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Safeguarding Human Rights during the COVID-19 Pandemic

K2P COVID-19 Series

Key Messages

The rapid spread of the novel coronavirus pandemic has had a disruptive impact on many lives around the world, exacerbated the vulnerability of the least protected groups in society, and uncovered structural inequalities and problems in multiple areas of social, economic, civil and political life. Integrating a human rights-based approach during this pandemic is not only a moral imperative but it is also key to an effective COVID-19 response. A human rights-based approach entails integrating human rights principles into the COVID-19 response, relying on the best available evidence to inform decision-making, and fostering global collaboration to ensure equitable allocation of resources needed to mount an effective response.

Safeguarding the right to health stands at the cornerstone of a human rights-based approach in responding to the COVID-19 pandemic. This document will address the implications of the right to health for specific individuals and groups during the COVID-19 pandemic in Lebanon and globally, calling on countries to continue to respect and fulfill their obligations and duties to protect and respect human rights. To address these implications, we will tackle the following key issues:

- **Stigma and Discrimination**
  Stigma and discrimination have been directed towards people diagnosed with COVID-19. Stigmatized groups are likely to be subjected to physical violence, social avoidance or rejection and possibly be denied healthcare, education, housing or employment.

- **Gender and Social Inequalities**
  Pre-existing gender and social inequalities are exacerbated by COVID-19, where harmful gender norms and discriminatory practices are perpetuated and thus women and girls are disproportionally affected by this pandemic.

- **Special Needs of Vulnerable Populations**
  Certain vulnerable groups, including the elderly and people with chronic diseases, front line health workers, refugees, migrants, and prisoners are likely to suffer greater health risks from COVID-19 as compared to the general population.

Working with other countries, supporting international development and providing aid are more likely to support the safeguarding of health especially in developing countries. Recommendations for action should be multi-sectoral and should integrate a human-rights based approach in the full spectrum of the COVID-19 response:

- Emphasize that health is a human right and ensure that COVID-19 emergency responses are inclusive, equitable and non-discriminatory
- Provide access to accurate and transparent information on COVID-19
- Foster collaboration, communication and coordination nationally and internationally to secure services during the COVID-19 pandemic
- Safeguard the rights and wellbeing of front-line health workers

As the COVID-19 pandemic continues to unfold and bring greater uncertainties, the global community is facing a highly unpredictable and dynamic situation that poses critical public health and development challenges. All stakeholders-including governments, international organizations, the private sector, and civil society-have a responsibility to ensure that the COVID-19 response is grounded in human rights and focused on eliminating barriers that hinder the ability of people to protect themselves and their communities.

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الرسائل الأساسية

كان تأثير انتشار وباء كورونا السريع مدمرًا على حياة العديد من الأشخاص في جميع أنحاء العالم، وزاد من ضعف بعض الفئات في المجتمع، وكشف عن انعدام المساواة بسبب اختلالات هيكلية في مختلف مجالات الحياة الاجتماعية والاقتصادية والمدنية والسياسية،. إن اتباع نهج مرتكز على حقوق الإنسان خلال هذه الجائحة ليس فقط واجبًا أخلاقيًا، إنما أيضًا مفتاح للاستجابة الفعالة لـ كوفيد-19. يستند النهج المرتكز على حقوق الإنسان على أفضل الأدلة والبراهين العلمية المُتاحة لترشيد عملية صنع القرار، وتعزيز التعاون العالمي لضمان التوزيع المنصف للموارد اللازمة لاستجابة فعالة.

حماية الحق في الصحة هي حجر الأساس في النهج المرتكز على حقوق الإنسان في الاستجابة لوباء كوفيد-19. يتناول هذا المستند العلمي تأثير الجائحة على الحق في الصحة لبعض الأفراد والمجموعات في لبنان والعالم، داعياً الدول إلى مواصلة احترامها والتزامها بواجباتها لحماية حقوق الإنسان وتعزيزها. لمعالجة هذا التأثير، يتناول هذا المستند القضايا الرئيسية التالية:

- **وصمة العار والتمييز**
  تم التعامل مع الأشخاص المصابين بـ كوفيد-19 ضمن إطار تمييزي وموصوم. ومن المحتمل أن تتعرض المجموعات الموصومة للعنف الجسدي أو التهميش الاجتماعي وربما حرمانها من الرعاية الصحية أو التعليم أو السكن أو العمل.

- **عدم المساواة بين الجنسين وانعدام العدالة الاجتماعية**

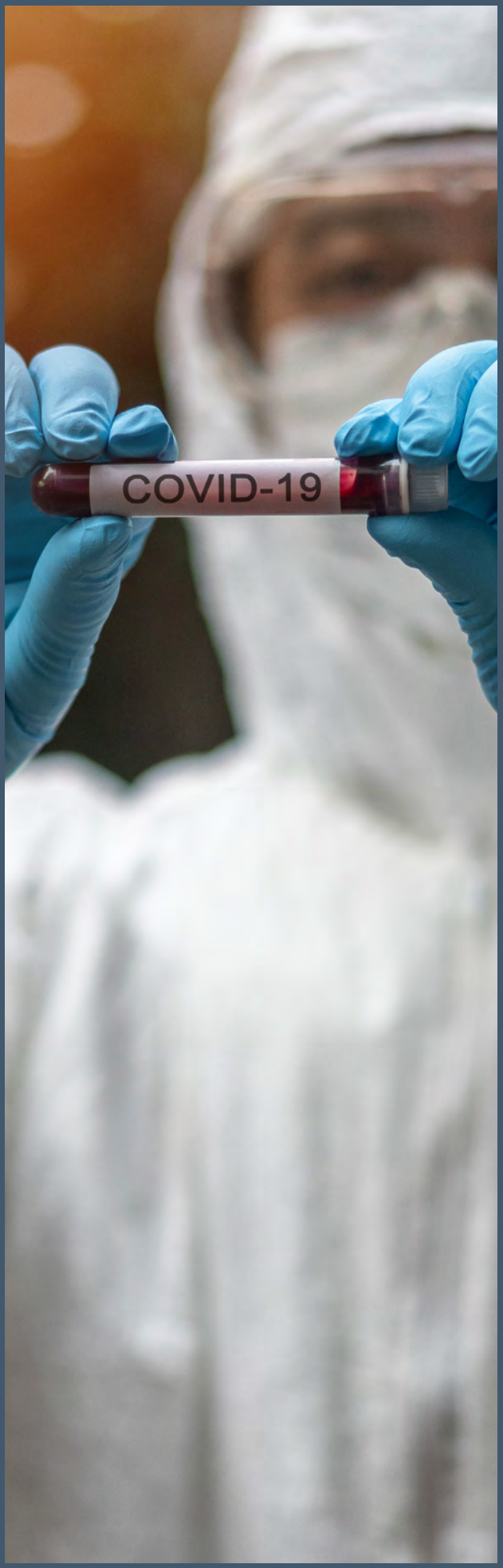
  بسبب فيروس كورونا، تفاقمت ممارسات عدم المساواة بين الجنسين والتفاوتات الاجتماعية، حيث اثرّت المعايير الجنسانية الضارة والممارسات التمييزية على وضع النساء والفتيات خلال الجائحة بشكل غير مسبوق.

- **الاحتياجات الخاصة للفئات المهمشة**
  من المحتمل أن تعاني بعض الفئات المهمشة، بما في ذلك كبار السن والعاملين الصحيين في الخطوط الأمامية واللاجئين والنازحين والسجناء، من مخاطر صحية أكبر من كوفيد-19 مقارنة بعامة المجتمع.

تعزيز التعاون بين الدول ودعم التنمية الدولية وتقديم المساعدات، من المرجح أن يدعموا حماية الحق في الصحة وبخاصة في البلدان النامية. لا بد أن تكون توصيات العمل متعددة القطاعات، وأن تضم نهجًا مرتكزاً على حقوق الإنسان في كامل نطاق الاستجابة لـ كوفيد-19:

- التأكيد على أن الصحة حق من حقوق الإنسان والتأكد من أن الاستجابة لحالات الطوارئ المتعلقة بفيروس كوفيد-19 شاملة، منصفة، وغير تمييزية
- توفير الوصول إلى معلومات دقيقة وشفافة حول كوفيد-19
- تعزيز التعاون والتواصل والتنسيق على الصعيدين الوطني والدولي لتأمين الخدمات اللازمة أثناء جائحة كوفيد-19
- حماية حقوق وسلامة العاملين الصحيين في الخطوط الأمامية

مع استمرار انتشار جائحة كوفيد-19، تستمر أوجه عدم اليقين التي تحيط بهذا الوباء بالتفاقم، ويواجه المجتمع الدولي حالة ديناميكية صعبة التنبؤ، مما يشكل تحديات خطيرة للصحة العامة والتنمية. تتحمل جميع الجهات المعنية - بما في ذلك الحكومات والمنظمات الدولية والقطاع الخاص والمجتمع المدني - مسؤولية التأكد من أن الاستجابة لكوفيد-19 ترتكز على حقوق الإنسان وعلى إزالة الحواجز التي تعيق قدرة الأفراد على حماية أنفسهم ومجتمعاتهم.



Preamble

The rapidly spreading COVID-19 coronavirus has had a disruptive impact on many lives around the world. The pandemic exacerbated the vulnerability of the least protected groups in society, and uncovered structural inequalities in multiple areas of social, economic, civil and political life which are often manifested in poor access to care including testing and treatment and susceptibility to infection and severe illness (United Nations, 2020b; United Nations, 2020a). In the haste of responding to a pandemic that caught the world by surprise, fundamental public health values of equity and social justice have been overlooked and disregarded (Afifi et al., 2020).

As of September 7, 2020, more than 26 million people have been infected with the virus with a death toll exceeding 850 thousand across 215 countries (WHO, 2020d). While these numbers are alarming, they only convey part of the story. There are human rights considerations to the pandemic that have been overlooked. Integrating human rights into our analysis of and response to the COVID-19 pandemic is not only a moral imperative but is also key to an effective COVID-19 response which will shape the future of global health (Khosla, Allotey & Gruskin, 2020). This has been emphasized in the World Health Organization's (WHO) call on governments to fight the pandemic.

"All countries must strike a fine balance between protecting health, minimizing economic and social disruption and respecting human rights"- WHO Director General on March 11, 2020 (WHO, 2020k).

Responding to the call from WHO entails integrating human rights principles into the COVID-19 response, relying on the best available evidence to inform decision-making, and fostering global collaboration to ensure equitable allocation of resources needed to mount an effective response (UNAIDS, 2020). It also demands ensuring that health policies and programs prioritize the needs of those left behind in order to achieve health equity, a principle that has been echoed in the 2030 Agenda for Sustainable Development, which adopted the target of Universal Health Coverage (United Nations, 2015; United Nations, 2019). Failing to integrate equity and human rights into the COVID-19 response threatens the achievement of the Sustainable Development Goals (SDGs) especially SDG 10 which aims to reduce inequality within and among countries (United Nations, 2020a).

This document invites adopting a human-rights approach to address the needs of specific individuals and groups during the COVID-19 pandemic calling on countries to respect and fulfill their obligations and duties. It highlights prioritizing the needs of those "most-at-risk" populations, shifting from a biological to a social framework to understanding the underlying causes of health and illness in order to mount a more effective control of the pandemic (Afifi et al., 2020). To address this, we focus on the following key issues:

- Stigma and Discrimination
- Gender and Social Inequalities
- Special Needs of Vulnerable Populations

This document will also highlight the importance of global collaboration and support in the COVID-19 response and provide a snapshot of how different countries are addressing human rights amid COVID-19. It concludes with recommendations for governments to adopt a human rights-based approach in their response to COVID-19.

Selection Process

A search of the literature was undertaken to identify studies addressing the human rights situation (in particular the right to health) amid the COVID-19 crisis. A combination of free word and controlled vocabulary to combine the following concepts on Medline "(Severe Acute Respiratory Syndrome/ OR Pandemics/ OR Middle East Respiratory Syndrome Coronavirus/ OR SARS Virus/) AND (Human Rights/ Right to Health/ OR social stigma/ OR Discrimination, Psychological/ OR Social Discrimination/ OR women/ OR vulnerable populations/ OR bedridden persons/ OR caregivers/ OR disabled persons/ OR grandparents/ OR medically uninsured/ OR prisoners/ OR refugees/ OR terminally ill/ OR Health Personnel/). As for Pubmed, the following search was implemented (("severe acute respiratory syndrome coronavirus 2" [All Fields] OR sars-cov-2[All Fields] OR "COVID-19" [Supplementary Concept]) OR (NOVEL[All Fields] AND ("coronavirus"[MeSH Terms] OR coronavirus[Text Word])) OR ("Coronavirus Infections"[Mesh] OR "Middle East Respiratory Syndrome Coronavirus"[Mesh]) or ("SARS Virus"[Mesh]) OR ("Pandemics"[Mesh]) OR ("Epidemics"[Mesh])) AND ("Human Rights Abuses"[Mesh] OR "Patient Rights"[Mesh] OR "Human Rights"[Mesh] OR "Reproductive Rights"[Mesh] OR "Women's Rights"[Mesh] OR "Civil Rights"[Mesh] OR "Social Justice"[Mesh] OR "Right to Health"[Mesh] OR "Access to Information"[Mesh] OR "Ethics, Professional"[Mesh] OR "Ethics, Nursing"[Mesh] OR "Ethics, Medical"[Mesh] OR "Ethics, Dental"[Mesh]). Health Systems Evidence, Cochrane Library and Google Scholar were also used in addition to grey literature and media news reports. Last search was done on August 24, 2020.

Content

The Right to Health

The right to health is globally recognized as a fundamental human right. The right to the enjoyment of the highest attainable standard of physical and mental health was first articulated in the 1946 Constitution of the World Health Organization (WHO), which states that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (WHO, 2006). The 1948 Universal Declaration of Human Rights also highlighted health in its 25th Article as part of the right to an adequate standard of living. The declaration also addressed the social and political determinants of health and emphasized that the right to life and health extends to all human beings irrespective of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status (United Nations, 1948b). The right to health is also enshrined in the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the International Convention on Protection of the Rights of All Migrant Workers and Members of Their Families, and in other international and regional treaties as well as in at least 115 constitutions (United Nations & WHO, 2008). The right to health is relevant to all countries which have committed themselves to protecting this right through international declarations, domestic legislations and policies, and at international conferences.

> “All human beings are born free and equal in dignity and rights
>
> (United Nations, 1948b)

The human rights frameworks listed below are crucial to strengthen global efforts to address health inequalities associated with the COVID-19 pandemic. These frameworks serve to redress human rights violations, hold governments accountable, and mobilize civil society action to achieve the realization of the right to health (London, 2008).

WHO Constitution 1946	"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO, 2006).
Universal Declaration of Human Rights 1948	Article 25: "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" (United Nations, 1948b).
International Convention on the Elimination of Racial Discrimination 1965	Article 5: "In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, color, or national or ethnic origin, to equality before the law, notably in the enjoyment of the right to public health, medical care, social security and social services" (United Nations, 1965).
International Covenant on Economic, Social and Cultural Rights 1966	Article 12: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (United Nations, 1966).

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) 1979	Article 12: "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" (United Nations, 1979).
Convention on the Rights of the Child 1989	Article 24: "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services" (United Nations, 1989).
International Convention on Protection of the Rights of All Migrant Workers and Members of Their Families 2005	Article 43: "Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to access to social and health services, provided that the requirements for participation in the respective schemes are met" (United Nations, 2005).

Key Emerging Issues

Below we highlight human rights issues that have emerged during the COVID-19 pandemic including country experiences.

01 Stigma and Discrimination

Public health emergencies are often associated with stigma which is defined as discrimination towards certain communities, groups, and affected individuals (CDC, 2020c). Disease outbreaks such as COVID-19 result in undue stress for people and communities; the fear and anxiety experienced during these times can lead to rampant social stigma. Within the context of the pandemic, stigma and discrimination have been directed towards people infected with COVID-19, people of Asian descent, people who travelled to or arrived from affected countries, and, surprisingly, emergency responders and healthcare professionals (CDC, 2020c). Stigmatized groups may be subjected to physical violence, social avoidance or rejection and they may be denied healthcare, education, housing or employment (UNAIDS, 2020). This leads to a range of negative physical and mental health consequences for stigmatized groups and their communities (United Nations & WHO, 2008). Furthermore, stigma and discrimination can lead to significant human rights breaches and abuses, leaving the most vulnerable further behind and jeopardizing the response to the pandemic and beyond (Khosla, Allotey and Gruskin, 2020).

Since the novel coronavirus outbreak, news reports from several countries have documented racism, bias, xenophobia and discrimination against people of Asian descent (Human Rights Watch, 2020b; Human Rights Watch, 2020a). Incidents included physical attacks, angry threats, discrimination and bullying at schools or workplaces, and the use of derogatory language in news reports and on social media (Human Rights Watch, 2020b; Human Rights Watch, 2020a).

Media have reported alarming incidents of hate crimes in the United Kingdom (UK), United States (USA), Spain and Italy that targeted people of Asian descent who have been blamed for the spread of COVID-19 (Human Rights Watch, 2020b). According to the United Kingdom's Home Office Minister for Countering Extremism, anti-Asian hate crimes increased by 21% in the UK during the coronavirus crisis (The Guardian, 2020a). In the USA, the New York Police Department reported 14 hate crimes against Asian-Americans related to COVID-19 during the month of April; and the FBI (Federal Bureau of Investigation) issued an intelligence report warning about a potential surge of anti-Asian hate crimes across the United States due to the spread of the novel coronavirus (Yang, 2020; ABC News, 2020).

Senior US government officials, including the United States President, referred to the novel coronavirus as the "Chinese Virus" thus re-awakening anti-Chinese sentiments and fanning the flames of xenophobia (New York Times, 2020a). Additionally, anti-immigrant leaders in Europe like the Hungarian Prime Minister and the Italian Interior Minister have used the pandemic as an opportunity to stoke xenophobic sentiments (NBC News, 2020b).

The United Nations voiced its concern over the "tsunami of hate and xenophobia" unleashed by the COVID-19 pandemic through its Secretary General who urged governments to act to strengthen the immunity of their societies against "the virus of hate". The Secretary General also called on political leaders to show solidarity with all members of their communities and to build and reinforce social cohesion (United Nations, 2020d).

02 Gender and Social Inequalities

COVID-19 exposed social inequalities including those based on gender. Data shows that women and girls have been disproportionally affected by this pandemic due to their role as primary caregivers and increased various forms of gender-based violence (Wenham & Morgan, 2020; Al-Ali, 2020). Women and girls carry a greater risk of exposure to COVID-19 as a result of their caregiving roles, which in many countries are dictated by social norms and expectations (Smith, 2019; Hall et al., 2020). Women also do three times as much unpaid care work at home as men (Hall et al., 2020). During disease outbreaks, women act as "shock absorbers" by shouldering the burden of care both at home and in healthcare settings. National health systems often rely on women as home-based care providers during times of crisis, yet they fail to recognize their unpaid care work and to provide them with adequate support (Smith, 2019).

As women comprise 70% of the global health workforce, they are at greater risk of contracting the virus and of bearing the burden of the social and economic impact of the lockdown that ensued (WHO, 2019; WHO, 2020a; Hall et al., 2020). As frontline health workers combatting COVID-19, women may be exposed to discrimination and violence in their work environment or at home and thus, special attention should be given to their psychosocial, sexual and reproductive health needs (UNFPA, 2020). Health managers need to have plans to address the safety of their female health workers such as provision of psychosocial support, non-performance based incentives, and childcare support (The George Institute for Global Health, 2020).

In times of crisis such as the COVID-19 pandemic, women and girls may be at a higher risk of domestic violence due to increased tensions in households (UNFPA, 2020; WHO, 2020a). In fact, gender-based and domestic violence is one of the consequences of enforced self-quarantine or compulsory quarantine policy (Tang et al., 2020). Furthermore, social distancing measures and lockdowns keep domestic violence victims trapped at home with their abusers. Reports from China, the United Kingdom, the United States, France, and several countries in the Middle East and North Africa (MENA) region showed a surge in domestic violence cases since the beginning of the COVID-19 outbreak (Angharad, 2020; CNN, 2020; Euronews, 2020; Foreign Policy, 2020; Godin, 2020; New York Times, 2020b; Sixth Tone, 2020; The Guardian, 2020b; OECD, 2020). The health impact of domestic violence on women and their children is significant. Violence against women can result in serious physical, mental, sexual and reproductive health problems (WHO, 2020e).

Moreover, women's sexual and reproductive health rights is a significant public health issue that requires special attention during pandemics (UNFPA, 2020; Hall et al., 2020). Women's access to sexual and reproductive health services is severely impacted due to mobility restrictions and financial challenges imparted by the COVID-19 pandemic (WHO, 2020e; Hall et al., 2020). The sexual and reproductive health rights of women need to be prioritized during this pandemic especially when it comes to infection prevention for safe pregnancies and childbirth (UNFPA, 2020).

03 Special Needs of Vulnerable Populations

The COVID-19 pandemic has revealed a unique ecology of disease based on the social determinants of health. Ample evidence from high-, middle-, and low-income countries revealed that certain social groups were disproportionately affected by COVID-19 due to underlying medical and social vulnerabilities. A human rights-based approach to health helps ensure that no one is left behind, that particular attention is paid to the most vulnerable, and that inequities are eliminated. Vulnerable groups include the elderly and people with preexisting chronic conditions, front-line health workers, people with disabilities, refugees, migrants, and prisoners (WHO, 2020c; UNHCR, 2020). The special needs of vulnerable populations need to be explicitly accounted for, or else their higher risk of infection can undermine broader response. National COVID-19 responses should include specific measures to protect the human rights of vulnerable groups by protecting them from discrimination and ensuring their access to information, healthcare and social services.

Elderly and people with preexisting chronic diseases

According to WHO, individuals over 60 years of age and those with cardiovascular disease, diabetes, chronic respiratory disease and cancer are at highest risk of contracting the novel coronavirus (WHO, 2020c). The risk is more acute for the elderly in nursing facilities where the virus can spread rapidly (Human Rights Watch, 2020b). The WHO also indicates that the risk of suffering severe COVID-19 symptoms increases with age starting from the age of 40 years (WHO, 2020c). Thus, elderly are not only at a heightened risk of infection, but are also more prone to suffer serious and life threatening complications from COVID-19 infection (Human Rights Watch, 2020f). According to WHO Europe, more than 95% of the people who have died of COVID-19 in Europe were over age 60 (WHO Europe, 2020). The United States Centers for Disease Control and Prevention (CDC) reported that COVID-19 fatality in the United States was highest in people over 85, followed by people aged 65 to 84 (CDC, 2020d). The CDC also identified additional categories at risk, including individuals with blood disorders, chronic kidney or liver disease, compromised immunity, endocrine disorders, neurological conditions and current or recent pregnancy (CDC, 2020a). This means that a large proportion of people are at risk, especially in upper-middle and high income countries, which have a higher proportion of ageing populations.

Due to their high risk of infection and complications from COVID-19, the elderly have the focus of social distancing policies and thus are more prone to suffer negative psychological impact as a result of social isolation and the associated fear and anxiety (Kuwahara, Kuroda & Fukuda, 2020). Furthermore, the COVID-19 pandemic unleashed a wave of ageism and discriminatory attitudes and actions towards older people (Human Rights Watch, 2020f; Sibai, 2020). COVID-19-related policies such as rationing medical interventions and ventilators in favor of the younger age groups has created a perception that older adults' lives are less valuable or even expendable thus putting older people at greater risk of discrimination (Sibai, 2020). A United Kingdom newspaper opinion piece about the economic impact of the coronavirus suggested that "culling elderly dependents" or the death of older people could be actually beneficial for the economy (The Telegraph, 2020a). In an interview last March, Ukraine's former health minister said that people over age 65 are "already corpses" and that the government should focus its COVID-19 efforts on people "who are still alive" (Kyiv Post, 2020). Some governments, such as Bosnia and Herzegovina, have placed severe restrictions on the freedom of movement of the elderly forcing them to remain confined in their homes or face fines or other penalties (Balkan Insight, 2020).

Frontline health workers

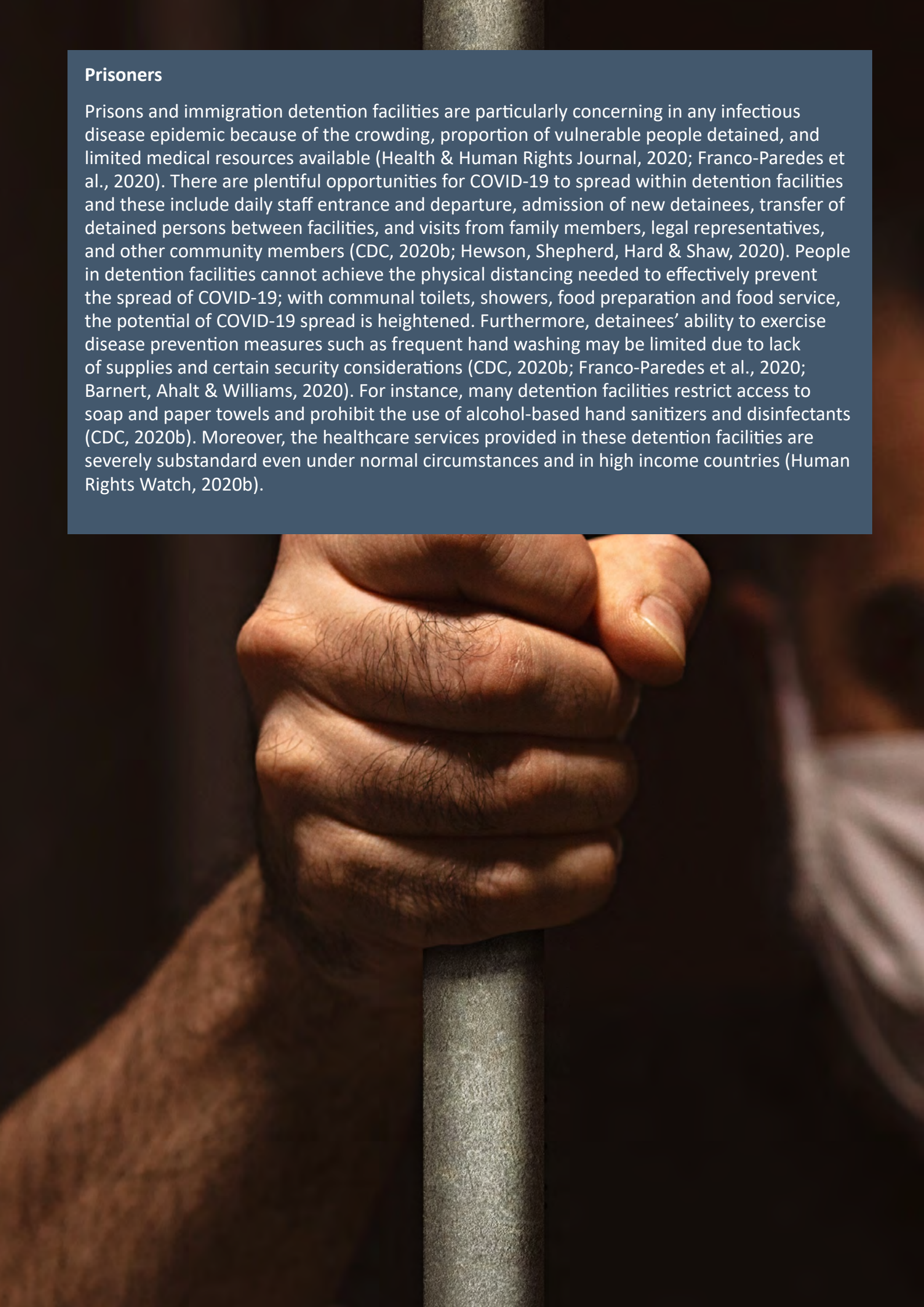
The COVID-19 pandemic has put healthcare workers in an unprecedented situation, where they have had to make difficult decisions and work under extreme pressures (Greenberg, Docherty, Gnanapragasam & Wessely, 2020). Medical professionals are fighting this pandemic despite a plethora of challenges including isolation due to reduced interaction with families and friends for fear of transmitting disease and adjustment issues while managing illnesses that are beyond their usual scope of practice (Albertsen & Thaysen, 2017; Goh & Chia, 2020). In addition to caring for their own physical and mental wellbeing, they are providing care to severely sick patients which may lead not only to physical but also moral injury or mental health problems (Greenberg, Docherty, Gnanapragasam & Wessely, 2020; Goh & Chia, 2020). Furthermore, frontline healthcare workers dealing with COVID-19 patients might experience stigmatization, racism, social isolation and ostracism (The George Institute for Global Health, 2020). Thus, it is essential to provide them with psychosocial support (peers and family), non-performance based incentives, childcare support, and additional transport allowance to help them cope with their daily stress and to help renew their purpose in continuing to serve their community and country (The George Institute for Global Health, 2020). Another major challenge facing countries during the COVID-19 pandemic, irrespective of their income levels, is the shortage of equipment and supplies needed to manage COVID-19. With limited testing kits, supplies, personal protective equipment, and ventilators, government officials and health workers are confronted with the ethical dilemma on how to distribute these scarce resources and equipment among all those who need them (WHO, 2020j; Neto et al., 2020). Shortage of equipment and supplies not only undermines infection prevention and control efforts, but also directly impacts health workers who are at heightened risk of exposure and infection (WHO, 2020j). In these times of dual loyalty, where both health workers' and communities' human rights are threatened, health professionals' practice can benefit from targeted guidelines that address their rights and wellbeing during such crises. Furthermore, institutional accountability for protecting human rights is essential to avoid shifting the responsibility entirely onto healthcare professionals (London, 2008). The protection of frontline health workers is paramount for effective management and control of COVID-19 not only through providing personal protective equipment (PPE) but also mass testing to limit the spread of the virus and alleviate their anxiety (Black, Bailey, Przewrocka, Dijkstra & Swanton, 2020). Thus, PPE including medical masks, respirators, gloves, gowns and eye protection, must be prioritized for healthcare workers and those caring for COVID-19 patients.

People with disabilities

People living with disabilities are at higher risk of serious illness or death from COVID-19 and the social and economic consequences of lockdown. For those who are placed in institutions, the risks are even higher due to overcrowded and unhygienic conditions (Mesa Vieira, Franco, Gómez Restrepo & Abel, 2020). People living with disabilities are constantly faced with marginalization, discrimination and barriers that impede their access to healthcare services. These challenges tend to become more acute during the COVID-19 pandemic. Thus, it is essential that they receive reliable information regarding the pandemic and support to adopt preventive strategies (Human Rights Watch, 2020e). Information about the pandemic and protective measures should be developed in a variety of formats to cater to the accessibility needs of people with different disabilities. The social isolation resulting from the imposed lockdowns may cause severe distress for people with psychosocial disabilities, and thus they might require additional mental health support services (Human Rights Watch, 2020e). COVID-19 could be catastrophic for people with disabilities who live in refugee camps where they already face significant obstacles to shelter, sanitation and medical care.

Refugees and migrants

Millions of refugees and migrants live in close proximity in overcrowded unsanitary camps and detention centers and these appalling conditions are fertile grounds for infectious disease outbreaks. The COVID-19 pandemic is exacerbating an already precarious health situation for refugees and migrants (The Lancet, 2020). Now that most countries have closed their borders, people fleeing their countries due to war and conflicts are struggling to find shelter. The International Organization for Migration (IOM) and the United Nations High Commissioner for Refugees (UNHCR) announced on the 10th of March 2020, that resettlement travel for refugees will be temporarily suspended, although the agencies have appealed to states to ensure emergency cases are exempted (UN News, 2020). The majority of refugees and migrants lack adequate housing, and have poor access to healthcare services and social support. Refugees typically face administrative, financial, legal and language barriers to access the healthcare system (WHO, 2018; Liem, Wang, Wariyanti, Latkin & Hall, 2020; United Nations, 2020a). Migrant workers are overrepresented in occupations that put them at higher risk of COVID-19 infection and are often not eligible for health benefit schemes due to employment restrictions which puts them at even greater risk of falling into extreme poverty (United Nations, 2020a; Wickramage et al., 2018). Refugees are also victims of xenophobia and discrimination, and are often accused of contributing to spreading the coronavirus (Daniels, 2020; Kluge, Jakab, Bartovic, D'Anna & Severoni, 2020). Such unacceptable attitudes further risk wider public health outcomes since refugees may be fearful of seeking treatment or disclosing symptoms (Kluge, Jakab, Bartovic, D'Anna & Severoni, 2020). Under normal conditions, they have high burden of common mental disorders and a lower quality of life than citizens and the pandemic may exacerbate these conditions further (Liem, Wang, Wariyanti, Latkin & Hall, 2020; Orcutt et al., 2020). Basic public health measures such as physical distancing, proper hand hygiene and self-isolation are difficult to implement in refugee camps making it more likely that COVID-19 will spread quickly inside these settings (Volkin, 2020; Kluge, Jakab, Bartovic, D'Anna & Severoni, 2020). Site- specific epidemiological risk assessments must be done to determine the extent of the risk of COVID-19 introduction and transmission in refugee camps, together with case management protocols and rapid deployment of outbreak response teams if needed (Kluge, Jakab, Bartovic, D'Anna & Severoni, 2020). Global attention needs to be directed towards refugees and migrants, especially in humanitarian settings that are facing severe disruption of essential supplies of food, medicine and other forms of aid. Currently, 80% of refugees live in Low- and Middle-Income Countries (LMICs) which present the sites of the fourth expected wave of COVID-19 after China, Europe and the United States. LMICs already have weak healthcare systems, scarce protective equipment and poor testing and treatment capacity, thus necessitating global support to prepare these countries for an impending crisis (The Lancet, 2020).



Prisoners

Prisons and immigration detention facilities are particularly concerning in any infectious disease epidemic because of the crowding, proportion of vulnerable people detained, and limited medical resources available (Health & Human Rights Journal, 2020; Franco-Paredes et al., 2020). There are plentiful opportunities for COVID-19 to spread within detention facilities and these include daily staff entrance and departure, admission of new detainees, transfer of detained persons between facilities, and visits from family members, legal representatives, and other community members (CDC, 2020b; Hewson, Shepherd, Hard & Shaw, 2020). People in detention facilities cannot achieve the physical distancing needed to effectively prevent the spread of COVID-19; with communal toilets, showers, food preparation and food service, the potential of COVID-19 spread is heightened. Furthermore, detainees' ability to exercise disease prevention measures such as frequent hand washing may be limited due to lack of supplies and certain security considerations (CDC, 2020b; Franco-Paredes et al., 2020; Barnert, Ahalt & Williams, 2020). For instance, many detention facilities restrict access to soap and paper towels and prohibit the use of alcohol-based hand sanitizers and disinfectants (CDC, 2020b). Moreover, the healthcare services provided in these detention facilities are severely substandard even under normal circumstances and in high income countries (Human Rights Watch, 2020b).

Snapshot

A Snapshot of Human Rights Situation in Lebanon amid COVID-19

The spread of the novel coronavirus in Lebanon since February 2020, has exacerbated the existing economic, social and political crises in the country adding to it a health and humanitarian dimension. The COVID-19 pandemic in Lebanon is a crisis within a crisis. The pandemic came after months of upheaval following the October 17th Revolution in 2019, at a time when the healthcare system and state institutions were not prepared to deal with its repercussions (Social Watch, 2020).

Stigma and Discrimination

The imposed lockdowns have increased both inter and intra community tensions in Lebanon and heightened discrimination and stigmatization against refugees with municipalities enforcing restrictions, such as curfews, on refugees but not on others (Arab Reform Initiative, 2020). Furthermore, some municipalities tended to prioritize their local communities in terms of water and sanitation, and waste collectors were afraid of working in areas with perceived high risk such as informal refugee settlements (International Alert, 2020). Furthermore, relationships between the Lebanese themselves have become increasingly strained as a result of the pandemic (International Alert, 2020). Some political parties have mobilized to provide assistance exclusively to their supporters (International Alert, 2020). The media has also played a role in fueling tensions, stigma and discrimination, especially against refugees, through spreading misinformation and delivering misleading sensationalist reports (Norwegian Refugee Council, 2020b; International Alert, 2020). On a positive note, the government, civil society actors and international organizations (like the United Nations in Lebanon) acted quickly to counter misleading messages, cautioning that stigma and discrimination could undermine the efforts to control the outbreak (UNDP, 2020; International Alert, 2020).

Gender and Social Inequalities

In Lebanon, as in other patriarchal societies, women's roles are seen as secondary to men and women's domestic labor such as cooking, cleaning, and caring for the sick, elderly and children is undervalued and unpaid (UN Women, 2020). According to the International Men and Gender Equality Survey, only 33% of Lebanese women reported that men in their family have ever participated in at least one domestic task (UN Women & Promundo, 2017). With health systems overloaded and schools closed due to the COVID-19 pandemic, Lebanese women shouldered the burden of home schooling, caring for family members, all while continuing to carry the same and even more domestic responsibilities (UN Women, 2020). Female health care workers, social workers, migrant domestic workers and at-home caregivers comprise the bulk of the front-line responders to COVID-19 (UNSCOL, 2020). This places women under increased stress, affects their mental well-being, and increases their risk of COVID-19 infection and transmission (when they care for the sick). Moreover, in the context of the multiple crises in Lebanon which include economic and political challenges, women reported lay-offs, and income and wage reductions at a higher rate than men, which could result in a prolonged decline in women's engagement in the formal economy (UNSCOL, 2020; ILO & Fafo, 2020). According to a rapid assessment exploring the impact of COVID-19 on workers conducted by the International Labour Organization (ILO), women reported higher rates of dismissal from the workforce, income loss and increased household and childcare duties which have been and continue to be disproportionally undertaken by women (ILO & Fafo, 2020). "As a result of women's historic marginalization from the labour market in Lebanon, they were more vulnerable to economic shocks. They were significantly less likely to be in employment and when they were, they earned less and had less savings. Economic shocks are therefore more difficult to absorb and bounce back from, and they have fewer resources at hand to address violence they may experience, or inequalities they face', says the head of UN Women Lebanon (UNSCOL, 2020).

COVID-19 lockdown and quarantine measures in Lebanon have led to a considerable surge in domestic violence cases as victims became trapped at home with abusive partners or family members; and this was compounded by the devastating financial and economic situation where thousands of Lebanese lost their jobs or had their salaries slashed, while businesses closed and the currency depreciated by almost 50 percent (The Arab Weekly, 2020). Lebanese local Non-Governmental Organizations (NGOs) reported a 60% increase in domestic violence cases during the first month of the COVID-19 lockdown (Sharika Wa Laken, 2020). The Lebanese Internal Security Forces also reported a 100% increase in the number of complaints received on its domestic violence hotline this March 2020 compared to March 2019 (Sharika Wa Laken, 2020). These numbers reflect only the tip of the iceberg as many women refrain from reporting abuse due to their lack of privacy, shortage of cash to move out, or because they are not aware of the support services available to them during the lockdown; the nationwide closure of courthouses also prevented survivors of domestic abuse from seeking justice or protecting themselves from perpetrators (The Arab Weekly, 2020). For domestic violence survivors who have lost their jobs or have no income, leaving an abusive partner will become even more difficult during the COVID-19 pandemic owing to financial dependence especially amid the economic crisis that has hit the country (UN ESCWA & UN Women, 2020).

Lebanon witnessed six femicides (the intentional killing of females) that made national headlines during the month of April 2020; one of which involved the killing of nine people in addition to the female victim (KAFA, 2020). Furthermore, there are concerns that the law enforcement and justice system in Lebanon may tend to de-prioritize gender-based violence during the pandemic (UN Women et al., 2020). These concerns were flagged after reports of forensic doctors being unable and/or unwilling to document physical abuse of survivors at police stations for fear of the spread of COVID-19, with judges refusing to waive these requirements in most cases (UN Women, UNFPA, WHO, & NCLW, 2020; UN Women et al., 2020).

Special Needs of Vulnerable Populations

- **Elderly:** Lebanon records the highest percentage (10%) of older adults (aged 65 years and above) and the highest life expectancy among all Arab countries (Sibai, Juergens, & Côte, 2020). It is projected that this number will increase to 21% by the year 2050 (Sibai, Rizk, & Kronfol, 2015). Lebanese elderly lose their medical insurance after retirement, which limits their access to all medical services (Chemali, Chahine, & Sibai, 2008). The mental health of the elderly amid the COVID-19 pandemic is particularly concerning given the rising concerns over an increase in elder abuse in Lebanon during the pandemic, particularly physical and psychological abuse by caregivers (Khoury & Karam, 2020). This is critical given that the lifetime prevalence rate of having a mental disorder among Lebanese older adults is 17.4% (Karam et al., 2016). Furthermore, the lockdown has negatively impacted the mental wellbeing of older adults in Lebanon as it deprived them from activities that used to bring them a sense of joy and connectedness such as family gatherings, seeing their grandchildren, and participating in religious services (Khoury & Karam, 2020). The mental health of the elderly in nursing homes has also been affected negatively as a result of the suspension of all kinds of activities and the banning of family visits to limit COVID-19 transmission (Khoury & Karam, 2020). The Institute for Development, Research, Advocacy and Applied Care (IDRAAC), a local NGO dedicated to mental health, reported a decrease in older adults' use of mental health services since the Lebanese authorities officially announced lockdown on March 15 (Khoury & Karam, 2020). Thus, the mental health of the elderly needs to be prioritized and strategies to enhance their mental wellbeing must be formulated; especially given the lack of geriatric mental health specialists as Lebanon has only two geriatric psychiatrists (El Hayek et al., 2020). Furthermore, during the COVID-19 pandemic, the elderly become particularly vulnerable to food insecurity and poor nutrition as they may already be susceptible to malnutrition and limited purchasing power. This vulnerability is compounded by the phenomenon of "panic buying" or the hoarding that has been taking place in Lebanon since the beginning of the COVID-19 outbreak (Naja & Hamadeh, 2020). Hoarding, where people buy and stockpile extra food more than they need, can pose devastating consequences on at risk-populations like the elderly as it leads to extreme shortages in markets and rapidly rising prices (Timmer, 2010).

- **Frontline health workers:** At the beginning of the COVID-19 crisis in Lebanon, doctors at the Rafik Hariri University Hospital (the leading public hospital that was treating coronavirus patients) decided to go on a strike (Al Arabiya English, 2020). In a televised news conference, the doctors reported that they took this decision to protest delays in paying their salaries and poor working conditions (The Daily Star, 2020b). They expressed their dissent towards the management's indifference to the dangers, hardships and harsh conditions that the hospital staff suffered (Middle East Monitor, 2020b). It is also worth noting that the healthcare system in Lebanon has been in disarray long before the pandemic due to years of mismanagement with the government owing private facilities an estimated $1.3 billion in unpaid dues – used to pay staff and purchase medical supplies – since 2011 (Al Arabiya English, 2020). Additionally, since October 2019, Lebanese hospitals reported shortages of medical supplies due to the economic crisis in the country where importers of medical supplies, and other goods, have struggled to secure enough dollars to pay for their imports (Al Arabiya English, 2020).

  Lebanese women's caregiving roles are not limited to the home, but extend to healthcare settings. According to the latest numbers published by the Lebanese Order of Nurses, almost 80% of Lebanese nurses are females (Lebanese Order of Nurses, 2020). Female nurses are at the forefront of the fight against COVID-19 as the main caregivers in hospitals which places them at heightened occupational health risks (Gupta, 2020). The head of the Lebanese Order of Nurses reported in a televised press conference on the occasion of the International Nurses Day on May 12th that nurses are suffering from unfavorable work circumstances, declining wages, and unsafe conditions; and that health institutions are exploiting nurses and pushing them to leave their profession. She warned that nurses will carry escalatory protest steps if the government fails to meet their demands for better pay and working conditions (The Daily Star, 2020a). As per MOPH and WHO figures for March 2020, 60% of infected healthcare workers in Lebanon were females (UN Women, UNFPA, WHO, & NCLW, 2020). The occupational health risks endured by Lebanese female healthcare workers can have multiple repercussions such as exposing their families to higher risk of infection as well as significant economic and social costs (IFI, 2020).

  The COVID-19 quarantine has been posing intense psychological challenges among Lebanese healthcare workers and these are worsened by the economic instability in the country (Fawaz & Samaha, 2020). Lebanese physicians and nurses have expressed their concern and fear regarding contracting the COVID-19 virus during their duty and spreading it to their families and communities, which is making them follow infection control measures more stringently (Fawaz & Samaha, 2020). Furthermore, the decision to care for COVID-19 patients presented a dilemma among these healthcare providers and brought a sense of frustration as they felt torn between their duties toward their families and their obligations toward their professions (Fawaz & Samaha, 2020). Lebanese healthcare providers also reported being stigmatized for working in a hospital in the time of the outbreak especially when people knew that they were working in the coronavirus unit; and this was further exacerbated with the spread of inaccurate information among the general public (Fawaz & Samaha, 2020).

- **People living with disabilities:** In Lebanon, people with disabilities face increased vulnerability due to the poor accessibility to healthcare. The two most commonly cited barriers to accessing needed healthcare services among this social group are financial and geographic (Social Promotion Foundation, 2020). Social assistance programs targeting people with disabilities in Lebanon are very limited in scope and not sufficiently funded (Sibai, Juergens, & Côte, 2020). The only support mechanism available in Lebanon is the disability card, which in theory entitles card holders to coverage of some assistive products, certain tax exemptions and free healthcare (Sibai, Juergens, & Côte, 2020; UN ESCWA, 2020). However, in practice, governmental hospitals are reluctant to provide care to disability card holders (Social Promotion Foundation, 2020; UN ESCWA, 2020). This has been attributed to the lack of funding allocated by the government to reimburse hospitals, and the fact that the disability card is not linked to any central information unit (like insurance cards) and hence does not provide either medical history or extents of coverage (UN ESCWA, 2020; Social Promotion Foundation, 2020). Aside from the disability card, the country has no system in place to provide direct income support for people with disabilities to cover their basic disability related costs; and the provision of community support services is also limited (Sibai, Juergens, & Côte, 2020). The marginalization of the Lebanese people living with disabilities has been further amplified during the COVID-19 pandemic. According to Human Rights Watch, the Lebanese government's COVID-19 response did not include the rights and needs of people with disabilities (Human Rights Watch, 2020c). Disability rights activists and parents of children with disabilities reported neglect of their special healthcare needs. The government's plan did not account for the accessibility of people with disabilities to healthcare, support services, and public health information amid the COVID-19 lockdown (Human Rights Watch, 2020c). The Lebanese Physical Handicapped Union reported receiving a large volume of calls from people with disabilities asking for help in getting necessary medications and respirators (for underlying health conditions) during the lockdown period (Human Rights Watch, 2020c). The Friends of the Disabled Association in Lebanon, has claimed that there is a lack of accessible information on the pandemic on television and social media, which compromises the ability of people with disabilities to protect themselves, make life-saving decisions, and access basic necessities and services during quarantine (Human Rights Watch, 2020c).

- **Refugees:** Lebanon hosts the largest number of refugees per capita worldwide with almost one million Syrian refugees (UNHCR, 2020), 178,000 Palestinian refugees (Lebanese Palestinian Dialogue Committee, Central Administration of Statistics & Palestinian Central Bureau of Statistics, 2018), as well as an additional 18,500 refugees from other countries (UNHCR, 2019). Refugees in Lebanon suffer from extremely difficult conditions that are threatening to spread the virus widely within fragile communities that are densely crowded (Social Watch, 2020). While there are only a few confirmed cases among refugees to date, the situation is highly unpredictable and the overcrowded settlements of refugees need to be closely monitored (Arab Reform Initiative, 2020). The COVID-19 pandemic increased the prevalence of stigma and discrimination against refugees in Lebanon. As of January 2020, and even before the government declared a nationwide curfew, at least 21 Lebanese municipalities had taken discriminatory measures against Syrian refugees as part of their efforts to combat COVID-19 and these included imposing curfews and restrictions on their movement (Human Rights Watch, 2020d). These measures contravene Lebanon's international human rights obligations and the Lebanese domestic law (Human Rights Watch, 2020d). Syrian refugees have also raised concerns about their ability to get healthcare and the lack of information on how to protect themselves against infection. In a recent survey conducted by the Norwegian Refugee Council, 81% of refugees living in informal settlements in Bekaa lacked the information on the national protocol or appropriate information on what to do if they developed symptoms or wanted to report a suspected case of COVID-19 (Norwegian Refugee Council, 2020a). Survey respondents expressed major concerns related to their children being infected, their inability to access healthcare due to financial barriers, their fear of being discriminated against in hospitals and primary healthcare centers, the overcrowding of their tents and their lack of hygiene items (Norwegian Refugee Council, 2020a). In focus group discussions conducted by Oxfam in Bekaa and Tripoli, Syrian refugees expressed that they may refrain from seeking medical care even if they experienced symptoms due to financial barriers and fears of stigma and discrimination (Human Rights Watch, 2020d).

- **Migrants:** Migrant workers in Lebanon, especially female domestic workers, have been hit hard by the economic and financial crisis shaking the country since last fall and which has been exacerbated by the coronavirus pandemic (Khalifeh, 2020). An estimated 250,000 migrant domestic workers live in Lebanon under the country's kafala system, putting their rights and lives at risk during the COVID-19 outbreak (Amnesty International, 2020). Kafala or the sponsorship system binds a worker to a specific employer and deprives him/her of labour protections under national laws. Kafala is associated with unacceptable labor conditions and the entrapment of workers in the home of their employer (Amnesty International, 2019). Under kafala, a large proportion of employers of domestic workers withhold her passport, limit her mobility, and oftentimes deny her the right to go out on her day of rest (Abdulrahim & Cherri, 2016). While staying at home will help prevent the spread of COVID-19, it increases the risk of exploitation and other forms of abuse suffered by live-in migrant domestic workers; such as being forced to work extreme hours, being denied rest days, having pay withheld or deductions applied, having communications restricted, and being deprived of food (Amnesty International, 2020). Access to healthcare is one of the key perils facing migrant domestic workers, both those who are in regular or irregular status (ILO, 2020). While the government has committed to offering free testing for COVID-19 to all, it is unclear whether this also applies to undocumented workers, and who will cover the cost of the treatment if a migrant worker is infected with the virus (ILO, 2020). The economic collapse has rendered a large number of migrant domestic workers homeless putting them at high risk of both COVID-19 infection as well as other health and social risks. News outlets reported extensively on Ethiopian domestic workers who have been abandoned by their employers and who sought shelter in front of the Ethiopian consulate in Beirut (Annahar, 2020). These domestic workers found themselves homeless, destitute and sometimes undocumented after their employers who could no longer pay their wages abandoned them (Amnesty International, 2020). These incidents are likely to get worse in the weeks to come given the shortage of dollars and the depreciation of the value of the Lebanese pound have caused a sharp decline in the purchasing power of many Lebanese families which have rendered the Lebanese families unable to afford the salaries of migrant workers (Khalifeh, 2020). Furthermore, the cessation of economic activity due to the coronavirus pandemic has led to a sharp increase in unemployment (Khalifeh, 2020). Under these dire circumstances, the majority of migrant domestic workers lost their jobs and those lacking legal documentation were the most vulnerable (ILO, 2020). Moreover, many employers can no longer afford to finance the repatriation of their migrant domestic workers and have turned to international organizations such as the International Labor Organization (ILO) and the International Organization for Migration (IOM) to try to find a solution for this humanitarian crisis (Amnesty International, 2020; Khalifeh, 2020).

- **Prisoners:** Lebanon has long struggled with notoriously cramped and unsanitary prisons and detention facilities (Arab Reform Initiative, 2020). According to statistics gathered by the Beirut Bar Association, there are 10,000 detainees distributed among 25 prisons and 261 detention facilities most of which are very small (Al Jazeera, 2020; Middle East Monitor, 2020c). Prisoners and their families have long demanded an amnesty law be passed to release thousands who were detained for petty crimes such as drug use and possession, in addition to those held for long periods of time without being sentenced and those who served their time but were unable to leave because they could not pay fines (Al Jazeera, 2020). Successive governments have promised to endorse the amnesty law, but none fulfilled this promise which resulted in recurrent hunger strikes and riots in most of Lebanon's prisons (Al Jazeera, 2020). On March 17, riots erupted in two of Lebanon's largest prisons in Roumieh and Zahle with prisoners demanding to be released over fears that the novel coronavirus would rapidly spread among them (Al Jazeera, 2020; Middle East Monitor, 2020c). On April 7th 2020, dozens of prisoners set their beds on fire at Qubbah prison in Tripoli to draw attention to the government's inaction with regards to issuing the general amnesty law amid the novel coronavirus pandemic (Anadolu Agency, 2020a). Ninety percent of the prisoners in three of the major prisons in the country (Roumieh, Qubbah and Zahleh) went on a hunger strike demanding general amnesty and affirming their right to be informed about all health risks that endanger them (Legal Agenda, 2020). The fear of the spread of the virus in prisons has also led to escape attempts. For instance, security forces uncovered a several-meter-long tunnel under the Zahleh prison and several prisoners and a member of the administration were injured during the operation (Prison Insider, 2020). The Lebanese Order of Physicians denounced the inhumane health conditions in the country's prisons. The order demanded that protective masks, gloves and disinfectants be provided to prisoners, as well as accelerating the rate of releases and establishing health isolation centers in case prisoners get infected with the virus (L'orient Le Jour, 2020).

  Despite the dire situation, Lebanon only adopted preventive measures such as suspending all activities and reducing family visits; unlike other countries like Iran or Turkey that have released thousands of prisoners to halt the COVID-19 outbreak (Arab Reform Initiative, 2020). To reduce the fear and anxiety among prisoners, the United Nations Office on Drugs and Crime (UNODC) provided them with mobile SIM cards to communicate with their families (UNODC, 2020). Furthermore, UNODC supported prisons in terms of providing comprehensive packages of preventive and protective tools such as hygiene kits that include detergents, disinfectants, sanitizers, masks and gloves, clear standard operating procedures, and awareness raising materials on recommended standard hygiene practices (UNODC, 2020). The Beirut Bar Association has also sought to provide free legal aid to prisoners whose cases were stalled due to the lack of legal representation, and to raise the money to pay fines for prisoners who have served their sentences (Middle East Monitor, 2020c).

How are other countries addressing human rights during the COVID-19 pandemic

Many governments worldwide instituted proactive measures to address inequities and human rights violations that ensued from COVID-19 and its control measures (physical distancing and quarantine). The table below lists measures undertaken in response to each one of the specific vulnerability areas that became exacerbated by COVID-19.

Gender and Social Inequalities

- The **Australian** government implemented a number of modifications to allow the justice system to better respond to domestic violence cases during quarantine. These measures included imposing electronic monitoring requirements for bail and conditionally suspend imprisonment orders; online filing of restraining orders, increased fines, and extended limitation period for restraining orders (Guedes, 2020).
- The **Canadian** government committed 15 million dollars to support women entrepreneurs and help them navigate through the COVID-19 crisis (Simpson, 2020).
- The **Canadian** government pledged 50 million dollars to assist domestic violence shelters, sexual assault centers and women refuge centers throughout the COVID-19 crisis. These funds are intended to help these centers implement public health recommendations to protect against an outbreak thus reducing the need for services to shut down (CBC, 2020).
- The **French** Minister of Interior announced setting up alert systems and assistance points for domestic violence victims in pharmacies during the COVID-19 lockdown (Rivais, 2020; Le Figaro, 2020). The French Government will also contribute 1 million euros to organizations that fight domestic abuse (NPR, 2020). And, it will be paying for 20,000 hotel bookings for domestic violence victims during the COVID-19 lockdown (NPR, 2020).
- The **Italian** government launched a mobile application that enables domestic violence victims to ask for help without having to make a phone call (NBC News, 2020a). Furthermore, domestic violence victims are exempt from strict lockdown rules such as the requirement to carry a document justifying why they are leaving their home if they need to visit a refuge center (Straits Times, 2020). Prosecutors ruled that in situations of domestic violence the abuser must leave the family home, not the victim (The Guardian, 2020b).
- The **Scottish** government announced the funding of £1.35 million to Scottish Women's Aid to ensure the maintenance of key support services for domestic violence victims and alternative access via online video platforms and text messaging as ministers insisted that the message to stay at home should not deter women from seeking urgent help (Grierson, 2020).
- The **United Kingdom** government pledged 95 million dollars to support victims of domestic abuse throughout the COVID-19 pandemic (CGTN, 2020)

Special Needs of Vulnerable Populations

Elderly

- The **Australian** government allocated 205 million dollars to provide COVID-19 specific support packages for residential aged care providers. This takes the total COVID-19 specific federal government funding for aged care to more than 850 million dollars (Prime Minister of Australia, 2020).
- The **Canadian** government announced aid in the form of a one-time payment of 500 dollars for eligible seniors to offset any increased living expenses that have incurred as a result of the COVID-19 pandemic (CTV News, 2020).
- The **Russian** government distributed 42 billion Russian rubles (RUB) as social payments for elderly over the age of 65 years who were obliged to stay home during the COVID-19 pandemic (Statista, 2020).
- With millions of senior citizens in **Turkey** confined to their homes due to the coronavirus pandemic, Turkish authorities are ensuring their daily needs are met swiftly and help is just a phone call away. The Interior Ministry has mobilized support groups to help people older than 65 during the self-isolation period. Senior citizens can contact the police or other groups through dedicated hotlines to convey their needs. Social assistance groups, made up of officials from the police, gendarmerie, and disaster relief agency, then bring them whatever they need, including food, household goods, or even pension payments. According to the ministry, to date the support groups have assisted more than one million people (Anadolu Agency, 2020b).

Frontline health workers

- The **Canadian** government pledged 3 billion dollars to top-up wages of frontline health workers dealing with COVID-19 cases (National Post, 2020).
- The **French** Prime Minister announced that frontline health workers dealing with COVID-19 cases would receive a bonus of 1,500 euros as well as higher pay than usual for overtime (France 24, 2020b).
- The **Russian** government started providing extra allowance for frontline health workers treating COVID-19 patients. Doctors will receive RUB 80,000 extra pay per month, paramedical staff will receive RUB 50,000, and nurses will receive RUB 25,000. Emergency Medical Services (EMS) doctors will also receive a surcharge of RUB 50,000 per month. Paramedics, nurses and EMS drivers will receive RUB 25,000. The allowance will be paid for three months starting April (Moscow Mayor, 2020).
- The Vice President and Prime Minister of the **UAE** and Ruler of Dubai, issued instructions to relevant authorities to grant 10-year residency visas for frontline health workers at the Dubai Health Authority in an expression of thanks and appreciation to their efforts in the fight against coronavirus pandemic (Gulf News, 2020).

People living with disabilities

- The **Canadian** Disability Inclusion Minister appointed an advisory task group consisting of academics and organization leaders spanning a range of physical and intellectual disabilities to apprise the government of the barriers their communities face and ensure their needs are adequately addressed (The Globe and Mail, 2020).

Country Experiences

Refugees and Migrants

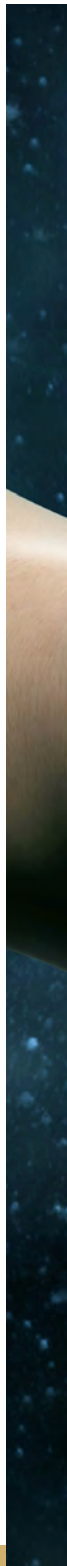
- The **Maldivian** authorities opened a free clinic for expatriate workers, including undocumented/irregular migrants where no identification documents are required to improve their access to healthcare without fear and help contain a larger outbreak (OHCHR, 2020).

Prisoners

- The **Canadian** government approved early release of hundreds of prisoners considered as low risk offenders from federal prisons to stave off potential COVID-19 outbreak in federal institutions (APTN National News, 2020).
- The **French** government released 10,000 prisoners from its chronically overcrowded prisons to halt the spread of the novel coronavirus (France 24, 2020a).
- Iran, the epicenter of the COVID-19 outbreak in the **Middle East**, released 85,000 people from jail, including political prisoners (Reuters, 2020).
- The **Iraq** Supreme Judicial Court authorized the release of over 16,000 prisoners as a preventative measure against the coronavirus pandemic. It has also issued pardons to more than 1,000 convicts (The New Arab, 2020).
- The **Jordanian** Judicial Council released 3,081 people jailed for civil debts, as part of the Hashemite Kingdom's efforts to combat the coronavirus outbreak and preserve the prisoners' health and safety. The judges have decided to postpone their prison sentences for a period of one month for those whose total debt does not exceed 10,000 Jordanian Dinars. The decision does not infringe the rights of the creditors because the release is temporary due to the state of emergency (Middle East Monitor, 2020a).
- **Saudi Arabia** has released 250 foreign detainees held on non-violent immigration and residency offences as part of efforts to contain the spread of the novel coronavirus (Reuters, 2020).
- The **Scottish** government passed a regulation to allow the early release of around 450 short term prisoners nearing the end of their time in custody to help tackle the COVID-19 outbreak (Scottish Government, 2020).
- In order to decongest jails and contain the risk of them turning into hotspots of the coronavirus pandemic, the **Turkish** parliament passed a law on April 14, to release 90,000 prisoners from overcrowded jails in the country. Half of these prisoners are to be released temporarily under judicial oversight till the end of May. Their term of parole can be extended by the justice ministry twice at the maximum for a two-month period each time. The other half will be released permanently (Peoples Dispatch, 2020).
- **Dubai**'s main prison has released hundreds of prisoners serving sentences for minor crimes as part of efforts to reduce the prison population. The move has seen prisoner numbers at Dubai Central Prison fall by up to 35 per cent in recent weeks. Hundreds are pardoned by the country's rulers for Ramadan every year, but the move this year was part of broader attempts to protect inmates during the coronavirus outbreak, officials said (The National UAE, 2020)

Global Collaboration and Support

The COVID-19 pandemic has had detrimental health and economic effects on many high-income countries and it is likely to exert even more devastating consequences on LMICs as they respond to this pandemic. In the short period of time since the COVID-19 outbreak started, the demand for the International Monetary Fund (IMF) has skyrocketed. Never in the history of the institution have so many countries (85 countries so far) found themselves in need of IMF emergency funding (The Telegraph, 2020b). LMICs will require international assistance and cooperation to effectively manage the impacts of COVID-19 on their populations. Under the International Human Rights Law and the International Health Regulations, countries have an obligation to share technical and financial resources and information (United Nations, 1948a; WHO, 2005). This obligation for international assistance and cooperation is not subsidiary but rather akin to countries' domestic obligations. For instance, the successful response to the HIV epidemic over the past few decades would not have been possible without the pooling and sharing of resources globally and the coordination and sharing of information on the nature of the virus and methods for prevention, testing and treatment (UNAIDS, 2020). As with HIV, no country should be left behind in the global effort to prevent and respond to the COVID-19 pandemic. The lack of diagnostics in many countries highlights the urgent need to share knowledge, information and resources to scale up quality testing for COVID-19 across all countries. This obligation to share knowledge, information and resources should be maintained during the development and roll out of a vaccine, should it become available (UNAIDS, 2020). A global pandemic like COVID-19 is a shared responsibility and it reminds us of our global connectedness which calls for global solidarity (United Nations, 2020a). Thus, supporting LMICs through international assistance and cooperation, both fiscal and technical, is crucial not only for individual nations' efforts to address this pandemic but also to global efforts.



WHO 1948 Constitution

The States Parties to this Constitution declare, in conformity with the Charter of the United Nations that (WHO, 2006):

- "The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States"
- "Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger"

Multi-sectoral recommendations to implement a human rights-based approach in the COVID-19 response

The COVID-19 pandemic is a powerful reminder to the world about the necessity of global cooperation. Each country has a vested interest in controlling the spread of an infectious disease pandemic in other countries. In the case of COVID-19, isolationist attitudes will not serve to defeat the virus. Instead, working with other countries, supporting international development and providing aid are more likely to support the safeguarding of health (Emanuel 2003).

International human rights law states that countries must prohibit and eliminate discrimination in all its forms and guarantee the right of everyone regardless of race, color, descent, or national or ethnic origin (United Nations, 2020a). Principles of inclusiveness, equity and social justice should form the basis of crisis response strategies and tools (Schiariti, 2020; Smith & Judd, 2020). It is imperative to raise awareness of collective human rights in order to ensure equitable access of services and that all people are treated with dignity and respect (Schiariti, 2020).

Community engagement is integral in pandemic planning and response and can support in maximizing the effectiveness of interventions by tailoring them to the needs of crisis-affected populations and communities (Poole, Escudero, Gostin, Leblang, & Talbot, 2020). In this context, multi-level community interventions have more effective and sustainable outcomes as they have a higher potential for efficacy in altering the course of the pandemic (Eaton & Kalichman, 2020).

Recommendations for action should be multi-sectoral and grounded in the principles of fostering community engagement; focusing on eliminating discrimination; working to ensure the availability, accessibility, acceptability and quality of services; providing access to information; and striving to ensure transparency and accountability in the response to the pandemic (Hussein, 2020).

01 Emphasize that health is a human right and ensure that COVID-19 emergency responses are inclusive, equitable and non-discriminatory

- Provide guidance to the media and community leaders on how to best discuss the pandemic in a manner that is non-stigmatizing, non-discriminatory, and respects people's privacy and confidentiality (UNAIDS, 2020; CDC, 2020c).
- Urge political and religious leaders to speak out and take action against discrimination, xenophobia, hate speech or violence arising from this pandemic (United Nations, 2020a; Bhala, Curry, Martineau, Agyemang & Bhopal, 2020).
- Adopt a COVID-19 response that does not perpetuate gender inequity by ensuring equal representation of women in COVID-19 response planning and decision-making to mitigate the gendered impacts of the pandemic (United Nations, 2020c).
- Recognize the extent to which COVID-19 has affected women and men differently and work to create effective and equitable policies and interventions (including those for female workers) and integrate gender dimensions into the design and implementation of the COVID-19 response (UN Women, 2020; UNFPA, 2020; Sharma, Scott, Kelly & VanRooyen, 2020).
- Incorporate gender mainstreaming into emergency preparedness plans for future disease outbreaks, because addressing structural issues such as gender inequality requires foresight and planning (Smith, 2019).
- Combat ageism and ensure that the response to the COVID-19 pandemic does not undermine the human rights and dignity of the elderly (WHO Europe, 2020; Human Rights Watch, 2020f).
- Comply with the principle of non-discrimination in relation to people with disabilities, and ensure their inclusion into the COVID-19 response by actively engaging them in all stages of the COVID-19 response planning; and by ensuring their accessibility to public health information, facilities and services (United Nations, 1966; United Nations, 2000; United Nations, 2006; United Nations, 2020b).
- Ensure that national COVID-19 response and recovery plans identify and incorporate targeted measures to address the disproportionate impact of the current pandemic on refugees and migrants and ensure that they have equitable access to information, testing and treatment without any discrimination or restrictions on their freedom of movement (United Nations, 2020a; Human Rights Watch, 2020d; Brandenberger, Baauw, Kruse & Ritz, 2020).
- Guarantee prisoners' right to health, with no discrimination based on their legal status, as articulated in the United Nations Standard Minimum Rules for the Treatment of Prisoners or what is known as "The Nelson Mandela Rules" (United Nations, 2016).
- Ensure meaningful engagement of all sectors of the society and diverse civil society actors in the planning and decision making processes of the COVID-19 response, in order to fulfill the pledge of "leaving no one behind" and to guarantee the right of health to all (United Nations, 2020a).

02 Provide access to accurate and transparent information on COVID-19

- Adopt proactive measures to ensure that information disseminated is accurate and is presented in ways that do not stigmatize certain social groups (United Nations & WHO, 2008; WHO, 2020g; Poole, Escudero, Gostin, Leblang, & Talbot, 2020; United Nations, 2020a).
- Demonstrate leadership and transparency in discussing the COVID-19 pandemic and the communities that are affected, including healthcare workers (UNAIDS, 2020; CDC, 2020c)
- Collect and report data on confirmed COVID-19 cases and deaths that are disaggregated by sex and age, in accordance with WHO's global and national surveillance guidance; conduct gender analysis; and invest in gender responsive research on the potentially differential adverse health, social, and economic impacts of COVID-19 on women and men (WHO, 2020h; WHO, 2020g).
- Ensure continuous two-way communication and sharing of information and resources from governmental and health care agencies, institutions, and professional societies to support mental health and wellbeing of health professionals (Bansal et al., 2020).
- Disaggregate data by citizenship and communicate clearly to refugees and migrants that they can seek medical care without being penalized, even if they lack legal residence or documentation (Human Rights Watch, 2020d; Kluge, Jakab, Bartovic, D'Anna & Severoni, 2020).

03 Ensure accessible, affordable, acceptable and high-quality healthcare services

- Provide social protection packages that directly benefit groups least able to cope with the crisis and help mitigate the long term economic and social consequences of the pandemic (United Nations, 2020a).
- Establish priority criteria or priority groups for the allocation of particular health care resources (Smith & Silva, 2015). Include essential support services, such as psychological and first line support, to address violence against women in preparedness and response plans for COVID-19 that are adequately funded and accessible in the context of lockdown measures (WHO, 2020e; WHO, 2020g).
- Ensure that all women have equitable access to sexual and reproductive health services and include these services in the essential package of health services for the COVID-19 response (WHO, 2020a; WHO, 2020f; Roesch, Amin, Gupta, & Garcia-Moreno, 2020).
- Issue clear policies to guide medical personnel in decisions about allocating resources and monitor for possible discrimination among high risk groups (especially elderly) in accessing healthcare services (Human Rights Watch, 2020f).
- Support vulnerable older adults financially, provide them with their basic needs, and ensure their legal protection from abuse (Khoury & Karam, 2020).
- Ensure the availability of elderly-friendly technological applications to fulfill the mental and social needs of elderly during times of crisis, in terms of connecting them with their loved ones and providing them with reliable information (Khoury & Karam, 2020).
- Fulfill legal and moral obligations to provide adequate healthcare services to prisoners and immigration detainees (United Nations, 2000).

04 Foster collaboration, communication and coordination nationally and internationally to secure services during the COVID-19 pandemic

- Strengthen international cooperation in ensuring that COVID-19 treatments are available and affordable for all, in developing a vaccine or treatment for the novel coronavirus, in expediting trade and transfer of essential medical supplies and equipment (including PPE for frontline healthcare workers), and in sharing knowledge and resources (United Nations, 2020a).
- Include refugees and migrants in national public health plans, without risk of financial or legal consequences on them (Kluge, Jakab, Bartovic, D'Anna & Severoni, 2020; Wickramage et al., 2018).
- Urge international organizations to assume their full responsibility towards refugees to guarantee the provision of all necessary resources required to maintain their safety and contain the pandemic (Social Watch, 2020).
- Work closely and collaborate with charities/NGOs to ensure the necessary support for the most vulnerable people throughout this pandemic and prevent the spread of COVID-19 (Barbieri, 2020).
- Engage and coordinate with stakeholders and NGOs to ensure that prisoners and detainees have access to all necessary prevention, diagnostics and treatment services, including the ability to self-isolate and mental health and anxiety support services (CDC, 2020b; Sanchez, Simas, Diuana, & Larouze, 2020).
- Negotiate release of inmates who are especially vulnerable to COVID-19 with relevant stakeholders; this includes older people, low-risk offenders and prisoners in pretrial detention for non-violent offences, and divert drug offenders to evidence-based treatment programs to reduce prison overcrowding and limit COVID-19 transmission in prisons (Burki, 2020; Health & Human Rights Journal, 2020; Human Rights Watch, 2020b).

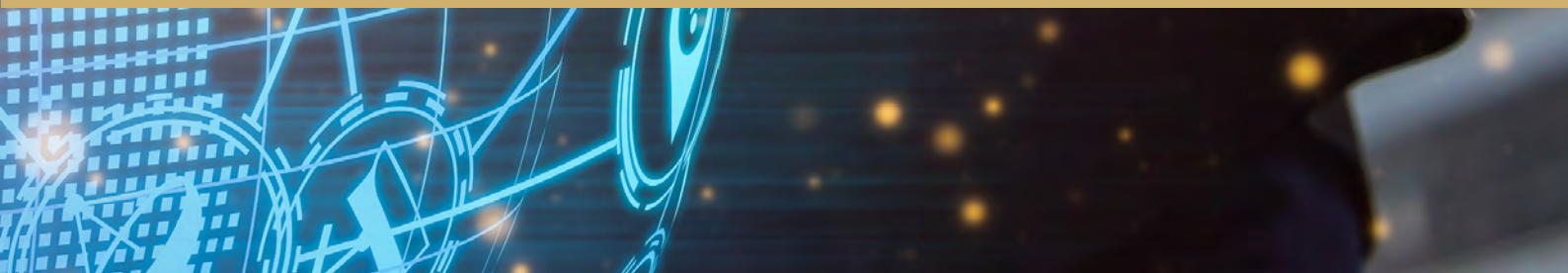
05 Safeguard the rights and wellbeing of front-line health workers

- Ensure that all frontline health and social workers and caregivers have equitable access to training, PPE and other essential products, psychosocial support and social protection, taking into account the specific needs of women who constitute the majority of these workers (WHO, 2020g).
- Utilize scientific evidence and principles of healthcare safety and safe care delivery in developing measures for workload minimization for healthcare workers and facilitate optimal availability and appropriate use of PPE (WHO, 2020b; WHO, 2020i; Chen et al., 2020).
- Train staff to effectively implement contact precautions and flow processes (Chen et al., 2020).
- Develop plans and processes to manage employee absenteeism and strongly recommend that employees remain at home if they have symptoms compatible with COVID-19 (D'Adamo, Yoshikawa & Ouslander, 2020).
- Provide healthcare workers with adequate emotional support and reasonable hours of risk exposure to prevent burnout (Chen et al., 2020; Bohlken et al., 2020).
- Grant essential healthcare workers insurance, medical and family benefits, psychosocial support and adequate resources (Sharma, Scott, Kelly & VanRooyen, 2020).
- Allow NGOs, health volunteers, and community health workers to contribute towards the doorstep delivery of essential drugs to socioeconomically vulnerable patients, the elderly, and those lacking mobility and social support (Basu, 2020).

As the COVID-19 pandemic continues to unfold and bring greater uncertainties and challenges, the global community is facing a highly unpredictable and dynamic situation that poses critical public health and development challenges. The response to this pandemic should not be fear and stigma, but rather support and solidarity. All stakeholders-including governments, international organizations, the private sector, and civil society-have a responsibility to ensure that the COVID-19 response is grounded in human rights and focused on eliminating barriers that people face in their daily realities and that hinder their ability to protect themselves and their communities. Governments should uphold the core principles of ethical decision making in the response to COVID19 through ensuring fairness, inclusivity, transparency, accountability and responsiveness (Isaacs, Britton & Preisz, 2020).

A multi-sectoral response to safeguard human rights is not only a moral imperative but also key to an effective COVID-19 response as these decisions will not only shape the trajectory of this pandemic but will also impact the lives of billions. Everyone, regardless of their social, legal or economic status, should have access to the health care they need (United Nations, 2020b).

The priority now is to save lives while maintaining and respecting human rights so we can emerge from this global crisis as more equitable and sustainable societies (United Nations, 2020b). It is time to rethink health as a human right that is based on our collective conscience and responsibility to safeguard global health and reshape the future of the generations to come (Khosla, Allotey & Gruskin, 2020).



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