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Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, submitted in accordance with Human Rights Council resolutions 6/29 and 33/9.

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Final report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras

Summary

The present report is the final report of Dainius Pūras to the General Assembly in his capacity as the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The original vision for the present report was to bring together the key themes explored during his tenure, providing a retrospective look at key right-to-health elements explored and extended during the past six years. That vision has evolved, given the global health and human rights crises that have emerged from the coronavirus disease (COVID-19) pandemic in 2020. As the appointed independent expert of the United Nations on the right to health, the Special Rapporteur finds it both relevant and necessary to provide formal comments on the pandemic, which must be considered from a right-to-health perspective.

The key themes of the Special Rapporteur's work, underpinning his reports, country visits and other interventions, provide an important lens through which to view the fragile socioeconomic and political institutions of the global community, which have been further undermined by COVID-19. However, the pandemic and observations arising throughout the Special Rapporteur's tenure of the mandate provide him with reason for hope that emerges from the power of participatory democracy and solidarity and the ongoing strength and resilience of the collective humanity during challenging crises and unjust expressions of power. The most effective "vaccine" for global health challenges has been and will always be the full realization of all human rights, including the promotion of physical and mental health through the meaningful participation and empowerment of all people.

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I. Introduction

1. Throughout his mandate, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, has emphasized the interdependence of all human rights and stressed the indivisibility of the right to health and other human rights: the right to health enables the attainment of other rights and vice versa. As indicated in his report on the determinants of mental health (A/HRC/41/34), although the right to health is a social and economic right, that does not deny the importance of civil and political rights for physical and mental health promotion. In the present report, his final one, he applies this understanding of human rights to the biggest global health emergency of the past 100 years – the coronavirus disease (COVID-19) pandemic.

2. The Special Rapporteur specifically examines the interdependence of rights, power imbalances, corruption and overemphasis on the biomedical paradigm to comment on their contribution to the spread and impact of COVID-19. He notes that the impact of the coronavirus is determined more by public health policy, leadership, socioeconomic inequality, systemic racism and structural discrimination than by biological factors.

3. Importantly, the Special Rapporteur advises that the present report should not be considered a comprehensive analysis of COVID-19 and the right to health. Rather, it should be read as a report developed early in the COVID-19 pandemic in which the principles essential to the realization of the right to health, and which have been included in the conclusions and recommendations of his earlier reports, are applied.

4. The emergence of the novel coronavirus in December 2019 in Wuhan, China, led to the declaration by the Director General of the World Health Organization (WHO) on 30 January 2020 of a public health emergency of international concern and to the issuance of temporary recommendations under the International Health Regulations (2005). On 11 March 2020, he further characterized the international health emergency as a pandemic.

5. The actions taken by all countries to contain COVID-19 present myriad human rights challenges and opportunities. In a joint statement initiated by the Special Rapporteur and issued by over 60 United Nations special procedures mandate holders in March 2020, it was observed that "the COVID-19 crisis cannot be solved with public health and emergency measures only; all other human rights must be addressed too".[1] The global spread of COVID-19 and the impact of measures to contain it provide graphic illustration of the interdependence, interrelatedness and indivisibility of human rights.

6. As well as being guided by civil, cultural, economic, political and social human rights, the associated principles of equality, non-discrimination, participation, transparency and accountability must be applied to health-related policies, including responses to COVID-19. There is no possibility of achieving universal health coverage, or containing a pandemic, if discrimination excludes different segments of society from information or services. Robust human rights review procedures at the national and international levels provide opportunities to hold duty bearers to account for their human rights obligations, including in the context of COVID-19.

7. A human rights-based approach to health recognizes that inequality and discrimination are major contributors to poor health outcomes. Throughout the past six years, the Special Rapporteur has examined processes within health systems,

[1] Office of the United Nations High Commissioner for Human Rights (OHCHR), "No exceptions with COVID-19: 'Everyone has the right to life-saving interventions' – UN experts say", 26 March 2020.

paying particular attention to imbalances of power and wealth and their impact on a system's capacity to respect, protect and fulfil the right to health.

8. Effective health system responses – in policy and law – at all times, including in a global pandemic, require access to information for all people, and meaningful participation and accountability mechanisms. Decisions to suspend or curtail certain human rights in response to a pandemic must be made in accordance with international law, and the decision makers must always be held accountable.

9. The right to health requires that health goods, services and facilities are available in adequate numbers; accessible on a financial, geographical and non-discriminatory basis; acceptable, including culturally appropriate and respectful of gender and medical ethics; and of good quality.[2] It also requires that States take steps for "the prevention, treatment and control of epidemic, endemic, occupational and other diseases" and to assure "medical service and medical attention in the event of sickness".[3] When States are unable to meet their right-to-health obligations, they have a duty to seek assistance from other States, and in the context of COVID-19, this aligns with the Secretary-General's call for global solidarity.[4]

10. States are obligated under international human rights law to provide technical and financial assistance to other States when requested, to assist them in meeting right-to-health obligations. In his reports, the Special Rapporteur has urged States to reaffirm the commitments made in the Declaration of Alma-Ata and the Ottawa Charter for Health Promotion, 1986, to reduce the global health and economic inequalities. He further calls for the reaffirmation of pledges from the Declaration of Astana adopted at the Global Conference on Primary Health Care in 2018 to renew political commitment to placing primary health care at the foundation of achieving universal health coverage and the Sustainable Development Goals.

11. In response to COVID-19 specifically, States that can assist should: share research, medical equipment, supplies and best practices; coordinate to reduce the economic and social impacts of the pandemic; limit economic sanctions, debt obligations and intellectual property regimes that impede access to needed resources; and, in all this, focus on groups in vulnerable and disadvantaged situations, fragile countries and conflict and post-conflict situations.[5]

12. The Special Rapporteur has previously commented on the need for official development assistance to support national health plans and health systems to reduce health inequities between and within countries.[6] He observed in his report on the Sustainable Development Goals (see A/71/304) that "health systems are all too often not a priority for States or for bilateral and multilateral donors". He regrets that nationalist populist leaders in certain countries have directly challenged multilateral institutions, including those in the area of global health and human rights, withdrawing from multilateral institutions when they most need global support.[7] He stresses the importance of multilateral efforts to enhance international assistance and cooperation.

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[2] General comment No. 14 (2000) on the right to the highest attainable standard of health.

[3] International Covenant on Economic, Social and Cultural Rights, art. 12.

[4] United Nations University (UNU), "UN Secretary-General: COVID-19 pandemic calls for coordinated action, solidarity, and hope", 19 March 2020.

[5] Dainius Pūras and others, "The right to health must guide responses to COVID-19", *Lancet*, vol. 395, No. 10241 (20 June 2020).

[6] See A/74/174.

[7] Judith Bueno de Mesquita and Benjamin Mason Meier, "Moving towards global solidarity for global health through multilateral governance in the COVID-19 response", *COVID-19, Law and Human Rights: Essex Dialogues – A Project of the School of Law and Human Rights Centre*, Carla Ferstman and Andrew Fagan, eds. (University of Essex, 2020).

13. Pandemics quickly expose weak health systems, in which inadequate measures are in place to provide information to everyone in the languages and formats required so as to enable meaningful participation in decision-making, or to provide equitable access to testing and treatment. As COVID-19 has demonstrated, health systems that are fragmented and inadequately funded, and that lack transparency and accountability, are weak performers in containing the spread of the virus. These features are not limited to low- or middle-income countries.

14. Without focused investment in health system strengthening and in international human rights implementation, there is little prospect of achieving the Sustainable Development Goals by 2030, or containing global pandemics. This requires adequate funding, as well as investment in good governance, transparency, participation and accountability mechanisms.[8] International assistance must also recognize that the pandemic will exacerbate poverty and poor health in low- or middle-income countries, in which people are less able to maintain physical distancing and sanitation recommendations[9] and are more likely to experience disruptions in access to medications for serious illness, such as AIDS, tuberculosis and malaria, resulting in soaring death rates.[10]

15. It is also essential that the measures adopted by States to combat this pandemic are in agreement with the Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights (1984) and are therefore time-limited, reasonable, proportionate, non-discriminatory and grounded in law to ensure protection of all human rights, recognizing that human rights are indivisible and inalienable.[11] These principles call for due regard for the International Health Regulations, which specify that individuals be treated in a way that respects their dignity, human rights and fundamental freedoms; deference to WHO guidance beyond the International Health Regulations could help countries to develop more rights-respecting approaches.[12]

16. The Special Rapporteur stresses the need to redress human rights failings and revitalize universal human rights principles as part of the recovery from the pandemic. He acknowledges that there are multiple human rights issues and elements of COVID-19 to examine, all of which are important, but in the present report he limits his comments to those which reflect the themes he has consistently raised throughout his mandate, and issues which he considers in most urgent need of attention, namely people held in detention, mental health and right-to-health threats posed by the increasing use of digital technology.

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[8] See WHO on financing common goods for health, at www.who.int/publications/i/item/financing-common-goods-for-health.

[9] Olivier Bargain and Ulugbek Aminjonov, "Poverty and COVID-19 in developing countries", Bordeaux Economics Working Papers (2020). Available at https://ideas.repec.org/p/grt/bdxewp/2020-08.html.

[10] Madhukar Pai, "AIDS, TB and malaria set to get deadlier due to coronavirus", *Forbes*, 11 May 2020.

[11] Statement by the Committee on Economic, Social and Cultural Rights on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights (E/C.12/2020/1); Lorna McGregor, "Contact-tracing apps and human rights", EJIL: Talk! (blog of the *European Journal of International Law*), 30 April 2020.

[12] K. W. Todrys, E. Howe and J. J. Amon, "Failing Siracusa: Governments' obligations to find the least restrictive options for tuberculosis control", *Public Health Action*, vol. 3, No. 1 (21 March 2013).

II. Interdependent and interrelated rights and COVID-19

17. In his thematic and country visit reports and other activities, the Special Rapporteur has acknowledged that all human rights are interdependent, interrelated and indivisible and stressed the importance of these principles in the full realization of the right to health. In his first report (A/HRC/29/33), he expressed concern that taking a selective approach to human rights has detrimental effects on population groups which face inequality and discrimination, including women, children and persons with disabilities. It is not feasible to ensure enjoyment of the right to health without addressing other human rights failings which lead to social exclusion, stigmatization and humiliation. Responses to the COVID-19 pandemic in all its phases must avoid positioning the right to health, and health care, in isolation from all other rights. Rather, responses must acknowledge that the right to health can be fulfilled only when all other rights are respected and protected, and that advancing other rights promotes the right to health.

18. From the start of the spread of the novel coronavirus in Wuhan, China, in December 2019, the Special Rapporteur has observed the interrelatedness between civil and political rights and the right to health. People in some countries were detained for reporting on the pandemic on social and mainstream media; in others, health-care workers have been threatened with disciplinary action for speaking out about severe shortages of essential supplies. These responses infringe on concerned people's freedom of expression and information and have a direct bearing on the right to health.

19. There are multiple examples of interrelated human rights in this pandemic, such as gender inequality and failure to respect women's rights, including access to sexual and reproductive health services, and failure to observe everyone's right not to be discriminated against. In the United States of America,[13] there has been a disproportionate burden of illness and death from COVID-19 among people of African descent. Globally, indigenous peoples are also at higher risk of COVID-19-related illness and death because they experience poorer health, less access to health-care services and worse underlying and social determinants of health.

20. The Special Rapporteur urges State agencies to collect data on gender, ethnicity, age and other criteria for grounds of discrimination for accountability reasons and so that immediate action can be taken to redress these impacts of discrimination.

21. Physical distancing to contain the spread of COVID-19 is difficult to achieve when there are inequalities in the underlying and social determinants of health, such as adequate housing, safe drinking water and sanitation, food, social security and protection from violence. These central elements of the right to health are protected under international law as interconnected rights.

22. In the absence of rights-based protections, government orders to "stay in shelter" (or other restrictions as lockdown measures are adjusted) can impoverish vulnerable communities, keep children from school, prevent access to basic necessities and support services, increase gender-based violence and widen health inequities across populations. These risks underscore the imperative for coordinated human rights-based responses to all public health measures, including those in times of crises, which must include the participation of those in marginalized or vulnerable situations so that their circumstances can be understood.

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[13] See the letter of 13 May 2020 from various special procedures mandate holders addressed to the Permanent Representative of the United States of America to the Office of the United Nations and Other International Organizations in Geneva (reference: AL USA 10/2020). Available at https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=25252.

23. While lockdowns have been very difficult for those groups that experience hardships, the converse situation is that many people have not been able to stay safe in shelter because they are considered "essential workers". Essential workers include front-line health-care workers, as well as those working in food supply chains, public transport, freight and cleaning services, many of whom may come from disadvantaged sectors of society.

24. In Spain, about 3,000 female migrants from Morocco who travel each year for the annual strawberry harvest continued to be deployed as "essential workers" while the rest of the country was under lockdown, in addition to being paid below minimum wage and sometimes not paid at all.[14] In areas of the United States of America, more than 60 per cent of warehouse and delivery workers belong to minorities and 75 per cent of janitors are people of African descent, with many living on the poverty line.[15]

25. The Special Rapporteur joins international calls on States to implement a universal basic income and reiterates his call for the realization of universal health care so as to protect those already suffering from disadvantage and, often, discrimination. In this way, people will not be compelled to work, especially when unwell, which violates their own rights and risks the spread of disease.

26. The right of essential workers to health requires measures put in place to protect them from COVID-19, including the provision, where needed, of personal protection equipment and hand-washing facilities. Women make up 70 per cent of the global health workforce and are at significant risk of frequent exposure to patients with high viral loads.[16] Of the total number of health-care workers infected with COVID-19 in Spain and Italy, 72 per cent and 66 per cent, respectively, were women.[17]

27. Lockdowns and physical isolation have been causing stress for many people, especially those who are poor, older persons, those in marginalized situations and those who are either alone or in violent living arrangements. The number of COVID-19 infections and deaths in care facilities that reach 40–60 per cent of total deaths in some countries[18] reflects discrimination against older persons. COVID-19 was often transmitted to older persons by the people caring for them (families and care staff), who in many cases reported delays in receiving protective gear, appropriate guidance, equipment, funding and health-care workers.

28. Around the world, employment and financial security are now precarious. People in marginalized situations may have no access to State social protection if they do not work or if their work is not recognized, as is the case for sex workers in many countries.[19] A lack of worker rights has forced many people to continue working even when unwell, thus risking their own health and contributing to the spread of COVID-19. This illustrates the interrelatedness and indivisibility of economic and employment rights and the right to health.

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[14] OHCHR, "Spain: passing the buck on exploited migrant workers must end, says UN expert", 26 June 2020.

[15] Mae Anderson, Alexandra Olson and Angeliki Kastanis, "Women, minorities shoulder front-line work during pandemic", AP News, 1 May 2020.

[16] WHO, "Gender and COVID-19: advocacy brief", 14 May 2020.

[17] United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), "Policy brief: the impact of COVID-19 on women", 9 April 2020.

[18] Adelina Comas-Herrera and Joseba Zalakain, "Mortality associated with COVID-19 outbreaks in care homes: early international evidence", LTCcovid.org, 12 April 2020.

[19] See UNAIDS, "Six concrete measures to support women and girls in all their diversity in the context of the COVID-19 pandemic", 15 June 2020.

III. Power imbalances, asymmetries and COVID-19

29. Key human rights principles include equality, non-discrimination, participation, transparency and accountability. Over time, with the consistent application of these principles and a free press and active civil society to help to monitor them, the population enjoys trust in the State. Trust is a crucial component in pandemic responses, and in the fulfilment of the right to health at all times. In States that have long upheld these principles, and in which there is trust in the leadership, there appears to have been less loss of life and disruption. These populations have generally supported and accepted a temporary loss of some freedoms in an effort to save lives and return to normal economic and social function as soon as possible.[20]

30. Countries which are not transparent in policy development and implementation, in which people do not engage in government processes and Governments are not held to account for their social policies and political processes, have used fear and force to achieve compliance with pandemic restrictions. This engenders negative attitudes and stigmatization towards people who contract COVID-19 because they are seen as having failed to comply, which creates a downward spiral of those people not wanting to seek testing or health care and further spreading the virus.[21] Fear of testing and treatment also plays a role for migrants, in particular irregular migrants, who risk being reported to immigration authorities. Clear and transparent processes are needed, with firewalls in data collection and information-sharing between authorities, to effectively contain the pandemic.

31. Throughout his mandate, the Special Rapporteur has highlighted the damage that asymmetries in power can cause to the right to health and to trust. These can exist in the relationship between health-care workers and patients, between primary health care and specialized medicine, between stakeholders and interest groups within and outside the health sector[22] and between the private sector and the public. These imbalances have resulted in many health systems being underprepared for a pandemic, because in many countries public health has not been prioritized in health systems and has been chronically underfunded. There has also been a historic funding imbalance between physical and mental health-care services.[23]

32. Where public health systems are unable to cope with the demand for COVID-19 testing and treatment, international human rights obligations require Governments to make use of maximum available resources, such as private hospitals and laboratories, to satisfy economic and social rights.[24]

33. Important components of trust are transparency and the inclusion of civil society in governance and policy processes. People working for civil society, including human rights defenders, should be able to do their work for the promotion and protection of human rights, including the right to health, during the pandemic and should not suffer from criminalization, stigmatization or harassment of any sort because of the work that they do.[25] This is especially important in times of pandemics because regulations and legislation passed to promote public health in an emergency, but which curtail rights and freedoms, must be closely monitored.

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[20] See Mark Lawrence Schrad, "The secret to coronavirus success is trust", *Foreign Policy*, 15 April 2020.

[21] See Ariana A. Berengaut, "Democracies are better at fighting outbreaks", *Atlantic*, 24 February 2020; Zeynep Tufekci, "How the coronavirus revealed authoritarianism's fatal flaw", *Atlantic*, 22 February 2020.

[22] A/HRC/29/33, para. 50.

[23] Ibid., para. 51.

[24] E/C.12/2020/1, para. 14.

[25] See A/HRC/25/55.

34. Since the beginning of the pandemic, international human rights mechanisms have sounded the alarm about the use by States of emergency powers, which must be used for legitimate public health goals only and not as a basis to target particular groups, minorities or individuals, to supress dissent or to silence the work of human rights defenders or journalists.[26] This is a crucial element of human rights accountability.

35. A letter from former global leaders warned against democratically elected Governments amassing emergency powers that restrict human rights and enhance State surveillance during COVID-19.[27] The letter states that repression does nothing to protect public health and that "assaults on freedom, transparency, and democracy will make it more difficult for societies to respond quickly and effectively to the crisis through both government and civic action".

36. A lack of trust creates an environment in which fake news and conspiracy theories related to COVID-19 proliferate. This in turn fuels mental distress, anxiety and fear and has an impact on people's right to mental health,[28] among other rights. Honest and transparent engagement between authorities and people is needed to prevent the spread of both the virus and misleading information.

IV. Corruption and COVID-19

37. The Special Rapporteur has previously drawn attention to the devastating effect of corruption on good governance, the rule of law, development and the equitable enjoyment of all human rights, including the right to health.[29] It occurs in both the public and private sectors and across low-, middle- and high-income countries, and it is estimated that €180 billion is lost to fraud and corruption in health care globally every year.[30]

38. In many countries, health care is among the most corrupt sectors. This is of concern during the COVID-19 pandemic, owing to the increase in urgent government procurement and distribution. Corruption originates from power imbalances, is perpetuated by non-transparent decision-making and reinforces ineffective and harmful policymaking and health-care services provision. When there is a perception of corruption within institutions and on the part of public officials, trust in Government is further eroded, and the public is less likely to follow public health advice in crises.

39. As large funds will be made available for pandemic responses and emergency assistance, it is crucial that transparency and accountability are adhered to by all countries, not just those that are historically considered corrupt. For example, some reports suggest that COVID-19 economic stimulus responses in some countries have authorized billions of dollars in loans, loan guarantees and other investments to businesses, with minimal oversight requirements and inadequate conflict-of-interest provisions.[31] Stimulus packages are being developed worldwide, but without

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[26] OHCHR, "COVID-19: States should not abuse emergency measures to suppress human rights – UN experts", 16 March 2020.

[27] International Institute for Democracy and Electoral Assistance (IDEA), "A call to defend democracy", 25 June 2020.

[28] OHCHR, "COVID-19 has exacerbated the historical neglect of dignified mental health care, especially for those in institutions: UN expert", 23 June 2020.

[29] See A/72/137.

[30] Jim Gee, Mark Button and Graham Brooks, "The financial cost of health-care fraud: what data from around the world shows", 2010.

[31] Joseph J. Amon and Margaret Wurth, "A virtual round table on COVID-19 and human rights with Human Rights Watch researchers", *Health and Human Rights Journal*, vol. 22, No. 1 (June 2020).

requiring transparency and accountability for all money allocated and/or spent. The Special Rapporteur agrees with the recommendations of the Health Systems Governance Collaborative to mitigate corruption risks in COVID-19 responses.[32]

40. Many political decisions made at the early stages of the COVID-19 pandemic suggest an allegiance to business and profits rather than to people's human rights entitlements. Examples include travel restrictions being placed on people, rather than imposing physical distancing requirements on businesses and individuals and ensuring that testing and contact-tracing procedures are in place.[33] When political leaders do not act transparently, and when their countries' populations suspect that they are benefiting personally from the decisions that they make, mistrust develops not only in the health-care system but also in local and national authorities.[34]

41. To address the suspicion of corruption, the Special Rapporteur urges States to be transparent and to follow the advice of the Committee on Economic, Social and Cultural Rights to use the best available scientific evidence to protect public health as reflected in guidance from WHO.[35]

V. COVID-19 in the context of the biomedical paradigm and current economics

42. In his report on health workforce education (see A/74/174), the Special Rapporteur drew attention to power imbalances that accompany the medical hierarchy and are linked to the biomedical paradigm. He observed that representatives of prestigious medical specialities often receive political appointments to guide health policies. However, in pandemics it is imperative that responses are informed and led by public health, social medicine and human rights expertise, to reflect a holistic understanding of the determinants of vulnerability to a rapidly spreading virus.

43. In the COVID-19 context, an emphasis on biomedical interventions focuses on the development of vaccines and medical treatments. However, without broader public health and human rights inputs, these developments will fail to reach everyone, and groups in more vulnerable, remote, disadvantaged or discriminated situations will be less likely to receive them. Viral infections do not have a perfect technical fix: immunity is not guaranteed for everyone, it can be short-lived, or not found at all, as for example with HIV and herpes simplex, or new strains of the virus may keep emerging.[36]

44. However, the Special Rapporteur understands that controlling the spread of COVID-19 will require a vaccine as part of a larger containment campaign, and he is supportive of research for, and the equitable distribution of, an affordable "people's vaccine",[37] without diverting funding from responses needed to protect persons in vulnerable situations. Nonetheless, he agrees with "the most consequential fact about infectious illness: the wealthy protect themselves; the suffering is done by the poor".[38]

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[32] Aneta Wierzynska and others, "COVID-19: promoting accountability and transparency during the pandemic", Health Systems Governance Collaborative, 22 May 2020.

[33] Benjamin Mason Meier and Judith Bueno de Mesquita, "Realizing the right to health must be the foundation of the COVID-19 response", blog, Universal Rights Group, 6 May 2020.

[34] A/72/137, para. 12.

[35] E/C.12/2020/1, para. 10.

[36] Philip Alcabes, "Beyond technical fixes for coronavirus", *American Scholar*, 20 April 2020.

[37] Pūras and others, "The right to health must guide responses to COVID-19"; see also www.unaids.org/en/resources/presscentre/featurestories/2020/may/20200514_covid19-vaccine-open-letter.

[38] Alcabes, "Beyond technical fixes for coronavirus".

45. The biomedical paradigm focuses on the cure of disease rather than the underlying and social determinants of poor health. This approach fits well with economic approaches that emphasize individual responsibility for health and well-being, and insurance for health care.

46. Despite relevant literature indicating that medical treatment accounts for only a small percentage of overall health outcomes, it receives the bulk of health funding.[39] Doctors are educated to manage diseases by prescribing medicines rather than to address the underlying, social, psychosocial and environmental conditions which contribute to poor health. Pharmaceutical companies benefit from this focus and lobby decision makers to support this approach to health care, which is not rights based.

47. Just as a biomedical paradigm overlooks the role of the determinants in health, so too does it disregard humankind's relationship with the environment and with climate change. WHO acknowledges that most emerging infectious diseases, and almost all recent pandemics, originate in wildlife, and there is evidence that increasing human pressure on the natural environment is driving disease emergence.[40]

48. In his report which addressed the Sustainable Development Goals (see A/71/304), the Special Rapporteur urged States and other actors to recognize the particular health impact that these environmental issues have on certain populations, due in part to socioeconomic inequality, cultural norms and intrinsic psychological factors. With its effects set to intensify in years to come, climate change has already increased the prevalence of diseases that disproportionately affect people in poverty, such as malaria and diarrhoea. Environmental pollution contributes to the growing burden of non-communicable diseases, again disproportionately experienced by the poor, reinforcing the vicious cycle of poverty.[41]

49. A statement by leaders of the Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services puts the responsibility for COVID-19 squarely on human activity and the current global financial and economic systems, which prize economic growth at any cost.[42]

VI. Health-care systems, universal health coverage, international assistance and COVID-19

50. The Committee on Economic, Social and Cultural Rights, in its statement on COVID-19 and human rights, commented that the pandemic is threatening to overwhelm public health-care systems.[43] It noted that health-care systems and social programmes have been weakened by decades of underinvestment in public health-care services and austerity in other social programmes and that, consequently, they are ill equipped to respond effectively and expeditiously to the intensity and length of the current pandemic.

51. Universal health coverage is an expression of the right to health, a commitment made in the 2030 Agenda for Sustainable Development and essential to stopping the

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[39] Carlyn M. Hood and others, "County health rankings: relationships between determinant factors and health outcomes", *American Journal of Preventive Medicine*, vol. 50, No. 2 (1 February 2016).

[40] WHO, "Q&A: Climate change and COVID-19", 22 April 2020.

[41] A/HRC/32/23, para. 24.

[42] Josef Settele and others, "COVID-19 stimulus measures must save lives, protect livelihoods and safeguard nature to reduce the risk of future pandemics", IPBES guest article, 27 April 2020.

[43] E/C.12/2020/1, para. 1.

spread of COVID-19, and it cannot be achieved without well-functioning, well-resourced, well-governed and accessible health systems.

52. The Special Rapporteur noted in a previous report that the Ebola crisis in 2014–2015 provided meaningful lessons with regard to many elements of the right to health.[44] The crisis brought into question national, regional and global preparedness for public health emergencies. It raised important issues, such as access to information, trust in public authorities and safety of health-care personnel, and it drew attention to the importance of upholding the human rights of the affected populations in the context of public safety concerns. Furthermore, the Ebola experience pointed to the need for strong public leadership in addressing global health challenges. Despite these lessons, the world was not well prepared for COVID-19.

53. The impact of COVID-19 in terms of mortality and morbidity, and economically, has demonstrated the critically important role of public health, primary care, universal health coverage and strong, well-resourced health systems.

54. Health is a human right, and access to public health is a powerful way to develop and strengthen social justice and social cohesion. The Special Rapporteur has observed that many States face difficulties in ensuring the availability and accessibility of COVID-19-related health coverage, leading to "shortages in essential medical care, including diagnostic tests, ventilators, and oxygen, and in personal protective equipment for health-care workers and other front-line staff".[45] Human rights elements within components of health systems during COVID-19 include the following.

Health-care services and facilities

55. Inadequately funded health facilities have had insufficient capacity to cope during the pandemic, but even in countries that made temporary facilities available, there were human rights failings. For example, there has been discrimination in the selection of individuals who could get tested and treated, with groups in marginalized situations missing out as care was rationed, including Roma,[46] people of African descent and older persons. Globally, non-COVID-19-related health-care services have been less available during the pandemic, including sexual and reproductive health-care services in wealthy countries.[47]

56. The Special Rapporteur fears that there will be an inequitable impact of loss of services on low- and middle-income countries. WHO predicts an additional 500,000 deaths from AIDS-related illnesses[48] and 768,000 extra malaria deaths in sub-Saharan Africa in 2020,[49] and the Stop TB Partnership estimates between 342,000 and 1.4 million excess deaths between 2020 and 2025 because of COVID-19-related interruptions to medicine supplies and other health-care services.[50]

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[44] A/HRC/29/33, para. 57.

[45] Pūras and others, "The right to health must guide responses to COVID-19".

[46] OHCHR, "Bulgaria/COVID-19 response: 'Stop hate speech and racial discrimination against the Roma minority' – UN experts", 13 May 2020.

[47] Colleen Marcoux, "Sexual and reproductive health during the COVID-19 crisis", International Women's Health Coalition, 25 March 2020.

[48] Britta L. Jewell and others, "Potential effects of disruption to HIV programmes in sub-Saharan Africa caused by COVID-19: results from multiple mathematical models", 11 May 2020. Available at https://doi:10.6084/m9.figshare.12279914.v1.

[49] WHO, *The Potential Impact of Health Service Disruptions on the Burden of Malaria: A Modelling Analysis for Countries in Sub-Saharan Africa* (Geneva, 2020).

[50] Stop TB Partnership, "The potential impact of the COVID-19 response on tuberculosis in high-burden countries: a modelling analysis", May 2020.

Health-care workers

57. The Special Rapporteur has stressed the importance of an adequate primary health-care workforce. He has previously noted that health systems can improve equity, efficiency and responsiveness by strengthening primary care while decreasing the disproportionate use of specialists and hospital care.[51] However, failure to do so has resulted in too few primary health-care workers, which has been problematic during the COVID-19 pandemic.

58. Health-care workers have had their rights to life and health, and fair employment, threatened throughout the pandemic with inadequate supplies of personal protection equipment for those who need them, lack of support for the trauma that they have experienced throughout the pandemic, and exhausting hours of work. There are also important ethnic and gender dimensions in the health-care workforce.

59. Despite the reliance on these workers, appropriate mental health and psychosocial support has often not been made available to them. The Committee on Economic, Social and Cultural Rights reminded States that it is essential that they consult with front-line health-care workers and that they pay due regard to their advice.[52] The Special Rapporteur acknowledges the huge burden on health-care workers and the loss of lives of so many.

Financing

60. Financial barriers to health care to treat COVID-19 are contrary to the right to health and work against its containment. User fees have left essential services unaffordable for people in vulnerable situations around the globe, in both high- and low-income countries.[53] The Special Rapporteur welcomes the advice from WHO on equitable financing systems for health care and for individuals affected by COVID-19.[54]

Medicines and supplies

61. Fraud, corruption and price gouging all have a direct impact on purchase and supply chains of medicines and devices, profoundly affecting the availability of essential supplies. The Committee on Economic, Social and Cultural Rights urges States to put regulatory measures in place to prevent profiteering on essential medicines and supplies.[55] Transparent purchasing processes and policies and strong accountability mechanisms are necessary to fulfil States' human rights obligations to make testing, and eventually a vaccine, available to all, especially those in the most vulnerable situations.

62. The Committee advises States to avoid imposing limits on the export of medical equipment if doing so would obstruct access to vital equipment for the world's poorest victims of the pandemic. Consistent with international human rights obligations on international assistance and cooperation, the Committee also commented that any restriction on exports based on the goal of securing national supply must be proportionate and take into consideration the urgent needs of other countries.

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[51] A/HRC/35/21/Add.2, para. 36.

[52] E/C.12/2020/1, para. 13.

[53] See Abigail Abrams, "Total cost of her COVID-19 treatment: $34,927.43", *Time*, 19 March 2020; Sean D. Hamill, "Woman who died of COVID-19 refused to go to hospital, worried about bills, her son says", *Pittsburgh Post-Gazette*, 25 March 2020.

[54] Joe Kutzin, "Priorities for the health financing response to COVID-19", P4H Network, 2 April 2020.

[55] E/C.12/2020/1, para. 17.

Health information

63. Effective containment of COVID-19, not just in the absence of a vaccine but even after a vaccine is available, depends on accurate and appropriate public health information being available and relevant to all. Furthermore, as noted by the Committee on Economic, Social and Cultural Rights, the public needs to be protected against dangerous misinformation spread for political and commercial purposes.

64. States which have been led by public health experts who have communicated directly and regularly with the public, and in which there is trust in the Government, appear to have been effective in stopping the spread of the virus. Accurate, accessible and culturally appropriate information is crucial in reducing the risk of stigmatizing and harmful conduct against vulnerable groups, including those infected by COVID-19.[56]

Leadership and management

65. Health systems cannot function well without good leadership and transparent, participatory processes that include the Government and broad representation from within the health sector and the public. Poor leadership has failed to contain COVID-19, even in highly resourced countries.

66. As has been witnessed in the COVID-19 responses, people's rights cannot be protected unless their circumstances inform policy. This must include people already in vulnerable situation and those who are at risk of becoming vulnerable, such as the homeless, the ill, the poor, older persons, those in long-term care, persons with disabilities, migrants and refugees, sex workers, people who use drugs, minority communities, indigenous peoples, internally displaced persons, people living in overcrowded settings, people in detention, lesbian, gay, bisexual and transgender (LGBT) and gender-diverse persons, and others whose human rights are already violated in various ways.

67. The Special Rapporteur urges all countries to support global health governance through WHO, and WHO to remain committed to the essential role of human rights in responding to and guiding policy on all public health issues. This aligns with the Secretary-General's call for global solidarity[57] and the centrality of international assistance and cooperation to the COVID-19 response. It is only with rights-based global leadership and national and regional support that health systems can realize the right to health for all.

VII. Issues in focus

A. COVID-19 and deprivation of liberty

68. The relationship between the right to health and specific forms of deprivation of liberty and confinement in penal and medical facilities has been highlighted by the Special Rapporteur throughout his mandate.[58] Confinement remains the policy tool preferred by States to promote public safety, "morals" and public health, but as has been illustrated throughout the pandemic, crowded and unhygienic penal institutions are a danger to public health.

69. The Special Rapporteur calls for the full and urgent implementation of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson

[56] Ibid., para. 18.

[57] UNU, "UN Secretary-General: COVID-19 pandemic calls for coordinated action".

[58] See A/HRC/38/36.

Mandela Rules) and for the development of supportive community-based services as alternatives to confinement and deprivation of liberty as much as possible and in line with human rights standards.

70. It is estimated that, globally, more than 10 million adults are imprisoned.[59] However, these statistics fail to capture the global scale of persons restricted in other settings, including migrant detention centres and refugee camps. Countless more adults and children are confined in medical and social institutions, including persons with tuberculosis. While the places of confinement differ, the shared experience of exclusion exposes a common narrative of deep disadvantage, discrimination, violence and, at the present time, a great risk of being infected with or dying of COVID-19.

71. The Special Rapporteur joins the United Nations High Commissioner for Human Rights in her call on States to relieve prison congestion and reduce the prison/detainee population,[60] in line with human rights standards. He also welcomes WHO guidance on prison measures[61] and the advice of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment relating to COVID-19 (CAT/OP/10); accordingly, States should reduce prison populations and other detention populations, wherever possible, by implementing schemes of early, provisional or temporary release for those detainees for whom it is safe to do so, taking full account of the non-custodial measures indicated, as provided for in the United Nations Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules).

72. The Special Rapporteur appreciates global discussions about the effectiveness of incarceration and encourages alternatives, for example by decriminalizing activities deemed immoral, such as drug use and sex work. Community-based alternatives grounded in social justice and human rights would also help to fulfil the right to health. He is hopeful that conditional or early release schemes, which are a critical component of the COVID-19 response adopted by many States, will extend beyond the pandemic.

73. States in which such programmes have not taken place, or only partially, are not protecting the rights of staff and prisoners to health and life. As prison staff live outside the facilities, this creates a direct link between prisons and communities, which promotes the spread of the virus.

74. The Special Rapporteur called for the detention of children to be abolished and urged the development of alternative arrangements for incarcerated mothers in his report on the deprivation of liberty and the right to health (A/HRC/38/36). He is greatly concerned that children have not been released from prisons immediately as a result of the pandemic.

75. The Committee on the Rights of the Child has called on States to release children in all forms of detention, whenever possible, and to prevent the arrest or detention of children for violating State guidance and directives relating to COVID-19.[62] Moreover, the United Nations Children's Fund (UNICEF) has expressed concern about the serious risk of children in detention contracting

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[59] Roy Walmsley, *World Prison Population List*, 12th ed. (Institute for Criminal Policy Research, 2018).

[60] OHCHR, "Urgent action needed to prevent COVID-19 'rampaging through places of detention' – Bachelet", 25 March 2020.

[61] See, for example, "Preparedness, prevention and control of COVID-19 in prisons and other places of detention: interim guidance", 15 March 2020; "Checklist to evaluate preparedness, prevention and control of COVID-19 in prisons and other places of detention", 9 April 2020.

[62] Statement of the Committee on the Rights of the Child on COVID-19, 8 April 2020. Available at https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT/CRC/STA/9095.

COVID-19, and called on States to urgently release all detained children.[63] It is estimated that about 1.4 million children are held in either detention facilities or police custody.[64]

76. Other international human rights mechanisms have further expressed concern at the greater risk of violence and exploitation to which children in closed settings are exposed during COVID-19 times. Measures of confinement and the disruption of already limited child protection services aggravate the vulnerability of children in psychiatric and social care institutions, orphanages, refugee camps, immigration detention centres and other closed facilities due to, inter alia, the likelihood that cases of violence, sexual abuse and exploitation of children go undetected.[65]

77. One final issue that the Special Rapporteur raises concerning detention is to question the wisdom of congregating people in care facilities under any circumstances. He has been alarmed at the global tragedy of high fatality rates in care homes for older persons (see para. 27 above). He stresses the need to learn from these preventable deaths and to create alternative approaches which are based in the community and which respect the dignity, rights and freedoms of older persons.

B. COVID-19 and mental health

78. Throughout his mandate, the Special Rapporteur has highlighted the importance of mental health as a part of the right to health and universal health coverage. He has drawn attention to the impact of power imbalances, and the influence of vested interests, in keeping biomedical approaches to mental health as the first line of treatment. He has stressed, especially in his report on the determinants of mental health (A/HRC/41/34), that the main causes of mental distress are inequalities, injustice, discrimination on any grounds, and violence.

79. The Special Rapporteur has recently expressed his concern that there will be an increase in mental health issues in the wake of COVID-19. He anticipates that prolonged mental distress will be fuelled by the direct threats associated with the spread of disease, requirements of distancing and isolation, economic downturn and unemployment. These are exacerbated by massive attacks of misinformation, fake news and conspiracy theories.

80. Consistent with his support for calls to temporarily release people in prisons during COVID-19 times wherever possible and in line with human rights standards, the Special Rapporteur urges similar strategies for people deprived of their liberty in psychiatric institutions. During his mandate, he has stressed the need for a paradigm shift in mental health, to abandon outdated measures resulting in mandatory confinement of persons with intellectual, cognitive and psychosocial disabilities. In the urgent need to protect against COVID-19, he calls on States and other stakeholders to radically reduce the use of institutionalization in mental health-care settings, with a view to the full elimination of institutional care.

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[63] UNICEF, "Children in detention are at heightened risk of contracting COVID-19 and should be released: statement by UNICEF Executive Director Henrietta Fore", press release, 13 April 2020". Available at www.unicef.org/press-releases/children-detention-are-heightened-risk-contracting-covid-19-and-should-be-released.

[64] Penal Reform International, *Global Prison Trends 2020* (London, 2020). Available at https://cdn.penalreform.org/wp-content/uploads/2020/04/Global-Prison-Trends-2020-Penal-Reform-International.pdf.

[65] OHCHR, "UN experts call for urgent action to mitigate heightened risks of violence against children", 7 April 2020; see also OHCHR, "COVID-19: Governments must protect the rights of migrants during the pandemic and beyond, UN experts urge", 26 May 2020.

81. He agrees that decades of neglect and underinvestment in people's mental health needs have been exposed by the COVID-19 pandemic. He supports the Secretary-General's call for ambitious commitments from countries in the way in which they treat mental health conditions, amid a potential spike in mental distress, suicide and drug abuse resulting from the measures taken to combat the pandemic, especially when they are disproportionate and discriminatory.

82. School closures and lockdown conditions have combined to have a particularly severe impact on the stress, anxiety and mental health issues experienced by children.[66] This is particularly worrying given the lack of recognition or awareness of the scale of mental health problems among adolescents in many countries.[67] Evidence is building of the detrimental impact of adverse childhood experiences and toxic stress on physical and mental health throughout the child's entire life. The Special Rapporteur urges States to acknowledge this impact of COVID-19 and to increase funding to support the mental well-being of children and to promote non-violent parenting.

83. He also advises States to adopt human rights-based approaches to the support of all people experiencing mental distress and to stop the overuse of biomedical interventions and coercive treatments when addressing any treatment gaps. Rights-based approaches can mitigate the psychological distress of an economic crisis by ensuring that people who lose their income are protected by government support packages, that they do not lose their homes and that their social rights are protected.

84. It is imperative that the burden of managing and coping with the social, financial and mental health impacts of COVID-19 does not fall on individuals but that they are well supported by health care and other social services. States have an obligation to help those seeking access to rights-based treatment, care and support (including social support, user-led provision or other alternative services) and to ensure that individuals can exercise their right to decline treatment.

C. COVID-19 and digital surveillance and immunity documentation

85. Even before the COVID-19 pandemic, the Special Rapporteur had expressed his concerns about the pervasive and invasive use of technology to govern everyday life. In his report on the determinants of mental health (A/HRC/44/48), he warned that advances in digital technology were transforming the capabilities of States and private entities conducting mass surveillance over entire populations to an unprecedented degree. Throughout the pandemic, the use of these technologies has expanded with little opportunity for civil society to participate in deciding whether these technologies are excessive, necessary or even helpful.

86. Technologies deployed in the COVID-19 context have included drones and street cameras with face recognition software identifying people in public without masks, and digital tracing tools that monitor individuals' movements for the purpose of controlling the spread of the virus through rapid contact tracing. These systems can have a chilling effect across society because their lack of transparency, and the difficulty of achieving redress if errors of identification or supposition are made, leaves everyone vulnerable to their determinations. Furthermore, this surveillance, particularly when linked to systems of social credit scoring, breaks down trust in a society.

87. Digital contact tracing has been taken up by many Governments as part of their COVID-19 responses to contain the spread of the virus. However, the use of such

[66] Aoife Nolan, "A child rights crisis", *London Review of Books* blog, 6 May 2020.

[67] A/HRC/32/32, para. 71.

surveillance technologies poses threats to human rights – beyond those posed by traditional tracing methodologies – especially if their use is not voluntary. If digital contact tracing replaces manual tracing, risks arise about equal access to protection for people who do not use smartphones.

88. Furthermore, the Special Rapporteur is concerned that States' use of invasive technologies, adopted to promote the right to health during the pandemic, could lead to the permanent deployment of strategies that infringe human rights and were only ever acceptable in a crisis situation, under specific conditions and guided by the Siracusa Principles. He therefore urges States to ensure, and to demonstrate through the human rights monitoring mechanisms, that any authoritarian actions undertaken during COVID-19 do not become permanent features of State control.

89. Some States are considering the use of "immunity passports", a mechanism through which people whose blood tests show antibodies to the virus are granted greater freedoms of movement and liberty. The Special Rapporteur agrees with WHO that it is not currently possible to verify a person's immunity to COVID-19, as no effective test has been developed, nor is there evidence that recovery from the virus confers sufficient and long-lasting immunity.[68]

90. The request for written verification for international travel is not permitted under article 35 of the International Health Regulations. There are also concerns about medical privacy and patient confidentiality, risks of falsifying or buying certificates, discrimination in access to testing, and pervasive incentives to contract COVID-19 in order to obtain a certificate.

91. The Special Rapporteur draws attention to human rights issues raised by these proposals, and the potential discriminatory impact of using such certificates on fundamental rights, including the right to just and favourable conditions of work, education and public participation. He reminds States that similar approaches in the past relating to mandatory testing for HIV, for certificates of disclosure and status, lead to significant discrimination and stigma and associated risks of physical and mental stress for those already in a marginalized or vulnerable situation, as well as creating and perpetuating inequalities. Importantly, he observes that these processes are ineffective at protecting public health and can even have serious expansive negative effects if they replace alternative effective public health strategies.

VIII. Past recommendations and positive trends

92. The Special Rapporteur takes this opportunity in his final report to the General Assembly to comment on shifts that he has observed during his mandate from 2014 to 2020. He stated in his first report in 2014 (A/HRC/29/33) that lessons should be learned from past and present experiences that any hierarchy among human rights, a prioritizing of one right or one group of rights over another, leads to detrimental outcomes and systemic violations of human rights. This remains relevant in the present COVID-19 environment, in which prioritization of public health can – but must not – be used to curtail human rights.

93. The restriction of rights, including freedom of movement and the rights to liberty and privacy, must occur only when necessary and must be proportionate, non-discriminatory, time-bound and purpose-limited to the current pandemic. He welcomes the return to the full enjoyment of all human rights in some countries as they have successfully contained the spread of COVID-19.

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[68] WHO, "'Immunity passports' in the context of COVID-19: scientific brief", 24 April 2020.

94. The interdependence of human rights, and the need to respect, protect and fulfil all human rights in order to give effect to any human right, is another message that the Special Rapporteur has stressed. He is confident that this is resonating with States and civil society as they witness the disproportionate impact of COVID-19 on people who experience human rights failings, such as discrimination. He anticipates that, as COVID-19 takes its toll on those in poor health and in vulnerable situations, older persons and those without safe homes or experiencing discrimination, people will demand leadership that will protect those in disadvantaged situations. The world is looking for leaders who can be trusted, who will use science and human rights to respond to these crises.

95. Throughout his 11 official country visits,[69] the Special Rapporteur observed States' increasing investment in primary health care, the importance of which has been reinforced by the focus in the Sustainable Development Goals on universal health coverage. Nearly all of the countries visited reported improved health statistics; however, within these general statistics there remain hidden pockets of poverty and marginalization, and groups that experience discrimination and poor health outcomes.

96. The Convention on the Rights of Persons with Disabilities has had a positive impact on the perception of and support for persons with intellectual, cognitive and psychosocial disabilities and people experiencing mental distress.

97. The Convention requires a shift away from medical and coercive models of treatment to rights-based approaches, and the Special Rapporteur has observed the many measures taken to develop and strengthen primary and specialized health care, with investment in innovative efforts in mental health reforms and interdisciplinary approaches to address drug use and dependence, as well as in the provision of dignified care for persons with chronic conditions. As noted in his report on deprivation of liberty and the right to health (A/HRC/38/36), the Convention, supported by powerful political commitments,[70] has brought the world to the verge of freeing itself from a pattern of coercion and institutionalization in mental health settings.

98. The Special Rapporteur also welcomes the establishment of new and stronger international political commitments to reduce incarceration where appropriate.[71] He has noted that several United Nations entities and human rights mechanisms have called for the immediate closure of compulsory drug detention centres and/or movement towards the decriminalization of non-violent drug offences, same-sex sexual activity and sex work and affording legal recognition to transgender persons.[72]

99. The Special Rapporteur has appreciated the acceptance of his thematic reports and those arising from country visits. He has been encouraged by States and civil society, which have welcomed his focus on the need to improve the underlying and

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[69] These visits covered Malaysia, Paraguay, Croatia, Indonesia, Nigeria, Algeria, Armenia, Kyrgyzstan, Canada, Ecuador and Fiji.

[70] See, for example, Human Rights Council resolution 36/13.

[71] For example the Doha Declaration on Integrating Crime Prevention and Criminal Justice into the Wider United Nations Agenda to Address Social and Economic Challenges and to Promote the Rule of Law at the National and International Levels, and Public Participation.

[72] See A/65/255; A/HRC/32/32; the joint statement by United Nations entities on compulsory drug detention and rehabilitation centres of March 2012, available at www.unodc.org/documents/southeastasiaandpacific//2012/03/drug-detention-centre/JC2310_Joint_Statement6March12FINAL_En.pdf; the joint United Nations statement on ending discrimination in health-care settings of June 2017, available at www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf; and OHCHR, "Tackling the world drug problem: UN experts urge States to adopt human rights approach", 18 April 2016.

social determinants of health and to recognize the role that violence and disempowerment play in preventing people from fully enjoying their right to health.

100. The Special Rapporteur has been pleased to observe that, from COVID-19, human rights protective factors have emerged, including solidarity, resilience of communities and societies and, in some countries, more trust than previously between authorities, civil society and the private sector. He hopes that universal human rights principles, which are crucial for the realization of the right to health, the achievement of the Sustainable Development Goals and the promotion of peace and security, will be revitalized and supported by States.

101. Recognition of health as a human right became widespread because of the HIV epidemic. The challenges and successes on the road to eliminating AIDS illustrate the indivisibility of all human rights and the need to overcome discrimination in law and practice both within and beyond health-care services.

102. Throughout his tenure, the Special Rapporteur has applied a right-to-health framework, integrated and indivisible within universal human rights principles, to various public health priorities, and this has been invaluable in informing rights-based responses to COVID-19. From his observations over the past six years, he makes the following final recommendations.

IX. Conclusions and optimism

103. **A human rights-based approach is a powerful way to address health-related issues and contribute to the realization of the right to health. During epidemics, pandemics or other public health crises, the promotion and protection of all human rights, especially for people in vulnerable situations, becomes crucial for the effective management of the crisis.**

104. **The indivisibility and interdependence of human rights became obvious during the AIDS epidemic. It remains important as the world faces the COVID-19 pandemic. Realizing the right to physical and mental health – whether before, during or after a public health crisis – requires all human rights to be fully embraced. Therefore, the prevention of public health emergencies addresses civil, political, economic, social and cultural rights and ensures that health promotion is available, accessible and acceptable to everyone.**

105. **The Special Rapporteur strongly encourages WHO to remind its member States and other stakeholders that it was founded on the principles of human rights, and the protection of these principles is an obligatory precondition for the sustainable and effective management of COVID-19 and for the full realization of the right to physical and mental health. In keeping with the Secretary General's call for global solidarity, it is imperative that Member States fully support WHO, financially and politically, to execute its mandate on global health comprehensively and clearly and grounded in human rights.**

106. **A human rights-based response to COVID-19 requires universal health coverage and strong health systems so that testing and treatment are available to everyone who needs them. Beyond immediate health care, there is also a need to protect the groups in vulnerable or marginalized situations against the economic and social impacts of the pandemic.**

107. **The COVID-19 pandemic has brought urgency towards rethinking approaches and policies on prisons and punishment. The Special Rapporteur reminds all States that decisions made at this time must respect the rights of prisoners and incarcerated children, including their right to health, and that the**

pandemic responses could pave the way towards transformative directions for reform.

108. **There is an urgent need to address outdated discriminatory laws and attitudes about global mental health and to adopt rights-based approaches to support persons with intellectual, cognitive and psychosocial disabilities, as well as those experiencing mental distress. In particular, coercion and mandatory confinement of people requiring mental health care and support are no longer acceptable. The legacy of separating mental health care and its facilities from services that provide physical health care must end.**

109. **When designing pandemic recovery stimulus and support packages, States should adopt human rights principles to ensure that the voices of people in communities are listened to in an effort to protect their environments and their livelihoods in sustainable and nature-positive ways.**

110. **Health inequities can never be overcome by the health-care system alone. The underlying and social determinants of health extend beyond the health-care sector. Many of the major causes of poor mental and physical health arise from violations of other human rights, including rights to equality, dignity, security and equal participation in society. The Special Rapporteur urges health-care worker education systems to promote a broader understanding of the causes of poor health. He encourages all health-care workers to become human rights advocates.**