

Health and human rights are inextricably linked in the COVID-19 response

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ABSTRACT

To mitigate the spread of COVID-19, governments throughout the world have introduced emergency measures that constrain individual freedoms, social and economic rights and global solidarity. These regulatory measures have closed schools, workplaces and transit systems, cancelled public gatherings, introduced mandatory home confinement and deployed large-scale electronic surveillance. In doing so, human rights obligations are rarely addressed, despite how significantly they are impacted by the pandemic response. The norms and principles of human rights should guide government responses to COVID-19, with these rights strengthening the public health response to COVID-19.

INTRODUCTION

Human rights are fundamentally linked to global health in the context of the COVID-19 pandemic. The HIV/AIDS pandemic first underscored that rights-based approaches are one of the most effective paths to achieving public health, and this inextricable linkage between health and human rights has evolved over 30 years to provide a foundation for the COVID-19 response.¹ Human rights provide a universal framework for advancing global health with justice, transforming moral imperatives into legal entitlements in key domains relevant to COVID-19. Rather than viewing human rights as placing unjustifiable restrictions on public health measures, they should be acknowledged as crucial to public health responses that employ rationality, proportionality and accountability, build public trust through transparency and participation, and prioritise the safety and protection of vulnerable and marginalised populations.

This article examines how human rights are central to three interconnected domains of COVID-19 responses: (1) the restriction of individual rights to protect public health, (2) the realisation of the right to health and its underlying determinants such as social security, food, water, housing and education in the context of health system responses

Summary box

- ▶ There is an inextricable linkage between health and human rights, first identified in the early response to the HIV/AIDS pandemic, which has evolved over 30 years to provide a human rights foundation for the COVID-19 response.
- ▶ Human rights should guide government responses to COVID-19, strengthening the public health response to COVID-19 by: framing restrictions on individual liberties, managing COVID-19's impacts on medical care, public health and social and economic rights, and realising global solidarity through international collaboration and assistance.
- ▶ Many governments have introduced emergency laws in response to COVID-19 that restrict individual rights, including limitations on the freedom of movement through home confinement and limitations on the right to privacy through public health surveillance.
- ▶ While pandemics may require restrictions of individual rights to protect public health, these limitations must be necessary (following proper scientific evidence), proportionate (to the public health threat and time limited) and non-arbitrary (non-discriminatory).
- ▶ To ensure that public health measures employ a rights-based approach to health, governments must prioritise protecting the most vulnerable people in society through transparent policymaking and public participation.
- ▶ Beyond respect for individual liberties, states also bear obligations under the human right to health to ensure available, accessible, acceptable and good quality health responses to prevent and treat COVID-19.
- ▶ A wide range of economic and social rights are necessary to support underlying determinants of health through periods of physical distancing, including rights to work, social security, housing, food, water and sanitation.
- ▶ Governments have shared responsibilities to provide international assistance and collaboration to realise access to food, essential supplies, and testing and medical support in overcoming the COVID-19 pandemic through global solidarity.

and physical distancing measures, and (3) the fulfilment of international obligations of collaboration and assistance. Looking to



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international human rights law, we apply human rights to assess state responses to COVID-19 and also explore how human rights could better support policy responses to COVID-19. We find that the social and economic inequalities illustrated by COVID-19 underscore a key proposition of international human rights law—that all human rights are universal, indivisible and interdependent.² Based on these interconnected rights, we conclude that human rights should guide what governments do to protect those most at risk from discriminatory and harmful state responses to the pandemic—framing restrictions on individual liberties, managing COVID-19's impacts on medical care, public health and social and economic rights, and realising global solidarity through international collaboration and assistance.

RESTRICTING RIGHTS UNDER EMERGENCY LAWS

International human rights obligations do not cease within global pandemics; however, many governments have introduced laws that restrict rights by limiting travel, banning public gatherings and widening powers of detention and force on people failing to self-isolate. Drawing from the 1966 International Covenant on Civil and Political Rights, international human rights law offers principles to ensure that restrictions on individual rights to protect public health are not needlessly restrictive or harmful. Limitations of rights must be necessary (following proper scientific evidence), proportionate (to the public health threat and time limited) and non-arbitrary (non-discriminatory).³ The United Nations (UN) Secretary General has reiterated the need for a human rights approach, arguing that state responses can respect human rights and the rule of law through measures that are proportionate to immediate threats and do not go further than necessary.⁴ It is crucial to consider how this human rights balancing can be used to assess and guide policy responses to home confinement and public health surveillance.

Limitations on freedom of movement through home confinement orders

New emergency laws have come into force in many countries requiring that almost all individuals stay within given geographical areas or remain confined to their homes. China's lockdown of Wuhan and the wider Hubei Province confined about 60 million people to their homes.⁵ Other countries, including India, France, Italy, New Zealand, South Africa and Poland, have imposed nationwide lockdowns, save for 'essential workers' such as doctors, nurses, pharmacists, grocery cashiers, government workers and food delivery services.⁶ Governments have enforced these lockdowns with sanctions, including imprisonment, as in Australia, where leaving home without a 'reasonable excuse' can incur fines of up to \$A11000 or 6 months' imprisonment.⁷ In India and Uganda, impoverished populations in informal settlements have been threatened with violence by authorities.^{8,9} Some of these

lockdowns have been partially or fully lifted, but they will likely be reimplemented as new outbreaks arise. While we do not dispute the public health necessity of lockdowns as a legitimate response to COVID-19, some of these measures (as in India and Uganda) use unnecessary and disproportionate force.

Other countries have imposed explicit human rights violations in responding to the COVID-19 crisis, most egregiously in Hungary's enactment of a state of emergency without a clear time limit, allowing the prime minister to rule by decree.¹⁰ In other countries, lockdowns have had more indirect human rights impacts: for example, in Panama, the *pico y género* rule, which allowed men to leave their homes to buy food/medications on certain days and women to do so during other days, has disproportionately impacted transgendered women. There have been multiple reports of police harassment of trans women who had gone out to buy foods on days when women could do so.^{11,12} Reinforcing existing societal fault lines through confinement orders, Myanmar and Russia have introduced lengthy prison sentences and incarcerated greater numbers of individuals from marginalised populations for violating COVID-19-related measures,¹³ with overcrowding in prisons and detention centres inevitably increasing the potential for the rapid spread of COVID-19, worsened by substandard health-care in prisons. Groups such as migrants and refugees are particularly vulnerable to discrimination: Nepalese and Thai citizens working abroad have found themselves in desperate circumstances when their governments denied them the right to return home during the pandemic.^{14,15}

Human rights principles offer a clear lens for assessing the legitimacy of such confinement measures. First, while many human rights can be derogated from (or limited) to protect public health, certain rights, such as the right to life, cannot.^{3,16–18} Second, sanctions for violating home confinement and restricted movement orders should be proportionate to national threats of COVID-19 and should not be unduly punitive. The High Court of Kenya recently held that while curfews were lawful, the use of unreasonable force in its imposition was unlawful, finding that the police were liable for violating the rights to life and dignity of people who were alleged to have broken the curfew. Additionally, this case highlights the importance of judicial review of rights limitations.¹⁹ To ensure that such measures are not discriminatory or used as a weapon against minorities, governments must operate through transparent policymaking, engaging the participation of vulnerable populations as a basis to ensure rights realisation and public cooperation in emergency responses.

Limitations on privacy through public health surveillance

In their emergency public health responses, some states have drafted or relaxed data protection laws to monitor compliance with social distancing measures and facilitate disease surveillance.^{20,21} Through smartphone location data, Israel used emergency laws to introduce

a surveillance programme using the national security agency to track potentially infected people;²² and South Korea released detailed identifying information on infected individuals through private apps, alerting users in their vicinity and leading to discrimination against elderly people.²³ In China, all citizens must install phone software to predict health status, track and share locations with police and determine whether people can enter public spaces.²⁴

In promoting contact tracing through digital tools, governments may also be intensifying inequalities, as many people may not have modern smartphones that support contact tracing technologies.²⁵ Thus, when the data collected through these apps and other technologies are used to inform decision-making processes, they may omit vulnerable groups in policymaking. In Argentina, for instance, the government adopted the CuidAR COVID-19 app to facilitate contact tracing; however, the policy did not consider that many people living in informal settlements (who are among the most vulnerable to COVID-19) do not have smartphones.^{26–28}

Increased surveillance in a health emergency may be useful to support social distancing efforts as well as to inform epidemiological research to trace contacts of infected persons in responding to outbreaks. Yet, the expansion of surveillance technologies beyond traditional public health mechanisms heightens longer standing tensions between individual rights and collective interests. Without adequate safeguards to protect or at least minimise the impact on individual rights (such as privacy and freedom of movement), emerging surveillance technologies pose serious long-term risks to human rights. In line with the principle of proportionality under human rights law, all COVID-19 surveillance tools must be proven to be strictly necessary (based on epidemiological evidence), temporary and proportionate. Large-scale data collection tools that do not identify individuals could meet those human rights requirements.²⁹ Beyond deidentified data, governments should consider opt-in approaches first (as in Canada, Iceland and Italy, where people consent via apps for their data to be used for research).³⁰ International human rights law also requires governments to ensure that opt-in consents are not exploited by unnecessary extensions or used for profit by the private sector.³¹ Private corporate surveillance on behalf of governments should be time limited and not be normalised after the pandemic.

These examples of rights restrictions under emergency laws suggest several cross-cutting human rights principles to frame public health-related limitations of human rights: governments must prioritise protecting the most vulnerable people in society. Initiatives like social distancing and self-isolation will disproportionately affect vulnerable people, including the precariously employed, migrant populations and homeless.³² Before restraining individual liberties, states must be transparent in communicating the scientific advice informing decision-making. Governments must also enable public participation by

vulnerable populations to the greatest extent possible, building trust among citizens, compliance with government rights restrictions and accountability for rights violations.³³ Additionally, governments should ensure that even in times of crisis, there are restrictions on the circumstances under which state agents can use force, limiting the use of coercive measures such as fines and imprisonment to enforce public health objectives.

FULFILLING THE RIGHT TO HEALTHCARE AND UNDERLYING DETERMINANTS OF HEALTH

Beyond respect for individual liberties, states also hold duties to ensure adequate medical and public health responses to COVID-19 under rights to health and to underlying determinants of health, including work, social security, housing, food, water and sanitation. In 1946, states recognised in the WHO Constitution that ‘the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being’.³⁴ Subsequently, the right to health has been elaborated repeatedly in international and regional human rights treaties.^{35–43} The International Covenant on Economic, Social and Cultural Rights (ICESCR) codifies the right to the highest attainable standard of physical and mental health,⁴⁴ which has been authoritatively interpreted to create duties to ensure access to available, accessible, acceptable and good quality healthcare and to provide for underlying determinants of public health, including water, sanitation, food, housing, education and gender equality.⁴⁵

The right to available, accessible, acceptable and good quality healthcare

COVID-19 has illustrated to many countries that their health systems are unable to withstand a prolonged health crisis. Many countries such as the UK, Italy, Spain and the USA are struggling to respond, partly due to years of budget cuts under austerity measures.^{46–51} As a result, they have struggled to source adequate diagnostic testing and personal protective equipment (PPE) to prevent disease transmission.^{52–53} Compounded by discrimination in healthcare settings, marginalised groups such as migrants and displaced persons, racial and ethnic minorities, women, sexual minorities, older persons, incarcerated populations and those living with HIV are particularly vulnerable to violations of the right to health.⁵⁴ For example, the UN High Commissioner for Refugees has identified thousands of migrants at risk of further harm without adequate healthcare. Bosnian authorities, for instance, transferred thousands of migrants to a remote camp in Lipa, 25 km from the Croatian border, without access to healthcare.⁵⁵ To comply with the right to health, states must ensure that access to appropriate COVID-related diagnostic testing and emergency healthcare for such groups is prioritised within healthcare policies, programmes and practices, and that states conduct human rights impact assessments to analyse the impacts

of healthcare inequalities on vulnerable and marginalised groups.

Yet many countries have been unable to operationalise the right to health to enable available, accessible, acceptable and good quality PPE, diagnostic testing, contact tracing and healthcare services.⁵⁶ Countries such as South Africa introduced a mass testing programme which was made free available to everyone,⁵² and in countries with health inequalities between public and private care (like Spain and the UK), private hospitals are being nationalised to ensure that all citizens have equitable access to treatment.^{57 58} However, in countries like the USA, those without medical insurance are being denied access to treatment or facing prohibitive user fees for basic COVID-19 treatment, resulting in inequitable mortality.⁵⁹⁻⁶¹

Rights relating to the underlying determinants of health

Beyond the right to health in healthcare settings, other economic and social rights impact public health during periods of physical distancing, including rights to housing, social security, employment, food, water and sanitation. Widescale social distancing highlights existing vulnerabilities within economic systems: large numbers of people are employed in service and manufacturing sectors not amenable to social distancing; the growth in precarious work has threatened continuing income, with social security systems weakened and housing increasingly insecure and inadequate.⁶² These underlying determinants to health, often reflected in other health-related human rights, must not be neglected amidst public health emergency measures. For those unable to work, social distancing disproportionately impacts vulnerable groups by harming the health of those who are poor, struggling to survive, homeless, or lacking food, water and sanitation.⁶³ Women across the world have been particularly impacted by the COVID-19 crisis. Many women who were already less likely to be in secure work or have access to unemployment benefits are more likely to stay home and care for family based on discriminatory policies and gender norms. National lockdowns are particularly dangerous for women at risk of domestic violence, who cannot access domestic abuse shelters, with an exponential increase in domestic abuse during the timeline of the pandemic.^{64 65}

The predominant policy response has been to facilitate economic bailouts of institutions and individuals to enable citizens to comply with social distancing while meeting basic needs. Businesses have received economic bailouts, cheap credit from central banks, altered tax laws and increased social security payments to support employees.⁶⁶ Some governments have indemnified workers' wages to allow company closures for as long as necessary.⁶⁷⁻⁷⁰ Spain specifically cited constitutional rights when it allocated resources to a 'social shield' package, which included a moratorium on mortgage and utility payments for people unable to pay; increased unemployment benefits and social services for citizens most at risk,

such as the elderly, disabled or those with low incomes; and the state acting as a payer of last resort to stave off mass lay-offs.⁷¹ Yet stimulus packages in France, Denmark, the UK and India did not explicitly mention social rights or address the plight of vulnerable groups, reinforcing a narrative of economic stimulus at the expense of the vulnerable.⁷² For instance, India's stimulus package only allocated food to vulnerable groups for 2 months, while South Africa gave out food parcels in ways that overlooked refugees and asylum seekers. Courts have stepped in to enforce rights amidst social distancing. In Malawi, the High Court instituted an injunction against the national lockdown because the government made insufficient provision to stop poor people from going hungry or being denied water and sanitation.^{73 74} UN Habitat is providing clean water to many citizens in informal settlements in many countries,⁷⁵ and the South African government increased water and sanitation measures in high-density public areas, informal settlements and rural areas.

INTERNATIONAL OBLIGATIONS: HUMAN RIGHTS OBLIGATION TO ASSIST

To meet this global threat, the world will require a formidable shift towards global solidarity and shared responsibility.⁷⁶ International assistance and collaboration to ensure access to food, essential supplies, and testing and medical support is a human rights imperative that will be crucial in overcoming this pandemic. Low-income countries will face unique obstacles to mitigating COVID-19, yet many isolationist laws in high-income countries have ignored this global emergency: the UK enacted laws to prevent exporting essential medicines,⁷⁷ the European Union curbed exports of hospital supplies⁷⁸ and the USA restricted PPE exports for healthcare staff.⁷⁹ International sanctions against Iran, one of the world's worst-hit countries, have exacerbated dire shortages in medical supplies and humanitarian aid.⁸⁰

Human rights law has long recognised an obligation of wealthy countries to assist low-income countries: since the adoption of the Universal Declaration of Human Rights, states have acknowledged that international cooperation is necessary to realise human rights.⁸¹ Through the ICESCR, states have bound themselves to international cooperation to progressively realise social and economic rights, including the right to health.⁴⁴ This obligation of international assistance is extended by the International Health Regulations, which impose a duty to assist other nations in preventing disease.⁸²

A failure to assist nations in need, denying necessary medical supplies or enforcing debt repayments that divert resources from essential services, would be short-sighted in controlling the pandemic and anathema to global solidarity. COVID-19 has illustrated that all countries are equally vulnerable to the spread of infectious diseases. Recognising this, some wealthy countries have directly supported low-income countries to address COVID-19,⁸³

with other nations offering support through the UN's COVID-19 Global Humanitarian Response Plan,⁸⁴ the UN Framework for the Immediate Socio-Economic Response to COVID-19⁸⁵ and the WHO COVID-19 Solidarity Response Fund.⁸⁶

Several proposals at the international level could enable wealthy countries to meet their international obligations to assist low- and middle-income countries, with full funding of WHO essential to meeting the emergency needs of this response. The International Monetary Fund, working with WHO, has offered to suspend debt collection to support global health.⁸⁷ On Costa Rica's initiative, the WHO launched a voluntary intellectual property pool for the sharing of COVID-19-related technologies and knowledge,⁸⁸ and low-income states have rallied behind a 'People's Vaccine' to ensure that prospective vaccines will be accessible to all.⁸⁹

CONCLUSION

COVID-19 is an unprecedented global threat, and human rights should be at the core of the global response—as states have legally binding obligations to do so and there is evidence that human rights-based policies strengthen public health. Where human rights are inextricably linked to public health outcomes and interconnected in the COVID-19 response, governments should adopt laws that are proportionate, necessary and non-discriminatory towards society's most vulnerable members and should ensure that laws alleviate the worst impacts of the crisis on vulnerable groups. Moreover, the indivisibility of human rights, which the pandemic brings clearly to light, also highlights the need for better coordination among a siloed human rights community. Second, governments must be open and transparent and ensure participation so that people can assure accountability in decision-making. Lastly, global solidarity is essential and must integrate human rights: cross-border financing must be increased and any vaccine must be globally accessible. COVID-19 underscores that human rights are critical for effective public and global health. The terrible scale of this crisis offers an opportunity to radically rethink state obligations to safeguard health systems and prepare for the future.

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