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COVID-19: Human rights trade-offs, challenges and policy responses

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1. Introduction

The COVID-19 virus pandemic stands out as one of the most devastating global humanitarian and economic crises in living memory, leading to human misery in virtually every country in the world. In the history of pandemics, it is about to become one of the worst pandemics since the Spanish Flu between 1918 and 1919.[1] It has overwhelmed health systems, threatened national economies, social security systems, as well as education and food production (E/C.12/2020/1). As of 5 September 2020, the death toll from COVID-19 was around 870,000 people and around 26.5 million people had been affected.[2]

The short and long-term impacts of COVID-19 on human rights are huge. There is still a lack of knowledge and uncertainty about how it is affecting countries, and differences among them, as this depends on how authorities and populations react to the pandemic and continue to react in the coming months. The transmission rate is unequal in time and space, with some countries declaring themselves

[1] It is estimated that the death toll from the Spanish Flu and influenza pandemic caused by the H1N1 Influenza virus was anywhere between 17–50 million people – and possibly as high as 100 million, making it the deadliest pandemic in history. Michael S. Rosenwald. Washington Post, 7 April, 2020. Accessed 6 June, 2020. The Hong Kong Flu pandemic of 1968 had an estimated death toll of 1–4 million people; and the HIV/AIDS pandemic that has lasted from 1981 to the present has a death toll of at least 30–40 million people. In 2009, the Swine Flu pandemic had an estimated death toll of between 150,000–575,000 people (Dawood, F. S., Iuliano, A.D., Reed, C., et al. *Estimated global mortality associated with the first 12 months of 2009 pandemic influenza A H1N1 virus circulation: a modelling study external icon*. Lancet Infect Dis. 2012 Jun 26).
[2] These figures are changing daily. For up-to-date statistics, see the WHO data at https://covid19.who.int and www.worldometers.info/coronavirus.

free or having a relatively low level of the virus, while others countries are experiencing a second phase of rapid growth in transmission rate and death toll.

Since the first recorded outbreak of COVID-19 in Hubei Province in China in late December 2019–early January 2020, numerous human rights challenges, dilemmas and trade-offs in human rights have arisen as the coronavirus spread worldwide and turned into a pandemic.[3] This paper addresses the pandemic in the context of international human rights law, and more specifically, we ask about the actual and potential human rights impacts on everyday life and various governmental responses to cope with the impact of the pandemic on the respect and protection of human rights. The purpose of this paper is to identify experiences and practical implications and draw some preliminary conclusions regarding legal and policy responses to the crisis with particular reference to the duty of states to respect and protect human rights in times of crisis and emergency.

The COVID-19 pandemic represents a composite crisis: it has fundamental human effects, it has huge economic repercussions; in 2020 the global economy is expected to shrink by more than 5% (The Economist Global Outlook, 25 August, 2020). National economies will suffer disproportionally, yet significantly, and unemployment is rising rapidly with millions of people losing their jobs and cash-strapped businesses unable to survive without government support. One key trade-off of COVID-19 is that necessary legal and policy responses to cope with the spread of the virus are significant and may lead to human suffering and temporary loss of human rights (by measures of derogation, see further discussion in section 4).

Thus, in the months and years ahead, empirical analyses will ascertain how the pandemic has affected the populations of different countries, some directly as a result of their vulnerability to the disease; others indirectly, by the measures taken to prevent its transmission. Several risk factors – old age, race, pre-existing health conditions, certain occupations, and compromised immune systems – make people particularly vulnerable to contracting COVID-19, and the possibility of dying from the disease. Doctors and nurses providing front-line medical support are particularly vulnerable and have suffered high mortality rates in several countries (e.g. Italy). In many countries, the spread of COVID-19 has been exaggerated by the lack of preparedness and poor quality of health systems, not least the availability and quality of health support for elderly people. In Africa, where the spread of the virus thus far has been less severe than in Western countries and Latin America, everyone has been affected

[3] For an interactive timeline of the spread of COVID-19, see www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline.

by other measures such as stay-at- home isolation, quarantines, travel restrictions and loss of income. Yet, some groups have been more severely hit, particularly residents of informal settlements, who have suffered disproportionally. Based on these insights, we must examine how government responses to the pandemic differ between countries. How do different models of response impact the spread and mortality rate of the virus on the one hand, and "costs" in terms of limitation of rights and freedoms on the other? An important related question is how popular trust and support for government policies vary among countries, and the impact this may have on policy effectiveness.

In the remaining part of the paper we map out human rights trade-offs and dilemmas and how they affect certain groups more than others and may therefore deepen existing patterns of inequality and vulnerability (sections 2–3). We then discuss the state of emergency regulations, temporary regulations and human rights protection in pandemic situations (section 4); quarantines, lockdowns and social distancing in daily life (section 5); and surveillance of citizens and public life as a particular human rights challenge in section 6. In section 7, we briefly address international collaboration and human rights obligations to protect, before concluding (section 8).

2. The Coronavirus ('COVID-19') pandemic: Human rights dilemmas and trade-offs

State parties to international human rights instruments are under an obligation to take measures to prevent or mitigate the impacts of a pandemic, and COVID-19 has illustrated the importance of the interdependence and indivisibility of all human rights. While primarily being a health threat, it also affects the enjoyment of other economic and social rights (employment, education, culture, etc). However, equally importantly, it affects compliance with civil and political rights, including rule of law and good governance practices. Government responses to COVID-19 require a balance between the legitimate use of state powers to protect public health, and restraints on the use of such powers to ensure that civil, political, economic, social and cultural rights are being respected. A pandemic situation will easily trigger human rights dilemmas, including whether the protection of some rights (e.g. the right to health) legitimises the restrictions of others (freedom of association, assembly, movement, etc). A human rights approach to the pandemic requires human rights concerns and trad-offs are being addressed in government responses to the pandemic, and used as a framework that can bring "crucial guideposts that can strengthen the effectiveness of global collective

responses".[4] Such dilemmas should be addressed with reference to the relevant legal framework, including that governing derogations from human rights instruments (cf. the discussion in section 4).

Around the world, state practices demonstrate a wide variety of government responses. Timing and the scope of the measures introduced appear to have significantly impacted the pattern of, and extent of, the transmission and spread of coronavirus in the population. While some countries were early in recognizing the risk to public health of the imminent pandemic in January and February 2020, the political leadership of other countries continued to deny the seriousness of the situation (Brazil, Nicaragua, the USA at a federal level, Burundi, etc). Early response and the introduction of measures restricting social interaction appear to have been very important in slowing the transmission of the virus and, eventually be reducing the transmission rate. By slowing down the spread of the virus (flattening the curve), the health sector would be able to prepare for an escalation in the number of COVID-19 patients requiring intensive, demanding and extremely expensive care.

Variations in how countries have responded may also be a consequence of the *institutional organization* of the epidemic and pandemic disease control in a given country. A notable example was the difference between Sweden and many other European countries, including Norway. As of early June, Sweden had one of the highest numbers of coronavirus-related deaths per capita in the world. By June 2, Sweden had 4,403 registered COVID-19 deaths out of a population of around 10 million, compared to Norway's 236 deaths and a population of around 5.5 million. We do not have a full overview of this extreme variation between the two neighbouring countries, both of which have advanced health systems and are close in culture, economic structure and political institutions. However, one factor that may help explain the difference is the institutional structure of the health authority system. While both countries have a system of health crisis management, the Public Health Agency (PHA) of Sweden has a different position, and more power, in a crisis situation than its counterpart in Norway. In Sweden, it is the mandate of the expert agency PHA to initiate all measures to prevent a virus in accordance with Swedish law. At the same time, the Swedish constitution prohibits *ministerial rule*, an informal term for when a public authority in Sweden at state or municipal level (i.e. the parliament or municipal assembly) attempts to influence decisions of the PHA in exercising its authority. In Sweden this would be a violation of the section *Instruments of Government* of the Swedish Constitution. This provides wide powers to the PHA to formulate and

[4] UN High Commissioner updates the Human Rights Council on human rights concerns, and progress, across the world. .https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25621&LangID=E. (Accessed 20th of August 2020).

determine the measures to be taken in response to COVID-19. In contrast, in Norway, the relevant health agencies have an advisory role, while the government is key in making administrative and legal decisions (regulations). Thus, it has been argued that these different *institutional management structures* have contributed to different policies. While the Swedish Public Health Agency assumed that the coronavirus (and lack of a vaccine) would lead to a high level of immunity in the population once a majority had contracted the virus (so-called 'herd immunity'), and therefore did not impose stringent regulations (including lockdown), on March 12 the Norwegian Government decided to impose a national lockdown. In other words, the two countries illustrate how different institutional structuring of the public health agencies potentially contributed to a huge variation in the outcome in terms of the number of COVID-19 victims. An initial "wait-and-see" *liberal* approach in Sweden was in significant contrast to Norway, which closed its borders and imposed strict regulations on its population.

There are, of course, many other factors that impact the choice of government responses to the COVID-19 pandemic, some of which we will return to below: public trust among citizens and of the government is important for how people react to measures imposed by the government. A government's use of stringent measures varies among countries; while some countries have introduced curfews and a state of emergency, other countries have relied on people's willingness and commitment to follow public advice and regulations. The capacity of the health system to respond and cope with the crisis also depends on the economic resources that are available and whether an early warning system is in place. The lack of knowledge of the nature of COVID-19 – its transmission pattern, health risk, who is most affected etc. – has created uncertainty about the choice and introduction of measures such as quarantines, lockdowns, closing of schools and businesses, as well as shutting down public transport. Misinformation, spurious advice and dubious claims, rumours and misinformation in social media have also had a negative impact and have spread fear among the public at large.

There is no blueprint for how a country should respond to the current COVID-19 pandemic, but coping with the crisis requires that it is recognised as a pandemic, and that while the public policy response is not delayed by a "wait-and-see" attitude, due consideration should be given to the different 'trade-offs'. A major dilemma, for example, is balancing the imperative of saving lives – including elderly population groups – with the consequences of economic lockdown for society as a whole (with indirect serious health consequences in the non-affected population). Public authorities must take responsibility and avoid blaming others (cf. the Trump administration's ongoing dispute

with China). Many countries emphasize that combating the virus requires national unity and a sense of togetherness and civic engagement. Past experiences of epidemics and pandemics may urge countries to introduce early and effective measures. A point in case about Africa is that the comparatively slow spread of the coronavirus on the continent may partially be related to previous experiences of epidemics – such as HIV/AIDS and Ebola – that have resulted in the introduction of early restrictive measures. Demography may also be a factor: by and large, COVID-19 affects elderly people, while the African population with a general low average age, may be less affected by the virus (retuned to below). Last but not least, early action combined with strong measures may have served many countries well, although in several cases this has been accompanied by serious human rights abuses.

3. Groups at Risk: Leaving No One Behind During the COVID-19 pandemic

The general COVID-19-related legislative and policy measures and restrictions being discussed need qualifying by examining how they affect different *groups* in *different ways* and in different *geographical contexts*. Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and directs state parties to create conditions to ensure health services and medical assistance. One of the sub-measures of Article 12 concerns the prevention, treatment and control of epidemics. However, this sub-measure and other measures should be implemented in a manner that ensures respect, protection and the promotion of rights. While general approaches and measures may be necessary to prevent, mitigate and treat the pandemic, they require the specific circumstances of particular groups and individuals to be taken into consideration. In other words, public health interventions, though vital for the health and well-being of populations should not be blindly implemented on a 'one-size-fits-all' basis, lest they risk negatively affecting health-seeking behaviour.

Take the United Kingdom, for example: at the beginning of the pandemic, the fact that Prince Charles and the (then) Prime Minister Boris Johnson contracted COVID-19 was initially taken to signify that the disease was a 'great equaliser' – i.e. anyone, anywhere could contract COVID-19 – even the rich and powerful. Certainly, science suggests that there is a generalisable risk of infection. However, since more time has elapsed, a more nuanced picture is developing in which the burden of COVID-related disease has been correlated with two distinct qualifiers:

- The '*social pre-determinants'* of health. Such predeterminants of health are not only the obvious ones – access to health care – but all the factors that are more likely to expose populations to illness in the first place, i.e. poverty, deprivation, physical environment, race, ethnicity and marginalised identities, as well as poor health care, in addition to various categories or groups that may be more exposed to the transmission of the virus than others. In other words, some people will be more likely to contract COVID-19, have more serious symptoms – and sometimes more fatally so – than others.
- *Disproportionate impacts of interventions*. The measures being taken, particularly restrictive measures, may place a disproportionate burden of public health interventions on some people more than others.

A useful lens for looking at how the universal threat of COVID-19 is unevenly experienced is the 'Leave No One Behind' framework associated with realising the Sustainable Development Goals.[5] The framework presents an explanation for why hundreds of millions of people more generally are 'unable to fully participate in or benefit from human development, innovation, economic growth or globalization.' There are five key drivers (UNDP, 2018) that shape peoples' exclusion from society and which we can use here to reflect on the causes of pre-determinants of health in the specific context of COVID-19:

1) *Discrimination*: What biases, exclusion or mistreatment do people face based on one or more aspects of their identity (ascribed or assumed), including gender, as well as ethnicity, age, class, disability, sexual orientation, religion, nationality, indigenous status, migratory status etc.?
2) *Geography*: Where exposure to isolation, vulnerability, missing or inferior public services, transportation, internet or other infrastructure gaps is made worse due to their place of residence?
3) *Governance*: Where do people face disadvantage due to ineffective, unjust, unaccountable or unresponsive global, national and/or sub-national institutions? Which groups are affected by inequitable, inadequate or unjust laws, policies, processes or public budgets? Who is less able or unable to gain influence or participate meaningfully in the decisions that impact them?
4) *Socio-economic status*: Who faces deprivation or disadvantages in terms of income, life expectancy and educational attainment? Who has less chance of staying healthy, being

UNDP (2018) 'What does it mean to leave no one behind?'[5] https://www.undp.org/content/undp/en/home/librarypage/poverty-reduction/what-does-it-mean-to-leave-no-one-behind-.html

nourished and educated? Competing in the labour market? Acquiring wealth and/or benefiting from quality health care, clean water, sanitation, energy, social protection and financial services?

5) *Shocks and fragility*: Who is more exposed and/or vulnerable to setbacks due to the impacts of climate change, natural hazards, violence, conflict, displacement, health emergencies, economic downturns, price rises or other shocks?

These drivers not only shape a person's ability to participate in global development, but also to deal with 'shocks and fragility' such as those associated with COVID-19. These dimensions can represent an entry point for understanding that the risk of disease and the impact of preventive measures are not only general, but are also highly correlated to particular groups. Special attention and care must be taken to define and identify vulnerable and underserved populations. A starting point is to first ask the question, who is most impacted by COVID-19's burden of disease and morbidity as a health threat? Second, who is then most affected by the side-effects of restrictive measures to control the transmission of the pandemic?

Group Risk I: Illness and Morbidity

While there is much to learn about the science and biology of COVID-19, its transmission and patterns of mortality and illness, some tentative common experiences can be collated with broad group factors.

Main dynamics

Age Group. By far the most significant group factor associated with mortality by COVID-19 is according to age group. In fact, people over 65 years of age account for 80% of COVID-19 deaths in the USA, with similar patterns occurring in Europe and also for those countries, such as China, for which data is available.[6] Care and nursing homes for the elderly in particular have been impacted by severe concentrated outbreaks of COVID-19. In the UK, 27% of all deaths from COVID-19 were in care homes,[7] rising to approximately one half of all deaths in Sweden. The generally inadequate measures for protecting elderly residents suggest limited attention has been paid to the right to health and life of these older groups. Conversely, children and adolescents are at much less risk of infection and morbidity – significantly less than the over 65s. Whereas some adolescents are being stigmatised,

[6] See, for example, https://ourworldindata.org/mortality-risk-Covid: Case fatality rate of COVID-19 by age group across countries (South Korea, Spain, China, Italy).

[7] Public Health England (2020), Disparities in the risk and outcomes of COVID-19.

for example, in Kenya, by drawing attention to their behaviour and labelling them so-called ‘super spreaders’ of COVID-19, actually 75% of the population is under 35 years of age, which means that the opposite is likely: countries with relatively young populations, i.e. 43% of Sub-Saharan Africa’s total population is under 15 years of age[8], are less vulnerable to age-related COVID-19 mortality than countries with aging populations (e.g. Italy and other predominantly Western countries). Furthermore, men are almost twice as likely as women to be amongst the fatalities and are therefore disproportionately represented in the higher age brackets comprising mortality rates.[9]

Underlying Conditions/Co-Morbidity. Underlying health conditions are most likely associated with all the factors that have been mentioned. In England and Wales, for example, of the deaths involving COVID-19 that occurred in March and April 2020, there was at least one pre-existing condition in 90.4% of cases. Pre-existing conditions particularly include diabetes, which has been identified as the most frequent co-condition in a recent Public Health England report, but also underlying conditions such as heart disease, respiratory disease and hypertension.[10] In many countries there is a correlation between, for example, heart disease, smoking and respiratory conditions that is likely to heighten vulnerability to COVID-19. Such conditions are more likely to be associated with critical COVID-19 disease and are more common amongst elderly groups. While HIV/AIDS has also been identified as one such pre-existing condition, there is, however, to date, a lack of evidence to suggest that a person living with HIV/AIDS whose level of HIV infection is controlled by medication is any more susceptible to COVID-19 disease than non-HIV positive groups.

[8] Partnership for Evidence Based Response to COVID-19 (2020) ‘Responding to COVID-19 in Africa: Using data to find a balance’.

[9] For example, males had a significantly higher mortality rate due to COVID-19; the age-standardised mortality rate (ASMR) for males in England was 781.9 deaths per 100,000 males compared to 439.0 deaths per 100,000 females; in Wales, this was 630.6 deaths per 100,000 males compared to 363.2 deaths per 100,000 females, in ‘Death involving COVID-19 in England and Wales: Deaths Occurring in April 2020’, Office of National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingCovid19englandandwales/deathsoccurringinapril2020. See also a recent study on socio-demographic risk factors in Sweden here:https://su.figshare.com/articles/Socio-demographic_risk_factors_of_COVID-19_deaths_in_Sweden_A_nationwide_register_study/12420347

[10] Public Health England (2020) op.cit.

Race and ethnicity. Preliminary evidence suggests that some race and ethnic groups may be at risk of a higher level of infection and death. In the USA and the UK, for example, race has been a prominent factor identified in illness and morbidity: the US infection rate is more than three times higher in predominantly black counties than in predominantly white counties. However, in terms of mortality rates, it is six times higher for predominantly black counties than in predominantly white counties. In the UK, another initial study found that although black and ethnic minorities comprise 13% of the population as a whole, 35% of almost 2,000 patients were non-white, i.e. nearly three times their population size.[11] A larger report found that people of 'Chinese, Indian, Pakistani, other Asian, Caribbean and other Black ethnicity had between 10 and 50% higher risk of death when compared to White British'.[12] Marginalised minorities are generally more prone to ill-health. It is likely that a fuller analytical picture of the contributory factors will need to be developed. For example, the influence of intergenerational family living and the effects of occupation and underlying health conditions. In relation, there has been disproportionately high mortality amongst certain ethnic minorities in some key jobs (see below, in the context of socioeconomic factors, and healthcare workers in particular). Nevertheless, 'underrepresented minorities are developing COVID-19 infection more frequently and dying disproportionately.'[13]

> Although racial and ethnic information is currently available for only around 35% of total deaths in the USA, even this limited sample shows that Black Americans and other historically disadvantaged groups are experiencing infection and mortality rates that are disproportionately high in terms of their proportion of the total population. For example, while Black Americans represent only around 13% of the population in the states reporting racial/ethnic information, they account for around 34% of total COVID-19 deaths in those states. Asian Americans and Latin Americans also show elevated impacts in some regions. (John Hopkins University, https://coronavirus.jhu.edu/data/racial-data-transparency).

Socio-Economic and Geographic factors. The factors mentioned above in the specific context of COVID-19-related health risks are also strongly correlated with socio-economic factors. Communities who live in cramped, crowded and more deprived conditions are presented with a physical environment that is more at risk of COVID-19 disease. An important rule of thumb is that social determinants – housing, overcrowding, poor sanitation and access to water, poor nutrition –

> Certain categories of workers, such as delivery workers, rubbish collection workers, manual labourers and workers in the agricultural sector are exposed to heightened risks of being infected, as the nature of their work does not allow them to take advantage of dispensations to work from home using digital technology. Many healthcare workers performing heroic work on the front lines in responding to the pandemic are being infected as a result of inadequacies in or shortages of personal protective equipment and clothing. Several groups are severely disadvantaged by the economic consequences of measures adopted in a number of countries to contain the spread of COVID-19. These include precarious workers in the "gig economy" or the informal sector,[1] along with other groups of workers who face retrenchment or loss of wages and social benefits, including domestic workers in many countries. Informal traders and a number of small businesses can no longer ply their trade or conduct business, resulting in profound economic insecurity for themselves and their dependents. (E/C.12/2020/1)

[11] 'BAME groups hit harder by COVID-19 than white people' Guardian, 7 April, 2020.
[12] Public Health England (2020), op.cit.
[13] Yancy, C. (2020) 'COVID 19 and African Americans', *the NOD*, 5 May.

all increase the effects of infectious diseases, such as tuberculosis, even before the issue of accessing effective medications. Recently, a large study in the UK found that local authorities with the highest diagnoses and mortality rates are primarily urban and 'death rates in London from COVID-19 were more than three times higher than in the region with the lowest rates, the South West'.[14] In many African cities, for example, over 50% of the population live in informal settlements. Due to their illegal status, they tend to be poorly serviced and have a higher burden of illness and infectious disease than more formalised areas, though initial COVID-19 thus far data are limited.

Healthcare and other key workers. There are also specific categories of workers who, due to the nature of their work, may be at greater risk of exposure to COVID-19. Healthcare workers in particular are more likely to encounter virus transmission through caring for patients. A fundamental global issue that has emerged during the pandemic concerns personal protective equipment (PPE) for nursing and medical staff, i.e. equipment such as clothing, goggles, masks and gloves. A surge in patient numbers has meant that the demand for PPE soon outstripped its supply in the first months of the pandemic. Without PPE, healthcare personnel are putting themselves at greater risk of contracting COVID-19. Furthermore, other categories of so-called key workers such as bus drivers, security guards, taxi drivers, chauffeurs, chefs, sales and retail assistants, lower-skilled construction workers and those in processing plants, as well as social care employees all had significantly high rates of mortality from COVID-19. UNAIDS recently called for the inclusion of community-led healthcare services on the lists of essential service providers and to treat them as equivalent to healthcare providers. Furthermore, it also called for the design of physical distancing restrictions and policies in ways that allow community-led services to continue operating safely.

Other specific groups at higher levels of risk are those with limited access to health services. These often overlap with socio-economic factors: the poor, people with disabilities, displaced populations including refugees, communities living with and affected by HIV and TB, homeless persons and those who have been incarcerated or otherwise detained, i.e. prisoners. In other words, different kinds of stigma and discrimination overlap and these categories are disproportionately represented among the world's poorest and most marginalised people. Due to discrimination, these groups may be denied access to health care and treatment. Many of them endure disease, deprivation and indignities that have long since been resolved elsewhere (UNDP, 2018).

[14] Public Health England (2020), op.cit.

An illustrative case in Sub-Saharan Africa – Angola

It is well known that the health systems of most African countries have numerous weaknesses – and Angola is no exception. Although considerable investments have been made in recent years, the fact remains that there have been enormous constraints in dealing with various epidemiological outbreaks. With an estimated population of approximately 31 million inhabitants[15], by the end of June, the country had fewer than 300 confirmed registered cases, 81 recovered and 11 deaths. Following the analysis above, a few comments regarding these figures have been made.[16]

Firstly, it is necessary to be clear that Angola probably has a high level of underreporting. However, from the start, Angola also took the COVID-19 pandemic quite seriously, contrary to many other countries, which minimized its seriousness. Steps were quickly taken to stem the spread of the virus. In February, the President of the Republic created the Inter-ministerial Commission for the Response to the COVID-19 Pandemic which, among various measures, adopted mandatory observation of homes and institutional quarantine for all citizens entering national territory from countries that already had community contamination.[17]

On 25 March, a State of Emergency was declared.[18] Subsequently, exceptional and temporary measures to prevent and control the spread of the COVID-19 pandemic were defined. [19]

Another factor to be taken into account and raised by public health specialists has to do with the fact that the Angolan population in particular, and the African population in general, have already faced and continue to face several epidemics such as malaria, cholera, Ebola and HIV. Thus, the government was already used to managing and reacting rapidly, as well as activating the protocols needed to combat epidemic outbreaks, and – in the case of COVID-19 – what turned out to be a pandemic.

Another determining aspect has to do with the low level of interaction of African countries with other countries in the world. In a regional context, Angola has a considerably low circulation flow compared to African countries that have registered a greater number of cases (South Africa, Egypt, Morocco, Tunisia).

[15] https://www.ine.gov.ao/images/Projeccao_Populacao_2020.pdf

[16] These figures were steadily rising after June 2020, but later in the year they were still comparatively low.

[17] https://www.governo.gov.ao/VerNoticia.aspx?id=49532

[18] Presidential Decree 81/20, 25 March. Provisional preventive measures were previously established through Provisional Presidential Legislative Decree 1/20, 18 March.

[19] Decree 82/20, 26 March, measures applicable during the State of Emergency.

Finally, it has been established that one of the risk factors for coronavirus is age and, as noted above, the African population is overwhelmingly young, i.e. Africa has the youngest population in the world with an average age of 19.7 years. In Angola in particular, 66% of the population is under the age of 25 and 48% is under the age of 15.

Angola has a universe of diseases that coexist with the general population, as already mentioned. To date, these pandemics associated with the coronavirus can further weaken the country's poor health system, with a high possibility of causing it to collapse.

In fact, regarding comorbidity issues in Angola, most people who have died had other pathologies, and most of them were over 55 years of age.[20] As far as the geographic issue is concerned, by the end of June, only two of the country's 18 provinces had registered cases of contamination. As Angola is still a predominantly rural society with large parts of the population having no access to drinking water and basic sanitation, the imperative of observing hygiene and sanitation conditions with strict care is self-evident. With weak healthcare coverage, the effects could undoubtedly be very harmful if the numbers were to eventually increase.

Group Risks II: Social, Economic and Health Costs of Restrictive Measures

In addition to these specific health-related risk factors, some of them illustrated by Angolan experiences, a disproportionate burden is also being placed on certain groups as a result of the 'side-effects' of restrictive practices. Social distancing and lockdown measures are intended to fulfil public health goals and slow transmission of the virus have a highly differential impact.

Workers and Economic consequences. There is a generalised risk to workers and economies. According to the International Labour Organization (ILO), more than 2.7 billion workers have been affected by complete or partial lockdowns. It is expected that by the end of the crisis, 195 million workers will have lost their jobs due to COVID-19 and its consequences.[21] Oxfam has warned that in the worst-case scenario, "the number of people living in poverty could increase by between 434

[20] http://www.novojornal.co.ao/sociedade/interior/covid-19-mais-11-casos-positivos-e-um-obito-em-actualizacao 89325.html.

[21] See ILO Monitor: https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/briefingnote/wcms_743146.pdf.

million and 611 million".[22] Two billion people in the world are informal workers, with no contract or regular salary, who depend on their daily earnings to survive and are left without the possibility of going to work and with no social protection. A number of countries have introduced direct financial compensation for workers or the provision of tax relief on salaries. However, workers in some countries say they have not seen any changes. Furthermore, in countries with a large informal workforce – up to 80% of all workers in some of them – the ability to be able move around for work is essential. Social distancing measures have meant that if people don't work then they have no money for food, compared to workers who are able work from home remotely. This has led to disincentives for some workers to stop working and social distance because the alternative to work is a reduced income, as well as the inability to pay rent and buy food.

Deprivation. In several countries, lockdown measures have had drastic consequences for poorer communities. There have been food riots related to the restrictive measures. In countries that have introduced some kind of social package for the poor, such as South Africa[23] and Kenya, people report that they register but are not receiving the packages because they are siphoned off – sometimes for political reasons – from those who are eligible. The resentment is made worse by a perception of inequality and corruption, particularly when the rich are regarded as using corrupt means to flout the law, in stark contrast to adolescents in a number of informal settlements being whipped, beaten and arrested for not wearing a mask.

Gender-based violence and children at risk. Though there is still a need for comprehensive studies, there is some initial evidence that domestic abuse has risen globally during the lockdown. With limited opportunities to go outside, domestic tensions can increase, and this can reinforce the abusive dynamics in the household. One indication of this rise is that domestic violence helplines have seen a significant increase in the number of calls, globally. The UN has called for urgent action to combat the global surge in domestic violence: "I urge all governments to put women's safety first as they respond to the pandemic," (Secretary General António Guterres).[24] Furthermore, children can be exposed to higher levels of violence in the home. Children with learning difficulties or social

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[22] Oxfam (2020) 'Dignity not Destitution', https://oxfamilibrary.openrepository.com/bitstream/handle/10546/620976/mb-dignity%20not%20destitution-an-economic-rescue-plan-for-all-090420-en.pdf

[23] 'Townships in lockdown – but poor South Africans fear hunger more than COVID-19', *Times*, 17 April, 2020.

[24] New York Times, 6 April, 2020, updated 14 April, 2020.

problems may also be unable to access the support and care they would be able to access in a school system, or other support services.

Other medical and health service conditions. People with other medical conditions have been unable to access medication or health care. For example, access to anti-retroviral medication has been curtailed, which may affect the ability to adhere to treatment. Other vital services including services for women such as family planning, abortion clinics, as well as maternity hospitals and clinics, are also restricted. Furthermore, the conditions encountered by people who have been forced into COVID-19 quarantine facilities have led to hundreds of people breaking out of such facilities.

Governance. Some governments have used the COVID-19 situation to attack historically marginalised groups and/or to pursue more authoritarian responses. Emergency laws and the consequential prohibition of mass gatherings or limitations of movement have been used as a political tool. Notable examples include protests in several African countries – including COVID-related protests in Zimbabwe, Ivory Coast, Malawi, Guinea, Uganda, Kenya, South Africa and Egypt. Some protests met with a violent response, including alleged torture (Zimbabwe) and fatalities (Guinea). UNAIDS, for example, has called for inclusive and transparent governance of COVID-19 responses including those organisations that focus on gender, equity and human rights, to ensure that COVID-19 policies are designed to support the range of service providers and activities necessary for an effective and equitable response.

While much remains to be understood about COVID-19, we can already conclude that the health and social effects of the pandemic exploit and amplify pre-existing inequalities and group differences. COVID-19 calls for extra attention to be paid to ensuring measures are put in place for social protection and safety nets to 'cushion' the communities and particularly vulnerable groups who either cannot work or cannot afford *not* to work.

There are clearly notable impacts when a set of restrictive practices are adopted, even if they aim to ensure social confinement with a view to meeting public health goals and cutting or slowing down the virus transmission chain.

Again, using Angola as an illustration, its economy has been considerably impacted. Firstly, there is the issue of financing. Since there is a need to reinforce measures to strengthen health capacity, what is essential is the State's ability to mobilize financial resources to meet the demands of the health

sector. This mobilisation should entail the acquisition of biosafety material, expansion of the capacity of the national health system, mobilization of health professionals, construction of hospital infrastructure and the acquisition of specialised equipment.

Yet, with the vertiginous decline of the country's main export product (oil) and the reduction in production, the restrictive measures are putting heavy pressure on the country's finances, reducing revenue collection. It is easy to see that the economic effects of COVID-19 may be aggravating the crisis the Angolan economy was already experiencing. Some vulnerable groups have been affected by the impact of these restrictions, despite a number of measures that have been adopted to mitigate the impact, mainly relying on the engagement of civil society. This concerns not least the "informal workers" who depend on their daily activities for family support.

In this scenario of impact, social conditions have considerably deteriorated, which may lead to an increase in the levels of urban violence. The fact that schools have been closed means that children are staying at home much longer, which could lead to an increase in domestic violence. The pressure on family budgets caused by the growing number of redundancies and salary cuts will force a reduction in families' financial capacity[25] and will increase begging and a recourse to crime in order to satisfy basic needs.

4. State of emergency regulations, temporary regulations and human rights protection during the pandemic

The COVID-19 pandemic caught many states unprepared from a normative legal framework perspective. In order to prevent the spread of the COVID-19 pandemic, states have adopted quite stringent emergency measures, particularly since March 2020. Practices have varied, with some states adopting national restrictive measures, without derogating from their international legal obligations under the main human rights treaties, and some states informing the depositaries of these treaties of wide-ranging derogations. The national response has differed, with some states declaring a state of national emergency, some states declaring a state of natural disaster, and other states just passing specific laws or decrees, without declaring an emergency at all. The reason for these different responses, besides political considerations, is that constitutions or basic laws use broad language concerning the situations, which make it necessary to resort to emergency powers.

[25] In order to reduce the impact of the pandemic on families and companies, immediate economic impact relief measures were approved as a result of the impact of the COVID-19 pandemic on companies, families and the informal sector of the economy (Presidential Decree 98/20, 9 April) and the Programme for Strengthening Social Protection of Less Favored Families "KWENDA" (Presidential Decree 125/20, 4 May).

Generally, there are three types of emergency situations: first, threats to territorial integrity (war, invasion, secession, etc), but more recently also the fight against terrorism and organized crime; second, natural disasters (earthquakes, floods or pandemics); and, third, economic and financial emergency (financial and currency crises, strikes or interruptions in fundamental service provision).[26] The current COVID-19 pandemic falls under the second type of emergency situations. In some countries, the restrictions relating to the pandemic are in addition to an existing state of emergency due to an armed conflict or other dire circumstances. Constitutions that have been adopted or amended more recently might provide a more detailed list of emergency situations. For example, Article 37 of the South African Constitution provides that a state of emergency may only be declared when "(a) the life of the nation is threatened by war, invasion, general insurrection, disorder, natural disaster or other public emergency; and (b) the declaration is necessary to restore peace."[27] This constitutional provision also adds several safeguards and provides a list of non-derogable rights. Similar safeguards, institutional checks and balances are included in the constitutions of other countries.[28] A pandemic situation appears to favour executive power, as the government has more levers of power than the other powers (the legislative and the judiciary) and the main state institutions within a given constitutional order.

What does international human rights law say about emergency situations and emergency laws? The UN has emphasized the importance of all actors, particularly governments, ensuring that international human rights, humanitarian and refugee law and standards are at the centre of all COVID-19 responses.[29] Human rights are generally protected on three levels: the national level, the regional level where such a system is present and functional (Europe, Africa, the Americas), and the international level. These layers of protection entail the monitoring of respect for human rights from regional or international human rights mechanisms. There are several treaties that are essential to human rights protection, i.e. the nine core international human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR, 1966), and three regional human rights treaties, i.e. the

[26] Giacomo Delledonne, History and Concepts of Emergency (Encyclopedia of Comparative Constitutional Law [MPECCoL]), para. 2.
[27] Constitution of the Republic of South Africa, Art. 37, para. 1 <www.gov.za/documents/constitution/chapter-2-bill-rights#37>.
[28] See Articles 57 and 58 of the Constitution of Angola; most constitutions have emergency provisions; for further information on these constitutional provisions, see <www.constituteproject.org>. For further details on some of the legislative acts, see the "Continuity of Legislative Activities during Emergency Situations" at the Library of Congress <www.loc.gov/law/help/emergency-legislative-activities/index.php>.
[29] António Guterres (UN Secretary General), COVID-19 and Human Rights: We are all in this together, April 2020, p. 21.

European Convention on Human Rights (ECHR, 1950), the American Convention on Human Rights (ACHR, 1969), and the African Charter on Human and Peoples Rights (ACHPR, 1981). The ICCPR allows for derogations under Article 4,[30] the ECHR under Article 15,[31] and the ACHR under Article 27.[32] By authorizing states to decide when and how they can derogate from their international obligations, international human rights law entrusts states with primary responsibility for determining the measures necessary to protecting and fulfilling the human rights of their people during national crises.[33] In this sense, derogation clauses function as an escape valve, allowing state authorities to limit the scope of their international legal obligations. The ACHPR has no specific clause on derogations. In this regard, the African Commission has clarified that:

> In contrast to other international human rights instruments, the African Charter does not contain a derogation clause. Therefore, limitations on the rights and freedoms enshrined in the Charter cannot be justified by emergencies or special circumstances. The only legitimate reasons for limitations of the rights and freedoms of the African Charter are found in Article 27.2, that is, that the rights of the Charter "shall be exercised with due regard to the rights of others, collective security, morality and common interest". [34]

The position of the African Commission appears to be that limitations need to be based on a balance between different interests. Even then, the *justification of limitations* must be *strictly proportionate with* and *absolutely necessary for the advantages which follow*. Most importantly, a limitation may not erode a right such that the right itself becomes illusory.[35] The African regional human rights system appears to be slightly different from the European or the Inter-American system, but given

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[30] For the text of derogations entered by State parties to the ICCPR, please see: <https://treaties.un.org/Pages/ViewDetails.aspx?chapter=4&clang=_en&mtdsg_no=IV-4&src=IND>.

[31] See Guide on Article 15 of the European Convention on Human Rights <www.echr.coe.int/Documents/Guide_Art_15_ENG.pdf> ; the factsheet of the European Court on Human Rights on "Derogation in time of emergency" <www.echr.coe.int/Documents/FS_Derogation_ENG.pdf>. See also the Venice Commission Compilation on States of Emergency, 16 April 2020 <www.venice.coe.int/webforms/documents/?pdf=CDL-PI(2020)003-e>. For the text of derogations entered by state parties to the ECHR, please see <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/005/declarations>.

[32] See, for example, the advisory opinion OC-8/87 on "Habeas Corpus in Emergency Situations"; advisory opinion OC-9/87 on "Judicial Guarantees in States of Emergency". For a discussion, see Mariela Morales Antoniazzi and Silvia Steininger, "How to Protect Human Rights in Times of Corona? Lessons from the Inter-American Human Rights System". EJIL:Talk, 1 May 2020 <www.ejiltalk.org/how-to-protect-human-rights-in-times-of-corona-lessons-from-the-inter-american-human-rights-system>.

[33] Evan J. Criddle, "Protecting Human Rights During Emergencies: Delegation, Derogation, and Deference", in Evan J. Criddle (ed), Human Rights in Emergencies (Cambridge University Press, 2016), p. 54.

[34] African Commission on Human and Peoples' Rights, *Constitutional Rights Project, Civil Liberties Organisation and Media Rights Agenda v. Nigeria*, Comm Nos. 140/94, 141/94, 145/95 (1999), para. 41 <www.achpr.org/communications>. See also Frans Viljoen, International Human Rights Law in Africa (Oxford University Press, 2012), p. 334.

[35] *Constitutional Rights Project, Civil Liberties Organisation and Media Rights Agenda v. Nigeria*, para. 42.

the relevant function of derogations, Article 27(2) might provide the necessary escape valve, provided the necessary legal safeguards are upheld.

During 2020, many statements have been issued by the various international and regional human rights mechanisms on measures related to countering COVID-19.[36] In its April 2020 statement on derogations from the Covenant in connection with the COVID-19 pandemic, the UN Human Rights Committee (HRCttee or Committee) called upon all state parties that have taken emergency measures in connection with the COVID-19 pandemic that derogate from their obligations under the Covenant to comply without delay with their duty to notify the Secretary General thereof immediately – if they have not already done so.[37] The Committee has reminded state parties of the requirements and conditions laid down in Article 4 of the Covenant and further explained in the Committee's general comments, particularly in general comment No. 29 (2001) on states of emergency, where the Committee has provided guidance on the following aspects of derogations: the official proclamation of a state of emergency; formal notification to the Secretary-General; the strict necessity and proportionality of any derogating measure taken; the conformity of measures taken with other international obligations; non-discrimination; and the prohibition on derogating from certain non-derogable rights.[38] Through its practice, the Committee has laid down several guidelines concerning the measures that states can adopt to counter the pandemic, while respecting human rights.

The UN Secretary-General, Antonio Guterres, has drawn attention to how the practice concerning countering the pandemic in some states reveals the following:

- "States of emergency" declared granting extensive executive powers with minimal oversight, no time limitations, but derogating from rights.
- Emergency legislation purportedly to respond specifically to COVID-19, but vulnerable to abuse, including powers to legislate by decree, criminal penalties for those "spreading false information" with a potentially chilling effect on freedom of expression.
- Cases of excessive use of force in order to enforce measures to restrict movement, including arrests and detention.

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[36] See, for example <www.un.org/en/coronavirus>. See Lisa Reinsberg, "Mapping the Proliferation of Human Rights Bodies' Guidance on COVID-19 Mitigation", (Just Security, 22 May 2020) <www.justsecurity.org/70170/mapping-the-proliferation-of-human-rights-bodies-guidance-on-Covid-19-mitigation>.

[37] Human Rights Committee, Statement on derogations from the Covenant in connection with the COVID-19 pandemic, UN Doc. CCPR/C/128/2, 24 April 2020, para. 1. There are 173 state parties to the ICCPR, including all African States, except South Sudan <https://indicators.ohchr.org>.

[38] HRCttee, Statement on derogations, para. 2.

- Use of surveillance technology to track and gather information on people in ways that are open to abuse.[39]

Many states have imposed time limits on the validity of special emergency powers or provided for a period of review as to whether they should be extended, in line with human rights law.[40] In Norway, the adoption of an emergency law aroused heated public debate, not as a form of resistance to stronger emergency legislation as a legal tool to introduce policies to handle the pandemic, but rather the way in which the bill was drafted, i.e. without applying the usual procedure of public hearing and consultation in law-making. Although the Norwegian Government had drafted the law in consultation with the Parliament (Stortinget), it did so "behind closed doors", without inviting the public. Also, the initial proposal went quite far in limiting rights with a long duration, as well as having vague checks and balances. However, the responsible minister and the Government soon acknowledged the public outcry (mainly from a number of individual lawyers, the Norwegian Bar Association and the Norwegian Association of Judges) and following a few days of public debate, the draft Bill was amended. The new Bill reduced the Government's power to make new regulations, limited the law to one month's duration (while the original draft Bill had proposed six months) and enhanced the judicial review mechanism of the law. While the initial draft of the law was criticized for being at odds with democratic and rule of law principles, the response of the public – the outcry and the debate – and the Government's acceptance of the opposition to the draft demonstrated that democratic principles of law-making can also prevail in a time of crisis.

To summarize, efforts to counter the pandemic have exposed the existing vulnerabilities in the domestic legal framework and the difficulties in ensuring the necessary constitutional checks and balances are in place, as well as the limitations of the regional and international mechanisms of human rights monitoring and enforcement. Nevertheless, as emphasized by the UN Human Rights Committee, ensuring the strict necessity and proportionality of any derogating measure taken, the conformity of measures taken with other international obligations, non-discrimination, and the prohibition on derogating from certain non-derogable rights, would make the burden of countering the pandemic more bearable for the population, including vulnerable groups. The use of force by law enforcement agencies should be guided by the principles of legality, necessity, proportion, precaution

[39] António Guterres (UN Secretary-General), COVID-19 and Human Rights: We are all in this together, April 2020, p. 17.

[40] António Guterres (UN Secretary-General), COVID-19 and Human Rights: We are all in this together, April 2020, p. 17.

and non-discrimination.[41] Complying with constitutional guarantees and international human rights standards and following the relevant recommendations of the UN and relevant regional organizations should ensure that the measures taken to counter the pandemic do not result in (massive) serious human rights violations.

5. Policy responses I: Quarantines, lockdowns and social distancing in daily life

Epidemics and global pandemics urgently require national and international responses. At the international level, collaboration on exchange of information and coordination of responses already existed in the 1800 century with several international conferences, and this work ultimately led to the International Health Regulations, which were adopted by 196 countries.[42] These regulations state that the health authorities of all countries should contribute to discovering looming epidemics as soon as possible, introduce measures to combat them or reduce their spread and inform the international community. In particular, the World Health Organisation (WHO) should be notified as a matter of urgency and it is tasked with leading and coordinating international efforts to curb the spread of a new virus. In the case of COVID-19, the WHO received information from the Chinese authorities on 1 January, 2020. The Chinese government has subsequently been criticized for withholding and being late in sharing information on the COVID-19 virus, potentially preventing an urgent and rapid international response.[43]

At national levels, responses to COVID-19 have varied in timing and form, but generally have included quarantining, rules on social distancing, hygienic advice on handwashing and lockdowns of society and the economy. Quarantine has historically been the most favoured response of societies to plagues and pandemics. During the COVID-19 pandemic, most countries introduced some form of quarantine – enforced isolation – when returning from areas with a high level of infection, or so-called stay-at-home isolation when becoming infected, or suspected of being infected, and able to stay at home. From a human rights perspective, quarantines should be legally grounded and strictly necessary to prevent the spread of the virus. Quarantined people should also have the opportunity to access basic necessities such as food, water, shelter and health care. Quarantining may also indirectly

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[41] See ICRC, "The use of weapons and equipment in law enforcement operations" <www.icrc.org/en/document/use-weapons-and-equipment-law-enforcement-operations>.

[42] The International Health Regulations stem from the International Sanitary Regulations adopted by the International Sanitary Conference in Paris in 1851, in response the cholera epidemic that his Europe in 1830 1n 1847. The regulations have subsequently been revised on several occasions; the current regulations were adopted by the WHO in 2005 and entered into force in 2007.

[43] A timeline of the WHO's response to COVID-19 can be accessed here: https://www.who.int/news-room/detail/27-04-2020-who-timeline---covid-19

apply to people living in public health institutions and it has caused problems of isolation for many elderly and sick people living in nursing homes and other health institutions.

The COVID-19 pandemic has reminded the world of the extreme indirect costs if a pandemic is not quickly addressed and mitigated. In a large scale, this is what has caused the need for wide-ranging lockdowns of societies and economies. According to *Business Insider*[44], by 26 March, 1.7 billion people were living under some form of lockdown, while this figure had increased to around 3.9 billion (more than one half of the global population) by the first week of April.[45] In Africa, lockdown measures were introduced early in many countries and were often combined with curfews. In Kenya, for example, all schools were closed on 15 March, and public and private sector workers were asked to remain at home in self-quarantine for a minimum of 14 days. While some of them were able to work from home, the vast majority, not least, manual workers and those working in the informal sector, had no employment and income-earning opportunities. In Kenya as in many other countries, travel restrictions were imposed to prevent non-citizens from entering the country. While being a necessary measure in an urgent situation, this derogation of freedom of movement was expected to be proportional and necessary in the interest of public health. It should be temporary and the dignity of those people who had been quarantined should be respected. Yet, in a number of situations, the curfew measure was brutally enforced, and police brutality was reported.

One of the most widespread and effective responses to the COVID-19 pandemic has been the imposition of rules regarding hygienic behaviour (in particular, coughing and handwashing), social distancing among individuals and restriction on people gathering, both in private and in public. Appropriate distancing between people is intended to limit and delay the pandemic.

Restrictions on gatherings are affected by the right to assemble and should be made according to law and be proportional and time-limited. Hygienic behaviour, on the hand is hard to regulate and its effectiveness rests on various factors. To observe it, people need to have trust in its effectiveness (legitimacy). Yet, for many people who live in poverty with no access to clean water, it is hard or impossible to follow a request to wash their hands. Also, low levels of social trust in governments make people inattentive to such advice.

[44] *"A third of the global population is on coronavirus lockdown—here's our constantly updated list of countries and restrictions". Business Insider. 28 March 2020.*
[45] "Coronavirus: Half of humanity now on lockdown as 90 countries call for confinement". *Euronews*, 3 April 2020.

As discussed above, this amply demonstrates that while the virus is indiscriminate and possibly affects everyone, it disproportionally impacts the poor because of resource constraints. As the WHO Global Preparedness Monitoring Board stated in its *World at Risk* report from last year: "Negative impacts (of disease outbreaks) are particularly profound in fragile and vulnerable settings, where poverty, poor governance, weak health systems, lack of trust in health services, specific cultural and religious aspects and sometimes ongoing armed conflict greatly complicate outbreak preparedness and response".

Referring again to Angola as an illustration, a state of emergency was introduced on 27 March 2020, with three subsequent extensions[46], the last of which was in force from 26 April to 10 May. During this period, from 27 March to May 10, a set of measures were gradually reduced in order to safely allow the return of economic activity throughout the country. It is important to assert that one of the measures adopted was the extension of the days of informal commerce and street sales. One of the reasons was to do with the strong representativeness of the informal sector for the Angolan economy.

During the period of validity of the state of emergency[47], which imposed social confinement, the use of face masks became mandatory in all institutions that provided public services, as well as in industrial units and commercial establishments. After 45 days of social confinement, the return of domestic workers to the service was authorized between 06.00 and 15.00, a decision that would always be subject to an employer's criteria, and they would be obliged to provide all biosafety material, particularly masks.

It is also important to note that at the time the coronavirus was declared a pandemic, Angola, like most countries, did not have a sophisticated legal framework to deal with the pandemic. Initially, as previously mentioned, a state of emergency was declared that imposed a constitutional emergency regime, making it more severe in terms of limiting fundamental rights. In Angola, the Civil Protection Law (Law no. 14/20, 22 May) was approved by the National Assembly. This law approves the Public Disaster Situation Institute[48], which allows for the adoption of a set of extraordinary measures that

[46] Presidential Decree 97/20, 9 April. Extends the State of Emergency for a period of 15 days; Presidential Decree 120/20 24 April. Extends the State of Emergency for a period of 15 days; Presidential Decree 128/20 8 May. Extends the State of Emergency for a period of 15 days.

[47] The State of Emergency was decreed after a period of consultations with the Council of the Republic and the National Assembly, and in accordance with articles 57 and 58 of the Constitution of the Republic of Angola; the State of Emergency Law No. 17/91, 11 May; and Article 4 of the International Covenant on Civil and Political Rights and limited to the exercise of some fundamental rights.

[48] On 26 May, a Public Disaster Situation was decreed (Presidential Decree 142/20, 25 May, based on Article 2 of Law 14/20, 22 May, which in Article 2 defines Calamity as "an event or series of serious events, of natural or technological

are less restrictive of fundamental rights until a return to normality. Currently, a situation of *public calamity* is in effect, a measure that does not establish a state of constitutional exception, and which better harmonizes fundamental guarantees and freedoms. Under these measures, activities involving more than 50 people were prohibited (or may be allowed by the health authorities provided that the biosafety criteria and the capacity of the space are taken into account). Religious meetings, children's centres and all general and university education institutions continue, but with face-to-face classes suspended, favouring online classes.

6. Policy responses II: The use of surveillance technology to prevent the spread of COVID-19

States have tried to use different measures to prevent or slow down the spread of COVID-19, from lockdowns to extensive testing, tracing and tracking through smartphone applications (apps). All these measures are aimed at ensuring that social distancing (or better, physical distancing) measures are observed and to alert persons to the potential risk of infection to which they might have been exposed. Many governments have tried to use surveillance technology tools that track an individual's movements to try to limit the spread of the pandemic. These surveillance measures have raised major concerns among human rights lawyers and organizations, particularly with regard to the right to privacy.

The UN has cautioned that the "use of technologies, including artificial intelligence and big data, to enforce emergency and security restrictions or for surveillance and tracking of impacted populations raise concerns."[49] Singapore's TraceTogether app, which sends short-range Bluetooth signals to connect with other people using the app, thereby giving the government a database with which to track potential coronavirus carriers, is the oft-cited archetype for future applications.[50] Norway also launched such an app (Smittestopp).[51] In May 2020, the first Google/Apple-based contact-tracing app was launched.[52] The UN has pointed out that all such measures must incorporate meaningful data protection safeguards, be lawful, necessary, and proportionate, time-bound and justified by legitimate

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origin, with prolonged effects in time and space, as a rule predictable, likely to cause high material damage and eventually victims, intensely affecting the living conditions of the populations, its assets and the socioeconomic fabric in large areas of the national territory.

[49] António Guterres (UN Secretary-General), COVID-19 and Human Rights: We are all in this together, April 2020, p. 16.

[50] Adam Smith, Using Big Tech to tackle coronavirus risks swapping one lockdown for another, The Guardian, 22 April 2020 <https://www.theguardian.com/commentisfree/2020/apr/22/using-big-tech-to-tackle-coronavirus-risks-swapping-one-lockdown-for-another>.

[51] See Norwegian Institute of Public Health, "Together we can fight coronavirus - download the Smittestopp app" <https://helsenorge.no/coronavirus/smittestopp>.

[52] Leo Kelion, "Coronavirus: First Google/Apple-based contact-tracing app launched", (BBC, 26 May 2020) <www.bbc.com/news/technology-52807635>.

public health objectives.[53] In its call for digital diligence, the ICRC has suggested that states use a decentralized protocol such as DP-3T and incorporate 'data protection by design' and up-to-date scientific, ethical and legal standards in their responses.[54] Concerns have been raised that these apps appear to be unable to protect the privacy of their users. The other key problem with such apps is that for them to be effective, everyone or least the overwhelming majority of the population needs to be using them. However, the voluntary introduction of these apps in several countries appears to have not gained enough traction, with large segments of the population refraining from using them.

In comparative terms, the number of persons infected in African countries has been low and the introduction of lockdowns and physical distancing measures will help keep this number down. However, if the overall number of infected persons starts to rise, the caseload of patients that need medical care could significantly disrupt the limited and relatively weak healthcare systems of African countries.[55] The UN Secretary-General, Antonio Guterres, has stated that more than ever, governments must be transparent, responsive and accountable and that civic space and press freedom are critical.[56] The recommendations contained in the document launched by the Secretary-General "COVID-19 and Human Rights: We are all in this together" provide a useful roadmap for governments in tailoring their responses, including the use of surveillance technology to prevent the spread of COVID-19.

As an alternative to these surveillance technologies, since 2019 Angola has established the Integrated Public Security Center (CISP)[57], with open and free telephone lines to serve its citizens, staffed by health professionals who support citizens throughout the country with information and advice. This facility has been interconnected with the National Institute of Medical Emergencies of Angola (INEMA)[58], which has a network of health professionals and ambulances all over the country.

7. Pandemics, international collaboration and human rights obligations to protect

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[53] António Guterres (UN Secretary-General), COVID-19 and Human Rights: We are all in this together, April 2020, p. 16.

[54] See ICRC, "COVID-19 and contact tracing: a call for digital diligence", 13 May 2020 <https://blogs.icrc.org/law-and-policy/2020/05/13/covid-19-contact-tracing-digital-diligence>.

[55] Cedric de Coning, COVID-19 and the African Union: Challenges, prospects and side-effects (Norwegian Institute of International Affairs, Policy Brief 7/2020), p. 2.

[56] Statement by the UN Secretary General, "We are all in this Together: Human Rights and COVID-19 Response and Recovery", 23 April 2020, <www.un.org/en/un-coronavirus-communications-team/we-are-all-together-human-rights-and-Covid-19-response-and>

[57] Integrated Public Security Center.

[58] National Institute of Medical Emergencies of Angola.

The UN's Framework for the Immediate Socio-Economic Response to the COVID-19 Crisis warns that "the COVID-19 pandemic is far more than a health crisis: it is affecting societies and economies at their core. While the impact of the pandemic will vary from country to country, it will most likely increase poverty and inequalities at a global scale, making achievement of SDGs even more urgent".[59] The Chairperson of the African Commission, Solomon Ayele Dersso, has stated that "affirming that socio-economic rights are fundamental rights and prioritizing investment in health for all, water and sanitation, education and social protection is a national and global public good, hence in the interest of all of humanity is a pre-requisite. Doing so is not only a human rights necessity for which governments nationally and the international community bear shared responsibility but also smart policy that will spare the world from the excessive consequences of global pandemics".[60] The African Union has published the African Union Member States – COVID-19 Emergency Numbers.[61]

As global governance is itself at risk from the COVID-19 crisis, we need now, more than ever, coalitions of like-minded actors – public and private, from West and East and North and South – to bring us from a path of stagnation and erosion to one of construction and hope.[62] Key lessons in combating COVID-19 include the use of science and being more self-sufficient in medical equipment, as well as international cooperation.[63]

A pandemic is by definition international, affecting the global community as a whole. This invokes an ethos of cooperation and sharing of knowledge, medical equipment, and basic necessities when countries are trapped in economic crises and hardship. Human rights law makes international cooperation an international human rights duty, stating in article 11(1) of the UN Covenant on Economic, Social and Cultural Rights "(t)he States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food,

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[59] See UNDP, "Socio-economic impact of COVID-19" <www.undp.org/content/undp/en/home/Covid-19-pandemic-response/socio-economic-impact-of-Covid-19.html>. See also A UN framework for the immediate socio-economic response to COVID-19 <https://unsdg.un.org/sites/default/files/2020-04/UN-framework-for-the-immediate-socio-economic-response-to-COVID-19.pdf>, April 2020.

[60] Statement of Commissioner Solomon Ayele Dersso, (PhD) Chairperson of the African Commission on Human and Peoples' Rights At the Africa Dialogue Series organized by the United Nations Office of the Special Advisor on Africa and the African Union under the theme COVID19 and silencing the guns in Africa: Challenges and Opportunities, 20–22 May 2020 <www.achpr.org/pressrelease/detail?id=508>.

[61] African Union Member States – COVID-19 Emergency Numbers <https://au.int/en/pressreleases/20200320/african-union-member-states-Covid-19-emergency-numbers>.

[62] Nico Krisch, COVID, Crisis and Change in Global Governance, (Verfassungsblog 17 April 2020), <https://verfassungsblog.de/Covid-crisis-and-change-in-global-governance>.

[63] Michael Safi, 10 key lessons for the future to be learned from fighting Covid-19, The Guardian, 1 May 2020 <https://www.theguardian.com/world/2020/may/01/10-key-lessons-for-future-learned-fighting-Covid-19-coronavirus-society>.

clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, r*ecognizing to this effect the essential importance of international co-operation* based on free consent" (author's emphasis added). In the midst of a crisis, and an absence of functional systems of coordination, there have been many occasions when states did not follow this ethos of sharing knowledge and available equipment and supporting those states and people in need. An opinion in the *Guardian* on 1 May 2020 sums it up very well: "The Corona virus got lucky: it emerged at a low point for Global cooperation".[64]

It is likely that COVID-19 will not be the last global virus pandemic of the 21st century and it is a duty for all societies to learn and draw lessons from the insights gained from the current crisis. How should societies respond, and how can a common international effort make us better prepared at national and international levels to withstand future outbreaks? Adding to the three insights referred to above, we can add several lessons for COVID-19 responses. Early action is perhaps the most important, which indeed requires the rapid sharing of information and knowledge in line with the International Health Regulations. The scaling of measures is also critical, in particular in a situation where there is a lack of accurate information. A 'wait-and-see' attitude could indeed be devastating. Some countries that have potentially had more success in controlling COVID-19 have opted to handle the knowledge gap using a 'more-rather-than-less' attitude, in spite of the potential short- term costs (Denmark, Norway). Other lessons – from Iceland and Singapore, two other relatively successful countries, have had early and widespread testing and tracing of infected citizens. Governance and political leadership play a critical role, and while some countries are able to take advantage of a long tradition of high societal trust, countries with low levels of trust tend to revert to "harsh" measures, such as curfews and states of emergency. This response certainly puts a strain on civil and political rights, as we have discussed in this paper.

8. Conclusion

This paper has argued that COVID-19 should be addressed and handled with due respect to international human rights law. As a monumental societal crisis, it has had a huge impact on people's most fundamental rights to life, nutrition, health, and to live in societies in which laws and the rule of law is respected and upheld. We have highlighted some of the most immediate human rights dilemmas and trade-offs and have argued that the highly unequal distribution of human suffering from the pandemic is a major human rights issue. We have also argued that regional and international

[64] Ibid.

human rights law should be adhered to in times of severe crisis when countries may – legitimately – have to temporarily derogate from their human rights obligations.

At present, countries are in different phases of the pandemic and some have started the difficult process of cautiously reopening their societies. New Zealand was one of the first countries to declare itself coronavirus-free, with zero infected cases since 23 May 2020, though even there cases are once again being detected.[65] While a WHO-approved vaccine is still lacking and many months away (December 2020 or January 2020, optimistically), the dilemma facing every country is: How should countries reopen society, its social and economic life? How can they return to a new normal while avoiding a return of coronavirus in second and third waves? A preferred approach by many states appears to be a cautious and gradual reopening, in which multiple restrictions still remain in place. In a recent document, the Centers for Disease Control and Prevention (CDC) in the USA proposed three phases of reopening with clear-cut criteria for moving from one stage to the next.[66] The criteria include "a drop in new cases, decreases in emergency department or outpatient visits for 'COVID-like illness' and 'robust' testing ability". Other criteria may include systems for tracing new cases and capacity for medical treatment. Above all, we may conclude that it requires "widespread community mitigation combined with ongoing containment activities" while addressing the "serious threat to the economic well-being of the country and the world."[67] Regrettably, until a safe vaccine has been approved and administered globally, the COVID-19 pandemic will continue to seriously impact the enjoyment of human rights. Nevertheless, the socio-economic crisis caused by the pandemic and the laying bare the inequalities and protection gaps will hopefully result in concrete steps being taken at different levels – national, regional and international – to strengthen human rights protection and ensure their enjoyment.

[65] For further information, see <https://www.businessinsider.com/countries-on-lockdown-coronavirus-italy-2020-3?r=US&IR=T>.
[66] For further information on the CDC, see <www.cdc.gov/coronavirus/2019-ncov/index.html>.
[67] For further information, see <https://www.cnet.com/news/cdc-releases-detailed-guidelines-for-reopening-america>.