead and the metaphysical forces of the universe;

Abbreviations

AIDS Acquired Immune Deficiency Syndrome

HIV Human Immune Deficiency Virus

HSCM Health Sector Committee of Ministers

HSCSO Health Sector Committee of Senior Officials

HSCU Health Sector Committee Co-ordinating Unit

SADC Southern African Development Community

STDs Sexually Transmitted Diseases

Article 2 – Principles

State Parties shall act in common in pursuit of the objectives of this Protocol, which shall be implemented in accordance with the following principles:

- a) striving for the formulation of regional health policies and strategies consistent with the principles contained in Article 4 of the Treaty;
- b) promoting, co-ordinating and supporting individual and collective efforts of State Parties to attain an acceptable standard of health for all their people;
- c) a commitment to the Primary Health Care approach;
- d) promoting health care for all through better access to health services; and
- e) ensuring equitable and broad participation for mutual benefit in regional co-operation in health.

Article 3 – Objectives

State Parties shall co-operate in addressing health problems and challenges facing them through effective regional collaboration and mutual support under this Protocol for the purposes of achieving the following objectives:

- a) to identify, promote, co-ordinate and support those activities that have the potential to improve the health of the population within the Region;
- b) to co-ordinate regional efforts on epidemic preparedness, mapping, prevention, control and where possible the eradication of communicable and non-communicable diseases;
- c) to promote and co-ordinate the development, education, training and effective utilisation of health personnel and facilities;
- d) to facilitate the establishment of a mechanism for the referral of patients for tertiary care;
- e) to foster co-operation and co-ordination in the area of health with international organisations and co-operating partners;
- f) to promote and co-ordinate laboratory services in the area of health;

- g) to develop common strategies to address the health needs of women, children and other vulnerable groups;
- h) to progressively achieve equivalence, harmonisation and standardisation in the provision of health services in the Region; and
- i) to collaborate and co-operate with other relevant SADC sectors.

Article 4 – Institutional mechanisms

The Health Sector

1. Member States hereby establish institutional mechanisms within the Health Sector necessary for the effective implementation of this Protocol. The institutional mechanisms shall be:
 - (a) The Health Sector Co-ordinating Unit (HSCU);
 - (b) Health Sector Committee of Ministers (HSCM);
 - (c) The Health Sector Committee of Senior Officials (HSCSO); and
 - (d) Technical Sub-Committees.

Health Sector Co-ordinating Unit

2. The HSCU shall be the executing organ of the Health Sector.
3. The HSCU shall be headed by a Director who shall be appointed by the Member State responsible for co-ordinating the Health Sector and shall be assisted by a complement of qualified and experienced personnel in the relevant fields.
4. The functions of the HSCU shall be to:
 - a) provide leadership in the articulation of the objectives of the Health Sector, including the preparation of necessary documentation on issues affecting the Health Sector, as well as initiating sectoral plans and projects;
 - b) advise Member States on matters pertaining to the development of the Health Sector;
 - c) organise and manage all policy and technical meetings of the Health Sector;
 - d) prepare annual reports of the Health Sector;
 - e) draft terms of reference for consultancies and studies as well as manage consultants hired by the Health Sector;
 - f) convey to and follow-up with relevant parties the decisions of the HSCM and the Council;
 - g) mobilise financial and technical resources for the implementation of the programmes and projects of the Health Sector; and
 - h) carry out any other activity aimed at the promotion of the work of the Health Sector.

Health Sector Committee of Ministers

5. The HSCM shall comprise the Ministers responsible for health issues in Member States.

6. The functions of the HSCM shall be to:
 - a) provide guidance and co-ordination of policies, programmes and projects for the Health Sector;
 - b) advise Council on policies to be addressed by the Health Sector;
 - c) liaise with the Secretariat on matters pertaining to the Health Sector; and
 - d) establish sub-committees and other institutional mechanisms for the work of the Health Sector.
 - e) The HSCM shall meet at least once a year under the chairpersonship of the Member State co-ordinating the Health Sector.

Health Sector Committee of Senior Officials

7. HSCSO shall comprise the Permanent Secretaries or persons of equivalent rank responsible for health in Member States.
8. The HSCSO shall meet at least once a year under the chairpersonship of the Member State co-ordinating the Sector.
9. Members of the HSCSO shall also be the Contact Points for the Health Sector in Member States, and be responsible for co-ordinating the participation of Member States in the work of the Sector. Each Health Sector Contact Point shall establish and maintain effective consultation with the Health Sector Co-ordinating Unit on matters concerning the Health Sector in Member States.
10. The functions of the HSCSO are the following:
 - a) to be the clearing house for the HSCM, and examine all reports and documents put before it by the HSCU, the Secretariat and technical sub-committees;
 - b) to advise the HSCM on issues, proposals and projects to be presented to the Council for consideration and approval;
 - c) to review the Health Sector Programme of Action to ensure that it is consistent with the objectives of the Health Sector and those of SADC;
 - d) to receive all communications from the HSCU pertaining to the work of the Health Sector and ensure that the relevant national institutions and key stakeholders, including the private sector, are kept informed of the work of the Sector; and
 - e) to report to the HSCM on matters relating to the implementation of the provisions contained in this Protocol.

Technical committees

11. There shall be technical sub-committees established to assist in the technical work of the Health Sector.
12. The composition and functions of the technical sub-committees shall be determined by the HSCM which may delegate this function to the HSCSO.

Article 5 – Financial provisions

1. Member States shall bear their own costs for participating at the regular and annual meetings of the Health Sector, except that the costs of the HSCU shall be borne by the Member State co-ordinating the Health Sector.
2. Projects, programmes and special studies may be financed from various sources and stakeholders such as international organisations and co-operating partners (donors), or contributions by Member States.

3. The Health Sector may accept gifts, grants, legacies, and donations from any source provided that this shall be done in conformity with the objectives of this Protocol, and any guidelines that may be determined by the HSCM. Information relating to such assistance shall be conveyed to the HSCM.
4. The HSCM shall consider and approve arrangements proposed by the HSCU for the self-generation of funds by the Health Sector.
5. Paragraphs 2, 3 and 4 shall not be construed as prohibiting subsidiary agreements for the purpose of adopting any other financing arrangements, provided that they are based on equity balance and a benefit to SADC.

Article 6 – Health systems research and surveillance

Member States shall—

- a) share information on health systems research and surveillance and co-operate and assist each other in its dissemination;
- b) identify and conduct health systems research using, among others, the Essential Regional Health Research; and
- c) co-operate and assist each other in regional surveillance with respect to communicable and non-communicable diseases, and to develop a common set of indicators for these diseases.

Article 7 – Health information systems

In order to ensure access to good quality health data and its use in planning and managing health systems, State Parties shall develop and formulate coherent, comparable, harmonised and standardised policies with regard to:

- a) development of a health information systems policy framework;
- b) development of common definitions and a common data dictionary;
- c) establishment of mechanisms for information exchange;
- d) establishment of a SADC Regional Data of Health and Social Service Indicators; and
- e) development of Tele-Health applications.

Article 8 – Health promotion and education

State Parties shall—

- a) co-ordinate efforts to prevent diseases and promote the well-being;
- b) formulate and implement appropriate policies with respect to:
 - (i) mechanisms to co-ordinate regional health promotion and education;
 - (ii) appropriate guidelines and material for health promotion and education; and
 - (iii) guidelines on healthy lifestyle and reduction of substance abuse.

Article 9 – Communicable disease control

1. State Parties shall co-operate to harmonise, and where appropriate, standardise policies in the areas of—
 - a) case definitions for diseases;
 - b) notification systems; and

- c) develop regional policies and plans that recognise the intersectoral impact of HIV/AIDS/STDs and the need for an intersectoral approach to these diseases; and
 - d) co-operate in the areas of—
 - (i) standardisation of HIV/AIDS/STDs surveillance systems in order to facilitate collation of information which has a regional impact;
 - (ii) regional advocacy efforts to increase commitment to the expanded response to HIV/AIDS/STDs; and
 - (iii) sharing of information.
2. State Parties shall endeavour to provide high-risk and transborder populations with preventative and basic curative services for HIV/AIDS/STDs.

Article 10 – HIV/AIDS and sexually transmitted diseases

[Please note: text of Article 10 is missing in the original.]

Article 11 – Malaria control

1. State Parties shall establish efficient mechanisms for the effective control of malaria in the Region.
2. State Parties shall co-operate and assist one another in order to reduce the prevalence of malaria, and with support from stakeholder, ensure the optimal use of resources for, *inter alia*—
 - a) sharing scarce technical resources and operational research;
 - b) harmonising goals, policies, guidelines, protocols, interventions and treatment regimens; and
 - c) integrating malaria control mechanisms into Primary Health Care Services.

Article 12 – Tuberculosis control

State Parties shall co-operate and assist one another:

- a) to develop strategies for the sustained control of tuberculosis, including the efficient supply and delivery of drugs; and
- b) to ensure, where appropriate, the harmonisation of tuberculosis control activities and HIV/AIDS programmes.

Article 13 – Non-communicable disease control

State Parties shall co-operate and assist one another to:

- a) define the magnitude of non-communicable diseases and risk factors; and
- b) adopt appropriate strategies for the prevention and control of non-communicable diseases.

Article 14 – Chronic diseases and conditions of older persons

State Parties shall co-operate and assist one another to:

- a) promote healthy lifestyles and to prevent and manage chronic diseases and conditions of Older Persons; and

- b) harmonise and standardise guidelines for the prevention, early detection, management and control of priority chronic diseases and conditions of older Persons.

Article 15 – Disabilities

State Parties shall co-operate and assist one another to:

- a) promote effective measures to prevent and manage disabilities;
- b) increase access to improved technology related to assistive devices and the creation of a barrier free environment for the equalisation of opportunities for persons with disabilities; and
- c) promote community-based rehabilitation programmes.

Article 16 – Reproductive health

State Parties shall formulate coherent, comparable, harmonised or standardised policies, strategies, programmes and procedures for reproductive health, particularly in:

- a) developing a surveillance system for monitoring maternal mortality;
- b) developing strategies to reduce maternal mortality;
- c) the reduction of genetic and congenital disorders leading to birth defects; and
- d) empowering men, women and communities at large to have access to safe, effective, affordable and acceptable methods for the regulation of fertility.

Article 17 – Childhood and adolescent health

In order to provide for appropriate child and adolescent health services essential for the critical foundation for growth and development of children, State Parties shall:

- a) co-operate in improving the health status of children and adolescents;
- b) develop and formulate coherent and standardised policies and set out targets with regard to child and adolescent health; and
- c) encourage adolescents to delay engaging in early sexual activity which may result in unwanted teenage pregnancies.

Article 18 – Health human resources development

State Parties shall, consistent with the Protocol on Education and training, co-operate in the development and utilisation of health personnel in, *inter alia*:

- a) curriculum development for health professional training;
- b) undergraduate and postgraduate training;
- c) health research training;
- d) exchange programmes; and
- e) accreditation of health professionals.

Article 19 – Health care resources

State Parties shall explore and share experience with regard to:

- a) alternative and effective strategies for the mobilisation of sustainable funding for health services, particularly additional sources of revenue; and
- b) optimal and efficient mechanisms for the allocation, utilisation and monitoring of health resources.

Article 20 – Traditional health practitioners

State Parties shall endeavour to develop mechanisms to regulate the practice of traditional healing and for co-operation with traditional health practitioners.

Article 21 – Prevention and treatment of trauma

Member States shall—

- a) co-operate and assist one another in the development and formulation of coherent and comparable standards to address the consequences of trauma in respect of its health effects;
- b) co-operate to promote a public health approach to the prevention of violence, particularly domestic violence, and road traffic accidents;
- c) collaborate in dealing with the health consequences of landmines; and
- d) share resources and experiences in the prevention and treatment of trauma.

Article 22 – Mental health

In order to promote mental well-being which is critical to sustained human and economic growth, State Parties shall co-operate and assist one another with regard to:

- a) developing compatible legislation in respect of mental health;
- b) developing regional guidelines for training, and the integration of mental health services into primary health care;
- c) the provision of proper treatment and care that respects the dignity and human rights of mentally ill persons;
- d) the development of supportive community care services and facilities; and
- e) cost-effective and culture specific mental health research.

Article 23 – Environmental health

State Parties shall collaborate, co-operate and assist each other in a cross-sectoral approach in addressing regional environmental health issues and other concerns, including toxic waste, waste management, port health services, pollution of air, land and water, and the degradation of natural resources.

Article 24 – Occupational health

In order to cater for the cross-sectoral nature of occupational health, State Parties shall assist each other in the development and delivery of integrated occupational health services and co-operate in reducing the prevalence of occupational injuries and diseases.

Article 25 – Emergency health services and disaster management

State Parties shall:

- a) co-operate and assist each other in the co-ordination and management of disaster and emergency situations;
- b) collaborate and facilitate regional efforts in developing awareness, risk reduction, preparedness and management plans for natural and man-made disasters; and
- c) develop mechanisms for co-operation and assistance with emergency services.

Article 26 – Health laboratory services

State Parties shall:

- a) co-operate and support one another to develop acceptable standards in laboratory services and the training of medical laboratory scientists; and
- b) develop coherent regional policies and strategies to strengthen laboratory services and quality assurance.

Article 27 – Health technology and equipment

State Parties shall co-operate in the:

- a) development and formulation of coherent, comparable, harmonised and standardised policies and strategies on health technology and equipment;
- b) procurement and maintenance of equipment;
- c) sharing of information, training and skills development on particular equipment; and
- d) control of ionising radiation and radioactive material.

Article 28 – Referral systems

State Parties shall co-operate and assist one another in the harmonisation of policies, mechanisms, procedures and strategies with regard to tertiary care services including—

- a) the establishment of appropriate clinical and administrative guidelines for referral, within and between State Parties;
- b) progressively building capacity in State Parties to provide appropriate high quality specialised care through the exchange and attachment of specialists in the Region; and
- c) the sharing of information on centres of excellence in the Region.

Article 29 – Pharmaceuticals

State Parties shall co-operate and assist one another in the:

- a) harmonisation of procedures of pharmaceuticals, quality assurance and registration;
- b) production, procurement and distribution of affordable essential drugs;
- c) development and strengthening of an Essential Drugs Programme and the promotion of the rational use of drugs;
- d) development of mechanisms for quality assurance in the supply and conveyance of vaccines, blood and blood products;

- e) research and documentation on traditional medicine and its utilisation; and
- f) establishment of a regional databank of traditional medicine, medicinal plants and procedures in order to ensure their protection in accordance with regimes and related intellectual property rights governing genetic resources, plant varieties and biotechnology.

Article 30 – Settlement of disputes

Any dispute arising from the interpretation or application of this Protocol, which cannot be settled amicably, shall be referred to the Tribunal.

Article 31 – Sanctions

1. Sanctions may be imposed against any State Party which:
 - a) persistently fails, without good reason, to fulfill obligations assumed under this Protocol; or
 - b) implements policies which undermine the objectives and principles of this Protocol.
2. The Council shall determine whether any sanction should be imposed against a State Party and shall make the recommendation to the Summit if it decides that a sanction is called for. The Summit shall decide, on a case-by-case basis, the appropriate sanction to be imposed.

Article 32 – Signature

This Protocol shall be signed by duly authorised representatives of the Member States.

Article 33 – Ratification

This Protocol shall be subject to ratification by the Signatories in accordance with their respective constitutional procedures.

Article 34 – Accession

This Protocol shall remain open for accession by any Member State.

Article 35 – Entry into force

This Protocol shall enter into force thirty (30) days after the deposit of instruments of ratification by two-thirds of the Member States.

Article 36 – Withdrawal

1. Any State Party may withdraw from this Protocol upon the expiration of twelve (12) months from the date of giving to the Executive Secretary a written notice to that effect.
2. Any State Party that has withdraw pursuant to paragraph I shall cease to enjoy all rights and benefits under this Protocol upon the withdrawal becoming effective but shall remain bound by the obligations herein for a period of twelve (12) months from the date of giving notice to the date the withdrawal becomes effective.

Article 37 – Depositary

1. The original texts of this Protocol and all instruments of ratification and accession shall be deposited with the Executive Secretary, who shall transmit certified copies to all Member States.
2. The Executive Secretary shall register this Protocol with the Secretariat of the United Nations and the Organisation of African Unity.

Article 38 – Annexes

1. State Parties may develop and adopt annexes for the implementation of this Protocol.
2. An Annex shall form an integral part of this Protocol.

Article 39 – Amendment

1. An amendment to this Protocol shall be in accordance with the procedures established in Article 36 of the Treaty.

IN WITNESS WHEREOF, WE, the Heads of State or Government, or duly authorised Representatives of SADC States, have signed this Protocol.

DONE at Maputo on this 18th day of 1999 August in three (3) original texts, in the English, French and Portuguese languages, all texts being equally authentic.