Human Rights Dimensions of the COVID-19 Pandemic

Background paper 11

by

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Executive Summary

The Independent Panel for Pandemic Preparedness and Response commissioned a background paper on the human rights impacts of the COVID-19 pandemic. The cataclysmic human rights impact of COVID-19, and responses to COVID-19, cannot be overstated, with UN Secretary-General Antonio Guterres decrying "a pandemic of human rights abuses in the wake of Covid-19" (Guterres, 2021). The principal human rights impacts of COVID-19 include:

- **The Rights to Life and the Highest Attainable Standard of Health**. The scale and distribution of COVID-19 infections and deaths raise significant concerns. In the context of COVID-19, the right to health includes entitlements to available, accessible, acceptable and good quality healthcare services and equipment, vaccines, treatment and health information for all, with many States' responses falling short in progressively realising necessary health entitlements. The adoption of evidence-based public health measures to protect the right to health, tailored to support the needs of different population groups, is also an integral component of the right to health, yet many countries experienced delays in appropriate measures, or failed to address the situation of vulnerable and marginalised populations.
- **Other Economic, Social and Cultural Rights**. These rights, which are also social determinants of health, include education; an adequate standard of living including food, housing, water and sanitation; social security; work (and protections at work); and to benefit from scientific progress. Profoundly impacted by COVID-19 and COVID-19 responses, economic, social and cultural rights shortcomings and violations arise particularly in the absence of measures to address their harmful effects.
- **The Limitation of Civil and Political Rights in the context of COVID-19.** International human rights law permits restrictions on civil liberties, notably freedoms of movement, right to family and private life and freedoms of peaceful assembly and association, to protect public health so long as those restrictions are proportional, grounded in law, and applied in a non-arbitrary and non-discriminatory way. Without attention to these human rights limitations, public health responses have often exceeded constraints under human rights law, with digital surveillance and criminal law approaches to compliance raising particular human rights concerns. Further, increasingly authoritarian governments have exploited emergency laws to clamp down on civil liberties and attack political opponents.
- The Obligation to Realise the Right to Health and Other Economic, Social and Cultural Rights requires **International Assistance and Cooperation**. These international obligations carry implications across a range of policy and legal fields, including for equitable global distribution of vaccines, treatment and equipment and broader support to address the socioeconomic consequences of the pandemic.
- The Cross-Cutting Human Rights Principles of a **Rights-Based Approach to Health,** namely the fundamental human rights principles of **equality and non-discrimination**; **participation**, **accountability and transparency, provide a foundation to ensure human rights in public health practice**. In practice, inequalities and discrimination have shaped patterns of human rights

> impacts in COVID-19 and COVID-19 responses, with marginalised and vulnerable groups, including racial and ethnic minorities, older persons, persons with disabilities, women, children, migrants, refugees, institutionalised persons, indigenous peoples and LGBTI+ persons experiencing multiple and intersecting obstacles to their fundamental human rights. All too often, COVID-19 responses have been top down, and have failed to engage those affected, especially vulnerable and marginalised groups, undermining public health and human rights for all. At a time of unprecedented health and human rights crises, when accountability is needed more than ever, legal responses have curtailed parliamentary oversight, whilst accountability has also been reduced through a lack of transparency in COVID-19 responses, operational difficulties of review and oversight bodies, and disproportionate restrictions on civil society and the press.

Grounded in international law, human rights constitute a universal, normative and legally binding foundation to prevent, protect against and control public health threats, and a basis for an equitable, participatory, transparent, accountable and effective public health response. Since the outbreak of COVID-19, the Office of the UN High Commissioner for Human Rights (OHCHR), international human rights accountability mechanisms including Treaty Bodies and Special Procedures, and the WHO and other international organisations have been united in robust commitment to human rights and have responded through extensive guidance on international human rights law in the context of COVID-19 (see Annex 1). These responses not only constitute indispensable tools to understand with precision the shortcomings in COVID-19 responses; they also provide a valuable foundation for States, international organisations, the Independent Panel on Pandemic Preparedness and Response, and other actors, to develop and implement human rights-based responses to COVID-19.

At the same time, action is needed to improve health and human rights governance. For their part, States must fully engage with, and improve support to, domestic and international human rights accountability procedures and comply with their recommendations. International organizations can also do more to support human rights-based responses to COVID-19. There is significant potential for collaboration between the WHO with OHCHR and international human rights procedures, including within a Framework of Cooperation of the WHO and OHCHR since 2017, to ensure that human rights are supported at WHO including at country level, and that the WHO supports international human rights mechanisms. Building on its Constitutional protection of the right to health and human rights mainstreaming work carried out over more than three decades, the WHO has an opportunity to strengthen its human rights policies, programmes, and practices, including within its emergencies team.

Recommendations

COVID-19, COVID-19 responses, recovery and future pandemic preparedness have multiple human rights impacts and implications. **The IPPPR should mainstream human rights considerations across its report, including in recommendations to States and the WHO.**

The following recommendations respond to themes emerging in the analysis of this report including: the human rights impact of COVID-19 and COVID-19 responses on human rights; the role of global health and human rights governance actors, including the WHO, World Health Assembly, Office of the High Commissioner for Human Rights and UN human rights oversight bodies, suggesting areas of action for strengthening the promotion and protection of human rights during the pandemic, in recovery and in future pandemics.

1. State recommendations

1.1 States have obligations under international law to respect, protect and fulfil human rights. Guided by COVID-19 human rights guidance from UN treaty bodies, Special Procedures and the OHCHR, and recommendations issued to individual States by international or domestic human rights bodies, **States must comply with their international human rights obligations in: (a) laws, regulations and policies for the prevention, treatment and control of COVID-19 (b) socio-economic responses and recovery policies and (c) future pandemic preparedness.**

Amongst others, States' obligations under international human rights law require them to:

(a) Collect and disaggregate data on COVID-19 infections and deaths on grounds including gender, race, ethnicity, disability, age, language, religion, national or social origin, birth, health status (including HIV/AIDS), LGBTI+ status.

(b) Enhance public health systems capacities to ensure COVID-19 testing, treatment and vaccines are available and freely accessible to all especially to the most vulnerable groups. This should include a range of measures to increase government spending on health, removing any suspension of essential services, tackling critical shortages of equipment and supplies, offering financial incentives, sick pay and childcare provision to the health workforce deployed in COVID-19 wards.

(c) Ensure optimal availability and appropriate use of PPE, address critical shortages and safeguard the rights, safety and well-being of frontline healthcare workers (WHO 2020f).

(d) Create avenues for participation and feed-back, including reaching out to those most at risk and those most likely to be excluded, including women, older persons and persons with disabilities, to ensure that they are engaged and able to participate in policy-making on an equal basis (OHCHR, 2020d).

(e) Prioritise vaccination through transparent protocols and procedures that respect human rights, ensuring that vaccines are available to all and accessible on the basis of non-discrimination (OHCHR, 2020e).

(f) Provide timely and effective measures to support the enjoyment of core economic and social rights of people affected by emergency restrictions, including through support for employment and livelihoods, housing, food, education, social protection and health in order to enable them to comply with the emergency measures (OHCHR, 2020c). This may include reasonable exceptions to ensure legal restrictions on movement do not restrict access to fundamental socio-economic rights (UNAIDS, 2020a). Any limitations to economic, social and cultural rights should be proportionate, time-limited and strictly necessary to protect public health (CESCR, 2000).
(g) Implement gender-responsive protection measures responding to, amongst others, increased caregiving, domestic violence and decreased access to sexual and reproductive health and rights services, considering how differently positioned women experience discrimination.
(h) Ensure that emergency legislation, regulations and policies comply with the Siracusa Principles tests of legality, necessity, proportionality, are time-bound and subject to regular review, and are not enforced in a disproportionate, arbitrary or discriminatory manner that violates human rights.
(i) Use digital technology in containment measures only insofar as: (i) there is scientific justification for its use to protect the rights to life and health, (ii) design and deployment meet the tests of legality, necessity, and proportionality, (iii) measures are in place to prevent harm to human rights, including privacy and non-discrimination, preventing normalisation or misuse in the future through use of sunset clauses.
(j) Avoid disproportionate, discriminatory or excessive use of criminal law.
(k) Provide accurate and full health information and refrain from recourse to punitive measures and laws to silence critics.
(l) Strengthen autonomous national institutions (e.g., periodic review and assessments by National Human Rights Commissions), and other equality mechanisms to strengthen oversight and compliance with anti-corruption, anti-discrimination legislation and international human rights treaties in the context of COVID-19.
(m) Preserve access to justice through keeping courts functioning, even in lockdowns.
(n) Exert regulatory oversight over private actors, including private health providers and contractors and monitor their actions and wider impact on health systems in response to the pandemic.
(o) Establish robust anti-corruption mechanisms and conduct independent enquiry on corruption in contracting private and other providers for national COVID-19 responses.
(p) Increase transparency in public contracting via timely publication of contracting data in open format, designing explicit rules and protocols for emergencies and ensuring their enforcement. It is also crucial to adequately document public contracting procedures during the crisis, and undertake risk assessments to focus resources on areas or processes more vulnerable to corruption.
(q) Actively track/ monitor and address conditions and triggers linked to religious, ethnic violence and the potential for hate crimes.

1.2. States must fulfil their international human rights obligations of international cooperation and assistance in their COVID-19 responses, recovery and future pandemic preparedness, including through universal and equitable global vaccine distribution.

1.3. States must fully engage with UN human rights oversight mechanisms on COVID-19, systematically addressing the impact of COVID-19 and their responses to COVID-19 in their periodic reports submitted to treaty bodies and under the Universal Periodic Review, and implementing these mechanisms' recommendations to improve rights-compliant COVID-19 responses.

2. WHO Recommendations

WHO has shown leadership in advancing the right to health as a foundation for the COVID-19 response — with crucial support across the global governance landscape, from select member states, and through civil society advocates — but WHO lacks (1) human rights advisors, (2) global health policy foundations, and (3) human rights system partnerships to mainstream human rights in global health — in the pandemic response, in recovery as a foundation for Universal Health Coverage, and in future pandemic preparedness.

2.1. Human Rights Staff

WHO's constitutional commitment to human rights must be matched by the health-specific bureaucratisation of human rights through the appointment of human rights advisors to support human rights implementation in WHO policies and guidance to member states. WHO currently has human rights focal points only within select technical offices — with only a single human rights technical staff member responsible for human rights across all WHO programming. Meeting WHO's commitment to mainstream human rights will require that WHO staff perceive the value of human rights to their organisational mission, embrace human rights as a normative basis for their efforts, and implement rights in their global health programming. In the context of wide-range human rights implications and impacts of COVID-19 and responses, **WHO should expand its human rights staff, including through appointing a Human Rights Advisor within the emergencies team, to support human rights capacity-building, advise on institutional programming, and enhance human rights based-approaches to COVID-19 guidance and policies**.

2.2. Global Health Policy

Global health policy is essential in framing national responses to globalised threats of infectious disease, yet the IHR (2005), which seeks to promote global health security while safeguarding human rights, has proven ineffective in supporting states in balancing public health imperatives and human rights obligations. As this international legal framework is revised to meet future global health threats, it is crucial that states renew their commitment to human rights and accountability in global governance to control infectious disease and strengthen human rights assessments of state disease control efforts. **Drawing from the Siracusa Principles, future revisions of the IHR, or a future pandemics treaty, should mainstream civil, political, economic, social and cultural rights throughout infectious disease control. To support compliance, future arrangements should embrace rights-based accountability through monitoring, review, remedies and action, and through supporting the human rights system to address public health emergencies.**

2.3. Human Rights Partnerships

The UN human rights system has arisen out of the interconnected institutions that support human rights implementation, including the UN's human rights bureaucracy in the OHCHR, intergovernmental policy making under the Human Rights Council, and independent monitoring and review through human rights treaty bodies and the Universal Periodic Review. In operationalizing human rights at the centre of WHO governance, the human rights system can welcome, encourage, foster, support and scrutinise WHO's human rights mainstreaming efforts. These complementary institutions of human rights governance can thus be seen as supportive of WHO in the mainstreaming of rights. The **WHO and the OHCHR must take action, supported by budgetary commitments, to operationalise their Framework of Cooperation in the pandemic response**. The WHO, in turn, is uniquely positioned to support international human rights accountability procedures in their oversight of State human rights obligations in the contexts of COVID-19 and pandemic preparedness more broadly. Building on existing engagements with treaty bodies and Special Procedures, and collaborating through UN Country Team partnerships, the **WHO and other agencies should routinely provide information on COVID-19, States' COVID-19 responses, and States' pandemic preparedness, to support: (i) State party reporting under international human rights treaties and (ii) the Universal Periodic Review**.

1. Introduction

The Independent Panel for Pandemic Preparedness and Response commissioned a background paper on the human rights impacts of the COVID-19 pandemic. The cataclysmic impact of COVID-19 and COVID-19 responses on human rights worldwide cannot be overstated, with UN Secretary-General Antonio Guterres decrying "a pandemic of human rights abuses in the wake of COVID-19" (Guterres, 2021).

This paper analyses the human rights impacts of COVID-19 and the COVID-19 response, recommending policy and governance reforms to safeguard human rights. Our point of departure is the understanding, endorsed across the United Nations public health and the human rights communities, that: "rather than a public health response and a rights-based response being opposing poles, public health responses are only fully effective if they are absolutely grounded in human rights" (UNAIDS, 2020a).

Part 2 of our paper opens with an overview of human rights standards established under international law to uphold public health. It is these standards that provide the foundational framework for rights-based responses. Yet, as Part 3 illustrates, responses to COVID-19 in the first year of the pandemic have all too often resulted in human rights obstacles and violations in the following areas:

- **Equality and non-discrimination:** Social inequalities and discrimination have caused differential impacts of COVID-19 and COVID-19 responses in terms of health, livelihoods, education, stigma and violence. Marginalised and vulnerable groups, including racial and ethnic minorities, older persons, persons with disabilities, women, children, migrants, refugees, institutionalised persons, indigenous peoples and LGBTI+ persons have experienced multiple and intersecting human rights violations and obstacles.
- **The Rights to Life and the Highest Attainable Standard of Health:** The scale and distribution of infections and deaths are grounded in right to health obstacles predating the pandemic, including weak health systems and neglect of social determinants of health. They also reflect failures in States' COVID-19 responses to uphold their right to health obligations for the "prevention, treatment and control" of infectious diseases, and to guarantee "medical care and assistance in the event of sickness" (UNGA, 1966).
- **Economic, Social and Cultural Rights:** Sweeping restrictions to control disease transmission have disrupted education; removed sources of income; increased hunger; interrupted social care; and increased poverty, and disproportionately impacted vulnerable populations in countries with limited social protection. The lack of appropriate government planning and relief measures has undermined economic, social and cultural rights, including the rights to education, an adequate standard of living, food and social security, leaving communities impoverished and vulnerable and bearing significant public health implications.
- **Civil and Political Rights:** International human rights law permits limitations of some civil liberties to protect public health so long as those limitations are proportionate, grounded in law, non-arbitrary and non-discriminatory. Yet COVID-19 responses have often exceeded these human rights constraints, undermining the public health response. Increasingly, autocratic governments

have taken advantage of the pandemic to carry out killings, torture, detention, crackdowns on freedom of expression and restrictions on civil society space. Not only is this an affront to human rights and dignity, it undermines the public health response and democracy.

- **Participation, transparency and accountability:** Together with non-discrimination and equality, these core tenets of a human rights-based approach have been neglected in the public health response to COVID-19. Laws and policies in response to the pandemic have been opaque, developed without engaging affected communities and imposed top down, often through emergency powers and without oversight. When accountability is needed more than ever, structures such as parliamentary scrutiny and social accountability (community-led) mechanisms have been bypassed, whilst courts and critical oversight bodies have been suspended. These practices erode opportunities to review, challenge and remedy human rights violations, increasing risks that public health policies may be non-responsive and ineffective.

Our recommendations, included above, provide suggestions to strengthen governance to uphold rights, looking to reforms across States and in the WHO Secretariat to realise human rights in global health — in the pandemic response and beyond. These recommendations draw on human rights guidance and recommendations from the Office of the UN High Commissioner for Human Rights, other UN agencies and UN human rights accountability procedures for a human rights-based response to COVID-19, which will not only safeguard dignity and well-being but enhance the effectiveness and equity of the COVID-19 response and recovery.

2. International human rights law: framework for pandemic responses

Human rights constitute a universal, normative and legally binding foundation to prevent, protect against and control public health threats, and a basis for an equitable, accountable and effective public health and socio-economic response to COVID-19. The development of human rights under international law provides a basis for respecting, protecting and fulfilling the human rights that underlie health. Health-related human rights have been firmly established under international and national law, codifying norms and principles for the realisation of:

- health care,
- an adequate standard of living, including associated determinants of health, and
- infectious disease prevention and control, commensurate with public health risks and avoiding unnecessary or disproportionate limitations on individual rights.

Part 2 provides an overview of the protection of human rights under international law, focusing on key state obligations relevant to COVID-19 and responsibilities in global health governance, including the evolving mandate and operations of the World Health Organisation (WHO).

2.1. The protection of human rights under international law

The 1945 UN Charter elevated human rights as a principal foundation of the post-war international system, with the UN holding a foundational role in "promoting and encouraging respect for human rights and for fundamental freedoms for all" (UN, 1945). The 1948 Universal Declaration of Human Rights (UDHR), proclaimed by the General Assembly as "a common standard of achievement for all peoples and all nations," recognised the human rights that underlying health:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (UNGA, 1948).

Drawing from the declaration of the right to health in the 1946 WHO Constitution, this expansive vision of health in the UDHR saw the fulfilment of necessary medical care and the realisation of underlying determinants of health as a basis for public health, recognising separately that some individual rights may be limited in order to protect the general welfare (Ibid.: art. 29).

States thereafter codified the human rights proclaimed in the UDHR in a set of core international human rights treaties, including:

- International Covenant on Civil and Political Rights (UNGA, 1966a)
- International Covenant on Economic, Social and Cultural Rights (UNGA, 1966b)

- International Convention on the Elimination of All Forms of Racial Discrimination (UNGA, 1965)
- Convention on the Elimination of All Forms of Discrimination against Women (UNGA, 1979)
- Convention on the Rights of the Child (UNGA, 1989)
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (UNGA, 1990)
- Convention on the Rights of Persons with Disabilities (UNGA, 2006)

These treaties, which have near universal ratification, are complemented by regional human rights treaties in Africa, the Americas and Europe, and the incorporation of human rights in national constitutions and other legislation. As a legal and normative foundation for human rights-based responses to COVID-19, these treaties provide binding obligations under the right to health and other human rights that underlie health and define the scope of permissible limitations of civil and political rights to protect public health.

2.1.1. The right to the highest attainable standard of health and other economic, social and cultural rights

The ICESCR provides the seminal legal obligations to safeguard the right to the highest attainable standard of physical and mental health and a wide range of economic, social and cultural rights that underlie health, including: education; an adequate standard of living, including adequate housing, food, water and sanitation; social security; education; work (and rights in work); cultural rights; and to benefit from scientific progress. States must: **respect** (not violate), **protect** (protect against harm by third parties, including the private sector) and **fulfil** (take positive measures to realise) these rights (CESCR, 2000). States have obligations to progressively realise these rights, in accordance with maximum available resources, through both domestic actions and international assistance and cooperation (UNGA, 1966b: art. 2.1). Any limitations to economic, social and cultural rights should be proportionate, time-limited and strictly necessary to protect public health (CESCR, 2000).

Providing further guidance, the Committee on Economic, Social, and Cultural Rights (which oversees implementation of the ICESCR) issued General Comment 14 to interpret the features of the right to health and provide a practical understanding of the obligations imposed on states, adopting a "3AQ model" to delineate that healthcare facilities, goods and services, and social determinants of health must be:

- ***available*** in adequate numbers;
- ***accessible*** physically and geographically, on the basis of non-discrimination, and affordable to all;
- ***acceptable***, including respectful of medical ethics, culture and gender; and
- *of good* ***quality***, including being medically appropriate (CESCR, 2000).

2.1.2. Civil and political rights: Limiting human rights to protect public health

States obligations under the ICCPR extend to the promotion and protection of rights to, among others: life; privacy; liberty and security of persons; equality before the law; fair trial; freedom of association; peaceful assembly; expression; religion; movement; and freedoms from torture and arbitrary detention. The ICCPR explicitly recognises an imperative for States to limit or derogate (suspend) from certain rights where strictly necessary to protect public health. The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights (1984) first sought to define the scope of permissible human rights limitations of civil and political rights, clarifying that in the context of a serious threat to the health of the population, measures to restrict human rights should only be undertaken when, among other things, the measure is:

(1) applied as a last resort and uses the least restrictive means available;
(2) prescribed by law and not imposed arbitrarily;
(3) responsive to a pressing public need (e.g., preventing disease or injury); and
(4) deemed necessary in pursuit of a legitimate aim and proportionate to that aim.

As distinguished from libertarian approaches, which are critical of any restrictions on individual liberty to protect public health (e.g. mask-wearing, social distancing), human rights law allows restrictions of most rights where strictly needed to protect public health, recognising the complementarity of health and human rights.

2.1.3. Realising human rights in the context of COVID-19

Building on international human rights instruments, the Siracusa Principles, and learning from human rights-based approaches to the HIV/AIDS pandemic, the UN Office of the High Commissioner for Human Rights (OHCHR), partner UN agencies, and UN human rights accountability bodies have issued extensive guidance on protecting public health whilst respecting, protecting and fulfilling rights in COVID-19 (see Annex 1). This guidance demonstrates that realising human rights is necessary both to protect public health and maintain the core international values that have bound the modern world together.

2.2. Human rights as a foundation for WHO governance

The WHO has been central to realising human rights under international law as a basis for public health, both in supporting member states and in its own policies, programmes, and practices. The 1946 WHO Constitution preamble opens with the unprecedented declaration that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”, defining health expansively to include “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1946). This constitutional framing of the right to health has structured the WHO’s policies, programmes, and practices for over 70 years (Gostin et al, 2018).

2.2.1. Human rights in global health law

Human Rights have been systematically embedded in key policies framing global public health, with WHO repeatedly reaffirming human rights as a foundation of global health law. The International Health Regulations (2005), the principal legal obligations governing the global response to pandemics, require that states implement the IHR "with full respect for the dignity, human rights and fundamental freedoms of persons" (WHO, 2005). Through the explicit protection of human rights, national measures under the IHR must be based on scientific risk assessment and must not be more restrictive of international traffic, or more intrusive to individuals, than reasonably available alternatives (Negri, 2018). Seeking international collaboration and assistance to support national public health capacities, these new commitments to control infectious disease reinforce human rights obligations through global solidarity.

2.2.2. Mainstreaming Human Rights across WHO

WHO has sought to "mainstream" human rights across all of its policies, programmes, and practices. This recognition of a human rights-based approach first arose in the context of its HIV/AIDS programme, which viewed respect for individual rights as a precondition for public health in the context of HIV prevention and control (Mann and Carballo, 1989).

Supporting the expansion of this rights-based approach to health, the UN Secretary-General called on all UN programs, funds, and specialised agencies in 1997 to "mainstream" human rights across their global governance efforts (UN Secretary-General, 1997). WHO thereafter considered a more systematic application of civil, cultural, economic, political, and social rights across global health governance. Most recently overseen by the Gender, Equity and Rights Team, mainstreaming has evolved significantly, but unevenly, across the Organisation (Meier et al., 2021).

WHO Director General Dr. Tedros Adhanom Ghebreyesus has reinvigorated WHO's political commitment to human rights, promoting the right to health as a foundation of all of WHO's global health efforts (Meier and Gostin, 2018a) and establishing a Framework of Cooperation between the WHO and the OHCHR to support human rights-based approaches at country level (WHO, 2017). WHOs Global Programme of Work (2019-23) has placed the right to health at the core of WHO's mandate, declaring "[c]onsistent with its Constitution, WHO will be at the forefront of advocating for the right to health in order to achieve the highest attainable standard of health for all" (WHO, 2019).

2.2.3. WHO Commitment to Human Rights in the COVID-19 response

In the early days of the pandemic response, Director-General Tedros declared in March 2020 that: "all countries must strike a fine balance between protecting health, minimising economic and social disruption, and respecting human rights" (Adhanom, 2020a). Providing human rights guidance in the initial response to COVID-19, WHO's April 2020 report, "Addressing Human Rights as Key to the COVID-19 Response," drew on WHO's constitutional recognition of the right to health, calling for human rights to

"continue to serve as a beacon for how countries respond to this and other public health emergencies" (WHO, 2020a). In responding to the COVID-19 pandemic, the World Health Assembly passed a May 2020 resolution calling on member states to implement national plans that ensure the conditions necessary to realise health through:

> respect for human rights and fundamental freedoms and paying particular attention to the needs of people in vulnerable situations, promoting social cohesion, taking the necessary measures to ensure social protection and protection from financial hardship, and preventing insecurity, violence, discrimination, stigmatization and marginalization (WHA, 2020).

Drawing from this World Health Assembly support, Director-General Tedros has continued to champion the right to health as a moral imperative in the COVID-19 response, with WHO looking to human rights as a foundation for national responses and global solidarity. At the September 2020 Session of the UN Human Rights Council, Dr. Tedros emphasised the imperative to adopt a human-rights based approach in the COVID-19 response and recovery, highlighting the dual benefits in minimising "sickness and death, especially among marginalised communities" but also contributing "to resilience and preparedness for future disease outbreaks as well as health and economic shocks" (Adhanom, 2020b). Looking to human rights as the only path to overcome this global threat, Dr. Tedros has argued forcefully that "health is a right of all — at all times — not a privilege to be enjoyed only in times of prosperity," reasoning that "to suggest that we must choose between health and human rights is completely wrong" (Adhanom, 2020c).

3. Human rights impacts arising from COVID-19 and State responses to COVID-19

The impact on human rights of COVID-19 and responses to COVID-19 is extensive and wide ranging. Far from the vision of a human rights-based response, a review of reports by international human rights accountability procedures, UN agencies and civil society organisations reveals that COVID-19 and COVID-19 responses have resulted in limitations to, and violations of human rights including: (1) equality and non-discrimination; (2) rights to health and life; (3) economic, social and cultural rights; (4) emergency laws that lead to unnecessary or disproportionate restrictions on human rights; (5) international assistance and cooperation; and (6) participation, accountability and transparency in governance. In describing these rights impacts, we provide illustrative country-based examples of violative practices. However, these national examples are not exhaustive of either the implicated countries or impacted rights.

3.1. Equality and non-discrimination

Article 1 of the UDHR recognises that "everyone is equal in dignity and rights," (UNGA, 1948). A foundational and cross-cutting pillar of international human rights law, this key principle of the rights-based based approach to health is embodied in legal protections of equality and non-discrimination in every international human rights treaty, and in the commitment to "leave no-one behind" in the 2030 Agenda for Sustainable Development (UNGA, 2015).

International human rights law explicitly proscribes discrimination across all rights on grounds including race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability, health status (including HIV/AIDS), LGBTI+ status, and civil, political, social or other status (CESCR, 2000). The uneven distribution of the impact of the pandemic reinforces the need for an intersectional lens to tacking inequalities and non-discrimination. An intersectional focus allows moving beyond a siloed and binary approach to addressing disadvantage on the basis of singular identity or other aspects of social position (such as race, gender, class, migrant status) that are used as a basis for discrimination. It requires understanding the diverse factors and processes and how these interact to produce intersecting forms of inequity (Hankivsky & Kapilashrami, 2020a). It also requires tailored and affirmative action to realise the human rights of vulnerable and marginalized population groups, including the above groups as well as institutionalised populations (in prisons, care homes, or psychiatric institutions), indigenous populations, refugees, migrants, and sex workers (Hankivsky & Kapilashrami, 2020b). With increasing reliance on information and communication technology in pandemic responses in fields including health information, surveillance, and education, inequitable access to those technologies, often playing out along existing fault-lines including income, age and gender, risks further marginalising already vulnerable and marginalised communities.

3.2. Rights to health and life

The rights to life and to the enjoyment of the highest attainable standard of physical and mental health are centrally relevant in the context of COVID-19 (WHO, 2020a). The right to life obligates States to take measures to address conditions in society such as life-threatening diseases, including preventive action, and access without delay to healthcare and other social determinants of health (Human Rights Committee, 2019).

The right to health, which the WHO has proclaimed a "beacon" for COVID-19 responses and other public health emergencies (WHO, 2020a), requires States to take steps for: "the prevention, treatment and control of epidemic, endemic, occupational and other diseases," (UNGA, 1966b: art 12.2), including through immunisation, surveillance, information campaigns and other infectious disease control strategies grounded in scientific evidence (CESCR, 2000). The experiences of countries such as New Zealand, Taiwan and Singapore underscore that effective, evidence-based and timely public health responses can pre-empt a downwards spiral for both public health and human rights.

States have obligations to create "conditions which would assure to all medical service and medical attention in the event of sickness," (UNGA, 1966b: art. 12.2), and for safe working conditions (CESCR, 2000). Vaccines should be distributed according to medical need or public health grounds, prioritising groups such as health staff and care workers or persons presenting greater risks of developing a serious health condition because of age, or pre-existing conditions, exposure or due to social determinants of health such as people living in informal settlements or other forms of dense or unstable housing, people living in poverty, indigenous peoples, racialized minorities, migrants, refugees, displaced persons, incarcerated people and other marginalised and disadvantaged populations (CESCR, 2020a). As elaborated in the WHO SAGE values framework for the allocation and prioritisation of COVID-19 vaccination, prioritisation of vaccination should be established through transparent protocols and procedures that respect human rights (OHCHR, 2020a).

3.2.1. Equality and non-discrimination in the right to health

State failures in realising the rights to life and health on the basis of equality and non-discrimination are evidenced by the uneven distribution of COVID-19 morbidity and mortality along lines of pre-existing inequities. This is triggered by inequalities in underlying determinants of health and policy responses that fail to protect vulnerable and marginalised persons including: racial and ethnic minorities; older persons in care homes (Amnesty et al., 2020a); persons deprived of their liberty (Amnesty et al., 2020b; HRW, 2020a); migrants, internally displaced persons and refugees; indigenous persons (Milhorance, 2021); people with disabilities (WHO, 2020b); and health and care works and other at-risk professions.

3.2.2. Availability, accessibility, acceptability and quality of healthcare

Many countries have faced difficulties in ensuring the availability, accessibility, acceptability and quality of COVID-19-related health coverage in accordance with the right to health (CESCR, 2000), experiencing shortages in the trained workforce and essential medical care, including diagnostic tests, ventilators, and oxygen, and in personal protective equipment (PPE) for health-care workers and other front-line staff (Special Rapporteur on the right to health et al, 2020a). Although COVID-19 elicited a swift response from African leaders, efforts have been hampered by a lack of capacity for testing, isolation, contact tracing and treatment of severe disease (HRW, 2020b). Shortages in PPE were affected by international obstacles (see Section 3.5 below), and national obstacles, for example in Thailand there was black-market profiteering, hoarding and corruption (HRW, 2020c). While the right to health requires non-discriminatory access to health facilities, goods and services (CESCR, 2000: para. 12b) access to services and equipment has often been inequitable. Despite acute needs, there were failures in many countries to provide adequate PPE in residential facilities for persons with disabilities and older persons (Disability Rights International et al., 2020). Inequitable access to healthcare has been an obstacle for vulnerable populations, including indigenous populations in Brazil; and populations living in non-government-controlled territory in Syria (Sehoole, 2020).

Obstacles to available and accessible healthcare are rooted in decades-long failures to devote maximum available resources to, and poor planning in, health systems, and were exacerbated by the global financial crisis of 2007–2008 (CESCR, 2020a; HRW, 2020c; Sekalala et al., 2020a). Underfinanced public health systems, affected by austerity and structural adjustment, have witnessed growing privatisation in most parts of the world - including both high income countries (Montel et al., 2020) as well as most low- and middle-income countries (Sehoole, 2020). In previous epidemic responses, including Ebola, countries with privatised health systems experienced worse health outcomes, higher out-of-pocket spending, and greater indebtedness (Pailey, 2014). States bear obligations to ensure that privatisation does not constitute a threat to the availability, accessibility, acceptability and quality of healthcare and must adequately regulate the private sector (CESCR, 2000). Yet, during the pandemic, market reforms and the 'purchase of care' model have posed particular problems for the right to health (Fig 1).

Fig 1: Privatised health services in the context of COVID-19: implications for the right to health

While many public health systems have been overwhelmed, there are distinct implications of privatisation with regard to availability, accessibility and affordability of the right to health care (CESCR, 2000). High costs of COVID-19 testing and hospitalisation in private sector facilities can prevent individuals from getting tested, putting them at greater risk (Wapner, 2020). Economic accessibility or affordability thus becomes a deterrent for socio-economically disadvantaged groups, and places greater burden on them as compared to wealthier families and nations. Weak accountability of privatised healthcare systems and risk of compensations arising from deaths led many private hospitals to close during the first surge of pandemic. When they did start providing for COVID-19 care, they did so at disproportionately high costs and without insurance cover (Sundararaman et al., 2021). Responding to shortages of care, the Spanish government nationalised private hospitals and the UK government rented private hospital beds to improve the availability of care (Sekalala et al, 2020a).

Yet, in many countries, reports indicate an acceleration of privatisation in countries under contingency measures that outsourced critical COVID services (contact tracing, testing) to large private corporations without a clear rationale and without transparency. For example, in the UK, major contracts were entered into with firms such as Serco to run contact tracing, Deloitte to manage drive-in centres and super-labs, and other firms brought in to procure and manage PPE, build data repository, manage and recruit health workers among other services. Citing gross failures of some of these firms in providing accurate data and "minimal oversight" from the NHS and the government, the British Medical Association has called for the "inclusion of private outsourcing in any future inquiry into the government's handling of the pandemic and greater transparency over the details of the State's agreement with firms" (British Medical Association, 2020).

Further, since the outbreak of COVID-19, through broader health system disruptions, the pandemic has had a sweeping, multidimensional impact on access to other core services for the right to health including: vaccination services (WHO, 2020c); contraceptives supply; family planning clinics (Special Rapporteur on the right to health et al., 2020b); abortion services and post-abortion care (HRW, 2020d; HRW, 2020e); and cancer care (UN News, 2021). Restrictions in access to sexual and reproductive health services have particularly affected women and girls, including women living in poverty, women with disabilities, Roma women, undocumented migrant women, adolescents, and women at risk or who are survivors of domestic and sexual violence (Amnesty et al., 2020c). Further, mental health services have been disrupted in almost every country (WHO, 2020d), even as COVID-19 has had a detrimental impact on the right to mental health (Puras, 2020) and demand for mental health services has increased exponentially.

This denial of the right to health has also extended to the distribution of COVID-19 treatment and vaccinations. In addition to human rights violations through inequitable global distribution (see Section 3.5), many countries have failed to adopt fair and rights-based prioritisation processes to allocate treatment, based on need, non-discrimination and equality (Michalowski et al., 2020). Vaccine prioritisation, with varying criteria being adopted, has sometimes embraced exclusionary approaches, including along existing lines of inequality. Of particular concern to human rights experts has been exclusion of population groups on grounds of ethnicity, nationality or documentation. In Israel, Palestinians living in the West Bank and Gaza have been excluded from vaccinations whilst Jewish settlers in the West Bank have received vaccinations (HRW, 2021a). In Mexico, access to vaccines for those over 60 years old is conditional on their Unique Population Registration Number (CURP), which excludes migrants, deported Mexicans, some binational people, and indigenous internal migrants (Amnesty et al., 2021).

3.2.3. Access to accurate health information

The rights to health and freedom of expression intersect to require States to provide access to accurate health information about the pandemic (CESCR, 2020a). Information must be accessible to all on the basis of non-discrimination. In New Zealand, The Ministry of Health worked quickly with Disabled People's

Organisations, and the Human Rights Commission, to set up a 'hub' within government that helps to streamline the provision of COVID-19 information in accessible formats (New Zealand Human Rights Commission Te Kāhui Tika Tangata, 2020). However, there were delays uploading information, and it was sometimes hard to locate the accessible format information, leading the New Zealand Human Rights Commission to recommend greater governmental engagement with persons with disabilities and their families to help enhance information accessibility (New Zealand Human Rights Commission Te Kāhui Tika Tangata, 2020).

Access to reliable information is also central for combating misinformation, with measures such as fact-checking, education and media literacy also key (OHCHR, 2020c). However, restrictive measures, including legal measures, to combat misinformation should be carefully crafted as they may lead to censorship (e.g., through refraining from restricting health workers disclosing information about COVID-19 outbreaks, or a lack of PPE, as has happened in some countries) undermining freedom of expression and a robust public health response.

3.2.4. Public health control measures to protect the right to health

The impacts on the right to life and health were exacerbated in some countries by failure to adopt effective control measures, through social distancing, isolation and quarantine. Nicaragua, Brazil, the United States and the United Kingdom are among countries that received criticism for failing to put in place, or delays in adopting, adequate measures, reflected in rapidly escalating cases and high death rates (Bueno de Mesquita et al., 2020).

Physical distancing policies were not always adapted to the right to health entitlements of vulnerable groups. Physical distancing for persons deprived of their liberty has been particularly problematic, with failures to implement measures in prisons, care homes and psychiatric hospitals, leading to outbreaks. Where measures were implemented, at times they led to severe isolation, with care home residents unable to see family members for lengthy periods, and persons in prisons confined to cells. The particular challenges of safeguarding lives and health in institutionalised settings led to rights-based calls to release some persons, including from detention and psychiatric institutions (Inter-Agency Standing Committee, 2020; Special Rapporteur on the right to health, 2020), with particular concerns also raised in terms of suspension of oversight activities of inspectorates of care homes or detention facilities (Organisation for Security and Cooperation in Europe, 2020). There have also been shortcomings in preventing transmission through physical distancing for other groups, resulting, for example, in transmission into remote indigenous communities (Droubi et al., 2020).

3.3. The economic and social rights consequences of restrictions

Economic, social and cultural rights protected in the ICESCR, including rights to adequate housing; water and sanitation; food; education; social security, and science, are reflective of social determinants of health. Timely and effective measures are needed to support the enjoyment of core economic and social

rights of people affected by emergency restrictions, including through support for employment and livelihoods, housing, food, education, social protection and health, in order to enable them to comply with the emergency measures (OHCHR, 2020c).

In the absence of rights-based protections, orders to "stay at home" are impoverishing communities, obstructing the right to education, preventing individuals from purchasing basic necessities, closing off necessary support services, facilitating gender-based violence, and widening health inequities across populations. A combination of economic consequences of COVID-19 and COVID-19 responses, and a lack of social protection, is expected to push hundreds of millions into extreme poverty, with enormous consequences for economic and social rights. Over one billion children have been affected by school closures, with particular impacts on the right to education of children with disabilities and children living in poverty (HRW, 2020f; Disability Rights International, 2020), and the right of children to adequate food (High Court of South Africa, 2020; HRW, 2020g). With schools closed and care services for older and disabled persons interrupted, women have shouldered a disproportionate burden of unpaid care responsibilities, been increasingly affected by the rise of gender-based violence, and have been at higher risk of losing their livelihoods due to working in economic sectors affected by COVID-19 (UN Women, 2020). Such inequalities in social determinants further translate into differentiated risks of infection and death for vulnerable populations.

While many countries instituted economic and food support programmes, in reality not all population groups were reached. In India, the emergency package did not adequately address the needs of workers in the informal economy and migrants, particularly affecting women - with informal economy workers in many other countries also similarly excluded (HRW, 2020h).

3.4. Emergency laws and civil liberties restrictions in pandemic responses

International human rights obligations do not cease within global pandemics; however, many governments have introduced laws that restrict rights to protect public health. The Siracusa Principles provide options for States to invoke exceptional emergency powers, enter derogation to human rights treaties and restrict certain human rights in the ICCPR to protect public health, provided that such limitations are necessary, proportionate, and non-discriminatory (UN Commission on Human Rights, 1984). To protect the right to life and health, the Human Rights Committee has highlighted that "States parties confronting the threat of widespread contagion may, on a temporary basis, resort to exceptional emergency powers and invoke their right of derogation from the Covenant [ICCPR] under article 4 provided that it is required to protect the life of the nation" (Human Rights Committee, 2020). However, derogation should be a last resort, with the Human Rights Committee favouring an approach of restrictions and limitations of certain human rights (e.g. freedom of movement) to protect public health. Yet, with few states officially derogating from the ICCPR or regional treaties in the COVID-19 response (Scheinin, 2020), the Human Rights Committee has expressed concern about States not following correct derogation notification procedures in accordance with the Siracusa Principles (Human Rights Committee, 2020), reducing the opportunity for human rights safeguards and state accountability.

In the absence of derogations, many States have introduced COVID-19 emergency laws. Assessing these emergency laws, the UN human rights system has found that any emergency powers must be used only as a last resort, the least intrusive route in view of necessary public health objectives, and include sunset or review clauses to revert to normal laws once the emergency is over (OHCHR, 2020b).

Yet, many governments have taken extensive actions that restrict human rights without any effort, in accordance with the Siracusa Principles, to justify the legitimacy, necessity, or proportionality of such actions to protect public health (HRW, 2020i). Without considering the necessity and proportionality of responses (Habibi et al, 2021), some States have introduced or enforced laws and regulations in ways that are not based on the best available evidence, undermining public health with justice. Law is an important determinant of health, establishing fair and evidence-based health interventions, yet the law can be developed or implemented in ways that are unsupported by scientific evidence (Gostin et al, 2019). Such unsupported laws can undermine public health and entrench inequalities, inappropriately or disproportionately punish individuals and limit space for dissent and debate (Gostin et al, 2019). States of emergency or other emergency laws, sometimes imposed by decree by the executive, have interfered with parliamentary or other forms of scrutiny. This removes safeguards against the abuse of power, and risks poorly-targeted laws, regulations and policies that infringe on, or lead to violations of, human rights while failing to protect public health (Fig 2).

Fig 2: Legislation and policies that did not comply with international human rights law and standards: extract from Amnesty International, COVID-19 CRACKDOWNS: POLICE ABUSE AND THE GLOBAL PANDEMIC (December, 2020)

"In response to the COVID-19 pandemic, many countries rushed through legislation and policies that did not comply with international human rights law and standards. This included legislation creating a presumption in favour of the police when determining whether it is reasonable to use of lethal force, such as in Peru, thus increasing the risk of police abuse and impunity. State of emergency laws further conferred unfettered powers on governments to take measures to respond to COVID-19. Early in 2020, countries including Hungary adopted broad states of emergency that contained no checks and balances or periodic reviews by parliament. Cambodia's government used COVID-19 as a pretext to pass a law enabling and regulating states of emergency. The law's vaguely worded provisions, if invoked, would give the authorities unprecedented powers to implement "other measures that are deemed appropriate and necessary in response to the state of emergency", with no checks and balances. In several other countries including France, Thailand, Kazakhstan and Morocco, such measures disproportionately restricted the rights to freedom of peaceful assembly and freedom of expression. Even where no official state of emergency was declared, measures claimed by the authorities to be justified to fight the pandemic were used to repress dissident voices and political opponents. In Greece, the head of police declared a blanket ban on public outdoor assemblies of four people or more for four days in November, which meant that yearly demonstrations to commemorate the 1973 Polytechnic student uprising against the military government were banned."

3.4.1. Travel Restrictions

Under the IHR, health responses "shall not be more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives" (WHO, 2005b:art. 23), yet in responding to the pandemic, many countries rushed to implement selective bans on international travel. These travel bans were implemented rapidly in lieu of less restrictive alternatives like social distancing measures that include adequate socio-economic safety nets (Habibi et al., 2020). Where such bans are not supported by public health evidence, they have the capacity to undermine the human right to freedom of movement and undercut the global solidarity needed in the pandemic response, especially where states fail to notify WHO as required by the IHR (UNGA, 2020).

3.4.2. Human rights abuses in enforcing public health measures

Many emergency powers relating to lockdowns, quarantines, curfews, isolation and other distancing regulations have been enforced arbitrarily and with violence by governments and in some cases armed opposition groups (HRW, 2021a; HRW, 2020j). Refugees, asylum-seekers, migrant workers, racial and ethnic minorities, LGBTI and gender non-conforming people, sex workers, homeless people and people at risk of homelessness, Roma populations, and persons deprived of their liberty, are among groups that have been particularly affected by discriminatory human rights violations in the context of social distancing (Amnesty et al., 2020d, 2020e, 2000f; HRW, 2020l). In several European countries police enforcement of lockdowns exhibited racial bias and discrimination (Amnesty et al., 2020g). Sudden lockdown measures and border closures and restrictions left migrant workers stranded in crowded temporary shelters, without work and food, forcing them to undertake long and dangerous journeys back to their villages within countries and across borders, by crossing at unofficial border points; increasing their vulnerability to violence and exploitation (Kapilashrami et al., 2020).

3.4.3. Excessive, disproportionate reliance on criminal law

Many States' responses turned rapidly to criminal law to compel compliance with lockdowns, physical distancing, isolation, curfews and travel restrictions. Criminal law approaches raise significant human rights concerns, and are often ineffective for, and risk undermining, public health. For example, criminal penalties can lead to discriminatory outcomes with those lacking access to reliable information, clean water or safe shelter, often from already marginalised groups, most likely to face arrest and detention (UNAIDS, 2020a). Around the world, hundreds of thousands of people have been arrested for violating COVID-19 orders (UNAIDS, 2020a). Subsequent detentions have sometimes been in overcrowded and insanitary conditions that risk fuelling COVID-19 transmission among those detained as well law enforcement personnel (UNAIDS, 2020a). This is contrary to guidance from the OHCHR that "deprivation of liberty must be reasonable, necessary and proportionate in the circumstances" and that governments should "pay specific attention to the public health implications of overcrowding in places of detention and to the particular risks to detainees created by the COVID-19 emergency" (OHCHR, 2020c). Further, the

enforcement of criminal law approaches can detract attention and resources from effective public health approaches, such as public information; testing, contact tracing and treatment; economic support for isolation, and it can undermine trust, partnership and community-led approaches (UNAIDS, 2020a).

3.4.4. Surveillance

Data collection is recognized as necessary under the ICESCR and the IHR to detect infectious disease threats. In responding to COVID-19, governments are increasingly turning to new surveillance technologies, including tracking apps, global positioning technology, and facial recognition technology. Digital technologies can add value to surveillance, helping identify cases, if integrated into a broader public health system, including testing and contact tracing (WHO, 2020e). With questions about the efficacy of these technologies for realising the right to health, these new technologies risk violations of the rights to privacy, have implications for equality, non-discrimination and autonomy; and have raised concerns about a new age of surveillance and future use of the technologies to surveil individuals or groups in society (McGregor, 2020). Mandatory use of apps, including in employment contexts, can have an exclusionary impact or lead to impoverishment. Despite the purported use of surveillance for public health purposes, these technologies are being abused by governments to exercise autocratic control and to facilitate other violations (Sekalala et al, 2020b).

3.4.5. Clampdowns on political opponents, the media civil society space

Emergency provisions for the protection of public health that restrict human rights such as freedoms of movement, expression and assembly have been abused to impose restrictions on democratic processes, media civil society, with these laws exploited to attack human rights defenders, health professionals, political opponents and the media.

In Ethiopia, the 2020 presidential election was indefinitely postponed until the pandemic “has subsided”, raising concerns about policies that restrict citizen’s ability to take part in public affairs without a valid public health reason (elections in other parts of the world have proceeded safely amid the pandemic with COVID-19 protocols). In Uganda, in the run up to presidential elections, COVID-19 regulations were used as a pretext by authorities to violate human rights of opposition leaders and members and clamp down on the media (HRW, 2020m). In Zimbabwe, political leaders and members of the opposition were abducted, tortured and sexually abused after participating in a protest against rising levels of hunger and abuse of government sourced food aid during the lockdown (Amnesty et al., 2020d). In Russia, whilst distancing restrictions were relaxed, including for sports and entertainment, a blanket ban on all outside activities persisted with suggestions that it was used to deny a protest over constitutional reform (HRW, 2020n).

UN High Commissioner for Human Rights Michelle Bachelet has expressed alarm at freedom of expression clampdowns in parts of the Asia-Pacific during the COVID-19 crisis, with arrests and detention of people criticising government’ responses to COVID-19 for spreading “fake news” (OHCHR, 2020b). Such actions

undermine effective health responses, Laws penalising expression based on vague concepts such as "fake news" or disinformation in relation to the COVID-19 pandemic, are incompatible with the requirements of legality and proportionality (OHCHR, 2020d).

3.4.6. Stigmatising and discriminatory rhetoric and hate crimes

Many of the national responses to the pandemic are grounded in racial scapegoating, xenophobia, and anti-immigrant sentiment. This has ranged from associating the virus with a particular ethnicity (e.g. Trump's references to "Chinese virus" in the US), to targeting particular religious minorities and other persecuted communities (e.g. allegations of culpable homicide on the chief of *Tablighi Jamaat* in India for having spread the virus, differential treatment of *Hazaras* returning to Pakistan from Iran) (Gover et al., 2020; Sarkar, 2020). Likewise, low-income migrants and refugees were scapegoated for spreading the virus, subjected to ill-treatment by authorities including being sprayed with chemical disinfectants or held in detention under very poor conditions (Kapilashrami, 2020; Samaddar, 2020).

Inflammatory rhetoric has led to violence, discrimination and stigma, undermining rights, public health objectives and deepening social division (HRW, 2020o). Framing these communities as 'carriers' and 'transmitters' of the virus created the ground for racially targeted hate crimes and physical assaults leading to deaths as well as ostracization and obstruction of welfare measures from reaching stigmatised groups (e.g. burning of quarantine centre for *Hazaras* by local residents in Pakistan) (Gover, Harper, and Langton, 2020). Further, such scapegoating and stigmatisation can drive people to not disclose their illness and prevent them from getting tested or from seeking immediate medical attention (Saeed et al., 2020). Racial victimisation has also been observed to have mental health consequences (Gee et al., 2007). Where the State apparatus was not complicit in commissioning or condoning such violence, several acts of omission were observed. Failure to counter the narrative of ethnically diverse cities being 'epicentres' of COVID has escalated xenophobia, racism and further ostracization.

Systematic attacks, intimidation and threats of disciplinary action, and retaliatory lawsuits from authorities against public health sector whistle-blowers who criticised government responses and reported shortages of supplies and corruption in procurement, were reported in several countries such as Thailand and China (HRW, 2020c). An increase in attacks on health workers and rise in instances of bullying, harassment from local residents and communities is reported. A cross-sectional study of HCWs in 173 countries reported an increased likelihood of experiencing COVID-19 related stigma and bullying, 13% of descriptions of which involved physical or verbal violence (Dye et al., 2020). Scholars noted such risks were in the context of increased racism, violence and police involvement in community settings.

3.5. International Assistance and Cooperation

Under treaties such as the ICESCR, States have an obligation to realise economic, social and cultural rights, including health, in other jurisdictions through international assistance and cooperation (UNGA, 1966b: art. 2). With an understanding that these international obligations are necessary for the full realisation of human rights, the UN's specialized agencies have taken the lead in directing this economic and technical

cooperation within their respective areas of competence, mainstreaming human rights across the full range of intergovernmental organisations, funding agencies, and international bureaucracies that advance global health (Meier and Gostin, 2018b). In supporting these international obligations of assistance and cooperation, the IHR provide a path for international collaboration and assistance in the development, strengthening, and maintenance of national public health capacities to respond to infectious disease threats (WHO, 2005: art. 44).

Yet many governments have failed to provide sufficient support in response to the pandemic, threatening the health and human rights of the most marginalized populations. Aligned with UN and WHO calls for global solidarity, human rights obligations of international assistance and cooperation are central to the COVID-19 response, requiring that countries coordinate efforts to reduce the economic and social impacts of health threats, cooperate with the WHO, and share data, health research, medical equipment, supplies, and best practices (CESCR, 2020a; Pūras et al., 2020b). This requires that states refrain from nationalist measures or sanctions that restrict the flow of essential goods, including health equipment, or obstructing the export of vital medical equipment that is also needed by the world's most vulnerable (CESCR, 2020b; OHCHR, 2020c). As seen in Iran, where international sanctions prevented the state from obtaining necessary medical supplies, including medicines, respirators and PPE, the UN High Commissioner for Human Rights called for the easing or suspension of sanctions. Additionally, global governance institutions must support universal and equitable access to COVID-19 vaccination. To this end, States must seek to reduce vaccine nationalism, as these protectionist policies are incompatible with obligations under international human rights law to ensure the equitable distribution of vaccines and medicines (Special Rapporteur on the Right to Health et al, 2020c); amount to discrimination; and undermine the achievements of Sustainable Development Goals 3 and 17 (CESCR, 2021). Recognising that many low-income countries are limited in their ability to realise the health of their peoples without international cooperation, UN human rights oversight bodies have sought to codify international obligations under the purview of the human rights to health and to benefit from scientific progress, drawing on human rights obligations of international assistance to support: the COVAX initiative; flexibilities in the TRIPS Agreement (and temporary waivers for some of the provisions of the TRIPS agreement) for vaccines and treatment for COVID-19; international scientific cooperation and vaccine development capacity to allow universal and equitable vaccine access in low-income nations (CESCR, 2020a; CESCR, 2021).

3.6. Cross-Cutting Human Rights Principles in Rights-Based Governance

Looking beyond specific rights, cross-cutting human rights principles and values extend across the realisation of all rights and underlie the governance of a rights-based approach to health necessary for the achievement of health outcomes. The core values embodied by a human rights approach, namely partnership and solidarity, responsibility, fairness, dignity, freedom, and protection, offer a useful compass for planning and implementing public health policy and socio-economic recovery. These values inform the foundational human rights principles of equality and non-discrimination (see 3.1 above), participation, accountability and transparency on which a rights-based governance approach is grounded.

3.6.1. Participation

Political and public participation rights underpin all human rights, as well as democratic governance, the rule of law, social inclusion and economic development. Participation is central to empowerment; countering discrimination, inequalities, marginalisation and stigma; and accountability for human rights. The UN Special Rapporteur on the Right to Health extended participation under the right to health, recognising that "[t]he right to health requires that health policies, programmes and projects are participatory. The active and informed participation of all stakeholders can broaden consensus and a sense of 'ownership', promote collaboration and increase the chances of success" (Hunt & Bueno de Mesquita 2006). WHO has drawn from this rights-based consensus to find that "[t]he principle of participation and inclusion means that people are entitled to participate in decisions that directly affect them, such as the design, implementation and monitoring of health interventions. Participation should be active, free and meaningful" (WHO, 2011).

WHO identifies participation of those affected by policies, laws, and decisions as one of the five key elements of pandemic governance, especially relevant for preparedness governance, as it serves an important opportunity to secure participation which may not be possible during a pandemic response. Yet, participation of affected communities has been a critical omission in the development of country preparedness plans and national task forces.

States have been encouraged to create avenues for participation and feedback and ensure existing channels for participation locally, nationally and internationally are maintained (OHCHR, 2020d). Drawing on experiences from HIV/AIDS, participation by way of community-led responses has been underscored as an essential tool to develop effective, rights-respecting COVID-19 responses (UNAIDS, 2020b). Participation of communities helps garner public support, increase uptake and success of interventions, and in the long-term build trust in government decision-making and in public facilities. It is also essential to ensure that measures will address structural inequalities that obstruct human rights in COVID-19; be culturally appropriate and sensitive to gender and the needs and rights of different groups; that they will be effective; and to address or avoid unintended consequences.

However, COVID-19 responses worldwide have tended to be top-down, with authorities establishing rules and regulations, obviating participation through democratic processes, and civil society and community engagement (Marston el al, 2020). The failure to engage marginalized communities and groups, including women, persons with disabilities, indigenous communities, children, ethnic and racial minorities, and persons in poverty, has fuelled responses that foster inequalities and discrimination, undermining both human rights and public health objectives.

3.6.2. Accountability

Rights-based accountability is a dynamic process for the promotion and protection of human rights. It comprises four components: monitoring (e.g., collecting qualitative and quantitative data, including indicators), review (assessing data and information against human rights commitments), remedies and action (putting matters right when review exposes a human rights deficit) (Independent Accountability Panel, 2016). Transparency, the rights to participate and a fair trial, and freedoms of expression, peaceful assembly and the right to a fair trial underpin accountability. As well as explicitly rights-based procedure, there are many accountability procedures that may facilitate the promotion and protection of human rights (Meier, Huffstetler and Bueno de Mesquita 2020). However, human rights considerations are often not systematically considered, which elevates risks that laws, regulations and policies will infringe on human rights, underscoring a specific role for human rights-based reviews. During the pandemic, accountability processes have had to cope with the challenges of the pandemic, including requirements to work in new, socially distanced ways, as well as coping with an escalation of human rights violations.

National level accountability

Human rights accountability can be provided at the national level by courts, national human rights institutions, parliamentary scrutiny, and administrative procedures and social accountability processes. In the UK, the parliamentary Joint Committee on Human Rights undertook a review, including making recommendations, of the impact of the Government's COVID-19 response on human rights (Joint Committee on Human Rights, 2020). In South Africa, the High Court found a violation of the right to adequate food as a result of the suspension of school meals when schools resumed after COVID-19 lockdown. In New Zealand, through engaging with communities, and both advising and holding accountable the government, the National Human Rights Commission pressed New Zealand's Government to ensure that its' COVID-19 response was human rights based (Hunt, 2021).

Beyond these examples of good practices, in many countries opportunities to hold duty bearers to account have been constrained, precisely at the time that these opportunities are needed more than ever in a context of widespread, systematic neglect and abuse of human rights. Emergency laws introducing rule by decree have limited the accountability functions of the legislature. Fast-tracked legislation has limited important opportunities to improve laws, regulations and policies: in this context, establishing ongoing review processes can help make amendments where necessary. Further, opaque decision-making, falling short of transparency requirements, has obstructed meaningful monitoring and oversight.

Data is essential to monitoring and accountability. In some countries, data has been suppressed, including in China in early 2020, compromising monitoring, accountability and an effective public health response domestically and globally. Further, the vast majority of national statistics offices in low- and middle-income countries have experienced reduced ability, including as a result of budget cuts, to meet international reporting requirements (UN Women, 2020). In many countries, data on COVID-19 and its impacts has not been sufficiently disaggregated, including by multiple dimensions, which means that the

differential impacts are often obscured (UN Women, 2020). Human rights impacts are not always identified clearly or consistently in monitoring, thus, to improve statistical oversight, the OHCHR developed a framework of 10 key indicators for monitoring human rights implications of COVID-19 (UN, 2020: Annex 1).

Justice systems, including courts, have been suspended or have been operating at reduced capacity. These interruptions have implications for access to justice for human rights violations including in COVID-19 responses, as well as curtailing options for public interest litigation to improve pandemic responses.

International level accountability

States are also held to account for their human rights obligations at the international level by: the UN treaty bodies, which are committees of independent experts overseeing States parties compliance with international human rights treaties; the Universal Periodic Review (UPR), a peer review procedure of all States by the Human Rights Council; and Special Procedures of the Human Rights Council, independent experts appointed to oversee human rights standards worldwide, such as the UN Special Rapporteur on the right to health. Additionally, the High Commission for Human Rights and the OHCHR are mandated to speak out against human rights abuses. Regional human rights procedures, including courts and commissions, have exercised essential accountability functions.

Since the outbreak of COVID-19, these human rights bodies have closely monitored the impact of COVID-19 on human rights, highlighting concerns and making guidance through reports submitted to the Human Rights Council, the General Assembly and in statements and press-releases (see Annex 2). In response to allegations of human rights violations relating to COVID-19, the UN Special Procedures have exercised accountability though numerous communications to governments highlighting these allegations, requesting written responses as well as remedial action where required. With State party reporting under international human rights treaties resuming in Spring 2021, States will be held to account for the compliance with these treaty obligations in their COVID-19 responses through interactive dialogues between treaty bodies and States' representatives, and Concluding Observations in which treaty bodies highlight concerns and make recommendations to improve compliance. The UN High Commissioner for Human Rights has highlighted both concerns and examples of good practice in the COVID-19 pandemic before the Human Rights Council (OHCHR, 2020a). The UPR, the only inter-governmental, peer-review based human rights mechanism in the UN, is yet to respond in a systematic way to COVID-19. Despite the cyclical nature of reporting, concerns should now be raised about COVID-19 and recommendations made: a small number of States have begun to do so yet there is scope for much improvement (Kothari, 2021).

Beyond the UN's human rights system, global health procedures have a predominant focus on reporting, with fewer opportunities for review and remedial action. In the absence of a review procedure, there have been limited opportunities to hold States to account for pandemic preparedness and responses to emerging crises under the IHR (WHO, 2005). Leaning from the UN human rights system, as well as promising good practices for accountability in global health, notably the Every Women Every Child Independent Accountability Panel, these is a need to develop robust, human rights-based accountability,

encompassing monitoring, review, remedies and action (IAP, 2016), to better prevent and protect against the international spread of infectious disease.

3.6.3. Transparency

Making available information to allow for understanding and monitoring of government decisions and performance, transparency is a prerequisite for accountable rights-based governance, as well as for non-corrupt and fair health systems (Bustreo and Doebbler 2020; Puras, 2017). Rights-based governance requires transparency in the development of national health strategies and plans (CESCR, 2000).

States' human rights obligations entitle people to the right to information on what measures governments are taking to protect public health, what evidence underlies these measures, the cost implications and how the government is allocating public funds. This information and transparency considerations (invoked through instruments such as freedom of information laws) can help expose "lax government oversight and contractual "deregulation" thus holding governments to account (HRW, 2020p). In addition, such measures also allow monitoring and oversight of the beneficiaries/ fund recipients of contracts preventing corruption and misuse of public funds. Non- transparency in resource allocation has been associated with corruption and inefficiency of crisis responses (Transparency International, 2021; Toebes, 2011).

Yet, to date, several governments have made very little information publicly available around funding agreements; decisions-making on outsourcing critical public health functions to corporations; as well as decision making on which populations are most affected. In many countries, deaths and infection rates were severely underreported, and many states failed to build public trust by explaining what measures were adopted and why.

While several aspects of transparency are critical to the pandemic, this report emphasises three core areas that states must attend to in increasing transparency:
i) communicating the scientific advice informing decision-making with regards to containment measures, suspension or prioritisation of services.
ii) reporting of funding pledges, bilateral agreements, terms and conditions on vaccine development.
iii) public contracting and procurement processes for PPE, testing, and drugs and vaccines.

Several mechanisms and tools are available to enhance transparency and accountability of states. These include right to information/ freedom of information acts, social audits and community-based monitoring approaches (Hausmann-Muela, 2011; Toebes, 2011). In addition, promising transparency initiatives, such as the WHO list of Medicine Price Information Sources and the Pharmaceutical System Transparency and Accountability Assessment Tool, can offer useful information regarding pricing etc. and strengthen mechanisms at the country level.

4. Conclusion

In the year following the emergence of COVID-19, the entire UN system has demonstrated a strong commitment to human rights in the COVID-19 response. Yet, with the exception of a few promising initiatives, State responses have exhibited a disconnect from their human rights obligations and guidance provided by UN human rights procedures, the OHCHR and the WHO. Learning from the consequences of these shortcomings, there is an opportunity to reset pandemic responses in a more equitable, effective and humane direction, providing a path through human rights to build back better and fairer and for stronger and resilient health systems. As recognised by the WHO, "embracing human rights as an integral part of our public health response will not only provide ethical guidance during these difficult times but set the foundation for how the world responds to public health crises going forward" (WHO, 2020a).

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The views expressed are those of the authors and do not necessarily reflect the views of the Independent Panel for Pandemic Preparedness and Response.

Annex: OHCHR Guidance

OHCHR, Communications Sent Report, https://spcommreports.ohchr.org/LatestReports/CommunicationSent

- This webpage includes communications sent to the Human Rights Council about human rights violation allegations, with many reports from 01 June 2020 to 30 Nov 2020 pertaining to violations in the context of COVID-19. When available, States' replies are also published on the site.

OHCHR, COVID-19 and Special Procedures, https://www.ohchr.org/EN/HRBodies/SP/Pages/COVID-19-and-Special-Procedures.aspx

- This webpage includes a range of Special Procedures' documents, guidelines, reports and statements that embrace human rights principles of non-discrimination, participation, empowerment and accountability in addressing the COVID-19 crisis.

OHCHR, COVID-19 and its human rights dimensions, https://www.ohchr.org/EN/NewsEvents/Pages/COVID-19.aspx

- The website includes OHCHR guidance on specific human rights issues in the context of the COVID-19 pandemic.

UN Secretary-General António Guterres, We are all in this together: UNSG delivers policy brief on COVID-19 and human rights, https://www.ohchr.org/EN/NewsEvents/Pages/UNSG_HumanRights_COVID19.aspx

- The UN Secretary-General's report places human rights at the centre of COVID-19 response and recovery. The report highlights the right to life and duty to protect life, the right to health and access to health care, and the right to freedom of movement as the three rights at the forefront of the pandemic, discussing both how these rights (along with others) are being threatened and good practices that protect human rights.

OHCHR, UNDP and UN SDG, Checklist for a Human Rights-Based Approach to Socio-Economic Country Responses to COVID-19, https://www.ohchr.org/Documents/Events/COVID-19/Checklist_HR-Based_Approach_Socio-Economic_Country_Responses_COVID-19.pdf

- OHCHR joins with other agencies in creation of a checklist to account for mainstreaming human rights in the socio-economic responses to COVID-19. The checklist includes potential actions, tools and resources consistent with the UN Secretary-General's policy brief on COVID-19 and Human Rights to ensure that no one is left out of pandemic socio-economic impact assessments, responses, or recovery plans.

OHCHR, Letter from High Commissioner for Human Rights to National Human Rights Institutions on COVID-19 Guidance, 21 April 2020, https://www.ohchr.org/Documents/Press/HCCOVID19lettertoNHRIs.pdf

- High Commissioner for Human Rights Michelle Bachelete acknowledges the important work conducted by the National Human Rights Institutions (NHRIs) and provides further guidance on how to integrate human rights in preparedness and response to COVID-19.

UN Committee on Economic, Social and Cultural Rights, Statement on universal and equitable access to vaccine for the Coronavirus Disease (COVID-19), 15 December 2020,E/C.12/2020/2, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E/C.12/2020/2&Lang=en

- Drawing up the right to the enjoyment of the highest attainable standard of physical health and the right to enjoy the benefits of scientific progress, CESCR declares that every person has a right to access a vaccine for COVID-19 that is safe and effective. States have an obligation to guarantee access to vaccines without discrimination. The statement encourages vaccine distribution that prioritizes international cooperation and assistance while limiting health isolationism or a race for COVID-19 vaccines among States.

OHCHR, Human Rights and Access to COVID-19 Vaccines, 17 December 2020, https://www.ohchr.org/Documents/Events/COVID-19_AccessVaccines_Guidance.pdf

- It is necessary to embrace a fair distribution system of vaccines, prioritizing evidence-based assessments of need instead of ability to pay. There is also a responsibility for pharmaceutical companies, like all businesses, to respect human rights as they work to assess harmful side effects and mitigate such effects.

Felipe González Morales and Tlaleng Mofokeng, COVID-19: Equitable vaccine access for all, including migrants, is crucial, say UN Special Rapporteurs, 22 January 2021, https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26684&LangID=E

- The Special Rapporteur on the human rights of migrants and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable of physical and mental health emphasize the importance for States to ensure migrants, regardless of migration status, are offered equitable access to COVID-19 vaccines.

OHCHR, Statement by UN Human Rights Experts Universal access to vaccines is essential for prevention and containment of COVID-19 around the world, 9 November 2020, https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26484&LangID=E

- This statement proclaims the need for human-rights based principles of international solidarity, cooperation and assistance to form the bedrock for preventing, treating and containing COVID-19. In particular, COVID-19 diagnosis and treatment goods must be made fully available, accessible and affordable on an international level. Moreover, COVID-19 vaccines and treatments must be safe and accessible to all who need them, including vulnerable populations often neglected from health services.

UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Advice of the Subcommittee to States parties and national preventive mechanisms relating to the coronavirus disease (COVID-19) pandemic, 7 April 2020, CAT/OP/10, https://undocs.org/CAT/OP/10

- When taking public health emergency measures, persons deprived of their liberty are a particularly vulnerable group. States must fully respect the rights for these detained individuals as well as staff and personnel working in detention facilities.

UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Advice provided by the Subcommittee to the National Preventive Mechanism of the United Kingdom of Great Britain and Northern Ireland regarding compulsory quarantine for coronavirus (COVID-19 virus), 31 March 2020, CAT/OP/9, https://www.ohchr.org/Documents/HRBodies/OPCAT/NPM/CATOP9_EN.pdf

- The Subcommittee provided advice for compulsory quarantine enforced for public health protections, including which safeguards must be in place to prevent ill-treatment.

OHCHR and African Union, 7 Possible Actions- Women's Rights and COVID-19, https://www.ohchr.org/Documents/Events/COVID-19_and_Women_Rights_7_Possible_Actions.pdf

- Considering how women are unduly affected by COVID-19, this information sheet outlines the human rights obligations of States in addressing the impact of COVID-19. It also guides potential actions to minimize the negative impact of COVID-19 on women and include a gendered perspective in government responses.

UN Inter-Agency Working Group on Violence Against Children, Agenda for Action, April 2020, https://www.ohchr.org/Documents/Events/COVID-19/Agenda_for_Action_IAWG-VAC.pdf

- Children are threatened by the economic insecurity, restrictions on movement and increased violence caused by the COVID-19 pandemic. This document details the need for age and gender disaggregated data, dispersal of age-appropriate information regarding COVID-19, the promotion of global unity, mobilization to protect child rights.

UN Inter-Agency Network on Youth Development, Statement on COVID-19 & Youth, https://www.ohchr.org/Documents/Issues/Youth/COVID-19_and_Youth.pdf

- The statement includes recognition for young people's actions to combat the spread of the virus provisions to make sure young people's efforts to engage during and after the pandemic are supported, and acknowledgments on the pandemic's repercussions for young people and their human rights.

UN Network on Racial Discrimination and the Protection of Minorities, Leave No One Behind: Racial Discrimination and the Protection of Minorities in the COVID-19 Crisis, 29 April 2020,

https://www.ohchr.org/Documents/Issues/Minorities/UN_Network_Racial_Discrimination_Minorities_COVID.pdf

- This statement responds to a growth in discrimination and exclusion of marginalized individuals, groups and communities amidst the COVID-19 pandemic and offers proactive measures to respect human rights.

UN, Guterres Hate Speech, 7 May 2020, https://www.unmultimedia.org/avlibrary/asset/2544/2544691/

- UN Secretary-General António Guterres discusses a rise in hate speech as individuals turn towards scapegoating and scaremongering. The Secretary-General appeals to political leaders, education institutions, the media, civil society and everyone else to assume their respective role to defeat both hate speech and COVID-19.

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