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

> The international community has a collective responsibility to address diseases

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).

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 re-occurrence of such crises, states should rethink the standards for global cooperation.

Amahirwe Denyse is a student in the Master's programme in Human Rights and Democratisation in Africa at the Centre for Human Rights, University of Pretoria

References

Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. 2001. Available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf (accessed 5 September 2014).

African Charter on Human and Peoples' Rights. 1981. Available at http://www.achpr.org/instruments/achpr/ (accessed 2 September 2014).

Boston University School of Public Health. 2014. Annas on Ebola treatment: Ethical issues at heart of debate over experimental drug use. 12 August 2014 Available at http://www.bu.edu/sph/2014/08/12/annas-on-ebola-treatment-ethical-issues-at-heart-of-debate-over-experimental-drug-use/ (accessed 17 September 2014).

Center for Disease Control. 2014. Outbreak's chronology: Ebola hemorrhagic fever. Available at http://www.cdc.gov/vhf/ebola/resources/outbreak-table.html (accessed 18 September 2014).

Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 14. 2000. The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4, 11 August 2000.

Declaration of Alma-Ata. 1978. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978 Available at http://www.who.int/publications/almaata_declaration_en.pdf (accessed 17 September 2014).

International Covenant on Economic, Social and Cultural Rights (ICESCR). 1966. Available at http://www.ohchr.org/en/professionalinterest/pages/cescr.aspx (accessed 2 September 2014).

Hunt, P. 2003. Neglected diseases, social justice and human rights: Some preliminary observations. Health and Human Rights Working Paper Series No 4. Available at http://www.who.int/hhr/news/en/Series_4_neglected%20diseases_social_justice_human_rights%20Paul_Hunt.pdf (accessed 17 September 2014).

Langford, M (ed). 2008. *Social rights jurisprudence: Emerging trends in international and comparative law*. Cambridge: Cambridge Press University.

Mann, JM. 1997. Medicine and public health, ethics and human rights. *Hastings Center Report*, 27(3): 6–13.

Pan American Health Organization. 2014. The Ebola epidemic is a serious public health problem, but it can still be controlled. Available at http://www.paho.org/hq/index.php?option=com_content&view=article&id=9822:la-epidemia-de-ebola-es-un-problema-serio-de-salud-publica-pero-todavia-puede-ser-controlado&Itemid=2&lang=en (accessed 22 September 2014).

Phelan, AL. 2014. The sins of the other or silence of the self? – Ebola in West Africa. Available at http://rightnow.org.au/writing-cat/the-sins-of-the-other-or-silence-of-the-self-ebola-in-west-africa/ (accessed on 10 September 2014).

Purohit and Others v The Gambia, AHLR 96 (ACHPR 2003).

SAPA IOL News. 2014. SA negating Ebola role: Expert. 17 September 2014. Available at http://www.iol.co.za/news/africa/sa-negating-ebola-role-expert-1.1752616#.VCod7meSz86 (accessed 27 September 2014).

Teh, J. 2014. The country has moved from pledge to action in health care spending. Available at http://cmiliberia.org/blog/2013/07/25/liberias-health-budget-all-hail-the-target-is-met/ (accessed 28 September 2014).

World Health Organisation (WHO) Regional Office for Africa 2013. State of health financing in the African region. Available at http://www.aho.afro.who.int/en/ahm/issue/16/reports/state-health-financing-african-region (accessed 20 August 2014)

WHO Ebola Response Team, 2014. Ebola virus disease in West Africa – The first nine months of the epidemic and forward projections. The New England Journal of Medicine Available at http://www.nejm.org/doi/pdf/10.1056/NEJMoa1411100 (accessed 30 September 2014).

WHO. 2014. Ebola situation in Liberia: Non-conventional interventions needed. Situation assessment – 8 September 2014. Available at http://www.who.int/mediacentre/news/ebola/8-september-2014/en/ (accessed 18 September 2014).

WHO. 2014. Ebola virus disease: Fact sheet no. 103. September 2014 Available at http://www.who.int/mediacentre/factsheets/fs103/en/(accessed 20 September 2014)

WHO 2014. WHO statement on the meeting of the International Health Regulations Emergency Committee regarding the 2014 Ebola outbreak in West Africa. 8 August 2014. Available at http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/ (accessed 20 September 2014)