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Editorial

This edition of the *ESR Review* includes two feature articles on the enjoyment of socio-economic rights.

The first, by Ngcimezile Mbano-Mweso, examines whether a human right to water for food production should be recognised for women. The author hails the recognition of a human right to water as a both relevant and timely development in view of growing concerns about the numbers of people without access to water and the impact that this has on human life, poverty and development. She highlights the multiple uses of water besides the consumption and hygiene uses that international human rights recognise as the essence of the right to water, pointing out that access to water for livestock and small home gardens is essential to avert starvation and malnutrition in poor households. She argues that a rights-based approach to water for the poor should include a human right to water for food production as this would greatly contribute to poverty alleviation for women, who represent the majority of the world's poor. However, she concludes that access to water for subsistence farming would best be accommodated under the right to food due to several limiting factors under the right to water.

The second feature, by Amahirwe Denyse, probes the responsiveness of the affected states and the international community to the current Ebola outbreak in West Africa. Although the affected states have taken several measures to contain the spread of Ebola, these strategies fall short of the requirement to realise the right to the highest attainable standard of mental and physical health. For several months the Ebola outbreak was largely neglected by the developed countries and by established drug companies, despite it having fatality rates of up to 90% and killing 2 296 people in just nine months. The response of the affected states and the international community so far has been non-pro-active and flawed, despite the obligation upon states to work together to curb the spread of diseases that lead to unprecedented human suffering and loss.

The first item in the updates section is a brief outline of the report about the right to participation in the context of realising the human right to water, released by the UN Special Rapporteur on the right to water and sanitation in September 2014. The second update is about the first report of the new UN Special Rapporteur on extreme poverty and human rights, which was presented in October 2014 to the General Assembly. Its focus was the importance of the implementation of the right to social protection.

The events section summarises crucial discussions at the regional sensitisation seminar on the promotion of the African Court on Human and People's Rights for the Southern African region, which took place in Lusaka, Zambia from 15–17 October 2014.

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Poverty, women and the human right to water to grow food

Ngcimezile Mbano-Mweso

Introduction

The global community is united in its commitment to remove the scourge of world poverty. One core factor to achieve this is access to water from which poor people, especially women, draw multiple benefits.

Such benefits include enhanced livelihood security, generation of wealth, reduced health risks and vulnerability (Poverty Environment Partnership 2006). On another front lack of access to water is both a cause and consequence of poverty and inequality. It undermines productivity and economic growth, reinforcing the deep inequalities that characterise current patterns of globalisation and trapping vulnerable households in cycles of poverty (Human Development Report 2006). In order to reduce poverty, therefore, serious consideration needs to be given to guaranteeing access to water that goes beyond domestic uses. Productive uses of water at the household level that comprise mainly small-scale activities, including growing food and earning an income, would significantly impact the living standards of many people. Such uses of water include fruit and vegetable gardening, keeping livestock and brewing beer.

However, predominantly it involves small home gardens for vegetables and fruit. Home gardens are a source of nourishment and contribute to achieving a balanced diet from the different types of vegetables or fruits; they are also a source of income through the sale of the produce. The income generated contributes to livelihood essentials such as clothes, school fees or medicines. Advocates argue that this brings the access to water for home gardens within the primary use of water, like water for domestic purposes. It is further argued that women, who represent the majority living in extreme poverty, stand to benefit the most from such recognition as they are the ones that manage small gardens for their families, thereby ensuring food security and improving living standards.

This article discusses whether access to water for subsistence farming should be accommodated under the human right to water and the implication this might have.

The human right to water

Women are guaranteed a human right to water in the two main instruments dealing with womens' rights at the global and regional level. The right to water is understood within the right to an adequate standard of living and food security, both of which are linked to poverty alleviation.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is among the few human rights instruments at the global level that guarantee the human right to water, but specifically for rural woman. CEDAW, a landmark international agreement that affirms principles of human rights and equality for women, recognises the rural and urban divide and specifically aims to address discrimination or disadvantage based on locality or geography. In article 14, States Parties are enjoined to take into account the particular problems faced by rural women and the significant roles that they play in the economic survival of their families, including their work in the non-monetised sectors of the economy, and to take all appropriate measures to ensure the application of the provisions of CEDAW to women in rural areas. It then calls for the provision of infrastructure and basic needs, including education, health care, water, sanitation, electricity, transport, and communications infrastructure, as conditions for adequate living.

The right to an adequate standard of living guarantees necessary conditions of life sufficient for well-being and human development in terms of physical, moral and mental development (Craven 293). It has been connected to the conditions necessary to enable a person live in dignity, to participate in society and to make a living for themselves and their family.

The survival and livelihood interest that the right to adequate standard of living guarantees is best expressed in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 11(1) requires states to provide for:

> the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions.

The Committee on Economic, Social and Cultural Right (CESCR) established that the human right to water is implicitly included in the list of rights required to ensure an adequate standard of living in Article 11(1). In its General Comment 15, which is held as the most authoritative elaboration of the right at the global level, the CESCR mainly relies on the interdependence of human rights, especially the rights to an adequate standard of health, food, life and dignity, to arrive at an independent right to water in mainstream human rights instruments.

Of interest for this article is the right to an adequate standard of living, understood as a right to a livelihood contributing to the continuous improvement of living conditions. Water is essential for survival by meeting basic human needs but also as an enabling resource for livelihoods.

> The regional human right to water elaboration recognises the strong link between the right to water and food production

For poor households in the rural and peri-urban areas, water supports livelihoods through small home gardens, livestock rearing and micro-enterprises such as brewing beer, brick making and pottery. Further, an adequate supply of good quality water within a reasonable distance frees up time that would otherwise have to be spent in fetching water, as well as contributing to good health and ultimately enabling people to work (Corpa 2010). This is crucial for poor people, particularly women, who often constitute the majority of the poorest and disproportionately bear the burden of providing water for their families.

The CESCR defines the right to water as entitling everyone to sufficient, safe, acceptable, physically accessible and affordable water for personal and domestic uses (para 10). Personal and domestic use of water is defined narrowly as water to meet the human need for consumption, personal sanitation, washing of clothes, food preparation, personal and household hygiene (para 12). This narrow definition excludes an entitlement to water for home gardens and other essential livelihoods. This is odd, especially when the CESCR acknowledges Article 1 Paragraph 2 of the ICESCR, which provides that 'a people may not be deprived of its means of subsistence'.

Further, it makes calls on States Parties to ensure that there is adequate access to water for subsistence farming and for securing the livelihoods of indigenous peoples and disadvantaged and marginalised farmers, especially women (para 7). The CESCR also makes reference to the United Nations Convention on the Law of Non-Navigational Uses of Watercourses, which declares that, in determining vital human needs in the event of conflicts over the use of watercourses, special attention is to be paid to providing sufficient water to sustain human life, including both drinking water and water required for production of food in order to prevent starvation. Furthermore, the CESCR specifies that water for both domestic purposes and for the prevention of starvation and disease must be prioritised (para 6). However, the CESCR does not establish a human right to water for growing food or for securing a livelihood.

At the African regional level, women's right to water has also been specifically provided for in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol). Article 15 on the right to food security obliges States Parties to take appropriate measures to provide women with 'access to drinking water, sources of domestic fuel, land, and the means of producing nutritious food'. The Rome Declaration on World Food 1996 stated that poverty 'is a major cause of food insecurity and sustainable progress in poverty eradication is critical to improve access to food.'

Food security contributes to poverty reduction and development mainly through its contribution to health and to reducing families' health cost burden. Water is key to food security as no food can be produced without it. Unlike the CESCR, the regional human right to water elaboration recognises the strong link between the right to water and food production, which accounts for 70% of water use.

The African Human Rights Commission (African Commission) has interpreted the right to water as deriving from the right to health in several of the cases brought before it. For instance, in the *Centre on Housing Rights and Evictions v The Sudan*, the African Commission found that the right to water was violated when the government of Sudan poisoned water sources. It did not pronounce an independent human right but linked it to the right to health as an auxiliary right that is necessary to realise the right to health, which is explicitly provided for in the African Charter on Human and People's Rights (Article 16).

Further elaboration of this right is found in the Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and People's Rights (the Guidelines), where the African Commission stipulated that although the human right to water is not directly protected in the African Charter, it is implied in the protection of other rights. The Guidelines state:

> [t]he human right to water entitles everyone to sufficient, safe, acceptable, physically accessible and affordable water for personal, domestic, and agricultural uses (para 88).

As already alluded to, home gardens play a vital role in helping poor households supplement food security. They produce a source of nourishment to prevent starvation but also nutritious foods that may help avert malnutrition and micronutrient deficiencies, and hence prevent disease. Home gardens usually grow a variety of vegetables and require limited resources as they are usually small and use traditional methods and locally available planting materials.

They also free up income that would otherwise have been spent to acquire the same food at high prices. The produce from home gardens may also generate an income for the family and hence improve its financial status and help to meet its other day-to-day needs.

As most home gardens are managed by women, they may be the only source of an independent income and contribute to women's poverty alleviation. A guaranteed access to water as a human right for food production would therefore have a huge potential to impact on poverty.

The human right to water for growing food

In 2012, the UN Food and Agriculture Organization estimated that nearly 870 million people of the 7.1 billion people in the world were suffering from chronic undernourish-

ment in 2010–2012. People go hungry because they cannot afford to buy food. It is on record that in 2008, the surge in food prices drove 110 million people into poverty. The majority of these undernourished people are in developing countries where food insecurity is high. Chopra (2010) wrote that it is people who lack access to water that are more likely to face acute or chronic hunger and vice versa.

The right to food is dependent on access to water as no food can be produced without it. Further, the largest use of water is for growing food: agriculture accounts for 70% of all water use. It would therefore be important to recognise a human right to water for food production, to prevent starvation.

This point was raised by the UN Special Rapporteur on the Right to Food, J. Ziegler, when commenting on an initial draft of General Comment No. 15. He stated that water should be viewed as a source of food security and included in the content of the right to water besides domestic uses. Unfortunately the right to food elaborated in General Comment 12 does not highlight this link.

With the exception of the Guidelines by the African Commission, the general elaboration and understanding of the right to water mainly concentrates narrowly on the public health perspective and prioritises the provision of safe and clean water for drinking, sanitation hygiene, and other domestic activities. There are several reasons. First, any food production requires much higher water supplies than the requirement to meet the basic human needs that is recognised in domestic water uses. This is one consideration that Winkler (2008) advances against formulating a human right to water for growing food as a priority alongside domestic uses. Whereas the WHO has established that 100 litres per capita per day are sufficient for domestic purpose, at least 2 000 litres per capita per day are required for producing food (Howard & Bartram 2003: 22, World Water Assessment Programme 2006: 247).

It is therefore argued that including a human right to water for growing food would be guaranteeing claims to large quantities of water (Winkler 2008). Such large quantities could be guaranteed progressively after meeting domestic water requirements. However, thus far there has been no movement to operationalise the provision of water beyond the basic domestic requirement (Hall & Others 2013).

A second consideration regards the degree of reliance on water for both domestic uses and food production (Winkler 2008:3–4). Winkler argues that water for drinking, cooking, washing and personal hygiene cannot be substituted and require direct access to water. Food production or provision can, however, be met through a variety of means other than subsistence farming or direct access to water. Not everyone needs to produce food as it can easily be transported from one area to another, hence not all people depend on direct access to water resources to meet this need.

Unlike the rural and peri-urban areas, in the urban areas only a small portion of the population grows its own food. How would the amount of water for growing food be allocated, bearing this in mind? Biswas et al (2008) suggest several approaches, including the direct additional allocation of water to farmers with the expectation that they will grow food for many families. A register may also be used to capture and address the needs of subsistence farmers, just like the indigent register in South Africa which entitles poor households to an additional free basic water provision over and above that allocated to others. This right would not be for individuals to claim but would rather be a household right.

Furthermore, whereas water for domestic purposes aims to fulfil direct human water requirements such as for consumption and personal hygiene, the human right to water for food production would be fulfilling food requirements rather than water requirements. According to Winkler, this would unduly broaden and undermine the right to water, which will then be relied on for so many additional requirements such as water for energy production or transport (Winkler 2008:5).

This would make the right intangible and perhaps impossible to implement. However, to avoid including just any other human use of water under the human right to water, the survival interest test may be implored. The human right to water would only guarantee the amount of water necessary for survival, which would include water for food production to prevent death by starvation while excluding other uses within the priority guarantees.

Conclusion and recommendation

Although a human right to water for food production would greatly contribute to women's poverty alleviation through food security, nutrition and income generation, its recognition would make this right unnecessarily vague and difficult to implement universally. Food production requires much higher quantities of water and is not directly required by everyone as food security does not require food production by each person.

However, the vital role that water plays in the livelihoods of poor rural and peri-urban residents cannot be ignored and requires special protection.The right to water for growing food can be incorporated within the right to water through progressive interpretation that moves beyond the public health considerations of domestic water uses. This will, however, require dealing with several considerations on the implementation of such a right, including determining the right amounts of water and how to distribute it.

The human right to food offers the best legal protection for subsistence farmers and the best way to alleviate concerns around poverty alleviation, especially for women. The right to food is guaranteed in Article 11(2) of the ICESCR, which recognises the fundamental right of everyone to be free from hunger. Under this right, States Parties are obliged to prevent starvation as a priority, and to

guarantee access to the minimum food, in sufficient quantity and which is nutritionally adequate and safe, to ensure freedom from hunger (CESCR General Comment 12 para 14). The core content of the right to food covers the promotion of subsistence farmers and their need to access water as this would ensure that the minimum essential levels of food are met both through production and income generation. The right to food can therefore guarantee, as a priority, the water that is necessary for home gardens and thereby contribute to poverty alleviation.

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Universality of the right to the highest attainable standard of health; but whose responsibility?

The Ebola crisis in Africa

Amahirwe Denyse

Introduction

Four decades after the discovery of Ebola, the highest outbreak in history is currently under way and has caused the death of 2 296 people in nine months (WHO Ebola Response Team, 2014:1). Ebola is the deadliest disease: fatality rates are up to 90% (WHO fact sheet no. 103).

The current outbreak in West Africa is a serious test of the capacity of the affected states and the international community to guarantee the right to the highest attainable standard of health to the most affected population. The responsiveness of the affected states and the international community to the current Ebola outbreak is the topic of this paper. It revisits the states' obligations under international law to guarantee the right to health in the context of epidemics and diseases. Then, drawing on the reports of health organisations, affected states and the media, it assesses the interventions made by the states and the international community in line with their obligations to realise the right to health. Lastly, it calls for the rethinking of global cooperation in order to prevent such a loss of life from occuring again.

Overview of Ebola outbreak in West Africa

The first outbreak of Ebola, a highly infectious disease that is spread by contact with the blood, bodily fluids, or tissue of infected animals or humans, occurred in 1976 in the Democratic Republic of Congo (DRC) and Sudan. Other outbreaks were reported later, the major ones being in the DRC and Gabon (1995–1997), in Uganda (2000–2001), in Gabon and the Republic of Congo (2001–2003) and in Uganda and the DRC (2007–2008) (Center for Disease Control and Prevention, 2014). It is worth noting that although the Ebola outbreaks were in Africa, sporadic cases were reported in Western countries.

The current Ebola outbreak is the deadliest so far. It has killed 2 296 people in nine months, and has an estimated fatality rate of 70.8%. Since the first case was reported in Guinea, the disease has spread to six countries in West Africa (WHO Ebola Response Team, 2014:1). It has killed many physicians, health workers and social workers, which is unprecedented. According to the World Health Organisation (WHO), as of 8 September 2014, 152 social workers and four physicians had died (WHO, http://www.who.int/mediacentre/news/ebola/8-september-2014/en/). The ill-preparedness of hospitals in the most affected states (Sierra Leone, Liberia and Guinea), coupled with the fragility of these states, which were recovering from long periods of civil wars or dictatorships, has been said to have facilitated spread of the disease. Moreover, in the beginning it was considered a localised disease and thus attracted little attention from the international community. However, recently it has been qualified by WHO as a serious public health threat, deserving a strong multinational response. The question arising here is, whose responsibility is it to address such a situation?

Obligations to respond to diseases: A shared states' responsibility under international law

In terms of Article 12(2)(c) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), states have the responsibility to prevent, treat and control epidemic, endemic, occupational and other diseases in view of guaranteeing the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Although this right should be progressively realised by maximising available resources (Art. 2(1)), states have immediate obligations to guarantee the right to health without discrimination of any kind (Art. 2.2) and to take deliberate, concrete and targeted steps (Art. 2.1) towards the full realisation of this right (CESCR, para 30).

The right to health contains the interrelated elements, namely availability, accessibility, acceptability and quality (CESCR, para 12), the particular significance of which in the context of pandemics and diseases will be discussed shortly. Similarly, in the African context, where the problems of poverty hinder the immediate full realisation of the right to enjoy the best attainable state of physical and mental health as required by Article 16(1) of African Charter on Human and Peoples' Rights (ACHPR), the African Commission has held that states should take concrete and targeted steps, including ensuring that there is no shortage of drugs supplies, and that, in the event of drug shortages, all efforts are made to alleviate the problem (*Purohit* case, paras 84 & 85).

> The international community has a collective responsibility to address diseases

On the other hand, states, as a global community, have an obligation to cooperate and provide economic and technical assistance towards the full realisation of the right to health (CESCR, para 38). This is consistent with the commitment of states to join efforts towards the full realisation of the right to health under the Alma Ata Declaration. Additionally, economically developed states have a special responsibility towards and interest in assisting the poorer developing states in times of disease because some diseases are easily transmittable beyond states' frontiers. Thus, the international community has a collective responsibility to address diseases (CESCR, para 40).

Ebola in West Africa: A flawed response of the international community

Prevention and education programmes for behaviour-related health concerns

One of states' three-fold obligations in addressing diseases is conducting prevention and education programmes for behaviour-related health concerns (CESCR, para 40). This obligation is crucial for the current Ebola outbreak because of the fast spread of this disease and its high fatality rate.

To discharge their obligations, states have initiated various community education campaigns on hand washing and stopping the shaking of hands, as well as limiting the traditional burial of persons who have died of Ebola. Sierra Leone has gone further and criminalised the hiding of Ebola patients. One may argue that these efforts to educate the population about Ebola-related health concerns were sufficient. Why, then, have they not produced the expected results?

The effectiveness of these efforts could be better understood if accessed through their timeliness and acceptability among the target population. Although the first Ebola case was reported in December 2013 in Guinea, the disease only got media attention in June 2014 after a number of cases had been reported in other countries. It is thus arguable that when the moment was ripe to start campaigns, states missed the opportunity and this meant fewer positive results from the campaigns.

Health interventions should be respectful to the cul-

> Treatment facilities set up by the international community fall short of the requirements of availability and accessibility

ture of, and culturally accepted by, the targeted community. However, interpersonal physical contacts, be they through shaking hands, caring for sick people and, importantly, honouring and burying loved ones when they die, are deeply imbedded in African culture. It is therefore not surprising that traditional beliefs and rituals related to burial were reported as causes of community resistance to adopting preventive measures. Who is accountable in such cases? It is submitted that states have an obligation to make interventions that are both timely and acceptable by the community. In the present Ebola outbreak, targeting the community leaders who are the custodians of the culture as suggested by the WHO emergency managers would help in creating community-based solutions.

Treatment of disease: Setting up a system of urgent medical care

Concerning treatment of the disease, states have an obligation to set up a system of an urgent medical care (CESCR, General Comment no 14, para 16). Despite the ranges of actions expected from the states under this obligation, our discussion here covers only two aspects that have been spotlighted during the current Ebola outbreak.

Putting in place accessible health facilities for disease treatment

Urgent treatment of diseases obliges states to not only make sufficient health facilities available, but also to staff them with sufficient trained medical personnel. The health facilities must also be within safe physical reach of all sections of the population by whom they are needed (CESCR, para 12). However, reports on the most affected states (Liberia, Sierra Leone and Guinea) indicate that hospitals and health centres were ill-equipped to deal with Ebola.

None of them had centres for Ebola treatment, including containment facilities. Moreover, trained medical staff were scarce. For instance, at the beginning of the outbreak Liberia had only one doctor per nearly 100 000 people in a total population of 4.4 million and the situation was exacerbated by deaths of medical staff due to disease (WHO, September 2014). Additionally, with the exception of Liberia, which only recently (2013) managed to set the health budget at 18.9% of the total government budget (Teh, 2013), the rest of the most affected states are far below the 15% mark that is the commitment of the African states under the Abuja Declaration (WHO, 2013:10). This situation indicates that health facilities fail both the availability and accessibility test.

On the other hand, in terms of the obligation of developed states to assist poor countries, at least three Ebola treatment facilities have been set up in each of three countries. In terms of international obligations, such facilities should be available in sufficient quantity and that they should be accessible.

However, WHO has indicated that the facilities that have been provided are far fewer than are needed. The number of beds and medical staff that are urgently needed are three times more than those currently available (WHO, September 2014). For instance, in Monrovia, a centre set up to manage 30 patients is receiving more than 70 patients (WHO, September 2014). However, various states have recently pledged to send more health experts to support affected countries. Although the international community has thus helped to set up treatment facilities, the latter fall short of the requirements of availability and accessibility in terms of the right to health.

Some may argue that such obligations are not immediately realisable and that states' contribution depends on their available resources. I argue that the obligation to 'immediately take steps' compels the international community to fulfil its responsibility to assist the poorer developing states in times of emergencies. I therefore contend that both the affected states and international community have failed the populations of Liberia, Sierra Leone and Guinea.

Ensuring equal and timely access to basic preventive and curative services including essential drugs

The obligation to treat diseases requires states to make the services and essential quality drugs available and accessible in a timely manner (P Hunt, 2003:7). Nevertheless, the reports on affected states indicate that at times, medical personnel have (understandably) abandoned treatment centres due to the shortage of protective masks and basic drugs, or they have been pulled out, leaving patients dying on their beds. Yet affected states, being party to the ACHPR, have the obligation to ensure, within their resources, that there is no shortage of drugs and in the event that that does happen, to make all efforts to solve the problem (*Purohit* case, para 84 & 85).

Efforts have been made by both affected states and the international community to re-supply basic materials and medicines, though this has been far less than needed. This is resonating with the findings of the special rapporteur on the right to health in the context of the neglected diseases (Hunt, 2003:5), that the existing medicines and mechanisms for neglected diseases do not always reach people living in poverty in developing countries because they are too expensive, or are not available in adequate numbers, or are inaccessible geographically.

The question is whether the international community

has an obligation to make drugs available for isolated diseases. If so, the question remains why, four decades after Ebola's discovery, there is no licensed cure for it.

States have committed to join efforts towards the full realisation of the right to health (Alma Ata Declaration, 2000, principle 2). That includes making available and accessible quality health-care services and goods, including essential medicines (CESCR, para 17). This may involve a responsibility for developed countries to promote research and development into neglected diseases, even though these diseases do not have a high incidence, or occur at all, within rich countries (Hunt, 2003:11).

In that regard, some efforts have been made to find a cure for Ebola. A number of drugs are in the experimental phase of development. Nonetheless, the slow pace has not escaped commentators. Some argue that the Western community has seen Ebola as 'another African disease' and hence not worthy of much attention (Phelan, 2004). Others argue that the response to the current Ebola outbreak would have been different if it was affecting Western communities (Annas, August 2014).

Others maintain that since Ebola affects poor societies in Africa, it does not attract a market for drug companies when compared with western diseases. The latter comments find support in the report of Hunt (2003:6), who argues that diseases that occur mainly among poor communities living in developing countries have attracted particularly little research and development.

The market mechanism, which increasingly determines research and development, fails these neglected diseases since they do not promise a good return on investment. While I strongly agree with the commentators on the negligible market to invest in Africa, the dynamics in treatment facilities also support the argument that the response would have been different if the disease had been prevalent in Western countries.

For purposes of illustration, whereas an estimated 70.8% of local medical doctors, healthcare workers and thousands of Africans who have been infected by Ebola and treated with re-hydration serum have died (WHO Ebola Response Team, 2014), two infected American medical staff were treated with new, unproven drugs, evacuated to well-equipped hospitals in their home countries, and recovered.

Although there is no evidence that the recovery of the Americans was due to the special treatment they received, the selective administration of new drugs does not square well with equal access to essential drugs, which is central to the obligation of non-discriminatory treatment, nor with the states' commitment to join efforts to tackle inequalities in realisation of the right to health. Nevertheless, despite its flawed administration, the introduction of new drugs in West Africa has stimulated international commitments to invest in research for Ebola drugs and make their technical assistance available to the affected states, though their timely fulfilment remains an open question.

> Less affected or unaffected states have focused on protective measures within their own borders instead of supporting most affected states

Disease control

Disease control requires states, individually and through joint efforts, to make available relevant technologies and other strategies for disease control, including immunisation programmes (CESCR, para 17). Some of the steps countries have taken to fulfil these obligations are the creation of isolation rooms in Ebola treatment facilities, quarantining the affected zones, flights bans coupled with Ebola testing at airports and borders, regular records and the compulsory reporting of Ebola cases.

The measures taken have been less effective in the most affected states. For instance, due to the lack of capacity to detect Ebola immediately, some patients continue to be treated in the same wards as other patients. Moreover, patients have no choice but to return to their communities after treatment. Furthermore, poverty ensures that people in quarantined zones always find ways to travel to other areas. The combined effects of the above increase the chances of spreading Ebola.

On the other hand, as Viljoen (September 17, 2014) argues, the less affected or unaffected states have focused on protective measures within their own borders instead of supporting the most affected states. Moreover, immunisation was not envisaged as a control option during the current Ebola outbreak until the infection of the Americans highlighted above.

The flawed use of Zmapp has opened international debate on the possibilities of finding an Ebola vaccine. Nonetheless, the central question remains about the quality and the timeliness of the vaccine. The perceived consensus of the international community is that some ethical steps could be skipped so that the experimental vaccine can be tested on humans and thereafter be administered to medical staff. Though promising, the quality of such intervention remains doubtful and dictates strict scrutiny.

Conclusion

The Ebola outbreak in West Africa is a serious test of the right to the highest attainable standard of life. It has proved not only the incapacity of states to fulfil their obligations towards their citizens but also the failure of the international community to realise the right to health.

Although the shared states' responsibilities require that the world be held accountable for responding to such

emergencies, which lead to unprecedented dimensions of human suffering, the response of the international community has been flawed and non-pro-active.

The view of Ebola as an African disease has led to there being little interest by the developed countries and drugs companies in investing in research on the disease. However, the introduction of experimental drugs in West Africa has revived the international community's commitment to respond to Ebola. In order to sustainably address the reoccurrence of such crises, states should rethink the standards for global cooperation.

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UN Report

Right to participation in the context of realising the human right to water

The annual report by the Special Rapporteur on the right to water and sanitation, Catarina de Albuquerque, focuses on the right to participation in the context of realising the human rights to water and sanitation. She states that during the course of her mandate she has witnessed the benefit of 'authentic' participation in water provisioning leading to sustainable results. She notes, however, that participation remains a mere façade that pays no attention to power relationships, including entrenched hierarchies, patriarchal structures and mechanisms of exclusion, and that perpetuates or reinforces inequalities. For participation to be empowering it must be implemented within a framework that guarantees democracy, autonomy, agency and human dignity.

She emphasises that participation is a human right that entitles people to take part in the decisions that affect their lives. She calls on states to ensure active, free and meaningful participation by creating spaces and reasonable opportunity to access them and influence decisions. To ensure access and voice on an equal basis, she calls on states to identify and address the specific barriers that the poor and marginalised face in realising the right to participate on an equal basis with others. Barriers to equal participation include physical, economic, institutional, attitudinal and social factors. Information, training and an incentive structure for public officials to facilitate genuine participation are some of the practical factors identified to ensure access and voice.

The Special Rapporteur underlines the fact that participation in realising access to water must be part of a broader project to ensure continuous and direct public participation in all public affairs. It must not be restricted to decisions at the local level regarding, for instance, where to locate a borehole or latrine, but must also include matters at the macro level, for example, the overall priorities set by the government, the distribution and redistribution of resources and the strategic decisions on legislative and policy frameworks and budgets.

The report is a good guide detailing measures and factors to be considered in implementing the right to participate generally and more specifically in realising the right to water.

The full report is available at http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N14/490/08/PDF/N1449008.pdf?OpenElement.

UN Report

Right to social protection floors

In his first report to the UN General Assembly the Special Rapporteur on extreme poverty and human rights, Philip Alston, focused on the importance of the implementation of the right to social protection.

The report examines the historical evolution of the concept of a social protection floor, including its characteristics and importance in providing succour for vulnerable and marginalised groups in society. According to the Special Rapporteur, while international organisations have been in the forefront of popularising this initiative, 'social protection initiatives by countries in the global South have also been an indispensable catalyst'. The report considers some of the challenges to the successful implementation of social protection floors internationally. These include overcoming the reluctance of key international actors such as the World Bank to embrace this initiative, lack of sufficient legal recognition of social protection as a human right, and the misgivings about the affordability of social protection floors.

In conclusion, the report makes important recommendations including the need for civil society groups working

in the human rights field to pay more attention to social protection floors, the need for the World Bank to adopt a more supportive approach and the need for the treaty monitoring bodies, such as the Committee on Economic, Social and Cultural Rights and other UN special mechanisms, to engage more with this concept.

The full report is available at http://daccess-dds ny.un.org/doc/UNDOC/GEN/N14/501/65/PDF/N1450165.pdf?OpenElement

Regional sensitisation seminar

Promotion of the African Court on Human and Peoples' Rights for the SADC region

The Community Law Centre was represented at the Southern African regional sensitisation seminar organised by the African Court on Human and Peoples' Rights (the Court), which took place from 15 to 17 October 2014 in Lusaka, Zambia.

The seminar was attended by representatives of 13 of the 15 countries of the Southern African region. The main objective was to publicise the Court's mandate and its role in promoting and protecting human rights in Africa. The Court was established by Article 1 of the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights (the Protocol), which was adopted on 9 June 1998 in Burkina Faso and came into force on 25 January 2004. It was formed to complement the protective mandate of the African Commission on Human and Peoples' Rights (the Commission) with a view of enhancing the protection of human rights in Africa. It has a broad mandate in protecting human rights, as provided in the Protocol, which states that 'the jurisdiction of the Court shall extend to all cases and disputes submitted to it concerning the interpretation and application of the Charter, the Protocol and any other relevant Human Rights instruments'. The Court has two main jurisdictions: adjudicatory and advisory.

However, since the Court started its operations in 2006, only 28 of the 54 African Union (AU) member states have ratified the Protocol and of these 28, only seven have signed the declaration required under Article 34(6), accepting the competence of the Court to receive cases under Article 5(3). Yet the Protocol stipulates that the Court shall not receive any petition under Article 5(3) involving a state party which has not made such a declaration. The seven countries that have signed the declaration are Burkina Faso, Cote d'Ivoire, Ghana, Malawi, Mali, Rwanda and Tanzania. The low level of ratification maybe attributed to a lack of institutional capacity at the domestic level, lack of information or unwillingness of AU member states, and/or a lack of adequate information on African Court's operations among several stakeholders. It is on this premise that the Court has been carrying out continent-wide sensitisation programmes since December 2010, aimed at publicising itself and its work in the region. These include regional seminars that were held for West Africa, North and Eastern Africa.

Participants at the seminar for the SADC region thus noted that for the Court to execute its role effectively, more countries need to ratify the Protocol and sign the declaration provided under Article 34(6). They further emphasised the need to encourage the African Commission and African inter-governmental organisations to submit more cases to the Court since both bodies are entitled to do so by virtue of Article 5(1) of the Protocol. Participants also highlighted the need for improved relations between the Court and the African Commission and the requirement to put mechanisms in place to ensure that the Court's decisions are implemented effectively. NGOs that have observer status before the Court were encouraged to consider approaching it with advisory opinions. Furthermore the participants representing sectors such as the judiciary, national human rights institutions, NGOs, academia and the media were also urged to assist the Court in raising public awareness about its existence, functions and accessibility, and to lobby and persuade their respective governments to ratify the Protocol and to deposit the declaration.