

# Health and Human Rights Journal

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## SPECIAL SECTION

### ECOLOGICAL JUSTICE AND THE RIGHT TO HEALTH

GUEST EDITOR

Hope R. Ferdowsian

in collaboration with Phoenix Zones Initiative

## SPECIAL SECTION

### HEALTH RIGHTS AND THE URGENCY OF THE CLIMATE CRISIS

GUEST EDITORS

Gillian MacNaughton and Carmel Williams

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# Table of Contents

## SPECIAL SECTION ECOLOGICAL JUSTICE AND THE RIGHT TO HEALTH

in collaboration with Phoenix Zones Initiative

- 1 EDITORIAL  
Ecological Justice and the Right to Health: An Introduction  
*Hope R. Ferdowsian*
- 7 PERSPECTIVE  
Beyond Anthropocentrism: Health Rights and Ecological Justice  
*Himani Bhakuni*
- 13 PERSPECTIVE  
Emerging from COVID-19: A New, Rights-Based Relationship with the Nonhuman World?  
*Mia MacDonald*
- 21 Slaughterhouse Workers, Animals, and the Environment: The Need for a Rights-Centered Regulatory Framework in the United States That Recognizes Interconnected Interests  
*Delcianna J. Winders and Elan Abrell*
- 35 One Health, COVID-19, and a Right to Health for Human and Nonhuman Animals  
*Laurie Sellars, Kimberly Bernotas, and Jeff Sebo*
- 49 Human Rights Perspective on Pesticide Exposure and Poisoning in Children: A Case Study of India  
*Leah Utyasheva and Lovleen Bhullar*
- 63 Shifting the Moral Burden: Expanding Moral Status and Moral Agency  
*L. Syd M Johnson*

## SPECIAL SECTION HEALTH RIGHTS AND THE URGENCY OF THE CLIMATE CRISIS

- 75 EDITORIAL  
Health Rights and the Urgency of the Climate Crisis  
*Carmel Williams and Gillian MacNaughton*
- 81 Climate Justice, Humans Rights, and the Case for Reparations  
*Audrey R. Chapman and A. Karim Ahmed*
- 95 Children, Adolescents, and Youth Pioneering a Human Rights-Based Approach to Climate Change  
*Giulia Gasparri, Omnia El Omrani, Rachael Hinton, David Imbago, Heeta Lakhani, Anshu Mohan, William Yeung, and Flavia Bustreo*
- 109 The Right to Health and the Climate Crisis: The Vital Role of Civic Space  
*David W. Patterson*
- 121 Challenges to Protecting the Right to Health under the Climate Change Regime  
*Chuan-Feng Wu*
- 139 Health Care in a Changing Climate: A Review of Climate Change Laws and National Adaptation Plans in Latin America  
*Thalia Viveros-Uehara*
- 153 Crises as Catalyst: A New Social Contract Grounded in Worker Rights  
*Diane F. Frey, Gillian MacNaughton, Andjela H. Kaur, and Elena K. Taborda*

## GENERAL PAPERS

- 167 PERSPECTIVE  
Who Deserves Health Care in a Global Pandemic?  
*Monica Gagnon, Rebecca Cheff, and Lisa Forman*
- 173 Ensuring Rights while Protecting Health: The Importance of Using a Human Rights Approach in Implementing Public Health Responses to COVID-19  
*Sophia A. Zweig, Alexander J. Zapf, Chris Beyrer, Debarati Guha-Sapir, and Rohini J. Haar*
- 187 A Global Review of Provisions on Emergency Care in National Constitutions  
*Taylor W. Burkholder, Madeline Ross, Lily Vartanyan, and Harveen Bergquist*
- 201 Physical Activity as a Human Right?  
*Sven Messing, Michael Krennerich, Karim Abu-Omar, Susanne Ferschl, and Peter Gelius*
- 213 The Scales of the European Court of Human Rights: Abortion Restriction in Poland, the European Consensus, and the State's Margin of Appreciation  
*Julia Kapelańska-Pręgowska*
- 225 Charting the Rights of Community Health Workers in India: The Next Frontier of Universal Health Coverage  
*Janani Shanthosh, Andrea Durbach, and Rohina Joshi*
- 239 Applying Human Rights and Reducing Coercion in Psychiatry following Service User-Led Education: A Qualitative Study  
*Susanna Every-Palmer, Leah Kininmonth, Giles Newton-Howes, and Sarah Gordon*
- 253 Building the Evidence for a Rights-Based, People-Centered, Gender-Transformative Tuberculosis Response: An Analysis of the Stop TB Partnership Community, Rights, and Gender Tuberculosis Assessment  
*Brian Citro, Viorel Soltan, James Malar, Thandi Katlholo, Caoimhe Smyth, Ani Herna Sari, Olya Klymenko, and Maxime Lunga*
- 269 LETTER TO THE EDITOR  
Privacy, Equity, and Human Rights Challenges in Public Health Surveillance  
*Rachele Hendricks-Sturup and Sara Jordan*

## EDITORIAL

# Ecological Justice and the Right to Health: An Introduction

HOPE R. FERDOWSIAN

In 1946, the Constitution of the World Health Organization defined health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”<sup>1</sup> Within 20 years, the International Covenant on Economic, Social and Cultural Rights recognized the right to health as a human right, and many states have reinforced the right to health through domestic legislation.<sup>2</sup> In 2002, the United Nations (UN) Commission on Human Rights, which was subsequently replaced by the Human Rights Council, built on these advancements. It mandated the appointment of a Special Rapporteur to promote the highest attainable standard of physical and mental health, including the right to social and environmental determinants of health such as safe drinking water, nutritious food, adequate shelter, education, opportunity, and freedom from discrimination.<sup>3</sup>

Almost 20 years after the Commission on Human Rights highlighted the importance of social and environmental determinants of health, on October 8, 2021, the Human Rights Council passed Resolution 48/13 recognizing the right to a clean, healthy, and sustainable environment.<sup>4</sup> Before its passage, Michelle Bachelet, UN High Commissioner for Human Rights, noted that “the triple planetary crises of climate change, pollution, and nature loss is directly and severely impacting a broad range of rights, including the rights to adequate food, water, education, housing, health, development, and even life itself.”<sup>5</sup> When the resolution passed, the typically quiet chamber erupted in applause, and the UN Special Rapporteur on human rights and the environment, David Boyd, raised his fist in celebration.<sup>6</sup> Through a second resolution, the Human Rights Council established a Special Rapporteur to address the human rights impacts of climate change.<sup>7</sup> Both resolutions acknowledge the damage inflicted by the climate crisis and environmental degradation, as well as their disproportionate effects on vulnerable populations.

These two notable resolutions were passed 59 years after scientist and writer Rachel Carson published *Silent Spring*, which presented an ecological view of health and challenged the notion that humans are separate from nature. At the time, Carson highlighted health threats to nonhuman animals as indicators of environmental destruction and ecological well-being, and as a foreshadow of what could befall humans.<sup>8</sup> Since then, many of Carson’s warnings have been realized. Despite Carson’s and many others’ attempts

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to challenge a paradigm of human invasion, dominance, and exploitation, this pattern has persisted in deeply rooted economic frameworks, far-reaching laws and policies, and entrenched social and cultural norms, irrevocably harming many human and nonhuman beings and much of the rest of the natural world.

Today, the climate emergency, the COVID-19 pandemic, environmental degradation, and other threats plainly illustrate how the rights, health, and well-being of humans, other animals, plants, and the shared environment are interconnected. As a result, public health perspectives increasingly emphasize links between the natural environment and health outcomes among humans and other animals. One example is the One Health framework, which aims to promote interdisciplinary collaboration among those working in human medicine, veterinary medicine, environmental conservation, public health, and other fields to address the risk of global health threats such as changing climate conditions and zoonotic diseases with pandemic potential.<sup>9</sup> Nonetheless, One Health, in its most common applications, has come under scrutiny for being too anthropocentric and for failing to include adequate attention to human and nonhuman rights and well-being.<sup>10</sup> These critiques also raise questions about whether other human-centered frameworks, such as international treaties that remain focused solely on human rights rather than on human and nonhuman rights, are sufficient to tackle interconnected problems that pose an existential threat to human and nonhuman existence. The papers in this special section of *Health and Human Rights Journal* attempt to address these and other questions.

The passage of Resolution 48/13 is perhaps a step in the right direction since it recognizes the importance of protecting ecosystems, which consist of relationships between humans, other animals, plants, and the shared environment.<sup>11</sup> Nevertheless, healthy ecosystems are virtually impossible to realize without ecological justice, which requires respect for the entitlements of human and nonhuman beings, as well as just relationships within

and between species. In too many areas of society, human rights, including the right to health, remain controversial, and nonhuman rights remain even more controversial. The legal and moral rights of human and other beings are commonly invoked through political institutions or instruments such as international councils and treaties.<sup>12</sup> But despite an urgent need to address the interdependent health of humans, other animals, and the environment, the health and human rights literature has rarely focused on relationships between the moral and legal rights of humans, other animals, and the natural environment, and how the recognition of these connections influences the right to health.

This special section explores the conceptual and practical connections between ecological justice and the right to health, including relationships between the legal, political, and economic treatment of humans, other animals, and the environment; how international frameworks such as One Health address, or could better address, the right to health; and the potential influence of expansive rights frameworks, including other than human rights, on human health outcomes. The papers go beyond locating and describing problems to identify leverage points for changes that could enhance the rights, health, and well-being of the most vulnerable human and nonhuman stakeholders.

The six papers in this section challenge various longstanding assumptions about relationships between humans, other animals, and the shared environment in light of moral, legal, and scientific advancements. They address how the health and well-being of humans and other animals intersect, and whether concepts historically reserved for human rights can be usefully extended to include the rights of other animals and nature. Authors explore how major concepts in human rights can and should be applied to other animals for the benefit of human and nonhuman beings. The papers frequently draw on the COVID-19 pandemic and the climate emergency to address the adequacy of certain international frameworks, legal constructs, and practices.

In the first paper, “Beyond Anthropocen-

trism: Health Rights and Ecological Justice,” Himani Bhakuni argues that the community of justice should be expanded to include all sentient and nonsentient beings. Bhakuni explores how an emphasis on ecological justice, instead of ecological preservation, could lead to a more robust notion of rights, including the right to health. As other authors argue, Bhakuni describes how ending the instrumentalism of nonhuman animals and the environment could result in a richer health rights framework for human and nonhuman beings. Bhakuni emphasizes the intrinsic links between legal and natural rights (“rights that are derived from existence”), which have commonly been used as the basis for human rights, and which could similarly inform the legal basis for nonhuman rights. Although Bhakuni does not address how to weigh the interests of sentient and nonsentient beings, or whether certain types of rights should be weighed more heavily than others, Bhakuni concludes with a focus on legal strategies that offer the greatest potential to enhance and expand the right to health and ecological justice.

In “Emerging from COVID-19: A New, Rights-Based Relationship with the Nonhuman World?,” Mia MacDonald uses the COVID-19 pandemic to show how inattention to the rights of nature threatens the right to health, other positive and negative rights, and resulting health outcomes. MacDonald writes that now is a timely and urgent opportunity to address inequities that have been created by distortions in profit and power—distortions that Carson cautioned about in 1962 in *Silent Spring*. MacDonald notes that solutions must include attention to interlinked threats to Indigenous populations, individuals who have suffered from racial and gender inequities, and nonhuman animals living in captivity and the wild. As one example, MacDonald observes how the suffering of nonhuman animals in corporate farms is entangled with the suffering of workers and communities disproportionately made up of immigrants and people of color, and how these intersecting harms impede the right to health. MacDonald therefore argues for the rights of human and nonhuman populations to be accepted as complementary and to be advanced

together to further the right to life and health. She goes on to suggest potential paths forward, such as a One Welfare approach, which builds on a One Health framework and the World Health Organization’s definition of health.<sup>13</sup> MacDonald invokes the words of her mentor, Nobel Peace Prize recipient Wangari Maathai: “We cannot tire or give up. We owe it to the present and future generations of all species.”<sup>14</sup>

Delcianna J. Winders and Elan Abrell likewise draw on the COVID-19 pandemic in “Slaughterhouse Workers, Animals, and the Environment: The Need for a Rights-Centered Regulatory Framework in the United States That Recognizes Interconnected Interests.” The publication of their paper follows the release of a memorandum by the US House of Congress Select Subcommittee on the Coronavirus Crisis, which revealed that COVID-19 infections and deaths among workers at five of the largest meatpacking conglomerates were three times higher than originally estimated.<sup>15</sup> Winders and Abrell discuss how the pandemic has shone a spotlight on US industrial slaughterhouses that exploit humans and other animals, and they explore how the current regulatory system violates the labor rights of workers, the moral rights of nonhuman animals, and the legal and moral rights of communities, including the right to a healthy environment. Winders and Abrell propose a federal Slaughterhouse Oversight Commission, guided by an expanded One Health framework, which would protect workers from severe threats to their health and life, and shelter communities from air pollution, the direct discharge of wastewater, and antibiotic-resistant pathogens. They argue that their proposal would also offer basic protections to nonhuman animals who suffer egregious harms to their physical and mental well-being up to the moment in which they are killed. Winders and Abrell insist that their Slaughterhouse Oversight Commission proposal would necessitate an expanded recognition of rights, but they concede that their approach would not immediately protect nonhuman animals from threats to their right to life, nor would it offer workers the highest standard of physical and mental health. Their approach is

both practical and aspirational in a system in which many workers are visible to the law only through their labor and a system in which nonhuman animals are visible to the law only upon their deaths.

While Winders and Abrell use an expanded One Health approach to argue for strengthened regulatory requirements, in “One Health, COVID-19, and a Right to Health for Human and Nonhuman Animals,” Laurie Sellars, Kimberly Bernotas, and Jeff Sebo argue that the right to health ultimately requires moving beyond the instrumentalism of humans and other animals. They begin by making the case for the human and nonhuman right to health and then examine the impacts of COVID-19 on human and nonhuman populations. Their analysis centers on areas in which the human right to health and the nonhuman right to health clearly intersect—industrial farming, medical research, the home, and urban and rural spaces. Through their analysis, they reveal the limitations of standard interpretations and applications of a One Health framework. Whereas Winders and Abrell focus on reforming existing systems that harm the health of humans and other animals, Sellars, Bernotas, and Sebo argue for the replacement of these systems. They insist that such changes must include an expansive emphasis on rights rather than a focus on solitary health outcomes, and they propose steps that the international community can take to respect and promote human and nonhuman rights and a fuller definition of health. These steps, they argue, would include disruption of the status quo, extension of the legal right to health to nonhuman animals, and a more just One Health construct. They point out that such an effort would require more research on how humans and other animals are impacted by various policy and infrastructure decisions, such as how child impact assessments are used to advance the rights and health of children.<sup>16</sup>

In “Human Rights Perspective on Pesticide Exposure and Poisoning in Children: A Case Study of India,” Leah Utyasheva and Lovleen Bhullar examine the impact of a failure in law and policy to protect children from agrochemical poisoning, an issue that remains salient decades after the initial publication of *Silent Spring*. Utyasheva and Bhul-

lar argue that taking seriously children’s rights, including their right to health, requires the elimination of these poisonous agents from everyday use in India and globally. They argue that such an approach would also honor “the best interest of the child” standard emphasized in the Convention on the Rights of the Child.<sup>17</sup> The authors demonstrate how the precautionary principle, which would lead to bans of some industrial chemicals, would benefit children, the adults they become, nonhuman animals, plants, and the greater environment. They do not accept specious objections to their proposal, such as concerns about food security, agricultural productivity, or costs to farmers, and they demonstrate how these objections are false and misleading.

In the final paper of the section, “Shifting the Moral Burden: Expanding Moral Status and Moral Agency,” L. Syd M Johnson examines a critical question that lies at the heart of many of the other papers: Who matters enough to warrant a right to health? Using the “problem of marginal cases” and African communitarian conceptions of moral status and moral agency, Johnson proposes a broadly inclusive view of moral status and the right to health. Such an approach, she argues, would not only help humans and other animals who have been marginalized. A broadly inclusive approach would inevitably protect many individuals and populations from the public health threats posed by global pandemics, environmental degradation, and the climate emergency. As Johnson notes, successfully combatting these global challenges requires concerted, collective action and multilateral strategies, including a focus on the most marginalized individuals, communities, and populations. Johnson explores to whom moral protections and responsibilities belong, and her contribution highlights the importance of ethical analysis in deliberations about the right to health.

As a guest editor of this special section, I would like to express my gratitude to the authors for their commitment to this issue and to the editors of the journal for their interest in this timely subject. Ideally, this section will stimulate greater interest and scholarship in the subject matter, including exploration of the merits of a Just One

Health approach, which can build on and expand a One Health framework by centering One Health on ecological justice and the interconnected rights, health, and well-being of humans, other animals, and the natural environment.<sup>18</sup> As several of the authors note, an emphasis on justice would arguably enable a more effective and impactful realization of One Health's potential by freeing human and nonhuman beings to thrive in clean, healthy, and sustainable environments, so that they may claim their right to health.

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PERSPECTIVE

# Beyond Anthropocentrism: Health Rights and Ecological Justice

HIMANI BHAKUNI

## Introduction

Almost two decades ago, in light of mounting evidence of the extinction of various species and biodiversity hotspots, Brian Baxter, in *A Theory of Ecological Justice*, argued that we should expand our community of justice to include all sentient and non-sentient beings.<sup>1</sup> This essentially means that biotic and abiotic nonhumans have a claim in justice against moral agents. This broader notion of ecological justice defended by Baxter entails that humans as moral agents must not deprive (at least not without a stronger moral reason) sentient and non-sentient beings of the environmental basis of their continued existence and ability to reproduce themselves.<sup>2</sup> While much can be said about the plausibility of Baxter's account, ecological justice remains a rather misinterpreted notion, especially when employed by advocates who rely on its normative significance to push for better outcomes for human health and, in doing so, conflate ecological preservation with ecological justice. While these advocates are accurate in linking human health and ecological preservation, ecological justice requires a viewpoint that goes beyond anthropocentrism—where human health is not *above* the health of nature. In this piece, I suggest that the idea of ecological justice, along the lines proposed by Baxter, can help us develop a more robust notion of health rights.

At face value, the existing health rights framework *seems* to be geared toward a broader community of justice, which may lead one to question the very intelligibility of providing a *more* robust notion of health rights. For example, the right to a healthy environment under article 12(2)(b) of the International Covenant on Economic, Social and Cultural Rights requires state parties to improve “all aspects of environmental and industrial hygiene.”<sup>3</sup> But this face-value impression is misleading. Environmental and animal health finds a mention in the right to health framework not because of the recognition that *all* nonhuman entities on this planet might have a reasonable claim to health (in and of themselves); rather, these entities are included in the framework on purely *instrumental* grounds: they are protected only to the extent that their lack of health would affect human well-being.

By treating the health of biotic and abiotic environments non-instrumentally, not only would we take steps toward fostering ecological justice, but the expansive health rights framework would become richer by treating the health rights of biotic and abiotic nonhumans on an equal footing with the human right

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to health. The jurisprudential theory around the rights of nature (RoN) has taken the initial steps by extending the rights created for humans and other legal entities to nature. RoN theory focuses on the rights of ecosystems to exist, persist, flourish, and regenerate regardless of the benefits to humans or corporations.<sup>4</sup> RoN are usually sought by extending personhood to formerly excluded aspects of non-human nature (including environmental support systems).<sup>5</sup> The recognition of RoN is important for modern legal systems because any applied effort in achieving ecological justice requires human rights to work in tandem with RoN to ensure that the interests of nature are not (so easily) defeated when they conflict with the rights and interests of other subjects of law.

### The link between human rights, rights of nature, and legal protection

Hernán Santa Cruz, a Chilean member of the drafting subcommittee of the Universal Declaration of Human Rights, wrote that the consensus on recognizing and institutionalizing human value “did not originate in the decision of a worldly power, but rather in the fact of existing.”<sup>6</sup> Similarly, nature’s rights arise from the existence of nature and from it being a thing of value. If we accept RoN and the premise that nature and things can be ascribed rights, then we can make a case for ascribing a right to health to biotic and abiotic nonhumans.

The dialogue around RoN has rested on the idea that in order for nature to have rights, it must be ascribed some sort of personhood. This idea has increasingly been contested in recent literature, along with the idea that the concept of “person” is not necessary even for human rights.<sup>7</sup> In law, when we attribute personhood to a thing, “we do nothing more than recognize an entity as a valid object of legal concern.”<sup>8</sup> This is seen in legal personhood ascribed to corporations, states, embryos, fetuses, brain-dead patients, rivers, dolphins, and so forth. The term “person” then stands not for a single concept but for a “cluster of ideas” that is usually relative to a given situation.<sup>9</sup> Sometimes we might use “person” to talk about rational agents, sometimes

the word might highlight a biological composition, occasionally the term is used to signify continuity of consciousness, and other times we use it as a normative idea that denotes a holder of legal entitlements and burdens.<sup>10</sup> In order to avoid confusion between these uses of the term, and to circumvent the unending debates around personhood, some scholars prefer using the term “nonhuman subjects of law” to talk about all nonhuman things that hold certain legal entitlements.<sup>11</sup>

A human person is primarily capable of holding all types of rights, be they rights that protect their interests or those that protect their freedoms. But nonhuman subjects of law are capable of holding only those rights that predominantly protect their interests. Incorporating RoN into our legal systems, whether through legal personhood or through non-personal subjecthood of law, for all practical concerns “may be reduced to the legal recognition of one single right only, namely the right to be taken into account, or ... to have one’s own individual interests considered as relevant in all decisions that may affect their realization.”<sup>12</sup> This, when stretched further, essentially means that these interests can be compromised or defeated if they conflict with the rights and interests of other subjects of law. Such legal protection remains at the mercy of the anthropocentric idea of the “common good.” Conflicts between two sets of rights-bearers are usually resolved in the name of and for the common good, which might come at the cost of the interests of nature.

If we are to pursue ecological justice earnestly, we need stronger protections of the interests of nature—where the interests of nonhuman subjects of law are not deemed lesser when weighed against the immediate or long-term interests and freedoms of humans. Here, “interests of nonhumans” should be read as acts and omissions that would be advantageous to their existence, persistence, regeneration, and flourishing. And “nonhuman subjects of law” should be read as all sentient and non-sentient (biotic and abiotic) planetary existence. Note that whether nonhumans can have rights or even an interest in liberty is a morally contentious notion.<sup>13</sup> While much has been written about the capacity

of animals to possess rights and freedoms, there is significantly less scholarly work on the rights and freedoms of non-sentient or abiotic systems. Legally, the interests of nonhumans can be protected through legislation and regulation. But the proponents of RoN seek perpetual court protection of the interests of nature irrespective of any legal standing. Before I outline how the legal protection of the interests of nature is in the process of being accomplished, let me first clarify what I mean when I say that all sentient and non-sentient nonhumans also have a claim to health.

### All sentient and non-sentient beings have a non-instrumental claim to health

Decades ago, Aldo Leopold's pioneering notion of land ethic unequivocally recognized nature's "right to continued existence" and aimed to amend the position of "Homo sapiens from conqueror of the land-community to plain member and citizen of it."<sup>4</sup> This progressive idea for its time finds deep resonance with the notion of ecological justice as propagated by Baxter, who claims that humans as moral agents must not rob sentient and non-sentient beings of the environmental basis of their continued existence and ability to reproduce themselves.<sup>5</sup> Building on this, I propose that a claim of these beings to health, or a right to health, would then entail a right to a state of security where non-sentient nonhumans (like the abiotic elements of our ecosystem) can continue to exist in a meaningful state where they can support the safe reproduction and preservation of sentient human and nonhuman beings.

The right to health for all biotic and abiotic nonhumans requires further clarification. First, this would essentially be a *claim right*, meaning a right that would entail responsibilities, duties, or obligations on humans regarding the right-holders (who would be all sentient and non-sentient nonhumans). Second, to continue to exist in a *meaningful state* is distinct from simply continued existence. A "continued existence" for the abiotic elements of the ecosystem could very well mean a polluted or value-less existence. To avoid this interpretation, a

right to health for the abiotic environment would necessitate a meaningful existence that would support the safe reproduction and preservation of the biotic environment. Third, like the human right to health, the right to health for all biotic and abiotic nonhumans would be subject to progressive realization by states where they "would have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization" of the right.<sup>16</sup> Given that our biotic and abiotic nonhuman environment is in an extreme state of distress, it would require sustained efforts to undo the damage and to refrain from doing further damage by humans individually and by states.

It is important to note that while the right to health of biotic and abiotic nonhumans is similar to the human right to health, rights that are derived from existence are unique to different kinds of beings. Thomas Berry has argued that rights "are species specific and limited" (like bird rights, river rights, and human rights) and that the difference between human rights and other species-specific rights is "qualitative, not quantitative."<sup>17</sup> Earlier, I mentioned how, in the legal rights landscape, the interests of some can be defeated in pursuit of others, but it is equally true that human rights and RoN can be "co-violated."<sup>18</sup> For instance, between the years 1967 and 1992, the pollution caused by Texaco's oil drilling operations in the Ecuadorian Amazon resulted in widespread incidents of miscarriages, birth defects, and cancer deaths. The operations also resulted in 18 billion gallons of toxic wastewater and pollutants being released into the local waterways, which severely damaged a once pristine rainforest (teeming with rich biodiversity) and caused an estimated one million acres of deforestation.<sup>19</sup> Thus, the same government-backed industrial action that violated the human rights to life and health also violated the health rights of abiotic and biotic nonhuman natural systems.

### The onward struggle for ecological justice

There have been leaps and gains in recognizing RoN across different jurisdictions and levels of government, but one approach to ascribing legal

rights to nature has arguably been more successful than the other. The first approach—let us call it the “legal personhood approach”—has faced certain problems. For instance, the Indian High Court of the State of Uttarakhand, after invoking its *parens patriae* jurisdiction and granting provincial authorities the legal guardianship of the abiotic systems, declared

glaciers including Gangotri and Yamunotri, rivers, streams, rivulets, lakes, air, meadows, dales, jungles, forests wetlands, grasslands, springs and waterfalls, legal entity/legal person/juristic person/juridical person/moral person/artificial person having the status of a legal person, with all corresponding rights, duties and liabilities of a living person, in order to preserve and conserve them.<sup>20</sup>

This order was suspended by the Indian Supreme Court after the provincial authorities filed an appeal, arguing that the order was legally unsustainable and untenable. In their appeal against the High Court’s order, the provincial authorities presented two problems with the order:

- First, things such as rivers run across different territories and provincial borders, and by virtue of the provincial authorities being declared legal guardians of the rivers, they would unreasonably be sued in any illegality involving the rivers, even if it was committed in other provinces. Given that local authorities do not have the power to pass instructions to authorities and people in other provinces, the order was unimplementable.
- Second, if rivers, lakes, and so forth have duties, then it would be possible to bring a claim against them, and that would be legally unsustainable.<sup>21</sup>

One can assume that the latter query was along the lines of, how could the river’s right to flow without inhibition be reconciled with a duty to provide hydropower electricity to the people living by the riverbanks? This has to be read in light of the fact that the River Ganga is one of the most engineered rivers in the world.

Ascribing legal personhood to rivers (or sys-

tems) possibly has greater impact when the river (or system) in question is less engineered and has a protected status, such as the Whanganui River in New Zealand.<sup>22</sup> The protection of the interests of the abiotic and biotic nonhuman entities would perhaps be more successful if they were *only* ascribed claim rights. If states agree to the protection of their claim to health, as outlined before, the claim would be subject to progressive realization by national and local governments, making it logistically less burdensome for them. Nevertheless, given how some of our legal systems actually function—assuming that ascribing rights or personhood must be followed by ascribing duties as well, when actually one need not entail the other at all (like how some legal systems ascribe newborns claim rights with no duties)—their claim to health would remain at risk of being outweighed by more pressing human claims and freedoms.

The second approach—let us call it the “constitutional approach”—has been slightly more successful than the first. In 2008, Ecuador amended its Constitution to include a recognition that “[n]ature, or Pacha Mama, where life is reproduced and occurs, has the right to integral respect for its existence and for the maintenance and regeneration of its life cycles, structure, functions and evolutionary processes.”<sup>23</sup> The Constitution further adds that any person can enforce these rights by calling on public authorities for the observance of such rights and that nature’s right to be completely restored is independent of the obligation to compensate people affected by the deterioration of natural systems.<sup>24</sup> A fairly recent empirical study compared 13 RoN lawsuits in Ecuador to analyze the pathways and strategies that were used by RoN advocates and opponents to build, and counter, the force behind judicial processes that were meant to bolster the enforcement of RoN norms.<sup>25</sup> These were a mixed bag of successful and unsuccessful lawsuits. Among influential pathways that included interdependent processes between state agencies, civil society, and the courts, the study found that the civil society pathway was the least successful, as many activists lost lawsuits that were highly publicized. But these high-profile cases “facilitated judicial mo-

mentum by working on less-politicized local cases and training lower-level judges.<sup>26</sup> When the local governments used the constitutionally enshrined RoN laws instrumentally (or rather hypocritically by invoking them when they served a purpose and ignoring them when they challenged government policies), it produced inadvertent consequences, including the establishment of precedent and the education of judges. Further, the study found that well-informed judges were unilaterally applying RoN in their orders, even when neither claimants nor defendants alleged violations of RoN.<sup>27</sup>

The two approaches to ascribing legal RoN are different in their scope and implementation. We are still at an early stage of the RoN movement, but the movement is progressing at a steady pace. As of 2021, 13 countries have recognized some form of RoN.<sup>28</sup> My proposal of a right to health for biotic and abiotic nonhumans requires further refinement, but if recognized as nature's distinct claim to health, it would transform and enrich the more expansive health rights framework.

Currently, there is a bombardment of too many ideas, and too few strategies, concerning the protection of our ecosystem, which has prompted some scholars to pronounce that the “dialectic of justice has reached an impasse in which the struggle over ideas—though present in abundance—has come to have very little effect on real human-human and human-nature relations.”<sup>29</sup> Here, I have proposed one possible legal strategy of ascribing a right to health to biotic and abiotic nonhumans, which (depending on the legal approach taken) has the potential to secure some aspects of ecological justice. But as long as we continue to feed our moral imagination with the Leopoldian idea that “[a] thing is right when it tends to preserve the integrity, stability and beauty of the biotic community. It is wrong when it tends otherwise,” we might be on the right track.<sup>30</sup>

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## PERSPECTIVE

# Emerging from COVID-19: A New, Rights-Based Relationship with the Nonhuman World?

MIA MACDONALD

### Abstract

This essay argues that the global response to COVID-19 should lead to new thinking and action, and specifically, a new relationship with the nonhuman world that is centered on mutuality and respect, not commodification and exploitation. Such a response would acknowledge and embed concepts like ecological justice and One Welfare in policy and practice, particularly regarding the consequences of intensive animal agriculture and production of monocultures of feedstock for the billions of farmed animals used in food production each year. Drawing on examples from the Global South and Global North, the essay suggests ways forward that provide opportunities for new thinking, research, and action, with the COVID-19 crisis contextualized by the urgency of the climate and biodiversity crises. With deep inequalities and infringement of rights embedded in each of these global challenges, successfully addressing them likely depends on useful disruptions in, and a bridging of, the divides that have separated human and nonhuman rights and have limited the intersections between public health, the environment, and animal welfare and rights.

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Any way it's said, it's going to be an understatement: the wreckage caused by the COVID-19 pandemic has been enormous. Across the world, more than five million lives have been lost and millions more have been upended.<sup>1</sup> Children have missed months of vital schooling; rates of child marriage, domestic violence, and social isolation have increased; and many individuals have been unable to work, visit others, and grieve. The pandemic has also revealed the shortcomings and short-sightedness embedded in the relationships of most human societies with the nonhuman world, whether due to our failure to combat zoonoses, our reckless overuse of antibiotics, or the chronic vulnerability of our food systems. Yet, as governments apportion trillions of dollars to post-COVID-19 recovery, we await a true reckoning—including another pandemic. For COVID-19 is “not necessarily the big one,” according to Michael Ryan, head of emergencies at the World Health Organization.<sup>2</sup>

This essay argues that our response to COVID-19 should lead to new thinking and action, and specifically, a new relationship with the nonhuman world that is centered on mutuality and respect, not commodification and exploitation. Such a response would acknowledge and embed concepts like ecological justice and One Welfare (which I discuss later) in policy and practice, particularly regarding intensive animal agriculture and monocultures of feedstock.

### A globalized commodity-based food system

Over the last several decades, the model of food production embedded in the United States, Europe, Australia, and New Zealand has spread across the world, encompassing countries as varied in their economic and development status as China, Kenya, and Paraguay.<sup>3</sup> Here, what is often referred to as “big ag”—including “big meat,” “big dairy,” “big feed,” and the factory farms and feedlots they rely on—has moved from the margins closer to the center of food systems.

China is now the world's biggest producer and consumer of food products, including meat, and

factory farms there are growing in number and size.<sup>4</sup> Brazil is among the world's leading producers and exporters of meat—including beef, chicken, and pork—and of soybeans, a prime component of feed for farmed animals (corn is another).<sup>5</sup> India's poultry industry is largely industrialized, and India has the world's largest herds of cows and buffaloes. Although used mainly to produce milk for domestic consumers, buffalo meat in particular has made India one of the top global exporters of red meat.<sup>6</sup>

Even in Ethiopia, with a tragic history of food insecurity and famine, industrial meat operations are expanding, as people in middle- and upper-income brackets seek to eat more “Western” diets and industrialists look to export markets in the Middle East and the European Union. Intense new competition is likely to ensue in the country for grains and oilseeds, as well as access to water and land, between fast-rising populations of people and livestock.<sup>7</sup>

Contrary to claims made by its defenders that this method of farming is modern, sustainable, and necessary, industrial animal agriculture poses immense challenges to the human and nonhuman worlds, and it makes many bad problems worse. Global greenhouse gas (GHG) emissions from food systems account for one-third of all human-caused GHGs, with animal agriculture contributing at least 14.5% of overall GHGs.<sup>8</sup> Agricultural expansion, including for cattle grazing and feedcrops fed to billions of animals raised on factory farms and feedlots, is a principal driver of biodiversity and habitat loss and land use change and conversion.<sup>9</sup> Large-scale animal agriculture also consumes immense quantities of potable water, wasting much of it.<sup>10</sup> And it edges out smaller-scale producers, and, in some cases, “grabs” land illegally (sometimes through threats, intimidation, and violence), as in Brazil's Amazon forest and Cerrado savanna.<sup>11</sup>

The meat and dairy industries argue that they are meeting demands from growing, urbanizing populations around the world for more animal-based foods through global supply chains that maximize efficiency and lower costs.<sup>12</sup> The truth, however, is more complex. At least 80 *billion* chickens, pigs, cows, sheep, goats, ducks, and

geese are raised and slaughtered globally each year. Feeding those animals, who are usually confined in crowded sheds or barren feedlots, requires vast quantities of corn, soybeans, or other grains, as well as the routine use of antibiotics to accelerate the animals' growth to "slaughter weight" and keep them alive in insalubrious surroundings.

A record harvest for corn (maize)—1.16 billion tons—is anticipated in the 2020–2021 growing season.<sup>13</sup> And yet hunger is a reality for more than 800 million people, and this number will almost certainly continue to rise in the wake of COVID-19.<sup>14</sup>

One of the reasons for the scarcity amid so much productivity is that more than 40% of crop calories, including from soybeans and corn, are used to feed farmed animals or to manufacture bio-fuels.<sup>15</sup> These monocultures rely on fossil fuel-based fertilizers that leach chemicals into waterways and groundwater, causing eutrophication and pollution. "Intensified agricultural production degrades soils and ecosystems, driving down the productive capacity of land and necessitating even more intensive food production to keep pace with demand," according to the United Kingdom-based Chatham House think-tank and nongovernmental organization Compassion in World Farming.<sup>16</sup>

And what of those who live around or are employed in factory farms and slaughterhouses—not to say of the animals who are raised and killed there? At the most fundamental level, both of these groups should have their basic rights respected, whether that be the right to a safe working environment, to access clean air and water, to a decent standard of living, to be able to flap their wings or turn around in their stalls, to be free of sickness and to rear their young, or to have a life free from the deliberate infliction of pain.

Yet in modern animal agriculture, none of these is the case. Factory farms foul their surroundings, bedeviling communities with persistent odors, polluted water and air, and infestations of insects that drive people indoors. Most of those affected are lower-income residents or people of color, or both. It is these communities, too, who are the most affected by climate change and yet have contributed the least to the crisis. The animal

agriculture industrial complex relies on a poorly paid and marginalized workforce that is exposed to zoonoses such as avian and swine flu and has some of the highest rates of injuries compared to other industries.<sup>17</sup>

The animals themselves are bred for such fast growth that their skeletal structure struggles to support their weight, leading to bone breaks and injuries. Billions are routinely mutilated—horns, tails, toes, and genitalia removed with no pain relief—and newborns are often removed from their mothers soon after birth, leading to documented psychological distress.<sup>18</sup>

The interlinked inhumane conditions for humans and animals alike, and the indifference of "big ag" to both, were brought out in sharp detail by the COVID-19 pandemic. In 2020 and 2021, meat-processing facilities became hotspots for COVID-19 infections and deaths in the United States, Brazil, and Germany. In the United States, the Trump administration forfeited its role in enforcing COVID-19 worker safety measures, deemed meat processing an essential activity, and left personal protective equipment, social distancing, masking, hand washing, and testing to the processors. Despite protestations that worker safety was their top priority, including in a statement by Cargill that acknowledged the "tragic impacts" of COVID-19, most of the big producers—for example, Tyson, JBS, Smithfield, and Cargill—were slow to act on providing personal protective equipment, social distancing protocols, sanitary measures, and testing.<sup>19</sup>

The consequences were dire for the rights to health and life for the workers, who are overwhelmingly Black, brown, or recent immigrants. According to Deborah Berkowitz of the US-based National Employment Law Project, more workers in the meat packing industry died of COVID-19 in the 12 months between April 2020 and April 2021 than from all other work-related hazards combined *over the last 15 years*.<sup>20</sup>

COVID-19's disruption of the institutional supply chain also led in the United States to the "depopulation" (culling) of millions of piglets, chicks, and calves who could not be slaughtered before

they grew too large due to COVID-19-related staff shortages in processing facilities.<sup>21</sup> Vast amounts of milk, meat, and vegetables were thrown away.

### Antimicrobial resistance

Another urgent challenge posed by industrial animal agriculture is its role in the emergence of antibiotic-resistant diseases. Antibiotics are used routinely by large-scale livestock producers to prevent and treat diseases that, not surprisingly, can spread easily in the crowded, dirty conditions of a factory farm. According to the World Health Organization, drug-resistant diseases lead to 700,000 deaths a year and could rise to 10 million by 2050 if antibiotic resistance is not combatted.<sup>22</sup>

Yet an astounding 65% of antibiotics that are sold each year in the United States are for use in food production.<sup>23</sup> Indeed, one recent study found that 44% more antibiotics by volume are administered to cows and pigs than for treatment of infections in people.<sup>24</sup> Globally, as industrial animal agriculture expands, antibiotic use in farmed animals is expected to skyrocket. Researchers project that the indiscriminate use of antibiotics in farmed animals will increase 67% by the year 2030, with “almost twice this increase in countries such as China, Brazil, India, South Africa and Russia.”<sup>25</sup>

One might have imagined that the COVID-19 pandemic would have spurred an immediate reckoning within big ag concerning its misuse of such a vital component of public health. That doesn't seem to be the case, and antimicrobial resistance is only one of big ag's threats to public health revealed by the COVID-19 crisis. The Western diet, high in saturated fat from the oversupply of meat and dairy, sugars, oil, salt, and highly processed and fast foods, exerts a heavy toll. Noncommunicable diseases such as obesity, diabetes, and heart disease linked to unhealthy food ecosystems affect millions of people in industrialized countries, as well as developing regions. Noncommunicable diseases also pose a grave risk to those who contract COVID-19. A study cited by the National Institutes of Health found that in the United States “nearly two-thirds

of COVID-19 hospitalizations ... could be attributed to obesity, diabetes, hypertension, and heart failure.”<sup>26</sup> Here, too, racial and ethnic minorities have borne a disproportionate burden, as they have in many aspects of the pandemic.<sup>27</sup>

Clearly, such a systemic breakdown in public health requires more expansive and systemic thinking. “To respond to the [COVID-19] pandemic we need to broaden our political imaginations,” write theorists and activists Astra Taylor and Sunaura Taylor, adding that “our conception of solidarity must cross the species barrier.”<sup>28</sup> That applies to recognizing that COVID-19 was only one in a series of zoonotic diseases that have occurred. Indeed, zoonoses make up 70% of all emerging infectious diseases.<sup>29</sup> Zoonoses occur because of increasing human encroachment on the natural habitat of wildlife, as well as breeding, confinement, and consumption of animals, whether wild or domesticated. The bush meat trade (widely thought to be the origins for Ebola and Lassa fever outbreaks in West and Central Africa) and global traffic in live, wild animals have been enabled by incursions into forested areas to extract timber and minerals or to produce palm oil, graze cattle, or grow feed crops for animals used in food production. Deforestation, and resulting displacement, have sped COVID-19 in Brazil: for each kilometer of forest lost, a 9.5% rise in COVID-19 cases among Indigenous peoples has been documented.<sup>30</sup>

Even as COVID-19 has ravaged countries around the world, avian and swine flu have also broken out in the United States and Europe. Additionally, there have been continued outbreaks of African swine fever in East Asia, which in 2019 led to the death via culling of up to 200 million domesticated pigs in China alone.<sup>31</sup> “The thing is, the next pandemic is already on its way,” writes UK-based academic and activist Alex Lockwood.<sup>32</sup> “But its causes are certain to be the same: animal agriculture, trafficked animals, destruction of animal habitats, weakened wild animals. It is up to us to act, and leverage this moment to save animal and human lives.”<sup>33</sup>

## Acting now, not when it's too late

A report on preventing the next pandemic published by the UN Environment Programme and the International Livestock Research Institute declares, “Pandemics such as the COVID-19 outbreak are a predictable and predicted outcome of how people source and grow food, trade and consume animals, and alter environments.”<sup>34</sup>

Consider this statement for a moment. What it is saying is that a commodity-based, just-in-time, globalized food system that denies basic rights to its workers and animals, disregards fundamental principles of public health, and ignores precautionary measures to prevent pathogen transmission (zoonotic or otherwise) has shown itself to be a global threat; and it's one that is likely only to intensify as the climate crisis deepens. COVID-19 has revealed industrialized animal agriculture to be rigid, flawed, and, despite its size and political and economic power, profoundly vulnerable.<sup>35</sup> And it has also shown that it is impossible to grapple with these interlinked issues without acknowledging race, class, and our disregard for or destruction of the natural world.

What is infuriating is that, by one estimate, preventive measures, such as additional protections for intact forests and wild animals, would cost a paltry 2% of the financial damage attributed to COVID-19.<sup>36</sup> Advancing other-than-human rights by cutting drastically the amount of land given over to support meat and dairy production could lessen deforestation, lower antibiotic use, reduce pollution, and conserve water and topsoil. A localized, human-scale, and diversified agricultural system, meanwhile, could secure land rights for those, such as Indigenous peoples, who were disinherited and who offer foodways and practices that might foster greater resilience as droughts lengthen, floods grow more intense, wildfires rage, and sea levels rise. Likewise, promoting environmental justice and access to rights to a healthy work environment, livable communities, and decent wages could orient land use away from extraction and exploitation toward restoration, reforestation, and biodiversity protection and resilience.

## Dismantling the silos

The intertwined realities laid bare by COVID-19 offer an opportunity for new interdisciplinary collaborations across environmental and climate policy, agriculture and food systems, biodiversity and forest protections, public health, human rights, and animal welfare and rights. Through these collaborations, powerful and practical forms of exchange and solidarity can emerge to inform praxis.

That praxis would mean dismantling the monocultures and monoliths of a broken food system and siloed priorities that assumes that “big” always means “better.” It would also forge joint policy frameworks for preparing for and preventing future pandemics that span human societies and the nonhuman world. Such collaborations could occur within and among academic institutions (faculty, researchers, and students), international bodies (such as the World Health Organization and the UN Environment Programme), policy makers (at global, national, and subnational levels), and civil society organizations.

An existing framework with relevance for a post-COVID-19 world is One Welfare, which builds on the more widely known One Health concept. As described in the *Animals' Manifesto: Preventing COVID-X*, published in December 2020, “One Welfare further eliminates silos by recognizing that linkages between human wellbeing, animal welfare and the environment affect more than just health, and indeed impact issues as diverse as food security, food safety, livelihoods, climate change, and biodiversity.”<sup>37</sup> While not specifically rights oriented, by spanning disciplines that still often don't work together, One Welfare offers some guidance for envisioning more rights-based strategies as well.

The manifesto's ambit goes beyond calling for One Welfare to detailing additional policies and actions for pandemic prevention. These include transforming farming and changing food consumption habits; ending the unnecessary exploitation of wildlife; increasing efficiencies in vaccine development; ensuring the well-being of companion and working animals; and calling for “visionary, prudent, and necessarily bold leadership

by global institutions at the center of the COVID-19 response,” including UN bodies and international financial institutions.

Other interesting frameworks are emerging from further analysis of the origins and impacts of COVID-19 and what lessons should and must be learned. One of these was incubated by the Harvard T.H. Chan School of Public Health, which convened a set of global experts for a Scientific Task Force for Preventing Pandemics at the Source. This group’s report was released in August 2021.<sup>38</sup> Its recommendations include strengthening health care systems and One Health “to jointly advance conservation, animal and human health, and spillover prevention” and to invest “in sustainable intensification of agriculture and in the prevention of crop and food waste ... to reduce biodiversity losses, conserve water resources, and prevent further land use change while promoting food security and economic welfare.”<sup>39</sup>

Another framework is a push for a formal global treaty, which would be led by the World Health Organization, to prevent future pandemics. Environmental and animal welfare researchers are working with public health experts to advocate for a focus on prevention and preparedness, not solely improving preparedness. That’s necessary, but also insufficient, as this essay has sought to argue. Four Paws, an animal welfare organization based in Vienna, convened a group of experts in the lead-up to the 2021 World Health Assembly to review the lessons from the COVID-19 pandemic and how future pandemics could be prevented. The group, of which I was a member, concluded that “zoonoses are a clear symptom of the serious crisis between humans, animals, and the environment,” pointing to live animal markets, factory farming, and fur farms as leading risk spots for the emergence of future pandemics. The Four Paws-organized *Future Study* urges policy makers to take animal welfare seriously as part of pandemic prevention plans and the “paradigm shift” required post-COVID-19. While not a rights-based instrument, this concept of a global pandemic treaty links prevention and preparedness, animal welfare, environmental protections, health care systems, justice, and equity in

provocative and yet eminently pragmatic ways.<sup>40</sup>

Realizing the potential of these three frameworks, and this moment, which is also freighted by a growing global awareness of the urgency of the climate and biodiversity crises, and the deep inequalities and infringement of rights embedded in them, will require an openness to new thinking, research, and action. Success likely depends on useful disruptions in, and a bridging of, the divides that have separated human and nonhuman rights and have limited the intersections between public health, the environment, and animal welfare and rights.

Some of this will be destabilizing for sure, but the urgency of resolving the staggering scale of the ecological crisis and advancing justice and rights demands new theory and praxis *this decade*, as climate scientists tell us, or it will be too late to avoid catastrophic planetary warming. It is a daunting challenge—perhaps unprecedented in human history. But is there another option? As Wangari Maathai, the first environmentalist and first African woman to be awarded the Nobel Peace Prize, wrote in her memoir, *Unbowed*:

*Those of us who witness the degraded state of the environment and the suffering that comes with it cannot afford to be complacent. We continue to be restless. If we really carry the burden, we are driven to action. We cannot tire or give up. We owe it to the present and future generations of all species.*<sup>41</sup>

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# Slaughterhouse Workers, Animals, and the Environment: The Need for a Rights-Centered Regulatory Framework in the United States That Recognizes Interconnected Interests

DELCIANNA J. WINDERS AND ELAN ABRELL

## Abstract

The COVID-19 pandemic has shone a bright light on industrial slaughterhouses in the United States and their impacts on the vulnerable beings—both human and animal—they exploit. But the severity of these impacts is the result of a long history of failed regulatory oversight. This paper highlights the inadequacies of the current regulatory system in the United States and how they have contributed to dangerous conditions for slaughterhouse workers, environmental degradation, and severe animal suffering. Further, it argues that a rights-centered One Health approach would provide the necessary conceptual foundation for a new regulatory framework that can meaningfully address the interconnected rights, health, and well-being of humans, animals, and the environment. As a first step in establishing this new framework, the United States should create a federal Slaughterhouse Oversight Commission to strengthen the rights, health, and well-being of humans and animals.\*

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## Introduction

When COVID-19 came to the small city of Waterloo, Iowa, where a Tyson Foods pig slaughterhouse is based, it spread quickly through the communities of slaughterhouse workers and their families, many of whom are immigrants or refugees. The impact of the Tyson outbreak was devastating to the city, disproportionately harming some of its most vulnerable community members. The desperation and fear of workers is palpable in their phone calls describing conditions at the slaughterhouse to state legislator Ras Smith, who represents Waterloo's historically Black east side: "A coworker vomited on the line and management let him continue to work ... There are eight people working in front of me and another 10 or more behind me ... I am scared I will die because of work, but I need to work to buy food for my family."<sup>1</sup> As of December 2020, between 1,500 and 1,800 of the 2,800 workers at the Waterloo slaughterhouse had been infected with the virus, and eight workers had died; with contact tracing, the cases tied to the Tyson outbreak were between 2,500 and 3,000, "making it one of the largest—if not the largest—workplace outbreaks in the country."<sup>2</sup> Although a combination of factors led to this public health disaster, the long history of failed oversight of the animal slaughter industry in the United States played a significant role in shaping the disastrous conditions at the Waterloo slaughterhouse and scores of other slaughterhouses throughout the United States.

The failure of regulatory oversight in the US slaughter industry is actually multifold, negatively affecting workers, animals, and the environment (including the communities that live near slaughterhouses). We argue that these regulatory failures are rooted in a conceptual failure to recognize the interconnection between human, animal, and environmental health and well-being and the central role of legal rights in protecting them. In this paper, we therefore make the case for a new regulatory framework governing the US slaughter industry that prioritizes protecting, strengthening, and enforcing rights to improve the health and well-being of both humans and animals. Particularly relevant rights in this context include the rights to bodily

safety; to be free from cruel, inhumane, and degrading treatment; to just and favorable conditions of work; to health; and to a healthy environment.<sup>3</sup> However, due to the disparity between legally recognized rights afforded to humans and those afforded to animals, there are admittedly practical limitations on the degree to which they can be equally enforced on behalf of workers and animals under the regulatory framework we propose. Nonetheless, we argue that it would be a significant improvement over current conditions and could serve as the initial step on a pathway to meaningful legal recognition of nonhuman interests.

This paper begins with a description of how the inadequacies of the current regulatory system contribute to dangerous conditions for slaughterhouse workers, environmental degradation, and severe animal suffering. It then argues that an expanded One Health approach that centers rights and justice for both humans and animals to maximize optimal health outcomes provides the necessary conceptual foundation for a new regulatory framework for the slaughter industry that can better address the interconnected rights, health, and well-being of humans and animals.<sup>4</sup> We conclude by proposing that the US government, as the first step in establishing this new framework, create a federal Slaughterhouse Oversight Commission.

## Industrial slaughter and the interconnected interests of workers, the environment, and animals

As the meat industry often points out, slaughter is one of, if not the, most heavily regulated points of industrial animal agriculture. Given the shocking lack of legal oversight over animal raising, this is not saying much.<sup>5</sup> Most slaughterhouse oversight focuses on food safety, and even in that space there are myriad shortcomings that are beyond the scope of this paper. As for workers, the environment, and animals, there are some laws in place that, in theory, provide at least basic rights in the form of legal protections against harm.<sup>6</sup> However, these laws are both inadequate and poorly enforced, as detailed below. It is well recognized that a right

without a remedy is no right at all, and too often that is the case for those exploited by slaughterhouses: the baseline legal rights—including labor rights and animal welfare protections—promised to humans and animals by Congress become virtually meaningless when enforcement is left solely to administrative agencies that have demonstrated a pattern of apathy at best, and at worst an affirmative desire to put industry profits over the interests of those vulnerable beings they are tasked with protecting.

### *Slaughterhouse workers*

Slaughterhouses are incredibly dangerous places to work, populated by some of the most exploited and disempowered members of society. Data from the US Census Bureau documents that the meat- and poultry-processing workforce is “overwhelmingly made up of people of color, with a large percentage of immigrants and refugees,” the vast majority of whom are noncitizens, and an unknown percentage of whom are undocumented workers.<sup>7</sup> “Immigrants are particularly overrepresented in frontline meatpacking occupations.”<sup>8</sup> They work elbow to elbow, engaged in fast, repetitive movements with sharp tools and exposed to dangerous chemicals and high noise levels. Because of their vulnerable status, these workers often do not report their injuries.<sup>9</sup> Nevertheless, reports of amputations and hospitalizations are high. As the National Employment Law Project recently noted, according to self-reported industry data—which is recognized to be an undercount—“meat and poultry workers are injured at rates on average 50% higher than all other workers in the private sector, with injury rates in red meat plants running almost twice as high.”<sup>10</sup> Injuries are not only more prevalent—they are also more severe, even when compared to other dangerous industries.<sup>11</sup> Slaughterhouse workers also suffer psychological harms that have been documented and connected to “increased rates of domestic violence, substance abuse, and post-traumatic stress disorder.”<sup>12</sup>

In addition, these workers have been especially hard hit by COVID-19—though the full scope of the impact on this vulnerable population

remains unknown. An examination of COVID-19 deaths by occupation from March to October 2020 found that death rates were the highest among food and agriculture workers.<sup>13</sup> As the US Centers for Disease Control and Prevention (CDC) has recognized, slaughterhouse conditions, including “the close proximity of workstations and prolonged contact between employees,” facilitate rapid COVID-19 spread.<sup>14</sup> According to publicly available data gathered by the Food and Environment Reporting Network, as of September 2, 2021, at least 59,148 meatpacking workers had tested positive for COVID-19 and at least 298 had died (by comparison, this same dataset documents COVID-19 infections in 18,793 food-processing workers and 13,776 farmworkers, and the deaths of 61 food-processing workers and 107 farmworkers).<sup>15</sup> According to the National Employment Law Project, “More workers have died from COVID-19 in meat and poultry plants to date during the pandemic than died from all causes in the industry in the past 15 years.”<sup>16</sup> The vast majority of these victims are racial and ethnic minorities.<sup>17</sup> Moreover, these numbers are undercounts, as state and local governments and industry alike have concealed worker illness data.<sup>18</sup> Most meat companies have not released any information about COVID-19 among their workforces, there are increasingly fewer public sources for that information, and there is no federal record.<sup>19</sup> Recognizing that COVID-19’s toll on slaughterhouse workers is likely even more extensive than previously thought, a House panel is currently investigating the issue.<sup>20</sup>

And these risks do not remain contained within slaughterhouse walls. One study linked community transmission of COVID-19 to “livestock-processing plants,” estimating the total excess COVID-19 cases and deaths associated with proximity to these plants to make up 6%–8% of all US COVID cases, and 3%–4% of all US COVID deaths as of July 21, 2020.<sup>21</sup>

Despite the high risks posed to workers and their communities, slaughterhouses resisted providing even the most basic protections during the early months of the pandemic. A *Washington Post* investigation found that three of the largest meat processors in the United States “failed to provide

protective gear to all workers, and some employees say they were told to continue working in crowded plants even while sick.<sup>22</sup> Some slaughterhouses workers were instructed to use hair nets as masks and to not use their own masks they had brought themselves.<sup>23</sup> Meat companies took out full-page ads in major newspapers suggesting that Americans would face food shortages and skyrocketing prices if slaughterhouses weren't able to conduct business as usual during the pandemic—even as they exported record levels of meat abroad.<sup>24</sup>

When worker sickness levels became so high that slaughterhouses did not have enough people to maintain operations, companies resorted to bribing and threatening sick workers to get them to return to work, and obtaining permission from the United States Department of Agriculture (USDA) to increase slaughter line speeds—even as the CDC recommended line speed *reductions*, as faster line speeds require even closer quarters and have been linked to even higher rates of COVID-19 spread (in addition to higher injury rates).<sup>25</sup>

The government agencies that are supposed to protect workers from these harms did not step in to meaningfully mitigate these harms—worse, in some instances they actively facilitated harms. As former Occupational Safety and Health Administration (OSHA) senior policy advisor Debbie Berkowitz details, OSHA denied an emergency petition to protect slaughterhouse workers and drastically reduced inspections, refusing to inspect slaughterhouses even in the face of repeated, serious COVID-19-related complaints.<sup>26</sup> Meanwhile, the CDC softened safety recommendations in response to industry pressure.<sup>27</sup> And when a local health official tried to curb a COVID-19 outbreak at a slaughterhouse by temporarily shutting down operations, the USDA intervened, contending that he had to allow the slaughterhouse to continue to operate and could not even investigate.<sup>28</sup>

### *Slaughter and the environment*

Slaughter is a resource-intensive, waste-extensive business, and its environmental impacts are disproportionately borne by low-income communities, particularly Black communities and other commu-

nities of color. Federal data show that almost half of the slaughterhouses in the United States “are in communities with more than 30 percent of their residents living beneath the poverty line (more than twice the national level),” and a third “are in places where at least 30 percent of the residents are people of color.”<sup>29</sup>

Meat processing facilities are responsible for 29% of the agricultural sector's total freshwater consumption worldwide, and the diversion of such massive amounts of water has a significant impact on wildlife and aquatic resources—impacts that are exacerbated by increasing drought conditions driven by climate change.<sup>30</sup> Slaughterhouses in the United States consume billions of gallons of water annually—and then often discard the used, polluted water directly into waterways.<sup>31</sup> A recent Environmental Protection Agency study found that “74% of [meat and poultry-processing] facilities that directly discharge wastewater to surface waters are within one mile of census block groups with demographic or environmental characteristics of concern,” indicating that these facilities may be disproportionately impacting communities of concern.<sup>32</sup> The study further found that this industry “discharges the highest phosphorus levels and second highest nitrogen levels of all industrial categories.”<sup>33</sup> Pollutants also enter drinking water supplies via runoff and groundwater seepage from agricultural fields where slaughter facilities frequently spray their waste, resulting in a host of issues, including asthma attacks, autoimmune disorders, bacterial infections, birth defects, cognitive impairment in children, cancer, gastrointestinal problems, miscarriages, and even death.<sup>34</sup> Slaughterhouse wastewater pollutants include organic matter such as blood and feces that carry pathogens like *E. coli*, antibacterial agents (which have been linked to a proliferation of antibiotic-resistant pathogens), pesticide residues, growth-promoting and other drugs, and high nutrient loads that cause algal blooms and “dead zones” in water bodies that are fatal to aquatic life and dangerous to human health.<sup>35</sup> Slaughterhouses also create large amounts of solid waste, including contaminant- and chemical-laden toxic sludges and air pollution that not

only make it impossible for nearby residents to sit outside or open their windows but cause serious health problems and contribute to climate change.<sup>36</sup>

Despite these well-documented impacts, the USDA has refused to consider the environmental impacts of its slaughterhouse policies, including policies that significantly increase pollution by increasing the number of animals slaughtered.<sup>37</sup> Moreover, many slaughterhouses routinely violate even lax federal environmental standards with impunity. An analysis by the Environmental Integrity Project found that three-quarters of US slaughterhouses examined “exceeded at least one of the pollution limits in their” Clean Water Act permits, “rack[ing] up a total of 1,142 separate violations for exceeding pollution limits”—less than 1% of which had been resolved by the Environmental Protection Agency.<sup>38</sup> And those cases that were resolved involved fines that were a minuscule fraction of the potential penalties faced, making them a cost of doing business, at most.<sup>39</sup> Yet in defending its refusal to consider the environmental impacts of its slaughterhouse policies, the USDA routinely points to slaughterhouses’ obligation to comply with federal environmental policies.

### *Animal suffering at slaughter*

Animal suffering at slaughterhouses has been well documented, including through numerous undercover investigations, whistleblower reports, and government reports. Although the Humane Methods of Slaughter Act (HMSA) mandates that slaughterhouses handle and kill livestock “humanely,” the USDA has interpreted this law to apply only to mammals, thus excluding birds—the vast majority of land animals killed for food—from even these basic protections.<sup>40</sup> The agency purports to nevertheless require humane handling and slaughter of birds under the Poultry Products Inspection Act, but its stated policy is to take action *only* if inhumane handling or slaughter rises to the level of “a process control issue,” meaning that the agency does not require humane treatment on a “bird-by-bird” basis and considers enforcement only if there is an “ongoing pattern or trend of” inhumane handling or slaughter.<sup>41</sup> As a result,

slaughterhouses have been repeatedly documented throwing and hitting chickens, even ripping their bodies from their legs, without enforcement, as well as allowing fully conscious chickens to enter scald tanks intended to remove feathers from dead birds.<sup>42</sup> These birds—about a million of them annually, according to USDA data—die from scalding or asphyxiation.<sup>43</sup>

Despite the HMSA, mammals also suffer similarly at slaughterhouses, including violent handling and being fully conscious when having their throats slit, when entering scald tanks, and even when being dismembered.<sup>44</sup> The USDA’s own Office of Inspector General has repeatedly condemned the agency’s poor enforcement of the HMSA, concluding that it “lacks assurance that inspectors working at slaughter establishments are ensuring that animals are humanely treated.”<sup>45</sup> The Government Accountability Office has likewise concluded that the USDA “cannot ensure that it is preventing the abuse of livestock at slaughter plants or that it is meeting its responsibility to fully enforce HMSA.”<sup>46</sup>

Downed animals—those who are too sick or injured to stand or walk—are especially vulnerable to inhumane handling at slaughter. For example, recent USDA records document slaughterhouse workers kicking, shocking, and dragging downed pigs to try to get them to rise.<sup>47</sup> Downed animals are also often set aside in overcrowded slaughterhouse pens for prolonged periods without water or protection from the elements.<sup>48</sup> The USDA has documented fatal trampling, frostbite, and confinement in direct sunlight when temperatures exceed 100 degrees Fahrenheit in these pens.<sup>49</sup> Downed animals also pose heightened zoonotic risks. For example, an industry-funded study found that more than half of downed pigs were actively infected with H1N1, an airborne flu virus transmissible between pigs and humans.<sup>50</sup> In 2009, H1N1 sickened 60.8 million Americans, killing 12,469 people.<sup>51</sup>

Because of the unique humane handling issues and other concerns implicated by downed animals, in 2002 Congress directed the USDA to study and report on their treatment and promulgate any regulations needed to protect these animals.<sup>52</sup> Despite the passage of nearly two decades, the agency has

yet to comply with these mandates. That same year, Congress also passed a resolution “expressing the sense of the Congress that the Humane Methods of Slaughter Act ... should be fully enforced so as to prevent needless suffering of animals.”<sup>53</sup> This precatory resolution has likewise gone unheeded by the USDA.

### *The compounding impacts of slaughter deregulation*

In recent years, rather than address these regulatory failures, the USDA has exacerbated them by deregulating slaughter, including removing or increasing line speed limits, with an explicit goal of increasing the overall number of animals slaughtered annually by millions.<sup>54</sup> These production increases lead to even greater demands on natural resources, more pollution, and more animal suffering.<sup>55</sup> And faster line speeds increase the likelihood that animals will be violently handled and will be conscious when having their throats slit and entering the scald tank, as well as the likelihood that workers will be injured.<sup>56</sup> Because faster line speeds aggravate harms to workers, animals, and the environment, they underscore the interconnectedness of these interests.

### Slaughter and an expanded One Health approach

#### *Need for an expanded One Health framework*

As we argue below, the current regulatory framework’s failure to protect workers, animals, and the environment underscores the need for a new regulatory approach. However, any new regulatory apparatus would risk reproducing the same harms if it is not guided by an alternative paradigm that recognizes the interconnection and interdependency of human, animal, and environmental health. Emerging almost two decades ago out of growing concern over the danger of a global pandemic stoked by the emergence of zoonotic diseases such as SARS and avian influenza, the “One Health” concept is a public health policy approach based on the interconnected health of people, animals, plants, and the environment.<sup>57</sup> The CDC defines

One Health as “a collaborative, multisectoral, and transdisciplinary approach—working at the local, regional, national, and global levels—with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment.”<sup>58</sup> Similarly, the World Health Organization defines One Health as “an approach to designing and implementing programs, policies, legislation, and research in which multiple sectors communicate and work together to achieve better public health outcomes.”<sup>59</sup> The One Health approach is essential to effective public health policy efforts, a fact only underscored by the COVID-19 pandemic. However, One Health’s potential for improving the health and well-being of humans, animals, and the environment at every scale has yet to be fully realized, with application of the approach focused primarily on issues such as food safety, antibiotic resistance, and targeted zoonoses.<sup>60</sup>

One path through which the One Health approach could more effectively deliver on its intended goals entails recognizing rights and justice as fundamental priorities in achieving health policy goals. As philosopher Joachim Nieuwland observes, “human rights are not a prominent part of discussions on [One Health]. This absence is alarming considering the fact that human rights reflect the basic entitlement of justice.”<sup>61</sup> By centering rights and justice for humans and animals as the primary mechanisms for realizing optimal health outcomes, an expanded One Health approach would enable a more effective and impactful realization of One Health’s potential by enlarging its focus to a broader range of social and environmental contexts, including the prevention of physical and mental trauma to individual humans and animals in the industrial food system. Rights are essential to this approach precisely because they shape and are shaped by the same interspecies connections that are so influential on the health and well-being of humans and animals.

Slaughterhouses in the United States provide an exemplary model of how human and animal rights are as interconnected as human and animal health. As the problems outlined above demon-

strate, the deprivation of even basic legal protections for animals in the slaughterhouse setting negatively impacts the rights of human workers as well. On the other hand, implementing policies that recognize and strengthen animals' rights would also improve the health and well-being of workers. We thus argue that protection measures grounded in this recognition are a necessary (though not sufficient) condition for ameliorating many of these harms.

The interconnected harms described here can be completely eliminated only by ending industrial slaughter entirely. However, safeguarding and strengthening rights in the regulation and oversight of slaughterhouse work would provide an essential and obtainable form of harm reduction in the short term, as well as a platform on which to build more robust protections.

### *Integrating an expanded One Health approach into slaughter regulation*

In her analysis of how the regulation of slaughter line speeds in Canadian slaughterhouses negatively impacts both humans workers and animals, legal scholar Sarah Berger Richardson illustrates how “regulatory decisions in food safety governance have profound implications on animal welfare and occupational health and safety,” and when these decisions “discount social-cultural and moral perspectives about how workers and animals should be treated in the decision-making process, real harm results.”<sup>62</sup> Considering how the safety and health of animals, human workers, and (indirectly through meat products) consumers are all affected by conditions such as the speed of the slaughter line, she argues that it is “imperative to take seriously the interconnectedness between all three and the social impacts of the acceleration of [slaughter] on the well-being of humans ... and animals that meet on the kill floor.”<sup>63</sup> A One Health approach that prioritizes the interests of the human and animal rights-bearers on the kill floor, albeit constrained by the practice of slaughter itself, is a prerequisite to any regulatory system that can begin to adequately address these concerns.

The current regulatory framework, ostensibly intended to protect the health and well-being

of workers, animals, and consumers in the US slaughter industry, is frequently undermined by the USDA's primary mandate to promote US agricultural production, leading to the prioritization of industry economic interests and the enabling of extensive externalization of ecological, animal, and worker and public health costs. Take food safety, for example. As Berger Richardson observes in the Canadian context (which shares many parallels with US slaughter regulation), “A fast-paced and efficient assembly line is central to modern industrialized methods of meat production,” so the meat processing production line is designed to “disassemble an animal into food as quickly as possible.”<sup>64</sup> Within this context, “food safety is defined negatively. Safety is assessed on the basis of the absence of hazards, with little guidance as to the positive attributes that we want in our food.”<sup>65</sup> However, this approach “results in a failure to account for other tangential harms, societal or environmental, associated with production methods. Consequently, even the most thorough study of the impact on microbial safety of speeding up or slowing down production lines can rule out corresponding risks for workers and animals as outside its jurisdiction.”<sup>66</sup>

Most recently, the waiving of line speed restrictions during the COVID-19 pandemic has exposed human workers to greater risk of both injury and viral infection while exposing animals to increased risk of severe suffering, including from having their throats slit and entering scald tanks while still conscious, not to mention increased food safety risks as a result of meat contamination.<sup>67</sup> The USDA's approval of an unprecedented number of line speed waivers coincided with former US President Donald Trump—citing concerns about potential liability to meatpacking corporations—signing an executive order in April 2020 to use the Defense Production Act to give slaughterhouses cover to stay open. These actions were taken despite the obvious danger to workers as slaughterhouses rapidly became significant hubs of infection early in the pandemic. In fact, meat companies knowingly fueled the virus's spread by intentionally concealing early cases among workers while requiring employees to work in close proximity without any

protection.<sup>68</sup> A lawsuit filed against Tyson Foods, for example, alleged that managers at the Waterloo pig slaughterhouse described above not only misled employees about the risk of COVID-19 exposure but even bet on how many workers would be sickened by the coronavirus.<sup>69</sup> As Berger Richardson notes, the “prevalence of COVID-19 among slaughterhouse workers should come as no surprise ... With COVID-19, dangerous working conditions were made worse.”<sup>70</sup>

A regulatory framework prioritizing rights, particularly the rights of both humans and animals, and recognizing the fundamental interdependence of human and animal health would have led to radically different policies during 2020–2021, which likely would have prevented human and animal suffering that was instead aggravated by the current regulatory system. An expanded One Health approach to slaughterhouse regulation would have not only prevented line speed limit waivers but also drastically curtailed current speeds. Similarly, the obvious necessity of closing slaughterhouses entirely until companies could implement social distancing measures, ventilation infrastructure, and access to personal protective equipment would have likely led to much lower infection rates at US slaughterhouses and the communities they are situated in. Of course, the meat industry would have experienced financial impacts from such policies, but a rights-centered approach to human and animal health would have enabled policymakers to clearly identify and follow courses of action that prioritized rights, health, and well-being without the distraction of industry interests seeking to skew that process toward policies that maximize profit at the expense of vulnerable humans and animals.

To facilitate such a shift in policy priorities, though, we must stop looking to the USDA to provide protections that conflict with its primary mandate: the support of US agricultural industries. Historically, the USDA has had primary responsibility for slaughterhouse oversight, a responsibility that its own Office of Inspector General has found it to have failed to take seriously. It should perhaps come as no surprise that an agency whose primary mandate is to promote agriculture has a tepid—at

best—interest in regulating agribusiness. In other words, the USDA is structurally unable to meaningfully implement anything like an expanded One Health approach to slaughterhouse regulation because doing so is incompatible with its goal of industry support. In the United States and around the globe, the meat industry is one in which “vulnerable animals are often slaughtered by some of society’s most vulnerable humans.”<sup>71</sup> For policies that reduce that vulnerability and improve the well-being of both humans and animals, we need a regulatory agency that can embrace the principles of an expanded One Health approach to the fullest extent possible within a context that still allows the slaughter of animals.

### *Proposing a federal Slaughterhouse Oversight Commission*

The gross failure of our federal laws and agencies to protect even the most basic interests of workers, the environment, and animals from the myriad harms inflicted by slaughterhouses—and, indeed, the role of these agencies in actively disregarding the interests of these stakeholders to facilitate greater industry profits—warrants urgent attention. The COVID-19 pandemic has aggravated the longstanding plight of slaughterhouse workers, while simultaneously giving industry cover to further disregard worker interests, including in ways that inflict further harms on animals and the environment, such as faster line speeds.

Scholar Jeff Welty has recommended that responsibility for HMSA enforcement be removed from the Food Safety and Inspection Service of the USDA and given to the Animal and Plant Health Inspection Service (APHIS), another USDA sub-agency, citing APHIS’s existing responsibilities under the Animal Welfare Act and lack of ties to agribusiness.<sup>72</sup> However, given APHIS’s chronic failure to adequately enforce the Animal Welfare Act and its focus on treating regulated entities as “customers” to whom it provides “services,” we strongly disagree with this recommendation.<sup>73</sup>

David Cassuto and Cayleigh Eckhardt have expanded on Welty’s passing alternative suggestion of a new, standalone agency, proposing the creation

of an entirely new—and, importantly, independent—federal agency, which they tentatively call the “Animal Welfare Agency.”<sup>74</sup> For many reasons—some addressed in this paper, including the USDA’s failure to adequately enforce the HMSA, refusal to apply that statute beyond mammals, and failure to adequately protect birds from inhumane handling under the Poultry Products Inspection Act—and others beyond the scope of this paper, we strongly support the creation of an independent animal protection agency. Assigning primary HMSA responsibility to such an agency would help ensure that protecting animals does not take a back seat to promoting agriculture. Moreover, greater protections for animals at slaughter would frequently align with safer conditions for workers and the environment. For example, slower line speeds reduce the likelihood of both animal suffering and worker injuries, while also limiting overall production, which translates to reduced resource demands and pollution.

The creation of an entirely new federal agency—especially one that will likely meet opposition by agribusiness—will take significant time and resources. It is a worthwhile endeavor, but the irreversible harms being inflicted daily on workers, the environment, and animals by slaughterhouses need timely attention. Moreover, as detailed in this paper, workers and the environment also suffer discrete and serious harms inflicted by slaughterhouses that, though they may be mitigated by an animal protection agency, warrant closer scrutiny and swift remedial attention in their own right. The interconnected interests implicated by slaughterhouses call for an integrative regulatory approach.

Accordingly, we recommend the creation of a Slaughterhouse Oversight Commission that is tasked with applying, to the fullest extent possible within the context of animal slaughter, an expanded One Health framework to investigate, report on, and make recommendations regarding the issues set forth in this paper. Of course, numerous nonprofit organizations are already engaged in investigations, reports, and recommendations related to these issues—indeed, many of them are cited and relied upon herein. But none of them address the

issues holistically. Moreover, these private bodies lack the ability to readily access the information needed to fully assess these issues. A government commission, by contrast, could be fully empowered to issue subpoenas. Recommendations from a federal commission would also carry more weight. Furthermore, federal commissions are uniquely positioned to facilitate cross-agency collaborations and communications, which is especially important in the context of slaughterhouses, given the overlapping responsibilities of various federal agencies, including the USDA, OSHA, and Environmental Protection Agency.

There is ample precedent for such an approach, including the US Commission on Civil Rights, Marine Mammal Commission, and many more. Admittedly, no such commission has taken an explicitly interconnected approach. But no other issue has called out so clearly for such an approach. And never before in our history has the overlapping nature of human, animal, and environmental interests been so clear. Indeed, such a commission could serve as a model for tackling other issues affecting the health of humans, animals, and the environment.

There is also existing momentum that could be seized, including from the House Committee on Appropriations’ March 2021 Hearing on Health and Safety Protections for Meatpacking, Poultry, and Agricultural Workers; the Select Subcommittee on the Coronavirus’s ongoing investigation into widespread coronavirus infections and deaths in meatpacking plants; and strong coalition work by animal, consumer, environmental, and worker protection advocates against the deregulation of slaughter.<sup>75</sup> As Berger Richardson observes, “the pandemic has created a unique policy window to address systemic problems with the way animals are currently slaughtered for food; a policy window that should be seized.”<sup>76</sup>

## Conclusion

The dual, and intertwined, impacts of the COVID-19 pandemic and line speed increases on slaughterhouses and the vulnerable beings they

exploit have shone a bright light on the usually hidden world of industrial animal slaughter. These recent developments have exacerbated an already bad situation for workers, animals, and the environment, but in doing so have garnered unprecedented attention—attention that highlights the interconnected nature of human, animal, and environmental health and well-being and the central role of rights in protecting them. This unique historical moment is an opportunity to take a novel regulatory approach that recognizes the interconnection and interdependency of human, animal, and environmental health. A rights-centered and expanded One Health approach provides the necessary conceptual foundation for a new regulatory framework for the slaughter industry that can better address the interconnected rights, health, and well-being of humans and animals.

### \*Postscript

As this article went to print, two significant developments unfolded that underscore the need for a rights-centered regulatory framework in the United States that recognizes the interconnected interests of slaughterhouse workers, animals, and the environment. First, the House Select Subcommittee on the Coronavirus issued a damning report finding that COVID-19 deaths and infections among slaughterhouse workers were up to three times higher than previously thought, that meatpacking employers prioritized profits and production over worker safety, that the government agencies charged with protecting these workers failed to do so, and that minority workers were disproportionately impacted.<sup>77</sup> Second, the US Department of Agriculture announced the launch of a new trial program allowing pig slaughterhouses to operate without line-speed limits so long as they implement baseline worker safety measures and assess worker impacts, but without any special requirements regarding animals or the environment.<sup>78</sup>

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# One Health, COVID-19, and a Right to Health for Human and Nonhuman Animals

LAURIE SELLARS, KIMBERLY BERNOTAS, AND JEFF SEBO

## Abstract

COVID-19 is a reminder that human, nonhuman, and environmental health are linked, and so efforts to improve human, nonhuman, and environmental health should be linked as well. But current efforts to link these issues fall short by not doing enough for humans, not doing enough for nonhumans, and focusing narrowly on health instead of expansively on health, welfare, and rights. This paper surveys the case for respecting and promoting human and nonhuman welfare, health, and rights simultaneously. It then surveys the impacts of COVID-19 on human and nonhuman populations and proposes steps that humans can take to respect and promote human and nonhuman health, welfare, and rights ethically and effectively in this context.

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## Introduction

COVID-19 makes all too apparent the many links between human and nonhuman health, welfare, and rights. While stories about the origin of COVID-19 vary, one common story is that COVID-19 originated in bats, then spread to other animals, then spread to humans at a live market in Wuhan, China.<sup>1</sup> More generally, wild animals carry an estimated 10,000 viruses that have the potential to spread to humans.<sup>2</sup> Human exploitation and extermination of animals in factory farming (that is, intensive animal farming), deforestation, the wildlife trade, and other such industries not only increase the risk that existing diseases will spread but also increase the risk that novel diseases will develop.<sup>3</sup>

As a result of these links, many people now support One Health, a policy framework that seeks to promote human, nonhuman, and environmental health simultaneously. According to this framework, since human, nonhuman, and environmental health are linked, efforts to promote human, nonhuman, and environmental health should be linked as well.<sup>4</sup> For instance, many people believe that we should reform practices such as factory farming, deforestation, and the wildlife trade to reduce the risk of disease spread.<sup>5</sup> Many people also believe that we should learn more about nonhuman health so that we can learn more about human health and improve nonhuman health so that we can improve human health.<sup>6</sup>

For all these reasons, One Health is a step in the right direction. At the same time, One Health, as standardly interpreted, is not enough to address all the risks of health threats such as pandemics. It falls short for humans, since it does not do enough to mitigate the risks that factory farming, deforestation, the wildlife trade, and other such practices impose on humanity, and it fails to recognize the connections between human health and human rights. It also falls short for nonhumans, since it treats nonhuman health as important primarily for the sake of humans rather than primarily for the sake of nonhumans, and, as with humans, it fails to recognize the connections between nonhuman health and nonhuman rights.

This paper argues that the COVID-19 pandemic illustrates the need for an expanded One Health. In particular, not only does human use of nonhumans increase the risk of health threats such as pandemics, but health threats such as pandemics also increase nonhuman suffering, both directly, via outbreaks, and indirectly, via increased exploitation and extermination of nonhuman animals. Thus, mitigating and adapting to health threats such as pandemics requires thinking about human and nonhuman health, welfare, and rights holistically and structurally, so that we can develop solutions that improve lives across species rather than improving some lives by worsening others.

We begin the paper by making the case for human and nonhuman legal rights, including a human and nonhuman legal right to health. We then survey the limits of One Health for human and nonhuman health, welfare, and rights. Next, we examine the impacts that the COVID-19 pandemic has had on captive and wild animals. Finally, we outline a series of steps that the international community can take to respect and promote human and nonhuman health, welfare, and rights simultaneously. Since our aim is to show the connections across many issues, we aim for breadth rather than depth in this paper. But we hope that this general discussion will be useful for framing and motivating next steps.

## A human and nonhuman right to health

The human right to health is enshrined in international law, arising from the International Covenant on Economic, Social and Cultural Rights (ICESCR). This treaty, adopted by the United Nations General Assembly in 1966, commits member states to granting humans a wide range of legal rights, including the rights to work, family, education, health, and an adequate standard of living.<sup>7</sup> This treaty is part of the International Bill of Human Rights, which also includes the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights.<sup>8</sup> While far from perfect, these documents together establish a strong commitment to human health, welfare, rights, and justice.

The human right to health in the ICESCR is stated in particularly strong terms. It recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”<sup>9</sup> It also commits member states to the pursuit of concrete steps toward this goal, including the reduction of infant mortality, the improvement of the environment, the prevention of outbreaks, and the “creation of conditions which would assure to all medical service and medical attention in the event of sickness.”<sup>10</sup> These commitments are important, since they make clear that improving public health requires a combination of individualized care and structural change that makes individualized care less necessary.

As with many modern legal rights documents, the ICESCR states that these human rights are grounded in our shared humanity. For example, the document recognizes “the inherent dignity” and “equal and inalienable rights of all members of the human family,” as well as “the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms.”<sup>11</sup> This language implies that all and only members of the species *Homo sapiens* merit legal rights and that humans merit these legal rights by virtue of their species membership. In fact, the document makes this idea explicit by stating that “these rights derive from the inherent dignity of the human person.”<sup>12</sup>

Seen from one perspective, the idea that all and only humans merit legal rights is highly progressive. In a world where humans harm, kill, and neglect one another on a regular basis, the aspiration to treat *all* humans with “inherent dignity” and “inalienable rights” is important. However, seen from another perspective, the idea that only humans merit legal rights is not nearly progressive enough. In a world where humans harm, kill, and neglect nonhuman animals on a regular basis as well (and at a much higher scale), the aspiration to treat *only* humans with “inherent dignity” and “inalienable rights” erases more than 99% of the victims of human activity, including captive and wild animals.

In part for this reason, many moral, legal, and

political theorists are now starting to challenge the assumption that only humans can have legal rights.<sup>13</sup> According to these scholars, membership in the species *Homo sapiens* is not an acceptable basis for legal rights. Species are nothing more than abstract taxonomic categories that scientists use to explain particular facts about evolution, cognition, and behavior. There is significant variation within species, significant overlap across species, and significant change in species over time. There is no good reason to hold that membership in this kind of taxonomic category can, in itself, be necessary or sufficient for possession of legal rights, including the right to health.<sup>14</sup>

Similarly, according to these scholars, membership in the species *Homo sapiens* is not acceptable as a necessary condition for legal rights. One might think that only humans can have legal rights because abstract language and reason are necessary for legal rights, and only humans have abstract language and reason. But whether or not this claim about language and reason is true, the claim about legal rights is false. For instance, humans develop the capacity for language and reason only gradually, some lose this capacity later in life, and others never develop it at all. Yet even if humans lack *legal duties* in these moments, they still have *legal rights* in these moments, because they still have relevant interests and needs.<sup>15</sup>

What these considerations reveal is that if someone has interests and needs, then they merit legal rights that protect their interests and needs. And while animal rights scholars might disagree about what it takes to have interests and needs in the relevant sense, they generally agree that consciousness, emotionality, a sense of self, or bonds of care are sufficient. This conception of legal rights includes all humans without treating membership in the species *Homo sapiens* as the basis of legal rights. Yet it also includes many nonhumans, including the billions of captive animals and the trillions of wild animals humanity kills each year, since, after all, many of these animals have relevant capacities and relationships as well.<sup>16</sup>

While there are many other views to consider, the general upshot is that there is no non-arbitrary

conception of the basis for legal rights that includes all and only humans. The species membership view includes all and only humans in an arbitrary way, and alternative views can include *all* humans or *only* humans, but not both. And while a view that includes only humans might initially seem tempting, this kind of view is ultimately incompatible with the idea of universal human rights and justice. Thus, the only acceptable kind of view about the basis for legal rights is one that includes human and nonhumans alike, since only this kind of view is both non-arbitrary and compatible with the idea of universal human rights and justice.<sup>17</sup>

Of course, to say that humans and nonhumans alike should have legal rights is not to say that they should have all the same legal rights, or that they should all have legal rights of the same strength. For example, insofar as members of different species have different interests, needs, and vulnerabilities, they might merit different legal rights accordingly. Moreover, insofar as members of some species have stronger interests, needs, and vulnerabilities than members of other species, they might merit stronger legal rights with respect to those interests, needs, and vulnerabilities accordingly. So, there is no risk that extending legal rights to humans and nonhumans alike will collapse legally relevant distinctions among them.<sup>18</sup>

In any case, while nonhuman animals might not have an interest in, or need for, all the legal rights contained within the ICESCR, they do have an interest in, and need for, mental and physical health. For humans and nonhumans alike, mental and physical health are basic goods that facilitate the pursuit of many other goods, and achieving the highest attainable standard of mental and physical health requires a combination of individualized care and structural change.<sup>19</sup> So insofar as nonhuman animals merit legal rights at all, a right to health as described in the ICESCR is plausibly among them. It is worth asking what it might mean to respect such a legal right—and how far away humans are from doing so at present.

## The nature and limits of One Health

One Health is a policy framework that seeks to promote human, nonhuman, and environmental health simultaneously. For example, the Food and Agricultural Organization of the United Nations describes One Health as an “integrated approach” that recognizes that “the health of animals, people, plants and the environment is interconnected,” and it claims to promote One Health “in work on food security, sustainable agriculture, food safety, antimicrobial resistance (AMR), nutrition, animal and plant health, fisheries, and livelihoods.”<sup>20</sup> While One Health can improve our understanding of many practices, it will be enough for present purposes to consider three: factory farming, deforestation, and the wildlife trade.

Take factory farming first. Humans currently breed and kill more than 100 billion farmed animals (land and aquatic) annually for food.<sup>21</sup> Not only does this practice harm nonhumans, but it also harms humans in many ways. For example, many factory farms dump untreated waste in local environments, causing workers and community members to suffer from mental and physical health impacts.<sup>22</sup> Additionally, since factory farms place nonhuman animals in close proximity with one another in cramped, toxic environments, and since many factory farms also use antibiotics to prevent the spread of disease, they create the ideal conditions for antimicrobial resistant pathogens to develop and spread.<sup>23</sup>

Now, take deforestation. Humans have already cleared an estimated 40% of forested land for agriculture and other purposes, and rates of deforestation are increasing in many regions.<sup>24</sup> Not only does deforestation harm many animals—an estimated 80% of terrestrial species live in forests—but it also harms humans in many ways.<sup>25</sup> For example, deforestation can pollute the land, water, and air near forests, harming humans who rely on these natural resources for food, water, or income. It also increases the risk of zoonotic disease spread by increasing interaction between humans and nonhumans and by reducing biodiversity, which

functions as a buffer for the spread of zoonotic diseases.<sup>26</sup>

Finally, take the wildlife trade. Humans capture many wild animals—potentially trillions, if we count aquatic animals—to sell for food, medicine, and other purposes every year. This activity harms many nonhumans, who suffer during capture, transport, captivity, and interactions with humans. It also harms many humans, since it increases the risk of zoonotic disease spread, not only to new nonhuman populations but also to human populations.<sup>27</sup> Indeed, as noted in the introduction, the wildlife trade might be complicit in the COVID-19 pandemic, since the virus might have spread from a wild animal to another animal, and then spread again to humans in a live market, via the wildlife trade.

Importantly, COVID-19 is not the only disease that might have spread to humans through our treatment of other animals. The 2009 H1N1 pandemic, the 2003 SARS epidemic, and many other outbreaks seem to have resulted from practices that involve harming and killing animals in these ways as well.<sup>28</sup> Moreover, these risks are linked. For instance, since animal agriculture is a leading contributor to deforestation, it increases the risk of pandemics not only directly, via its use of antibiotics and intensive confinement, but also indirectly, via its contribution to biodiversity loss and human-nonhuman contact.<sup>29</sup> We need to think about these issues holistically and structurally to see all these links clearly.

Part of what makes One Health powerful, then, is that it draws attention to how practices such as factory farming, deforestation, and the wildlife trade are harming humans and nonhumans simultaneously, and, as a result, it draws attention to the need for solutions that can reduce and repair harms for humans and nonhumans simultaneously. That said, standard interpretations of One Health are limited in at least three related ways.<sup>30</sup> They do not do enough for humans, they do not do enough for nonhumans, and they focus narrowly on health rather than more expansively on health, welfare, and rights. This includes human welfare and rights as well as nonhuman welfare and rights.

First, One Health, on standard interpretations, does not do enough for humans. While many people use the One Health framework to advocate for reforms to harmful practices, such as limits on antibiotic use, these reforms are not enough to solve the problem.<sup>31</sup> For example, part of how factory farming impacts global health is through antibiotic use, but another part of how it impacts global health is by producing too much waste for the planet to absorb and by contributing to the health risks involved with deforestation.<sup>32</sup> Unless we are willing to not only *reform* but also *reduce* or *replace* our use of animals for food and income, there is a limit to how much progress we can make for human health.

Second, One Health, on standard interpretations, does not do enough for nonhumans. One Health treats nonhuman animals as having only instrumental value. On this approach, humans should learn about nonhuman health to learn about human health as a result, and humans should improve nonhuman health to improve human health as a result. But humans might not have reason to learn about nonhuman health or improve nonhuman health otherwise. As a result, humans might not only neglect nonhuman health in many cases, but might also harm nonhuman health in many cases, for instance by “culling” farmed animals or wild animals when doing so appears to benefit human health.

Third, and relatedly, One Health, on standard interpretations, focuses narrowly on health rather than expansively on health, welfare, and rights. When human health is seen as merely a good to promote rather than a basic right, it might seem easier to sacrifice in many cases. Similarly, when nonhuman health is seen merely as a good to promote *for humans* rather than a basic right *for nonhumans*, it might seem *much* easier to sacrifice in many cases. In order to promote human and nonhuman health in the right kind of way, then, humans must view this project not only as a matter of promoting human health but also as a matter of respecting human and nonhuman legal rights, including a legal right to health.<sup>33</sup>

The upshot is that assessing the impacts of

global health threats such as pandemics requires assessing the impacts on human and nonhuman health, welfare, and rights together. This includes not only the impacts of outbreaks but also the impacts of related disruptions. To see how this might work, the next four sections examine some of the impacts of COVID-19 on animals. In particular, we show that COVID-19 has impacted animals not only by exposing them to zoonotic disease but also by both increasing and decreasing human neglect, exploitation, and extermination of particular animals. We need to consider all these impacts, good and bad, to know how to proceed.

### COVID-19 and farmed animals

In April 2020, reports of widespread COVID-19 infections among US slaughterhouse workers—many of whom are low-income people, people of color, or undocumented immigrants who do not have easy access to health care—began to emerge.<sup>34</sup> The conditions in meat-processing plants facilitate the rapid spread of airborne pathogens: workers typically stand close to one another during long shifts and might also share transportation and housing.<sup>35</sup> As of September 2, 2021, at least 59,148 meatpacking workers, 18,793 food-processing workers, and 13,773 farmworkers had contracted COVID-19 and at least 466 workers in those industries had died from COVID-19 in the United States alone.<sup>36</sup> There is evidence that this industry fueled significant community spread far beyond plant workers as well.<sup>37</sup>

Many other countries experienced similar problems. For instance, at least 1,000 humans associated with mink farms or mink pelting have contracted COVID-19 in Europe.<sup>38</sup> Transmission between minks and humans has also produced variants of COVID-19, some of which may be less susceptible to antibodies.<sup>39</sup> Farmers and workers have endured other hardships during this time as well. For instance, many farmers needed to “cull” farmed animals due to slaughterhouse shutdowns and reported experiencing mental health issues as a result.<sup>40</sup> Many have also experienced economic hardship, since they lost income during shutdowns, though many received compensation for

these losses.<sup>41</sup>

COVID-19 has also had profound impacts on farmed animals, some of which have been more salient for humans than others. The pandemic disrupted the transport and slaughter of animals used for food. For instance, border shutdowns in Europe created long queues of trucks transporting live animals internationally, and some animals were subjected to waiting periods of up to 18 hours.<sup>42</sup> Additionally, when farmers had to “cull” farmed animals due to temporary slaughterhouse closures, many used particularly brutal methods: for example, animals were gassed, shot, overdosed, electrocuted, beaten, suffocated, and subjected to ventilation shutdowns, among other methods.<sup>43</sup>

This pandemic has been particularly impactful for farmed animals who are vulnerable to contracting COVID-19.<sup>44</sup> For example, minks can contract, spread, and suffer and die from COVID-19, and they are particularly vulnerable in factory farms, since they are forced to live in cramped conditions and are already vulnerable to disease.<sup>45</sup> As a result, thousands of minks have died from the virus, and millions more have been “culled.”<sup>46</sup> For instance, in the largest cull of the pandemic to date, the Danish government recommended the extermination of approximately 17 million minks after discovering that a mutated COVID-19 variant was transmitted from minks back to humans.<sup>47</sup>

COVID-19 has also impacted fisheries and aquaculture.<sup>48</sup> Restaurant shutdowns decreased demand for seafood, and restrictions disrupted fishing industry supply chains. Many commercial fishing activities were reduced, and global fishing activity had decreased by 6.5% in April 2020 compared to previous years. COVID-19 restrictions have also hampered fisheries assessments, forcing scientists to postpone observation programs and management meetings. Meanwhile, the impact on aquaculture has varied by region, the fishes farmed, and characteristics of individual farms. Aquaculturists unable to sell fishes face increased feeding costs to keep fishes alive, leading some to implement growth-slowing measures to conserve supplies.<sup>49</sup>

## COVID-19 and lab animals

As of September 8, 2021, approximately 41.1% of the global population had received at least one dose of a COVID-19 vaccine.<sup>50</sup> The vaccine is an incredible accomplishment, and to the degree that animal research was necessary to accomplish this goal, we should count that as a benefit of animal research. At the same time, we can question whether animal research was, in fact, necessary to accomplish this goal. After all, nonhuman health is an unreliable model for human health, and so we can expect this research method to regularly produce false positives and negatives for both efficacy and toxicity.<sup>51</sup> In addition, the wide range of presentations of COVID-19 made the task of identifying analogous animal models particularly difficult.<sup>52</sup>

Moreover, not only is animal research potentially unreliable (as well as increasingly outdated as other methods, such as organ-on-a-chip research, become available), but it can also slow vaccine development.<sup>53</sup> In general, animal research during preclinical stages of vaccine development can take anywhere from 18 to 30 months.<sup>54</sup> As a result, the first two vaccine candidates to be approved for use in the United States “skipped” this preclinical phase entirely and instead tested vaccines on human and nonhuman animals concurrently.<sup>55</sup> The success of running these trials concurrently raises the question of whether the resources used to run animal trials might have been better spent elsewhere.

In any case, in addition to asking how much good animal research does, we also need to ask how much harm animal research does, as well as whether animal research violates rights. According to the US Centers for Disease Control and Prevention, experimental research related to COVID-19 has involved cats, dogs, ferrets, fruit bats, hamsters, tree shrews, mice, pigs, chickens, and ducks.<sup>56</sup> Researchers have also infected nonhuman primates, including rhesus and cynomolgus macaques, grivets, and common marmosets with COVID-19 to try to model human infection.<sup>57</sup> And while not all animals infected with COVID-19 become sick, many—including common marmosets, cynomolgus macaques, ferrets, grivets, hamsters, and rhesus macaques—do.<sup>58</sup>

Humans have harmed nonhumans in other ways in the course of producing COVID-19 treatments and vaccines. For instance, squalene, a boosting agent harvested from shark livers, is used in at least one major vaccine candidate.<sup>59</sup> Blood harvested from horseshoe crabs was used to test COVID-19 vaccine candidates too.<sup>60</sup> That said, determining the net effects on sharks and horseshoe crabs is difficult. For instance, drug makers have stated that squalene is harvested from sharks caught for other purposes but are not transparent about their suppliers.<sup>61</sup> They have also stated that COVID-19 will not unduly burden horseshoe crab populations, but even if so, it would still be harming horseshoe crabs.<sup>62</sup>

The pandemic has also impacted lab animals who were not used in COVID-19 research, with mixed results for the animals. For instance, in the spring of 2020, universities reduced on-site activity to meet social distancing requirements during the pandemic.<sup>63</sup> With fewer staff to care for lab animals, many institutions reportedly exterminated them.<sup>64</sup> Such killings occur when experiments are completed in normal times, but the pandemic led to unusually large culls. However, determining the net effects of these changes on animals is difficult, since, as with farming, it can be difficult to tell whether an earlier death is good or bad for animals who would be used, harmed, and killed for human purposes either way.

## COVID-19 and companion animals

At the start of COVID-19, companion animals were reportedly a source of stress for many humans. For instance, many humans were concerned that companion animals might be vectors for COVID-19 and that they might expose humans and nonhumans alike to COVID-19. Many other humans were concerned that they might not be able to properly care for companion animals, for instance due to illness, death, or economic hardship. At the same time, companion animals were reportedly a source of relief for many humans during a difficult time. If nothing else, the opportunity to spend more time with one’s family, including companion animals,

can make an otherwise isolating time easier to endure.

Some companion animals have benefited from the COVID-19 pandemic, while others have suffered. Fosters, adoptions, and sales of companion animals have increased during the pandemic, to the point where many shelters and rescues have struggled to keep up with the demand.<sup>65</sup> As a result, many companion animals have benefited from adoption and from spending more time with human guardians. But even in cases where animals benefit from increased interaction, there is a risk that many will experience separation anxiety when humans spend less time at home after the pandemic. There is also a risk that many will be abandoned after the pandemic, though the extent of this risk is not yet clear.<sup>66</sup>

Additionally, not all companion animals have benefited from increased interaction during the pandemic. First, while many humans ordinarily see companion animals as family, we can easily switch to seeing companion animals as “pests” during a pandemic. And even though COVID-19 appears to be rare, mild, and asymptomatic in companion animals, a fear of disease can still increase the risk of violence or abandonment.<sup>67</sup> At the start of the pandemic, fear of contracting COVID-19 led to a rise in abandonments in some countries.<sup>68</sup> In many cases, this fear also made it difficult for human guardians who contract COVID-19 to find temporary homes for their companion animals during quarantine and recovery.<sup>69</sup>

Relatedly, when humans suffer during a pandemic, companion animals can suffer as well. For instance, when humans contracted COVID-19 at the start of the pandemic, many companion animals were taken in by shelters.<sup>70</sup> The social, psychological, and economic impacts of COVID-19 can also increase risks for companion animals. For example, while many companion animals might enjoy additional affection from humans, many others might be overwhelmed by additional affection, and, of course, some might also experience additional abuse. Moreover, an economic recession can increase rates of surrender or euthanasia of companion animals as humans are no longer able

or willing to properly care for them.<sup>71</sup>

Animal rescues and shelters—along with institutions like sanctuaries—can face other problems during a pandemic too. When social and economic disruptions occur, these institutions can be particularly vulnerable because of how much they depend on donations and volunteers. With fewer donations, there will be less compensation for staff and less food and medicine for animals. And with fewer volunteers, there will be less support for staff and care for animals. As a result, as in all of the other cases discussed above, a pandemic can lead not only to increased deprivation for animals in captivity but also, as a result, to increased rates of euthanasia when no alternatives are available.

## COVID-19 and wild animals

In some respects, the COVID-19 pandemic has had the same effects on wild animals as companion animals, but in other respects, it has had the opposite effects. For instance, whereas social distancing might lead to increased interaction with many companion animals, it might lead to decreased interaction with many wild animals. This can be good for humans in some ways but bad for us in other ways. When there are fewer cars on the road, we benefit not only from less air, light, and noise pollution, but also from fewer vehicle collisions with nonhumans.<sup>72</sup> At the same time, when humans depend on, say, wildlife tourism for income, they might experience economic hardship during social distancing.<sup>73</sup>

The impact of the COVID-19 pandemic on wild animals has been similarly mixed. On one hand, many wild animals have benefited from the social and economic changes produced by the pandemic. Insofar as humans were social distancing, wild animals were able to explore cities, roads, canals, and other spaces more, prompting the media to publish (in some cases overblown) stories about wild animals “reclaiming” these spaces. This can be good for animals, as bees, birds, whales, and many others benefit from a quieter planet.<sup>74</sup> And of course, given that tens of millions of animals are killed in vehicle collisions every year, animals stand

to benefit from fewer vehicles on the road as well.<sup>75</sup>

On the other hand, many other wild animals have been harmed by the social and economic changes produced by the COVID-19 pandemic. For instance, the pandemic led to a substantial increase in single-use plastics.<sup>76</sup> Humans have relied more on plastic bags for shopping, delivery, and take-out, and we have also relied more on personal protective equipment such as face masks. While some of these changes have reduced the spread of COVID-19, they have also increased plastic pollution, as well as other kinds of pollution that can harm wild animals. For instance, when humans throw away face masks without cutting the ear loops, nonhuman animals can easily get tangled up in the loops and suffer or die.

Reduced tourism has also had mixed effects on wild animals. US wildlife agencies have reported increases in hunting and trapping licenses since the pandemic began.<sup>77</sup> Raja Ampat, a popular Indonesian dive site, is a good example of these mixed effects. Shark, manta ray, and sea turtle populations have increased, likely in response to fewer dive boats in the area.<sup>78</sup> However, fees from tourists, which fund conservation law enforcement, have also decreased.<sup>79</sup> Meanwhile, poaching has intensified in areas where communities rely on international tourism for income and conservation, and animals who rely on food from tourists, such as Thai macaques, have faced possible starvation without their usual food sources.<sup>80</sup>

Of course, many wild animals are also vulnerable to zoonotic diseases. So, during a pandemic, many wild animals are not only at risk of contracting the relevant disease but also at risk of being seen as “pests” and treated accordingly.<sup>81</sup> While humans tend to be responsible for zoonotic disease spread, we also tend to blame nonhumans rather than ourselves for the resulting outbreaks. For instance, bats are important not only intrinsically but also instrumentally, because of their contributions to ecosystems.<sup>82</sup> But since many humans see bats as a possible origin of COVID-19, there is a risk that violence against bats will increase or that support for bats will decrease in the wake of the pandemic.

## Lessons for the future

The COVID-19 pandemic has highlighted the myriad ways in which human and nonhuman animal health, welfare, and rights are linked. The virus might have come from the wildlife trade, which brings humans and nonhumans into close contact. And as of September 8, 2021, the virus has infected more than 221 million humans and killed over 4.5 million humans.<sup>83</sup> In one sense, then, the pandemic underscores the importance of nonhuman health because of its impact on human health. If we want to reduce the frequency and intensity of future pandemics, then we should either regulate or abolish the wildlife trade, which might have led to this pandemic, as well as factory farming and deforestation, which can easily lead to others.

But if human and nonhuman animals alike deserve a right to health, then the COVID-19 pandemic underscores a broader set of lessons as well. Nonhumans matter for health threats such as pandemics not only because our exploitation and extermination of nonhumans via factory farming, deforestation, and the wildlife trade contributes to these threats, but also because these threats contribute to nonhuman suffering and death. Moreover, health threats harm nonhumans not only directly, by increasing the risk of outbreaks, but also indirectly, by increasing the risk that humans will harm nonhumans in the search for food, medicine, or income, as well as because humans are either unable or unwilling to care for nonhumans during crises.

Thus, if humans want to mitigate and adapt to the impacts of health threats such as pandemics in an effective and inclusive manner, then we need to address all of these impacts. That is, we need to reduce our use of animals as part of our mitigation efforts and increase our support for animals as part of our adaptation efforts. And insofar as we do this work, we need to address not only the direct harms that pandemics can impose on animals, such as the harm of illness, but also the indirect harms that pandemics can impose on animals, including the harm of increased exploitation or extermination. This requires promoting human and nonhuman health, welfare, and rights simultaneously, including but not limited to the right to health.

This discussion makes it clear that addressing the harms of pandemics is not a simple matter of restoring the status quo that existed prior to COVID-19. After all, this status quo was massively and unnecessarily harmful for humans and nonhumans alike. And while many humans and nonhumans suffered more during the pandemic, many also likely suffered less, either because they received more affection (as with some companion animals) or less abuse (as with many other captive or wild animals). Therefore, learning the right lessons from this pandemic requires creating a new status quo by attempting to mitigate the negative impacts while building on the positive impacts of this disruption.

Since it would take much more space to fully explore the implications of this discussion, we will close by noting six implications here. First, and generally, humans should extend a legal right to health to humans and nonhumans alike. Following the ICESCR, this legal right to health would ideally commit states to recognizing “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and to taking concrete steps toward this goal. And while different concrete steps will make sense for different species, as a general matter they should reflect the reality that promoting public health requires a combination of individualized care and structural change that makes individualized care less necessary.

Second, and relatedly, humans should revise and expand policy frameworks such as One Health to consider human and nonhuman health, welfare, and rights (including the right to health) holistically and structurally. We should consider these issues holistically so that we can improve human and nonhuman lives simultaneously, rather than, say, improve human lives by worsening nonhuman lives unnecessarily. And we should think about these issues structurally so that we can track how our basic social, political, and economic systems reinforce the status quo and how changing them can disrupt the status quo, for instance by transitioning from animal-based food systems to humane, healthful, and sustainable plant-based alternatives.

Third, and as a result, humans should research

our impacts on human and nonhuman populations and should include human and nonhuman health, welfare, and rights considerations in impact assessments. Many people are increasing their support for academic research in nonhuman health and welfare for this reason. Additionally, some cities, such as Mexico City and New York City, have created animal welfare offices so that humans can be empowered to represent the interests of nonhumans in policy discussions.<sup>84</sup> While states can and should do much more to increase representation for other animals, even these first steps can have a major impact on health and environmental policy.

Fourth, insofar as humans include nonhumans in impact assessments, humans should also include nonhumans in policy decisions regarding education, employment, and social services. As states build more healthful and sustainable food, energy, and transportation systems, they can work to build more humane food, energy, and transportation systems too, and they can expand opportunities for doing that work. This can include expanded opportunities for veterinary education and employment, so that humans have more opportunity to care for wild animals in addition to particular kinds of captive animals. The more states invest in such work, the more they can improve the lives of humans and nonhumans as a result.<sup>85</sup>

Fifth, and relatedly, humans should include animals in decisions about infrastructure. In the same way that states can transition to more humane, healthful, and sustainable food, energy, and transportation systems, at the same time, they can also transition to more humane, healthful, and sustainable lived environments. For instance, insofar as states require building materials to be energy efficient, they can also require that building materials be animal friendly, such as by reducing collisions with birds. And to the extent that states expand urban parks for beautification and clean air and water, they can also install habitats, feeding stations, and water stations for the nonhuman animals they expect to reside in these spaces.<sup>86</sup>

Finally, and in general, humans should stop punishing nonhuman animals for human-caused problems. At present, humans kill captive and wild

animals alike for a wide range of reasons, including but not limited to food, medicine, income, and disease containment. This approach is incompatible with nonhuman health, welfare, and rights. Before humans can support nonhumans in achieving the “highest attainable standard of physical and mental health,” we must first support them in achieving at least a *minimal* standard of physical and mental health, such as by not killing them unnecessarily and by not using them in such high numbers that killing them during a disruption is seen as necessary.

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# Human Rights Perspective on Pesticide Exposure and Poisoning in Children: A Case Study of India

LEAH UTYASHEVA AND LOVLEEN BHULLAR

## Abstract

Pesticide exposure and poisoning among children can lead to devastating long-lasting health effects that impact their human rights, with communities in low- and middle-income countries experiencing the negative impacts of pesticides more profoundly than those in high-income countries. While United Nations agencies recommend banning highly hazardous pesticides responsible for serious pesticide poisonings, childhood pesticide poisoning is rarely discussed, especially from a human rights perspective. In India, a country with a large population of children and widespread pesticide use, no law or policy addresses pesticide poisoning among children. This lack of prioritization leads to gaps in poisoning surveillance and lack of government action to prevent poisoning, causing violations of children's rights. The proposed pesticides ban can reduce pesticide poisoning among children in India, but to fully protect children's rights, the government needs to establish comprehensive pesticide poisoning surveillance and ensure the mainstreaming of pesticide poisoning prevention into law and policy based on a human rights framework.

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## Introduction

If we take children's rights to life and health seriously, the prevention of pesticide exposure and poisoning needs to become a global priority. Highly hazardous pesticides (HHPs)—pesticides that are acknowledged to present particularly high levels of acute or chronic hazards to health or the environment according to internationally accepted classification systems—are a global concern.<sup>1</sup> Organophosphates and carbamates and other HHPs belonging to class I and class II of the World Health Organization's (WHO) classification of pesticides by hazard are the most common causes of pesticide poisoning.<sup>2</sup> The Food and Agriculture Organization (FAO) and WHO have repeatedly emphasized the need to reduce reliance on, the use of, and harms from HHPs, and the FAO has recognized children as one of the vulnerable groups for pesticide exposure.<sup>3</sup>

Children are affected by acute pesticide poisoning and chronic effects of exposure through ingestion, inhalation, and dermal contact.<sup>4</sup> They are more vulnerable than adults to the uptake and adverse effects of pesticides due to developmental, dietary, and physiological factors.<sup>5</sup> Pesticide poisoning in children may occur because of accidental exposure during play, occupational exposure during pesticide handling and agricultural work, and intentional self-harm (suicide or suicide attempt).<sup>6</sup> The environmental media of pesticide exposure and poisoning among children include air, water, and soil.<sup>7</sup> Pesticide exposure and poisoning is also experienced by plants and animals, leading to adverse impacts on plant and animal health.<sup>8</sup>

Pesticide exposure during pregnancy may impair the growth of the fetus and the healthy development of the child.<sup>9</sup> Chronic exposure and acute poisoning are associated with childhood cancers, neurodevelopmental issues, respiratory health issues, and low birth weight.<sup>10</sup> The United Nations Special Rapporteur on toxics and human rights has noted that "there is a 'silent pandemic' of disability and disease among children, associated with exposure to toxics and pollution during child-

hood, many of which do not manifest themselves for years or decades."<sup>11</sup>

This paper uses a human rights lens to address this neglected issue of HHP exposure and poisoning in children, both globally and in India specifically. India is one of the world's top producers, exporters, and users of pesticides.<sup>12</sup> It also has the largest child population in the world, with nearly 548 million children under the age of 18, representing almost 40% of its total population.<sup>13</sup> Moreover, 73% of all children live in rural areas, meaning that they face a high risk of exposure to pesticides in everyday life and sometimes use pesticides themselves. We assert that HHP exposure and poisoning puts children in a situation of vulnerability and represents a threat that requires special measures of protection.<sup>14</sup> Unfortunately, pesticide exposure and poisoning among children is reported in many other countries as well, making this paper's findings relevant to other jurisdictions.<sup>15</sup>

The paper consists of four parts. Beginning with the context of pesticide exposure and poisoning among children globally and in India, the first part underlines the lack of data on the negative consequences of HHPs on children, and the need to eliminate HHPs from everyday use. The second part addresses the international human rights framework, and the third part analyzes how international obligations are reflected in India's national legislation and policies. We conclude by highlighting the need to identify and ban HHPs and to include pesticide poisoning prevention in laws and policies in India and globally. While acknowledging the role of the pesticide industry in mitigating the harmful effects of HHP use, this paper concentrates on the state as the primary duty-bearer.

## HHP exposure and poisoning as a human rights and equality issue

The vast majority of pesticide poisonings and deaths occur in low- and middle-income countries (LMICs) where pesticides are widely used in rural areas by small-holder farmers.<sup>16</sup> Since HHPs may be cheaper and are more easily available than the new

generation of less toxic pesticides, LMICs use more HHPs than high-income countries, which have banned the domestic use of many HHPs but still manufacture and export them to other countries.<sup>17</sup> For example, in 2015, 59% of all pesticide sales in India were of HHPs, in contrast with 11% in the UK.<sup>18</sup>

HHP poisoning is a common hazard for many in LMICs, where people may lack information about the adverse effects of pesticide use and where poisoning treatment services may be scarce, difficult to access, and under-resourced.<sup>19</sup> Children belonging to low-income communities are particularly vulnerable to HHP poisoning and face multiple levels of impact and disadvantage due to their developing bodies, residence in rural areas with higher risk of exposure, and work with pesticides.<sup>20</sup>

The inverse relationship between exposure to pesticides and enjoyment of rights, particularly the rights of children, is recognized at the international level. The United Nations Special Rapporteur on the right to food has noted that

*hazardous pesticides impose substantial costs on governments and have catastrophic impacts on the environment, human health and society as a whole, implicating a number of human rights and putting certain groups at elevated risk of rights abuses... Among those at grave risk of becoming victims of HHPs are agricultural workers, children, and low income and minority communities, especially in developing countries.*<sup>21</sup>

The Committee on the Rights of the Child has expressed concern over the use of pesticides in state parties and their impact on children.<sup>22</sup> It has recommended that states prohibit the importation and use of any pesticides or chemicals whose use has been banned or restricted in exporting countries.<sup>23</sup>

### *HHP poisoning among children*

Global systematic data on harms associated with pesticide poisoning in children are limited. Poisoning is reported as injuries, with accidental poisoning reported separately from intentional self-harm. According to WHO's injury estimates from 2004 (the most recent year for which data are available), 345,814 people died worldwide that year because of accidental poisoning, with 13% of such poisonings

occurring among people under 20.<sup>24</sup> Intentional pesticide poisoning, responsible for at least 20% of all suicide deaths in LMICs, was a common cause of death in older children.<sup>25</sup> WHO notes that there is substantial under-recording and under-reporting of childhood poisoning incidents.<sup>26</sup>

In India, data on pesticide poisoning among children are fragmented. Several agencies are responsible for data collection, but coordination on surveillance and data analysis is lacking.<sup>27</sup> In 2017, "injury, poisoning and certain other externalities" made up the third leading cause of deaths for children aged 5–14 (10.1% of all deaths) and was the leading cause of death for children aged 15–24 (20.5% of all deaths).<sup>28</sup> Similar to global data, India's data are not disaggregated by cause of poisoning generally or among children specifically. Wolfgang Boedeker et al. place non-intentional pesticide poisoning in India in the range of 145 million people between 2006 and 2018, but specific data related to children are unavailable.<sup>29</sup>

Hospital studies find that HHP poisoning is the second to third most common cause of childhood poisoning, with cases of pesticide poisoning increasing over time.<sup>30</sup> Accidental poisoning is more common among younger children, while deliberate self-harm is more common among adolescents.<sup>31</sup> According to a 2013 study, children under the age of one had the highest rates of fatal accidental poisoning, with mortality decreasing with age until 14 years, after which it increased again due to self-harm.<sup>32</sup>

At least 10.1 million children participate in the workforce in India, of whom about 70% are involved in agriculture and related sectors, where they face higher risks of pesticide exposure and poisoning.<sup>33</sup> Several accidental pesticide poisoning cases also highlight the serious effect of wide pesticide use on children and the need for prevention (see Table 1).<sup>34</sup>

### *Elimination of HHPs: The most effective way to save health and the environment*

The most effective way to prevent exposure and poisoning is the elimination of hazards.<sup>35</sup> Figure 1 depicts the hierarchy of hazard controls.

The elimination and substitution of hazards,

such as through a ban on HHPs, is the most effective way to prevent pesticide exposure and poisoning. Other risk mitigation measures include (in order of effectiveness) engineering controls, administrative controls, and the use of personal protective equipment (PPE). Studies show that engineering and administrative control measures (label instructions and the safer storage of HHPs) and PPE use have not proven effective in LMICs.<sup>36</sup> Farmers may not be able to read or understand label instructions; PPE may be expensive, unavailable, or not feasible

to use in hot climates; and the safer storage of HHPs is not effective for poisoning prevention.<sup>37</sup>

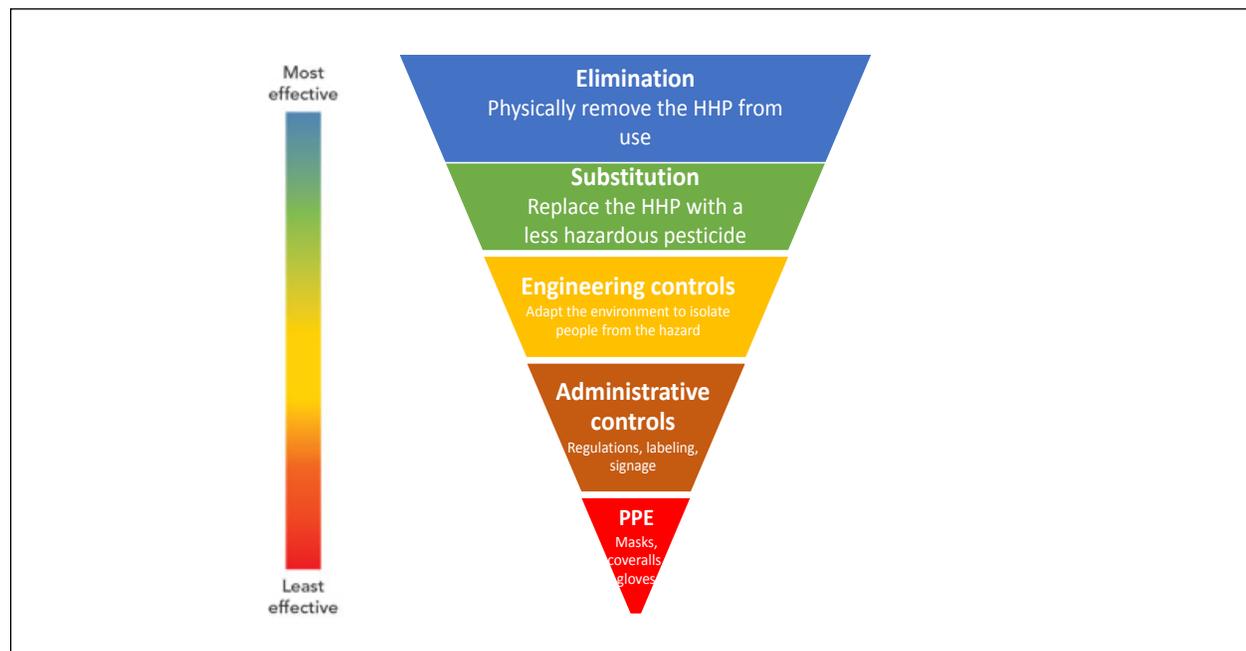
International regulations on pesticide management have a limited role in HHP exposure and poisoning prevention because of their information-sharing- and consensus-based approaches.<sup>38</sup> In contrast, national bans on HHPs have been effective in preventing pesticide poisoning and deaths.<sup>39</sup> HHP bans have led to significant reductions in deaths from intentional and unintentional poisoning in Sri Lanka, South Korea, and Bangladesh.<sup>40</sup>

TABLE 1. Examples of accidental HHP poisoning in India

Year	Place	Source	Effect
1984	Bhopal, Madhya Pradesh	Release of methyl isocyanate gas used in the production of carbamate pesticides	Premature deaths; birth of physically and mentally disabled children
1977-1987	Kasargod, Kerala	Aerial spraying of endosulfan in cashew plantation	Poisoning of villagers, including children
2005	Magrawa village, Gujarat	Food contamination with ethion (a pesticide) at a social gathering	15 people poisoned, many of whom died
2013	Dharmasati Gandaman village, Bihar	Food prepared in cooking oil kept inside a can of monocrotophos (an insecticide) in a government-run primary school	Poisoning and death of 23 children

Source: PAN Asia Pacific, *Global governance of hazardous pesticides to protect children beyond 2020* (2017); A. Dewan, B. Patel, R. Pal, et al., "Mass ethion poisoning with high mortality," *Clinical Toxicology* 46/1 (2009), pp. 85-88.

FIGURE 1. Hierarchy of hazard controls



Source: National Institute for Occupational Safety and Health, *Hierarchy of controls* (2015). Available at <https://www.cdc.gov/niosh/topics/hierarchy/>.

For example, Sri Lanka's pesticide suicide prevention policy—which combines pesticide legislation, a suicide prevention strategy, and a high-level task force—has led to a notable decrease in poisoning and deaths.<sup>41</sup> The bans are accompanied by a data-driven approach that contributes to improvements in poisoning surveillance—an important component of a comprehensive response.<sup>42</sup>

More generally, HHP bans illustrate the application of the precautionary principle in the face of scientific uncertainty about the adverse impacts of HHPs.<sup>43</sup> In addition, national pesticide legislation should encourage the minimization of HHP use through stricter rules for risk assessment during pesticide registration (also applying the precautionary principle), the elimination of financial and other incentives, and the prohibition of export of domestically banned pesticides and import limitations.

### International law on pesticide exposure and poisoning among children

Human rights are universal and indivisible, and while HHP exposure and poisoning have a particularly ruinous impact on children's rights to life and health, a whole range of rights is affected. We will address other rights through the prism of the rights to life and health.

#### *The right to life*

Article 3 of the Universal Declaration of Human Rights, article 6 of the International Covenant on Civil and Political Rights (ICCPR), and article 6 of the Convention on the Rights of the Child (CRC) guarantee the right to life.<sup>44</sup> The ICCPR stipulates that every child shall have the right to special measures of protection as required by their status as a minor.<sup>45</sup> General Comment 36, which helps states implement the ICCPR's provision on the right to life, requires states to adopt appropriate measures to protect life from all reasonably foreseeable threats and to take special positive measures of protection toward persons in situations of vulnerability or whose lives have been placed at risk because of specific threats.<sup>46</sup>

A child's right to life is violated when easy access to HHPs puts their life in danger due to accidental or intentional pesticide poisoning. States' obligation to protect children's right to life includes creating an environment that ensures, to the maximum extent possible, the survival and healthy development of the child. States need to identify risks that underlie life, survival, growth, and development of the child, and design and implement evidence-informed interventions to protect the right to life.<sup>47</sup>

#### *The right to health*

The right to health derives from article 25 of the Universal Declaration of Human Rights, article 24 of the CRC, and article 12 of the International Covenant on Economic, Social and Cultural Rights.<sup>48</sup> Children's right to health is an inclusive right extending to timely and appropriate prevention and health promotion, a right to grow and develop to one's full potential, and a right to live in conditions that enable them to attain the highest standard of health.<sup>49</sup> It includes the underlying determinants of health, such as access to safe and potable water; an adequate supply of safe food, nutrition, and housing; healthy occupational and environmental conditions; and access to health-related education and information.<sup>50</sup> Children are entitled to the prevention of diseases and accidents as one aspect of health services.<sup>51</sup> HHP exposure and poisoning represent states' failure to prevent injury and disease and to discharge their obligation to protect children's right to health.<sup>52</sup> The realization of mothers' right to health and their protection from pesticides, as underlined by the Committee on the Elimination of Discrimination against Women (the expert body that monitors the implementation of the Convention on the Elimination of all Forms of Discrimination against Women), is also crucial for the protection of children's right to health.<sup>53</sup>

The availability of information about risks associated with HHPs is important for the protection of the right to health.<sup>54</sup> Most small-holder farmers and their families in LMICs possess little information about toxicity, correct application, and hazards

associated with pesticide use. The right to health is threatened when health-related information about pesticide harms is unavailable, inaccessible, or hard to understand.<sup>55</sup>

Healthy occupational conditions are one of the underlying determinants of health. Occupational exposure to pesticides infringes on children's right to health, which requires that children "be protected from performing any work that is likely to be hazardous ... or to be harmful to [their] health or physical, mental, spiritual, moral or social development."<sup>56</sup> The International Labour Organization does not allow children under 18 to be employed in hazardous work, including pesticide use.<sup>57</sup> In 2020, the FAO adopted the Framework on Ending Child Labour in Agriculture, calling for a renewed commitment to ending child labor and children's exposure to pesticides.<sup>58</sup>

Three of the four overarching principles identified by the Committee on the Rights of the Child as fundamental principles guiding the implementation of the CRC are directly applicable here. The best interest of the child (article 3(1)), the inherent right to life (article 6), and the right to nondiscrimination (article 2) suggest the development of a rights-based approach to secure the holistic physical, psychological, moral, and spiritual integrity of the child, to promote their human dignity, and to ensure to the maximum extent possible their survival and development. The best interest of the child in attaining the right to health requires the prevention of HHP exposure and poisoning, as adverse health effects are often irreversible and may not manifest themselves for years.<sup>59</sup> These principles need to guide all laws and policies in order for states to fully realize children's rights.<sup>60</sup>

### The rights of the child and India's domestic legal and policy framework

India's domestic legal and policy framework recognizes children's rights to life and health and the corresponding duties of the state. However, this framework does not consider the link between pesticide exposure and poisoning, on the one hand, and children's rights, on the other.

### *The right to life*

Children are among the holders of the fundamental right to life entrenched in article 21 of the Constitution of India. The Supreme Court has expanded the scope of this right to life beyond "protection of limb or faculty" to include "the right to live with human dignity and all that goes along with it, namely, the bare necessities of life."<sup>61</sup> A person's right to life is "secured only when he is assured of all facilities to develop himself and is freed from restrictions which inhibit his growth."<sup>62</sup> The right embraces "quality of life," which is described as "all those aspects of life which go to make a man's life meaningful, complete and worth living."<sup>63</sup> The Supreme Court cited article 21 of the Constitution when passing an order to ban the use, sale, production, and export of endosulfan (a DDT-like organochloride insecticide), applying the precautionary principle.<sup>64</sup>

As discussed above, pesticide exposure and poisoning may result in the loss of life or in long-term health and developmental impacts. A child who is affected by exposure or poisoning may exist physically but be unable to enjoy the right to live with dignity or enjoy quality of life. In other words, their constitutional right to life is violated, and it is the duty of the state to prevent pesticide exposure and poisoning, such as through the introduction and implementation of appropriate measures.

### *The right to health*

While India's Constitution does not explicitly guarantee a right to health, the Supreme Court has read this right into the constitutional right to life and defined it as the "right to live in a clean, hygienic and safe environment."<sup>65</sup> The Constitution also includes Directive Principles of State Policy, which, though non-enforceable, are "fundamental in the governance of the country" and shall be applied by the state in making laws. Two of these principles address children's health: article 47 establishes a state duty to improve public health, while article 39(e)-(f) notes that the state shall direct its policy toward ensuring that the tender age of children is not abused and that children are given opportunities and facilities to develop in a healthy manner. HHP exposure and poisoning undermine the real-

ization of children's constitutional right to health and represent the state's failure to discharge its constitutional duties.

Health falls within the purview of state governments.<sup>66</sup> Gujarat is one of the few states that has enacted a health law with an explicitly rights-based approach.<sup>67</sup> The law's preamble recognizes the importance of fundamental human rights and of improving the quality of life of all citizens. Chapter V explicitly incorporates the rights to health and dignity, which could ensure protection from pesticide exposure and poisoning. In the state of Goa, the Children's Act of 2003 explicitly recognizes children's rights and sets out the duty of the state government to ensure that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity.<sup>68</sup> The CRC's provisions on the rights of the child are directly enforceable subject to certain exceptions, and state governments are permitted to specify higher standards for children. These provisions represent opportunities to protect children from pesticide exposure and poisoning.

### *The right to health and the prohibition of child labor*

Article 23 of the Constitution prohibits forced labor. The system of forced and partly forced labor was abolished in 1976 and is today a punishable offense.<sup>69</sup> However, adults and children continue to be forced to work on farms where pesticide use might lead to exposure and poisoning.<sup>70</sup> Article 24 of the Constitution prohibits the employment of children in hazardous work. According to the Child and Adolescent Labour (Prohibition and Regulation) Act, the employment of children under 14 in any occupation or process, and of adolescents aged 14–18 in specified hazardous processes, is prohibited.<sup>71</sup> These hazardous processes include insecticides, fungicides, and herbicides, among others.<sup>72</sup> By referring to the potential of hazardous processes to cause material impairment to workers' health, the law implicitly acknowledges the right to health of workers who are children. At the same time, the law permits a child to help their family in a family enterprise subject to certain conditions.<sup>73</sup>

Children may work on farms where pesticides are used, thus risking pesticide exposure and poisoning. The continuance of child labor after the enactment of relevant laws and the absence of measures to prevent HHP exposure and poisoning of children represent the state's failure to discharge its duties corresponding to children's right to health. The elimination of child labor is a complex issue that impacts the entire range of children's rights and requires comprehensive approaches that are beyond the scope of this paper.

### *Children's rights and pesticide use in panchayat laws*

The main use of pesticides in India is in agriculture. The extensive network of panchayats—self-governing institutions for rural areas—could play a role in the protection of children from pesticides exposure and poisoning.<sup>74</sup> A 2005 World Bank report recognizes the need to enhance the regulatory role of gram panchayats for the controlled use of pesticides.<sup>75</sup> In Kerala, a license is required for the use of any place in the panchayat area for purposes that are likely to be offensive or dangerous to human life or health, including storing, preparing, packing, and selling pesticides.<sup>76</sup> There is implicit recognition of the adverse impacts of pesticides on the rights to life and health. In Andhra Pradesh and Telangana, the panchayat secretary (a non-elected representative appointed by the state government to oversee panchayat activities) is required to assist in giving information to concerned officials about black-market sales of pesticides.<sup>77</sup> Elimination of the black market is necessary for the successful enforcement of pesticide management rules, which in turn enhances protection of the abovementioned rights.

### *National policies and children's rights*

Children's rights form the exclusive focus of many national policies.<sup>78</sup> The National Policy for Children of 2013 explicitly affirms the government's commitment to a rights-based approach.<sup>79</sup> In addition, the National Youth Policy of 2014 recognizes health as a priority and highlights the need for a targeted approach to emotional and mental health issues. Since there is a clear link between the incidence of

intentional pesticide poisoning among youth and their emotional and mental health issues, implementation of this policy could include measures directed at the prevention of intentional poisoning. Further, children are the beneficiaries of several other policies, including the National Health Policy of 2017, the National Population Policy of 2000, and the National Education Policy of 2020. These policies could provide the overarching framework for the incorporation and realization of children's rights and the integration of pesticide exposure and poisoning prevention in regulatory instruments.

### Prevention of HHP exposure and poisoning among children: The way forward

India is currently discussing a new pesticide management law to replace the Insecticides Act of 1968. The Union Cabinet approved the Pesticide Management Bill in February 2020, and it was introduced in the Rajya Sabha (the upper house) the following month.<sup>80</sup> The bill includes several features to decrease HHP use and exposure, including requirements for pesticide labels, the promotion of organic pesticides, and prescription requirements for the sale of class I pesticides. States have the power to organize and carry out poisoning surveillance.<sup>81</sup>

The objective of the bill is “to regulate pesticides ... to ensure availability of safe and effective pesticides and to strive to minimize risk to human beings, animals, living organisms other than pests, and the environment.” However, the use of terms such as “to strive to” creates a hierarchy among objectives. The bill follows the traditional command-and-control approach—for example, by subjecting the registration of pesticides to the fulfillment of certain formal criteria instead of mitigating and eliminating negative health effects by decreasing pesticide use and introducing bans on HHPs. Further, it does not ban HHPs that are harmful to health, nor does it prohibit the registration of pesticides banned in other countries.<sup>82</sup>

The bill follows in the steps of India's ban on 12 pesticides in 2018 and the proposal to ban 27 other pesticides in 2020.<sup>83</sup> Some stakeholders opposed

these bans on the ground that they may decrease agricultural productivity, endanger food security, increase farmers' production costs, and adversely impact the profitability of the pesticide industry.<sup>84</sup> The bill, together with the proposed pesticide ban, if adopted, can form a part of the country's response to HHP exposure and poisoning among children. However, to be effective, these solutions must be accompanied by the introduction of HHP poisoning prevention measures in laws and policies on children, women, health, agriculture, and labor.

As illustrated above, the failure of regulatory instruments to protect children from HHP exposure and poisoning happens due to weak surveillance systems, a lack of government prioritization and coordination of response measures, and the government's hesitation to ban HHPs. First, although childhood mortality and morbidity are discussed widely, data on the health effects of pesticides on children remain lacking.<sup>85</sup> A pesticide incidence surveillance system is necessary to convince decision-makers of the seriousness of the situation. Second, currently, the issue of pesticide exposure and poisoning among children in India sits at the periphery of concern for different central government ministries, such as the Ministry of Health and Family Welfare, Ministry of Women and Child Development, Ministry of Agriculture and Farmers' Welfare, Ministry of Labour and Employment, and Ministry of Human Resources Development. A similar situation exists at the state level. This fragmentation must be replaced by a comprehensive and integrated approach, which would also promote the implementation of existing laws and policies that emanate from government agencies with different mandates.

Third, the belief that pesticide use is necessary for food security and agricultural productivity is a misconception. The Special Rapporteur on the right to food has underlined that “the assertion by the agrochemical industry that pesticides are necessary to achieve food security is not only inaccurate, but dangerously misleading.”<sup>86</sup> Replacing chemicals with biological plant protection products and promoting agricultural practices that stimulate soil fertility are more beneficial for sustainable food

production than indiscriminate pesticide use.<sup>87</sup>

The wide availability and use of HHPs and their impact on children's rights deserve urgent recognition and attention from international and national decision-makers. Our discussion of India's legal and policy framework highlights the complexities and intricacies of developing responsive and child-centered laws and policies. Our review identifies elements of the domestic framework that could form a part of a multipronged response (Figure 2) to pesticide exposure and poisoning among children. Nationally in India and globally, HHP bans can save the lives and health of the present and future generations and positively impact animal health and the environment. As highlighted in this paper, policy coordination and prioritization, as well as information about best practices, are needed to formulate effective responses.

## Conclusion

The universality and indivisibility of children's rights are particularly relevant for pesticide poisoning prevention, as children's rights to life and health provide the rationale for stricter pesticide regulation and, ultimately, the phasing out of HHPs. The principle of the best interest of the child points to the need to adopt a human rights-based and child-centered approach to the development and implementation of pesticide management laws and policies. Collaboration among the industry, international bodies, and national decision-makers on strengthening pesticide management is needed to promote a children's rights-based approach. The human rights-based framework discussed in this paper could ensure the integration of the interests of children into relevant domestic laws and policies in different jurisdictions.

FIGURE 2. Multipronged response



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# Shifting the Moral Burden: Expanding Moral Status and Moral Agency

L. SYD M JOHNSON

## Abstract

Two problems are considered here. One relates to who has moral status, and the other relates to who has moral responsibility. The criteria for mattering morally have long been disputed, and many humans and nonhuman animals have been considered “marginal cases,” on the contested edges of moral considerability and concern. The marginalization of humans and other species is frequently the pretext for denying their rights, including the rights to health care, to reproductive freedom, and to bodily autonomy. There is broad agreement across cultural and philosophical traditions about the capacities and responsibilities of moral agents. I propose an inclusive and expansive way of thinking about moral status, situating it not in the characteristics or capacities of individuals, but in the responsibilities and obligations of moral agents. Moral agents, under this view, are not privileged or entitled to special treatment but rather have responsibilities. I approach this by considering some African communitarian conceptions of moral status and moral agency. I propose that moral agency can also be more expansive and include not just individual moral agents but collective entities that have some of the traits of moral agents: power, freedom, and the capacity to recognize and act on the demands of morality and acknowledge and respect the rights of others. Expanding who and what is a moral agent correspondingly extends moral responsibility for respecting rights and fostering the conditions for the health and well-being of humans and animals onto the collective entities who uniquely have the capacity to attend to global-scale health threats such as pandemics and human-caused climate change.

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## Introduction

Some of the most significant health threats for humans are environmental and global. They include global pandemics of infectious diseases, such as that caused by SARS-CoV-2, as well as the looming and catastrophic effects of human-caused climate change. These same threats also jeopardize the nonhuman animals who share the planet with humans. The International Covenant on Economic, Social and Cultural Rights recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”<sup>1</sup> The steps required to achieve this goal include “the improvement of all aspects of environmental and industrial hygiene” and “the prevention, treatment and control of epidemic, endemic, occupational and other diseases.”<sup>2</sup> Notably, these are goals that cannot be achieved by individuals alone, acting as moral agents. Rather, they require concerted collective action, including action by states and other collective entities that have the capacity to enact multilateral strategies and measures to tackle global problems that threaten human health and human rights. For this reason, it is important to consider whether, how, and to whom such entities can have moral obligations and responsibilities.

We frequently think of moral responsibilities as borne by individual humans with the capacities necessary for moral agency. A vexing problem in moral philosophy has long been deciding not who is a moral agent, but who has moral status—that is, to whom do moral agents have responsibilities and obligations? This is an urgent problem in the context of climate change, where the beneficiaries of our actions are not the individual humans to whom there are clear moral obligations but rather entire cultures and societies, as well as nonhuman animal species (with their own cultures and societies), ecosystems, and future generations of humans and nonhumans. All of these will be affected, their survival and flourishing contingent on actions taken now. Similarly, although pandemics affect the health and well-being of individual humans and nonhuman animals, they also cause larger-scale changes and problems that affect all humans, entire species, and future generations.<sup>3</sup>

Human and animal well-being and health are entangled—what affects one affects the other—which gives us a human-centered reason to think about our moral obligations to nonhumans. But the moral marginalization of other species is frequently justified by the same reasons used to marginalize some humans. Challenging those justifications situates both vulnerable humans and nonhumans within the same sphere of moral consideration and expands our moral obligations to address common threats to the health and flourishing of all species.

## The problem of marginal cases

To have moral status is to matter morally and to be the kind of being to whom others can have moral obligations. An entity with moral status is someone who matters, not a mere thing. It matters, in a moral sense, what others do to and for them. The term “marginal cases” is used to name a putative problem that arises when humans are granted unequal, greater moral consideration or status compared to nonhumans. The problem is one of moral inconsistency in the presence of overlap in the capacities and characteristics between species and, in particular, considerable similarities between the capacities of some less-developed humans (such as infants and young children), or some humans with cognitive or intellectual disabilities, and the capacities of many nonhuman animals.<sup>4</sup>

Here I sketch two different conclusions about moral status and marginal cases as a brief introduction to the problem. An example of how the problem of marginal cases (PMC) can be stated is provided by Alastair Norcross:

*Whatever kind and level of rationality is selected as justifying the attribution of superior moral status to humans will either be lacking in some humans or present in some animals. To take one of the most commonly-suggested features, many humans are incapable of engaging in moral reflection. For some, this incapacity is temporary, as is the case with infants, or the temporarily cognitively disabled. Others who once had the capacity may have permanently lost it, as is the case with the severely senile or the irreversibly comatose. Still others never had and never will have the capacity, as is the case*

*with the severely mentally disabled. If we base our claims for the moral superiority of humans over animals on the attribution of such capacities, won't we have to exclude many humans?*<sup>5</sup>

The charge of moral inconsistency sticks if (1) humans are granted superior moral status compared to nonhumans, and (2) that superior moral status depends on the respective capacities of humans and nonhumans, and (3) the superior moral status of humans is maintained even if the required capacities are absent in some humans and present in some nonhuman animals. It is claimed that, given the existence of so-called marginal cases, it is not possible to consistently maintain the superior moral status of humans without resorting to speciesism or mere bias that favors humans. If the morally relevant capacity is of a cognitively sophisticated or complex kind—such as rationality, self-awareness, the capacity to communicate using language, or problem solving—then it becomes clear that some humans will lack those capacities while some nonhuman animals will have them, and thus granting enhanced or superior moral status to all humans, while denying that some animals have the same status, is morally inconsistent.

Carl Cohen, in rejecting the argument of the PMC, contends that

*the capacity for moral judgment that distinguishes humans from animals is not a test to be administered to human beings one by one. Persons who are unable, because of some disability, to perform the full moral functions natural to human beings are certainly not for that reason ejected from the moral community. The issue is one of kind.*<sup>6</sup>

Cohen's response to the PMC, then, is to argue that it is not the capacities of *individual* members of a species but the *essential* capacities that are *typical for the species* that matter morally. For Cohen, the essential capacity requires autonomy and rationality of a sophisticated kind: moral agency, or the ability to respond to the demands of morality. Cohen accepts the charge of speciesism as well:

*I am a speciesist. Speciesism is not merely plausible; it is essential for right conduct, because those*

*who will not make morally relevant distinctions among species are almost certain, in consequence, to misapprehend their true obligations ... Every sensitive moral judgment requires that the differing natures of the beings to whom obligations are owed be considered.*<sup>7</sup>

Both Norcross and Cohen agree that moral agency is a relevant characteristic of humans. They disagree about how it affects moral status. For Cohen, the superior moral status of humans and the inferior moral status of nonhuman animals depend on the moral agency of (typical) humans, a capacity that, he claims, *all* nonhuman animals lack. Norcross denies that moral agency confers superior moral status:

*That animals can't be moral agents doesn't seem to be relevant to their status as moral patients. Many, perhaps most, humans are both moral agents and patients. Most, perhaps all, animals are only moral patients. Why would the lack of moral agency give them diminished status as moral patients? Full status as a moral patient is not some kind of reward for moral agency.*<sup>8</sup>

Norcross recognizes two equal ways of mattering morally, or two ways of belonging to the moral community: being a moral agent and being a moral patient. (The morally relevant capacity for Norcross is sentience, which is a widely distributed capacity shared by many animals, including humans.) Moral patients are beings who matter morally and are subjects of moral consideration and moral obligations. They can, but might not, be moral agents. Put another way, moral agents have moral obligations and responsibilities to moral patients, but moral patients do not have similar or reciprocal obligations and responsibilities because they are not capable of acting as moral agents. This approach explains two things: why so-called marginal cases matter morally, and why moral agents have moral obligations to them. And it explains these things without moral inconsistency—that is, without relying on morally arbitrary distinctions or biases such as speciesism and without resorting to special pleading concerning members of species who do not (or who do, if they are nonhumans) have the qualifying capacities or characteristics.

## The problem for marginal cases

So-called marginal cases occupy conceptual spaces at the margins of moral considerability. The PMC, which is employed primarily in discussions of animal rights and moral status, is an objection to placing all animals *outside* the margins while all humans remain inside. For some commentators, the problem is easily resolved without resorting to speciesism by admitting that both some humans and some nonhumans belong *outside* the margins of moral considerability.<sup>9</sup> If we reject that solution, however, it must still be acknowledged that even a low threshold like sentience can exclude some humans and nonhumans. For example, for decades there has been philosophical debate about the moral status of humans with disorders of consciousness—such as the vegetative state (also known as unresponsive wakefulness syndrome) and the minimally conscious state—where their marginalization depends on their diminished consciousness and cognitive capacities.<sup>10</sup> A stark example is the use of the pejorative term “vegetable” to describe individuals in the vegetative state.<sup>11</sup> The right of individuals with impaired consciousness to health care, including life-sustaining treatment, has frequently been contested.<sup>12</sup> Animals who are questionably sentient might include bees and other insects and invertebrates, sharks, and creatures such as sponges and corals.<sup>13</sup> Fundamentally, many responses to the PMC do not in principle question or reject the marginalization of humans or non-human animals, but merely dispute the criteria for mattering morally.

One reason this warrants ethical concern is that it appears to justify marginalizing some entities who might have other morally significant features. Another reason is the epistemic burden of proof regarding who is and is not justifiably marginalized. For example, the longstanding debate about teleost fish sentience was fairly recently resolved in favor of the conclusion that teleost fishes feel pain.<sup>14</sup> One consequence of denying fish pain and well-being is the lack of welfare regulations for fishes used in research in many jurisdictions (including the United States) and for the trillions of fishes raised on farms or caught in the wild. Pain and sentience

in preterm neonates—on the presumption that their nervous systems were too underdeveloped to experience pain—was denied until a few decades ago, when it was experimentally demonstrated that they not only felt pain but experienced significant distress and morbidity as a result of untreated surgical pain.<sup>15</sup> The default position concerning both fish and neonate pain was to presume they were insentient until proven otherwise. That presumption resulted in a disregard for the significant pain and distress experienced by these two groups—and in infants, disregard for the long-term physiological and health effects of that pain (including hyperalgesia and neurodevelopmental effects in children).<sup>16</sup> When moral status depends on the possession of some capacity or on satisfying criteria, the entity with contested moral status must show itself to “pass the test.” Yet the “pain behaviors” exhibited by fishes and neonates were not sufficient, because the marginalized lack the power, ability, and epistemic authority to show that they don’t deserve to be marginalized.

Marginalization doesn’t occur in the absence of someone willing to marginalize or to decide on or devise the justification for marginalization. The early-20th-century eugenics movement, enacted most vigorously in Nazi Germany, sought to marginalize and eliminate those deemed unfit, those who lived a *Lebensunwertes Leben* (“life unfit for life”), including disabled persons, LGBT persons, and members of ethnic and religious minority groups.<sup>17</sup> In the United States, the endorsement of eugenics resulted in the forced sterilization of thousands of poor and socially marginalized women, such as Carrie Buck, who as a teenager was raped and then institutionalized, and sterilized with a seal of approval from the US Supreme Court. Justice Oliver Wendell Holmes infamously justified the decision with the dehumanizing statement that “three generations of imbeciles are enough” (thus affirming the subhuman status of Carrie Buck; her infant daughter, Vivian; and her mother, Emma).<sup>18</sup> Buck’s rights to bodily autonomy and to reproductive health were denied because she was marginalized. Part of what it is to be marginalized, then, is to be vulnerable in this way to the whims of

others and to their views of one's moral worth and moral rights. Marginal cases are not marginalized by *their own* capacities or traits (or lack thereof)—that is merely the pretext for their marginalization. They are marginalized because they lack power and because others view them as *deficient* in some way, as lacking the necessary traits to warrant a place securely within the margins.

### Moral status projects

There are two moral status projects: one that is inclusive and one that is exclusive. The inclusive moral status project is the project of those, like Norcross, who would bring some nonhuman animals inside the moral status circle. The PMC is employed as an argument and aims to show that, as a matter of moral consistency, if “marginal” humans belong inside the margins, then so do many animals. The *exclusive project* seeks to limit who belongs inside the margins, perhaps by excluding some who are currently inside or near the margins. This is the aim of those who conclude that nonhuman animals, unconscious humans, humans with intellectual or cognitive impairments, or any creature who isn't a moral agent belongs outside the margins.<sup>19</sup> One project expands the margins, and one contracts them. It's important to recognize, however, that even the expansive, inclusive project can reinforce the margin and exclude those who don't make it across even a low bar, such as those who are not sentient or not conscious.

There is grave potential harm in marginalizing someone and treating them as if they are morally insignificant. Such moral mistakes have been made frequently in human history.<sup>20</sup> Both the inclusive and the exclusive moral status projects fail to guard against such mistakes because they approach the question of who matters morally as a problem of sorting out who belongs and who doesn't based on the characteristics, traits, and capacities of the contested being. They try to sort out whether a being is rightly or wrongly marginalized, which presumes that some are *rightly* marginalized and not subjects of moral concern. The PMC tackles the marginalization of nonhumans by comparing them to those

humans who do not satisfy the criteria. Moral consistency requires that we either grant that some humans have the same diminished status as animals or admit that many animals should have the same status as humans.<sup>21</sup> Both positions have been endorsed. The problem with both positions is that they don't question the underlying assumption that a being's moral status must depend on some traits or capacities. They don't question the assumption that there are testable criteria for mattering morally. They merely disagree about which criteria are the right ones. Thus, even the inclusive moral status project can exclude and marginalize.

### The responsibilities of moral agents

Rather than focus on the traits or capacities of marginalized and contested entities, the emphasis should be on the responsibilities of moral agents. One reason to do this is that we already have a good idea of what moral agency requires and who might be an individual moral agent, with considerable agreement across cultures and philosophical traditions that have the concept.<sup>22</sup> Tom Regan provides a definition of moral agents typical of Western philosophical positions:

*Moral agents are individuals who have a variety of sophisticated abilities, including in particular the ability to bring impartial moral principles to bear on the determination of what, all considered, morally ought to be done and, having made this determination, to freely choose or fail to choose to act as morality, as they conceive it, requires.*<sup>23</sup>

Cohen, in defining moral agents as rights-holders, describes similarly stringent requirements:

*The holders of rights must have the capacity to comprehend rules of duty, governing all including themselves. In applying such rules, the holders of rights must recognize possible conflicts between what is in their own interest and what is just. Only in a community of beings capable of self-restricting moral judgments can the concept of a right be correctly invoked.*<sup>24</sup>

There is a spectrum of views regarding the moral

agency of nonhuman animals (although there is growing evidence that some animals govern their own behavior according to recognizable moral principles such as justice, fairness, loyalty, non-maleficence, and beneficence, including sacrificing their own interests for the sake of others), as well as expansive interpretations of human moral agency that include heteronomous (as opposed to autonomous) moral agency.<sup>25</sup> If moral agency requires sophisticated cognitive capacities, including autonomy, the ability to identify oneself as the author of one's choices and actions, to recognize the rights of others, and to recognize and act on the demands of morality (consistent with the Western philosophical view), then clearly many humans and nonhumans are not moral agents. Infants and very young children, and some persons with cognitive disabilities, are not moral agents, although some will become moral agents as they develop the required capacities, and some will lose their agency when they lose the required capacities. If moral agency so defined is the threshold for mattering morally, then some humans and nonhuman animals do not matter morally.

If moral agency so defined is the criterion for mattering morally, then a morally justified, nonarbitrary reason for it being the criterion is needed. There is no such reason. Moral agency is simply not the condition for mattering morally; it does not grant special privileges to those who have it. As Rachels argues, "Autonomy and self-consciousness are not ethical superqualities that entitle the bearer to every possible kind of favorable treatment."<sup>26</sup> As Norcross puts it, in explaining why humans have moral obligations to nonhuman animals, "Full status as a moral patient is not some kind of reward for moral agency ... Humans are subject to moral obligations because they are the kind of creatures who *can* be."<sup>27</sup> Moral agents, then, are not the bearers of unique rights or privileges. Rather, they bear moral responsibilities and duties to others, simply by virtue of the fact that they *can* bear those responsibilities and duties.

Since we know who moral agents are, what they can do, and what they are obliged to do, we can explain mattering morally as the property of

being an entity to whom moral agents owe moral consideration.

## Moral patients

Moral patients are subjects of moral concern or consideration. We could simply say that moral patients are those to whom moral agents have moral duties. Humans and other animals, then, are *all* moral patients, regardless of their capacities and traits, and *some* of them are also moral agents. I will limit the scope of my discussion of moral obligations here to humans and nonhuman animals because if they matter morally, it is in the same way: they matter non-instrumentally and for their own sake.

The PMC matters not as a mere philosophical exercise but because the diminished status of some beings has, throughout human history, been used to justify all manner of rights violations. As Godfrey Tangwa notes, this emphasis on the qualifications of moral patients rather than on the obligations of moral agents has an insidious history that shifts or avoids the burden of responsibility:

*By concentrating on the patient rather than the agent, Westerners have been able to shift critical attention from themselves and their actions onto their victims. In that way, they have been able to carry out colonization, enslavement, and exploitation with quiet consciences, by stipulating "objective" criteria for being human that their victims did not fulfill.*<sup>28</sup>

Tangwa points here to the way that marginalization is employed to justify exploitation, as well as the way it is meant to exculpate moral agents who would otherwise be guilty of injustice and rights violations if their actions were perpetrated against those who matter.

One reason to be inclusive rather than exclusive about moral status is so that we don't mistakenly exclude moral patients from moral consideration. As moral agents, if we wrongly marginalize those who matter morally, we will have failed in our moral obligations to those moral patients, treated them unjustly, and caused harm. One way to be more inclusive about moral status is to be pluralists

about mattering morally and recognize that there are many pathways to moral status. The Western focus on individuals views possession of certain individual traits or capacities as being *essential* to admission into the moral community. This tends to obscure other ways of being a moral patient that depend not on one's own traits or capacities but on the obligations others have toward one. Here I sketch out some non-Western philosophical views that are more expansive about membership in the moral community.

Tangwa describes the differences between Western and African conceptions of mattering morally:

*If the African perception of a person differs from the Western perception, this is not because it does not recognize the various developmental stages of a human being or qualitative differences based on the degree of attainment of positive human attributes or capacities, but rather because it does not draw from these facts the same conclusions as are drawn in Western ethical theory. In particular, the differences between, say, ... an infant and a fully self-conscious, mature, rational, and free individual do not entail, in the African perception, that such a being falls outside the "inner sanctum of secular morality" and can or should thus be treated with less moral consideration.<sup>29</sup>*

In Tangwa's native language Lamnso', the phrase *wir dzē wir* translates roughly to "A human being is a human being is a human being, simply by being a human being." This might sound like a tautology, but it amounts to the belief that moral consideration is due to all humans regardless of their individual capacities or characteristics. It says that being human is enough to matter morally. This has advantages. It includes under the protection of moral status all humans, regardless of their age, abilities, or capacities. But it does not exclude other species or nonhuman entities from also mattering morally. As Tangwa explains, the onus is on moral agents to be responsible for acting morally toward others:

*A moral agent can do moral good or evil, irrespective of whether the patient of his or her action (or lack thereof) is a person, a nonhuman*

*animal, a plant, or even an inanimate thing. What the attributes of self-consciousness, rationality, and freedom of choice do, as well as those of power and wealth, is load the heavy burden of moral liability, culpability, and responsibility on the shoulders of their possessor. Human persons are not morally special, they are morally liable.<sup>30</sup>*

The traditional Zulu saying "A person is a person through other people" and the Ubuntu phrase "My humanity is caught up, is inextricably bound up in yours" describe another way of mattering morally—by being a member of a community where each has "the fundamental moral-social goal posited by a morality of duties of securing the well-being of all human beings."<sup>31</sup> Both express the idea that one is a person through participation in the social life of a community of other persons. One doesn't belong to a community of persons because they are already a person; one is a person *because* they belong to a community of persons.

*What begins to emerge here is that one cannot become a normal functioning human being without being inserted in an "environment" with other human beings; hence, the idea, "I am because we are." Personal identity here is understood primarily in terms of "being-with-others."<sup>32</sup>*

This meaningfully acknowledges the interconnectedness of persons, the ways we are dependent on each other for our status as persons who matter morally, and dependent on others acting on their duties and obligations to us. Importantly, this way of mattering morally is radically inclusive and does not depend on the traits or capacities (or species) of individuals:

*Individuals with cognitive disabilities are no different in this respect. Neither are infants, toddlers, children, adolescents, or persons with mental illness or advanced dementia. They may lack some capacities of typical adults, and the moral duties and citizenship responsibilities that accompany them. Nonetheless, all of them are fully embedded in the web of interpersonal relationships in which personhood is realized.<sup>33</sup>*

Belonging to a community as a way of being

a person, someone who matters morally, may sound precarious for the marginalized if they are vulnerable to being excluded. But we are all born into communities of at least a few persons, and none of us could survive infancy if we were not. Unlike exclusionary moral status projects, the ideology behind *belonging to a community* as a way of mattering morally is that one's very membership is the reason moral agents have responsibilities and duties to one, and a reason against exclusion and marginalization. Something else is important about belonging to a moral community. What moral agents do to and for one member of the community matters to the others, and so the direct duties of moral agents multiply. Harming an infant *also* harms the infant's parents. Harming a bird *also* harms those who love and value the bird. The moral burdens of moral agents are many, and to many, within moral communities.

Nonhuman animals can belong to their own communities. Wolf packs, prides of lions, pods of orcas, flocks of birds, and shoals of fish all constitute interdependent communities of social beings. Nonhuman animals can also belong to human social communities, and this would include the animals we share our homes with (such as dogs, horses, gerbils, and goldfish), who form with us interdependent relationships of affection and care. It also includes other captive animals who have been brought into human spaces (such as zoos, aquaria, and farms) in which they are vulnerable and dependent on humans. Captive animals, including those born in captivity, have been denied the ability and right to be part of their natal communities, denied the possibility of being in the communities in which their orca, or chimpanzee, or fish personhood might be realized. This has also happened to humans, to enslaved persons, to children stolen from their parents, and to incarcerated and institutionalized persons. Their marginalization—their identification as marginal cases—logically and morally precedes their removal from their own communities. That kind of unjust marginalization, of both humans and nonhuman animals, places the responsibility for their care and treatment on the moral agents who perpetrate it. That they were

not and are not cared for in ways that respect their rights and moral status is a moral failing on the part of those moral agents.

Belonging to a community (that includes humans or animals or both) can thus be sufficient for mattering morally. Both the communities and *some* of their individual members have the capacities required for moral agency. Human communities abundantly demonstrate that certain kinds of collective entities can have the capacities of moral agency even when individual members might not.

### Demarginalizing marginal cases and expanding moral agency

As individual moral agents, one of our obligations to others is to not unjustly marginalize them. Those who do not satisfy ostensible criteria for mattering morally are vulnerable to marginalization, to being treated as if they lack rights and are not entitled to moral and just treatment. Exemplifying the way the diminished status of marginalized humans is falsely attributed to *their* characteristics, Carrie Buck and her mother, Emma, were said to “belong to the shiftless, ignorant, and worthless class of anti-social whites of the South” (according to Albert Priddy, the superintendent of the Virginia Colony for Epileptics and Feeble Minded).<sup>34</sup>

What has been true of historical and contemporary interactions between humans has also been true of human-animal interactions. And in the justification for exploiting animals—whether domesticated or free-living—the ideology of marginalization can be seen in its fullest expression. Animals, having some traits and capacities different than humans, are judged to be in some sense deficient, justifying their treatment as food, as trophies, as entertainment, or as things without moral value or rights. Their diminished status is also falsely attributed to their characteristics.

As Tangwa notes above, moral agents have a multitude of obligations and “can do moral good or evil, irrespective of whether the patient of his or her action (or lack thereof) is a person, a nonhuman animal, a plant, or even an inanimate thing.”<sup>35</sup> If we think about rights in terms of the moral obli-

gations of moral agents to do what will promote the well-being of humans and animals, then both rights and the obligations of moral agents can radically expand. Tangwa likens the attributes of moral agents, including rationality and freedom of choice, to attributes such as power and wealth, all of which “load the heavy burden of moral liability, culpability, and responsibility on the shoulders of their possessor.”<sup>36</sup> Here we see how moral agency can be a capacity not just of individuals but potentially of collectives with power and wealth—corporations, countries, and associations of countries (such as NATO, the European Union, and the G7)—that can also bear the heavy burdens of moral responsibility and have the capacity, the freedom, and the responsibility to act as moral agents.

Only moral agents can have action-demanding duties; and when those duties involve actions that cannot be performed by individuals, and require collective action, we must either view collective entities and groups as moral agents, or we must conclude that no one has moral responsibility. Stephanie Collins notes that it is quite common to ascribe moral obligations to groups in cases where collective action is required:

*When morally pressing circumstances call for synchronized actions by several individuals, we often say the group has a duty: “The hikers have a duty to lift the fallen tree off the child,” “The pedestrians have a duty to stop the mugging,” “The beachgoers have a duty to save the drowning person.” In each case, suppose the morally desirable outcome can be brought about only if the individuals work together.<sup>37</sup>*

Of course, not just any grouping of individuals can function as moral agents in the relevant sense. “Only groups with sufficient structure ... have the necessary agency. Moreover, if duties imply ability then moral agents (of both the individual and collectives varieties) can bear duties only over actions they are able to perform.”<sup>38</sup> Further, some morally urgent problems, such as global climate change and global pandemics, require state action, and here, too, it is sensible to ascribe moral agency to those state actors:

*We tend to think states have moral duties: duties to alleviate global warming, protect citizens’ moral rights, admit asylum seekers, or wage only just wars. This common-sense view accords with a growing philosophical consensus that states are corporate moral agents, able to bear duties as entities conceptually distinct from—though supervenient upon and constituted by—their members.<sup>39</sup>*

The World Health Organization conceives of states and collective entities as having duties:

*States and other duty-bearers are answerable for the observance of human rights. However, there is also a growing movement recognising the importance of other non-state actors such as businesses in the respect and protection of human rights.<sup>40</sup>*

It also recognizes that

*health as a human right creates a legal obligation on states to ensure access to ... the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality.<sup>41</sup>*

These statements acknowledge the agency of states and other collective entities and their obligations to promote the right to that which fosters health. Indeed, only such entities have the capacities to act on health threats of national, regional, and global scales.

We would not want to take the comparison too far, however, and suggest that corporations, states, and organizations of the powerful and wealthy also have moral *rights*. This is a reason to harden the distinction between moral agents and moral patients—the latter have rights, including rights to moral treatment and to the promotion of their health and well-being. The former, the moral agents who are not also moral patients—including those human collectives that have the power, capacity, and responsibility to understand moral obligations, recognize to whom they have moral obligations, and act on those obligations—have duties to respect and promote the rights of moral patients.

## Conclusion

The well-being of humans and animals is increasingly entangled, and the debts incurred by marginalizing humans and animals are coming due. Deforestation for agriculture and monoculture directly destroys the habitats of wildlife and contributes to climate change, thus indirectly resulting in further habitat loss, as well as the loss of habitable and arable land for humans.<sup>42</sup> Economically precarious and marginalized humans will be disproportionately affected by those losses.<sup>43</sup> Animals living in precarious and shrinking environments as humans encroach into their native habitats will be literally marginalized, pushed further and further out to the shrinking margins of forests, prairies, and coral reefs, and will be pushed closer to extinction, while the proximity of humans and animals will increase the spillover of zoonotic diseases, with the potential to create regional and global pandemics.<sup>44</sup> The history of resource, land, environmental, animal, and human exploitation is long and deep but always involves, at some turn, the marginalization of someone and the subsequent violation of someone's rights. It now also threatens the health of all humans and nonhuman animals and of the ecosystems in which they live and on which they depend.

The criteria for mattering morally have long been disputed, and many humans and nonhuman animals have been considered "marginal cases" on the contested edges of moral concern. This has long been a pretext to justify their exploitation, mistreatment, and killing. On the other hand, there is broad and overlapping agreement about the capacities and responsibilities of moral agents. An inclusive and expansive way of thinking about moral status is to situate mattering morally not in the characteristics or capacities of individuals but in the responsibilities and obligations of moral agents. But moral agency can also be more expansive, including not just individual moral agents but entities such as corporations and states that have some of the traits of moral agents—power, freedom, and the capacity to recognize and act on the demands of morality. This expanded view of who and what is a moral agent shifts some of the burden

of moral responsibility for attending to the health and well-being of humans and animals onto these collective entities who uniquely have the capacity to attend to global-scale health threats such as pandemics and human-caused climate change.

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## EDITORIAL

# Health Rights and the Urgency of the Climate Crisis

CARMEL WILLIAMS AND GILLIAN MACNAUGHTON

This special section on health rights and the urgency of the climate crisis could not be more timely. The world came together in Glasgow at the COP26 summit last month to try to avert the global disaster that will result if carbon emissions are not cut sufficiently or with enough haste. But in this matter, the summit was not successful. Despite the unanimous agreement on the goal of limiting global warming to just 1.5°C above pre-industrial levels, state parties did not agree on the speed at which to take the necessary steps to achieve this goal. Scientists are adamant that our primary challenge is to drastically reduce emissions by 2030 and that if this is not achieved, the world will be tipping toward self-destruction. The 1.5°C goal requires global carbon output to be halved by 2030, and countries had to submit their plans on how they would achieve this objective before the Glasgow talks began. But the plans, when analyzed by the Climate Action Tracker, were found to allow emissions at a rate that would “lead to a disastrous 2.4°C of heating.”<sup>1</sup> So the negotiations will continue in 2022 and 2023. Time, one thing not in the state parties’ hands, marches on.

In 2018, the Intergovernmental Panel on Climate Change report detailed the harsh differences in climate change likely to result from moving above 1.5°C, including increases in mean temperature in most land and sea regions, hot extremes in most inhabited regions, heavy precipitation, and probably droughts in other regions.<sup>2</sup> It also outlined the detrimental impacts on low-lying cities and coastal areas, on food production, and on most essential systems, including health systems, of a 2.0°C (compared to 1.5°C) increase. Further, it demonstrated the extra hardship that the added 0.5°C would mean for vulnerable and poor communities. But still, COP26 was unable to convince its member parties to transition away from fossil fuels quickly enough to save lives, livelihoods, and, in the case of small island states, entire nations. India and China both fought against “cutting out” the use of fossil fuels. Instead, they opted for the soft language of “phasing down” coal-fired power plants.

The Glasgow agreement particularly fails low-income countries. The United States and the European Union refused to create a new fund that low-income countries could draw on for crisis responses, even though—as all the papers in this special section acknowledge—low-income countries are far more exposed than high-income countries to loss and damage from adverse climate impacts. Christian Aid delivered a report to COP26 showing that, under current climate policies, the most vulnerable and “least developed

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countries” can expect to see climate change reducing their GDP by 19.6% by 2050 and by 63.9% by 2100. If governments limit global heating to 1.5°C, then the damage would be reduced but would remain significant. In a 1.5°C world, these nations would see their GDP hit by 13.1% by 2050 and 33.1% by 2100.<sup>3</sup>

Low- and middle-income countries report that climate change is already costing them as they repair the damages it causes, for which they rightly seek compensation. In his 2019 report to the UN General Assembly, David Boyd, UN Special Rapporteur on human rights and the environment urged states to establish a new financing mechanism to fund payments for loss and damage suffered by vulnerable low-income countries due to climate change.<sup>4</sup> Reparation is a complex and challenging issue and is the subject of Audrey R. Chapman and A. Karim Ahmed’s paper, “Climate Justice, Human Rights, and the Case for Reparations.” The underpayment of pledges from high-income, high-emissions (historically and currently) countries to help low- and middle-income countries adapt to and mitigate climate impacts has led to Chapman and Ahmed’s suggestion for a new human rights-oriented fund for reparations. They suggest that the fund should be supervised by the United Nations Human Rights Council, linked to human rights accountability mechanisms, and organized similarly to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Further, they identify the parties most responsible for the climate crisis, whom they argue, from an equity perspective, are obligated to contribute the most to reparation funds.

Like the COVID-19 pandemic, climate change is a global crisis that is hardest on the countries and people who are least privileged and least resourced. Successful responses to COVID-19 required interdisciplinary and cross-sectoral responses based on public health leadership, political commitment, state funding, legal underpinnings and regulations, and people’s trust. Many governments around the world accepted that the pandemic posed extreme threats to health, lives, and livelihoods, and they found the funding necessary to subsidize businesses that had to close temporarily, to help individuals

who lost their jobs, to provide shelter for homeless people, to purchase and distribute vaccines, to bolster intensive care capacity in hospitals, and, generally, to keep society functioning to the greatest extent possible to enable a full recovery as quickly as possible. These actions showed that states can respond expeditiously to crises when deemed necessary.

It is therefore puzzling that state responses to the existential crisis of climate change remain lackluster. Perhaps it is a function of the fact that many who hold political power will not be around to face the future that a 2.0°C-warmer world promises. In contrast, youth are very engaged and vocal in their demands for action for climate justice—it is their lives and their opportunities that are most threatened. Giulia Gasparri et al., in their paper “Children, Adolescents, and Youth Pioneering a Human Rights-Based Approach to Climate Change,” draw on the authors’ own experiences in the youth activist space to show the many ways in which youth are operationalizing rights-based responses to climate change. These rights-based approaches include a demand for young people’s participation and inclusion in the global and local arenas where decisions on climate action are made. Not surprisingly, youth were present at COP26 but, like the rest of civil society, not in the negotiating rooms, and they were frustrated with the outcomes. The paper also describes young people’s focus on equality and nondiscrimination and their heightened awareness of climate change impacts on vulnerable and marginalized populations. The authors explain that young people are driving climate accountability through formal contributions to legislative and judicial processes and by engaging international human rights mechanisms.

Also raising the key human rights principle of participation, David W. Patterson, in his paper “The Right to Health and the Climate Crisis: The Vital Role of Civic Space,” expresses concern at the lack of community participation in climate crisis discussions. He notes the restrictions placed on civic space—such as bans on public gatherings and protests—throughout the COVID-19 pandemic, and he fears that these restrictions could continue

into the future when they are no longer needed to reduce the spread of disease. Patterson calls for human rights, public health, and environmental activists to collaborate to address climate change and to defend the civic space necessary for their participation in climate discussions. Recognizing the interrelatedness of all human rights, he contends that the right to health provides a valuable opportunity for engaging a broader range of advocates in the response to the climate crisis, while warning that civil and political rights—such as the rights to information, to participation, to freedom of association, and to peaceful assembly—must also be protected if these actors are to contribute meaningfully and be heard.

Chuan-Feng Wu, in his paper “Challenges to Protecting the Right to Health under the Climate Change Regime,” looks at the contributions of the judiciary to addressing the harms inflicted by the climate crisis. While recognizing the many difficulties in litigating climate cases—including the challenge of proving causal links between specific state actions (or lack of action), climate change, and specific harms to individuals—Wu shows that there is potential for courts to play an important role in pushing states to take actions to mitigate and adapt to climate change, as well as in compensating victims for losses due to climate crises. Wu argues for building bridges between the climate regime and the human rights regime by centering actions on the right to health. Although not all courts consider right to health claims in the realm of climate protection to be justiciable, Wu notes that several courts at the domestic and international levels have done so, and he outlines such cases from around the world. He concludes that climate change and the right to health do not occupy entirely separate legal spheres and that a failure to mitigate or adapt to climate change may be tantamount to violating the right to health.

Along similar lines, Thalia Viveros-Uehara, in her paper “Health Care in a Changing Climate: A Review of Climate Change Laws and National Adaptation Plans in Latin America,” examines the extent to which legal and policy responses to climate change incorporate a human rights-based

approach to health care systems, using the case studies of Brazil and Colombia. Analyzing the climate laws and national adaptation plans of both countries, she finds that they only partially incorporate concerns for equality and nondiscrimination, participation, transparency, and monitoring and accountability, and pay even less attention to the key elements of the right to health—availability, accessibility, acceptability, and quality of health care. Further, although the World Health Organization has issued guidelines on incorporating health into national adaptation plans, these two countries’ plans do not explicitly embrace health rights. As a result, the climate laws and plans in Brazil and Colombia fail to ensure that their public health care systems will be adequately prepared to meet the health needs of the people most vulnerable to climate change impacts.

The COVID-19 pandemic drew attention to the underpreparedness of health systems around the world to cope with public health crises. Underinvestment throughout the past 40 years has led to extreme staff shortages and facility overloads, which increased the death toll from COVID-19. In their paper “Crises as Catalyst: A New Social Contract Grounded in Worker Rights,” Diane F. Frey et al. recognize the devastating impacts that three intersecting crises—climate change, the pandemic, and extreme economic and social inequality—have had on workers and their families. Crises may act as catalysts, however. In this context, they argue that the recovery from COVID-19 and the related economic crisis presents opportunities for a just transition to also address climate change and extreme inequalities. In particular, they argue that the neoliberal social contract is failing workers and the planet alike, and they call for a new social contract grounded in workers’ rights to decent work, to favorable conditions of work, to join and form trade unions, and to social protection. They conclude optimistically that a new transformative social contract grounded in human rights—specifically worker rights—would reduce inequalities, protect the health and livelihoods of workers and their families, and promote a sustainable future.

The complexities of climate change, including

the global power differences between those most responsible for emissions (states and nonstate enterprises) and those suffering most from the human and environmental consequences, demand a more progressive interpretation of international human rights. While, traditionally, states are accountable for human rights concerns within their territory or jurisdiction, climate change impacts do not stop at national borders. Further, legal actions usually call for proving a direct causal connection between the action of the respondent and the harm of the claimant—a connection that is almost impossible to draw in climate cases. However, some courts and legislatures have interpreted human rights more progressively to include, for example, the “precautionary principle” and other means of protecting the human right to health and the sustainability of the planet. Such progressive interpretations are necessary to meet the human rights challenges posed by climate change.

We are also encouraged by the recently adopted Human Rights Council resolutions to create a new human right to a safe, clean, healthy, and sustainable environment and a new mandate of the Special Rapporteur on the promotion and protection of human rights in the context of climate change.<sup>5</sup> Both actions signal that climate change and a sustainable environment are now regarded as key human rights concerns that warrant greater attention and greater accountability. As many of the papers in this special section note, linking state climate change responsibilities to international human rights accountability mechanisms would greatly enhance global attention to the actions (or lack of action) taken by states to protect the human rights threatened by global warming.

We end this editorial with four recommendations that we believe the new Special Rapporteur should consider as necessary next steps to deepen engagement with human rights in global and national climate change discussions and actions:

- Explicit acknowledgment should be made that deep and immediate transformational action is needed to avert the current and impending

threats from climate change to the health and livelihoods of millions of people, and that respecting, protecting, and fulfilling human rights must be part of the solution.<sup>6</sup>

- Explicit acknowledgment should also be made that neoliberal policies contribute to the causes of climate change and prevent adequate responses to the human rights harms from climate change. Solidarity, both globally and domestically, is necessary to protect our human rights.
- Human rights-based climate impact assessments should be required of all state-proposed policies and projects at the local, national, and international levels, including those of multinational organizations and international financial institutions.
- State reporting on climate change actions and inaction, including analysis in comparison to their United Nations Framework Convention on Climate Change national adaptation plans, should be required by all human rights accountability mechanisms, including the Universal Periodic Review.

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# Climate Justice, Humans Rights, and the Case for Reparations

AUDREY R. CHAPMAN AND A. KARIM AHMED

## Abstract

The global community is facing an existential crisis that threatens the web of life on this planet. Climate change, in addition to being a fundamental justice and ethical issue, constitutes a human rights challenge. It is a human rights challenge because it undermines the ability to promote human flourishing and welfare through the implementation of human rights, particularly the right to life and the right to health. It is also a human rights challenge because climate change disproportionately impacts poor and the vulnerable people in both low-income and high-income countries. Those living in many low-income countries are subject to the worst impacts of climate change even though they have contributed negligibly to the problem. Further, low-income countries have the fewest resources and capabilities at present to adapt or cope with the severe, long-lasting impacts of climate change. Building on human rights principles of accountability and redress for human rights violations, this paper responds to this injustice by seeking to make long-neglected societal amends through the implementation of the concept of climate reparations. After discussing the scientific evidence for climate change, its environmental and socioeconomic impacts, and the ethical and human rights justifications for climate reparations, the paper proposes the creation of a new global institutional mechanism, the Global Climate Reparations Fund, which would be linked with the United Nations Human Rights Council, to fund and take action on climate reparations. This paper also identifies which parties are most responsible for the current global climate crisis, both historically and currently, and should therefore fund the largest proportion of climate-related reparations.

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## Introduction

At the beginning of the third decade of the 21st century, we are confronting an unprecedented crisis of global climate change. However, neither the causes nor the impacts of climate change are equally shared among different regions of the world. While the first scientific evidence that global warming from the continuing emission of greenhouse gases posed an existential threat to life on earth was pointed out many decades ago, it did not become a priority concern for policy makers until recently. The scientific evidence now leaves no doubt that climate change is human induced. Above all, its current and potential environmental impacts and socioeconomic consequences are well documented and agreed on by the global scientific and policy-making communities.<sup>1</sup>

In discussions about climate change and global warming, one policy issue that needs greater and more immediate attention is the question of who bears the primary ethical responsibility and financial obligation for addressing this crisis. There is increasing reason to believe that the severest consequences of global warming will fall most heavily on low-income countries and vulnerable groups who have been of priority concern to the human rights community. This paper examines the human rights dimensions of this problem, placing it within a climate justice context. The critical question we consider is this: What role should high-income countries undertake in meeting their obligation to not only significantly reduce and mitigate their current emissions of greenhouse gases but also to make reparations for the harm their emissions, both historically and at present, have inflicted on low- and middle-income countries (LMICs)?

### Impact of climate change on the web of life

Today, climate change and its accompanying global warming are a fact of life. We have already reached a global mean temperature of 1.1°C over pre-industrial levels.<sup>2</sup> In its 2018 interim special report, the expert Intergovernmental Panel on Climate Change (IPCC) predicted that a global temperature increase of 1.5°C over pre-industrial levels would

occur sometime between 2030 and 2052, which could have catastrophic effects on the web of life on this planet.<sup>3</sup> In its most recent assessment report (published in August 2021), the IPCC concluded in no uncertain terms:

*It is unequivocal that human influence has warmed the atmosphere, ocean and land. Widespread and rapid changes in the atmosphere, ocean, cryosphere and biosphere ... The scale of recent changes across the climate as a whole and the present state of many aspects of the climate system are unprecedented over many centuries to many thousand of years ... Human-induced climate change is already affecting many weather and climate extremes in every region across the globe. Evidence of observed changes in extremes such as heatwaves, heavy precipitation, droughts, and tropical cyclones, and in particular, their attribution to human influence, has strengthened since AR5 [an assessment report published by IPCC in 2014].<sup>4</sup>*

What is not entirely clear is where our future lies—whether we can slow this rate of increase or whether we will allow this trend to continue, with climatic conditions that would undermine the web of life and render many regions of our planet problematic for human flourishing.

### Present and historical sources of greenhouse gas emissions

One way of assessing the contribution of current and past greenhouse gas emissions to global warming is to examine its major contributing component, namely carbon dioxide (CO<sub>2</sub>), a major by-product of fossil fuel combustion. The estimated global annual emissions of CO<sub>2</sub> were about 5 billion metric tons in 1950, increasing to 22 billion metric tons by 1990, with the most recent estimate (2019) reaching over 36 billion metric tons.<sup>5</sup> This amounts to greater than a sevenfold increase in annual atmospheric CO<sub>2</sub> emissions in 70 years, while the world population rose only threefold in that same time frame (2.5 billion to 7.8 billion).<sup>6</sup> These figures reflect a sharp increase in per capita combustion of fossil fuels, which have provided the main source of energy for a fast-growing world economy. However,

this dependence on fossil fuels has come at a high a price—a warming planet at the edge of a precipitous global calamity.

A significant contributor to global warming is the amount of greenhouse emissions emitted by high-income countries. A recent analysis conducted by the World Resources Institute points out the stark differences between top and bottom greenhouse gas emitters:

*The top three greenhouse gas emitters—China, the European Union and the United States—contribute 41.5% of total global emissions, while the bottom 100 countries account for only 3.6%. Collectively, the top 10 emitters account for over two-thirds of global [greenhouse gas] emissions.<sup>7</sup>*

Currently, China leads the world in annual atmospheric carbon dioxide emissions, followed by the United States, India, the Russian Federation, and Japan. In the last decade, China overtook the United States as the largest annual source of emissions of CO<sub>2</sub>. In Table 1, the top 10 annual emitters of CO<sub>2</sub> from fossil fuel combustion in 2018 are listed by country.

With regard to historical greenhouse gas emissions, since the beginning of the industrial age in the mid-18th century, the United States has been by far the biggest contributor to atmospheric CO<sub>2</sub>. Table 2 lists the top 15 historical contributors.

As can be seen in Table 2, the United States and the European Union's 28 countries (which

included the United Kingdom until last year) are the largest cumulative contributors to present-day global warming, accounting for over half (51%) of the historical emissions of greenhouse gases. Additionally, the top 15 contributors account for over 88% of past cumulative CO<sub>2</sub> emissions.

Countries' per capita annual emissions differ significantly. Table 3 presents the per capita CO<sub>2</sub> emissions of the top 21 countries in 2018, the latest year for which such data are available.

## The human rights impact of global climate change

Global climate change constitutes a major human rights challenge because the magnitude and severity of its adverse consequences will not be experienced equally by all people—rather, it will be felt most acutely in low-income populations and other groups already susceptible to human rights abuses. In her opening statement to the 42nd session of the Human Rights Council in 2019, Michele Bachelet, the United Nations High Commissioner for Human Rights, warned that “the human rights implications of currently projected levels of global heating are catastrophic.”<sup>8</sup> She went on to state that “climate change threatens the effective enjoyment of a range of human rights including those to life, water and sanitation, food, health, housing, self-determination, culture and development.”<sup>9</sup> Consistent with our call for a human rights response to climate

TABLE 1. Top 10 current atmospheric CO<sub>2</sub> emitters from fossil fuel combustion

Rank	Country	Annual CO <sub>2</sub> emissions (billion metric tons) 2018
1	China	9.5
2	United States	4.9
3	India	2.3
4	Russian Federation	1.6
5	Japan	1.1
6	Germany	0.67
7	South Korea	0.61
8	Iran	0.58
9	Canada	0.57
10	Indonesia	0.54

Source: International Energy Agency, *IEA atlas of energy: CO<sub>2</sub> emissions from fuel combustion* (Paris: International Energy Agency, 2021). Available at <http://energyatlas.iea.org/#/tellmap/1378539487/0>.

change, she added that “states have a human rights obligation to prevent the foreseeable adverse effects of climate change and ensure that those affected by it, particularly those in vulnerable situations, have access to effective remedies and means of adaptation to enjoy lives of human dignity.”<sup>10</sup> She reiterated these concerns in 2021 in her statement to the 48th session of the Human Rights Council, stating that as the interlinked crises of climate change, pollution, and biodiversity loss multiply, “they will constitute the single greatest challenge to human rights in our era.”<sup>11</sup>

Clearly, global climate change is already undermining the ability to promote human flourishing and welfare through the implementation of economic and social rights in many societies and will increasingly be problematic. The global climate crisis also affects the ability to protect and promote specific human rights. Among them are the right to life and the right to health, as well as several social determinants of the right to health, such as access to nutritious food, safe water, sanitation, and housing. In relation to public health, the adverse health consequences caused by climate change include heat-related disorders, greater incidence of water-related and vector-borne diseases, respiratory

and allergic disorders, malnutrition, violence, and mental health problems.<sup>12</sup>

Underscoring the impact of climate change on human health, more than 230 leading medical journals from a wide range of countries published a joint editorial a few weeks ahead of the 2021 COP26 climate conference in Glasgow to warn that the greatest threat to public health would be the failure to prevent the global temperature from rising above 1.5°C. The editorial echoes the warnings that health is already being harmed by global temperature increases.<sup>13</sup> Such health consequences will most severely impact infants and young children, especially those living in low-income countries in Asia, Africa, and Latin America. This is because, compared to adults, children require more food and water per unit of their body weight, are less able to survive extreme weather events, and are particularly susceptible to toxic chemicals, temperature changes, and diseases.<sup>14</sup> According to a recently published UNICEF report, one billion children are at extremely high risk of the impacts of the climate crisis.<sup>15</sup> The report indicates that the aggregate disease burden of children living in LMICs from climate-related outcomes, such as malnutrition, diarrhea, and malaria, is likely to increase. Henri-

TABLE 2. List of largest historical emitters of atmospheric CO<sub>2</sub> (1751 to 2017)

Rank	Country	Cumulative CO <sub>2</sub> emissions (billion metric tons)	Percentage of global CO <sub>2</sub> emissions
1	United States	457	29
2	European Union (28 member states)	353	22
3	China	200	12.7
4	Russian Federation	101	6
5	Japan	62	4
6	India	48	3
7	Canada	32	2
8	South Africa	19.8	1.3
9	Mexico	19	1.2
10	Ukraine	19	1.2
11	Australia	17.4	1.1
12	Iran	17	1
13	South Korea	16	1
14	Brazil	14.2	0.9
15	Saudi Arabia	14	0.9

Source: H. Ritchie, “Who has contributed most global CO<sub>2</sub> emissions?” Our World in Data (2019). Available at <https://ourworldindata.org/contributed-most-global-co2>.

etta Fore, UNICEF's executive director, warns that "virtually no child's life will be unaffected," making climate change a children's rights crisis. Moreover, she notes that children from countries that are least responsible will suffer most.<sup>16</sup>

Among the people most vulnerable to climate change are members of minority and Indigenous groups, older individuals, people with chronic diseases and disabilities, and low-income people living in marginal environments. Climate change will make women's responsibility for gathering water, food, and fuel for their households in poor countries more difficult. Because the lives of Indigenous people are so closely tied to the natural environment, they are likely to suffer both disproportionate physical loss and a sense of spiritual loss and a lack of well-being.<sup>17</sup> People who will be particularly susceptible to the health consequences of climate change also consist of many of the vulnerable groups of concern to the human rights community: those who are poor, members of minority groups, older people, people with chronic

diseases and disabilities, and workers exposed to extreme heat.<sup>18</sup> Moreover, individuals from these communities will lack the resources to adapt to and cushion the blows from climate change. There is thus concern that the intranational socioeconomic disparities between affluent and disadvantaged groups due to the impacts of climate change may enter into a self-reinforcing vicious circle, whereby the initial inequality will result in disadvantaged groups suffering disproportionately, leading to greater subsequent inequality.<sup>19</sup>

Most unjustly, even though individuals in LMICs have contributed negligibly to global warming, they are being subjected to the worst impacts of climate change currently and will be increasingly into the future. Eight of the 10 countries most affected by the quantifiable impacts of extreme weather events in 2019 were in the low-to lower-middle-income category and half were least-developed countries.<sup>20</sup> Small island states are particularly vulnerable to the sea level rise. Some of them, such as the Bahamas, Kiribati, the Mar-

Table 3. Per capita annual emissions of CO<sub>2</sub> by country (2018)

Rank	Country	Per capita annual CO <sub>2</sub> emissions (tons)
1	Saudi Arabia	18.48
2	Kazakhstan	17.60
3	Australia	16.92
4	United States	16.56
5	Canada	15.32
6	South Korea	12.89
7	Russian Federation	11.74
8	Japan	9.13
9	Germany	9.12
10	Poland	9.08
11	Iran	8.82
12	South Africa	8.12
13	China	7.05
14	United Kingdom	5.62
15	Italy	5.56
16	Turkey	5.21
17	France	5.19
18	Mexico	3.77
19	Indonesia	2.30
20	Brazil	2.19
21	India	1.96

Source: Union of Concerned Scientists, Each country's share of CO<sub>2</sub> emissions (August 12, 2020). Available at <https://www.ucsusa.org/resources/each-countrys-share-co2-emissions>.

shall Islands, and the Maldives, are currently only a mere three to four meters above mean sea level. Like other LMICs, many of these small island states also have limited funds and poorly developed infrastructures, making it difficult for them to adapt to these challenges.<sup>21</sup> Likewise, Bangladesh, with its flat, low-lying and delta-exposed topography and high population density, is very vulnerable to sea level rise.<sup>22</sup> Much of the population in many LMICs lives in rural areas and is dependent on agriculture, a sector that is highly vulnerable to environmental conditions, particularly when it comes to steady access to a supply of water. African countries, already some the poorest and most disadvantaged countries, are among the most vulnerable to climate change because of multiple existing stresses and low adaptation capacity. Prolonged drought in many areas is drastically reducing water resources and food productivity, resulting in severe famine conditions.<sup>23</sup>

Recently, the Human Rights Council, at its 48th session, adopted a resolution recognizing a new right: the right to a safe, clean, healthy, and sustainable environment. The resolution encourages member states to build capacity for efforts to protect the environment. It also asks member states to adopt policies for the enjoyment of the right.<sup>24</sup>

Several Special Rapporteurs in the United Nations human rights system have mandates that overlap with policy issues related to the climate crisis; these include the Special Rapporteurs on health, on food, on safe water and sanitation, and on Indigenous peoples. The Special Rapporteur on human rights and the environment does so even more directly. During its 48th session in October 2021, the Human Rights Council also established a Special Rapporteur with a mandate to promote and protect human rights in the context of climate change.<sup>25</sup>

## The case for climate reparations

Human rights obligations require that states cooperate toward the promotion of human rights globally, and as the High Commissioner for Human Rights has stated, this should include adequate financing from those who can best afford it for

climate change mitigation, adaptation, and rectification of damage.<sup>26</sup> Moreover, for equity to be at the center of the global response, countries that have disproportionately created this environmental crisis must do more to compensate for damages they have caused, particularly with respect to the most vulnerable countries. This brings us to the subject of reparations.

Reparations are generally understood as an effort to redress significant societal harm through acknowledgment of wrongdoing and through in-kind and monetary means. Reparatory justice also entails acceptance of responsibility, followed by undertaking measures that seek to address and repair societal injustices and widespread harms.<sup>27</sup> Applied to climate change, reparations would first entail identifying those entities—both countries and private corporations—whose greenhouse gas emissions have contributed the most to climate change. It would require countries and the international community to recognize the harms they have caused, in order to rectify the serious damage being inflicted disproportionately on low-income countries as a result of climate change.<sup>28</sup>

Climate reparations are justified by the principles of fairness and equity. Here, the principles identified by philosopher Henry Shue are helpful to consider.<sup>29</sup> According to Shue, the “first principle” of equity is the following:

*When a party has in the past taken an unfair advantage of others by imposing costs upon them without their consent, those who have been unilaterally put at a disadvantage are entitled to demand that in the future the offending party shoulder burdens that are unequal at least to the extent of the unfair advantage previously taken, in order to restore equality.<sup>30</sup>*

To put it more simply, those who have made a greater contribution to a harmful problem and received its benefit have an obligation to rectify it. According to Shue, in the area of development and the environment, the initiation of global warming by the process of industrialization, which has enriched the Global North but not the South, constitutes a clear example of this principle. In response to those who

argue that today's generation in the industrialized states should not be held responsible for damage done by previous generations, he points out that contemporary generations are reaping the benefits of rich industrial societies and have continued to contribute to global warming despite their awareness of its harmful consequences.<sup>31</sup> This means that the countries that have received most of the historical benefits of industrialization and enjoyed the highest income from oil and gas extraction should bear the burden of financing reparations to benefit the most affected low-income countries, which have generally made little contribution to the serious, long-lasting consequences of climate change.

Shue's "second principle" of equity is related to certain parties' greater ability to pay. This principle states, "Among a number of parties, all of whom are bound to contribute to some common endeavour, the parties who have the most resources normally should contribute the most to the endeavour."<sup>32</sup> When applied to the climate crisis, this principle further places the equity burden on high-income countries, which are most able to pay for adaptation to the climate crisis, and not the low-income countries, which are least able to pay to make themselves more resilient to climate risks. This principle additionally lays at least some of the responsibility on the major corporations involved with fossil fuel extraction and sales.

Shue's "third principle" of equity serves the purpose of avoiding making those who are already worst off even more worse off. According to Shue, in a situation of radical inequality, fairness demands that those people with less than enough for a decent human life be provided with enough. This principle of equity states:

*When some people have less than enough for a decent human life, other people have far more than enough, and total resources available are so great that everyone could have at least enough without preventing some people from retaining considerably more than others have, it is unfair not to guarantee everyone at least an adequate minimum.<sup>33</sup>*

Maintaining a guarantee of an adequate minimum could mean either not interfering with others'

ability to maintain a minimum for themselves or embracing a stronger requirement to provide assistance to enable others to do so. One implication is that any agreement to cooperate made between one group of people having more than enough and another group of people who do not have enough cannot justifiably require those in the second group to make sacrifices. Applied to the climate crisis, countries that are operating climate harmful industrial processes cannot ask low-income countries, which are poor in large part because they have not industrialized, to make sacrifices in order to rectify the problem.

Taken together, these equity principles require that whatever needs to be done about global climate change, the costs should be borne by those most responsible and not by the countries currently most affected. In a detailed review of the key factors that should be considered in framing a rationale for climate reparations, Maxine Burkett states:

*In the absence of a substantial commitment to remedy the harm faced by the climate vulnerable, reparations for damage caused by climate change can provide a comprehensive organising principle for claims against those most responsible while placing key ethics and justice concerns—concerns that have been heretofore woefully under-emphasised—at the centre of the climate debate.<sup>34</sup>*

Applied here, climate reparations would require raising funds and material resources from the governments in the countries most responsible historically for the climate crisis. We also propose that the major fossil fuel extraction corporations be held responsible for their role in contributing to climate change and therefore be asked to contribute to reparations. Not only have they profited financially over time, but these corporations have led a campaign over many years to deny the existence of human-induced climate change, funding scientists and lobbyists to do their bidding—and then when it was no longer possible to deny the existence of climate change, they argued that fossil fuel extraction and use were not the cause.<sup>35</sup>

A one-off payment would not offer a permanent solution to the disproportionate impacts

of climate change. Instead, climate reparations should be envisioned as a series of initiatives to raise financial assistance, transfer resources, and provide technical expertise to low-income and vulnerable countries, as well as requiring all countries, particularly the affluent industrialized countries in Western Europe, the United States, and China, to adopt significantly more carbon-free energy policies.<sup>36</sup>

### International framework to implement climate reparations

A program of global climate reparations requires an international mechanism for implementation. There is an existing institution—the Green Climate Fund (GCF)—intended to provide economic assistance to low-income countries detrimentally affected by climate change. The GCF was agreed to by the Conference of the Parties in 2010 under the aegis of the United Nations Framework Convention on Climate Change. It became operational a few years later, with administrative offices located in Incheon, South Korea.<sup>37</sup> It is currently the largest international fund dedicated to fighting climate change. Part of its mandate is to assist low-income countries in mitigating and adapting to climate change through project design and implementation.<sup>38</sup> Its 24-member board has equal representation from low- and high-income countries. Its funds are derived from public and private sources, including multilateral, regional and national development agencies; international and national banks; and private equity institutions.<sup>38</sup> It should be noted that the GCF operates on technical and economic grounds, not ethical or human rights principles.

Unfortunately, the GCF has been unable to raise sufficient funds to fulfill its mandate and meet the needs of the low-income countries most affected by climate change. At the COP15 held in 2009 in Copenhagen, Denmark, participating countries committed to raise US\$100 billion per year by 2020 through public and private sources to fund climate-related programs.<sup>39</sup> While there is considerable controversy over what should be counted as part of that US\$100 billion per year, one of the

mechanisms for collecting and distributing these funds to low- and middle-income countries is the GCF. According to its latest annual report (2020), the GCF had raised US\$2.1 billion, with another US\$2.8 billion committed through private investments to programs related to mitigation (63%) and adaptation (37%). However, only US\$1.5 billion of these funds were allocated to lower-income countries, African states, and climate-vulnerable countries, such as small island states.<sup>40</sup> It is believed that such a shortfall of climate-related funds can be laid primarily at the feet of many industrialized countries, whose financial contributions to the GCF have been quite disappointing to date.<sup>41</sup> Therefore, the present international mechanism for providing funds for climate-related programs is seriously failing to meet its intended purpose, let alone serve as the potentially chief instrument for a more ambitious climate reparations initiative.

We think that it is important to respond to climate change on the basis of equity and human rights rather than on economic or technical grounds, including with regard to the manner in which programs will be executed. It may well be that the reason the GCF has raised only a fraction of the funds committed 10 years ago at COP16 is in part because neither ethical nor human rights appeals have been made. Moreover, donations to the GCF have been voluntary and haphazard. There have been no formulas setting forth expected donations. A human rights and ethical approach centered on reparations principles with a related levy mechanism may be more effective in garnering financial support. The most recent IPCC report's warning concerning the dire consequences of not lowering carbon dioxide emissions—documented by reports of rising temperatures, extreme weather events, and waves of wildfires in many regions—will hopefully convince policy makers that the effects of climate change are occurring now and are not something that will happen in the distant future. It might also spur them to respond in a more urgent and meaningful manner at the present time. Above all, an international assessment scheme for climate reparations based on criteria linked to responsibility for global climate change, as we recommend

here, combined with high-visibility reporting on whether each country has made its rightful contributions, would likely provide greater motivation and accountability.

Therefore, we propose the establishment of a Global Climate Reparations Fund (GCRF) that would operate more consistently within human rights and equity principles and have a substantially more robust budget. The main goals of the envisioned GCRF would be to provide compensation for damages inflicted by climate change on low-income countries and small island states. This assistance would apply to those countries that have been or are being threatened by global climate change, in accordance with the level of loss and damages already experienced or those damages that are projected in the near term. Some middle-income countries confronting climate-induced problems, such as severe loss of water resources and other climate-related calamities, would also qualify for technical and financial assistance.

We anticipate that the proposed GCRF would be more successful than the GCF in raising climate-related funds for several reasons. As noted above, the worsening climate crisis and the warnings of expert bodies of a dire future provide an incentive to take more immediate action. The current plight of small island states and coastal communities provides additional motivation for the global community to initiate a joint response much more urgently. Also, the issue of reparations for past abuses and harms has received considerable currency historically and in recent years for several different purposes. Some well-known examples are financial payments made by the German government to Holocaust victims and their families beginning in 1952 through payments to the government of Israel; the Canadian government's compensation in 2019 to Indigenous persons who were forcibly removed from their families and made to attend Indian residential schools to assimilate them into white society; and the US government's payments in 1988 to Japanese Americans interned during World War II. In addition, several of the transitional justice commissions established in countries experiencing patterns of severe human

rights abuses, violence, and conflict have gone beyond efforts to document the perpetrators to recommend some form of recompense to victims. Currently, the question of reparations for the labor of enslaved Black Africans is being discussed in the United States, including among several city governments and universities that have made financial commitments to provide long-deferred reparations for that purpose.<sup>42</sup> As mentioned above, we believe that framing contributions to a reparations fund as an ethical and human rights obligation is more likely to engender a successful monetary response than the GCF's more technically related approach. Further, fundraising seems more likely to be effective if the contributions are assessed on the basis of formulaic criteria linked to responsibility for global climate change, as we recommend here.

We recommend that the GCRF be headquartered in Geneva, where it could operate as an innovative kind of Special Procedures mechanism under the Human Rights Council. This would emphasize that climate reparation is a human rights issue, with the fund's collection and distribution of resources, as well as its operating procedures, determined by human rights principles. Like other Special Procedures expert working groups, its members would be appointed by the Human Rights Council, and it would issue reports to be reviewed by the council at least once a year. The role of this working group would be to make major decisions about priorities in countries receiving funding and to oversee operations and funding commitments.

What we have in mind is to model the operation of the GCRF after the Global Fund to Fight AIDS, Tuberculosis and Malaria, often referred to as the Global Fund. The Global Fund was independently established in 2002, with administrative offices based in Geneva.<sup>43</sup> Before the COVID-19 pandemic, the Global Fund raised and invested some US\$4 billion annually in grants to support programs and projects submitted by applicant countries.<sup>44</sup> Hopefully, the proposed GCRF would handle an even larger portfolio of funding.

Similar to the Global Fund, the GCRF would have a country-centered partnership model of shared governance that incorporates key stake-

holders. We envision that it would provide funding on a priority basis to countries affected by climate change, with the use of the funds being determined by the recipient countries. In-kind and technical assistance could be provided if requested.

At present, the Global Fund has a secretariat to conduct day-to-day operations, oversee fundraising, and provide support for program implementation under the aegis of a broadly representative board. It operates through five subcommittees focusing on strategy development, governance oversight, commitment of financial resources, assessment of organizational performance, and resource mobilization and advocacy.<sup>45</sup> The proposed GCRF may need a somewhat similar structure, with working groups appointed by the Human Rights Council, which would serve as a governing body in order to make key policy decisions and oversee the distribution of funds.

### Climate reparations financing

Consistent with Henry Shue's first principle of equity, we propose that the funding for climate reparations come from the countries and private corporations most responsible historically for the CO<sub>2</sub> emissions that have caused the present climate crisis, along with the countries contributing the highest current levels of emissions that are intensifying climate change. Reflecting Shue's second principle of equity, these countries and corporations also have the greatest means to do so.<sup>46</sup> In line with Shue's third principle, this funding scheme for climate reparations would avoid making those who are already worst off even worse off. For this reason, it would not be appropriate to impose reparations charges on low-income countries. We would leave the precise formula as to how to levy these sources of funding to the leaders of the GCRF.

As seen in Table 2, the United States (29%), European Union countries (22%), and China (12.7%) account for the largest cumulative amount of atmospheric CO<sub>2</sub> emissions since the start of the industrial age in the mid-eighteenth century. Therefore, we anticipate that these three would be a major source of climate reparations financing, with

the funds levied in accordance with their overall historical contributions to atmospheric emissions. Russia, Japan, and India are also among the top six CO<sub>2</sub> emitters historically, but on a much smaller scale, and would be levied proportionately less in their contributions to climate reparations.

Table 1 lists those countries most responsible for current annual emissions of CO<sub>2</sub>. China, with 9.5 billion metric tons, is by far the leading emitter, contributing more than twice the amount as the United States, which is in second place. The other countries in the top 10 are India, the Russian Federation, Japan, Germany, South Korea, Iran, Canada, and Indonesia. If the countries of the European Union were listed as a group, they would most likely be the third-largest source of annual CO<sub>2</sub> emissions.

Table 3 lists the per capita atmospheric annual CO<sub>2</sub> emissions for 2018, the most recent year for which data are available. Unfortunately, these data do not provide a cumulative total for the countries in the European Union, as does Table 2 on largest historical emitters of atmospheric CO<sub>2</sub>. Given the major differences in countries' populations, it is important to consider per capita emissions so that large-population middle-income countries such as China and India are not unduly penalized. In Table 3, the order of responsibility for current emissions is quite different from the order in Table 2 on largest historical emitters. The 10 highest per capita atmospheric emitters are Saudi Arabia, Kazakhstan, Australia, the United States, Canada, South Korea, the Russian Federation, Japan, Germany, and Poland. We believe that these countries, particularly those near the top of the list, should also be major contributors to climate reparations funding.

In addition to imposing climate reparations based on countries' historical emissions, we propose levying reparations in accordance with countries' current levels of emissions. In this regard, we propose that a scheme of global carbon taxation or other financial contribution be levied in accordance with each country's current annual total CO<sub>2</sub> emission levels (see Table 1), balanced with current per capita emissions (see Table 3). This dual source would complement the levy based on coun-

tries' historical emissions (see Table 2). We think that such a measure is appropriate for assessing climate reparations because, as noted above, countries with large populations should not be unduly penalized for their numbers. A country's total annual CO<sub>2</sub> emissions are also relevant for assessing climate reparations since this figure reflects public policies that result in excessive energy consumption, including both a lack of initiatives to reduce per capita emissions and decisions about the kind of energy sources to promote. Here, the fact that China is currently the biggest annual CO<sub>2</sub> emitter (9.5 billion metric tons) is due both to its population size and to its continuous construction of coal-fired power plants—currently outnumbering those in the rest of the world combined—in order to drive its economy.<sup>47</sup> The United States is in second place (4.9 billion metric tons), followed by India, Russia, Japan, Germany, South Korea, Iran, Canada, and Indonesia. The imposition of a global carbon tax would provide additional financial resources to the climate reparations fund, while encouraging countries to lower their CO<sub>2</sub> emissions by cutting their fossil fuel consumption.

Major corporate contributors to CO<sub>2</sub> emissions in the past 50 years should also be an important source of funding. Data compiled by the Climate Accountability Institute reveal that 20 private corporations have contributed over one-third of all energy-related carbon dioxide and methane emissions worldwide since 1965. Many of them also previously played a major role in financing campaigns promoting false and misleading information that climate change was not occurring, followed by campaigns claiming that even if it were, CO<sub>2</sub> emissions were not responsible. Twelve of the top 20 companies are state-owned entities, with Saudi Aramco topping the list. Other major contributors are Chevron (United States), Gazprom (Russia), ExxonMobil (United States), BP (United Kingdom), and Shell (the Netherlands).<sup>48</sup> Just as the countries mentioned above, these corporate giants should be required to donate generously to the climate reparations fund. Their claim that they were not directly responsible for how the petroleum and other fossil fuel products they extracted, transported, and marketed were used by consumers is a

spurious argument, especially since their continual denial of global warming over the past half century has helped delay the global response to climate change.<sup>49</sup>

Dealing in depth with the complex subject of climate-related migrations that will inevitably occur in a warming planet is beyond the scope of this paper, but responding to the forced displacement of large numbers of people due to the impacts of climate change will need to become yet another prong of climate reparations. The major international initiatives to assist with the impact of climate change envisioned here, if adopted, would help reduce the level of migration. However, they would not eliminate this challenge, since the international environmental refugee problem has already begun and will only grow in future years. In a recent article on this subject, the authors expressed their concern in fairly stark terms, anticipating that over the next 30 years, the global climate crisis will displace more than 140 million people within their own countries and drive many more across national borders.<sup>50</sup> The question of how to deal with the growing challenge of “climate refugees” is a greatly troubling one for which no easy solutions exist at present. Nevertheless, the countries whose emissions played the largest role in contributing to climate change should also bear the greatest responsibility in addressing the challenge, whether that be by financing resettlement programs or accepting refugees within their borders, or both.

## Conclusion

The current climate crisis looms as one of the greatest challenges that humanity has ever faced. What makes it even more disturbing is the unequal nature of its adverse impacts, which fall heavily on those least responsible and most vulnerable. These populations are also unable to protect themselves from the disastrous consequences of climate change and global warming in the near term. It is debatable whether the world will meet the goal of the Paris Climate Agreement of limiting global temperature to 1.5°C above pre-industrial levels. This failure is likely to have increasingly disastrous consequences

for many low-income countries. In recent years, the development of a conceptual framework for climate reparations has gained greater interest.<sup>51</sup> However, the means to achieve such an objective has remained elusive. It is doubtful that present-day mitigation and renewable energy programs alone in high-income countries will soften the blow of climate-related impacts on low-income countries in the future. It is therefore incumbent on policy makers to prepare for a series of worst-case scenarios in low-income countries and island states, such as those related to sea level rise, extreme weather events, water scarcity, loss of agricultural productivity, and vector-borne diseases. Financing adaptation programs and building resilience should be given the highest priority for most low-income countries. The assessment of reparation funds to enable these countries to do so should be based on responsibility for past carbon dioxide emissions, along with a carbon tax imposed on current annual emissions of countries and private corporate entities.

In the recently concluded COP26 meeting held in Glasgow, United Kingdom (October 31–November 13, 2021), the question of climate reparations to countries most affected by the impacts of climate change was prominently raised. While expressing disappointment that the previous goal of US\$100 billion per year by 2020 had not been met, representatives at the meeting approved doubling such financial assistance for climate change adaptation by 2025. On a more controversial topic, funding for climate-related “loss and damage” currently suffered by low-income countries was acknowledged for the first time (in article VI of the final draft document), calling for “dialogue among parties, relevant organizations, and stakeholders to discuss the arrangements for the funding of activities.”<sup>52</sup>

At present, an effective international financial mechanism is not in place to solicit and administer climate reparations funds to low-income countries in a timely manner. In our opinion, raising the funds and distributing climate-related reparations should be administered by a newly instituted agency overseen by the Human Rights Council, in conjunction with other multilateral agencies, there-

by linking reparations to human rights standards, including equity, transparency, and accountability. These should be the chief objectives in establishing a human rights-oriented and well-funded Global Climate Reparations Fund.

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# Children, Adolescents, and Youth Pioneering a Human Rights-Based Approach to Climate Change

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## Abstract

Climate change is the greatest challenge of our century. Children, adolescents, and youth will bear the most severe impacts, physically, socially, economically, and psychologically. In response to this immense threat and to the failure of international climate negotiations to date, young people are taking to the streets and using global fora to call for climate justice. While these protests have received much attention, there has been limited examination of these and other youth-led efforts through the lens of a human rights-based approach and its operational principles: participation, equality and nondiscrimination, accountability, and transparency. This paper draws from academic and gray literature, as well as the authors' experience as practitioners and young activists, to argue that young people, by promoting human rights-based operational principles at the international, national, and local levels, are pioneering a human rights-based approach to climate change. The paper concludes by suggesting how policy makers can support and empower young people to advance an explicit human rights-based agenda, while concurrently translating human rights-based operational principles into climate change policies and practice.

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## Introduction

Climate change is the 21st century's largest global threat to our planet and to human rights.<sup>1</sup> There is now widespread international consensus that climate change directly and indirectly threatens all human rights, particularly the rights to life, health, and food.<sup>2</sup> Wealthier industrialized countries account for most of the world's greenhouse gas emissions, causing climate change. However, the people who will suffer the greatest burden, including the worst health risks, are those who have historically contributed the least to climate change—namely, those living in low- and middle-income countries (LMICs) and small island developing states.<sup>3</sup> Children (under 18 years old), adolescents (aged 10–19), and youth (aged 15–24) are among those most heavily affected.<sup>4</sup> In this paper, unless otherwise specified, the term “young people” refers to children, adolescents, and youth. The 2019 *Lancet* Countdown report shows how young people disproportionately bear the impacts of climate change, both physically and psychologically.<sup>5</sup> In addition to affecting their health, climate change threatens children's rights to education, food, and recreation, among others.<sup>6</sup> Given that young people are inherently less responsible for climate change than their adult contemporaries, climate change is defined by the Human Rights Council as the “most significant intergenerational injustice of our time.”<sup>7</sup>

Recognizing the interconnectedness between human rights and climate change, scholars and United Nations (UN) policy makers have urged the adoption of a human rights-based approach (HRBA) to address climate change, from both a legal and a policy perspective.<sup>8</sup> An HRBA is underpinned by several operational principles: participation, equality and nondiscrimination, accountability, and transparency.<sup>9</sup> Adopting an HRBA is a legal obligation of nation-states that are party to the International Covenant on Civil and Political Rights and other human rights instruments, including the Convention on the Rights of the Child.<sup>10</sup>

Despite decades of international climate change negotiations, states have as yet failed to meet their obligations under the United Nations

Framework Convention on Climate Change (UNFCCC) to “protect the climate system for the benefit of present and future generations” (article 3.1) and under the Convention on the Rights of the Child to act “in the best interests of the child” (article 3.1).<sup>11</sup> In response to these failures, young people are taking to the streets and using global fora to call for climate justice. They are participating in UNFCCC Conferences of Parties (COPs) and other international events to demand that their rights be guaranteed in international climate change agreements. Young people are also working at the community level to build awareness and facilitate climate change action, and acting with integrity in making individual lifestyle changes to reduce their own carbon footprints, however minor in comparison to the carbon emissions of governments and corporations. With these efforts, together with their focus on the rights of the most vulnerable beyond just themselves, young people currently play a key role in advancing an HRBA to climate change.

Some scholars have focused on youth's involvement and participation in UN processes, including the UNFCCC COPs.<sup>12</sup> Overall, the literature is very positive about the actions led by young people, claiming that they have indeed helped push for more ambitious climate action.<sup>13</sup> However, some scholars argue that young people have become a disruptive power—rather than constructive agents—in climate change policymaking.<sup>14</sup> Their use of the rhetoric of generational conflict, in which adult leaders are portrayed as blameworthy and irresponsible, has created polarization. Others have specifically examined climate change from a children's rights perspective and how this has been leveraged in litigation.<sup>15</sup> Despite this work, there has been little examination of young people's efforts through the lens of an HRBA and its operational principles.

This paper therefore highlights, with examples from the above literature and our own experiences as practitioners and young activists, how young people are promoting the operational principles of an HRBA to address the climate crisis. We make some practical suggestions concerning how policy makers can support and empower young people's

efforts to explicitly advance an HRBA while concurrently translating the HRBA operational principles into climate change policies and practice.

### What is a human rights-based approach to climate change?

An HRBA “is founded upon the human rights obligations that states have accepted under international law.”<sup>16</sup> It aims to ensure that policy development and implementation are grounded in the fulfillment of human rights and the obligations of duty-bearers, in order to empower rights-holders, promote policy coherence, and improve accountability.<sup>17</sup> As already shown in its application in the fields of development, health, and the environment, an HRBA has two practical implications for addressing climate change. First, it requires that climate change policies and actions be both responsive and targeted to address the basic human rights of all, but especially those of the most vulnerable and those who suffer most from climate change.<sup>18</sup> Second, it indicates operational principles that should be followed by policy makers when designing and implementing climate-related policies (see Box 1).<sup>19</sup>

Scholars and UN officials argue that applying an HRBA to climate change will produce greater political will to address the issue and promote equity in climate change responses. They also argue that it will provide stronger accountability mechanisms, grounded in human rights law, and ensure a more synergized approach to addressing climate change within the Sustainable Development Agenda.<sup>20</sup> Much can be learned from the ways in which young people are applying the operational principles of an HRBA in their climate change actions.

### How have young people been advancing the operational principles of a human rights-based approach?

Over the past decade, and increasingly since a small number of youth activists protested outside the Swedish Parliament in 2018, the climate movement led by young people has produced what have been described as the largest global climate protests in history, gaining worldwide attention.<sup>21</sup> This paper shines a light on various efforts by young people that address climate change from a human rights-based perspective. Each subsection also notes the

#### Box 1. Operational principles of a human rights-based approach to addressing climate change

*Principle 1: Participation.* An HRBA holds that meaningful and active contribution and engagement by all individuals and civil society groups, especially those most affected by climate change, is not only mandatory but also improves the success of climate change decision-making.

*Principle 2: Equality and nondiscrimination.* An HRBA, based on the universality of human rights and recognizing that all people are equal, mandates that all policies and actions be nondiscriminatory and targeted to alleviate inequalities. Positive measures must be included for the most disadvantaged and minority groups, including women, children, indigenous peoples, people with disabilities, and future generations.

*Principle 3: Accountability.* An HRBA entails allowing the public to use administrative, institutional, and legal measures to hold state duty-bearers, and increasingly also private actors, accountable for their climate change commitments and policies and to use legal measures to challenge any human rights violations.

*Principle 4: Transparency.* As a prerequisite for the fulfillment of other principles (such as participation by all and accountability), transparency requires that information be made available for everyone to review climate change decision-making, scientific evidence, policy implementation, and ensure monitoring.

Sources: F. Bustreo and C. Doebbler, “The rights-based approach to health,” in L. Gostin and B. M. Meier (eds), *Foundations of global health and human rights* (Oxford: Oxford University Press, 2020), pp. 96–97; M. J. Hall, “Advancing climate justice and the right to health through procedural rights,” *Health and Human Rights Journal* 16/1 (2014), pp. 15–16; United Nations Environment Programme, *Climate change and human rights* (Nairobi: UNEP, 2015), pp. 16–17.

practical challenges that young people face in their attempts to operationalize the four operational principles outlined above.

*Principle 1: Young people advocate for participation and meaningful engagement in global and domestic arenas*

Young people have led efforts to advocate for and achieve deliberate and meaningful engagement in the global dialogue about the Paris Agreement on climate change and its implementation.<sup>22</sup> These efforts are driven by the collaborative work of youth-led organizations from the local to the international level, where they are formally recognized as YOUNGO, the official youth constituency of UNFCCC, which participates as an observer in the COPs. Despite their observer status, these organizations are advancing various programs to augment young people's participation and attempt to influence international negotiations and conferences, including through the organization of annual Conferences of Youth. From our experience, the engagement of young people at these negotiations has amplified advocacy efforts and put pressure on states to meet their commitments on emission reductions. During the 2019 UNFCCC COP25 in Madrid, young activists drafted the Intergovernmental Declaration on Children, Youth and Climate Action, which acknowledges young people's right to a healthy environment and their role as agents of change.<sup>23</sup> With the COVID-19 pandemic moving advocacy efforts online, young people have been actively engaging in online events for climate action. For instance, in February 2021, the Children's Environmental Rights Initiative organized an online Tweetstorm event on Twitter, urging governments to sign the intergovernmental declaration.<sup>24</sup> Moreover, in recent years, universities have become a growing platform for youth participation in international climate decision-making.<sup>25</sup> Students are participating in university observer delegations to the COPs, often as part of the Research and Independent Nongovernmental Organizations (RINGO) constituency. Significant networks have emerged to amplify student voices in climate advocacy and leverage partnerships with

academia to raise global awareness, for example through the COP26 Universities Network and the University Climate Change Coalition.<sup>26</sup>

Young people worldwide are also advocating for and achieving participation in climate change policymaking at the national and local levels. In the Philippines' Eastern Samar province, children organized a Children's Coalition for Adaptation and Resilience, urging the local government to include children affected by 2013's Typhoon Haiyan in consultations on recovery and adaptation plans. The children's coalition persuaded the Hernani Municipal Council to appoint a child representative, as well as establish a local youth development council.<sup>27</sup> As in other Pacific Islands countries, young people in Fiji and the Solomon Islands struggle with limited representation in formal governance systems: the hierarchical social structure sees them as recipients of authority rather than agents of change.<sup>28</sup> In response, young people have come together through youth councils and civil society organizations, such as Be the Change and 350 Pacific, to advocate for participation in climate change policymaking.<sup>29</sup> Young Pacific people are pushing for changes in the status quo, fighting against adult-centric hierarchical decision-making, and expanding opportunities for young people's engagement in decision-making.<sup>30</sup>

To achieve meaningful participation, young people have understood the need for and asked for further support to sharpen their skills to analyze climate change proposals using a rights-based lens, evaluate policy outcomes, run advocacy campaigns, and participate in climate-related discussions.<sup>31</sup> Recognizing the capacity-building required for effective youth participation, youth-led international organizations, such as the International Federation of Medical Students' Associations and the UN Major Group for Children and Youth, provide worldwide support to young people in building proficient advocacy capacities and enhance management skills by facilitating workshops and providing resources, such as toolkits and training manuals.<sup>32</sup>

Despite such efforts, young people's leadership and engagement are often undervalued by senior negotiators and policy makers.<sup>33</sup> For example, only

12 governments have signed the Intergovernmental Declaration on Children, Youth and Climate Action.<sup>34</sup> Other challenges include the frequent exclusion of young people from decision-making discussions, and their tokenization when present.<sup>35</sup> Their exclusion from such events is often offset by the organization of siloed youth-targeted events, such as the Youth4Climate event held in Milan in September 2021. The inclusion of young people in national delegations and national government institutions is generally also neither mandatory nor common.<sup>36</sup> Political quotas for young people apply in only a few countries, and many national governments limit themselves to selecting youth spokespersons and envoys.<sup>37</sup>

*Principle 2: Youth-led initiatives prioritize equality and nondiscrimination*

Young climate change activists are important proponents of the principles of equality and nondiscrimination. Climate justice and equity are at the heart of the Fridays for Future international movement.<sup>38</sup> Evidence in the literature shows that not only have they been advocating for climate justice through an intergenerational equity lens demanding recognition of themselves and future generations as equals to current adult generations, but they have increasingly used calls for climate justice to recognize other minority groups as equal.<sup>39</sup> When speaking at international negotiations and through their activities as YOUNGO, young people are advocating for a fair and equitable transition toward climate neutrality, which incorporates the needs of all, especially the vulnerable and marginalized, including indigenous people, people of color, LGBTQ+ people, people with low socioeconomic status, and those living with disabilities.

This approach is also being adopted by young people acting at the national level. The Australian Youth Climate Coalition (AYCC) has been actively campaigning and working with Aboriginal people and Torres Strait Islanders for climate justice.<sup>40</sup> The AYCC supports indigenous people in capacity-building exercises, focused on networking and learning from one another's experiences, to lead climate justice campaigns through fundraising and bootcamps.<sup>41</sup>

In 2018, the AYCC joined indigenous communities in the Northern Territory to protest against fracking and supported their travel to Sydney to confront the companies responsible for that practice.<sup>42</sup>

Gender equality is another key focus of the youth climate movement, which is primarily led by young women.<sup>43</sup> Many have denounced the lack of attention to gender issues and solutions in the Paris Agreement and the unequal gender representation in climate negotiations: only one-third of the delegates at COP21 were women.<sup>44</sup> In addition, many young activists and youth-led programs are focusing on the intersectionality between climate change and racial discrimination. Environmental racism—the silencing of marginalized people and activists of color—has been widely reported.<sup>45</sup> Vanessa Nakate, a youth activist from Uganda, founded the Rise Up Movement to give voice to African climate activists who have been systematically silenced by the media in international settings and addressed primarily as victims of climate change.<sup>46</sup> Nakate experienced this discrimination herself when the Associated Press removed her image from a photograph with other (white) youth climate activists participating in the 2020 Davos World Economic Forum Summit.<sup>47</sup> For Nakate and many other young activists of color, the fight for climate justice starts with the eradication of racial injustice.

Young people face many challenges in ensuring equality and nondiscrimination while addressing climate change, especially in terms of achieving intergenerational equality in policies and investment decisions. Some of them might not be immediately obvious or evident. For example, policy makers and financial institutions often use high social discount rates when designing climate change policies and financial investments. Social discount rates are used to “calculate how much guarding against future carbon emissions is worth to us now.”<sup>48</sup> While the use of social discounting is not intended to treat one population group differently from another, when high social discount rates are used in cost-benefit analyses to inform policy decisions, short-term economic benefits for the current generation are prioritized over long-term benefits for future generations.<sup>49</sup> This impedes

intergenerational climate justice, leads to policy inaction, and limits investment in innovative mitigation and adaptation projects. Another barrier that many young people face is accessing internet due to a lack of funding, technology, and infrastructure. For instance, two-thirds of people under the age of 25 do not have access to the internet at home.<sup>50</sup> Moreover, many young people also face challenges in traveling, due to high prices and visa restrictions, to participate in global and national events. Overall, this limits the opportunities of many young people, especially those in LMICs, to participate equally in climate change events and to access accountability mechanisms and information.

*Principle 3: Young people are using accountability mechanisms to hold stakeholders responsible for their commitments*

Young people are playing a fundamental role in driving climate change accountability in both formal and informal settings. Especially through the use of new media technologies, they are able to galvanize their peers and other generations to collectively hold governments and private actors accountable for their contributions to, and lack of action to counter, climate change. For example, during the youth-led 2019 global climate strikes, young people protested against governments' inaction and failed pledges, gaining the support of older generations, including their teachers.<sup>51</sup> Similarly, students are holding nonstate actors, such as universities, accountable for their fossil fuel investments. For example, in the United Kingdom, a 2019 student-led divestment campaign resulted in many universities nationwide committing to divest from fossil fuels.<sup>52</sup> The aim is for divestment from fossil fuels to become mainstream university policy in the United Kingdom.

Young people are also driving climate accountability through more formal contributions to legislative processes. For example, in July 2020, over 150 Fridays for Future activists proposed legislation to the European Union (EU) via the European Citizens' Initiative. The initiative urges the EU to adjust its nationally determined contributions goals under the Paris Agreement to ensure an 80% reduction

in greenhouse gas emissions by 2030 and net zero emissions by 2035; implement an EU carbon border adjustment mechanism; legislate that free trade agreements cannot be signed with countries that do not have climate policies aligned with the 1.5°C warming limit; and create educational materials for all EU members on climate change impacts.<sup>53</sup> According to the Fridays for Future movement, the European Citizens' Initiative now has over 89,000 signatories and has been enshrined in legislation in 15 EU member states.<sup>54</sup>

Young people are also framing climate change as an issue of health, human rights, and equity and are using this framework to hold governments accountable for their constitutional duties to protect their citizens. Young plaintiffs, many of them children, have filed lawsuits against governments in Australia, Canada, Colombia, India, Mexico, Pakistan, and South Korea.<sup>55</sup> Children have also filed complaints against Argentina, Brazil, France, Germany, and Turkey through the UN Committee on the Rights of the Child for their failure to reduce carbon emissions and their violation of children's rights to life, health, and a healthy environment.<sup>56</sup> These efforts show the efficacy of arguing for a legally enforceable connection between climate change and governments' constitutional duties to protect citizens' health and safety. For instance, Colombia's Supreme Court ruled that the deforestation of the Colombian Amazon contributed to climate change and that the Colombian government's failure to limit it constituted a serious attack on the rights of current and future generations.<sup>57</sup> Moreover, young people have also filed suits against other stakeholders, such as fossil fuel companies. Young Friends of the Earth (Netherlands) was a co-plaintiff in the recent successful suit *Milieudefensie et al., v. Royal Dutch Shell PLC*, in which the Hague District Court ruled in favor of young people and ordered the company to reduce its emissions by 45% by 2030, relative to 2019, to come into compliance with human rights obligations.<sup>58</sup> Unlike other claimants, the organization was allowed to remain a plaintiff in this case, as it had sufficient grounds to represent Dutch citizens and because its members' interests were directly affected.<sup>59</sup> This example indicates that

young people can play a critical role in leveraging judicial systems to support climate change efforts.

Despite these recent encouraging events, young people's engagement in formal accountability mechanisms is made extremely challenging by the high costs of legal action. In many countries, hierarchical social norms relating to gender and social status also impede young people's ability to hold their elders and those in power to account. Young people often lack support from lawyers and civil society, and don't always have the legal standing, to file lawsuits. To these challenges are added the legal difficulties of establishing a direct causal link between climate change and the violation of citizens' rights, including the right to health.<sup>60</sup> However, as science and medicine continue to advance our understanding of the connections between environmental conditions and health, the centrality of young people to climate change accountability, and their standing to pursue legal proceedings in cases concerning climate change, will only increase.

*Principle 4: Young people are demanding transparency in information, governance processes, and investments*

The principle of transparency underpins the other principles of an HRBA. To be able to participate and hold governments and other stakeholders to account, young people must have the information necessary to review and evaluate policies and progress, as well as the capacity to do so. For example, young people suggest that when they are armed with facts and knowledge about climate change, they are more likely to consider it a priority issue and want to act.<sup>61</sup> To this end, youth-led organizations have campaigned for climate change education to be included in all school curricula.<sup>62</sup> In November 2019, following months of petitions by young Italians, Italy became the first country to pledge to make climate change teaching compulsory in all public schools.<sup>63</sup> Similarly, in Cambodia, climate change education has recently become compulsory in higher secondary school curricula.<sup>64</sup>

Young people also play a fundamental role in scrutinizing and pushing for transparency in government and private sector climate change

governance, including fossil fuel subsidies and investments. For example, many young people are voicing their concerns over the rise of "greenwashing": marketing something as environmentally friendly, with no certification, while continuing to engage in polluting activities, such as investing in fossil fuels. In January 2021, using Tik Tok and Instagram, more than 300,000 youth activists denounced Procter and Gamble's Charmin toilet paper brand for its "greenwashing" sustainability claims while the company continues to contribute to deforestation and the violation of Canadian indigenous peoples' rights.<sup>65</sup> Similarly, young Norwegians have been vocal about their government's double standards: on the one hand, the Norwegian government praises itself for its climate change pledges (such as to become carbon neutral by 2030 and its role as a major donor of the Green Climate Fund, which supports climate-related efforts in LMICs), while on the other hand it continues to subsidize oil and gas extraction in Norwegian waters and sell fossil fuels abroad.<sup>66</sup> Young leaders of the Nature and Youth group have called for an end to the Norwegian government's support to the fossil fuel industry and for divestment in its sovereign wealth fund.<sup>67</sup> The UN Secretary-General's Youth Advisory Group on Climate Change has also warned against the risk of "greenwashing" in the use of COVID-19 financial recovery funds destined for green transition plans, given that there is "no internationally agreed taxonomy of green jobs."<sup>68</sup>

Young people have also been pivotal in denouncing the lack of transparency in international climate change negotiations. They have pushed for meetings to be opened to more observers, including youth-led civil society organizations. Despite these efforts, young people's right to seek information from their governments is constantly challenged. Climate-related information from governments and other stakeholders is often inaccessible to the public or lacks transparency, both in the methodology used to collect climate data (leading to distorted policy evaluations) and in the partial disclosure of information (contributing to misinformation and policies based on incomplete data, as illustrated by the "greenwashing" examples above). The use

of highly technical language in climate-related negotiations, reports, and assessments also renders information inaccessible, particularly for children and adolescents. Further, the subscription fees of many journals and newspapers make current scientific information unattainable for many students. All these restrictions on young people's access to comprehensible climate-related information limit their ability to hold governments and other stakeholders to account.

### Driving a human rights-based approach to climate change: The way forward for young people

Much can be learned from the successes and challenges faced by young people in applying the principles of an HRBA to climate change. We recognize that not all youth-led actions are explicitly framed around an HRBA. However, an HRBA must be made explicit in climate policies and practice, to achieve maximum impact and ensure the fulfillment of human rights. Based on the above findings and our experiences as practitioners and young activists, we offer some suggestions below on what policy makers can do to support and empower young people in advancing an HRBA, while simultaneously translating the HRBA's operational principles into climate change policies and practice.

#### *Principle 1: Create opportunities for the meaningful engagement of young people*

To implement an HRBA, local, national, and international institutions must create more opportunities for young people to participate actively in climate change policymaking. A first step would be to ensure young people's participation in conferences and meetings. Many international institutions, including the UNFCCC, have already done this, but, from our experience, it is still uncommon in national policy discussions. An additional step would include regular consultations with young representatives to inform and engage them in climate policy and decision-making. This practice, common within international institutions, such as the Organization for Economic

Cooperation and Development and UN agencies, should be expanded to the national level. Such consultations should become the norm, starting from decision-making on post-COVID-19 recovery plans and green transition plans, whose outcomes will affect the current and future generations of young people most profoundly.

However, both these approaches risk young people's participation being tokenized and restricted to siloed events. A more forceful solution would be to appoint a youth delegate, empowered to influence decision-making, to participate regularly in climate negotiations and policymaking. This has already been done by some countries, including the Netherlands, Mexico, and Sri Lanka, as well as by several UN agencies, including the Secretary-General's Office, which has appointed an envoy on youth.<sup>69</sup> Participation by at least one youth delegate should be made obligatory in every national delegation at the UNFCCC COPs and ideally at all other national and international conferences relating to climate change mitigation and adaptation. The youth delegate should be empowered with capacity, skills, and knowledge, and supported in being able to meaningfully engage in decision-making.

While the appointment of youth delegates has some benefits, even more effective would be the introduction of quotas for young people in leadership positions in both national and international institutions. Similar to gender quotas in parliaments, quotas for young people in national ministries and international organizations would provide young people with the opportunity to hold leadership positions.<sup>70</sup> Although young people represent one-fifth of the global population, they make up only 2% of world parliamentarians.<sup>71</sup> Only nine countries, including Uganda and Rwanda, have mandatory parliamentary youth quotas.<sup>72</sup> At the international institutional level, in support of the Global Consensus Statement on Meaningful Adolescent and Youth Engagement, the Partnership for Maternal, Newborn and Child Health (PMNCH) has introduced a requirement for all constituencies and governing committees to assign a vice chair role to a young person (under the age of 30).<sup>73</sup> This has in-

creased the number of young people in leadership positions, allowing them to help shape the work of PMNCH and empowering them to advocate for women's, children's, and adolescents' health.

Overall, all institutions should aim to increase meaningful adolescent and youth engagement so that power is shared in an inclusive, intentional, mutually respectful partnership among adolescents, youth, and adults. To this end, we urge all national and international actors to confirm their commitment by signing the Global Consensus Statement on Meaningful Adolescent and Youth Engagement and the Intergovernmental Declaration on Children, Youth and Climate Action.

*Principle 2: Ensure that young people are treated equally and without discrimination*

Much can be done to promote equality for young people in national and international fora, policies, campaigns, media, and communication. Young people participating in international events must be remunerated for their time, expertise, and out-of-pocket expenses. Most young people are still students and rely on family income to attend events and work as youth envoys. This creates inequalities between those who can afford to participate and those who cannot. Thus, scholarships must be made available for young people, especially those from the Global South, to cover travel expenses, accommodation, and meals when attending events. To bridge the digital divide, funding and policies must be put in place to build the necessary infrastructure and support young people in LMICs with funds to access better internet connectivity. In addition, international organizations and national governments should financially support young people who formally and regularly contribute to climate change policy. As well as making it easier for young people to contribute to climate change policymaking, governments and international organizations should ensure that youth engagement and data gathering is expanded at the local and rural levels where young people are most active. Town halls, listening groups, and social network events should be prioritized to ensure that a larger and more representative sample of young people is reached.

Acknowledging the requests of young people, governments should ensure that girls, women and those belonging to marginalized groups—including people of color, indigenous people, people with disabilities, and LGBTQ+ people—have equal opportunities to participate in climate change policymaking. Media outlets should also make sure these groups are given equitable visibility in the media. Policy makers, researchers, and journalists should examine and report on the efforts of young people belonging to marginalized groups. Additionally, the voice of future generations should be included by engaging children as much as possible in events and programs.

*Principle 3: Enhance the legal enforceability of states' human rights obligations regarding climate change*

Despite successful recent litigation, young people still face many challenges in holding states accountable for their climate change obligations and commitments. To reduce these, as an initial step, national governments should sign the Intergovernmental Declaration on Children, Youth and Climate Action, which commits states to “scale up efforts to respect, promote and consider the rights of children and young people in implementation of the Paris Agreement at all levels.”<sup>74</sup> The intergovernmental declaration also reinforces commitments that policies and decisions be taken in the best interest of future generations.<sup>75</sup> This would discourage policy makers and financial institutions from using high social discount rates in policy and investment assessments and from focusing solely on short-term economic returns. Such a commitment would incentivize states to meet their human rights obligations to children under the Convention on the Rights of the Child and demonstrate willingness to expand their duties to young people over the age of 18.

In October 2021, the Human Rights Council approved a landmark resolution recognizing the “right to a safe, clean, healthy and sustainable environment.”<sup>76</sup> Although the resolution provides a significant opportunity to reinforce the human rights obligations of governments during climate

change litigation, it is not legally binding. Therefore, countries must also sign regional treaties that recognize the right to a healthy environment for all individuals (not only for children, as in the Convention on the Rights of the Child), such as the Aarhus Convention and the Escazú Agreement, to increase the enforceability of this right, making successful climate litigation even more achievable.<sup>77</sup> These treaties require that the right to a healthy environment be achieved through participation, equality and nondiscrimination, accountability, and transparency. Beyond these two regional instruments, the legal enforceability of national governments' human rights obligations to engage in ambitious climate change action can be augmented further by the creation of a more powerful, legally binding international agreement incorporating the right to a safe, clean, healthy, and sustainable environment, such as an optional protocol to an existing international human rights covenant or a new international covenant.<sup>78</sup> Hopefully, this new Human Rights Council resolution, as well as the appointment of a new Special Rapporteur on climate change, might expedite this process.<sup>79</sup>

#### *Principle 4. Strengthen transparency in policymaking, governance, and investments*

The principle of transparency is the foundation for the fulfillment of the principles of participation, equality and nondiscrimination, and accountability. To ensure that information is maximally accessible, the simplest possible language should be used so that lay people, including the young, can understand the issues. Patronizing and tokenistic language must be avoided. Training, led by young people, should be used to teach policy makers at the international and national levels how to make their communications accessible and inclusive.

Another step toward strengthening transparency requires the inclusion of environmental and climate change courses in all school and further education curricula, which teaches the most recent science and findings. Such courses should teach students what climate change is from a physical and earth science perspective; how it affects human rights; and what rights young people have. All

further education courses should offer a module on the intersectionality between the subject being studied and climate change. For example, health care students should be taught about the impact of climate change on health, while fashion degree programs should teach students about how to reduce the carbon footprint of the fashion industry. This would ensure that young people are equipped with the knowledge, awareness, and skills to understand the consequences of climate change and to engage meaningfully in developing solutions in response. National and local governments should also commit themselves to the "Climate and Environmental Literacy" campaign issued by Earth Day.<sup>80</sup>

As described above, another growing challenge that young people have identified as a threat to their activism is the trend of "greenwashing" by governments and companies. Building on the recommendation of the UN Secretary-General's Youth Advisory Group on Climate Change, governments should require a regionally or internationally recognized environmental certificate, such as the carbon trust standard, as evidence of any company's or project's claimed sustainability or "greenness."<sup>81</sup> Governments must also develop clearer rules for a "green" taxonomy. For example, the EU is currently developing a classification system to establish activities that can be considered environmentally sustainable, and under what terms.<sup>82</sup>

As called for by young people's activism against double standards, governments and companies, especially financial institutions, should also be required to sign conflict of interest policies to ensure the disclosure of investments in the fossil fuel industry or any other activity producing high carbon emissions. The UNFCCC should create conflict of interest guidelines to fight lobbying from companies invested in the fossil fuel industry and large-scale industrial agriculture, and to ensure greater transparency in the process. At the national level, countries should follow the example of the United Kingdom's financial conduct authority, which has made climate-related disclosures mandatory in the annual filings of companies with premium listings and which will extend this requirement to all companies by 2025.<sup>83</sup> Such cli-

mate-related disclosure should be made mandatory by large businesses, including banks, insurance companies, and asset managers. Requiring companies to disclose information on climate-related financial risks would incentivize low-carbon strategies. Young consumers would then have a clearer and more comprehensive view of companies' climate-related activities, and investors would be able to better assess the risks of their portfolios.

## Conclusion

Young people's demands and activism for climate justice reinforce the intersection between climate change and human rights. They champion the operational principles of an HRBA, namely participation, equality and nondiscrimination, accountability, and transparency. Through their actions, young people are pioneers in ensuring that an HRBA to climate change is translated into policies and practice. To support these efforts, policy makers must create opportunities for young people to meaningfully engage in decision-making and ensure that they do not face discrimination. Equally important is strengthening the legal climate change framework through a legally binding international agreement on the right to a safe, clean, healthy, and sustainable environment and ensuring that the right to health is upheld in climate change decision-making. Finally, transparency must be improved in policymaking, governance, and investments, including by increasing access to understandable and actionable information and education on climate change. Ultimately, young people have been leading the way, and it is now the time for adults, practitioners, policy makers, and governments to support and join young people as allies in this action.

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# The Right to Health and the Climate Crisis: The Vital Role of Civic Space

DAVID W. PATTERSON

## Abstract

Under the United Nations Framework Convention on Climate Change and its protocols, states have legal obligations to address the climate crisis. The principle of participation is increasingly acknowledged as central to the protection and promotion of human rights, including the right to health. This paper explores states' obligations to address the climate crisis—and concomitant health crises—from a right to health perspective. The right to health lens provides a valuable opportunity for engaging diverse civil society constituencies in the response to the climate crisis. However, civic space must be protected if these actors are to participate meaningfully. The climate crisis discourse has lacked an explicit recognition of the interconnected nature of the right to health, environmental degradation and climate change, and civic space. There is also concern that restrictions on civic space will continue after the COVID-19 pandemic. While the public health community is an important constituency in the design and implementation of laws, policies, and programs to address climate change, the human rights literacy of this community remains to be strengthened. This paper addresses these lacunae within the context of the right to health as enshrined in United Nations human rights treaties and related international law.

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## Introduction

As of May 2021, estimated planned reductions in global net anthropogenic greenhouse gas emissions fell far short of what is required to limit global warming to the Paris Agreement target of well below 2°C, let alone 1.5°C, above pre-industrial levels.<sup>1</sup> A pervasive “discourse of denial” continues while vested interests lobby for a slow transition away from fossil fuels, as the experience of Australia, the world’s largest exporter of coal and gas, exemplifies.<sup>2</sup> In September 2021, the United Nations (UN) Secretary-General warned that the world was on a “catastrophic pathway” to 2.7°C of heating by the end of the century.<sup>3</sup>

The present and likely impact of the climate crisis on the right to health is well documented.<sup>4</sup> Climate change poses an existential threat to communities, states, and human health and life.<sup>5</sup> Some commentators are already preparing for a postapocalyptic world. Paul Kingsnorth wrote in 2010, “Once we stop pretending the impossible can happen, we are released to think seriously about the future.”<sup>6</sup> Carl Cassegård wrote in 2018 that “accepting [irreversible or unavoidable] loss as a fact may free the imagination to find new ways of adapting to the world.”<sup>7</sup>

Although the imperative to reduce greenhouse gas emissions is clear, the most cost-effective and sustainable pathways to achieving net zero and adapting to the impact of climate change remain hotly contested. For example, there are sharply differing views on the role of nuclear energy as an alternative to fossil fuels during the transition to renewable energy sources.<sup>8</sup> Civil society organizations—including organizations of young people and of indigenous peoples, environmental groups, labor unions, professional associations, faith communities, and community-based organizations—will continue to advocate for climate action, including through print and online media and through their democratic representatives. There will also be street demonstrations and other forms of visible, public dissent if governments are perceived not to be responding adequately to the scale and urgency of the climate crisis. The mobilization for climate action will increasingly involve public health actors who

have not previously been engaged and whose efforts can benefit from a human rights perspective. As Alexandra Phelan noted in 2020, “framing climate change through a global health and human rights lens is a powerful catalyst for action to mitigate and adapt to the greatest threat to global health and human rights.”<sup>9</sup>

It is well recognized that states have legal obligations to address the climate crisis under the United Nations Framework Convention on Climate Change (UNFCCC) and its protocols. This paper explores states’ obligations to address the climate crisis—and concomitant health crises—from a right to health perspective. In doing so, the paper notes the value of the evolving concept of civic space in international law. Until recently, civic space was an underexplored aspect of rights discourse on health and climate change. The right to health provides a valuable opportunity for engaging diverse constituencies in advocacy for climate action. However, civil and political rights, and notably civic space, must be protected if these actors are to participate meaningfully. The climate crisis discourse has lacked an explicit recognition of the interconnected nature of these issues. Further, human rights literacy in the context of climate change remains to be strengthened within the public health community. This paper addresses these lacunae within the context of the right to health in UN human rights treaties and related international law. Although the right to health is also addressed in regional human rights treaties, these obligations are not discussed here.

The first part of the paper explores the connections between the climate crisis and the right to health in international law. The paper then expands on the role of civil and political rights in the realization of the right to health, with a focus on the principle of participation in the context of the climate crisis. Next, the paper argues that civic space is an underexplored aspect of the principle of participation in human rights law and is under threat, with dire implications for climate action. The limitations of these evolving approaches are then discussed. The paper concludes that greater dialogue between human rights, public health, and

environmental advocates offers rich possibilities for promoting healthy people and a healthy planet. While tracing the evolution of the right to health and the principles of participation and civic space in the context of the climate crisis, the paper draws on various sources of authority, including treaties, resolutions of intergovernmental bodies, commentary by treaty committees, independent scholarly comment, and the statements of UN experts, rapporteurs, and organizations.

### The climate crisis and the right to health in international law

The seeds of the climate crisis were sown in the Western colonial period and the industrial revolution that followed. Air pollution related to the shift from artisanal to industrial production was already well recognized in 19th-century Europe.<sup>10</sup> However, the Universal Declaration of Human Rights, adopted by the UN General Assembly in 1948, makes no reference to the right to a healthy environment.<sup>11</sup> The first mention of the environment in a UN treaty is in the International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted in 1966, which affirms “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (the right to health), noting the importance of “the improvement of all aspects of environmental and industrial hygiene.”<sup>12</sup>

Shortly afterward, the intersection between health and the environment began to be acknowledged in other intergovernmental forums. In 1972, the Stockholm Declaration and Action Plan for the Human Environment was adopted at the UN Conference on the Human Environment. The Convention on the Rights of the Child, adopted in 1989, notes the dangers of environmental pollution and the importance of child education to develop respect for the natural environment.<sup>13</sup> The UNFCCC was opened for signature at the 1992 UN Conference on Environment and Development, which also adopted the Rio Declaration on Environment and Development. Two protocols followed the UNFCCC: the 1997 Kyoto Protocol and the 2015 Paris Agreement. The latter protocol includes an

explicit reference to human rights, including the right to health, in its preamble. In 2021, the Human Rights Council issued a resolution recognizing “the right to a safe, clean, healthy and sustainable environment as a human right that is important for the enjoyment of human rights.” The resolution acknowledges that “environmental degradation, climate change and unsustainable development constitute some of the most pressing and serious threats to the ability of present and future generations to enjoy human rights, including the right to life.”<sup>14</sup>

UN treaty committees and other UN organs have also addressed the impact of the environment, including the climate crisis, on the right to health. In 2000, the Committee on Economic, Social and Cultural Rights, which monitors the implementation of the ICESCR, issued its General Comment 14 exploring states’ obligations in the context of the right to health. The general comment notes that “the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as ... a healthy environment.”<sup>15</sup> In 2016, the Office of the United Nations High Commissioner for Human Rights (OHCHR) explored the relationship between climate change and the right to health, noting the key impacts of climate change on health and the related obligations of states and other actors.<sup>16</sup>

In 2018, the Committee on Economic, Social and Cultural Rights issued a statement on climate change and the ICESCR, noting that climate change constitutes a massive threat to the enjoyment of economic, social and cultural rights, including the right to health.<sup>17</sup> In 2019, the Human Rights Committee, which monitors the implementation of the International Covenant on Civil and Political Rights (ICCPR), observed in its General Comment 36 that “environmental degradation, climate change and unsustainable development constitute some of the most pressing and serious threats to the ability of present and future generations to enjoy the right to life.”<sup>18</sup> The committee also noted that the duty to protect life implies that states should take measures to ensure access to essential goods and

services, such as health care and adequate food, water, shelter, electricity, and sanitation. These goods and services are among the essential determinants of the full realization of the right to health. Hence, the rights to life and to health are both threatened by environmental degradation and climate change, reflecting again the indivisible nature of human rights.

UN independent experts and Special Rapporteurs have also addressed the impact of climate change on the right to health. In 2007, the then Special Rapporteur on the right to health, Paul Hunt, addressed global warming in the context of the underlying determinants of health. Hunt noted that despite disturbing climate trends, “the international community has not yet confronted the health threats posed by global warming. The failure of the international community to take the health impact of global warming seriously will endanger the lives of millions of people across the world.”<sup>19</sup> In short, the foundations in international law are well established to address the climate crisis from a right to health perspective.

### Civil and political rights, the principle of participation, and the climate crisis

The Universal Declaration of Human Rights states, “Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.”<sup>20</sup> The 1987 Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights were drafted by international law experts convened by the International Commission of Jurists. The Limburg Principles state that “a concerted national effort to invoke the full participation of all sectors of society is, therefore, indispensable to achieving progress in realizing economic, social and cultural rights. Popular participation is required at all stages, including the formulation, application and review of national policies.”<sup>21</sup>

In 1993, UN member states affirmed in the Vienna Declaration and Programme of Action of the World Conference on Human Rights that “all human rights are universal, indivisible and inter-

dependent and interrelated.”<sup>22</sup> In other words, we cannot make progress toward achieving the highest attainable standard of physical and mental health for all without also respecting, protecting, and fulfilling the other human rights guaranteed in international law, including civil and political rights.

In 1990, the Committee on Economic, Social and Cultural Rights noted that while the ICESCR “provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes various obligations which are of immediate effect” irrespective of a state’s level of economic development.<sup>23</sup> In 2000, the committee clarified in its General Comment 14 that even when resources are constrained, states’ core obligations include the adoption and implementation of a national public health strategy and plan of action that has been developed through a participatory and transparent process. According to the committee:

*The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people’s participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12 [of the ICESCR]. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people’s participation is secured by States.*<sup>24</sup>

General Comment 14 also highlights the importance of “participation of the population in all health-related decision-making at the community, national and international levels.” States are also enjoined from “preventing people’s participation in health-related matters.”<sup>25</sup>

The principle of participation has also been addressed by the Human Rights Committee. Article 25 of the ICCPR refers to “the right of every citizen to participate in the conduct of public affairs” and includes “all aspects of public administration, and the formulation and implementation of policy at

international, national, regional and local levels.” In 1996, the Human Rights Committee issued General Comment 25, advising that

*citizens may participate directly by taking part in popular assemblies which have the power to make decisions about local issues or about the affairs of a particular community and in bodies established to represent citizens in consultation with government ... Citizens also take part in the conduct of public affairs by exerting influence through public debate and dialogue with their representatives or through their capacity to organize themselves. This participation is supported by ensuring freedom of expression, assembly and association.*<sup>26</sup>

The general comment also highlights the importance of “free communication of information and ideas about public and political issues,” which “implies a free press and other media able to comment on public issues.”<sup>27</sup> The committee has provided detailed guidance on the freedoms of opinion and expression and of peaceful assembly in General Comment 34 and General Comment 37, respectively.<sup>28</sup> In 2008, Helen Potts argued that the active and informed participation of people and groups in all health-related decision-making is a core obligation of the right to health. Participation relies in part on other rights, such as the right to express views freely and the right to education. However, according to Potts, participation should be distinguished from education, informing, and consultation, although they clearly play an important role.<sup>29</sup> The principle of participation rests squarely on the realization of civil and political rights. It is in turn central to the realization of other human rights, and hence to effective responses to the climate crisis.

In 2009, the Committee on the Rights of the Child, which monitors the implementation of the Convention on the Rights of the Child, issued General Comment 12, which affirms the importance of the child’s right to be heard, including in national and international settings.<sup>30</sup>

In 2018, the OHCHR issued guidelines for states on the effective implementation of the right to participate in public affairs. The Human Rights Council took note with interest of the guidelines and presented them “as a set of orientations for

States, as well as for, where appropriate, other relevant stakeholders in relation to the effective implementation of the right to participate in public affairs.”<sup>31</sup> The guidelines offer a succinct, powerful justification for the principle of participation:

*Participation enables the advancement of all human rights. It plays a crucial role in the promotion of democracy, the rule of law, social inclusion and economic development. It is essential for reducing inequalities and social conflict. It is also important for empowering individuals and groups, and is one of the core elements of human rights-based approaches aimed at eliminating marginalization and discrimination. While the responsibility and accountability for taking decisions ultimately rests with public authorities, the participation of various sectors of society allows the authorities to deepen their understanding of specific issues; helps to identify gaps, as well as available policy and legislative options and their impact on specific individuals and groups; and balances conflicting interests. As a consequence, decision-making is more informed and sustainable, and public institutions are more effective, accountable and transparent. This in turn enhances the legitimacy of States’ decisions and their ownership by all members of society.*<sup>32</sup>

Specifically in environmental matters, the principle of public participation in decision-making and access to information was first explicitly affirmed in principle 10 of the 1992 Rio Declaration on Environment and Development, which states:

*Environmental issues are best handled with the participation of all concerned citizens, at the relevant level. At the national level, each individual shall have appropriate access to information concerning the environment that is held by public authorities, including information on hazardous materials and activities in their communities, and the opportunity to participate in decision-making processes. States shall facilitate and encourage public awareness and participation by making information widely available.*<sup>33</sup>

In 2012, the then UN independent expert on the issue of human rights obligations relating to the enjoyment of a safe, clean, healthy, and sustainable environment, John H. Knox, noted the relevance of both “rights whose enjoyment is particularly

vulnerable to environmental degradation” (substantive rights) and “rights whose exercise supports better environmental policymaking” (procedural rights). Knox cited as examples of procedural rights the rights to freedom of expression and association, to information, to participation in decision-making, and to effective remedies.<sup>34</sup> These rights have also been explicitly recognized in regional environmental treaties in Europe and the Americas. In 1998, the Convention on Access to Information, Public Participation in Decision-making and Access to Justice in Environmental Matters (Aarhus Convention) was adopted under the auspices of the United Nations Economic Commission for Europe.<sup>35</sup> In 2005, the state parties to the Aarhus Convention adopted guidelines on promoting the application of the principles of the convention in international forums.<sup>36</sup> In 2014, the Economic Commission for Europe issued comprehensive recommendations under the Aarhus Convention on promoting effective public participation in decision-making in environmental matters.<sup>37</sup> In 2018, the Regional Agreement on Access to Information, Public Participation and Justice in Environmental Matters was adopted in Escazú, Costa Rica, under the auspices of the Economic Commission for Latin America and the Caribbean.<sup>38</sup>

Some commentators have noted the importance of the participation of specific groups. Ann Sanson and Susie Burke note that decisions about climate change today will determine the lives of children far into the future. They suggest that giving children “the opportunity to actively combat climate change can also provide important psychological protection” and build resilience. They also acknowledge the critical role that today’s children, as the next generation of adults, will play in shaping global responses to climate change.<sup>39</sup>

The preamble and article 13 of the Paris Agreement also affirm the importance of public awareness, public participation, and public access to information. In 2019, the UN General Assembly stressed the importance of the empowerment and capacity-building of indigenous women and youth, including in decision-making processes in matters that affect them directly. Consequently, in 2019 the

General Assembly expanded the mandate of the United Nations Voluntary Fund for Indigenous Peoples to assist representatives of indigenous peoples’ organizations and communities wishing to participate in the UNFCCC Conference of Parties.<sup>40</sup> Also in 2019, the UN Special Rapporteur on the rights to freedom of peaceful assembly and association, Clément Nyaletsossi Voule, noted that

*the effective adoption and implementation of integrated policies and plans towards inclusion, resource efficiency, mitigation and adaptation to climate change and disasters is wholly dependent on the participation of community and civil society actors, including women’s organizations, youth groups and indigenous communities.*<sup>41</sup>

Also in 2019, David R. Boyd, the current Special Rapporteur on human rights and the environment, published a study of good practices relating to both the procedural and the substantive elements of the right to a healthy environment. The procedural elements include access to information, public participation, and access to justice and effective remedies.<sup>42</sup>

In 2020, the Committee on the Elimination of Discrimination against Women, the Committee on Economic, Social and Cultural Rights, the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families, the Committee on the Rights of the Child, and the Committee on the Rights of Persons with Disabilities issued a joint statement on human rights and climate change. In the statement, the committees emphasized that states must guarantee the right of women, children, and other persons, such as persons with disabilities, to participate in climate policymaking. They noted that “given the scale and complexity of the climate challenge, States must ensure that they take an inclusive multi-stakeholder approach that harnesses the ideas, energy and ingenuity of all stakeholders.” The committees reiterated the importance of public participation in the design and implementation of climate policies.<sup>43</sup>

Based on the authoritative guidance of various UN treaties, the UN General Assembly, the Human Rights Council, treaty committees, UN Special

Rapporteurs, and other respected scholars, this paper contends that civil and political rights—including the right to participate in the conduct of public affairs, the right of peaceful assembly, and the freedoms of opinion and expression—are integral to the full realization of the right to health, including in the context of climate change.

### The principle of participation, civic space, and the climate crisis

As noted, the principle of participation in the conduct of public affairs, including environmental decision-making, has received substantial attention. Until recently, largely missing from this framing of the principle of participation was an overt acknowledgment of the importance of the conditions under which civil society can participate meaningfully. In 2016, Michel Forst, the UN Special Rapporteur on the situation of human rights defenders, addressed the issue of threats to environmental activists and advocates. He noted the importance of fundamental freedoms such as the rights to expression, privacy, association, and peaceful assembly. Forst also welcomed the development of legally binding regional instruments on access to information, public participation, and justice on environmental matters, such as the Aarhus Convention, noting that they would be an effective tool in responding to many challenges, including climate change.<sup>44</sup>

The concept of “civic space” has been defined by the OHCHR as “the environment that enables civil society to play a role in the political, economic, and social life of our societies.”<sup>45</sup> In 2018, Antoine Buyse described civic space as “the layer between state, business, and family in which citizens organise, debate and act.”<sup>46</sup> Also in 2018, Knox proposed framework principles on human rights and the environment.<sup>47</sup> The framework principles acknowledge the importance of civil and political rights, and specifically the rights of human rights defenders who strive to protect and promote human rights relating to the environment. Reflecting the 1998 Declaration on Human Rights Defenders, framework principle 4 notes, “States should provide a safe and enabling environment in which

individuals, groups and organs of society that work on human rights or environmental issues can operate free from threats, harassment, intimidation and violence.”<sup>48</sup> Civic space also implies access to public space—both physical, in print and online—in which to debate, demonstrate, and hold states to account.

Since the terrorist attacks in New York City in 2001 and subsequent similar atrocities, civic space has been increasingly constrained on security grounds in many countries. In 2017, Mattias Wahlstrom and Joost de Meer noted that civil society is faced with a double challenge: terrorism’s attack on liberal democracies on the one hand and authorities’ compromise of civil liberties for the sake of security on the other.<sup>49</sup> There are profound implications for climate action: Håkan Thörn, Carl Cassegård, Linda Soneryd, and Åsa Wettergren have described how climate justice movements in the Global North have been constrained in this context.<sup>50</sup> In 2019, Saskia Brechenmacher and Thomas Carothers noted the lack of conceptual and strategic clarity regarding threats to civic space, including siloed approaches to foreign policy agendas and development assistance, and government ambivalence in established democracies.<sup>51</sup>

Since 2020, civic space has been further constrained in response to the COVID-19 pandemic, often beyond what is arguably justifiable on public health grounds. The International Center for Not-for-Profit Law notes that the trend, which started prior to the COVID-19 pandemic, is global and includes measures that impede the formation of civil society organizations, their ability to seek and secure resources, and the freedom to assemble peacefully.<sup>52</sup> In 2020, writing in the context of the COVID-19 pandemic, the UN Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression noted that “freedom of opinion and expression goes hand-in-glove with public health.”<sup>53</sup> Also in 2020, Buyse noted how the COVID-19 pandemic and related government restrictions have led to greater use of online media for social organizing and dissent.<sup>54</sup> Maya Gros and Norman Eisen have also since noted how civil society has migrated online in re-

sponse to limitations on physical civic space in the name of public health, such as quarantines and the prohibitions of in-person gatherings.<sup>55</sup>

Today, civic space is as much digital as it is physical, and it is under threat. There is concern that restrictions on civic space will continue after the COVID-19 pandemic, with negative implications for civil society responses to other global challenges, including the climate crisis. In 2020, Voule noted that “active citizenship is key in times of crisis” and warned that “democracy cannot be indefinitely postponed.”<sup>56</sup> Also in 2020, noting the “gratuitous toll being inflicted on democracy, civil liberties, fundamental freedoms, healthcare ethics, and human dignity” by unjustified limitations on civil and political rights, Stephen Thomson and Eric Ip warned that COVID-19 emergency measures may herald an “authoritarian pandemic.”<sup>57</sup> In 2021, Voule directly addressed threats to the freedoms of peaceful assembly and of association in the context of the climate change and noted that “addressing the climate crisis and ensuring a just transition requires the existence of a vibrant and dynamic civic society.” He added that the freedoms of peaceful assembly and of association are inextricably linked with the right to take part in public affairs. His report challenges us to consider the limits of peaceful dissent in the face of state intransigence. Voule argues that states should recognize and provide space for civil disobedience and nonviolent direct action campaigns, “which are employed by many climate justice activists around the world who are following in the footsteps of other major transnational social movements.” He notes that “States must exercise great restraint on imposing restrictions on [these] forms of peaceful protest, including when taking decisions on whether to arrest, prosecute, impose pre-trial detention, convict or award damages against climate justice activists for engaging in such actions.”<sup>58</sup>

As noted, responses to the climate crisis are hotly contested. To ensure the fullest participation of all stakeholders in the design and implementation of these responses, it is essential that civic space be maintained and extended.

## Limitations of these evolving approaches

The concepts of participation and civic space in international human rights law are useful tools to address the climate crisis. However, potential gaps remain. In 2010, Conor Gearty noted that the focus on the rights of the human species to the exclusion of other living organisms—animals, plants, and, indeed, the planet—has been interpreted by some observers to imply that “human rights” may actually *hinder* environmental protection. Nonetheless, Gearty acknowledges the value of the civil and political rights to the environmental movement, noting that “the assertion of civil and political rights gives activists a universal language—understandable even to those who do not share their substantive concerns—with which to fight back against a state intent on silencing them.”<sup>59</sup>

Also missing from the international human rights framework is empathy for the nonhuman world contained in the perspectives of Indigenous peoples who have curated their environments for millennia. Angela Roothaan notes that Indigenous peoples focus on “how the spirits tell them to maintain an environmental balance with specific local surroundings, out of respect and love for the actual living beings that make up those surroundings, on which human life depends, and which human life can help sustain.”<sup>60</sup> One approach to addressing this gap is to ensure that UN human rights treaties are read alongside other UN treaties. For example, although still framed as important for meeting *human* needs, the Convention on Biological Diversity, the UNFCCC, and these treaties’ respective protocols all promote respect for planetary health and are important adjuncts to the international human rights framework.

A related concern is the issue of intergenerational rights, which are not yet clearly articulated in the human rights framework. In 2019, Samudu Atapattu and Andrea Schapper reviewed arguments that future generations also have rights, such as the right to clean drinking water, the right to health, and the right to adequate food. They argue that our actions today should not compromise the ability of future generations to enjoy these rights.<sup>61</sup> Atapattu has explored these issues from

the perspective of the Convention on the Rights of the Child within a framework of sustainable development and intergenerational equity, noting that some environmental treaties also embody the intergenerational principle.<sup>62</sup> In 2020, Lydia Slobodian reviewed court cases brought on behalf of child plaintiffs and future generations in the United States.<sup>63</sup> These arguments are gaining traction in diverse jurisdictions. In 2021, a German court upheld a complaint brought by children and others that the government's climate change targets and annual emissions allowed until 2030 were incompatible with complainants' fundamental rights, including their rights to health and to life.<sup>64</sup> Also in 2021, the Committee on the Rights of the Child, responding to a complaint by 16 child complainants, found that a state party can be held responsible for the negative impact of carbon emissions originating within its territory, whatever the location of the harm, including outside its territory.<sup>65</sup>

## Conclusion

While cognizant of the above limitations, this paper contends that the right to health provides a valuable opportunity for engaging a broader range of advocates in the response to the climate crisis, including from the health sector, while warning that civil and political rights—and notably civic space—must be protected if these actors are to contribute meaningfully.

Civil and political rights—such as the rights to information, to participation, to freedom of association, and to peaceful assembly—are key. Current human rights perspectives acknowledge the importance of participation in advancing the right to health. However, the concept of civic space is not yet adequately developed as a central plank of the principle of participation. Perspectives from political science can enhance the framing of civic space, including in relation to climate change. This imperative is increasingly urgent as communities become more aware of the threats of climate change. Poonam Joshi urges us to rethink civic space in the context of climate change, noting that “the urgency to take action on climate will mean many more

people involved in direct action, protest, advocacy, and litigation.”<sup>66</sup> Even the postapocalyptic world of “decline, depletion, chaos and hardship” envisaged by Kingsnorth will be a better place to the extent that human rights are respected and promoted.<sup>67</sup>

Public health restrictions on civic space introduced during the COVID-19 pandemic must conform with the principles of international law and be lifted as soon as they are no longer justified, including by court order if governments delay. Nonetheless, governments with an authoritarian inclination and little tolerance for dissent may seek to maintain bans on public gatherings and protest, including regarding the climate crisis, in the name of public health.<sup>68</sup> In this context, human rights, public health, and environmental advocates must develop and strengthen collaborative platforms for joint engagement to address the climate crisis, while defending and extending the civic space essential to ensuring their voices are heard. This dialogue will require an openness to differing disciplinary paradigms and world views, which in turn offers rich possibilities for healthy people and a healthy planet.<sup>69</sup>

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# Challenges to Protecting the Right to Health under the Climate Change Regime

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## Abstract

Researchers and global policy makers are increasingly documenting negative health impacts from climate change, raising concerns for realizing the right to health. Importantly, courts have held that anthropogenic activities affecting climate may threaten a population's standard of health and compromise its inviolable right to health. However, legal hurdles—such as the fragmentation of climate change and human rights laws and the difficulties in proving causal links—hamper efforts to litigate right to health claims in the context of climate change. To address these challenges, this article assesses the detrimental effects of climate change from an international human rights perspective and analyzes climate change litigation to explore potential avenues to press for the right to health in the face of climate change.

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## Introduction

Climate change has been identified as one of the major crises facing the global community.<sup>1</sup> Researchers and international organizations—such as the Office of the United Nations High Commissioner for Human Rights (OHCHR), the Human Rights Council, the United Nations Environment Programme, and the World Health Organization—are increasingly documenting the negative health impacts of climate change, raising concerns for realizing the right to health under climate change.<sup>2</sup> However, associating aspects of climate change with the right to health remains a challenge, and the right to health implications of climate change are seldom discussed in court decisions.<sup>3</sup> The failure to associate climate change with the right to health is concerning because it may result in the health impacts of climate change being regarded as an issue that can be resolved only through political processes, and not human rights litigation.<sup>4</sup> Efficient protection of the right to health cannot be well developed under the climate change regime, nor can climate change protection be well developed under the right to health regime.<sup>5</sup> Furthermore, uncertainties in measuring the scale and impact of climate health risks, legal hurdles (such as proving complicated causal links), the uneven distribution of states' responsibilities, and issues of extraterritoriality also hamper efforts to link climate change with the right to health in litigation. To better understand the possibilities and challenges of making right to health claims in climate change litigation, this paper aims to delineate a right to health framework for climate change and to reaffirm the links that exist between the two.

### Addressing climate change impacts through a human rights lens: Attempts and obstacles

Addressing the impacts of climate change on human rights grounds is not a new idea. For example, the preamble to the Paris Agreement of 2015 affirms that “[since] climate change is a common concern of humankind, Parties should, when taking action to address climate change, respect, promote, and

consider their respective obligations on human rights.” In a 2005 petition by the Inuit to the Inter-American Commission on Human Rights, the US government’s failure to regulate greenhouse gas (GHG) emissions, which has exacerbated climate change leading to impacts on the Inuit people’s traditional way of life, was evaluated through the lens of human rights.<sup>6</sup> Recently, several courts have also recognized that anthropogenic activity affecting the climate may threaten the enjoyment of decent health and life and violate human rights (e.g., *Laghari v. Pakistan* and *Urgenda v. Netherlands*).<sup>7</sup> As the linkage between climate change and human rights gains increasing prominence, a human rights approach is expected to direct public and political attention to the detrimental human consequences of climate change, and to be applied to climate change cases across a range of scenarios.<sup>8</sup>

However, the interface between climate change and human rights was recognized only recently (for example, the first human rights and climate change resolution was adopted by the Human Rights Council in 2008) and is still evolving.<sup>9</sup> Due to the political and economic pressures from political entities (such as regional economic communities) and multinational enterprises, many states and international organizations still do not acknowledge the link between climate change and human rights.<sup>10</sup> For example, the OHCHR stated in 2009 that “the physical impacts of global warming cannot easily be classified as human rights violations, not least because climate change-related harm often cannot clearly be attributed to acts or omissions of specific States.”<sup>11</sup> Regarding the Paris Agreement, the final text does not include human rights in its operative provisions, despite pressure from civil society groups advocating for such recognition.<sup>12</sup> It therefore remains unclear whether the climate change–human rights connection is endorsed by the United Nations (UN) or high-income countries that are primarily responsible for climate change and seek to avoid liability by opposing human rights-based arguments.<sup>13</sup>

Furthermore, the dissociation of states’ responsibilities toward climate change and toward human rights is partially caused by an entrenched

disciplinary gap between these two arenas.<sup>14</sup> Climate change governance is rooted in objective scientific research and is economically oriented.<sup>15</sup> Human rights protection, on the other hand, is based on humanitarian values and prioritizes the protection of individuals and communities from abuses (such as those arising from climate change). Climate change negotiations are also centered on consensus-driven and economic welfare-based, rather than human rights-based, solutions.<sup>16</sup> For example, instead of referring directly to human rights, the UN Conference on Environment and Development in Rio de Janeiro could only reach the consensus that human beings “are entitled to a healthy and productive life in harmony with nature” in the Rio Declaration.<sup>17</sup>

Efforts toward international recognition of a new stand-alone right to a healthy environment are underway. In October 2021, the Human Rights Council adopted two landmark resolutions. The first of these recognizes “the right to a clean, healthy and sustainable environment” as a stand-alone human right for the first time.<sup>18</sup> The second appoints a Special Rapporteur to study, identify, and report on the adverse and far-reaching impacts of climate change on human rights.<sup>19</sup> However, how governments incorporate the new nonbinding right into their climate change legislation and how courts interpret this new right in light of existing climate change laws has yet to be observed. The debate concerning the pros (such as addressing climate change impacts through the procedural and substantive protections embodied in the UN human rights system) and cons (such as duplication of existing rights) of the UN’s recognition of the right to a healthy environment may also continue for a while.<sup>20</sup> This is partly because, due to the marginal status of human rights in the climate change regime, global climate change law focuses mainly on environmental damage and the state’s responsibility to constrain environmentally deleterious behavior rather than on the state’s responsibility to avoid climate change impacts on humans.<sup>21</sup>

For example, sustainable development is a principle of global climate change law, with population-wide health being one of its central goals, yet

no specific references to the protection of human health were made when the United Nations Framework Convention on Climate Change (UNFCCC) was adopted in 1992.<sup>22</sup> UNFCCC article 4.1(f) briefly states that parties should employ appropriate assessments with a view to minimizing adverse effects on the economy and public health when mitigating or adapting to climate change. However, the public health assessment requirement is stipulated in a vague and nonbinding manner, requiring only that parties consider public health impacts “to the extent feasible” and allowing them to sacrifice public health in the name of economic growth. The Kyoto Protocol of 1997, which aims to assist states in meeting GHG emissions reduction targets in mostly economic terms, does not clearly lay out any health-related objectives, either.<sup>23</sup> Further, most climate change rulings that have been issued by national courts are only indirectly based on human rights, with courts’ primary focus on a general duty to prevent environmental damage.<sup>24</sup> As a result, even though in theory it is assumed by the OHCHR and the Human Rights Council that human rights should shape states’ climate policies, in practice it remains uncertain how and to what extent human rights, including the right to a healthy environment, shape or direct these policies.<sup>25</sup>

### Linking climate change to the right to health

Despite political opposition, proponents argue that conceptualizing climate change in human rights terms can help individuals and societies personalize their vulnerability to the harms caused by climate change, identify the pathways in which the harms link law and justice, and contribute to a variety of procedural and substantive outcomes.<sup>26</sup> For example, the human rights approach provides an existing legal language with great legitimacy that can be used to connect human dignity and the abstract entity of the climate (or the environment).<sup>27</sup> Through the direct application of a human rights perspective in climate cases or through the indirect influence of human rights law on national climate legislation, the attempts of legislatures or

judiciaries to address climate change challenges may benefit from the normative strength of human rights arguments.<sup>28</sup> The human rights approach can also supplement the effective application of stakeholders' procedural rights in climate change law and increase public participation in climate management.<sup>29</sup>

Nevertheless, the application of human rights in the climate change regime may be flawed.<sup>30</sup> For example, opponents regard the human rights approach as inefficient because it reflects only common denominators rather than climate exigencies and is usually deployed after rights violations and environmental destruction has occurred.<sup>31</sup> Additionally, climate change mitigation and adaptation involve complex trade-offs between values, which cannot be properly addressed using the human rights approach alone unless the approach embraces the lessons of climate science and efforts to reach political solutions.<sup>32</sup> But these challenges, which are also found in climate change laws, cannot be resolved without technological developments or interstate negotiations, which take time.<sup>33</sup> In the meantime, the human rights approach, even if it alone cannot solve the climate change problem, can be instrumental in combating climate change and prodding the political process.<sup>34</sup>

By bringing the climate change regime into closer alignment with human rights protection, the right to health can be used to drive greater integration between currently separate international agendas and can provide a tangible legal framework for analyzing states' responsibilities with regard to climate change.<sup>35</sup>

### Health impacts of climate change

Researchers and UN bodies alike recognize that human health is widely impacted by climate change.<sup>36</sup> For example, the rise in temperature due to GHG emissions has induced heat stress and caused bodily dysfunction and even deaths.<sup>37</sup> Unreliable water availability, which is sensitive to climate change, also increases individuals' risk of exposure to vector-borne (such as malaria) and water-borne (such as cholera) diseases, especially for vulnerable popula-

tions in water-scarce regions.<sup>38</sup> Changing humidity levels can worsen air pollution and increase asthma attacks due to the effects of pollutants.<sup>39</sup> Excessive rainfall caused by climate change leads to blooms of micro-organisms entering drinking water, thus increasing the transmission of water-borne infectious diseases.<sup>40</sup> The World Health Organization has also identified myriad ways in which climate change is already affecting human health, and the organization is continuing to monitor the health impacts of climate change.<sup>41</sup> For example, it estimates that climate change will cause approximately 250,000 additional deaths per year between 2030 and 2050 from malnutrition, malaria, diarrhea, and heat stress.<sup>42</sup> A 2016 study led by the World Health Organization showed that specific diseases (such as dengue fever, malaria, diarrhea, leptospirosis, and typhoid fever) are highly climate sensitive in Pacific Island countries, which are more vulnerable to the health impacts of a changing climate.<sup>43</sup>

Since climate change poses a grave threat to human health, which includes the social and environmental determinants of health, the right to health is frequently invoked in climate change cases, and the call for right to health action and the mobilization of the human rights machinery to monitor states' climate change commitments is well justified.<sup>44</sup> Additionally, researchers are now working to build evidence that links cause (climate change) and effect (health impacts). For example, in an effort to map the connection between climate change and human health, both a 2016 OHCHR study and a 2016 US Global Change Research Program report draw attention to the vast body of climatology and public health research that identifies close correlations between climate change and health issues and makes predictions for different scenarios, including the risk of infectious disease transmission and negative impacts on mental health caused by heat, air pollution, extreme weather, storms and floods, drought, and wildfires.<sup>45</sup> Stakeholders—including civil society organizations, international organizations, and national human rights institutions—overwhelmingly agree that there is such a connection.<sup>46</sup> Solid empirical research and strong societal consensus

help provide a tangible basis to shape right to health claims in climate change cases.<sup>47</sup>

### *Expansion of the right to health*

On the recommendation of the Special Rapporteurs, the OHCHR, and the Committee on Economic, Social and Cultural Rights (CESCR), the scope of the right to health has gradually been expanded to offer protection against climate change.<sup>48</sup> For example, a major 2014 report of the Special Rapporteur on the right to health notes that states have health rights obligations to individuals and groups who have essential needs that fall under the purview of the right to health (such as clean water and adequate sanitation) owing to climate conditions.<sup>49</sup> The report also calls on the Human Rights Council to urgently study climate change impacts on human rights, particularly the right to health.<sup>50</sup> More recently, the Special Rapporteur on human rights and the environment and the OHCHR have confirmed that the mitigation of or adaptation to climate change impacts is fundamental for protecting the right to health and that “states, therefore, have clear obligations to take measures to prevent and remedy the negative impacts of climate change on the right to health, including with regard to the environmental and social determinants of health.”<sup>51</sup>

According to the CESCR, the right to health includes the traditional obligation of the state to ensure access to health care and other underlying determinants of health, as well as to provide protection against interference with individuals’ health affairs.<sup>52</sup> The underlying preconditions for health include an adequate supply of nutritious food, safe drinking water, basic sanitation, and *freedom from serious environmental health threats*.<sup>53</sup> This freedom constitutes the baseline below which no individuals should fall and is consistent with the emergence of a self-evident human right to a healthy environment.<sup>54</sup> Furthermore, the right to life claim, which is also frequently invoked in climate change litigation, is encompassed in the broad conception of the right to health because one’s health is obviously damaged when one’s life is threatened by climate change.<sup>55</sup> Namely, climate change that involves the risk of loss of health or life warrants protection un-

der the right to health.<sup>56</sup>

Even though the Human Rights Council recently passed a resolution recognizing the right to a healthy environment, there are still obstacles (political controversies and inertia) to the incorporation of the new nonbinding right into national climate change laws.<sup>57</sup> The right to health, which is linked with the right to a healthy environment, can be used as an alternative legal basis to require states to systematically carry out human rights impact assessments prior to and during the implementation of climate change measures, and to provide effective redress mechanisms for those whose right to health is violated due to climate change health threats.<sup>58</sup> Furthermore, because only a limited number of treaties—such as the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (article 11) and the African Charter on Human and Peoples’ Rights (article 24)—include the right to a healthy environment, there is a lack of sufficient normative power for advocates to effectively protect human rights from climate change impacts.<sup>59</sup> To fill the gap, the right to health can provide a basis for intervention against, or remedy for, climate change harms and for the guarantee of governments’ full compliance with global climate change principles.<sup>60</sup>

### *Emerging rights-based climate change litigation*

Not all courts consider right to health claims in the realm of climate protection to be justiciable.<sup>61</sup> This is because some courts understand climate change matters as political (climate change policy choices) rather than legal issues, which precludes the courts’ consideration of right to health claims.<sup>62</sup> But several courts at the domestic and international levels seem to be in favor of the right to health approach and of incorporating into it an entitlement to a safe environment.<sup>63</sup> For example, in *Marangopoulos Foundation for Human Rights v. Greece*, the European Committee of Social Rights found a human rights violation in the state’s failure to properly abate an activity previously identified as contributing to climate change based on scientific evidence collected by the World Health Organization; in its holding, the committee referred to article 11 of the

European Social Charter (the right to protection of health).<sup>64</sup> The committee further recognized the state's responsibility to design measures to remove the cause of the ill-health resulting from the climate threat.<sup>65</sup> In *Clean Air Foundation Limited and Gordon David Oldham v. Government of the Hong Kong Special Administrative Region*, the Hong Kong High Court recognized the government's right to health obligation to combat air pollution.<sup>66</sup> In *Montana Environmental Information Center v. US Office of Surface Mining*, a US district court's conclusion shows that the government has the responsibility to adequately consider the adverse effects of coal combustion, including on public health.<sup>67</sup>

Even though in some cases the right to health is not directly cited, jurisprudence addresses the right to life in the context of environmental degradation, where most aspects are also covered by the right to health due to the overlapping elements of these two rights.<sup>68</sup> For example, in *Urgenda*, the Dutch Supreme Court used the argument of the right to life (article 2 of the European Convention on Human Rights), along with the right to home and family life (article 8), to establish the state's duty of care regarding the development and implementation of adequate climate mitigation policy.<sup>69</sup> In *Leghari*, the Pakistan Lahore High Court found climate change to be a challenge to the right to life (article 9 of the Constitution of Pakistan), which includes the right to a healthy and clean environment, and concluded that the government's failure to implement a national climate policy framework in a timely fashion constituted a human rights violation.<sup>70</sup> In *Juliana v. United States*, a US district court concluded that the right to a stable climate system capable of supporting human life is a fundamental substantive due process right and a right under the public trust doctrine.<sup>71</sup> In *Gbemre v. Shell Petroleum Development Company of Nigeria Ltd.*, the Nigerian Federal High Court ruled that the constitutional right of individuals to life and dignity were violated by the oil company and the government because "the burning of gas by flaring in [the] community ... contribute[d] to adverse climate change as it emit[ted] carbon dioxide and methane, which

causes warming of the environment."<sup>72</sup>

These cases demonstrate that if litigants can establish that the state's failure to mitigate or adapt adequately to climate change resulted in damage to health or life, they then may claim a violation of the right to health.<sup>73</sup> Researchers and advocates also encourage claimants to utilize international human rights mechanisms in climate change cases to pursue their desired remedy.

### *The international right to health as an interpretative tool in domestic litigation*

Courts also use the international right to health as an interpretative tool in domestic climate change litigation, either to strengthen the justification for limiting other competing interests (such as economic development) or to validate stronger environmental protection.<sup>74</sup> For example, courts may rely on the right to health in interpreting undefined legislative requirements in climate change laws (such as the notion of "public interest"), and it can be used as a supplementary tool when assessing breaches of legal obligations under climate change law as well as other obligations related to climate change under international human rights law.<sup>75</sup> Therefore, taking the right to health into account can assist courts in judging the adequacy of mitigation and adaptation measures as a response to health risks posed by climate change.<sup>76</sup> As a result, international right to health obligations may help create a duty of care for governments not only to refrain from actions that may lead to violations of the right to health (the obligation to respect) but also to prevent such violations from occurring within their borders (the obligation to protect).<sup>77</sup> In *Urgenda*, the scope and content of the state's duty of care was delineated on the basis of human rights standards, which served as a source for interpreting undefined legal standards and concepts.<sup>78</sup> In *Earthlife Africa Johannesburg v. Minister for Environmental Affairs*, the court used human rights provisions as an interpretive aid to clarify undefined legislative requirements related to environmental impact assessments, such as the notion of public interest and the principle of intergenerational justice.<sup>79</sup> These

cases show that the international right to health may serve as a platform that offers a normative and institutional framework for strengthening the accountability of states.<sup>80</sup>

Additionally, addressing climate change impacts through individual claims for damages in the courts meets mixed success due to complexities in proving causation.<sup>81</sup> Litigants may be more successful by alleging that the government has failed to fulfill its right to health obligations relating to climate change. First, international legal instruments have delineated the scope and content of states' right to health obligations to prevent or control adverse impacts on individuals' enjoyment of the highest attainable standard of health. Therefore, instead of establishing that an actor's specific activity contributing to climate change caused the specific health harm of the plaintiff, the plaintiff in human rights-based climate change litigation needs to prove only that the state has failed to act in compliance with its right to health obligations delineated in human rights documents.<sup>82</sup> For example, the CESCR states that due process requirements (such as the right of individuals and groups to participate in decision-making processes that may affect their health) must be an integral component of any policy developed to discharge the state's right to health obligations.<sup>83</sup> Therefore, a court can hold a state responsible for violating the right to health in its climate change policies due to procedural deficits, regardless of whether specific climate change harms can be directly attributed to the state.<sup>84</sup>

According to the CESCR, the right to health imposes three types of obligations on states: the obligations to respect, to protect, and to fulfill. These obligations can provide an alternative route for litigants to pursue climate change litigation.<sup>85</sup> Violations of *the obligation to respect* the right to health are those state actions, policies, or laws that are "likely to result in bodily harm, unnecessary morbidity and preventable mortality."<sup>86</sup> Given that climate change is predicted to impact almost every facet of human health, a state's failure to refrain from acting in a manner that contributes to climate change, which would interfere (directly or indirectly) with health, may be regarded as a violation

of the right to health.<sup>87</sup> Regarding *the obligation to protect*, states are required "to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others."<sup>88</sup> The obligation then suggests a duty of the state to actively adopt climate mitigation legislation (such as setting GHG emissions targets) to protect individuals from negative third-party interference in their right to health.<sup>89</sup> *The obligation to fulfill* requires states to adopt appropriate legislative and administrative measures toward the full realization of the right to health.<sup>90</sup> These measures include producing climate-related health impact assessments and providing health-relevant climate information to potentially affected communities.<sup>91</sup> A state's failure to assess climate-related health risks in the decision-making process may then be identified as breaching the right to health standards.<sup>92</sup>

Second, pointing to general and universal negative impacts of climate change on the public health and the state's general inaction should be sufficient to establish a right to health violation associated with climate change.<sup>93</sup> For example, the *Leghari* court held that the state's failure to adhere to its own climate change plan and implementation framework violated its human rights obligations, based on the recognition of the general threat posed to the public by global warming.<sup>94</sup> In this manner, litigants in human rights-based climate change litigation can use the general association of climate change and health impacts, rather than a causal relationship between specific climate-relevant activities and explicit health harms, to establish a governmental duty to act and to support their right to health.<sup>95</sup> In practice, establishing a sufficient causal link between a given activity and specific health harms is of course the strongest approach to successful climate change litigation. But it is difficult for climate change victims to prove specific causation due to scientific uncertainties.<sup>96</sup> The right to health approach thus provides an alternative to establish the state's obligation to combat climate change.

However, we should keep in mind that the right to health approach should not supplant climate change laws, nor should it be used to undermine

democracy by shifting power from the legislature to the court.<sup>97</sup> The right to health serves as a bridge between the domains of climate change and human rights, where it can be used in the judicial branch as a supplementary policy instrument when legislative and administrative action is unlikely to be forthcoming. Additionally, although the right to health approach may enable individuals to claim against the state, right to health claims in climate change litigation still need to be supported by scientific evidence, environmental principles, and climate justice claims.<sup>98</sup>

### Legal hurdles to linking climate change to the right to health

Although the implications of climate change for the realization of the right to health are increasingly obvious on the ground, linking climate change to the right to health in law still faces several hurdles.

#### *Fragmentation of climate change and human rights laws*

The fragmentation of climate change and human rights laws has attracted the attention of the international legal community because it may create complex and sometimes conflicting relationships between climate change obligations and human rights obligations.<sup>99</sup>

First, from the perspective of climate change law, states may concentrate on actions to address climate change while overlooking systemic integration in the interpretation of states' obligations concerning climate change and human rights.<sup>100</sup> But some may challenge the existence of fragmentation, because international climate change documents advise member states on health impacts caused by climate change, thus linking climate change with public health. Even though the right to health is not explicitly mentioned in these documents, there seems to be room for right to health claims within the climate change regime. For example, article 3.1 of the UNFCCC states that "parties should protect the climate system for the benefit of present and future generations of humankind," where the protection of health—one of humankind's benefits—is

regarded as a necessary function of international climate change law.<sup>101</sup> The preamble to the Paris Agreement also requires parties to consider the right to health when taking action to address climate change.

However, it is questionable whether these provisions are sufficient to protect the right to health in the climate change regime due to the vagueness of states' responsibilities to protect public health in the context of climate change. For example, article 1 of the UNFCCC mentions the importance of minimizing the adverse effects of climate change on "human health and welfare." But article 3.4 specifically states that climate change measures "should be appropriate for the specific conditions of each Party ... taking into account that economic development is essential for adopting measures to address climate change," and article 4.1(f) specifies that a party's climate change responsibilities should take into account not only climate change considerations but also, "to the extent feasible, ... minimizing adverse effects on the economy, on public health and on the quality of the environment." According to these provisions, which are formulated in a rather open-ended manner, health is placed merely as a relevant consideration next to economic development and environmental quality, and wide discretion is left to state parties.<sup>102</sup>

Additionally, even if some courts start to consider changing the excessive emphasis on economic considerations, reducing the ignorance of health impacts in climate change policy, and adjusting the excessive margin of appreciation given to states, the basis of their decisions may be confined to the objectives set by the climate law. But the current objective of the climate change regime is generally to set solid evidence-based standards (for example, GHG emissions standards) for states to follow in the most cost-effective way.<sup>103</sup> As a result, even though climate change law refers to the conservation of human health, the right to health is merely a "reflex effect" of the implementation of climate change standards, and as such it may be sacrificed for greater economic interests.<sup>104</sup> For example, studies have shown that the health aspects of states' climate change measures still remain generally utilitarian,

relying on cost-benefit and other economic analyses regardless of the normative value of the right to health.<sup>105</sup>

To prevent a state from abusing its discretionary power, courts should use human rights norms and principles as interpretative tools when balancing public health and economic development concerns related to climate change measures.<sup>106</sup> Courts should also take note that ensuring the implementation of environmental standards set in climate laws, which are traditionally regarded as “pure” science, should not be viewed as equivalent to a state’s fulfillment of its right to health obligations relating to climate change.<sup>107</sup> Since human beings form part of the ecosystem that climate change law aims to maintain, it is important to evaluate whether climate change standards are sufficient to improve human rights and well-being.<sup>108</sup> Therefore, applying the right to health approach in addition to using the health-related provisions in climate change law (which focuses mostly on environmental, scientific, and economic issues) to scrutinize states’ adherence to their right to health responsibility to protect individuals or communities from health risks of climate change can provide an alternative that shifts the debate away from climate change science and onto the victims of climate change.<sup>109</sup>

Second, human rights law alone is not sufficient to protect the right to health in the climate change regime. For example, climate change issues, complicated by tensions between economic development, public health needs, human rights, and scientific uncertainty, cannot be addressed by individual states acting alone. This is why international climate change law is grounded in the need for mutual action.<sup>110</sup> But reciprocity is generally not taken into consideration in human rights law because one state’s respect for the right to health does not depend on, and may not be conditioned on, compliance by other states.<sup>111</sup> Critics thus argue that right to health claims in climate change litigation may oversimplify the highly complex problem of climate change and fail to give due consideration to the intrinsic value of the environment, which crosses national

borders.<sup>112</sup> In another example, individuals whose health is harmed by climate change and whose right to health is poorly protected are less likely to be well equipped to adapt to climate change effects or to lobby for government or international action to mitigate climate change. This vicious cycle, which links poor climate change governance, weak human rights protections, and vulnerability to climate change-related harm, demonstrates a deep and complex interlinkage between climate change and the right to health.<sup>113</sup>

In response to this challenge, climate-related health risks should not be regarded as merely another addition to the list of health hazards in the right to health regime.<sup>114</sup> Because the negative effects of climate change and poor protection of the right to health are mutually reinforcing, climate change law should also be regarded as an important tool to assist right to health protection in the climate change era.

In conclusion, climate change mitigation and adaptation policies cannot be well developed, implemented, or assessed without closely linking climate change and the right to health in a mutually beneficial manner.<sup>115</sup> First, due to the dynamic nature of climate change with regard to complicated legal and socioeconomic determinants across jurisdictions, the impacts of climate change cannot be fully addressed through climate change law alone; its implementation requires the input of right to health values.<sup>116</sup> Second, a state’s right to health obligation to combat health threats caused by climate change cannot be reviewed only through the lens of the human rights regime since climate change is actually a combination of many distinct problems.<sup>117</sup> Finally, it is important to alleviate the effects of the fragmentation of climate change and human rights laws because the “separate spheres” conceptualization may result in conflicting goals and aims at the interface of the right to health and climate change.<sup>118</sup> Unnecessary bifurcations of overlapping climate change and human rights obligations could also lead to right to health infringements in order to uphold other rights or economic interests.<sup>119</sup>

### *The principle of progressive realization*

According to article 2(1) of the International Covenant on Economic, Social and Cultural Rights, the right to health is subject to the principle of progressive realization, where the state must take steps to the maximum of its available resources with a view to progressively achieving the full realization of the right. By using the progressive realization principle in the context of climate change, states can avoid their right to health obligation to reduce climate-sensitive health risks by arguing that climate change mitigation and adaptation actions go beyond their reasonable available resources.<sup>120</sup> States can also justify their passive responses to climate change (and its impacts on health) by arguing that the pursuit of economic development (for example, by relaxing GHG emissions standards) ought to receive higher priority than the prevention of prospective health harms because the latter needs to be fulfilled only progressively.<sup>121</sup> Additionally, the progressive realization principle can be further reinforced in the climate change regime because the state's discretionary power is generally recognized in climate change law. For example, the UNFCCC grants states broad discretion in terms of the implementation of measures to mitigate and adapt to climate change.<sup>122</sup> In *Massachusetts v. Environmental Protection Agency*, the US Supreme Court also focused on the degree of discretionary power that the Environmental Protection Agency is entitled to exercise to regulate GHG emissions.<sup>123</sup>

However, the principle of progressive realization does not give states unfettered discretion.<sup>124</sup> The state still bears the burden of ascertaining, based on appropriate indicators and benchmarks, whether it is progressively protecting the right to health from the negative impacts of climate change.<sup>125</sup> The state also needs to prove that any retrogressive climate change protection measures that may cause negative health impacts “have been introduced after the most careful consideration of all alternatives” and “are duly justified by reference to the totality of the [right] ... in the context of the full use of the State party's maximum available resources.”<sup>126</sup> But in some cases, a state's claims of insufficient resources to justify its noncompliance with human rights

law in its climate change policies are made without informing the state's populace of its climate change strategies, indicators, and time-bound targets.<sup>127</sup> Without such information, it is difficult, if not impossible, to assess a state's progress in realizing the right to health under climate change threats.<sup>128</sup> The failure to make a transparent health impact assessment and the failure to set deliberate and concrete goals in climate change policies or decisions thus can be regarded as a right to health violation.<sup>129</sup>

Most importantly, the right to health includes some core obligations of immediate effect that are not subject to progressive realization, including ensuring access to essential food, basic shelter, and safe water; ensuring nondiscriminatory access to health care (especially for marginalized groups); and adopting national strategies to address public health concerns.<sup>130</sup> Considering that climate change affects these “minimum essentials” of the right to health, it is misleading to assume that the heterogeneous contents of that right are subject only to progressive realization when exploring the state's climate change responsibility in connection with the right to health. Failing to prevent, or tolerating the existence of, extremely grave risks imposed by climate change to these nonderogable minimum essentials, especially to vulnerable people, should be regarded by courts as a right to health violation.<sup>131</sup>

Concerns about accepting progressive realization and recognizing nonderogable minimum essentials of the right to health in different climate change scenarios may boil down to the administration's or the legislature's evaluation of the trade-offs and their adoption of precise regulations and standards governing climate change. Therefore, courts may be reluctant to enforce right to health protections or to determine the minimum essentials for fear of interfering with the lawful discretion given to policy makers, as shown in *Clean Air Foundation Limited and Gordon David Oldham*.<sup>132</sup> In this case, the court recognized the state's right to health obligation to combat climate change but nonetheless held that the state's decision to set low climate change standards was an issue of political governance rather than of legality.<sup>133</sup>

However, determining progressive realization

and minimum essentials of the right to health in connection with climate change raises not only political but also legal issues. Whether the climate change measures are reasonable within maximum available resources as described by the “progressive realization” principle or whether the “minimum essentials” are properly assigned are legal issues and subject to judicial review.<sup>134</sup> Because progressive realization and the minimum essentials are associated with the determination of the minimum decencies of human dignity and the minimum core of the state’s obligation concerning the right to health, they set the threshold of lawfulness/unlawfulness.<sup>135</sup> But this article is not proposing that the courts play a role as deputy legislators or administrators in the climate change regime. To clarify the minimum essentials of the right to health in the climate change regime and determine their scope, a balance between legislative/administrative action and judicial intervention needs to be explored and established.

### *Causal complexity in climate change*

Characterizing climate change harms to health in legal terms is a complex task because climate change occurs as a collective result of multiple elements regardless of national boundaries, such that connecting cause and effect is complex.<sup>136</sup> To complicate matters further, linking climate change to right to health claims is controversial because traditional right to health jurisprudence focuses on impacts faced by individuals rather than populations, and is tailored to a narrow set (biomedical model) of hazards. As a result, right to health violations cannot be promptly assessed.<sup>137</sup> For example, states’ violations of human rights resulting from GHG emissions are difficult to prove because (1) it is difficult to disentangle the complex causal relationships that link the GHG emissions of a particular country to a specific effect; (2) global warming is often one of several climate change-related contributing factors to human health harms; and (3) adverse effects of global warming often give rise to future impacts, whereas human rights violations are normally established after the harm has occurred.<sup>138</sup>

To address these challenges, several steps need to be taken to improve the protection of the right to health as it relates to climate change. First, guaranteeing accessibility to relevant information can help disentangle the complex causal links between a state’s engagement in climate change action/inaction and right to health infringements by providing an implicit reference to causation.<sup>139</sup> The state’s obligation to inform or educate the public about a broad range of health-related climate change issues and make such information accessible to individuals can be derived from paragraph 12(b) of the CESCR’s General Comment 14. More specifically, due to the complex and arcane characteristics of climate change knowledge and the obscure and indirect relationship between climate change and health, governments have leeway to use uncertain causation as an excuse to avoid their human rights responsibilities regarding climate change. Disclosure of health-relevant climate change information (such as geographic reach, assessed severity, and length of the negative climate change impacts on human health) can prevent the state’s exercise of paternalism and promote individuals’ understanding of and autonomous consent to climate change policies that may impact their health.<sup>140</sup>

Second, when causation is difficult to prove, after the plaintiff presents a *prima facie* case of climate change factors (such as warming or increased storms) and injuries, the burden of proof for causation in human rights-relevant climate change cases should be shifted to the government. The international community, governments, and courts should recognize that the evidentiary standard in climate change cases is too high for individuals to prove that their right to health is violated or threatened by climate change or by the state’s engagement in action/inaction in mitigating or adapting to climate change.<sup>141</sup> Therefore, instead of requiring injured individuals to prove a causal relationship between health harms and climate change, the burden should shift to the government to exculpate itself. Reversing the burden of proof in climate change cases is justified because the government has the resources to access, collect, and analyze the information and to understand the long-term im-

plications of climate change. For example, in *Tătar v. Romania*, the European Court of Human Rights ruled that the applicant was exempt from the burden of proof and did not have to prove the existence and certainty of a risk.<sup>142</sup> According to the court, the state was in a better position than the individual to provide evidence to prove a lack of causation and show that it had fulfilled its obligations.<sup>143</sup>

In many cases, courts have used different legal arguments to increase the state's burden of proof in climate change litigation. The right to health approach provides one alternative based on the widely recognized human rights framework, where the plaintiff needs to prove only that the state's lack of action to mitigate or adapt to climate change breached an international obligation from a right to health perspective, rather than adduce evidence of causal elements.<sup>144</sup> This approach was adopted by the *Urgenda* court to shift the burden of proof on causation from the plaintiff to the state.<sup>145</sup>

Third, despite theoretical notions that climate change and human rights laws should provide an objective standard by which to assess health-climate causality, what constitutes governmental compliance with human rights norms as they relate to climate change can be determined in relation to how other states are behaving, where the worst offenders can be targeted as actors violating human rights.<sup>146</sup> Namely, if a government is engaging in climate change-inducing practices that are out of step with other states, the government should be more likely to be found responsible for health impacts of climate change and to be in violation of the right to health.

#### *Attribution of responsibility*

In climate change litigation, the identification requirement—the victim must specifically identify the defendant and show that the defendant's activities caused the harm—can be unachievable.<sup>147</sup> This is because different states have made different contributions to climate change (for example, different shares of GHG emissions) and may debate the precise allocation of their responsibility.<sup>148</sup>

However, it is not necessary to accurately examine each state's individual contributions to

climate change when assigning the right to health responsibility related to climate change.<sup>149</sup> In most cases, victims of climate change do not need to meet the identification requirement to evaluate whether a state has violated its right to health obligations. A state can be found to have infringed on the right to health insofar as it can be proved that it is complicit (regardless of its “contribution ratio”) in climate change due to its actions or omissions, and that such climate change is scientifically proven to impose general (no need to be specific) negative impacts on human health. For example, in *Urgenda*, a causal link between Dutch GHG emissions and global climate change was assumed to exist because “the fact that [the state's GHG emissions] are limited on a global scale does not alter the fact that these emissions contribute to climate change.”<sup>150</sup> Therefore, at least at the aggregate state level, the state's proportionate contribution to climate change is irrelevant with respect to the state's duty of care.<sup>151</sup>

Furthermore, instead of focusing on the causal analysis and identification requirements, courts should recognize the general health threats posed by climate change.<sup>152</sup> Similar arguments can also be found in *Tătar* and *Asselbourg v. Luxembourg*, where the European Court of Human Rights focused on the probability of the occurrence of a human rights violation based on the precautionary principle, rather than on proof of specific causation or the identification requirement.<sup>153</sup> The precautionary principle envisages an “anticipatory preventive action” to prevent damages, even if there is no conclusive scientific proof relevant to a causal relationship between a cause and a harm.<sup>154</sup> In *Native Village of Kivalina v. ExxonMobil Corp.*, a US district court required evidence of a substantial likelihood, rather than a scientific certainty, that the defendant's effluent caused the plaintiff's harm.<sup>155</sup> In addition to climate protection, precautionary measures are also regarded as a key aspect of the protection of the right to health. For example, during the COVID-19 pandemic, states are required to take precautionary measures to prevent potentially dangerous effects of the virus even when there is only a preliminary uncertain scientific evaluation.<sup>156</sup> Therefore, in a climate change case

(especially in cases of serious or irreversible health damage), the state should not be allowed to avoid its obligations toward right to health impacts due to climate change merely because of a lack of full scientific certainty. Focusing on the general context of human rights damages ensuing from climate change does not mean that the causal analysis or identification requirements should be abandoned, but rather that population-based probabilistic, statistical evidence should be included in the decision-making process.<sup>157</sup>

## Conclusion

Climate change and the right to health do not occupy entirely separate legal spheres.<sup>158</sup> A state's failure to mitigate or adapt to climate change, for example, may be tantamount to not preventing, treating, or controlling disease, a violation of the right to health under article 12 of the International Covenant on Economic, Social and Cultural Rights. Climate change laws and policies should thus be evaluated with attention to their impacts on the right to health and to the norms of international human rights law. Additionally, because the right to health embraces the maintenance of a safe, healthy, and sustainable environment (regarded as underlying determinants of health), the right to health can serve as a bridge between the domains of climate change and human rights, may be useful to determine the scope of the state's legal obligations to mitigate or adapt to climate change, and may empower individuals and communities to demand state action on climate change to protect their right to health.<sup>159</sup>

However, there are still many challenges to linking climate change and human rights. For example, the state's right to health obligation is defined with reference to a limited category of rights holders—typically those within the state's territory or jurisdiction.<sup>160</sup> Traditional human rights law does not require states to respond to human rights threats wherever they arise.<sup>161</sup> Climate change and actions to address it, however, are not restricted to a territory or jurisdiction. Even though there is still a long way to go, understanding the limitations of and potential for the application of the right

to health in the climate change domain can help optimize the effectiveness of human rights-based arguments in climate change litigation.

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156. Human Rights Council, *Duty to prevent exposure to the COVID-19 virus*, UN Doc. A/HRC/45/12 (2020), paras. 26, 28, 74. See also European Committee of Social Rights, *Statement of interpretation on the right to protection of health in times of pandemic* (2020), p. 4. Available at <https://rm.coe.int/statement-of-interpretation-on-the-right-to-protection-of-health-in-ti/16809e3640>.

157. Bodansky (see note 32), p. 513.

158. Hesselman and Toebes (see note 89), p. 25.

159. Hunt and Khosla (see note 114), p. 256; Hesselman and Toebes (see note 89), p. 25.

160. Lewis (see note 12), p. 157.

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# Health Care in a Changing Climate: A Review of Climate Change Laws and National Adaptation Plans in Latin America

THALIA VIVEROS-UEHARA

## Abstract

Given that the health-related impacts of climate change in Latin America disproportionately affect the most marginalized sections of the population, there is a need to enhance countries' adaptive capacity through improved health systems. Though public health institutions have delineated guidelines to enhance health care systems' preparedness for climate change, embedding a human rights perspective in their translation into laws and policies further adds important value. Crucially, a rights-based approach strengthens health responses to climate change by calling attention to how climate law and policy fail to account for persistent and interlocking socioeconomic inequalities. This is an area that has not been fully present in the provision of health services in Latin America, which rely almost exclusively on a conventional epidemiological perspective and do not consider the historical and sociocultural nature of health challenges. Hence, this paper draws on two case studies—Brazil and Colombia—to identify the extent to which their national climate change laws and adaptation plans incorporate a human rights-based approach in their tasks to enhance their adaptive capacity through the expansion of affordable and quality health care. With respect to the countries' laws, the absence of explicit references to the right to health exemplifies the fragmentation between the international human rights framework and international climate change law. Further, both countries' adaptation plans hold considerable room for improving their engagement with the human rights framework, particularly by establishing mechanisms to promote transparency, monitoring, and the participation of marginalized groups.

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## Introduction

The impacts of climate change on health have already manifested in the Latin American region. Concerningly, an abundance of scientific evidence has revealed how climate change is exacerbating disease and pest transmission while also increasing morbidity, mortality, and disabilities due to extreme weather events.<sup>1</sup> The Office of the United Nations High Commissioner for Human Rights has documented these climate-related effects as threats to the realization of the right to health.<sup>2</sup>

The highly uneven access to and quality of health care in Latin America further aggravates such risks.<sup>3</sup> Public health researchers have shown that persons living in poverty and members of minority groups often lack access to quality health care—which denies them the opportunity to prevent, treat, cure, and rehabilitate climate-related health conditions.<sup>4</sup>

Health care systems are thus key determinants of countries' capacity to adapt to climate change.<sup>5</sup> In that vein, states have the obligation to take measures to develop sustainable and resilient health care systems and infrastructure to ensure climate-resilient populations, thereby fulfilling their minimum core obligations with regard to the right to health.<sup>6</sup>

Even though the United Nations human rights system has called for integrating a human rights-based approach (HRBA) into climate adaptation, which includes health-related policies, the technical guidelines for the elaboration of national adaptation plans (NAPs)—the primary instruments for vulnerability reduction under the United Nations Framework Convention on Climate Change (UNFCCC)—have not reflected this approach.<sup>7</sup> The health dimension of NAPs (H-NAPs) has been informed primarily by a public health approach to climate change.<sup>8</sup>

While an HRBA shares several commonalities with good public health practice, it adds further value due to its foundation in international law, which supplies legitimacy (given that countries have agreed to abide by these laws), imposes legal obligations and mechanisms of accountability, and ensures coherence across sectoral policies.<sup>9</sup>

Moreover, human rights principles and standards draw attention to how climate law and policy fail to account for persistent and interlocking socioeconomic inequalities. This is an area that has been lacking in the provision of health services in Latin America, which rely almost exclusively on a conventional epidemiological perspective and do not take into consideration the historical and sociocultural nature of health challenges.<sup>10</sup>

Hence, as the adoption of national climate change laws and NAPs has come to be the primary proxy for assessing countries' progress in adaptation (for example, in indicator 13.2.1 of the Sustainable Development Goals and indicator 2.1.1 of the 2020 *Lancet* Countdown report), examining the extent to which these laws and plans incorporate an HRBA to health yields useful learnings.<sup>11</sup> Significantly, such a review adds an analytical layer to these indicators by shedding light on the extent to which they capture how socioeconomic inequalities play out in climate adaptation in the health sector.

This paper provides the first review in the literature of the intersection between human rights, climate change adaptation, and health care for NAPs. It observes Brazil and Colombia as two case studies to identify the extent to which their national climate change laws and H-NAPs incorporate an HRBA in their tasks to enhance their adaptation capacity through the expansion of affordable and quality health care. More specifically, the study asks the following overarching question: Do these climate laws and national adaptation plans take a rights-based approach to expanding affordable and quality health care access, particularly for the most vulnerable persons and groups?

This review purposively studies Brazil and Colombia because they are the only two countries in Latin America that (1) have legally recognized the right to health (by agreeing to abide by the International Covenant on Economic, Social and Cultural Rights and the Protocol of San Salvador); (2) have enacted national climate laws; (3) have submitted their NAPs to the UNFCCC NAP Central; and (4) are experiencing the highest vulnerability across the *Lancet* Countdown's indicators pertaining to

the impacts of heat, extreme weather events, and climate-sensitive infectious diseases on health (indicators 1.1, 1.2, and 1.3, respectively).<sup>12</sup> It argues that both countries still have room to improve how they embed an HRBA into their national climate change laws and NAPs. This is not a minor issue. Given Brazil's and Colombia's socioeconomic inequalities, guiding adaptation efforts toward addressing persistent exclusion in health care and health care policy is a crucial step to avoid further human suffering and losses. An HRBA must therefore be explicitly invoked, starting with planning tools.

This paper begins with a brief overview of the relationship between climate change and health in Brazil and Colombia. It then presents the theoretical background in which an HRBA to health and public health approaches to climate change are brought into interaction. Next, it describes the review's comparative methodology, followed by a discussion of the findings. Finally, the conclusion comments on future avenues for research.

## Health and climate change in Brazil and Colombia

The Intergovernmental Panel on Climate Change has documented variations in the climatic patterns of Brazil and Colombia, along with their effects on human health.<sup>13</sup> While both countries exhibit high health vulnerability to climate change, and their projected climate scenarios indicate an increased frequency and intensity of extreme weather events, unequal access to health care services continues to be a major determinant of the health outcomes of minority groups and persons living in poverty, which is concerning.<sup>14</sup>

Over the last half of the 20th century, Southern Brazil has witnessed an increase of 0.6°C per decade in mean annual air temperature, as well as an increased frequency of heavy rainfall.<sup>15</sup> Meanwhile, dryness has increased in North and Northeast Brazil.<sup>16</sup> During the 1990s, changes in land development and regional climate contributed to a resurgence of malaria in the Amazon region.<sup>17</sup> Further, increases in hospital admissions due to diarrhea were associated with climatic variations.<sup>18</sup>

Disparities in health care access and quality within the country are worrying. Brazil's Amazonian North has 1.1 medical doctors per 1,000 inhabitants, compared to 2.8 per 1,000 in the richer Southeast.<sup>19</sup>

Even though recent decades have witnessed progress in neglected diseases' control and elimination due to increased policy attention and funding, this progress has been limited for remote populations located far from power centers.<sup>20</sup> Children's health care has also remained unequal. While Amazonas' population exceeds Brasília's by almost one million inhabitants, it has only 344 pediatricians compared to the federal capital's 1,347.<sup>21</sup> Furthermore, this state's remote rural settlements are less likely to have primary health care providers.<sup>22</sup>

According to Colombia's latest national communication to the UNFCCC, almost half of the country's territory is at high or very high risk of experiencing climate change impacts.<sup>23</sup> From 1959 to 2005, the Colombian Andes experienced a 1°C increase in air temperature.<sup>24</sup> In 1995, outbreaks of leptospirosis were associated with La Niña and El Niño phenomena—weather oscillations that climate change has intensified.<sup>25</sup> More recently, in 2010–2012, floods caused hundreds of deaths and displaced thousands.<sup>26</sup> Furthermore, the number of malaria cases has increased during the last five decades alongside increasing air temperatures.<sup>27</sup>

A view of Colombia's health care profile puts into perspective the country's capacity to address emerging climate-related health effects. Although the country introduced social welfare reforms aimed at expanding universal health coverage in the 1990s, the availability of health services is still limited for 29% of its population.<sup>28</sup> The number of nurses per 1,000 people and psychiatrists per 100,000 people remains below the Latin American average, and there is a large disparity between the lowest and highest income quintiles in accessing prenatal care.<sup>29</sup> Moreover, while there is limited research on health disparities along racial and ethnic lines, a few studies in Colombia consistently indicate a higher risk of stunting and wasting among children who self-identify as Indigenous or Afro-descendant.<sup>30</sup>

In conclusion, Brazil and Colombia both face serious and growing impacts on health, particularly among marginalized peoples and communities, due to climate change. At the same time, both countries currently have inadequate and unequal health care systems to meet present health needs.

### The right to health and climate adaptation

In the context of the UNFCCC, in 2010, parties to the convention agreed to design national NAPs with the primary objective of reducing vulnerability to current effects and future climate change-related risks.<sup>31</sup> Since then, the World Health Organization (WHO) has issued three guidelines to assist in the development of the health component of such plans—namely, *Guidance to Protect Health from Climate Change through Health Adaptation Planning* (2014), *Operational Framework for Building Climate Resilient Health Systems* (2015), and, more recently, *Quality Criteria for Health National Adaptation Plans* (2021).<sup>32</sup> Though such documents help strengthen national health care systems and are comprehensive from a conventional public health perspective, including health care services, they fail to fully embrace an HRBA.<sup>33</sup>

Hence, a necessary point of departure for the present review is the significance of the human rights framework. Public health practitioners may wonder what the added value of human rights is for increasing countries' adaptive capacity in health care. Drawing critical insights from recent Latin American perspectives on health sociology, this paper argues that even when both the human rights and the public health frameworks overlap in significant respects, there remain areas in which the former complements the latter.<sup>34</sup> Before elaborating on such a contention, this section offers a brief overview of the distinctive aspects of an HRBA to health.

What does a rights-based approach dictate in relation to health systems and health care provision? Although there is no universally agreed-upon definition of an HRBA to health, analysis of scholarship on the subject and guidance issued by WHO and the Office of the United Nations High

Commissioner for Human Rights sheds light on the minimal conceptual and operational attributes of such an approach.<sup>35</sup> These attributes are (1) equality and nondiscrimination; (2) availability, accessibility, acceptability, and quality (AAAQ); (3) participation; (4) transparency; and (5) monitoring and accountability.<sup>36</sup>

The United Nations Committee on Economic, Social and Cultural Rights clarifies the content of these features in its General Comment 14. The equality and nondiscrimination element confers upon states the legal obligation to ensure that health care systems are accessible to all, particularly to disadvantaged individuals and communities.<sup>37</sup> The AAAQ framework calls for the functioning of health care facilities with respect to goods and services that are available in sufficient quantity; accessible physically, geographically, and economically; culturally appropriate; gender sensitive; medically ethical; and of good quality.<sup>38</sup> With regard to participation and transparency, states have an obligation to ensure the informed and active involvement of all relevant rights-holders—especially those living in vulnerable circumstances—and their access to health information. Finally, accountability includes the monitoring of conduct, performance, and outcomes.<sup>39</sup> This means having effective mechanisms to provide individuals and communities with a clear understanding of *who* bears responsibility toward health care provision and *how* they carry out their duties.<sup>40</sup> Also, monitoring should include indicators and benchmarks that can be used to assess progress.<sup>41</sup>

An HRBA to health and a public health approach to climate change overlap in significant ways. The former's attribute of availability, economic accessibility (affordability), and quality resonates with the concept of "effectiveness" in the health literature.<sup>42</sup> Also, the monitoring and accountability aspect has been promoted by some of the WHO guidelines on health systems and climate change.<sup>43</sup> However, given that an HRBA focuses on the most vulnerable sections of the population, its attributes of equality and nondiscrimination, acceptability, participation, and transparency compel policy attention toward pervasive exclusionary

practices that affect people's health outcomes.<sup>44</sup> In other words, unlike the public health approach, an HRBA requires an analysis of the extent to which socioeconomic inequalities are taken into account in climate law and policy in order to redress discriminatory practices and unjust distributions of power.<sup>45</sup> This adds significant value to the organization and administration of health services in Latin America, which rely almost exclusively on a conventional epidemiological perspective and do not take into account the historical and sociocultural nature of health challenges.<sup>46</sup>

Furthermore, while public health approaches to climate change also commend *equal* access to quality health care as a determinant of countries' adaptive capacity, the operationalization of such a view remains at the margins of current assessments of NAPs.<sup>47</sup> For example, WHO's review of health in NAPs and the insights provided by indicator 2.1.1 of the *Lancet* Countdown on this subject do not look for discriminatory practices or the exclusion of the most marginalized communities in their assessments.<sup>48</sup>

In summary, the analytical layer that the HRBA adds to current assessments on public health responses to climate change makes a distinctive contribution. Particularly, given how Brazil's and Colombia's socioeconomic inequalities deeply affect their ability to cope with current climate-related health conditions, guiding adaptation efforts toward addressing persistent exclusion in health care and health care policy is a crucial step to avoid further human suffering and losses. An HRBA must therefore be explicitly invoked, starting with planning tools.<sup>49</sup>

## Methodology

This paper applies a qualitative content analysis to identify whether Brazil's and Colombia's national climate change laws and H-NAPs incorporate an HRBA. More specifically, it uses a rubric of questions to derive the extent to which such laws and plans embrace the five minimal conceptual and operational attributes of an HRBA to health (as discussed in the previous section)—namely, equal-

ity and nondiscrimination, AAAQ, participation, transparency, and monitoring and accountability. Table 1 presents the questions applied to the analysis for each of these attributes. The formulation of the rubric was informed by previous work assessing an HRBA to health policies and programs, particularly that of Sofia Gruskin and Laura Ferguson, as well as a subsequent methodological proposition of Laura Ferguson.<sup>50</sup> The coding and data analysis was conducted using NVivo software.

The applied qualitative content analysis is constructive in epistemology; it seeks to be meaningful when applied in specific contexts rather than being universally applicable.<sup>51</sup> That is, even though the rubric of questions guides a systemic analysis of the attributes commonly considered to be part of an HRBA, it focuses more on description and does not provide generalizable findings.<sup>52</sup>

This study selected national climate change laws and NAPs as units of analysis, since they constitute the immediate and overarching regulatory and planning instruments that direct how climate adaptation on health ought to be conducted. At the same time, as mentioned above, these instruments have become the measure by which indicator 13.2.1 of the Sustainable Development Goals and indicator 2.1.1 of the 2020 *Lancet* Countdown report assess countries' adaptation progress and health risks related to climate change.<sup>53</sup>

Nonetheless, this paper's methodological approach has some limitations. First, the study does not include the regulatory framework for health care or disaster risk prevention and management, which may also deal with climate-related challenges to health. Further, its scope does not stretch beyond the *planning* level. In other words, the *implementation* of Brazil's and Colombia's national climate change laws and adaptation plans falls outside the scope of this study.

## The review

In December 2009, Brazil enacted Law No. 12.187, establishing the National Climate Change Policy (Brazil-NCCP), which provided the foundation for the country's national adaptation plan

(Brazil-NAP).<sup>54</sup> The Executive Group of the Inter-Ministerial Committee on Climate Change developed such a plan over three years (2013–2016) through a process that included contributions from thematic networks and public participation.<sup>55</sup> Brazil submitted its NAP to the UNFCCC NAP Central in May 2016.<sup>56</sup>

Brazil-NAP entails one general and eleven sectoral strategies, one of which pertains specifically to health (Brazil-H-NAP). Brazil-H-NAP is relevant to Brazil's health care services, given that it provides inputs for the definition of objectives, goals, and actions of the country's Unified Health System management model.<sup>57</sup>

Colombia adopted Law 1.931 on Climate Change (Colombia-CCL) in July 2018, after a two-

year national consultation process convened by the Intersectoral Climate Change Commission.<sup>58</sup> This law sets the institutional and procedural arrangements for the design, implementation, and evaluation of mitigation and adaptation measures; it also creates the Intersectoral Climate Change Commission. Strikingly, while Colombia-CCL incorporates several ministries into this commission, it does not include its Ministry of Health (article 4 of the law). This is not a minor omission, considering that the commission is in charge of dictating the direction and content of climate change actions.

Colombia's 2016 National Adaptation Plan (Colombia-NAP) constitutes the country's overarching policy to reduce socioeconomic and environmental impacts from climate change.<sup>59</sup>

TABLE 1. Questions to determine whether climate change laws and national adaptation plans incorporate a human rights-based approach to health

Element	State obligation	Questions
Equality and nondiscrimination	States have a legal obligation to ensure that health care services are accessible to all without discrimination, including those living in poverty, minorities, Indigenous peoples, women, children, people with disabilities, and other disadvantaged individuals and communities.	Do laws and plans recognize the significance of paying particular attention to climate-related health effects of the most vulnerable population groups? What mechanisms do laws and plans establish to address discrimination in the provision of health care services dealing with climate-related health effects?
Availability, accessibility, acceptability, and quality	States must provide health care services that are available in sufficient quantity; physically, geographically, and economically accessible; culturally appropriate; gender sensitive; medically ethical; and of good quality.	Do laws and plans frame availability, accessibility, acceptability, and quality as essential elements of health care services dealing with climate-related health conditions?
Participation	States have an obligation to establish institutional arrangements for the active and informed participation of all relevant rights-holders, including disadvantaged communities.	What actors do laws and plans identify as relevant to participate in activities pertaining to the provision of health care services dealing with climate-related health effects? How do laws and plans ensure the participation of marginalized populations?
Transparency	States have an obligation to ensure access to climate-related health information, particularly among those living in vulnerable circumstances.	Do laws and plans describe or set mechanisms for making climate-related health information available to the public? How do laws and plans ensure that information is accessible for marginalized populations?
Monitoring and accountability	States must monitor the realization of the right to health; they should include indicators and benchmarks. States should also put in place effective mechanisms to provide individuals and communities with a clear understanding of who bears the responsibility toward health care provision and how they carry out their duties.	Do laws and plans describe or set mechanisms for monitoring and evaluating how health care services deal with climate-related health effects? Do these mechanisms place a particular focus on vulnerable population groups, and does this include the use of disaggregated indicators? Are accountability mechanisms in place to provide a clear understanding of who holds responsibility or to whom claimants can bring comments or complaints?

Sources: P. Hunt and G. Backman, "Health systems and the right to the highest attainable standard of health," *Health and Human Rights Journal* 10/1 (2008); Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000).

The National Planning Department spearheaded its drafting based on the 2010–2014 and 2014–2018 National Development Plans. Colombia-NAP was submitted to the UNFCCC NAP Central in February 2018.<sup>60</sup>

The remainder of this section offers a detailed look at the findings on the aforementioned regulations. For clarity purposes, this paper organizes the analysis according to each HRBA element. Table 2 outlines the reviewed laws and NAPs.

### *Equality and nondiscrimination*

Brazil-NCCP does not explicitly refer to nondiscrimination. However, it recognizes particular population needs according to their socioeconomic contexts (article 3). Moreover, eradicating poverty and reducing social inequalities form part of its objectives (article 4).

Likewise, Brazil-H-NAP embraces equality and nondiscrimination partially. While guideline no. 6 sets forth a specific focus on vulnerable social groups, it confines such differentiated attention to rural areas, wetlands, forests, Indigenous peoples, and homeless people. Given that Brazil's health disparities unfold beyond these spatial and group boundaries—as previous sections have noted—this guideline does little to summon efforts in all the directions required. Further, the plan does not set mechanisms to address discrimination in health care services.

Equality and nondiscrimination would be absent in Colombia-CCL if not for the law's definition of "vulnerability." By delineating this concept as the social and economic fragility to suffer adverse effects of climate change, article 3(19) opens an avenue within the law's scope to provide particular attention to excluded populations and groups. Contrastingly, article 8(3) undermines the significance

of supporting climate adaptation for *all* marginalized populations. By limiting adaptation programs, projects, and actions to coastal municipalities and districts, it takes critical focus away from the non-coastal territories, where poverty and exclusion are also everyday realities.<sup>61</sup>

Colombia-NAP explicitly mandates particular attention to vulnerable population groups: its objective no. 1 emphasizes the importance of following differentiated approaches that account for gender, age, and disability perspectives. However, the plan does not reiterate this specific objective across its objectives. Hence, unless bold interpretation efforts are applied, incorporating gender, age, and disability perspectives may not be central to actions arising from the plan's objectives no. 2 and 3. Moreover, Colombia-NAP does not set explicit mechanisms to address discrimination in health care provision.

### *Availability, accessibility, acceptability, and quality*

The AAAQ framework is absent from Brazil-NCCP. However, the country's H-NAP calls for ensuring that public health care infrastructure is well suited to resist and operate in extreme weather conditions (guideline no. 5). In the same vein, it focuses on training and building capacity for health professionals on climate change-related issues (guideline no. 3). While these provisions touch on crucial *quality* aspects of health care systems, Brazil-H-NAP does not include courses of action to ensure *availability, accessibility, or acceptability* in health care services.

Likewise, Colombia-CCL does not refer to the AAAQ framework. Nonetheless, the country's NAP embraces the health component of climate adaptation (objective no. 3). It underscores the

TABLE 2. Reviewed national climate change laws and policies

	Brazil	Colombia
National climate change law	Law No. 12.187 (2009) (Brazil-NCCP)	Law No. 1931 (2018) (Colombia-CCL)
National adaptation plan	Strategy for Health of National Adaptation Plan to Climate Change (2016) (Brazil-H-NAP)	National Adaptation Plan to Climate Change (2016) (Colombia-NAP)

importance of deploying coordinated action between the local, state, and national levels in epidemiological surveillance systems. Particularly, capacity-building among health professionals and community members is considered paramount to identifying and preventing health risks associated with climate change. Besides this provision, which refers to a crucial aspect for enhancing the quality of health care systems, the plan sets out no other consideration related to *availability, accessibility, or acceptability*.

### *Participation*

Brazil-NCCP sets out public participation as one of its five principles (article 3). Article 4 states that the NCCP will aim to implement climate change adaptation with the participation and collaboration of, among others, those especially vulnerable to its adverse effects. Further, article 5 emphasizes the involvement of organized civil society in developing and implementing policies, plans, programs, and actions related to climate change.

In the same vein, Brazil-H-NAP encourages community participation in the formulation of adaptation policies (guideline no. 3). In particular, it promotes the strengthening of community involvement in deciding the priority of public health policies. Moreover, it calls for public participation in the integration of climate change and human health themes on the agenda of the Standing Committees for Health Surveillance, which further supports the response actions of health care networks (guideline no. 8). While the plan prompts participation across several activities pertaining to health care systems, in some of them, such engagement is limited to institutional actors, thereby limiting the opportunities of marginalized communities to be involved in decision-making. For example, guideline no. 8 encourages the involvement of “partner institutions” in preparing and implementing public health emergency plans; however, it gives no consideration to the inclusion of disadvantaged communities.

Colombia-CCL conceives of participation as a *responsibility* (article 2). In doing so, this law shifts the burden of engaging in climate action to civil

society, as if participation were a matter of people’s mere willingness and personal choices. This clouds the fact that the state—as the sole human rights duty-bearer—holds the information, resources, and power necessary to promote participation. Thus, unless governments commit to making such tools available, civil society will not be able to take part in climate actions effectively.

Moreover, while Colombia-NAP refers to participation (objective no. 1), it does not place special emphasis on marginalized populations. As a result, the plan does not consider specific mechanisms to ensure the participation of these groups.

### *Transparency*

Brazil-NCCP embraces the dissemination of information as one of the main principles upon which climate policies should be built (article 5). In the same way, Brazil-H-NAP emphasizes the provision of data and information to promote adaptation in the health sector (guideline no. 4). However, unlike the country’s climate law, Brazil-H-NAP further calls for the establishment of mechanisms to promote the informed and active involvement of vulnerable populations in policies aimed at increasing the resilience of these groups (guideline no. 6).

Colombia-CCL creates a National Climate Change Information System, to which the law confers the mandate to provide *transparent* and timely data *for decision-making processes* related to climate change management (article 26). Nonetheless, because the law does not elaborate on how to ensure that such information is available and accessible to all populations, there remain some interpretative pathways that could eventually allow the system to limit certain information to decision-makers only. Likewise, while Colombia-NAP emphasizes the significance of transparent decision-making processes, it does not outline mechanisms to make information available to the most marginalized population groups.

### *Monitoring and accountability*

Brazil-NCCP mandates monitoring as a climate policy instrument. However, this is limited to

capturing meteorological data. The law does not address policy evaluation in terms of the performance or outcomes of health systems. To fill such a gap, Brazil-H-NAP handles monitoring to a greater extent. It covers various aspects, such as the quality of information (guideline no. 1), the importance of traditional knowledge (guideline no. 2), and multi-dimensional surveillance (guidelines no. 4 and 8).

Moreover, Brazil-NCCP identifies the institutions responsible for implementing the National Climate Change Policy—including adaptation (article 7). It also tasks public financial institutions with providing credit to support climate-related actions (article 8). Brazil-H-NAP also determines who is responsible for implementing each plan's objectives; however, it falls short in specifying mechanisms whereby affected populations can raise their concerns.

Colombia-CCL embraces the monitoring and evaluation of adaptation outcomes as components of climate change management. Nonetheless, no provisions ensure that these processes focus on including marginalized populations or calling for collecting multidimensional data. However, Colombia-NAP mandates monitoring (1) vulnerability and climate risk indicators and (2) the outcomes of adaptation measures to reduce climate impacts on health. In this regard, the plan sets forth a methodological framework specifically tailored to the country's circumstances and calls for related indicators. While these mechanisms do consider a particular focus on disadvantaged population groups, they do not consider the deployment of disaggregated indicators.

On the matter of accountability, both Colombia-CCL (article 6) and the country's NAP define the agencies responsible for accomplishing the country's adaptation goals. Yet neither of them outlines specific mechanisms before which complaints can be brought.

In brief, Brazil's and Colombia's climate change laws and NAPs incorporate an HRBA to varying degrees. While these regulations fall short in establishing mechanisms for advancing equality and nondiscrimination, participation, and transparency with a particular focus on marginalized populations, they include quality of health care services and monitoring to a greater extent. Table 3 summarizes these findings.

## Discussion

The review of Brazil's and Colombia's national climate change laws and NAPs reveals varying levels of engagement with an HRBA. In the case of laws, although both countries had legally recognized the right to health before joining the UNFCCC, the absence of explicit references to the key attributes of this right exemplifies the disconnect between international human rights law and international climate change law.<sup>62</sup>

The practical implications of such a weak integration should not be disregarded. Leaving human rights out of national climate change laws and NAPs has a large impact on the most vulnerable communities. Unless the key attributes of the HRBA to health are acknowledged and incorporated, it cannot be assumed that the actions directed

TABLE 3. Extent to which HRBA elements are incorporated into Brazil's and Colombia's climate law and national adaptation plans

	Brazil		Colombia	
	Law No. 12.187	National Adaptation Plan	Law No. 1.931	National Adaptation Plan
Equality and nondiscrimination	Partially	Partially	Partially	Partially
AAAQ	No	Partially	No	Partially
Participation	Yes	Partially	Partially	Partially
Transparency	Partially	Yes	Partially	Partially
Monitoring and accountability	Partially	Partially	Partially	Partially

by the laws will improve the realization of the right to health.<sup>63</sup> As former Special Rapporteur on the right to health Paul Hunt notes in his interpretative analysis of the right to health and the rights-based approach to health, “it is unrealistic to expect health policy makers or practitioners to read either a treaty provision or its corresponding general comment and then grasp how they are to operationalize the right to health.”<sup>64</sup> He argues that “a more detailed, specific, and practical human rights guidance is essential.”<sup>65</sup> References to an HRBA in the law are therefore crucial to facilitate legal interpretations that address discriminatory practices and existing and interlocking inequalities that hinder the ability of health care systems to cope with climate change.

While this paper has identified some interpretative pathways through which human rights elements can be inferred from the national climate change laws, it has also underscored the avenues in which the lack of their explicit reference can translate into weak attention toward marginalized communities. For example, full integration of the equality and nondiscrimination principles in Brazil-NCCP would provide a legal basis for pressuring decision-makers to address health disparities experienced by communities of color resulting from climate change. Furthermore, the fact that Brazil-H-NAP and Colombia-NAP pay no attention to the availability, accessibility, or acceptability elements of health care limits opportunities to prepare health care systems for a changing climate.

At the same time, however, this review has also laid bare how *some* of the attributes of the HRBA are taken on by Brazil’s and Colombia’s NAPs, such as in the case of monitoring.

Although these findings may seem to support the conclusion of the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) that “most countries of the region of Latin America and the Caribbean have incorporated international human rights standards into their climate change policies and strategic planning,” they are divergent in a fundamental way.<sup>66</sup> Specifically, by highlighting how the rights-based attributes identified in Brazil’s and Colombia’s NAPs support the preparation of health care systems to withstand

climate change, this review points to the *specific* areas in which the approach ought to be reinforced. That is, unlike ECLAC’s contention, the analysis drawn posits that both countries’ adaptation plans still hold considerable room for improving their engagement with the human rights framework, particularly with respect to their health care systems. For example, even though Colombia’s NAP refers to participation, transparency, and monitoring, it does not establish mechanisms through which these elements can integrate marginalized populations.

### The way forward

By providing an in-depth review of the extent to which Brazil’s and Colombia’s national climate change laws and NAPs incorporate an HRBA to health, this paper has broadened the analytical perspectives by which countries’ progress in adapting health care systems to accommodate climate change are currently assessed. From this view, simply counting the number of countries with a climate change adaptation plan, as a primary proxy for how well they are integrating climate change measures into health policy, is insufficient.

Furthermore, unlike similar studies on the mainstreaming of human rights in climate change legislation and policies, this review has indicated that more specific regulations are needed to promote health care systems that can respond to climate change. Because this appears to be the first review of the intersection between human rights, climate change adaptation, *and* health care in NAPs, further research is required to understand how rights-based approaches can facilitate the strengthening of health care systems at subnational levels. Analyses of these regulations’ interactions with specific health care systems and disaster risk prevention and management laws is also a key research gap.

Climate change laws and NAPs are the basis for translating planning into action. Thus, if health care systems are to contribute to the realization of the right to health in a changing climate, these regulations ought to provide a clear substantive and

operational basis to reduce marginalized populations' vulnerability to climate change. An HRBA can ensure that these groups are protected.

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# Crises as Catalyst: A New Social Contract Grounded in Worker Rights

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## Abstract

Three crises—climate change, the COVID-19 pandemic, and extreme economic and social inequality—intersect and have had devastating impacts on workers’ rights to health, as well as the right to decent work, an underlying determinant of health. Yet these crises may act as catalysts, as responses present opportunities for transformation. Indeed, multiple international governance institutions and nongovernmental organizations have proposed new social contracts that aim to address the multiple challenges facing workers today. These initiatives promise to transform society to make workers and their families healthier and the planet more sustainable. They join and supplement earlier efforts at transformation, such as the 2030 Agenda for Sustainable Development. This article critiques (1) the market-fundamentalist neoliberal social contract, which gave rise to, or exacerbated, the three crises, and (2) the 2030 agenda and recent International Labour Organization proposals, which are all built on this neoliberal platform. Finally, the article argues for a social contract that is grounded in human rights—specifically worker rights—to address these crises and ensure greater protection of the health

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## Introduction

The title of this article hints at a sci-fi nightmarish trifecta of challenges for workers—climate change, the COVID-19 pandemic, and extreme economic inequality. Unfortunately, they are real and not nightmares. Further, they are unfolding and compounding in real time. Conditions today are similar to those a little over 100 years ago, when a global flu pandemic and post-World War I economic devastation coincided with the founding of the International Labour Organization (ILO), which was intended to secure peace through social justice, including worker rights. Like COVID-19, the 1918 influenza pandemic caused a high degree of economic uncertainty, and the ILO's work on establishing the global standards that benefitted workers' health and well-being had a direct impact on the economic recovery.<sup>1</sup> Inspired by this past example, this article looks again to worker rights as key to addressing the current trifecta of challenges for workers.

Crises often act as catalysts, presenting opportunities for societal transformation.<sup>2</sup> Recovery from the COVID-19 crisis has opened space to address climate change and extreme inequality, two other crises that have attracted far too little attention and action over the past 30 to 40 years. Thus, proposals such as the United States' "Build Back Better" plan aim to rebuild the economy, drastically impacted by COVID-19, in a manner that also addresses myriad other problems in society. Two intertwined issues of particular importance to workers that are at the center of such proposals for the COVID-19 recovery are climate change and extreme economic inequality. Thus, the COVID-19 recovery holds potential to improve conditions for workers and their families by also addressing climate change and extreme economic inequality.

Given this opportunity, many actors have been working to identify solutions. Among them, human rights nongovernmental organizations, such as the Center for Economic and Social Rights, and trade union movements, such as the European Trade Union Confederation and the International

Trade Union Confederation, have seized this opportunity to propose that worker rights be central to a new social contract that would transform the existing neoliberal social contract—prioritizing market logics—under which the present crises have arisen.<sup>3</sup> This article joins these calls. It argues that a social contract grounded in human rights would address these three interacting crises and ensure greater protection of the health and livelihoods of workers and their families.

Following this introduction, the second part of the article presents the intersecting impacts of COVID-19, climate change, and growing economic inequality on the human rights of working people, particularly their rights to health and decent work, an underlying determinant of health. It thus sets the stage for discussion of possible solutions to the problems presented. The next part then explains the concept of "social contract" and describes the dangers of the current neoliberal social contract for workers and the incorporation of that paradigm into the Sustainable Development Goals (SDGs), specifically SDG 8 on economic growth and decent work.<sup>4</sup> It also presents recent ILO proposals for new and transformative social contracts, which have been highly influenced by the neoliberal paradigm. Finally, the subsequent part presents an initial exploration for a social contract grounded in human rights by examining the three intertwined crises through the lens of the right to decent work as defined in the International Covenant on Economic, Social and Cultural Rights (ICESCR). The overarching argument in this article is that human rights—specifically worker rights—provide a just and effective foundation for a new and transformative social contract to address these three crises for workers and their families.

## Impacts of COVID-19, climate change and economic inequality on workers

Worker health and livelihoods are harshly impacted by the trifecta of the COVID-19 pandemic, climate change, and economic inequality, implicating their rights to health and to decent work.

### *COVID-19: Impacts and recovery as opportunity*

The World Health Organization (WHO) reported that as of October 10, 2021, there had been 4,831,486 COVID-19 deaths from 236,599,025 confirmed cases worldwide.<sup>5</sup> For workers, the pandemic has wrought widescale but uneven pain and suffering. In January 2021, the ILO reported that 93% of the world's workers lived in countries with some degree of COVID-19-related workplace closures.<sup>6</sup> In 2020, COVID-19-related job and worktime losses were estimated at 8.8% over the prior year, equivalent to the loss of 255 million full-time jobs.<sup>7</sup> Not surprisingly, COVID-19 contributed to a significant loss of income for workers, with an estimated decline of US\$3.7 trillion (4.4% of the global GDP) in 2020.<sup>8</sup> The impacts of job and worktime losses vary widely between regions, with countries in Latin America, the Caribbean, Southern Europe, and Southern Asia most harshly impacted.<sup>9</sup> Job and worktime losses also vary by sector, with devastating losses in accommodation, food service, and retail sectors occurring alongside positive job growth in high-skilled services such as communications, finance, and insurance.<sup>10</sup>

For those who have kept their employment, COVID-19 presents stark dangers. The ILO and WHO estimate that up to 20%–30% of COVID-19 cases in some countries may be attributed to workplace transmission.<sup>11</sup> Indeed, looking at specific groups of workers, the devastation is apparent. For example, the International Council of Nurses reported in October 2020 that more nurses had died from COVID-19 than during World War I.<sup>12</sup> Despite calls for standardized global data collection on all health care worker infections and deaths, such data remained “scant,” and by May 2021, WHO estimated that at least 115,000 health care workers had died since the beginning of the pandemic.<sup>13</sup>

Despite the harsh impacts on workers and their families, recovery from COVID-19 and the related economic crisis presents an opportunity to adopt a new global social contract with the potential to address not just the economic and social devastation for workers from COVID-19 but also the interdependent crises of climate change and

extreme economic inequality.

### *Climate change: Impacts on workers and their families*

Climate change presents multiple harms for people through land degradation, pollution, climate disasters, and rising temperatures. The ILO estimates that global warming will result in a loss of 2% of working time globally, the equivalent of 72 million full-time jobs by 2030.<sup>14</sup> The impacts are not equally shared, however. In low-income countries, 79% of the population lives in tropical areas most vulnerable to rising temperatures.<sup>15</sup> Worker exposure to extreme heat is a recognized occupational health risk with disproportionate impacts on the self-employed and workers in agriculture, construction, transport, tourism, and refuse collection.<sup>16</sup> In addition to extreme heat, other recognized climate-related work hazards include wildfires, extreme weather events, air pollution, enhanced biological hazards and psychological stress.<sup>17</sup> The United Nations (UN) estimates that between 1998 and 2017, 1.3 million people died due to climate-related disasters.<sup>18</sup>

Most workers are not protected against these harms through workplace injury insurance and do not have access to other forms of insurance, such as for unemployment and disability.<sup>19</sup> In fact, globally, less than a third (30.6%) of working-age adults enjoy comprehensive social security, including workplace injury and health protections, as well as child and family benefits and old-age pensions.<sup>20</sup> Indeed, the ILO estimates that 4.1 billion people are left “wholly unprotected.”<sup>21</sup>

Global initiatives to combat and mitigate global warming also threaten livelihoods. Many traditionally well-paying jobs, especially in the Global North, are based on an unsustainable carbon economy. The transition away from carbon-based jobs inevitably disrupts industries and worker livelihoods. However, the ILO estimates that climate change mitigation should *ultimately* increase employment because the expansion of low-carbon infrastructure translates into new jobs, which means higher labor demand across many industries.<sup>22</sup> Overall, labor productivity, earnings,

and living standards are threatened in the short term by climate change and the efforts to combat it but have potential to improve conditions for workers and their families in the longer term.<sup>23</sup>

### *Economic inequality: Driving climate change and preserving the status quo*

Another crisis that has gained attention in the context of the COVID-19 recovery is extreme economic inequality, which negatively impacts the health of workers and their families, and drives climate change.<sup>24</sup> The Economic Policy Institute reported that compensation of chief executive officers of public companies in the United States skyrocketed 1,322% between 1978 and 2020, while worker pay grew by only 18% during the same period.<sup>25</sup> These economic inequalities drive climate change, as those in the richest 1% contribute 30 times greater carbon emissions than what would be compatible per person with the Paris Agreement goal of keeping global heating below 1.5°C.<sup>26</sup> Total emissions produced by the richest 10% by 2030 could exceed the total per person emissions limit for the entire global population—regardless of the actions of the other 90% of the population.<sup>27</sup> Hyper-carbon-intensive luxury travel—private jets, luxury superyachts, and space travel—as well as capital investments, make the uber-rich the greatest contributors to climate change.<sup>28</sup> Further, they have the power to influence political processes to preserve and increase their incomes and wealth and thus their high-carbon-emitting lifestyles.<sup>29</sup> For these reasons, climate change and gross economic inequality are intertwined and must be tackled together.

While global income and wealth inequalities between individuals and households have increased continuously since the late 1970s, the gap between the wealthiest and poorest people increased even more sharply as COVID-19 swept the globe. The World Bank estimates that global extreme poverty—people living on less than US\$1.90 per day—increased from 8.4% in 2019 to 9.1% in 2020.<sup>30</sup> Meanwhile, the combined wealth of US billionaires increased by 39% between March 2020 and January 2021.<sup>31</sup> Moreover, the *Global Wealth Report 2021*

indicates that the rise of wealth inequality in 2020 was significantly higher than that recorded in any other year this century.<sup>32</sup>

The economic and social devastation caused by COVID-19 now presents a “once in a lifetime opportunity” to transform the global governance framework in a manner that will address the intertwined crises of COVID-19, climate change, and extreme economic inequality, improving the health of workers through improved opportunities for decent work on a more equitable and sustainable planet.<sup>33</sup>

### Social contracts

To address these crises, the UN, regional and international trade unions, and many nongovernmental organizations have called for a “new” or “reinvigorated” social contract. The term “social contract” is rarely defined but vaguely draws on liberal philosophers such as Locke, Hobbes, and Rousseau, whose work dates from the 1650s to 1750s.<sup>34</sup> Definitions of social contracts also draw from non-Western sources such as the Quran in which there are expectations (a contract) between God and believers.<sup>35</sup> Historically, social contracts were thought to be pacts between individuals and their rulers that set out mutual expectations to prevent anarchy and chaos. They established “fundamental norms of common consent that provide social cohesion” and “moral ideals,” giving people a “sense of worth and happiness” in society.<sup>36</sup> In this way, social contracts served as a “pact for cooperative, mutually beneficial living together.”<sup>37</sup> Social contract theory has evolved beyond consideration of individuals and their sovereign ruler to encompass collective actors and also to be conceived as operating at many different levels, from the subnational to global.<sup>38</sup>

Social contracts are rarely written out, yet declarations and formal events can signal shifts and meaningful changes. Examples of written social contracts include the 1215 Magna Carta and the 1776 Declaration of Independence.<sup>39</sup> In other cases, without explicit declaration, social contracts may change due to shifts in power, the inability of the

state or other parties to uphold their obligations, or widespread realization that the present social contract no longer meets expectations due to “dramatic social or economic changes.”<sup>30</sup> This occurred in the Arab Spring uprisings in Egypt and Tunisia, for instance.<sup>41</sup> Other examples of changes in social contracts include South Africa following the end of Apartheid, the post-World War II European reconstruction, and the 1930s depression-era New Deal in the United States. In sum, social contracts, written or not, reflect and sometimes regulate social relationships in terms of the rights and obligations of actors in society, particularly the relationships between workers, employers, and the state.

COVID-19, the climate crisis, and extreme economic inequality have arisen under a neoliberal social contract in most global contexts and have had dire impacts on worker health and human rights.<sup>42</sup> Under this social contract, many national governments have privileged private markets and actors in specifying the duties and obligations of members of societies. Their neoliberal policies include low taxes on corporations and the wealthy to free up investment with the expectation that jobs, income, and economic growth will trickle down to all. Neoliberal policies also encompass austerity measures to attract private investment, cuts in public budgets, the privatization of publicly owned infrastructure, and a weakening of the welfare state and its safety net so that workers’ access to a decent living—including housing, food, and health services—is based on private markets rather than human rights, public resources, and a robust welfare state.<sup>43</sup>

Further, consistent with the neoliberal social contract, governments in many countries constrain worker and trade union rights to prevent their effective voice in politics and policy in the workplace, in national fora, and even in global regimes.<sup>44</sup> These arrangements are especially clear in the United States, where during the neoliberal period, corporations have vigorously supported and financed pro-business political candidates and policies and evaded their responsibilities for negative social and environmental outcomes, while trade unions have been

severely constrained from protecting workers. One indicator of these policies is that “[t]he share of workers covered by a collective bargaining agreement in the U.S. fell from 27.0% in 1979 to just 11.6% in 2019.”<sup>35</sup> Indeed, in most high-income countries, unions have been losing members for the past 30 years.<sup>46</sup>

At the global level, there has also been support for the neoliberal social contract from international institutions, which have implemented policies to make people and societies subject to market discipline and logics. The World Bank and the International Monetary Fund have championed neoliberal policies through their lending programs.<sup>47</sup> The UN has also embraced market and corporate logics in making public-private partnerships a positive model for international development and global governance, including the SDGs.<sup>48</sup> In this context, the SDGs have served as the global social contract, merging neoliberalism (including reliance on private sector actors to stimulate economic growth to bring people out of poverty) with minimal explicit references to human rights and generally only where they are compatible with the neoliberal paradigm.<sup>49</sup>

This is evident in SDG 8, which has been called a “paradigm shift” in its logic that a green economy, environmental conservation, and job creation can be achieved with entrepreneurial “courage to invest in innovative solutions” rather than government regulation alone.<sup>50</sup> SDG 8 aims to “promote sustained inclusive and sustainable economic growth, full and productive employment and decent work for all.”<sup>51</sup> The goal calls for the *promotion* of decent work, diminishing its status as a human rights obligation, and then grafts it onto economic growth, which is, at best, just one path to achieve decent work.<sup>52</sup> Further, the goal, by focusing on GDP and per capita growth, embodies gendered neoliberal assumptions by ignoring unpaid social reproduction work, which does not contribute to GDP.<sup>53</sup> Critics have also noted the problematic assumption that sustainable or “green growth” can actually decouple growth from carbon emissions quickly or sufficiently enough to have a meaningful impact on climate change.<sup>54</sup> Finally,

even prior to COVID-19-supercharged economic and social inequality, United Nations Conference on Trade and Development advisor David Woodward estimated that it would take between 123 and 209 years of sustained growth to lift out of poverty the 62.3% of the world's population living below the US\$5-per-day poverty line.<sup>55</sup> The planet, with its current technological capacity, could not support such growth.<sup>56</sup>

SDG 8 embodies a social contract far removed from earlier aspirations for workers. The ILO's 1919 Constitution formalized a social contract following World War I. Among its central elements were that (1) labor is not a commodity, and (2) sustainable peace can be achieved only through social justice in which the urgent needs of workers are met in the form of regulation of working hours; prevention of unemployment; provision of an adequate living wage; protections against sickness, disease, and injury; protection of children, young persons, women, and the elderly; equality in remuneration for work of equal value; vocational and technical education; and recognition of the right to freedom of association.<sup>57</sup> The 1944 ILO Declaration of Philadelphia, following World War II, recommitted to these central elements. It also emphasized the need for policy coherence, declaring that the central aim of national and international policy is to achieve the promises of the ILO social contract and that all proposed policies and measures must be assessed based on their contribution to achieving these purposes.<sup>58</sup>

This focus on social justice for workers and the obligations of states to regulate to ensure worker health and human rights has evolved since 1944 to a more neoliberal form now embodied in the 2008 ILO Declaration on Social Justice for a Fair Globalization and the 2019 ILO Centenary Declaration. The 2008 Declaration sidesteps the 1919 Constitution's expansive conceptualization of social justice, focusing instead on narrowly achieving the ILO's discreet decent work agenda as the central purpose of the ILO.<sup>59</sup> It also recognizes the importance of economic growth, albeit while pointing to some negative consequences and forms of growth,

such as the rise of unprotected work and informal employment.<sup>60</sup> In addition, businesses take a more prominent role, as evidenced by the declaration's acknowledgment that "productive, profitable and sustainable enterprises, together with a strong social economy and a viable public sector, are critical to sustainable economic development and employment opportunities."<sup>61</sup>

Further evolution and consolidation of a neoliberal-friendly social contract is evidenced by the ILO's 2019 Global Commission on the Future of Work and its miserly framing of the social contract as "a common understanding that in return for their contribution to growth and prosperity, workers are guaranteed a just share of that progress, with respect for their rights and protection from some of the jagged edges of the market economy."<sup>62</sup> This revised social contract was subsequently incorporated into the ILO's 2019 Centenary Declaration, which also emphasizes its close relationship with the SDGs.<sup>63</sup> The 2019 Declaration recognizes that the ILO must direct its efforts at "supporting the role of the private sector as a principal source of economic growth and job creation by promoting an enabling environment for entrepreneurship and sustainable enterprises ... in order to generate decent work, productive employment and improved living standards for all."<sup>64</sup> The ILO's revision of the 1919 and 1944 social contract promotes the private sector and trickle-down economic growth.

The COVID-19 pandemic, the climate crisis, and extreme economic inequality arise in and are exacerbated by the global neoliberal context in which they are embedded, which has led to divestment in public health systems, a focus on short-term gains from carbon emissions without adequate regard for long-term impacts, and extreme economic inequalities among individuals and families within and between countries. Recovery from the economic and social devastation caused by COVID-19 now presents a crucial opportunity to change the global framework to address climate change and extreme economic inequality—an opportunity to reject neoliberalism and adopt a new transforma-

tive social contract that addresses the crises at hand more justly and comprehensively.

### A social contract grounded in human rights

In place of the current neoliberal social contract, the international human rights framework provides an alternative foundation for a social contract that respects the dignity and equality of all human beings, recognizes that everyone has duties to the community, and requires a social and international order in which all human rights can be fully realized.<sup>65</sup> Moreover, UN members have already agreed to promote and protect these rights.<sup>66</sup> While the 2030 Agenda for Sustainable Development seemingly attempts to combine international human rights and neoliberal approaches into a single social contract, the contradictions, incongruities, and conflicts among the targets and indicators—as shown particularly in SDG 8—create an unworkable and ineffective plan for saving the planet and realizing human rights for all.<sup>67</sup>

Rather than economic growth and increasing consumption as pathways to “development” and prosperity for all, a social contract based on international human rights centers on promoting and protecting the health of people and the planet.<sup>68</sup> Labor and wage policies, social protection systems, public services, tax policy, and corporate regulation could all be aligned with the goal of achieving the full array of human rights for workers and their families.<sup>69</sup> Human rights is a legitimate basis for a

social contract to recover from the trifecta of crises because (1) governments have voluntarily agreed to human rights treaties, (2) human rights impose legal obligations on governments, and (3) human rights provide mechanisms of accountability.<sup>70</sup> A social contract grounded in human rights makes realizing the rights—such as the rights to health and decent work—central organizing principles of society, rather than potential dividends to economic growth as they are today under SDG 8.

This is not a new idea. Realizing human rights and social justice was core to the original visions of both the ILO and the UN. Indeed, in the 1940s, when the ILO Declaration of Philadelphia and the Universal Declaration of Human Rights were adopted, the health of workers and their families was a central concern of both regimes. Despite the drift of the governing bodies of both organizations toward the neoliberal paradigm, as seen in SDG 8 and the ILO Centenary Declaration, the human rights treaties and the ILO conventions remain true to the original vision of these organizations. The two legal regimes are now largely in sync because the Committee on Economic Social and Cultural Rights (CESCR) relies on the ILO conventions and recommendations to interpret the work rights in international human rights law.<sup>71</sup> How does human rights address the three pressing crises for workers—COVID-19, climate change, and extreme economic inequality? Some preliminary explorations based on the work rights enshrined in the ICESCR show how a social contract grounded in human rights puts the focus on the health and

TABLE 1. Key work rights in the ICESCR

Article 6	Right to decent work	<ul style="list-style-type: none"> <li>• to gain living by freely chosen work</li> <li>• to technical and vocational programs</li> <li>• to policies to achieve economic and social development</li> <li>• to conditions that safeguard political and economic freedoms</li> </ul>
Article 7	Right to favorable conditions of work	<ul style="list-style-type: none"> <li>• to fair wages and a decent living</li> <li>• to safe and healthy working conditions</li> <li>• to rest and reasonable working hours</li> </ul>
Article 8	Union rights	<ul style="list-style-type: none"> <li>• of workers to join and form trade unions</li> <li>• of trade unions to function freely</li> <li>• to collective bargaining</li> <li>• to strike</li> </ul>
Article 9	Right to social protection	<ul style="list-style-type: none"> <li>• to social security</li> <li>• to social insurance</li> </ul>

human rights of workers and their families to meet the challenges of our time. Table 1 sets out key work rights enshrined in the ICESCR.

### *The right to decent work (article 6)*

Human rights provide essential elements of a social contract to protect the health of workers and their families in the context of climate change. Under the neoliberal social contract, governments have not taken enough action over the past 40 years to reduce CO<sub>2</sub> emissions or to build resilience to climate change, much less to implement a plan to move workers into green jobs. However, the CESCR has recognized that “all States have human rights obligations that should guide them in the design and implementation of measures to address climate change.”<sup>72</sup> This includes the obligation under article 6 of the ICESCR to ensure “the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts” and to “technical and vocational guidance and training programmes, policies and techniques to achieve steady economic, social and cultural development and full and productive employment.”

Businesses have often pitted worker rights to gain a living by work against the demands of environmentalists and climate activists to protect the right to a healthy planet. It is now clear that workers in fossil fuel exploration and production will need to move into green jobs—to ensure their health and the health of the planet. Further, research shows that while 6 million jobs may be lost in the fossil fuel energy sector, 24 million new jobs could be created through a “just transition.”<sup>73</sup> Olivier De Schutter, UN Special Rapporteur on extreme poverty and human rights, has explained that workers and communities affected by this transformation to low-carbon societies are entitled to reskilling, including appropriate training and assistance in job transitions, as well as “broader investments aimed at creating economic opportunities.”<sup>74</sup> Protecting workers and their families through this transition will also require robust social protection (article 9) and strengthening social dialogue (article 8). These work rights align closely with the “just transition” espoused by the International Trade Union

Confederation and incorporated into the Paris Agreement.<sup>75</sup>

The CESCR has also made recommendations to state parties consistent with this just transition as a component of a social contract grounded in human rights. For example, in 2019, the CESCR stated in its concluding observations to Estonia:

*The Committee recommends that the State party intensify its efforts to improve its vocational education and training programmes in order to provide the workforce with the skills and knowledge to keep up with the changing demands of the labour market. It also recommends that the State party ensure that workers who are affected by industrial restructuring and the transition to renewable energy, including those in the textile and oil shale industries, are able to make an effective and smooth transition to new occupations that enable them to maintain an adequate standard of living.*<sup>76</sup>

Importantly, in October 2021, the Human Rights Council created a new mandate for a Special Rapporteur on the promotion and protection of human rights in the context of climate change.<sup>77</sup> Once the Special Rapporteur is appointed, the rights of workers in the context of climate change should be a central focus of the mandate to ensure a just transition.

### *Rights to just and favorable conditions of work (article 7)*

UN Secretary-General António Guterres explained that COVID-19 has made clear the shortfalls of the neoliberal social contract:

*It is exposing fallacies and falsehoods everywhere:*

- *The lie that free markets can deliver healthcare for all;*
- *The fiction that unpaid care work is not work;*
- *The delusion that we live in a post-racist world;*
- *The myth that we are all in the same boat.*

*Because while we are all floating on the same sea, it's clear that some are in superyachts while others are clinging to debris.*<sup>78</sup>

The neoliberal social contract has failed workers in the context of COVID-19 and similarly fails to recognize the health of workers and their families

as a central organizing principle for action on climate change. However, climate change has enormous impacts on work conditions. For example, it increases the frequency and duration of extreme heat for farm and construction workers, hazards of wildfires for firefighters, injuries and exhaustion of rescue workers due to extreme weather events, and psychological stress due to all these climate changes.<sup>79</sup>

Human rights provide the essential elements of a social contract to ensure just and favorable conditions at work, protecting the health of workers in the context of climate change. Article 7 of the ICESCR provides, among other work rights, the rights to fair wages, safe and healthy working conditions, and reasonable limitations on working hours. While many of the provisions of article 7 are relevant to workers in the context of climate change, UN human rights mechanisms have been largely silent on this subject. Indeed, CESCR General Comment 23 on article 7 does not mention “climate.” This is an area that the CESCR, as well as the new Special Rapporteur on human rights in the context of climate change, should address.

To respect, protect, and fulfill the right to just and favorable conditions of work in the context of climate change, several measures can be taken to prevent work-related illnesses and injuries. First, health care providers and other workers need improved information and training to accurately identify, diagnose, and prevent climate-related harms, especially those related to heat.<sup>80</sup> In addition, changes in work design are necessary to reduce physical labor during periods of extreme heat and to provide air conditioning when possible.<sup>81</sup> Other interventions include scheduling work breaks for rest, providing water for hydration, and ensuring appropriate work clothing to prevent heat-related harms.<sup>82</sup> The human rights mechanisms must make clear that these interventions are essential elements of the right to favorable conditions of work in the context of climate change.

### *Union rights (article 8)*

Climate change cannot be addressed without also addressing extreme economic inequalities, which

place the power to change in the hands of a few. The neoliberal social contract has led to these extreme inequalities in income, wealth, and power. Wage inequality is one of the major contributors to economic and social inequalities, and this has resulted from the dismantling of labor protections, in particular union rights, over the past four decades.<sup>83</sup> The erosion of worker bargaining power—by suppressing union organizing, decentralizing bargaining, and dismantling union tools such as the right to strike—has led to the suppression of wages and the deterioration of worker voice in national policy and planning.<sup>84</sup> This economic inequality drives climate change.

In contrast, a social contract grounded in human rights requires action to reduce economic inequalities in order for economic and social rights to be achieved by all. In particular, article 8 of the ICESCR enshrines the rights of workers to join and form trade unions, the right of trade unions to function freely, the right to collective bargaining, and the right to strike. Juan Pablo Bohoslavsky, then Independent Expert on debt and human rights, recognized in his 2016 report the importance of unions’ right to reduce inequalities:

*International human rights law addresses inequality on many levels. First, there are economic and social rights that clearly recognize the duties of States to address and/or prevent inequality as a threat to human rights realization. These include fundamental worker’s rights—in particular the right to form and join trade unions and the right to fair remuneration—and social rights—in particular the rights to education, health and social security.<sup>85</sup>*

Similarly, Philip Alston, then UN Special Rapporteur on extreme poverty and human rights, stated in his 2015 report, “The protection of core labor rights, such as the rights to freedom of association and collective bargaining, is also essential for a more equal division of power and the reduction of economic inequalities.”<sup>86</sup> Further, Danius Pūras, then Special Rapporteur on the right to health, stated in his 2019 report:

*History shows that improving conditions in the formal and informal labour market and*

*strengthening the accountability of employers depend on freedom of association or affiliation: the opportunity for meaningful relationships of mutual recognition with other workers. Relationships of solidarity, including through unionization to secure better pay, conditions and dignity at work, are critical to the promotion of mental health.*<sup>87</sup>

The CESCR has also recognized the importance of reducing economic inequalities to realizing economic, social, and cultural rights:

*In the context of the periodic reporting system, the Committee requires States parties to provide information on the impact of income and wealth inequalities on the enjoyment of economic, social and cultural rights. This reflects the common understanding that the eradication of poverty will not be achieved in the context of widening gulfs between rich and poor both within and between countries.*<sup>88</sup>

Nonetheless, the CESCR has yet to issue a general comment on article 8 (union rights). In the context of recovery from the COVID-19 pandemic and related economic crisis, as well as the deepening climate crisis, it would be timely for the CESCR to address article 8 and its connection to achieving greater income and wealth equality. As Special Rapporteur De Schutter explains, there is an environmental cost to inequality: “The frivolous desires of the most affluent, however unsustainable they may be, may take precedence over the satisfaction of basic needs of the least affluent.”<sup>89</sup> Thus, “equality matters to sustainability ... because more equal societies use resources more efficiently.”<sup>90</sup> Moreover, a massive reduction in economic inequality—and emissions by the ultra-wealthy—will be necessary to reach the goal of limiting global warming to 1.5°C. A social contract grounded in human rights can promote the worker voice that is necessary to bringing about greater economic equality.

In sum, UN human rights mechanisms have begun to address the challenges of climate change for workers, but there remains much to be done. Worker rights are fundamental to a social contract grounded in human rights. What is more, worker

rights could positively contribute to the solutions to the intertwined crises.

## Conclusion

The trifecta of the present day intertwined crises—climate change, COVID-19, and extreme economic inequality—clearly show that the current social contract is not operating for workers as a pact for cooperative and mutually beneficial living together. Indeed, the neoliberal social contract promotes (1) the spread of COVID-19 by limiting vaccines largely to high-income countries, (2) extreme economic inequality as a necessary outcome of market-based “development,” and (3) fossil fuel exploration and consumption as the foundation of that market-based economy. The 2030 Agenda for Sustainable Development—merging neoliberalism with human rights—is proving to be completely inadequate to change our course. What is needed is a far more radical change of path to ensure that vaccines reach people around the world, to reduce economic inequality and luxury spending, and to eliminate fossil fuel consumption. Human rights can provide that framework for a new social contract that is centered on promoting and protecting the health and human rights of workers and their families and securing a sustainable future for the planet.

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## PERSPECTIVE

# Who Deserves Health Care in a Global Pandemic?

MONICA GAGNON, REBECCA CHEFF, AND LISA FORMAN

### Abstract

The COVID-19 pandemic provides an opportunity for reflection on universal health coverage. We look at the case of the province of Ontario, Canada, which expanded health care entitlement during the pandemic to people not normally eligible for coverage, regardless of their citizenship or immigration status. We use the concept of health-related deservingness to examine why certain groups of people are deemed undeserving and are excluded in ordinary times but included in extraordinary times. We argue that tying health-related deservingness to citizenship or immigration status creates problematic inequities in health care access and outcomes and that entitlement to health care should be based instead on a person's right to health. A right to health approach could make health care systems truly universal and comprehensive. We recommend that expanded entitlement to care should be sustained, both in Ontario and elsewhere, beyond the COVID-19 crisis.

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## Introduction

On March 21, 2020, ten days after the World Health Organization declared the COVID-19 outbreak to be a global pandemic, the Ontario Ministry of Health took action to expand health care entitlement to all people living in Ontario, Canada, with or without publicly funded health coverage (nationally known as medicare). This was done to reduce the spread of COVID-19 by addressing financial barriers to care for uninsured residents during the pandemic.<sup>1</sup> Ordinarily, only certain categories of residents are eligible for medicare to cover the cost of a range of health services. The Canada Health Act, which states that the aim of Canadian health policy is to protect the health of residents of Canada, ties medicare entitlement to immigration status and to place of residence. It defines a “resident” as a person who is “lawfully entitled to be or to remain in Canada,” who makes their home here, and who is not a tourist or visitor. For the purposes of medicare eligibility, minimum residency requirements are set by each of the provinces and territories, which are responsible for administering and operating their own health insurance plans.<sup>2</sup>

In Ontario, the Health Insurance Act lays out specific eligibility requirements for the Ontario Health Insurance Plan (OHIP). These requirements exclude some residents (for example, new permanent and temporary residents in their first three months, international students, people with work permits but without full-time hours, and people with expired visas) while including others (for example, clergy members and internationally adopted children).<sup>3</sup> In non-COVID-19 times, there are some options for free health care in Ontario for people without OHIP, such as midwives and community health centers, which have special provincial funding to serve the uninsured, though their capacity is limited.<sup>4</sup> Beyond these options, people without OHIP face significant barriers to affordable health care. They are often required to pay for physician and hospital services, including emergency care. Fees for these services can be prohibitively expensive, which can result in delayed or deferred care.<sup>5</sup>

Now, however, according to Ontario’s 2020 COVID-19 memos to hospitals, everyone is entitled

to receive care for medically necessary hospital services, not just testing and treatment for COVID-19.<sup>6</sup> Faced with the threat of the pandemic, Ontario has expanded entitlement to health services, decoupling it from citizenship and immigration status, in order to accomplish the goal of protecting population health. At the time of writing, more than a year after the policy took effect, no timeline has been announced for rolling it back. It is easy to understand why, in the context of a global pandemic, Ontario has taken extraordinary measures to prevent the spread of disease by expanding entitlement so that more people can access health care. Yet, if the government has an interest in protecting the health of all people in a time of heightened anxiety about infectious disease, why are protections not guaranteed in ordinary times? Why are people who are not normally entitled to medicare deemed to be deserving in some times but not in others?

In this paper, we use the case of Ontario to illuminate a problematic gap in the universality of Canada’s publicly funded health coverage. Taking a rights-based approach, we raise questions about inequities in entitlement to medicare in Canada and point to directions for reform. As a public health PhD candidate, an equity researcher, and a human rights scholar residing in Ontario, we believe that Ontario’s approach to health care entitlement during the pandemic has both national and global relevance for thinking about universal health coverage. We argue that all people, regardless of citizenship or immigration status, are deserving of care and that in order to ensure truly universal health coverage, the right to health should always be the value guiding decisions around entitlement.

## A gap in the universality of publicly funded health coverage in Canada

The concept of “health-related deservingness” has been used to examine the exclusion of certain groups of people from state-sponsored health services.<sup>7</sup> Deservingness is conceptualized as a determination of a person’s worthiness of entitlement to services made by policymakers, service providers, or frontline workers.<sup>8</sup> Decisions about whether

to include or exclude someone are made according to deservingness judgments that may be based on a person's citizenship or immigration status, insurance status, ability to pay, or some other perceived characteristic.<sup>9</sup> Problematically, these decisions can be informed by racist and xenophobic ideologies, and they may not fully take into account a person's medical needs.<sup>10</sup> In Canada, immigrants with less-than-full, or "precarious," immigration status are often portrayed in a negative or undeserving light.<sup>11</sup> Such portrayals may be used to justify judging them undeserving and excluding them from entitlement to health care.<sup>12</sup> Some who support the exclusion of immigrants with precarious status from medicare draw on the argument that they are undeserving because they take advantage of Canada's health care system and burden taxpayers.<sup>13</sup> Such arguments disregard the many ways in which precarious-status immigrants are connected to and contribute to the places where they live.

There are many reasons why individuals may live, work, or study in Canada but not be entitled to medicare as a result of not having permanent resident status. Legal scholars have highlighted how deliberate changes to Canada's immigration policy have prioritized "flexible laborers" over permanent settlement, resulting in significantly increased proportions of immigrants with temporary status who have no entitlement to medicare.<sup>14</sup> The Canada Health Act's restrictive definition of resident, combined with the ways in which provinces and territories further restrict medicare eligibility and federal immigration laws and policies that produce increases in temporary residence, all result in a significant gap that compromises the universality of medicare, leaving immigrants with precarious status without coverage.

According to Ontario's current pandemic policy, immigrants with precarious status, while still not eligible for the full range of services covered under OHIP, are now considered deserving of medically necessary care. They are entitled to hospital services and specific physician consultations in community settings free of charge.<sup>15</sup> These changes take a significant step toward resolving the gap in universal health coverage described above. Still,

it is important to note that entitlement does not ensure access, and people with precarious immigration status face additional barriers to accessing care such as fear of deportation, discrimination, cultural and linguistic inadequacy of services, and difficulty navigating the health care system, among others.<sup>16</sup>

The implication of Ontario's expansion of entitlement to care is that in addressing a collective threat to public health, policymakers are willing to adopt far more generous criteria than usual for determining who deserves social benefits. Yet the expansion also suggests that the lives of people with precarious immigration status in Ontario hold only instrumental value, insofar as protecting their health safeguards the health of all Ontarians. This shines a light on an uncomfortable moral question embedded in the gaps within the universality of the health care system: Are we really only willing to value the health and lives of immigrants with precarious status when doing so protects the health of other people in Ontario and Canada? This concern is deepened by studies demonstrating that the health consequences of being unentitled to coverage are dire.<sup>17</sup> People living in Ontario without OHIP experience poorer health care and outcomes compared with those who are insured.<sup>18</sup> In tying health-related deservingness to citizenship and immigration status, Canada and its provinces and territories create problematic inequities in health care access and outcomes. As we have shown, the changes to OHIP entitlement motivated by the pandemic reveal that publicly funded health coverage is not at all universal in ordinary times.

### A human rights approach

True universality of health coverage in Canada may be more attainable if deservingness is determined based on the fundamental human right to health rather than on citizenship or immigration status. Canada is a state party to the International Covenant on Economic, Social and Cultural Rights (ICESCR), which articulates the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health."<sup>19</sup> Part of this right

is every person's right to adequate health care irrespective of citizenship or immigration status. While Canada has not directly protected this right in the Charter of Rights and Freedoms, it has ratified the ICESCR and other treaties that articulate the right to health, meaning that it is legally bound to realize this international treaty right.<sup>20</sup> Moreover, Canadian courts have explicitly recognized that charter rights to liberty and security of the person and to nondiscrimination extend into the health care context.<sup>21</sup> Courts have also implicitly recognized that the core principles of universality and accessibility that underlie the right to health underpin Canada's health care system. Most recently, the *Cambie* decision protecting the single-payer system from a private challenge strongly reinforced the foundational principle underlying Canada's health care system: that access to necessary care should be based solely on medical need and not on ability to pay.<sup>22</sup>

The question of whether the principle that entitlement to care should be based on medical need extends to immigrants with precarious status has been settled in relation to Canada. In 2018, the United Nations Human Rights Committee held that Canada's denial of health coverage to Nell Toussaint, an undocumented immigrant, violated her rights to life and nondiscrimination and that Canada had a positive obligation with regard to Toussaint's right to life, which required the state to provide essential health care. The committee held that Canada is "under an obligation to take steps to prevent similar violations in the future, including reviewing its national legislation to ensure that irregular migrants have access to essential health care to prevent a reasonably foreseeable risk that can result in loss of life."<sup>23</sup> This decision emphasizes that Canada's human rights protections dictate that universal health coverage be extended to all, including those with precarious immigration status, yet the Canadian government has been slow to implement the decision. This has prompted civil society actors behind the complaint to initiate legal action in the Ontario Superior Court of Justice to challenge Canada's refusal to implement the committee's views.<sup>24</sup> Since the decision, there has

been increasing pressure from advocates to ensure the rights of immigrants with precarious status to health care. These decisions underscore that the core norms of the right to health are already well recognized in Canada's legal and health care systems despite judicial reluctance to fully incorporate the right to health into Canadian law.

The current expansion of entitlement to health care in Ontario has been made possible by dedicating funding for medically necessary services for people without OHIP. While this is one option for expanding coverage, we recognize that such an approach reinforces a tiered health care system with differential entitlement for those with OHIP and those without, diluting the universality and comprehensiveness of health coverage. We recommend that Canada take a human rights approach to health policy, supporting universal health coverage at the federal level by requiring provinces and territories to expand medicare entitlement to all residents, regardless of citizenship or immigration status. We are in agreement with scholars who point out that simultaneous changes in immigration policy are needed in order for the issue of enforced temporariness to be fully addressed.<sup>25</sup> There is broad support for such an approach at the grassroots level across Canada, with advocates calling on the federal government to recognize that denial of health care based on immigration status denies human rights and threatens public health.<sup>26</sup>

## Conclusion

A human rights approach reinforces the notion that everyone is deserving of health care, whether or not there is a pandemic, and whether or not they are a Canadian citizen or permanent resident. Health-related deservingness, therefore, should be determined based on each person's inherent human right to health, rather than on their insider or outsider status. The Ontario Ministry of Health should broaden its expansion of entitlement to care beyond the end of the pandemic, and other provinces and territories should follow suit. Expanded entitlement would reinforce a socially just inter-

pretation of medicare, one of Canada's most valued social programs, and address significant gaps in the universality and comprehensiveness that undercut its foundational principles. The COVID-19 pandemic underscores that every person counts when it comes to protecting public health, and everyone is deserving of health care. We call on Canada to be a true global model for universal health coverage and take decisive moral leadership in building a more equitable health system for all, resolving a long-standing injustice.

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# Ensuring Rights while Protecting Health: The Importance of Using a Human Rights Approach in Implementing Public Health Responses to COVID-19

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## Abstract

In response to the COVID-19 pandemic, governments around the world have implemented public health policies that limit individual freedoms in order to control disease transmission. While such limitations on liberties are sometimes necessary for pandemic control, many of these policies have been overly broad or have neglected to consider the costs for populations already susceptible to human rights violations. Furthermore, the pandemic has exacerbated preexisting inequities based on health care access, poverty, racial injustice, refugee crises, and lack of education. The worsening of such human rights violations increases the need to utilize a human rights approach in the response to COVID-19. This paper provides a global overview of COVID-19 public health policy interventions implemented from January 1 to June 30, 2020, and identifies their impacts on the human rights of marginalized populations. We find that over 70% of these public health policies negatively affect human rights in at least one way or for at least one population. We recommend that policy makers take a human rights approach to COVID-19 pandemic control by designing public health policies focused on the most marginalized groups in society. Doing so would allow for a more equitable, realistic, and sustainable pandemic response that is centered on the needs of those at highest risk of COVID-19 and human rights violations.

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## Introduction

The global response to public health emergencies, such as pandemics, often requires enacting public health policy interventions to prevent disease and protect population health. These interventions can and do limit individual freedoms and are widely understood to be appropriate in public health emergencies. The COVID-19 pandemic has prompted the implementation of public health measures at an unprecedented global scale. Policies such as border and school closures, face mask mandates, limitations on social gatherings, and household confinement have been shown to be effective against COVID-19 transmission and disease outcomes.<sup>1</sup> While such interventions are crucial to pandemic mitigation, their public health benefits can result in substantial trade-offs, such as limited access to medical care and public health services for the diagnosis, treatment, and prevention of other diseases, as well as the loss of livelihood and disruptions to education and sociocultural interaction.<sup>2</sup> Furthermore, public health interventions can also come at human rights costs, disproportionately impacting already vulnerable and oppressed communities.<sup>3</sup>

International guidance on the rights-limiting measures allowable during states of emergency is based on the Siracusa Principles.<sup>4</sup> These principles state that regardless of the nature or severity of the emergency, restrictions on human rights must meet standards of legality, legitimacy, necessity, proportionality, evidence, and nondiscrimination.<sup>5</sup> General Comment 14 to the International Covenant on Economic, Social, and Cultural Rights (ICESCR) further emphasizes that states have “the burden of justifying such serious measures” with respect to “demonstrat[ing] that restrictive measures are necessary to curb the spread of infectious diseases so as to ultimately promote the rights and freedoms of individuals.”<sup>6</sup> However, the implementation of these guiding principles can be intricate given that derogations of human rights standards are multifaceted and may be complicated by complex interactions between competing aspects of public health, ethics, economics, and law.<sup>7</sup> Further, there are no international principles or standards

for state of emergency declarations, meaning that states are bound solely to national and local public health laws when making these declarations. Therefore, public health interventions can and have been practiced discriminatorily by restricting the social, economic, and cultural rights of specific populations, such as refugees and migrants, who are particularly vulnerable to movement restrictions.<sup>8</sup>

Blanket public health policies can be particularly challenging for disadvantaged populations. For example, people living in impoverished and densely populated urban housing or confined to refugee camps cannot realistically quarantine or avoid gatherings.<sup>9</sup> Incarcerated persons do not have the capability to follow sanitation and masking guidelines without the support of prison policy and resources, and the nature of correctional facilities is not suited to social distancing.<sup>10</sup> Hourly workers and day workers may not be able to afford food, medicine, or other necessities of life when COVID-19 restrictions impair their travel to work. Viewed through a human rights lens, public health interventions are designed to protect the most vulnerable members of society but in practice, the result may be the opposite. Furthermore, policies can be designed ostensibly for pandemic control while their true goal is political—for example, by limiting assemblies and thereby suppressing anti-government demonstrations. Evaluating COVID-19 public health interventions around the needs of vulnerable populations and prioritizing their needs may allow for a pandemic response that is not only more equitable but also more practicable and sustainable for those at highest risk of disease transmission, morbidity, and mortality.<sup>11</sup> To address these concerns, we provide a global overview of public health interventions implemented during the COVID-19 pandemic and analyze their human rights dimensions.

## Methods

### *Defining populations vulnerable to human rights abuses*

To examine COVID-19 public health interventions within a human rights framework, we must first

define groups vulnerable to human rights abuses. The Committee on Economic, Social and Cultural Rights notes that state parties to the ICESCR are obliged to “give special attention to those individuals and groups who traditionally face difficulties in exercising this right” in the context of social security and human rights.<sup>12</sup> We based our analysis of vulnerable groups on the ICESCR definition and added additional groups that may be relevant to the COVID-19 pandemic based on US research ethics standards.<sup>13</sup> Table 1 outlines the major groups used in our analysis.

### *Database for public health interventions and applied human rights norms*

To categorize the key types of public health interventions that were implemented in the first six months of the COVID-19 pandemic (January 1 to June 30, 2020), we utilized curated data on global public health interventions from the free, open-access Health Intervention Tracking for COVID-19 (HIT-COVID) database.<sup>14</sup> Established in April 2020, the HIT-COVID database catalogues the im-

plementation and relaxation of COVID-19 public health interventions at the national and subnational level, with geographic granularity down to the local level (cities and towns) where applicable. Within the available data for this period, 59% of the records were for the subnational level. The time frame from January 1 to June 30, 2020, was chosen because database entries during this period provided the most complete coverage and were therefore considered to yield more robust findings. As of March 31, 2021, there were 13,429 public health interventions catalogued in the database, of which 10,720 were implemented from January 1 to June 30, 2020. We abstracted these 10,720 public health interventions into 21 categories that the database had assigned a priori, based on the most common and relevant COVID-19 interventions. Then, we tabulated the absolute and relative frequency of public health interventions within these categories (Table 2). Notably, due to the time frame underlying our data extraction, more recent issues such as vaccine inequities, emerging COVID-19 variants, and global health disparities were not analyzed here.

TABLE 1. Disadvantaged and vulnerable groups impacted by COVID-19 interventions

Category	ICESCR groups	Additional groups
Vulnerability based on historical or personal identity	<ul style="list-style-type: none"> <li>• Women</li> </ul>	<ul style="list-style-type: none"> <li>• Indigenous people</li> <li>• LGBTQI+ groups</li> <li>• People of color</li> <li>• People with language barriers</li> <li>• Other historically disadvantaged groups</li> </ul>
Vulnerability based on economic disadvantage	<ul style="list-style-type: none"> <li>• Unemployed persons</li> <li>• Workers inadequately protected by social security</li> <li>• Persons working in the informal economy</li> <li>• Domestic workers</li> <li>• Home workers</li> <li>• Sick or injured workers</li> </ul>	<ul style="list-style-type: none"> <li>• Agricultural workers</li> <li>• Workers in crowded conditions, daily wage earners, and workers with job insecurity</li> <li>• People experiencing homelessness</li> <li>• Socioeconomically disadvantaged people</li> <li>• People without health insurance</li> <li>• Educationally disadvantaged people</li> <li>• Undocumented workers</li> </ul>
Vulnerability based on age or health status	<ul style="list-style-type: none"> <li>• People with disabilities</li> <li>• Older persons</li> <li>• Children</li> <li>• Adult dependents</li> </ul>	<ul style="list-style-type: none"> <li>• People living with chronic diseases, especially conditions that require continued access to medical care or therapeutics</li> <li>• Health workers and other essential or frontline workers at increased risk of contracting COVID-19</li> <li>• People with mental health conditions</li> <li>• People with COVID-19 and “long COVID”</li> </ul>
Other vulnerable groups	<ul style="list-style-type: none"> <li>• Racial, ethnic, religious, sexual, and political minority groups</li> <li>• Refugees, asylum seekers, returnees, and internally displaced persons</li> <li>• Non-nationals (immigrants and migrants)</li> <li>• Incarcerated and detained people</li> </ul>	

Guided by the standards set forth in the Universal Declaration of Human Rights (UDHR), we cross-compared the 21 intervention categories by their potential human rights impacts. For each intervention category, we also identified the population groups most likely to be impacted from a human rights perspective, identifying groups that were most vulnerable to human rights abuses in such categories (Table 2).

## Results

### *The most common public health interventions implemented in the first six months of the pandemic: School closures, border closures, and movement restrictions*

Of the 10,720 public health interventions recorded during the first six months of the pandemic in the HIT-COVID database, the majority (71.67%) were identified as restricting human rights in at least one way or for at least one population (Table 2). Among all 21 public health intervention categories in the database, the five most prevalent categories covered 57.60% of interventions. These five categories were school closures (28.61%), border closures (12.62%), quarantine and isolation (6.03%), limiting gathering size (5.23%), and household confinement (5.11%). School closures refer to limited hours or days at school, the utilization of online learning, and universal school closure. Border closures refer to the closing of borders to other countries or subnational units, including restrictions imposed on certain subpopulations (based on geographic origin or on COVID-19 exposure or test results). Quarantine refers to the separation and restriction of movement for individuals who have had potential COVID-19 exposure or who have not had a confirmed infection (such as travelers and persons in contact with confirmed or suspected cases). Home isolation refers to people who are symptomatic or have a confirmed infection (such as symptomatic suspected cases, non-hospitalized confirmed cases, and cases discharged from the hospital). Limiting gatherings refers to the imposition of size limits on indoor and

outdoor gatherings. Household confinement refers to curfews, stay-at-home orders, and lockdowns that require people to stay within their household except for essential trips (for example, for medical care or food). These orders may also restrict the movement of high-risk groups, such as elderly or chronically ill people.

### *Human rights dimensions most frequently impacted by public health interventions*

All of the 21 public health intervention categories have impacts on human rights. The most common human right that is impacted by these interventions is freedom of movement, which is affected by border closures, household confinement, public space and public transport closures, and quarantine and isolation. While limiting movement is aimed at reducing contact rates between infected and susceptible persons to control community transmission, medically and socially vulnerable populations are disproportionately affected by such restrictions. For example, elderly people and individuals with underlying medical conditions may experience reduced access to health care and essential therapeutics, which in turn can result in delayed detection and prevention or treatment of diseases.

Other human rights that are frequently impacted by public health interventions include the right to protection against interference with individual privacy and the right to peaceful assembly. The curtailment of these rights has often resulted in resistance and protest among affected populations globally.<sup>15</sup>

Nonetheless, it is important to emphasize that due to country-level variations in government structures and human rights standards, the impact of these public health interventions differs by country. For example, restrictions on the freedom of movement may be more accepted and realistic in countries with better internet coverage and digital infrastructure, which enables the continuity of work from home; and acceptance of interference with individual privacy to protect the health of others may be higher among societies that culturally value collective action and solidarity.

*Case studies from around the globe to explore the human rights impacts of COVID-19 restrictions*

Below, we review the five most frequent types of interventions in order to understand the range of restrictions enacted, the potential human rights concerns around these restrictions, and their potential sequelae, particularly for vulnerable groups.

**School closures.** School closures made up more than one-fourth of all public health interventions in the HIT-COVID database that were implemented from January to June 2020. The right to an accessible and affordable education is protected under article 26 of the UDHR.<sup>16</sup> Epidemiologically, in-person school settings were initially considered a high-risk environment for the spread of COVID-19, but updated data analyses consider them a lower-risk environment for transmission, especially at the elementary school level.<sup>17</sup> School closures have profound consequences for students' learning, social well-being, and mental health, as well as the ability of parents to work.<sup>18</sup> While various governments have provided virtual education due to in-person school closures, it is not feasible to guarantee quality education or equal access to virtual learning during the pandemic due to inequities in resources (such as internet access) and in parents' availability to supervise children adequately.<sup>19</sup> Many of these inequities were preexisting and were exacerbated during the pandemic. Thus, this disruption of learning inevitably results in substantial educational gaps for children across the world. The effects of educational gaps have been shown, both historically and currently, to negatively impact learning and life outcomes. A mere three-month school closure could reduce students' long-term learning by a year, as suggested by modeling simulations.<sup>20</sup> School disruption during World War II was found to be associated with significant income loss 30 years later in life.<sup>21</sup>

School closures also lead to increased prevalence and exacerbation of mental health issues, such as anxiety and depression, among students.<sup>22</sup> School closures place vulnerable children at higher risk of food insecurity, and in many low- and mid-

dle-income countries, lack of access to education puts girls in particular at increased risk of child marriage, gender-based violence, sexual assault, and teen pregnancy. For example, the rate of child marriage in Malawi increased by 83% from March to May of 2020 compared to 2019, and the rate of sexual assault, which is linked to child marriage, increased by 151%.<sup>23</sup> Given that child brides are more likely to drop out of school and face gender-based violence, protecting access to education, particularly for girls, should be an imperative in the COVID-19 response, especially in low- and middle-income countries.<sup>24</sup>

**Border closures.** Border closures and movement restrictions are in tension with article 13 of the UDHR, which states that "everyone has the right to freedom of movement and residence within the borders of each state."<sup>25</sup> Further, the International Health Regulations specifically state that public health interventions should be implemented "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."<sup>26</sup> Even though border closures and movement restrictions were almost universally implemented by governments early in the pandemic, their effectiveness in reducing COVID-19 transmission is disputed, as it remains methodologically complex to distinguish the independent impact of individual interventions that have been implemented at the same point in space and time.<sup>27</sup> While border closures may be effective in delaying the spread of COVID-19, if implemented prior to establishment of community transmission within a country, their overall effect on transmission of COVID-19 is modest and not sustainable.<sup>28</sup>

For country or territory borders that are fraught or politically unstable, changes to border policies can have drastic consequences. For example, in the United States, border entry for immigrants and asylum seekers has been severely restricted. In response to COVID-19, many legal immigration proceedings were halted, leaving

TABLE 2. Description of public health interventions in the HIT-COVID database (January 1-June 30, 2020)

Intervention type	N	%	Potential human rights impacted	Vulnerable groups affected
School closures	3,067	28.61	Right to access and quality of education; right to nutrition; right to work (for parents and teachers)	Low-income students and those without internet access; food-insecure families; parents without access to child care who cannot stay at home; children with learning disabilities or special needs
Border closures	1,353	12.62	Freedom of movement; right to seek asylum; right to health and well-being	Refugees; asylum seekers; undocumented individuals; expatriates; people who travel for work
Quarantine and isolation	646	6.03	Freedom of movement	People with physical and mental health issues; essential in-person workers; low-income workers; unemployed people; people with disabilities; elderly people; unstably housed persons; people living in crowded conditions
Limiting gatherings	561	5.23	Right to assembly; free speech; freedom of movement	Refugees and internally displaced persons (IDPs); people experiencing homelessness; protesters; people living in crowded conditions; minorities (racial/ethnic, religious, or political)
Household confinement	548	5.11	Freedom of movement; right to health and well-being	People experiencing homelessness; domestic workers; people with mental health conditions; refugees and IDPs; essential workers; elderly people; people living in crowded conditions
Leisure and entertainment venue closures	497	4.64	Right to leisure; right to participate in cultural life; right to work	Service industry employees, particularly low-wage workers
Retail store closures	469	4.38	Right to work	Retail industry workers, particularly low-wage workers; people without internet or with low retail store density
Restaurant (dine-in) closures and restrictions	450	4.20	Right to work; right to participate in cultural life	Food service workers, especially low-income people
Symptom screening at borders	425	3.97	Right to protection against interference with individual privacy	People with disabilities or chronic diseases
Office closures	362	3.38	Right to work	People who cannot work from home
Limiting movement within administrative borders	355	3.31	Freedom of movement	IDPs and refugees; unstably housed people
Public space closures	261	2.43	Freedom of movement; right to peaceful assembly	People from sociopolitical minorities; unstably housed people
State of emergency	256	2.39	Right to self-will	Groups who face discrimination
Testing symptomatic individuals	252	2.35	Right to protection against interference with individual privacy	People with disabilities or chronic diseases; people with poor access to health care; low-income people
Mandated face mask use	246	2.30	Right to freedom of expression (communication ability for disabled)	People with disabilities or underlying health conditions
Public transport closures	229	2.14	Right to a standard of living adequate for health and well-being; freedom of movement	Low-income people; people experiencing homelessness; schoolchildren; elderly people; undocumented individuals; rural populations
Contact tracing	170	1.59	Right to protection against interference with individual privacy	People with poor access to health care; low-income populations; people without internet access; undocumented people
Closure of nursing homes and long-term care facilities	163	1.52	Right to a standard of living adequate for health and well-being	Elderly people; people with disabilities or chronic diseases
Military or police deployment	162	1.51	Right to protection from violence and inhumane treatment or punishment; right to protection from arbitrary arrest	People at risk of police or military violence or harassment (racial/ethnic, religious, sexual, and political minority groups)

TABLE 2. *Continued*

Intervention type	N	%	Potential human rights impacted	Vulnerable groups affected
Testing asymptomatic individuals	157	1.47	Right to protection against interference with individual privacy	People with disabilities or chronic diseases; people with poor access to health care; low-income people
Religious venue closures	91	0.85	Freedom of worship and religious practice, teaching, and observance	People belonging to religious or faith-based groups, particularly stigmatized minorities
Total interventions with potential human rights impact	7,116	71.67	—	—
Total interventions	10,720	100.00	—	—

thousands in detention camps, where they are extremely vulnerable to contracting COVID-19 due to crowded living conditions, poor ventilation, and other inhumane treatment.<sup>29</sup> As of July 9, 2020, the cumulative test positivity rate among ICE detainees was 22.7%.<sup>30</sup> However, an independent investigation by the Vera Institute of Justice indicated that COVID-19 testing at ICE facilities was too limited to capture the actual number of cases and that the real number may have been much higher.<sup>31</sup> Furthermore, communication records indicate that some ICE officials ignored COVID-19 safety recommendations. For example, in one San Diego detention facility, testing guidelines were ignored, detainees did not receive face masks for weeks, and detainees were required to sign a waiver “saying that it wasn’t our fault if we got sick,” according to one detainee.<sup>32</sup> Due to the decentralized oversight of ICE facilities, many of which are under private ownership, the COVID-19 response has been slow moving and uncoordinated, putting detainees at high risk for contracting the virus.<sup>33</sup>

**Quarantine and isolation.** Quarantine and isolation are ancient but effective public health mitigation measures dating back to medieval Europe, when incoming ships were quarantined to prevent plague transmission.<sup>34</sup> Today, quarantine and isolation are regarded as necessary but not sufficient outbreak prevention strategies, as they require

additional actions such as contact tracing.<sup>35</sup> Despite the importance of such measures in pandemic response, they may erode human rights, especially for marginalized populations such as detained people, refugees, immigrants, women, and children.<sup>36</sup> Thus, governments should consider their human rights impacts, particularly with regard to the right to safe shelter, the right to protection from violence, and the right to medical treatment, testing, and mental health services.<sup>37</sup> Further, these measures should not extend beyond the required minimum time period based on the incubation period of the virus.<sup>38</sup>

Quarantine and isolation policies during the COVID-19 pandemic have had negative consequences for vulnerable populations such as children because they increase the risk of abuse and neglect.<sup>39</sup> These policies can also have adverse effects on mental health that may last for years, and both social isolation and poor mental health are risk factors for violence.<sup>40</sup> Quarantine and isolation also increase the risk of domestic violence by increasing daily proximity to perpetrators of violence under stressful conditions.<sup>41</sup>

However, some policy makers have utilized quarantine and isolation orders as an opportunity to provide safe housing and health protection for vulnerable populations who are unable to isolate or quarantine. For example, New York City and Baltimore have hotel quarantine and isolation programs

for COVID-19 positive or suspected positive patients who cannot otherwise isolate due to housing instability or crowding. Both programs are offered at no cost and include free meals, and the Baltimore program offers assistance to undocumented individuals.<sup>42</sup>

**Limiting gatherings.** Article 20 of the UDHR declares the right to freedom of peaceful assembly and association to be fundamental.<sup>43</sup> Limiting gatherings is a crucial public health intervention to contain transmission of COVID-19, especially for preventing “superspreader” events.<sup>44</sup> However, limitations on gatherings can easily be used to restrict the fundamental right to protest, and some governments have utilized the banning of gatherings to suppress political protesters. For example, in Algeria, all forms of street protests were banned in March 2020, ending a year of mass anti-government demonstrations by the Hirak movement, although protests reemerged in February 2021.<sup>45</sup>

Limiting gatherings is also unfeasible for people living in crowded areas, including people experiencing homelessness, residents of slums, and refugees housed in camps. For such populations, it is unrealistic to avoid gatherings when crowding is an integral part of unstable housing conditions.<sup>46</sup> Unstably housed populations are often already at higher risk of COVID-19 due to systemic inequities such as poverty, lack of health care access, unemployment, preexisting health conditions, and unsanitary living conditions. For example, Dharavi, India’s largest slum, is one of the most densely populated areas of the world, with an area of 2.1 square kilometers and about one million residents. Crowded housing and limited sanitation mean that residents share both private and public spaces. Under these conditions, it is impossible for Dharavi residents to avoid gatherings, close contact, and crowding, which increases their risk of COVID-19 transmission.<sup>47</sup> By implicitly violating these restrictions, people in these communities may face stigma or judgment and, in turn, avoid seeking health care services when ill. While limiting gatherings has a clear public health justification, there are circum-

stances where blanket restrictions can repress vital freedoms and harm health.

**Household confinement.** Article 13 of the UDHR states that people have the right to freedom of movement.<sup>48</sup> Household confinement policies such as curfews, lockdowns, and stay-at-home orders are a significant component of the public health response to COVID-19 because they aim to protect individuals from exposure and transmission. Such policies often aim to shield medically vulnerable populations, such as elderly persons and pregnant people. Various studies have found associations between household confinement policies and decreased COVID-19 transmission and mortality.<sup>49</sup> However, household confinement also inherently restricts the right to freedom of movement. Household confinement policies are dangerous and potentially deadly for those facing unsafe conditions at home, such as violence and abuse.<sup>50</sup> Additionally, adherence to home isolation orders is difficult, perhaps impossible, for housing-insecure people such as residents of slums, people living in refugee camps, and people experiencing homelessness. Many groups already facing housing insecurity have experienced the exacerbation of human rights threats during the COVID-19 pandemic.

When household confinement orders are followed, individuals are at risk of social isolation, poor mental health outcomes, and limited access to necessities such as food, supplies, and health care.<sup>51</sup> To address these issues, in China, medically vulnerable populations such as elderly persons have increasingly turned to technology and mobile apps for essential services such as home delivery of food and supplies.<sup>52</sup>

In other cases, the enforcement of household confinement measures can be a dangerous excuse for military and police personnel to use violence and corruption. For example, during the first 10 days of Kenya’s curfew, excessive police force resulted in the deaths of at least six people and injuries to many others. The dusk-to-dawn curfew was enforced with police brutality, including shootings, beatings, whipping, tear gassing, looting, and

financial extortion. In some cases, police began such violence well before the curfew began. Videos also show police not wearing masks and physically crowding civilians together.<sup>53</sup> Overall, public health and legal experts have argued that voluntary self-isolation efforts, compared to coercive efforts, are more likely to result in cooperation and trust in the public health system.<sup>54</sup>

Another key human rights impact of household confinement (and the inherent movement restrictions) is the potential infringement of the right to health and well-being as protected by article 25 of the UDHR, specifically with regard to access to health care.<sup>55</sup> While such extreme movement restrictions may affect most of the population, their consequences are especially pronounced among populations with an increased need to access health care, such as pregnant women and young children. The COVID-19 pandemic has reduced maternal health care seeking and provision globally, and slum communities in low- and middle-income countries have been particularly disadvantaged in terms of access to health care services.<sup>56</sup> While the underlying mechanisms are complex and most likely multicausal, disruptions to routine health care have been estimated to result in devastating child and maternal mortality.<sup>57</sup> Additionally, household confinements to contain the spread of COVID-19 have led to major disruptions to routine childhood vaccination coverage, resulting in immunity gaps for other infectious diseases such as measles, which most likely will exacerbate the pandemic's detrimental effect on maternal and child health.<sup>58</sup>

## Discussion

This paper demonstrates that COVID-19 public health policies enacted in the first six months of the pandemic present potential human rights violations and discusses the need to design such policies in a way that centers the needs of vulnerable groups. While pandemic containment policies are essential for controlling transmission and reducing mortality, governments must be vigilant against these measures slipping into human rights abuses by design or by negligence.

We analyzed COVID-19-related public health policies implemented from January 1 to June 30, 2020. Using the UDHR standards as a guide, we found that 71.67% of the 10,720 interventions implemented in these six months had potential human rights impacts. In particular, we examined the five most common types of policies (school closures, border closures, quarantine and isolation, limiting gatherings, and household confinement) in further detail through a human rights lens. We found that some COVID-19 public health interventions may be impractical or impossible to adhere to for vulnerable groups, such as refugees, unstably housed people, low-income people, and undocumented individuals. For instance, household confinement orders are impractical to follow for people who are unstably housed due to lack of housing or living in overcrowded settings. These interventions may also put these groups and others at risk of further human rights violations. For example, people who cannot follow household confinement orders, such as the unstably housed, may face violence by members of the police or military who are enforcing household confinement with force.

This paper has limitations. First, our analysis was descriptive and deductive: we did not focus on any specific subpopulations or analyze empirical data related to human rights violations. We did not directly assess the human rights implications of COVID-19 policies and thus cannot provide a causal analysis of any specific human rights violations as a result of COVID-19 policies. Due to data availability, we were able to discuss only those policies enacted in the first six months of the pandemic, which does not cover more current concerns such as vaccine inequities and treatments for novel SARS-CoV-2 variants that will require additional human rights analysis. While this article focuses on public health restrictions, the emphasis on vulnerable communities and negative human rights impacts is also relevant to other aspects of the COVID-19 response, such as vaccine hesitancy, ongoing debates about mask mandates, and public acceptance of policies related to COVID-19. Finally, due to the underreporting of COVID-19 policies in low-income countries, our data are probably not

fully representative of all policies implemented in the study period.-

An in-depth consideration of *whom* public health policies impact and *how* they may disproportionately affect specific groups, intentionally or not, is critical to ensuring meaningful equity and effectiveness of interventions. This pandemic has exacerbated many preexisting societal inequities and human rights violations affecting marginalized populations, making it even more crucial to design intentionally equitable policy responses that are based on human rights principles.

Human rights, such as the rights to assembly, movement, religion, and privacy, can be negatively impacted by COVID-19 public health policies, particularly with regard to already marginalized or vulnerable people. Socially equitable interventions might be more tailored, focusing human rights restrictions on communities in limited ways, or enforcing them with consideration of the needs and abilities of vulnerable communities. Blanket public policies run the risk of violating basic human rights without the necessity and proportionality laid out in the Siracusa Principles and the ICESCR. This idea is informed by the harm reduction approach of the HIV/AIDS pandemic and acknowledges that a strict all-or-nothing approach is not practical for

all.<sup>59</sup> As a result, there is an urgent need to consider the protection of vulnerable populations from human rights abuses when implementing COVID-19 interventions and ensure that any derogations from human rights norms are conducted “in accordance with the law; based on a legitimate objective; strictly necessary in a democratic society; the least restrictive and intrusive means available; and not arbitrary, unreasonable, or discriminatory.”<sup>60</sup> These stipulations, laid out in the Siracusa Principles, could protect citizens from discriminatory and unnecessary restrictions but will require more concrete integration into national and local public health laws and policies in order to be effective. In authoritarian settings, reliance on international accountability mechanisms will be critical to protect vulnerable people.

Consideration of human rights may also increase the effectiveness of public health policies. With sweeping public health interventions, those who are already at higher risk of morbidity and mortality may be subjected to more severe health and economic costs. Without considering the costs and trade-offs of interventions and ensuring that their design considers their secondary impacts, such public health policies may paradoxically violate the right to health as defined by the World

TABLE 3. Recommendations for future policy and practice

<ul style="list-style-type: none"> <li>Engage individuals and leaders from disproportionately affected populations as equal partners in all aspects of the public health agenda and establish liaisons to their communities. Example: Place community liaisons from vulnerable groups on decision-making committees so that their expertise can inform policy design to address the needs of vulnerable communities.</li> </ul>
<ul style="list-style-type: none"> <li>Explicitly recognize the impact of public health interventions on human rights and emphasize a human rights-focused approach to COVID-19 public health policymaking. Example: Acknowledge human rights restrictions as consequences of COVID-19-related policies and incorporate the Siracusa Principles into national, state/provincial, and local laws and policies.</li> </ul>
<ul style="list-style-type: none"> <li>Identify specific populations that may be affected by particular policies and interventions and understand the specific risks and challenges arising from these policies. Example: Add local, state/provincial, and national-level reporting requirements on the differential impacts of public policies, such as stratification by gender, race, ethnicity, income, etc.</li> </ul>
<ul style="list-style-type: none"> <li>Improve data collection related to vulnerable populations and factors related to human rights and health equity for these groups. Example: Relay qualitative and quantitative feedback from monitoring public policy directly to policy makers to inform them about the impact of policies and the data needs for policy monitoring.</li> </ul>
<ul style="list-style-type: none"> <li>Use these data to guide the development of more robust, targeted public health policies and to refocus existing policies and interventions by centering the COVID-19 response around the most vulnerable and marginalized groups. Example: Ensure that future public health policies consider the impacts on vulnerable communities and that protections are formally integrated into legislation.</li> </ul>
<ul style="list-style-type: none"> <li>Focus support and resources on communities known to be particularly affected by specific policies. Example: Provide financial, social, and health service support for communities disproportionately impacted by COVID-19.</li> </ul>

Health Organization: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>61</sup> In doing so, these policies can risk worsening the health of marginalized communities.

## Recommendations for future policy and practice at the nexus of public health and human rights

We argue that public health interventions should (1) prioritize the most vulnerable and underserved populations, (2) ensure additional support for such communities, including access to financial, social, and medical resources, and (3) be formulated to consider not only pandemic control but also the health and human rights of those they impact. Based on our analysis, public health decision-makers must ensure that public health interventions are executed with a human rights lens by taking concrete steps in both policy and practice (see Table 3).

Decision-makers must follow a forward-thinking approach while constantly assessing and reassessing policies and restrictions for potential impacts on human rights and inequities. Likewise, policy decisions need to be adapted to emerging issues and challenges that arise during long-lasting crises. Whereas our analysis focused on the early phases of the COVID-19 pandemic, global inequities in access to COVID-19 vaccines have emerged as the dominant human rights issue in 2021, with high-income countries controlling the vast majority of the global vaccine supply.<sup>62</sup> Our database did not include information on vaccination policies, but this example strikingly demonstrates how both data collection and policymaking need to flexibly adjust to rapid developments to ensure that emerging human rights issues can be addressed in a timely manner.

While these recommendations can help reduce the negative human rights impacts of public health interventions, there will still be communities that disproportionately suffer. It is imperative that any utilitarian approach look deeply at the short- and long-term impacts on marginalized communities and establish concrete mechanisms for redress and

compensation.<sup>63</sup> This could include financial support, additional health services, health insurance coverage, policy changes, and social support. While these steps may be aspirational in practice, they are required to build a healthier and fairer world. Curbing the COVID-19 pandemic requires a strong public health response—but to do it equitably and effectively requires a human rights framework.

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# A Global Review of Provisions on Emergency Care in National Constitutions

TAYLOR W. BURKHOLDER, MADELINE ROSS, LILY VARTANYAN, AND HARVEEN BERGQUIST

## Abstract

National constitutions are important tools for the realization of the right to health, and constitutional law linking health and human rights has been associated with improved access to health resources. Meanwhile, emergency care is a lifesaving service delivery platform with the potential to address much of the death and disability in low- and middle-income countries (LMICs). Yet even where services exist, access to emergency care may be systematically limited for vulnerable populations, except where laws explicitly protect the right to emergency care. We therefore sought to catalog and describe constitutional provisions related to emergency care. Through a comprehensive review of 195 national constitutions, we searched provisions for terms related to emergency care and performed qualitative framework analysis on these provisions. Eleven provisions met inclusion criteria, representing ten LMICs with constitutions written since 1996. While seven of the eleven provisions guarantee access to emergency care to all people, three narrow this guarantee to citizens only. Only three constitutions address the affordability of emergency care. While these constitutional provisions represent an important step toward the legal guarantee of access to emergency care for all people, further attention must be paid to the impact of such laws and regulation on the accessibility of emergency care and its related reduction of death and disability globally.

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## Introduction

Emergency medical conditions—including injuries, communicable and noncommunicable diseases, acute decompensation of chronic conditions, and complications of pregnancy—require timely, high-quality care to prevent death and permanent disability.<sup>1</sup> These health conditions are estimated to represent over half of global deaths and up to 2.1 billion disability-adjusted life years annually.<sup>2</sup> Whereas other parts of the health system may be incapable of the timely recognition and management of such conditions, emergency care is a service delivery platform intentionally oriented toward timely identification and management.<sup>3</sup> The integration of emergency care systems into the overall health system therefore has potential to save lives, particularly in low- and middle-income countries (LMICs), where the burden of these conditions is highest and the outcomes are disproportionately worse.<sup>4</sup>

Access to emergency care is markedly limited in much of the world. Estimates in Africa, for example, suggest that only 71% of people live within two hours of a hospital that could potentially provide emergency care.<sup>5</sup> Yet this method likely overestimates the true availability and accessibility of emergency care in these countries, since many hospitals do not have the trained personnel and resources capable of providing adequate emergency care.<sup>6</sup> Additionally, there are many other barriers to accessing emergency care that are not included in this geospatial method of estimating access. Issues of affordability (financial accessibility), discrimination against vulnerable populations, and quality and acceptability of emergency care practices can also create barriers to accessing care during a health emergency.<sup>7</sup> Barriers to accessing emergency care have been linked to delays in receiving care and to avoidable deaths.<sup>8</sup>

Reports of people being barred from hospitals due to the inability to levy upfront payments, or being required to purchase emergency medications and supplies before they can be administered, are not uncommon.<sup>9</sup> These and other barriers to accessing emergency care not only result in otherwise avoidable death and disability but also represent

systematic violations of human rights. As of the early 2000s, all nations had ratified at least one international treaty that enshrines the right to the highest attainable standard of health.<sup>10</sup> According to the United Nations Committee on Economic, Social and Cultural Rights' General Comment 14, the right to the highest attainable standard of health can be framed in terms of the AAAQ framework: availability, accessibility, acceptability, and quality. Special attention is paid to two dimensions of accessibility—nondiscrimination and affordability—to avoid the exclusion of vulnerable populations from health care programs.<sup>11</sup> The time-dependent nature of emergency conditions leaves people vulnerable to undue financial demands from providers and facilities. The concept of a right to emergency care has recently entered the academic discourse, along with a call to include a rights-based approach to developing emergency care systems.<sup>12</sup>

Simultaneously, the global agenda on universal health coverage focuses on improving access to care, ensuring quality care, and protecting against financial risk.<sup>13</sup> Recognizing this and the potential to save substantial lives, the 72nd World Health Assembly passed Resolution 72.16, titled “Emergency Care Systems for Universal Health Coverage: Ensuring Timely Care for the Acutely Ill and Injured,” in May 2019.<sup>14</sup> The resolution signals a public commitment by United Nations member states to build and strengthen emergency care systems that will improve access to and the affordability of lifesaving care as an essential component of the overall health system.

As part of its guidance on the development of such health system frameworks, the World Health Organization (WHO) has described six “building blocks” fundamental to best practices in this process. The sixth building block, leadership and governance, is vital to achieving high levels of availability and accessibility of quality emergency care within the broader health system. The realization of good governance relies on the coordination of varying, yet overlapping, mechanisms to formalize intended health system frameworks among a wide spectrum of actors, including governments, nongovernmental organizations, private compa-

nies and corporations, medical practitioners, the general public, and others. These mechanisms span all levels of organization, including international treaties, national constitutional and statutory law, and national and local regulations, guidelines, and policies.

At the highest level, international treaties obligate the ratifying parties to fulfill legal stipulations in the agreement. A recent comprehensive review of United Nations treaties found that eight treaties included language directly addressing the need for emergency and essential surgical care and anesthesia.<sup>15</sup> Given that emergency care systems are integral to the provision of emergency and essential surgical care and anesthesia, these treaty provisions can be applied to emergency care as a surrogate.

Although the enforcement of international treaties is challenging and often limited, these human rights laws have been used at the national level to substantiate legal claims around access to essential medications.<sup>16</sup> The use of international treaties in such a way may obviate the need for domestic law in countries that have ratified one of these treaties if a judicial challenge rules that the treaty obligations apply to the provision of emergency care.

However, given the inconsistency with which international treaties are both upheld and applied on a country-by-country basis, constitutional law serves as a powerful mandate to guarantee the right to health at the national level. Despite how widely legal systems vary in structure around the world, constitutions can be readily appraised and comparatively analyzed given their inherent uniformity in existence.<sup>17</sup> Constitutional law has previously been shown to produce tangible results. One study found that constitutional law was the most important contributor to expanding access to essential medications, as demonstrated by favorable judicial rulings when the right to access such medications was challenged in court.<sup>18</sup> These laws can serve both as indicators of nations' commitment toward health-related rights and as foundational directives in the creation of health policies and programs.<sup>19</sup>

### *Study objective*

To date, there have been no formal studies regarding

the existence or content of laws governing access to emergency care globally. Therefore, legislators and policy makers have a paucity of information on how to best draft and reform laws governing access to emergency care. Although we do not seek to develop a single "model text" for countries wishing to implement constitutional laws or amendments—owing to the complex nature of cultures, resource availability, and health care systems internationally—an analysis of common components of existing laws is likely to be useful for policy makers who are considering this approach to governing emergency care accessibility. In this study, we sought to (1) quantify and catalog constitutional provisions on emergency care worldwide and (2) qualitatively describe the characteristics of existing constitutional provisions on emergency care.

## Methods

### *Comprehensive review*

We conducted a comprehensive review of national constitutions from 195 countries as compiled by the Constitute Project (<https://www.constitute-project.org>). All constitutions were retrieved in their original English versions or English-language translations on January 26, 2019, and subsequently imported into ATLAS.ti to search for the terms "emergency," "illness," "injury," "life threatening," "life-threatening," "medical care," "medical treatment," "healthcare," "health-care," and "health care." Any constitutional provision (also known as clause or article) containing a search term was then compiled into Microsoft Excel for screening.

Two independent reviewers (MR and LV) screened each identified constitutional provision for inclusion if it was an original article or amendment that pertained to the delivery of emergency or acute care in any facility or pre-hospital setting for an individual experiencing a perceived health emergency. Provisions were excluded if they (1) addressed a state of national emergency or other non-health emergency law or regulation (e.g. armed conflict), (2) addressed a disaster or infectious epidemic rather than an everyday, individual health emergency, (3) addressed the health status of an

elected or appointed official as it related to his/her ability to perform the duties of office, (4) addressed non-health emergencies (e.g. fire, hostage situation, legal damages), or (5) related to health care provision or protected health status but did NOT directly address emergency or acute care. The final exclusion criteria were selected in order to focus the review on constitutional law that directly and unmistakably guarantees access to emergency care. A senior reviewer (TB) resolved any discordant inclusion decisions and randomly re-screened an additional 10% of the provisions to ensure systematic agreement.

Data collection in MS Excel included verbatim text from the included provision(s) as well as the country name, year of ratification, and amendment status. Three reviewers (TB, MR, HB) then conducted a framework analysis using a mixed inductive and deductive qualitative approach. A mixed approach was selected in order to explore overlap with previously identified domains of the right to emergency care while also leaving space to discover unexpected components of existing constitutional provisions. Using a set of preliminary codes, the reviewers independently coded the constitutional texts according

to pre-existing analytical frameworks, with new codes inductively added as deemed necessary by the reviewers. The code book was refined and texts were iteratively coded until consensus was reached by all reviewers and no new codes emerged. Thematic analysis of the codes was performed in ATLAS.ti followed by indexing according to framework analysis in MS Excel.

### *Analytical framework*

This review employed the use of three existing frameworks for the right to the highest attainable standard of health (“right to health”) and constitutional laws pertaining to right to health issues (Box 1). The first two frameworks draw from international human rights standards outlined in General Comment 14. Provisions pertaining to the right to health can be categorized by the type of legal obligation and by the AAAQ framework. Legal obligations can be divided into responsibilities to respect, protect, and promote (or fulfill) the right to health, while the AAAQ framework classifies right to health issues according to availability, accessibility, acceptability, and quality.<sup>20</sup> Legal obligations and the AAAQ framework are therefore

Box 1. Constructs used for framework analysis of constitutional provisions

#### **1. Availability, accessibility, acceptability, and quality (AAAQ):**

**Availability:** Health facilities and services are present in sufficient quantity.

**Accessibility:** Health facilities and services are within reach and can be utilized by everyone without discrimination.

**Acceptability:** Health facilities and services are respectful of medical ethics and culturally appropriate.

**Quality:** Health facilities and services are scientifically and medically appropriate and of good quality.

#### **2. Respect, protect, and promote:**

**Respect:** States refrain from interfering with the enjoyment of the right to health.

**Protect:** States take measures that prevent third parties from interfering with the right to health.

**Promote:** States adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures toward the full realization of the right to health.

#### **3. Kinney-Clark typology:**

**Statement of aspiration:** The constitution states a goal in relation to the health of the country's citizens.

**Statement of entitlement:** The constitution enshrines a right to health, health care, or public health services.

**Statement of duty:** The constitution imposes a duty to provide health care or public health services.

**Programmatic statement:** The constitution specifies approaches for the financing, delivery, or regulation of health care and public health services.

**Referential statement:** The constitution specifically refers to an international or regional human rights treaty recognizing a human right to health or health care.

clear, objective classifications of constitutional law that guarantee access to emergency care, and they have previously been used to analyze constitutional texts in other health system domains.<sup>21</sup>

The third framework used was derived from the Kinney-Clark typology of constitutional provisions on health.<sup>22</sup> In this taxonomy, constitutional provisions can be divided into five categories based on the intent and function of the provision: statements of aspiration, statements of entitlement, statements of duty, programmatic statements, and referential statements (Box 1). Classifying provisions that pertain to access to emergency care according to this framework allows for a more objective assessment of the level of government commitment and potentially of the enforceability of the law.

## Results

From the 195 constitutions compiled and searched, a total of 1,280 unique provisions were identified for screening, of which 1,269 were excluded based on predefined criteria. Eleven articles ultimately met inclusion, representing ten countries with constitutional laws containing provisions regarding emergency care (Appendix 1). Figure 1 shows the PRISMA flow diagram of screening results.

All ten countries are classified by WHO as low- or middle-income countries (three are classified as low income, four as lower-middle income, and three as upper-middle income). When mapped according to WHO regions, six of the ten countries are located in the African region. The remaining four countries are located in the Americas, the Eastern Mediterranean, the Western Pacific, and Southeast Asia. The earliest constitution to include a provision guaranteeing emergency care was passed in 1996.

As classified by the AAAQ framework, none of the included constitutional provisions directly addresses the availability, acceptability, or quality of emergency care. However, accessibility is addressed by nine of the ten constitutions in two distinct ways: nondiscrimination and affordability. Six of the constitutions guarantee universal access to emergency

care; three limit access to citizens only; and one implies (but does not directly specify) accessibility as it relates to nondiscrimination, stating that “for no reason” may a person be refused care. In terms of affordability, free emergency care is guaranteed in two of the ten constitutions (Sudan and South Sudan). Affordability is additionally addressed by one further constitution (Somalia), which states that access could not be limited by “economic capability.” Figure 2 maps countries with constitutional provisions on emergency care according to the AAAQ framework.

When analyzed under the obligations set forth by General Comment 14, the constitutional provisions were found to incorporate varying levels of commitment to the fulfillment of emergency care. One country (Zimbabwe) addresses all three levels of obligation: to respect, to protect, and to promote. However, the remaining nine countries are split, with five requiring respect for emergency care and four imposing protection of the right to emergency care.

Finally, as coded by the Kinney-Clark typology, six constitutions include statements of entitlement and five include statements of duty (Zimbabwe included statements of both), all surpassing the most basic level of statement of aspiration, but none addressing programmatic or referential imperatives. The combined results of the framework analysis are reported in Table 1.

## Discussion

Only 10 constitutions out of the 195 screened include provisions related to emergency care, demonstrating that a minority of countries have chosen to guarantee emergency care as a right in their most fundamental law. The reasons for this are likely multifactorial. The second half of the 20th century saw both a growth in the human rights movement, with an increase in the recognition of the right to health, and a surge in the adoption of constitutions containing more detailed rights, including not only civil and political rights but also economic, social, and cultural rights. All nations have now ratified at least one international agreement articulating

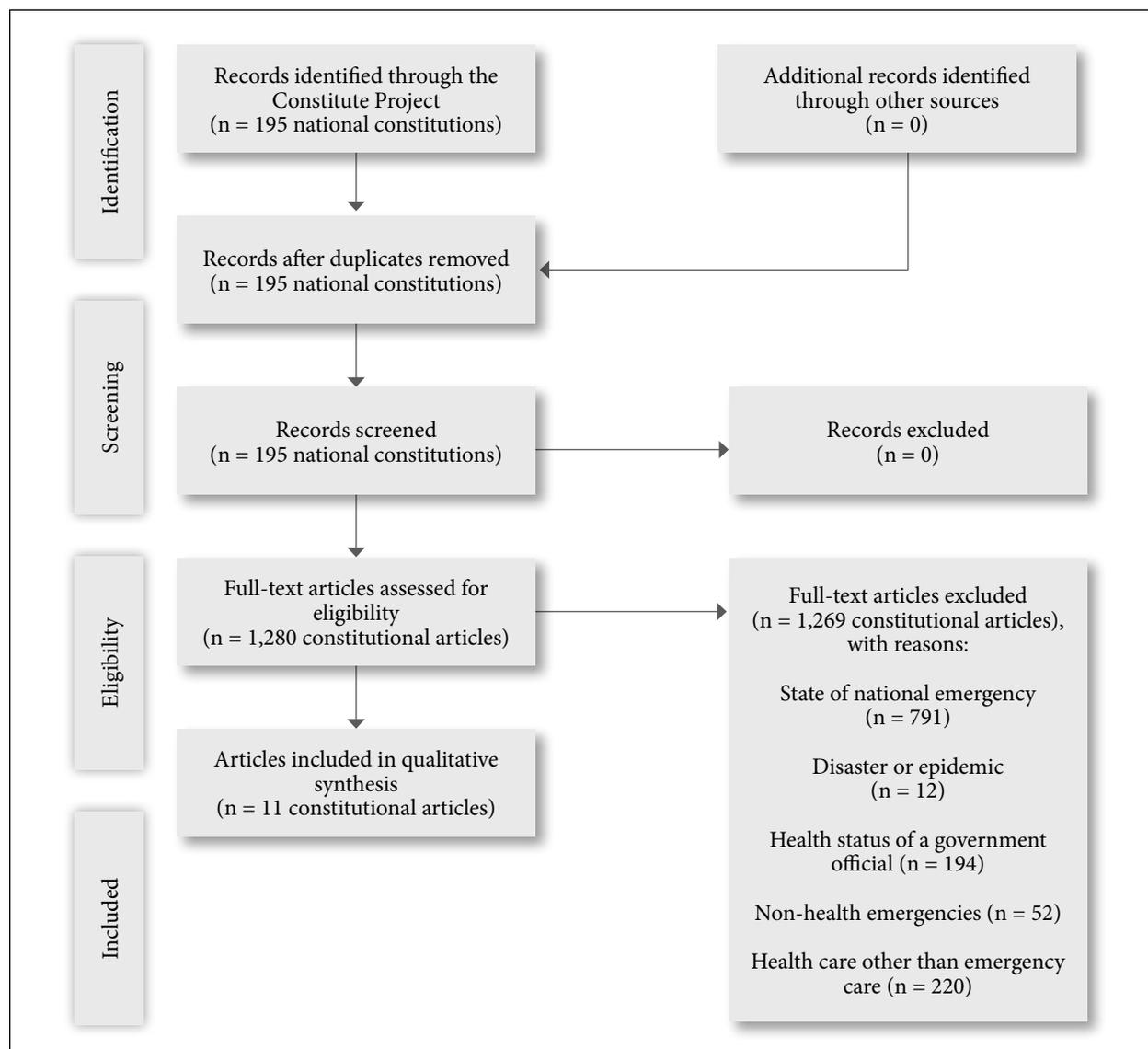
the right to health. Since then, several studies have demonstrated an increasing number of nations incorporating variations of health-related provisions in their national constitutions.<sup>23</sup>

Emergency care, however, is a newer health system delivery innovation, only recently acknowledged in many health system frameworks. Constitutions adopted before the advent of emergency care in the mid to late 20th century, and much later for many countries, are not likely to reference this system. As a result, all 10 of the constitutions included in our study were written or revised after 1996, with South Africa representing

the earliest incorporation of an emergency care provision into a constitution. We did not encounter any constitutional amendments that address a right to emergency care in those countries whose constitutions predate the advent of emergency care.

Countries with constitutional provisions meeting our inclusion criteria revealed an Afro-centric geographic distribution and a predominance of low- and middle-income levels. According to Jody Heymann et al., provisions addressing the overall right to health, defined as “constitutional references to physical or overall well-being, health protection, health security and/or a life free of illness or dis-

FIGURE 1. PRISMA flow diagram



ease,” are most common in low-income countries.<sup>24</sup> Not surprisingly, constitutions incorporating a right to emergency care as part of the right to health also demonstrate this predominance.

It may be more crucial for governments and policy makers in LMICs to support a constitutional right to emergency care, given that emergency care systems have been shown to address a wide range of illnesses and injuries that disproportionately lead to death and disability in LMIC populations.<sup>25</sup> Others have theorized that the constitutional incorporation of economic, social, and cultural rights plays a different role in different types and stages of national systems. With regard to the right to health, Colleen Flood and Aeyal Gross recommend that nations transitioning to democracy, and thus toward equity in general, include health rights in their constitutions in an attempt to address societal inequities.<sup>26</sup>

Acknowledging the important role that national constitutions can play in fulfilling the right

to health, we focused our framework analysis on the AAAQ framework from General Comment 14. The first essential element of the AAAQ framework is availability. Though the availability of emergency care may seem implicit in the discussion of accessibility of such services, none of the 10 constitutions referencing emergency care explicitly mandate that the care exist in sufficient quantity.

In contrast, accessibility is addressed in all 10 constitutions. In General Comment 14, accessibility is subdivided into the categories of nondiscrimination, physical accessibility, affordability, and information accessibility. Nondiscrimination in emergency care is best addressed by six of the ten constitutions. Kenya stipulates universal access by stating that “[a] person shall not be denied emergency medical treatment.”<sup>27</sup> Meanwhile, South Africa decrees that “[n]o one may be refused emergency medical treatment.”<sup>28</sup> In another example of nondiscrimination, Egypt states that “[d]enying any form of medical treatment to any human

FIGURE 2. Map of countries with constitutional provisions on emergency care



in emergency or life-threatening situations is a crime.<sup>29</sup> A seventh constitution (Ecuador) implies this same universal access, as well as the accompanying enforcement, in its article 365, stating that “[f]or no reason shall public or private institutions

or healthcare professionals refuse emergency care. This refusal shall be punishable by law.<sup>30</sup> The remaining three countries that address emergency care in constitutional provisions inherently limit access by using the term “citizen” in place of “per-

TABLE 1. Framework analysis: Characteristics of constitutional provisions

Country	WHO region	Income level*	Article number	Kinney-Clark typology†	Access: Affordability	Access: Nondiscrimination	Government obligation‡
Ecuador	Americas	Upper-middle income	365	Duty	Not specified	N/S	Protect
Arab Republic of Egypt	Eastern Mediterranean	Lower-middle income	18	Duty	Not specified	All people	Protect
Republic of Fiji	Western Pacific	Upper-middle income	38	Entitlement	Not specified	All people	Respect
Republic of Kenya	Africa	Lower-middle income	43.2	Entitlement	Not specified	All people	Respect
Federal Democratic Republic of Nepal	Southeast Asia	Low income	35.1	Entitlement	Not specified	Limited (citizens)	Respect
Federal Republic of Somalia	Africa	Low income	27.2	Entitlement	Addressed	All people	Respect
Republic of South Africa	Africa	Upper-middle income	27.3	Entitlement	Not specified	All people	Respect
Republic of South Sudan	Africa	Low income	31	Duty	Free	Limited (citizens)	Promote
Republic of the Sudan	Africa	Lower-middle income	46	Duty	Free	Limited (citizens)	Promote
Republic of Zimbabwe	Africa	Lower-middle income	29.2	Duty	Not specified	All people	Protect
			76	Duty & entitlement			Respect & promote

\* 2019 World Bank income classification (datahelpdesk.worldbank.org)  
 † The Kinney-Clark typology classifies constitutional provisions into statements of duty, entitlement, or aspiration, as well as programmatic or referential statements  
 ‡ As defined by General Comment 14

son” or “human.” For example, Nepal specifies that “no citizen shall be deprived of emergency health care,” thereby excluding vulnerable and marginalized populations, such as migrants or refugees, and potentially violating principles of the right to health.<sup>31</sup>

Affordability, as a subclassification of accessibility, is addressed by only three constitutions, two of which are classified as low income and one as lower-middle income by the World Bank. Sudan and South Sudan both state that emergency care will be free. Somalia, meanwhile, states that “no one may be denied healthcare for any reason, including lack of economic capability.”<sup>32</sup> In practice, these commitments will require substantial governmental funding or insurance schemes. It is important to note that seeking care has been linked to catastrophic health expenditures, further worsening the cycle of poverty and poor health.<sup>33</sup> In the context of emergency conditions, this is likely even more important for LMICs that are saddled with a disproportionate burden of conditions amenable to emergency care.<sup>34</sup> The two other categories of accessibility—physical and information accessibility—are not specifically addressed in any of the constitutions included in our study.

Likewise, the notion of acceptability—which encompasses cultural appropriateness and abidance by medical ethics—is not addressed by any of the 10 constitutions. Nor is quality, which refers to scientific or medical appropriateness. Without an emphasis on these attributes at the constitutional level, downstream policymaking may not yield focused guidance on these core components of comprehensive, effective emergency care delivery. Furthermore, any benefit that the availability and accessibility of emergency care affords may be negated if the care does not successfully manage the death and disability of emergent medical conditions through quality emergency care. As much as the human rights-based approach to health system development aims to develop the “capacity of duty bearers to meet their obligations,” it also serves to empower “rights-holders to effectively claim their health rights.”<sup>35</sup> Without explicit attention to the acceptability or quality of emergency care systems

in the law, it remains unclear if rights-holders will be able to demonstrate these rights as effectively in the judicial system.

When we applied the Kinney-Clark typology for health-related provisions in national constitutions, we classified the majority of articles as either statements of duty or statements of entitlement. For example, article 29 of the Constitution of Zimbabwe reads, “The State must take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution,” representing a statement of duty on the part of the government.<sup>36</sup> In contrast, article 38.2 of the Constitution of Fiji states, “A person must not be denied emergency medical treatment,” enshrining an entitlement of the people but not specifically addressing the role of the government.<sup>37</sup> We found no constitutional provisions that could be classified as statements of aspiration, programmatic statements, or referential (to treaties or other statutes) statements. While programmatic statements would have been more detailed and prescriptive, it is not surprising that this level of detail is often omitted from constitutional provisions. However, the statements of duty and entitlement serve to prioritize a particular agenda and enable subsequent legislation, regulation, and judicial rulings that elaborate on the specifics of the guarantee of access to emergency care.

According to General Comment 14, governments must respect, protect, and promote (or fulfill) the right to health. Of the 11 provisions identified in our search, many contain language that suggest an obligation to respect or protect a right to emergency care, yet only three contain language that implies a duty to actively promote this right. Whereas the obligation to respect requires nations to refrain from interfering with the right to emergency care and the obligation to protect requires nations to prevent third parties from violating the right, an obligation to fulfill or promote would necessitate nations to “adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures toward the full realization of the right to health.”<sup>38</sup>

The overall significance of identifying 10 con-

stitutions that address access to emergency care in LMICs is twofold. From a human rights perspective, these provisions establish a legal guarantee for access to a lifesaving service that, without such laws, could be afforded to some but denied to others based on factors such as ability to pay, national origin, or other discriminated status. From a public health perspective, these constitutional provisions—in conjunction with not-yet catalogued laws and regulations—are hypothesized determinants of increased access to quality emergency care. The aim of increasing access to quality emergency care is to reduce a substantial proportion of the global burden of disease that disproportionately affects LMICs. While there have been no studies demonstrating an association between constitutional laws and improved health emergency outcomes, anecdotal descriptions of post-ratification progress in countries such as Kenya and South Africa suggest that constitutional laws should not be ignored by policy makers. In fact, the increasing use of such constitutional provisions since their first appearance in 1996 could indicate a trend toward the adoption of constitutional guarantees of emergency care in more countries in the near future.

### *Limitations*

Our study is limited to constitutional law, and as such, our results do not necessarily correlate with the prevalence or characteristics of other governance mechanisms for guaranteeing access to emergency care, such as statutory law (legislation), regulations, policies, and court rulings. For example, the United States, with a constitution long predating the advent of emergency care, has a statute protecting people's right to access emergency care (called the Emergency Medical Treatment and Labor Act) but does not have a constitutional guarantee.<sup>39</sup>

The Constitute Project is a repository of national constitutions and includes English translations of documents originally published in other languages. There is thus the potential for subtle alterations in the meaning of articles that have been translated into English. Our search returned only 11 provisions from 10 national constitutions, and

many of these provisions employ similar wording. The limited number of texts available for qualitative analysis and the homogeneity of their wording restricts the identification of other important themes for legislating access to emergency care. Finally, our study did not aim to correlate the presence of constitutional provisions on emergency care to any real-time markers of accessibility or emergency care system development.

Further studies are needed to understand the impact and effectiveness of constitutional provisions on emergency care. There remain questions regarding downstream legislation and regulation, as well as the judicial challenges that are made possible by such constitutional provisions. With a limited number of constitutions containing guarantees of emergency care accessibility, it is not currently feasible to correlate with health or human rights outcomes without a more detailed causal link analysis. However, countries such as Kenya have seen further codification of the right to emergency care since the passage of their constitutions, including through legislation and regulations that further detail and codify the right to emergency care.<sup>40</sup> Future studies are needed to assess the degree to which these constitutional rights impact health and human rights outcomes. Such analysis could provide insights into the barriers that need to be overcome in order to truly guarantee access to emergency care. Additionally, there remains uncertainty regarding which components (e.g., scope of coverage, types of obligations, penalties, and enforcement) of emergency care legislation are necessary, which components can be practically and ethically modified to cultural context and resource availability, and which financing options are best suited to govern access to emergency care.

### *Conclusion*

Constitutional law has the potential to empower governments to respect, protect, and promote the right to emergency care, an essential lifesaving health resource. As demonstrated by our review of national constitutions from 195 countries, constitutional guarantees of this right currently exist on a

limited basis and are phrased as either statements of duty or statements of entitlement. They address nondiscrimination and affordability but do not address the acceptability or quality of emergency care. Despite the limited number of constitutions that guarantee access to emergency care, the provisions of the 10 that were identified speak to the potential to harness such governance tools to expand the right to emergency care where none previously

existed. While consensus is still needed regarding the most essential components of these provisions, these findings demonstrate a recent movement to codify and guarantee emergency care in many of the countries that are most in need of strengthened emergency care systems. The international community is urged to consider how constitutional laws can best improve the availability, accessibility, acceptability, and quality of emergency care globally.

#### APPENDIX 1. Full text of constitutional provisions on emergency care

Country	Year of ratification	Article number	Article text
<b>Ecuador</b>	2008 (revised 2015)	365	For no reason shall public or private institutions or healthcare professionals refuse emergency care. This refusal shall be punishable by law.
Arab Republic of <b>Egypt</b>	2014	18	Every citizen is entitled to health and to comprehensive health care with quality criteria. The state guarantees to maintain and support public health facilities that provide health services to the people, and work on enhancing their efficiency and their fair geographical distribution. The state commits to allocate a percentage of government expenditure that is no less than 3% of Gross Domestic Product (GDP) to health. The percentage will gradually increase to reach global rates. The state commits to the establishment of a comprehensive health care system for all Egyptians covering all diseases. The contribution of citizens to its subscriptions or their exemption therefrom is based on their income rates. Denying any form of medical treatment to any human in emergency or life-threatening situations is a crime. The state commits to improving the conditions of physicians, nursing staff, and health sector workers, and achieving equity for them. All health facilities and health related products, materials, and health-related means of advertisement are subject to state oversight. The state encourages the participation of the private and public sectors in providing health care services as per the law.
Republic of <b>Fiji</b>	2013	38	1. The State must take reasonable measures within its available resources to achieve the progressive realisation of the right of every person to health, and to the conditions and facilities necessary to good health, and to health care services, including reproductive health care. 2. A person must not be denied emergency medical treatment.
Republic of <b>Kenya</b>	2010	43	1. Every person has the right- a. to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; 2. A person shall not be denied emergency medical treatment.
Federal Democratic Republic of <b>Nepal</b>	2015 (revised 2016)	35	1. Every citizen shall have the right to seek basic health care services from the state and no citizen shall be deprived of emergency health care. 2. Each person shall have the right to be informed about his/her health condition with regard to health care services. 3. Each person shall have equal access to health care. 4. Each citizen shall have the right to access to clean water and hygiene.
Federal Republic of <b>Somalia</b>	2012	27	1. Every person has the right to clean potable water. 2. Every person has the right to healthcare, and no one may be denied emergency healthcare for any reason, including lack of economic capability.
Republic of <b>South Africa</b>	1996 (revised 2012)	27	1. Everyone has the right to have access to- a. health care services, including reproductive health care; b. sufficient food and water; and c. social security, including, if they are unable to support themselves and their dependents, appropriate social assistance. 2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. 3. No one may be refused emergency medical treatment.

APPENDIX 1. *Continued*

Country	Year of ratification	Article number	Article text
Republic of <b>South Sudan</b>	2011 (revised 2013)	31	All levels of government shall promote public health, establish, rehabilitate and develop basic medical and diagnostic institutions and provide free primary health care and emergency services for all citizens.
Republic of the <b>Sudan</b>	2005	46	The State shall promote public health, establish, rehabilitate, develop basic medical and diagnostic institutions, provide free primary health care and emergency services for all citizens.
Republic of <b>Zimbabwe</b>	2013 (revised 2017)	29	1. The State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe. 2. The State must take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution. 3. The State must take all preventive measures within the limits of the resources available to it, including education and public awareness programmes, against the spread of disease.
		76	1. Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services. 2. Every person living with a chronic illness has the right to have access to basic healthcare services for the illness. 3. No person may be refused emergency medical treatment in any health-care institution. 4. The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section.

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# Physical Activity as a Human Right?

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## Abstract

Public awareness of the importance of physical activity has increased due to the many lockdowns imposed during the COVID-19 pandemic. This has brought more widespread attention to a question previously confined primarily to parts of the physical activity promotion community: Do humans have a right to be active? While the public health benefits of physical activity are undisputed, up to now no clear understanding has emerged as to whether physical activity represents a human right. Even though the right to physical activity is not explicitly recognized in international human rights treaties, it seems possible to derive it from well-established human rights such as the right to health, the right to rest and leisure, the right to education, and the principle of nondiscrimination. This paper shows how a right to physical activity could be derived from international human rights treaties, how the attributes of such a right could be defined, and which state obligations would be associated with it. Given that the current human rights discourse in this field focuses mainly on the interconnections between sport and human rights, we would like to argue that there is added value in a debate about physical activity as a human right.

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## Introduction

The quarantines, curfews, and other political restrictions imposed by governments around the world to counteract the COVID-19 pandemic have severely restricted the mobility of people in many countries. During the initial lockdowns in many countries in the spring of 2020, some governments allowed people to play individual sports or to go for walks, while others did not recognize physical activity as a sufficiently relevant reason for going outside.<sup>1</sup> As a result, public awareness of the importance of physical activity has increased, at least in many European countries.<sup>2</sup> This has brought more widespread attention to a question previously confined primarily to parts of the physical activity promotion community: Do humans have a right to be active?

From a public health perspective, sufficient health-enhancing physical activity is highly relevant due to its numerous health benefits. As a concept, health-enhancing physical activity includes any physical activity that benefits health and functional capacity without undue harm or risk.<sup>3</sup> This includes sport in a narrow sense, but also activities such as hiking, biking to work, cleaning the house, gardening, and taking the stairs at the office. Systematic reviews have shown that there is a dose-response relationship between physical activity on the one hand and premature mortality and the prevention of chronic diseases (such as type II diabetes, certain types of cancer, and many cardiovascular diseases) on the other.<sup>4</sup> Additionally, studies have shown that physical inactivity is responsible for premature mortality and causes several million deaths per year worldwide.<sup>5</sup>

Consequently, the low prevalence of physical activity is a global problem that affects both highly industrialized countries and a growing number of developing nations.<sup>6</sup> In response, international organizations have developed evidence-based recommendations on the amount and intensity of physical activity for different age groups, accompanied by documents providing policy guidance to national governments.<sup>7</sup> At the country level, many governments have developed their own physical activity promotion policies in accordance with such

public health recommendations.<sup>8</sup>

While the public health benefits of physical activity are undisputed, up to now no clear understanding has emerged as to whether physical activity represents a human right. Arguably the most specific document on this issue is the International Charter of Physical Education, Physical Activity and Sport adopted in 2015 by UNESCO's General Conference.<sup>9</sup> Based on an earlier UNESCO document from 1978, the charter declares that every human being has a fundamental right of access to physical education, physical activity, and sport.<sup>10</sup> The World Health Organization's Global Action Plan on Physical Activity refers to this charter and states that a human rights-based approach should be a guiding principle for countries during the implementation of the action plan.<sup>11</sup> In addition, the Special Rapporteur on the right to health has emphasized the obligation of states "to reduce the extent to which individuals adopt unhealthy or risky lifestyles," including physical inactivity, a position that has also been supported by the United Nations General Assembly.<sup>12</sup> Besides these documents, however, the idea of physical activity as a fundamental right has, to our knowledge, not been reflected on in other major international human rights documents or in the academic literature on human rights so far.

By contrast, other health-related behaviors (such as nutrition, smoking, and alcohol consumption) have already been investigated from a human rights perspective. In the field of nutrition, numerous studies have been conducted in recent years, especially in the context of the human right to adequate food.<sup>13</sup> Similarly, the human rights literature has investigated tobacco production and smoking, as well as certain aspects of alcohol consumption.<sup>14</sup>

This paper aims to shed light on the question whether there is a human right to physical activity, how such a right could be defined in concrete terms, and which state obligations would be associated with a right to physical activity. The paper focuses only on the interface of human rights and the promotion of health-enhancing physical activity. It is beyond the scope of this paper to discuss human rights violations in the sport sector.

## Is physical activity a human right?

The UNESCO charter postulates that the practice of physical education, physical activity, and sport is a fundamental right for all.<sup>15</sup> However, because the right to physical activity is not explicitly recognized in international human rights documents, it needs to be derived from well-established human rights. In this section, we demonstrate how a right to physical activity can be linked to the Universal Declaration of Human Rights (UDHR); International Covenant on Economic, Social and Cultural Rights (ICESCR); Convention on the Rights of the Child (CRC); Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); and Convention on the Rights of Persons with Disabilities (CRPD).<sup>16</sup>

The right to health is of particular relevance for deriving a right to physical activity. The right to health is established in article 25 of the UDHR, which states that everyone has the “right to a standard of living adequate for the health and well-being of himself and of his family.”<sup>17</sup> Similarly, article 12 of the ICESCR recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”<sup>18</sup> Similar wording is used in article 24 of the CRC and article 25 of the CRPD.<sup>19</sup> It is generally acknowledged in the scientific literature that physical activity can contribute to achieving the highest attainable standard of health since it has many proven health-promoting effects.<sup>20</sup>

Additionally, the right to physical activity is related to the right to rest and leisure, which is enshrined in article 24 of the UDHR and article 7 of the ICESCR.<sup>21</sup> The right includes periodic holidays with pay and a reasonable limitation of working hours. Scientific evidence suggests that there is a relationship between hours worked and leisure-time physical activity.<sup>22</sup> The right to rest and leisure is also part of other conventions: article 31 of the CRC, for instance, creates a link to the right “to engage in play and recreational activities appropriate to the age of the child.”<sup>23</sup> In its general comment on this right, the Committee on the Rights of the Child highlights the importance of play and recreation for children and notes, for example, that

play involves physical activity and that recreation includes participation in sports.<sup>24</sup> Furthermore, the committee draws attention to children who require particular attention to realize this right, such as girls (who generally have a higher prevalence of insufficient physical activity), children living in poverty, children with disabilities, children in institutions, children from indigenous and minority communities, and children in situations of conflict and humanitarian and natural disasters.<sup>25</sup> In this context, the Committee on the Rights of the Child recommended in its concluding observations on a periodic report of Denmark that the state party increases the availability of sports activities for children in Greenland.<sup>26</sup> Also, article 13 of CEDAW and article 30(5) of the CRPD mention a right to participate in recreational activities.<sup>27</sup>

Another aspect of the right to physical activity is related to the right to education, which is widely recognized internationally and enshrined in article 26 of the UDHR and article 13 of the ICESCR.<sup>28</sup> The right requires, among other things, that education be directed to the full development of the human personality. Article 29(1)(a) of the CRC highlights that the child’s personality, talents, and mental and physical abilities should be developed to their fullest potential.<sup>29</sup> In its concluding observations on the Irish state report, for instance, the Committee on the Rights of the Child criticized insufficient physical activities in school that can be enjoyed by all students.<sup>30</sup> The scientific evidence shows that engagement in physical activity is positively associated with the psychological and emotional development of young people and that policies and interventions targeting physical education lessons are effective in increasing children’s physical activity.<sup>31</sup> From a human rights perspective, the right to education is not limited to children and includes the equality of men and women in the field of education, as well as the right of persons with disabilities to education.<sup>32</sup>

Lastly, nondiscrimination is a basic principle of human rights. The UDHR and the abovementioned human rights treaties all include the prohibition of discrimination in conjunction with the rights set out in these documents. For example, article 2 of the UDHR states that everyone is entitled to all the

rights and freedoms set forth in the declaration, without distinction of any kind.<sup>33</sup> This principle is of particular relevance and requires a special focus on vulnerable and marginalized groups. Potential sources of inequalities related to physical activity include age, gender, cultural background, disability, and financial resources. This is in line with efforts in the field of physical activity promotion to promote health equity by focusing on these target groups.<sup>34</sup>

### Attributes of physical activity as a human right

If a right to physical activity is derived from well-established human rights, its attributes need to be defined appropriately to express the right in concrete terms. In this context, the Committee on Economic, Social and Cultural Rights has defined four attributes that conceptualize the measures required to ensure the effective enjoyment of the right to health: availability, accessibility, acceptability, and quality.<sup>35</sup> The committee explicitly states that these attributes are interrelated and essential but that their precise application depends on the conditions prevailing in each state.<sup>36</sup> This section explains all four attributes and links them to the field of physical activity promotion.

#### *Availability*

Availability refers to “functioning public health and health-care facilities, goods and services, as well as programmes” that need to be “available in sufficient quantity.”<sup>37</sup> For physical activity, this could include the provision of purpose-built indoor and outdoor facilities, as well as the provision of public and green open spaces.<sup>38</sup> Furthermore, the availability of the right to physical activity could be improved by developing and implementing exercise programs in different settings.<sup>39</sup> Additionally, the availability of respective facilities, public spaces, and exercise programs seems to be important to support health-enhancing physical activity.

#### *Accessibility*

Accessibility has four overlapping dimensions:

nondiscrimination, physical accessibility, economic accessibility, and information accessibility.<sup>40</sup> Nondiscrimination means that physical activity-promoting “facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population.”<sup>41</sup> Physical accessibility refers to the fact that the respective “facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable and marginalized groups.”<sup>42</sup> Economic accessibility means affordability, and information accessibility includes “the right to seek, receive and impart information and ideas concerning health issues.”<sup>43</sup> In summary, physical activity-promoting facilities, goods, and services need to be accessible to everyone without discrimination, within safe physical reach, and affordable. This could include the provision of specific exercise programs that are adapted to the needs of vulnerable groups, which are highly relevant from a human rights and public health perspective.<sup>44</sup> The right to seek, receive, and impart information could include recommendations on the amount and intensity of physical activity needed to achieve certain health benefits; these recommendations should be available in the official language(s) of each state (since the World Health Organization recommendations are published only in selected languages).<sup>45</sup> Alternatively, states could develop such recommendations at the national level, as is already done in many countries.<sup>46</sup>

#### *Acceptability*

Acceptability means that “all health facilities, goods and services must be respectful of medical ethics and culturally appropriate.”<sup>47</sup> This can include physical activity programs that respect the culture of participating individuals and are sensitive to gender and life-cycle requirements (for example, tailored programs for the least active groups, girls, women, older adults, rural and indigenous communities, or vulnerable groups).<sup>48</sup> Program planners and decision-makers need to be aware of the specific barriers to physical activity for different target groups and develop strategies to overcome them.<sup>49</sup> For example, in some cultural

contexts, women might perceive it as inappropriate to use a public bath at the same time as men, and introducing bathing times only for women could be a strategy to overcome this barrier. Additionally, the use of a participatory approach that involves all relevant stakeholders and the target group in decision-making processes seems to be an appropriate method to overcome political barriers that might occur when implementing a culturally appropriate physical activity program.<sup>50</sup>

### *Quality*

Finally, quality means that “health facilities, goods and services must ... be scientifically and medically appropriate and of good quality.”<sup>51</sup> This requires, among other things, skilled medical personnel. In this context, it would be important to strengthen the pre- and in-service training of professionals within and outside the health sector.<sup>52</sup> In order to ensure a high quality of interventions promoting physical activity, it is also important to be aware of evidence-based quality criteria for the conception, implementation, and evaluation of such interventions.<sup>53</sup> States could also define appropriate standards in policy documents on safety and quality in health care: the Australian NSQHS Standards, for example, include a standard on preventing falls and harm from falls.<sup>54</sup>

### State obligations

If physical activity is considered a human right, this entails a number of obligations for states imposed by international human rights treaties and customary law. In particular, states are obliged to respect, protect, and fulfill this right.<sup>55</sup>

### *Obligation to respect*

The obligation to respect refers to the fact that human rights oblige states to refrain from interfering in the enjoyment of rights by individuals and groups.<sup>56</sup> An example of a required measure in the context of the right to health is that states must refrain from denying or limiting access to health care services on the basis of an individual’s status, such as age, gender, or citizenship.<sup>57</sup> The Special Rappor-

teur on the right to health has explicitly stated that the obligation to respect extends to physical activity promotion, which means that all people should be permitted to access state-run sporting facilities on an equal basis.<sup>58</sup> Another important aspect is that physical activity should be taken into account in all governmental policies in accordance with the Helsinki Statement on Health in All Policies.<sup>59</sup> This includes the requirement that states ensure that discriminatory laws, policies, and programs in non-health sectors are not adopted or are amended or rescinded.<sup>60</sup>

Additionally, the obligation to respect seems to be of particular relevance for vulnerable population groups, especially when they live in an environment of liberty deprivation and under the total authority of the state, as is the case with prisoners. In this case, the United Nations Standard Minimum Rules for the Treatment of Prisoners include assistance to prisoners of a sports-based nature, as well as one hour of daily exercise in the open air or employment in outdoor work.<sup>61</sup> Those rules would have to be transposed into binding international and national legislation, based, for example, on the checklist for internal inspection mechanisms of the United Nations Office on Drugs and Crime.<sup>62</sup> However, the obligation to respect the right to physical activity is also relevant for other population groups: historically, there are numerous examples of discrimination against women both in recreative and in competitive sports, such as the ban on women’s participation in national competitive sports in Saudi Arabia and, in the last century, the ban on women’s soccer in Germany between 1955 and 1970.<sup>63</sup>

In the context of the obligation to respect the right to physical activity, the lockdowns during the COVID-19 pandemic are another pertinent example. In Spain, exercising outdoors was not allowed for 48 days, while in the German state of Bavaria, doing sports and being physically active were explicitly considered relevant reasons for being outside during the lockdown.<sup>64</sup> One could discuss whether political measures that banned outdoor physical activity alone or with persons living in the same household can be considered unjustified

restrictions on the right to physical activity or whether they were reasonable due to the exceptional circumstances of the COVID-19 pandemic. In this context, in April 2020, the Committee on the Rights of the Child called on states to explore “alternative and creative solutions for children to enjoy their rights to rest, leisure, recreation and cultural and artistic activities” that “include supervised outdoor activities at least once a day which respect physical distance protocols and other hygiene standards.”<sup>65</sup>

### *Obligation to protect*

Second, the obligation to protect describes the need to protect individuals against abuses by nonstate actors, foreign state agents, and state agents acting outside of their official capacity.<sup>66</sup> With regard to the right to health, the literature urges states to ensure that third parties do not deny access to health care services; similarly, in order to protect the right to physical activity (for example, to ensure freedom from discrimination), states need to ensure that third parties do not deny access to physical activity facilities or programs.<sup>67</sup> In particular, the Special Rapporteur on the right to health urges states to ensure full compatibility between sport policies, rules, programs, and practices and human rights law and to intensify efforts to prevent systemic and ad hoc rights violations perpetrated by third parties.<sup>68</sup>

The workplace is another relevant setting for potential violations of the right to physical activity. It is highly important that employees have the possibility to be active in a work context (such as through active breaks or, for office workers, by being able to work at height-adjustable standing desks), as there is evidence of the effectiveness of such policies and interventions.<sup>69</sup> States could ensure this, for example, by amending their labor laws or by conducting information campaigns that encourage companies to create a work environment that promotes the physical activity of all employees.

### *Obligation to fulfill*

Finally, the obligation to fulfill requires that states take positive action to ensure that human rights can be realized.<sup>70</sup> Similar to the current debate

on the right to health, this obligation could be implemented by giving recognition to the right to physical activity in national political, budgetary, and legal systems and by adopting a national physical activity policy for realizing this right.<sup>71</sup> The Special Rapporteur on the right to health urges states to take three primary steps to ensure “that sufficient resources and infrastructure are devoted to enabling people to access and participate in sport and physical activity, as part of a broader strategy to encourage the adoption of healthy lifestyles”: (1) include the facilitation and promotion of physical activity and healthy lifestyles in national planning, (2) establish quality physical education programs, including in school and health-care settings, in accordance with human rights standards, and (3) progressively implement, expand, or improve goods, facilities, services, and information provision relevant to sport and physical activity.<sup>72</sup> Physical activity-promoting policies have already been adopted in many countries worldwide; however, their comprehensiveness leaves room for improvement.<sup>73</sup> Additionally, there is a paucity of national physical activity guidelines in low- and middle-income countries.<sup>74</sup>

Another aspect of the obligation to fulfill is that governments should create an environment that enables humans to do sports.<sup>75</sup> Similarly, from the right to health, one could derive an obligation to create an environment that enables humans to be physically active. Examples include, among others, the promotion of active transport and the promotion of physical activity in the education sector. In both sectors, states can use policy documents of the World Health Organization Regional Office for Europe that showcase success stories and examples from European countries as guidance.<sup>76</sup>

## Discussion

This paper has attempted to show that a right to physical activity can be derived from well-established human rights such as the right to health, the right to rest and leisure, the right to education, and the principle of nondiscrimination. Each of these rights is related to an important aspect of physical

activity, such as its health-promoting effects, the relationship between hours worked and leisure-time physical activity, and the importance of physical activity for the psychological and emotional development of young people. Therefore, we believe that compared to recognizing physical activity only as an element of the right to health, conceptualizing it as a standalone right would better recognize its multidimensional nature and sharpen its profile. A good precedent for this is the right to water, which was originally derived from the right to health and the right to an adequate standard of living but has received significantly greater attention since having been defined as a standalone right.<sup>77</sup> However, even if physical activity were not recognized as a standalone right, a debate about the importance of physical activity for other human rights would be beneficial.

In any case, a right to physical activity is founded in human dignity, as are other (aspects of) human rights. This becomes particularly obvious in situations when this right is strongly restricted or even denied (such as in prisons and psychiatric institutions). In these contexts, the right to physical activity overlaps with (or can even be partially derived from) the right to humane treatment of persons deprived of their liberty.<sup>78</sup> Furthermore, the CRPD has been especially important in highlighting human dignity as a basis of human rights. In that context, the participation of people with disabilities in recreation and sport is required to ensure their full development of human potential and sense of dignity and self-worth.<sup>79</sup>

If physical activity is considered a human right, the attributes of this right can be defined based on its availability, accessibility, acceptability, and quality. Furthermore, this implies that states have the obligation to respect, protect, and fulfill the right to physical activity. In particular with regard to the obligation to fulfill, the principle of progressive realization that is described in article 2 of the ICESCR is highly relevant: states are obliged to “take steps ... to the maximum of [their] available resources, with a view to achieving progressively the full realization” of a human right, “including particularly the adoption of leg-

islative measures.”<sup>80</sup> The ICESCR also highlights that states can meet this requirement “individually and through international assistance and co-operation.”<sup>81</sup> Consequently, three aspects seem to be important: First, states need to take initial steps toward achieving the realization of a human right even if they have only limited resources. Second, states need to increase their efforts over time to realize a human right progressively. And third, the question arises whether minimum core obligations of physical activity as a human right can be defined, for example, with regard to the lockdowns during the COVID-19 pandemic.

This paper has several limitations. First, we included only global human rights declarations and conventions in our analysis. Regional human rights documents might include additional aspects that are relevant at the interface of physical activity and human rights. Second, due to the intersectoral aspect of physical activity promotion, we could provide only illustrative examples instead of an in-depth analysis for each relevant sector (for example, the sport sector). Sport is an important “subset of ‘physical activity,’” and the International Olympic Committee as a sport organization has even claimed that “the practice of sport is a human right.”<sup>82</sup> Future research could compare sport and other physical activities from a human rights perspective in order to identify similarities and differences. Additionally, this paper focuses on health-enhancing physical activity and its promotion. The harmful effects of physical activity—such as on construction sites or production lines—are not covered by our research. Another example is the rights of young athletes that are endangered by child labor, violence, doping, early specialization, overtraining, and exploitative forms of commercialization.<sup>83</sup> These aspects are highly important for drawing a complete picture of physical activity and human rights but are not covered by our paper.

Considering physical activity as a human right could broaden the perspective of the current human rights discourse that focuses mainly on the interconnections between sport and human rights.<sup>84</sup> Recent policy documents in this field provide important points of reference: a progress report

of the Human Rights Council Advisory Committee states that sport not only includes (physical) exercise but is also “a tool to improve lifestyle, provide employment opportunities, and promote peace, development, respect and anti-racism.”<sup>85</sup> It also argues that sport can strengthen respect for human rights and promote human rights for all.<sup>86</sup> Similar to our line of argument, the Human Right Council Advisory Committee states that the right “is rooted in different other rights and concepts,” such as the rights to health, participation in cultural life, and development.<sup>87</sup> For children, participation in sports and games is officially recognized as being covered by article 31 of the CRC, which is also highlighted by organizations advocating for children’s rights.<sup>88</sup> In 2020, the Centre for Sport and Human Rights analyzed the sport-related impacts of the COVID-19 pandemic on children in detail from a human rights perspective, covering different aspects such as their physical and mental health, social inequalities, and physical education at school.<sup>89</sup> While all of these aspects are important, they do not cover physical activity at work, at home, or during travel, or other forms of leisure-time physical activity besides sports. For this reason, we argue that there is added value in a debate about physical activity as a human right.

In public health, the increasing global prevalence of chronic diseases has resulted in more attention being paid to their underlying behavioral risk factors and their intersections with human rights. In contrast to other fields of noncommunicable disease prevention (such as nutrition, tobacco, and alcohol), physical activity has so far not been part of the human rights discourse. This manuscript might provide a starting point for such a discussion.

Such a discussion would need to recognize that some of the central human rights documents were developed in the middle of the 20th century, whereas the concept of health-enhancing physical activity evolved only in the 1990s.<sup>90</sup> Consequently, a debate about health-enhancing physical activity as a human right might need to consider that evidence for the benefits of regular physical activity for public health have emerged quite recently.

As the COVID-19 pandemic has shown, contrasting obligations can be derived from the same human right, such as the right to health: while physical activity is generally highly relevant for the prevention of noncommunicable diseases, the acute need to contain COVID-19 has required governments to limit the mobility of people. In such cases, all rights need to be weighed in a way that does justice to each of them.

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# The Scales of the European Court of Human Rights: Abortion Restriction in Poland, the European Consensus, and the State's Margin of Appreciation

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## Abstract

In October 2020, the Polish Constitutional Court held unconstitutional an exception in the Family Planning Act of 1993 that provided for legal abortion in cases of fetal abnormalities. This retrogressive step has led to an almost total ban on abortion in Poland. Drawing on existing Strasbourg case law and other relevant legal material, this paper attempts to anticipate a possible outcome of applications recently filed before the European Court of Human Rights by more than 1,000 Polish women who were denied abortions or who postponed their reproductive decisions out of fear. I focus on two factors that play a determining role in the adjudication of cases related to reproductive rights. The first one is a public interest in restricting abortion—namely, the “protection of morals.” The second is the margin of appreciation doctrine, which determines the degree of freedom that states enjoy in regulating certain issues, such as abortion, and which is highly dependent on the concept of a European consensus. I argue that this consensus—revealed through the domestic laws and practice of 47 Council of Europe member states—shows considerable unity and should thus restrict individual states’ discretion in limiting human rights and freedoms. The European Court of Human Rights, by acknowledging the relevance of a European consensus in abortion regulation, as well as evolving universal standards concerning reproductive rights, would avoid two pitfalls: one connected with analyzing the doubtful public interest in protecting morals, and another with a potential criticism of judicial activism and the court’s imposition of its own moral evaluation of an abortion ban.

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## Introduction

Poland's Family Planning Act of 1993, which provides for legal abortion in three specific situations, has been perceived by international bodies as restrictive and often ineffective. After the country's repeated attempts to ban abortion, the United Nations (UN) Human Rights Committee explicitly called on Poland to refrain from pursuing any legislative reform that would amount to the retrogression of an already restrictive law.<sup>1</sup> Despite this appeal, the country's Constitutional Court, in a judgment issued on October 22, 2020, ruled that one of the grounds for abortion was unconstitutional.<sup>2</sup> It was to be expected that, sooner or later, this restricted access to abortion in Poland would be raised in individual applications to the European Court of Human Rights (ECtHR). This paper attempts to anticipate a possible outcome of abortion-related cases against Poland by drawing on existing Strasbourg case law and other relevant legal material. Given the fact that almost all abortion cases adjudicated by the ECtHR to date have dealt with the problem of real and effective access to legal abortion—and only one (*A., B. and C. v. Ireland*) has concerned the lack of legal abortion per se—this case could serve as a point of reference for future considerations.<sup>3</sup>

This paper addresses the challenges of a dynamic interpretation of the European Convention on Human Rights in this specific context, with a focus on the European consensus and its impact on the margin of appreciation afforded to states.<sup>4</sup> The existence of a consensus has very significant consequences: the more similar the laws of the Council of Europe states are, the less regulatory maneuver is left. Another critically assessed problem relates to the interpretation of a legitimate aim that is traditionally put forward by domestic authorities to justify restrictions on abortion—namely, public morals. I argue that a change of approach and a redefinition of “morals” as a relevant public interest in this context is necessary. I also suggest that the ECtHR should take a broader systemic perspective into account when examining cases against Poland and look into the evolution of inter-

national standards concerning reproductive rights. In other words, would the court pronounce a ban on abortion on embryo-pathological grounds as amounting to a violation of the European Convention on Human Rights because it does not pursue a legitimate aim or does not reach a fair balance between competing interests and rights? Which rights and interests could be weighed on the scales of justice, and which factors would be decisive for the purpose of the balancing exercise?

## Abortion law and practice in Poland

Abortion legislation in Poland's modern history may be described as taking one step forward and two steps back. Between 1956 and 1993, abortion was widely accessible on therapeutic and socioeconomic grounds (when a woman was experiencing “difficult living conditions”).<sup>5</sup> The interpretation of the law varied from a restrictive interpretation in the late 1950s to a permissive reading that allowed abortion on request in the 1960s and 1970s.<sup>6</sup> In fact, for many years, abortion was frequently used as a means of birth control due to a lack of availability and use of contraceptives.

The Family Planning Act of 1993 permitted abortion in three circumstances: (1) when the pregnancy posed a threat to the life or health of the pregnant woman; (2) when prenatal examinations or other medical conditions indicated that there was a high probability of a severe and irreversible fetal defect or incurable illness that threatened the fetus's life; and (3) when there was a reasonable suspicion that the pregnancy was the result of an unlawful act.<sup>7</sup> A step toward liberalization was taken in 1996, when an amendment to the 1993 law allowed abortion in cases where a pregnant woman was experiencing a difficult personal or living situation.<sup>8</sup> This amendment, however, was repealed in 1997 by the Constitutional Court.<sup>9</sup> Over the past few years, access to abortion has increasingly been a subject of national discussion, with repeated attempts to change the act. Legislative initiatives seeking to introduce a total ban on abortion, as well as ones aimed at liberalization of the law, were in-

roduced in 2013, 2015, and 2016. The latest attempt to ban abortion spurred large protests known as the “Black Protests.”<sup>10</sup>

Apart from these debates and changes within the legal framework, the implementation of the 1993 law has raised serious concerns. Access to legal abortion has been impeded by a lack of clear procedural mechanisms, prolonged waiting periods, and the denial of prenatal genetic testing.<sup>11</sup> To date, none of the three judgments of the ECtHR in cases against Poland where violations of the European Convention on Human Rights were found have been properly executed (when it comes to general measures).<sup>12</sup>

Poland has been repeatedly called on by various international human rights bodies to improve the quality of women’s access to health care, in particular to sexual and reproductive health services, and to examine the number of, reasons behind, and consequences of illegal abortions and their influence on women’s safety.<sup>13</sup> Poland has also been urged to ensure women’s access to abortion in cases where it is legal and to ensure that it is not restricted by the use of conscientious objection.<sup>14</sup> International experts have emphasized that restrictive abortion laws increase maternal mortality and morbidity rates, while also failing to reduce the abortion rate.<sup>15</sup>

Instead of implementing these recommendations and improving the accessibility of legal abortion, Poland has taken a step backward. On October 7, 2015, the Constitutional Court delivered a judgment in which it pronounced that a medical practitioner invoking conscientious objection to refuse to perform abortion should not be under a duty to refer the woman to another doctor or health care institution.<sup>16</sup> This decision has raised concerns by UN human rights treaty bodies because it has not been followed by the introduction of an effective systemic referral mechanism.<sup>17</sup>

Furthermore, in October 2020, the Constitutional Court removed fetal defects as a grounds for abortion (the ruling covered various conditions, including lethal defects resulting in nonviable pregnancies or death soon after birth, as well as chromosome abnormalities such as trisomy 18 and

trisomy 21).<sup>18</sup> In practice, this translates into an almost total ban on abortion in Poland, given that an estimated 96% of abortions were previously performed on these grounds. The court’s ruling placed an outright priority on the protection of the life of the fetus, even though the Polish Constitution does not state that the life of every person is legally protected from the moment of conception. In fact, the Constitution’s drafters deliberately intended to leave this matter open, and an attempt to amend this provision in 2006 was unsuccessful.<sup>19</sup> The judgment has spurred a new wave of protests.<sup>20</sup> From a legal point of view, seeking a constitutional review of the Family Planning Act of 1993 is controversial, as such socially important matters should be dealt by Parliament or be decided in a referendum, as was the case in Ireland in 2018. The judgment is yet another example of an abusive use of constitutional procedures to serve political objectives—a practice recently observed in Poland and Hungary.<sup>21</sup> It is also important to point to the controversies around the Constitutional Court’s impartiality and independence, as its composition and appointment of some judges has been questioned by lawyers and scholars and challenged before the ECtHR.<sup>22</sup> These doubts may have a bearing on applications against Poland, specifically on the question of the legality of an interference. If, due to formal and procedural defects, the judgment were to be declared invalid from the moment of its adoption, it would mean that there is no legal basis for the interference in question.

### What rights or interests are on the scales?

Compared to other European countries, Poland is witnessing an unprecedented retrogression in access to safe and legal abortion. Its recent actions are in direct contravention of the recommendations of UN treaty bodies and other human rights bodies. This leads to the question of how the ECtHR would adjudicate when faced with applications filed against Poland by women who were denied abortion on embryo-pathological grounds. As I argue below, the court should be guided by societal attitudes (developments in Polish society and

changes in the perception of reproductive rights), a consolidated European consensus regarding access to abortion, and universal human rights standards. The European Convention on Human Rights, as repeatedly emphasized by the court itself, should be subject to an evolutive (i.e., dynamic) interpretation.<sup>23</sup> In other words, the convention is a “living instrument” that should be interpreted in the light of the present-day conditions.<sup>24</sup>

The European Convention on Human Rights does not explicitly refer to the concept of reproductive health or reproductive rights. What is more, the treaty does not even contain a directly expressed right to health. However, in the light of the ECtHR’s case law, rights related to reproductive rights and their violations fall primarily within the scope of the right to respect for private and family life (article 8). Depending on the facts of a particular case, these violations may also be related to the right to life (article 2) and the prohibition of torture (article 3).<sup>25</sup> Furthermore, they might be related to the prohibition of discrimination (article 14) and other rights and freedoms.

To date, the ECtHR has delivered three judgments against Poland that identify violations of reproductive rights related to prenatal testing and abortion. In all three cases, the violation stemmed from the ineffective application of the existing law preventing access to legal abortion. Recently filed applications, however, challenge a different source of a violation—namely, the illegality of abortion on embryo-pathological grounds.

The only judgment in which the court has had to reflect on similar claims was the case of *A., B. and C. v. Ireland*, which the court ruled on in 2010.<sup>26</sup> At the time, Ireland had a very restrictive abortion law that prohibited abortion in all circumstances except in cases of a threat to the pregnant woman’s life. The first and second applicants in the case had sought abortions for reasons of health and well-being, and they claimed that the inability to obtain an abortion amounted to a violation of article 8 of the convention. In its ruling, the court made it clear that article 8 cannot be interpreted as conferring a right to abortion.<sup>27</sup> At the same time, however, relying on the previous case law, it reiter-

ated that “legislation regulating the interruption of pregnancy touches upon the sphere of the private life of the woman.” It also stated that “not every regulation of the termination of pregnancy constitutes an interference with the right to respect for the private life of the mother.”<sup>28</sup> In the court’s view, a prohibition of abortion sought for reasons of health or well-being is to be regarded as an interference. This conclusion correctly relied on a broad concept of private life within the meaning of article 8 that includes the rights to personal autonomy and to physical and psychological integrity.<sup>29</sup> Because an interference was found, the next step was to assess whether it had been justified. To that end, a limitation clause test of article 8(2) had to be applied—in other words, an examination of legality, legitimate aim, necessity, and proportionality.

As the court noted, the private sphere of a pregnant woman is not unlimited, and “Article 8 cannot be interpreted as meaning that pregnancy and its termination pertain uniquely to the woman’s private life as, whenever a woman is pregnant, her private life becomes closely connected with the developing fetus.”<sup>30</sup> The court thus put on one scale the woman’s right to respect for her private life, and unspecified “other competing rights and freedoms invoked including those of the unborn child” on the other scale.<sup>31</sup> It is important to recall that “other rights and freedoms” do not encompass the right to life or other rights of on the unborn because the court decided to leave this matter to the discretion of each state party to the European Convention.<sup>32</sup> Therefore, a legitimate aim that the impugned restriction was found to pursue was “the protection of morals of which the protection in Ireland of the right to life of the unborn was one aspect.”<sup>33</sup> In this regard, the court relied on its findings in *Open Door v. Ireland*, in which it found that the protection granted under Irish law to the right to life of the unborn was based on profound moral values concerning the nature of life, which were reflected in the stance of the majority of the Irish people against abortion during the 1983 referendum.<sup>34</sup> In the court’s view, these moral values had not changed significantly since then.<sup>35</sup>

When we compare this reasoning to the

current situation in Poland and try to apply it to recently filed applications, we can see some *prima facie* differences. The Family Planning Act of 1993 had been adopted as a compromise between the pro-life and pro-choice camps, and it had been in force for 27 years. It would thus be unjustified to argue that the near total ban on abortion resulting from the recent Constitutional Court judgment reflects the “profound moral views” of Polish society. The judgment has led to a retrogression that hardly reflects the views of the entire (or even a majority of) society.<sup>36</sup> While I share the ECtHR’s opinion that it is not possible to find in the legal and social orders of the contracting states a uniform European conception of morals, including on the question of when life begins, I am not convinced that it is easier to identify “national morals” or a public interest in their protection.<sup>37</sup> Is it possible to determine such morals in pluralistic and complex modern societies that—as repeatedly emphasized by the ECtHR—should share the values of pluralism, tolerance, and broadmindedness?<sup>38</sup> Contrary to other legitimate aims categorized as public interests—namely national security, public safety, the economic well-being of the country, the prevention of disorder and crime, and the protection of health—it is debatable whether morals may be objectively defined as such.<sup>39</sup>

I argue that morals should be treated with great caution (or even distrust) when invoked as a legitimate aim for interfering with human rights and freedoms.<sup>40</sup> Legal moralism, based on a particular belief and worldview, should be avoided as a tool for civil and human rights analyses.<sup>41</sup> The idea of public interest in protecting morals could be maintained if objectified and focused on the protection of the fundamental principles of human dignity, nondiscrimination, and equality.<sup>42</sup> In contrast, the October 2020 judgment of Poland’s Constitutional Court does not reflect the morals of Polish society or any other public interest but rather a populist agenda of the authorities holding political power. What, then, could be the alternative legitimate aim to the public interest in protecting morals? Maybe the ECtHR will eventually have to put on the second scale the protection of rights and

freedoms of others—more specifically, the freedom of conscience and religion of the members of the society who are in favor of the restrictions or the right to life of the unborn. Such an approach would ensure a more objective and liberal interpretation not involving the moralistic preferences of a part of the society (be it a majority or a minority) or of the governing political forces.<sup>43</sup>

### Balancing the scales and setting limits on states’ discretion to restrict abortion

Measures that limit human rights and freedoms not only have to serve a legitimate aim but also need to be necessary in a democratic society and to be proportional (well balanced).<sup>44</sup> A wide margin of appreciation (that is, states’ regulatory discretion) in the context of abortion laws has, for years, been treated as an irrefutable Strasbourg dogma. In order to review its validity, we must examine the constitutive elements of the doctrine of the margin of appreciation.<sup>45</sup>

In cases involving “sensitive moral or ethical issues,” states usually enjoy a wide margin of appreciation when limiting rights and freedoms.<sup>46</sup> However, this does not confer on them an absolute discretion or freedom of action, as the margin may be overstepped.<sup>47</sup> There are two important factors that are taken into consideration in order to determine the breadth of the margin of appreciation accorded to states. One of these is the importance of the right or freedom to the individual. In other words, when a particularly important facet of an individual’s existence or identity is at stake, the margin allowed to the state will normally be narrow.<sup>48</sup> In the abortion context, this consideration should be applied to the particular and specific circumstances of each case. It means that the degree of intensity and gravity of the dangers to the pregnant woman’s health or well-being must be taken into account.<sup>49</sup> Therefore, if there are grave dangers to the health or well-being of the woman wishing to have an abortion (for example, when there is a high probability of a severe and irreversible fetal defect or incurable illness that poses a danger to women’s physical or mental health and well-being),

the state's margin of appreciation is limited and the prohibition of abortion could be considered disproportionate.

Another factor is the level of consensus and its impact on the discretion left to states. The concept of European consensus relies on a comparative analysis of domestic legal systems. As is well established in ECtHR case law, when a substantial majority of Council of Europe states have a similar approach to a given issue, the court *usually* concludes that this consensus decisively narrows the margin of appreciation that states enjoy. Conversely, where there is *no consensus* within member states—either as to the relative importance of the interest at stake or as to the best means of protecting it, particularly where the case raises *sensitive moral or ethical issues*—the margin will be wider. It should be noted that there does not need to be total uniformity between all 47 member states. A relationship between the consensus and morality therefore cannot be regarded as antagonistic. In other words, the existence of “profound moral views” shared by the majority of society does not override the established European consensus. Such views can only widen the state's margin of appreciation when there is no or little consensus.

Importantly, the comparative method is not mechanically applied like a mathematical equation. It would be an oversimplification to say that the wider the consensus, the narrower the margin of appreciation of given state. This comparative approach has an important role to play for the European Convention's system because it is commensurate with the “harmonizing” role of the convention's case law.<sup>50</sup> European consensus and comparative methodology are crucial for the purposes of a dynamic and evolutive interpretation of the convention because they reflect social changes, scientific development, and so forth.<sup>51</sup> In fact, in a way, they resemble the idea of universality of human rights that should be equally enjoyed regardless of state jurisdiction. This harmonizing exercise, however, has limits. The idea of the universality of human rights on a global—or even a European—scale is often reconciled with cultural diversity, different legal traditions, and

specific contexts.<sup>52</sup>

In the abortion context, states enjoy a certain margin of appreciation when seeking to strike a fair balance between potentially competing rights and interests. There has to exist a pressing social need for certain measures, such as keeping or introducing restrictive abortion laws. Any such measures that interfere with individual rights also need to be proportionate to the legitimate aim pursued.

In *A., B. and C. v. Ireland*, relevant comparative data showed that in 2010 abortion was available on request (according to certain criteria, including gestational limits) in 30 out of 47 member states. Abortion justified on health grounds was available in 40 states and justified on well-being grounds in 35 states. Only three countries prohibited abortion in all circumstances (Andorra, Malta, and San Marino). Moreover, several states had recently extended the grounds on which abortion could be obtained (Monaco, Montenegro, Portugal, and Spain).<sup>53</sup> These data clearly reveal a consensus among “a substantial majority” of Council of Europe member states, as well as a tendency toward a broader accessibility of abortion services.<sup>54</sup> This fact, however, did not have any impact on the court's majority decision.<sup>55</sup> It appears that a “consensus amongst a substantial majority of the contracting states of the Council of Europe” was not considered as relevant (or relevant enough) to narrow Ireland's broad margin of appreciation.<sup>56</sup> This means that Irish authorities had a wide discretion to restrict access to abortion. One might wonder what arguments could be invoked to disregard this strong consensus—that the consensus was not strong enough? It appears that what had overridden the European consensus was “acute sensitivity of the moral and ethical issues raised by the question of abortion” and the “profound moral views” of a majority of the Irish people that, in the court's view, had not changed since the 1983 referendum.<sup>57</sup>

The reasoning offered in the judgment seems to suggest a clash between two issues subject to different European consensus. The court identified “no European consensus on the scientific and legal definition of the beginning of life, so that it was

impossible to answer the question of whether the unborn was a person to be protected for the purposes of Article 2,” and at the same time affirmed the existence of the consensus in favor of greater legal access to abortion.<sup>58</sup> In the court’s view, the latter “cannot be a decisive factor in the court’s examination of whether the impugned prohibition on abortion in Ireland for health and well-being reasons struck a fair balance between the conflicting rights and interests.”<sup>59</sup> Does this suggest that one European consensus takes priority over the other? In fact, it seems that this antagonism is factitious, because even if Council of Europe states do not all determine the legal status of the unborn in the same way, the unborn is protected by law. Nevertheless, the level and scope of protection differs from one state to another. Thus, states that allow greater access to legal abortion cannot be said to give priority to the protection of the right to life of the fetus at the same time.

The considerations presented thus far lead to the conclusion that, in the court’s majority view, the European consensus may be “relevant” or “irrelevant,” even though—when established—it should not be subject to value judgment. In *A., B. and C. v. Ireland*, moral views regarding the nature of life overrode the consensus, allowing Ireland to enjoy a broad margin of appreciation. This leads to the question of whether there is an absolute margin of appreciation in the context of “delicate” matters. The answer is no, since even a wide margin of appreciation may still be subject to scrutiny by the ECtHR. In other words, the margin of appreciation “is not unlimited” and does not give a *carte blanche* to introduce arbitrary measures, as it may be overstepped when such measures are disproportionate.<sup>60</sup> In the *A., B. and C.* judgment, Irish abortion regulations were considered proportionate for two reasons: because they reflected a “lengthy, complex, and sensitive debate” and because they allowed the termination of pregnancy abroad.<sup>61</sup> In the case of Poland, the latter argument might be considered valid, even though equally controversial. The former argument, as already indicated here, would not be applicable because restrictions on abortion have not been preceded by a public debate and were

imposed by the Constitutional Court.

*A., B. and C. v. Ireland* was decided by the Grand Chamber of the ECtHR in 2010. Have the abortion laws in Council of Europe member states undergone any changes since then? Currently, 41 out of 47 Council of Europe countries allow abortion on request or on broad social grounds (i.e., well-being). The most restrictive abortion laws remain in force in Andorra, Malta, and San Marino. Liechtenstein and Poland (since 2021) allow abortion only when a woman’s life or health is at risk or when the pregnancy is the result of sexual assault. In Monaco, a third ground is permitted: a severe fetal anomaly.<sup>62</sup> It means that the European consensus has become consolidated, and Poland is the only country where abortion has been restricted. The key question is whether this even stronger consensus will be regarded as significant and capable of narrowing the margin of appreciation.

### Universal standards and their possible impact on the ECtHR case law

In *A., B. and C. v. Ireland*, the fact that a consensus regarding access to abortion had been found led the court to the conclusion that it was not necessary to look further to international trends and views.<sup>63</sup> However, since this consensus was perceived as not relevant enough to narrow the state’s margin of appreciation, international standards are worth consideration because they may shed some light on the development of reproductive rights and thus influence interpretation of the European Convention on Human Rights.

Reproductive health, as defined by the Programme of Action of the International Conference on Population and Development, concerns the capability of reproducing and the freedom to make informed, free, and responsible decisions.<sup>64</sup> Informed, free, and responsible decision-making is the essence of reproductive rights. Hence, for many years now, the World Health Organization and human rights bodies have been calling for universal access to legal abortion and emphasizing that every illegal abortion is unsafe and poses a threat to women’s health and lives.<sup>65</sup> More recently,

the Committee on Economic, Social and Cultural Rights has explicitly called for the liberalization of restrictive abortion laws.<sup>66</sup> In addition, the Human Rights Committee, in its General Comment 36 on the right to life, in an attempt to reconcile the need to protect the life of the fetus with women's rights, has pointed out that

*restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering which violates article 7 [of the Covenant on Civil and Political Rights], discriminate against them or arbitrarily interfere with their privacy. States parties must provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or is not viable.*<sup>67</sup>

When we apply these considerations to the current Polish law, a lack of legal abortion in cases of fetal abnormalities ought to be regarded as running counter to international standards.

Several UN expert and monitoring bodies have pointed out that in certain circumstances, the denial of abortion services meets the threshold of torture and cruel, inhuman, and degrading treatment.<sup>68</sup> Severe pain or suffering can be physical or mental and, in certain cases, foreseeable.<sup>69</sup> International human rights practice increasingly recognizes the need for adequate health care for pregnant women, as well as their physical and mental well-being. This tendency can be observed not only in UN practice but also in the case law of the European Committee of Social Rights. The committee's approach has been clearly reflected in three cases concerning the conscientious objection of health care professionals, in which the committee emphasized that in the case of pregnancy and motherhood, women are the main beneficiaries of article 11 of the European Social Charter. In this context, the right to adequate health care cannot be impeded by exercising conscientious objection.<sup>70</sup>

It is also worth noting a rather novel approach to considering reproductive rights violations in

the context of gender equality and nondiscrimination.<sup>71</sup> This approach is most clearly established in the case law of the Committee on the Elimination of Discrimination against Women, but it also appears in the jurisprudence of the Human Rights Committee.<sup>72</sup> Although this perspective has not yet appeared in the ECtHR's case law, it is reasonable to assume that it might emerge over time.

Ineffective access to legal abortion has been successfully challenged before different UN treaty bodies.<sup>73</sup> More importantly, these committees, unlike the ECtHR, have also questioned the compatibility of restrictive domestic abortion laws with international human rights standards. In *L.C. v. Peru*, the Committee on the Elimination of Discrimination against Women not only obliged the state under review to guarantee real (and not theoretical) access to legal abortion but also ordered the state to amend its law to allow women to obtain an abortion in cases of rape and sexual assault. But the real milestone decisions were issued by the Human Rights Committee in *Amanda Jane Mellet v. Ireland* and *Siobhán Whelan v. Ireland*.<sup>74</sup> In both cases, fetuses were diagnosed with a fatal condition that would result in death in utero or shortly after birth. At the material time, Irish law provided for a single exception (risk to the life of the pregnant woman) to its general legal prohibition of abortion. Because the facts of these cases disclosed an interference with freedom from torture, inhuman, and degrading treatment, the committee held that the state could not invoke any justification or extenuating circumstances to excuse a violation.<sup>75</sup> The prohibition of torture and inhuman treatment is absolute and thus cannot be reconciled with considerations of striking a fair balance between competing rights or with pursuing a legitimate aim. With regard to an interference with the right to private life, the committee found that the balance that Ireland had chosen to strike between protection of the fetus and the rights of the women was unjustified and unreasonable, as the interference was perceived as intrusive and causing mental anguish.<sup>76</sup> In this way, these were the first—and thus far the only—international decisions to question criminalization and the lack of legal abortion services in cases where a

fetus was diagnosed with a fatal condition.

Given the evolution of international standards with regard to reproductive rights in general, and access to abortion services in particular, the question emerges whether the ECtHR would acknowledge and consider these developments in its jurisprudence. It should be emphasized that preventing unsafe abortions is one of the core obligations identified by the Committee on Economic, Social and Cultural Rights.<sup>77</sup> Therefore, it is hard to fathom how an almost complete ban on abortion is supposed to help to achieve this goal. If this retrogressive step by Poland is accepted by the ECtHR as accordant with the European Convention on Human Rights, then a discrepancy between European and universal standards would emerge. As I argue here, a broader international perspective should be taken into consideration to develop a consistent human rights approach to abortion.

## Conclusion

In this paper, I have attempted to analyze recent international developments concerning access to abortion services in order to anticipate the possible outcome of applications recently brought before the ECtHR against Poland. In *A., B. and C. v. Ireland*, the court left the content of the domestic abortion law to the discretion of national authorities. It relied on a broad margin of appreciation that had not been narrowed down by a strong European consensus. Over time, this consensus has become even stronger, meaning that giving the state nearly unlimited discretion in abortion regulations would run counter to harmonization. If the idea and interpretative function of the European consensus is to be maintained in a meaningful manner, this consensus should either narrow the margin or at least be a decisive factor in determining proportionality. A final reflection concerning the margin of appreciation concerns the methodology that is used to establish the “exact content of the requirements of morals” in a given country. The ECtHR has, on many occasions, presented a standpoint that by reason of “direct and continuous contact with the vital forces of their countries,” state au-

thorities are *in principle* in a better position than the international judge to give an opinion on the “requirement of morals.”<sup>78</sup> The determination of a structural margin of appreciation is based, *inter alia*, on “democratic legitimation” and the quality of the lawmaking process, especially “in matters of general policy, on which opinions within a democratic society may reasonably differ widely.”<sup>79</sup> With this in mind, it is doubtful whether the 2020 judgment issued by Polish Constitutional Court—whose legitimacy is being questioned—should be regarded as instructive on society’s views on abortion. In some circumstances, an exception from a rule is necessary.

By acknowledging the significance of a European consensus and the evolving universal standards concerning reproductive rights, the ECtHR would avoid two pitfalls: one connected with analyzing the doubtful public interest in protecting the convictions of a part of Polish society, and another with a potential criticism of judicial activism and the court’s imposition of its own moral evaluation of an abortion ban.<sup>80</sup> In embracing such an approach, the ECtHR would not anticipate or even channel change—it would simply recognize it.<sup>81</sup>

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# Charting the Rights of Community Health Workers in India: The Next Frontier of Universal Health Coverage

JANANI SHANTHOSH, ANDREA DURBACH, AND ROHINA JOSHI

## Abstract

Community health workers (CHWs) have the capacity to bring essential health services to under-resourced communities. Globally, CHWs have made significant contributions to poverty alleviation, increased food security, and reductions in health inequalities. India's one million accredited social health activists (ASHAs), the largest cohort of CHWs in the world, have been credited with increasing the rate of institutional deliveries and the uptake of vaccinations. ASHAs operate at the margins of health systems and the formal health workforce, often due to misperceptions of their skills and discrimination based on gender, socioeconomic status, education, and rurality. The "voluntary" nature of their work can entrench their precarious status, which is characterized by a lack of access to employment rights, adequate remuneration, and institutional support. This article argues that the prioritization of the labor rights of CHWs in the design and implementation of the World Health Organization's 2018 *Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes* can serve to ensure safe working conditions and freedom from discrimination, coercion, and violence. It further argues that the resultant enhancement and protection of CHWs' rights and long-term security provides an essential pathway for harnessing their potential to transform universal health coverage.

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## Introduction

*By fully harnessing the potential of community health workers, including by dramatically improving their working and living conditions, we can make progress together towards universal health coverage and achieving the health targets of the Sustainable Development Goals.<sup>1</sup>*

In 2017, the first international symposium on the work and role of community health workers (CHWs) was held in Uganda. The symposium marked almost 100 years of an extraordinary contribution to the provision of health care across the world, particularly the delivery of “preventive, promotive and curative services” in relation to communicable diseases, maternal and child health, and noncommunicable diseases.<sup>2</sup> Hosted by Makerere University School of Public Health and Nottingham Trent University, the symposium brought together researchers, practitioners, policy makers, and CHWs to address issues concerning the evolution, contemporary operation, and sustainability of CHW programs. In particular, it examined the contribution of CHWs to the attainment of the Sustainable Development Goals (SDGs), noting that CHW programs had the potential to be a “huge driving force to attain at least seven SDGs,” including ending poverty and ensuring food security, securing health and well-being, reducing inequalities, and enabling global health partnerships.<sup>3</sup>

Building on the 1978 Declaration of Alma-Ata, which acknowledged CHWs as key to the delivery of primary health care, the symposium recognized that there were significant benefits to be derived from investing in CHW programs, given their capacity to bring basic and essential health services to under-resourced, underserved, remote communities. The symposium was an important precursor to the development of the World Health Organization’s (WHO’s) *Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes*, and the guideline’s observation that investment in “community health workers represents good value for money” was subsequently reflected in many other WHO recommendations.<sup>4</sup> Launched in October 2018 to coincide with the

Global Conference on Primary Health Care held in Astana, Kazakhstan, the guideline speaks to measures that states might adopt to enhance the selection, training, supervision, and retention of CHWs.<sup>5</sup> To this end, it emphasizes the need to embed or integrate CHWs within their health systems or workforce to avoid “the risk of fragmentation, inefficiency and policy inconsistency.”<sup>6</sup>

Underlying this aspiration is a recognition that CHWs have historically operated at the margins or independently of formal health care systems and the health workforce, a status determined largely by perceptions relating to requisite skills and the structural operation of “barriers such as racism, gender inequalities, and discrimination based on poor socioeconomic status.”<sup>7</sup> Despite this lack of integration, the benefits of independent models of CHW delivery of health care are often fundamental to the implementation of primary health care objectives, namely brokering “linguistically and culturally appropriate” conduits to health care within diverse communities and facilitating “high levels of health promotion activity,” both of which serve to reduce barriers to access to care.<sup>8</sup> The integrated model may, however, offer *benefits to CHWs*, including professional recognition and career advancement, consistent levels of training and supervision, and improved working conditions. For states that might derive some cost-benefit advantage from the “voluntary” and unregulated nature of the work of CHWs (particularly low- and middle-income countries), these features of an integrated health workforce might be the rationale for a reticent or delayed assumption of the model.

While the work of CHWs can undoubtedly be optimized to facilitate the equitable expansion of universal health care coverage and potentially achieve some of the SDGs, the “working and living conditions of CHWs”—seemingly essential to their engagement, optimal performance, and retention—rarely feature as a prominent focus of international CHW conferences and attendant WHO guidelines and recommendations.<sup>9</sup> The 2017 symposium on CHWs in Uganda did include sessions where CHWs themselves addressed the advantages, limitations, and challenges presented by their work.<sup>10</sup>

In addition, the Guideline Development Group responsible for reviewing and analyzing evidence and devising the 2018 WHO guideline (which included policy makers, experts, end users, CHWs, health professional associations, and delegates from labor unions) was influenced by considerations of “best practice in relation to labour rights” and the International Labour Organization’s “decent work agenda” when formulating recommendations on CHW remuneration, written contracts (specifying role, responsibilities, and working conditions), and career progression.<sup>11</sup> In support of these recommendations, the Guideline Development Group noted that as the majority of CHWs globally were women, reliance on the voluntary nature of CHW work “could perpetuate gender disparities in access to employment and income opportunities.”<sup>12</sup>

This article considers how the “labour rights of CHWs themselves” might be prioritized in the design and implementation of the 2018 WHO guideline.<sup>13</sup> Although the guideline is aimed primarily at assisting national governments and their domestic and international partners in enhancing the impact of CHW programs, a key principle informing its implementation also envisages that consideration be given to ensuring the “safe and decent working conditions [of CHWs and their] freedom from all kinds of discrimination, coercion and violence.”<sup>14</sup> While labor rights have the potential to advance the health and well-being of CHWs, their absence remains a central barrier to the retention of this essential workforce and the achievement of universal health coverage. The lack of support, training opportunities, and adequate payment reduces the impact that health workers have on health outcomes, resulting in a weak health workforce and the undermining of universal health coverage. Drawing on a case study of CHWs in India, we trace the history of accredited social health activists (ASHAs), a cadre of workers—predominantly women and designated as “volunteers”—who form the backbone of the Indian health system. We examine the implications that their gender and voluntary status has for their working conditions and long-term security. Despite ASHAs being rec-

ognized as fundamental to the delivery of primary health care and as a solution to fast-tracking universal health coverage, they have recently become even further marginalized and undermined as a result of the COVID-19 pandemic.

### Accredited social health activists: A case study from India

The ASHA program was introduced by the Ministry of Health and Family Welfare as part of the National Rural Health Mission in 2005. India’s ASHAs have been touted as a solution to fast-tracking universal health coverage, achieving delivery quality, and ensuring comprehensive and accessible primary health care. Currently, South Asia requires a 50% increase in health workers to achieve universal health coverage by 2030, in line with the SDGs. It has been widely argued that the training and sustaining of CHWs, including the ASHA workforce, will be India’s best chance at meeting this goal.

The ASHA program follows India’s long tradition of community programs led by the Indian government since the 1960s and by the nonprofit sector since the 1970s. The program is powered by the contributions of one million female frontline health workers across India and represents the largest all-female CHW program in the world.<sup>15</sup> With the launch of the National Urban Health Mission in 2013–2014, ASHAs are also now available in urban areas, where they cater to vulnerable communities and people living in informal settlements. Currently, there are approximately 900,000 ASHAs in rural areas and over 64,000 ASHAs in urban areas.<sup>16</sup>

As an essential conduit between the public health system and the community, and as trusted community members, ASHAs extend the reach of health care centers to underserved and often rural and remote populations. In many cases, their work has been shown to be effective. For example, ASHAs have been credited with being a trusted source of health information and referral and with increasing the rate of institutional deliveries, visits to newborns within three days of their birth, and the uptake of vaccinations.<sup>17</sup>

*India's next frontier of universal health coverage*

With significant shortages in the health workforce, the ASHA program has considerable potential to increase health equity, particularly for Indians living in rural and remote areas. A central principle undergirding the program is community participation, with ASHAs available in every village in India (one ASHA per 1,000 population in rural areas).<sup>18</sup> The ASHA policy is based on local residency and community-based selection. Women are selected from and are accountable to the village in which they reside. ASHAs are generally married, widowed, or divorced and between the ages of 25 and 45. The selection process prioritizes women with 10th-grade qualifications or higher but allows for flexibility where necessary.<sup>19</sup> ASHAs are trained on an ongoing basis to gain knowledge, skills, and confidence. The vision and approach of the ASHA program reflects the values set out in the Alma-Ata Declaration, which reinforces effective primary health care as reliant “at local and referral levels, on health workers, including ... community workers ... suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.”<sup>20</sup>

The ASHA program sits alongside a number of health programs focused on achieving universal health coverage. These include Janani Suraksha Yojana, a safe motherhood intervention under the National Health Mission aimed at reducing maternal and neonatal mortality by promoting institutional delivery among poor and pregnant women.<sup>21</sup> Another program is Mission Indradhanush, which focuses on achieving full immunization coverage for all children and pregnant women.<sup>22</sup> Yet another is Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, which encompasses two complementary schemes: health and wellness centers and the National Health Protection Scheme. The first seeks to provide comprehensive primary health care, free essential drugs, and diagnostic services. The second provides financial risk protection to poor and vulnerable families to cover costs arising from secondary and tertiary hospitalization. The ASHA program is not only highly complementary to these programs but crucial to their reach and effectiveness,

as these projects are limited by the acute shortage of skilled health workers, and an increased coverage of essential services is not possible without qualified health workers at the community level.

The effective operation of health systems is central to the realization of the right to health. ASHAs are key institutions in health systems, playing a crucial role in ensuring availability, accessibility, acceptability, and quality, core components of the right to health as set out in General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights. The community-based ASHA model has strengthened *availability* through the delivery of health care and disease prevention activities by addressing coverage gaps for hard-to-reach populations. Further, this model has contributed to the *accessibility* of health care through nondiscrimination, physical accessibility, and information accessibility. ASHAs' recruitment from communities supports their culturally appropriate and *acceptable* modes of service delivery that are particularly sensitive to gender. In addition, the care they provide caters to the specific needs of their communities, including culturally appropriate means of obtaining consent and ensuring confidentiality. ASHAs play a crucial role in maintaining standards of health care *quality* by delivering evidence-based programs that are safe, effective, people centered, and timely (for example, by reducing waiting times and potentially harmful delays in receiving care), equitable (as care does not vary on account of ethnicity, geographic location, or socioeconomic status), and integrated (with treatment and prevention incorporated into ASHAs' activities). Critical to the progressive realization of universal health coverage and the right to health is the existence of a sufficient, equitably distributed, and well-performing health workforce. Additionally, it is imperative that national systems ensure nationwide capacity to produce a sufficient number of well-trained health workers whose terms and conditions of employment are enshrined in a domestic labor rights framework. Indeed, the effective implementation of the right to health is dependent on ensuring that “underlying determinants of health,” including gender equality

and healthy working conditions, are extended and applied to CHWs themselves.<sup>23</sup>

### *Accredited social health activists' designation as volunteers*

In spite of their significant contribution to India's health system, ASHAs often perform their work in precarious conditions. This is due in large part to their designation as volunteers, which has been used to justify and legitimize their exclusion from domestic rights frameworks that govern employment relations, dispute resolution, working conditions, wages, and social security. As a result, ASHAs remain perhaps the least empowered cadre of India's workforce.

This designation has been deliberate. For other categories of workers within the organized sector, India's legal system plays an important role in regulating the terms and conditions of employment. Legislative instruments such as the Factories Act, Contract Labour Act, Payment of Wages Act, Minimum Wages Act, and Equal Remuneration Act provide a broad range of entitlements and protections. For example, the Factories Act provides for the health, safety, welfare, working hours, and leave of workers in factories; the Contract Labour Act regulates the engagement of contractor and contract labor by the principal employer; the Payment of Wages Act regulates the payment of wages and provides responsibility for the payment of wages, fixation of wage period, and time and mode of payment of wages; and the Minimum Wages Act stipulates minimum rates of wages that must be paid to skilled and unskilled workers, taking into account factors such as the location and nature of work.

In addition to the voluntary status of ASHAs and their consequent exclusion from the formal regulation of employment conditions, labor-related discrimination against them is further exacerbated by their gender. Predominantly women, ASHAs face multiple, intersecting forms of discrimination due to their gender, lower socioeconomic status (as they often come from marginalized communities, including Dalits and Adivasis), rurality, lower levels of education, and low status within the health workforce.<sup>24</sup> In addition, women in in-

secure, part-time, or contract work confront many structural barriers to parity with male workers in similar work environments. Equal remuneration protections (enshrined in the Equal Remuneration Act) aim to ensure the equal remuneration of men and women and to prevent discrimination on the basis of gender in employment and professional opportunities. This relates not only to disparities in pay but also to recruitment processes, job training, and promotions. In 2002, India's second National Commission on Labour recommended legislative reform to ensure a minimum level of protection to workers in the unorganized sector given that the Labour Code on Wages Bill—which consolidates the Minimum Wages Act, Payment of Wages Act, and Equal Remuneration Act—does not include voluntary workers paid by honorarium in its definition of worker.<sup>25</sup>

As volunteer workers, ASHAs do not enjoy the protections offered by India's labor laws. Volunteers are generally those who enter into a service of their own free will and for little or no financial gain. Voluntarism is typically motivated by altruism rather than remuneration, and commitments are moral rather than legal. In effect, this designation allows India's central and subnational governments to utilize ASHAs as low-cost instruments of social mobilization through which the health workforce can improve health equity, access, and quality. It is unsurprising, then, that the provision of enforceable employment rights, adequate remuneration, and institutionally supported work has been noticeably absent from political discourse. The national and subnational governments, meanwhile, enjoy a great deal of freedom in designing the incentives they offer to ASHAs to encourage their participation, with minimal accountability. Despite the National Health Mission's claim that it has a well-functioning grievance redressal system, should ASHAs have a grievance in relation to their working conditions and entitlements due to their exclusion from the legal frameworks described above, there are no legal safeguards if the grievance procedure is not accessible, equitable, timely, effective, or procedurally fair.<sup>26</sup> Ultimately, where ASHAs' working conditions are unfavorable, their capacity and agency to

change their situation is severely compromised.

ASHAs' designation as volunteers, despite the payment of honorariums and monthly remuneration in some states, sets them apart from other workers and also shapes their lived experience in significant ways.<sup>27</sup> Prior to the COVID-19 pandemic, there was considerable dissatisfaction among ASHAs in belonging to the unorganized sector, despite working for government. In addition, ASHAs were burdened by a heavy workload, working long hours without receiving incentives for tasks such as medication adherence and noncommunicable disease (NCD) prevention. The inadequacy of their remuneration encouraged many ASHAs to take up second jobs to provide for their families, positions that were often compromised due to their increasingly demanding workload as ASHAs.<sup>28</sup>

As the COVID-19 pandemic continues, ASHAs are facing an exacerbated situation in order to carry out their lifesaving work. Further, they have often been reprimanded for using their social and political power to fight for their rights and promote their priorities—many of which do not align with national health objectives that benefit from their exclusion from labor rights. In 2020, during the COVID-19 pandemic, 22 ASHAs were threatened with dismissal by the state of Madhya Pradesh after demanding better pay, protective gear, and fixed tenures in nationwide protests, some during election rallies. The states of Haryana and Delhi filed police cases threatening termination against ASHAs for being absent from their work stations on the days of the protests.<sup>29</sup>

### *Conditions of work*

During the COVID-19 pandemic ASHAs have reported exhaustion, discrimination, stigma, and inadequate personal protective equipment.<sup>30</sup> This has led to feelings of alienation and being undervalued.<sup>31</sup> Despite being more likely to come into contact with COVID-19 cases, they have experienced a lack of sanitizers and masks, forcing them to use handkerchiefs or dupattas to carry out their work. In addition, ASHAs have been required to travel long distances on foot in temperatures as high as 46 degrees Celsius.<sup>32</sup> While the central government has

directed states to provide all ASHAs with personal protective equipment, this has often not occurred. ASHAs have reported receiving only five disposable masks (which generally last for a total of 10 days) and one sanitizer each per month of work. Due to ASHAs' low status, when additional masks become available, they are often given to higher-level health care staff. While ASHA unions have raised these issues before their state governments, there remains a significant shortage of personal protective equipment for ASHAs. In some cases, ASHAs have been asked by public health centers why they need masks at all, and ASHAs have reported that they sense that higher-level officials believe they are undeserving of such protective gear.<sup>33</sup>

### *Scope of work*

ASHAs are frequently the first port of call for health-related demands, particularly where women and children face challenges in accessing health services. Since the introduction of the ASHA program, their role within their communities has expanded in response to community need. Their expanding responsibilities include the promotion of universal immunization, the provision of referral and escort services for reproductive and child health programs, and counseling for women on birth preparedness, safe delivery, breastfeeding, contraception, and the prevention of common infectious diseases. In addition, ASHAs in some states undertake NCD prevention work, including listing individuals with hypertension, diabetes, and cancers (oral, cervix, and breast); encouraging the community to screen for NCDs; and providing medication adherence support.<sup>34</sup> Further, ASHAs are equipped with a drug kit to provide first-contact health care, are expected to encourage community participation in public health programs operating within their villages, and are equipped with knowledge of the health facilities near their village, including the closest Anganwadi (rural child care centers), subcenters, and primary health centers where mothers can access antenatal, postnatal, and other care.

During the pandemic, ASHAs have been required to undertake additional tasks mandated by

the Ministry of Health and Family Welfare, including delivering medicines, conducting home visits to the elderly, and ensuring critical care for those on dialysis. They have been required to track, test, and monitor COVID-19 patients within their villages and cities. This has involved visiting workers in the quarantine center in the village twice a day to monitor for symptoms and report to the public health center. It has also involved door-to-door surveys between 25–50 households a day to check for symptoms—particularly among older persons, those with heart conditions and respiratory issues, tuberculosis patients, pregnant women, and other high-risk populations—and report positive cases to the public health center. A recent report suggests that ASHAs in Andhra Pradesh and Telangana have been required to monitor individuals recently returning from overseas, migrant laborers, and lorry drivers up to four times a day. Their scope of work, estimated at 2–3 hours per day pre-pandemic has now increased to 12 hours a day, and they are expected to remain on call after these formal hours of work.<sup>35</sup>

### *Underpayment and nonpayment*

State health planning and budgeting makes minimal provision for the inclusion of ASHAs in human resources. They are compensated for their time only in specific situations (such as training attendance, monthly reviews, and other meetings). In addition, they are provided performance-based incentives for their services under various national health programs. These incentives are often inadequate and do not cover the full scope of services provided by ASHAs. States have been given the flexibility to design their own incentives for ASHAs, resulting in significant incentive variability across the country.<sup>36</sup>

For many years, ASHAs had demanded to be included within the cadre of permanent health care staff, with a fixed pay of 18,000 rupees (US \$256) per month. In 2018, ASHAs, through their unions, made demands for fixed tasks and work hours. Some progress was made with the increase in honorariums and the doubling of incentives. Currently, they are entitled to 2,000 rupees (US\$30) per month, conditional on the completion of their

tasks. In addition, ASHAs may receive incentives for specific tasks—for example, 1 rupee (US\$0.015) for every oral rehydration solution packet distributed, funded by the National Health Mission's child health program, and 300 rupees (US\$4.15) for facilitating an institutional delivery, funded by the National Rural Health Mission's maternal health program. Incentives are earned for state-specific activities. Eleven states with high fertility rates offer 200 rupees (US\$2.77) for the provision of family planning services.<sup>37</sup>

Some states (Andhra Pradesh, Kerala, Karnataka, Haryana, West Bengal, and Sikkim) have introduced fixed monthly honorariums for ASHAs or top-up incentives. In Rajasthan, ASHAs were selected from Anganwadi workers and this group continues to perform the activities of both ASHAs and Anganwadi workers. For this group, ASHAs receive fixed honorariums from the Integrated Child Development Services scheme and activity-based incentives from the National Health Mission.<sup>38</sup>

To support ASHAs' increased workload during the pandemic, the central government announced additional payments of 1,000 rupees (US\$15) per month. Some state governments have provided additional payments. For example, in Punjab, ASHAs are provided an additional 2,500 rupees and financial aid of 10,000 rupees when they are infected with COVID-19.

Despite these developments, there remains no standard procedure for the revision of honorariums and no incentives for NCD treatment and prevention work.<sup>39</sup> Further, claiming and releasing payments involve lengthy processes, leading to ASHAs often going unpaid for months. There is little accountability in ensuring that their incentives and benefits are received. As volunteers and activists, ASHAs are held to account under national health programs (despite not being government employees). However, health service stakeholders have not taken ownership of other institutional mandates of the ASHA scheme, such as ensuring that village health committees engage and receive payment on time. In addition, ASHAs often pay out of pocket for work-related costs (such as travel) that should be covered by village health committees.

### *Social security*

Social security is one area where there have been welcome improvements. For many years, ASHAs made demands for insurance and related benefits. In 2018, the Indian prime minister announced a social security benefit package for ASHAs, including life insurance, accident insurance, and pension. Prior to this, a number of subnational governments had implemented social welfare schemes using National Health Mission funds and state funds. In addition, an insurance scheme, Ayushman Bharat (discussed earlier), was launched in 2018 and provides health benefits of up to 5 lakh rupees (US\$7,417) per year for families, based on Socio-Economic Caste Census data.

### Framing rights: Prioritizing a model for community health worker protection

#### *Health volunteerism in under-resourced public health systems*

The notion of “health volunteerism” as foundational to CHW programs is critical to the supplementation of often overextended and under-resourced public health systems.<sup>40</sup> CHWs are often drawn to the role because they are keen to ensure and support the health and health literacy of their community, to build their own knowledge about health care, and to be associated with the effective operation of a health care system. Yet, the pressures they confront, both personally and professionally, frequently combine to undermine the sustainability of the CHW programs.<sup>41</sup> Where women make up the majority of the CHW workforce—as in the case of ASHAs—the retention of CHWs is further compounded by their vulnerability and exposure to physical harm and discrimination, the barriers posed by cultural norms, and their workplace exploitation.<sup>42</sup>

#### *Addressing employment discrimination to accelerate gender equality*

The year 2020 was projected to be a turning point for accelerating gender equality. It marks the 25th anniversary of the Beijing Declaration and Platform for Action, a visionary agenda for the

empowerment of women. A core component of the Beijing Declaration is the elimination of all forms of employment discrimination. This includes, but is not limited to, enacting and enforcing laws that reflect principles of equal pay and workers’ rights, as well as eliminating discriminatory practices by employers.<sup>43</sup> The declaration requires states, where necessary, to reformulate wage structures in women-dominated professions in efforts to address their low status; inadequate remuneration and exclusion from legal frameworks that would otherwise offer protections relating to employment relations; working conditions; wages; and social security.<sup>44</sup>

Global women’s health and women’s rights advocates had planned to leverage the anniversary of the declaration to trigger global collective action to transform the situation for women at work, particularly the most marginalized. In early 2020, when the COVID-19 crisis accelerated, global advocacy activities aimed at engaging global leaders in gender equality targets were stalled, with governments, international organizations, and civil society organizations turning their attention to managing the pandemic and their overburdened and inadequately resourced health systems, operationalized largely by women. Although the ASHA program has provided a significant mechanism for engaging CHWs, enhancing their skills and providing these women with a limited income, the demands of the pandemic have both exposed and exacerbated existing inequalities in social, political, and economic systems in general and in public health systems more specifically. As a consequence, the United Nations and gender equality advocates globally have expressed concern that the COVID-19 pandemic could reverse the limited progress that has been made for gender equality with the further exploitation of female health workers in insecure jobs or living close to poverty.<sup>45</sup>

#### *Community health worker rights and the sustainability of India’s health system*

Well positioned “to build on the foundations of trust” established within their communities of service and “to communicate and implement new and rapidly evolving community-level response

measures,” CHWs are clearly critical to endeavors directed at “fighting the pandemic, especially in low-income countries with vulnerable health systems.”<sup>36</sup> It is perhaps in times of severe pressures on health care systems, as in the case of pandemics or political conflict, that the aspiration to universal health care is most acute and the need for CHWs most urgent. However, the imperatives underlying these social and political crises can create environments where the safeguards required for the effective functioning of voluntary health workers are often suspended or nonexistent. Reports of health care workers facing increased stigma, discrimination, and physical violence in the COVID-19 environment prompted a number of humanitarian and medical organizations to release a declaration in May 2020 denouncing over 200 COVID-19-related attacks on health care workers and facilities.<sup>47</sup> The declaration called on “all governments ... to ensure that health care is protected by domestic law, that all health care professionals have a safe working environment, and that mental health support is offered not only to victims of violence, but also to those working under increased levels of stress.”<sup>48</sup> The absence of a framework of protection for essential CHWs, such as India’s ASHAs—who carry a disproportionate burden of the pandemic response—can serve to undermine the stable operation of CHW programs and the prospect of their long-term sustainability.<sup>49</sup>

Against WHO’s forecast that the global shortage of health workers by 2030 will reach approximately 18 million, numerous studies have been undertaken to examine and enhance incentives underlying the recruitment and retention of CHWs, given their vital contribution to ensuring “access to basic health services where the formal sector falls short.”<sup>50</sup> While most of these studies have made recommendations relating to the recruitment, training, remuneration, workplace environment, and career progression of CHWs, the extent of their implementation remains questionable. (A multicountry study conducted by researchers at the Frontline Health Project through Population Council and Johns Hopkins Bloomberg School of Public Health is yet to report on the evaluation of incentive preferences

to improve performance and retention of CHWs, strengthen CHW programs, and leverage limited government resources appropriately.)<sup>51</sup> In addition, despite evidence of discrimination against CHWs and workplace exploitation, the recommendations seem to omit consideration of incentives that ensure the “safe and decent working conditions [of CHWs and their] freedom from all kinds of discrimination, coercion and violence.”<sup>52</sup> The impact of discrimination on health care workers and the “close link between the fulfillment of the rights of health workers, including labour and employment rights of CHWs, and that of health care seekers” was the rationale for a dedicated plenary session at the 2017 Prince Mahidol Award Conference.<sup>53</sup> One of the speakers, Sarojini Nadimpally, executive director of the Indian women and health resource group Sama, described ASHAs “as central to delivering care to rural and marginalized populations” yet lacking commensurate recognition or reward: “the lowest rung of health providers ... paid one rupee for every packet of sanitary napkins that they sell.”<sup>54</sup> Speakers also highlighted the link between CHWs’ accountability toward the health system and their communities and the provision of equitable working conditions and appropriate tools, reasonable remuneration, and recognition: “[H]ealth accountability is attained when governments respect, protect, and fulfill the right to health, and when health sector employees are treated respectfully.”<sup>55</sup>

### *The need for a CHW charter of rights*

All these initiatives—the conferences and symposiums, the guidelines and goals, the declarations and calls to governments around the world—point to a clear need to declare and protect the rights of CHWs in order to effectively address the acute deficiency of global health workers. What form this will take will necessarily be determined by local conditions and experiences and the extent to which CHWs have developed “capacity for the ... collective action necessary to be heard by more powerful actors,” such as staging protests and strikes, drafting and securing political support for protective legislation, and advocating for labor rights through

an organized (or unionized) cohort.<sup>56</sup> Given the precarious status of many CHWs across the world (“at or near the bottom of the front-line health worker hierarchy”), the variability of their working conditions, and the degree to which they are perceived as integral (as opposed to an add-on) to a public health system, the development of a normative framework, equivalent, for example, to a broad universal charter of rights for CHWs, might require impetus at a global level via the combined advocacy and intervention of international health and human rights organizations or coalitions with strong CHW representation.<sup>57</sup> A charter, which might combine core principles reflecting CHW accountabilities (training, performance evaluation) and rights (remuneration, equipment and clothing, protection against discrimination and violence), would offer a significant incentive toward the maintenance and expansion of CHW programs. The United States Agency for International Development (USAID) has developed a Flagship Community Health Worker Resource Package for use by ministries of health, implementing partners, USAID missions, UNICEF country offices, and investors in the health sector and other development areas to strengthen CHW programs by integrating CHWs within broader health workforces and promoting their professionalization. Enablers listed in the program include considering the rights and perspectives of CHWs.<sup>58</sup>

The development and adoption of a broad charter of rights for CHWs would also build on the resolution adopted in January 2019 by the 72nd World Health Assembly, entitled *Community Health Workers Delivering Primary Health Care: Opportunities and Challenges*, which urges member states to “optimize community health worker programmes ... with the objective of the success of primary health care and the achievement of [universal health coverage].”<sup>59</sup> By reference to effective implementation of the *WHO Global Code of Practice on the International Recruitment of Health Personnel*, the resolution underscores the importance of cooperation among

*health ministries, civil service commissions, and employers to deliver fair terms for health workers*

*and a positive practice environment to enable their effective deployment, retention and adequate motivation to deliver high-quality care and build a positive relationship with patients.*<sup>60</sup>

Facing similar imperatives that underlie the recruitment of CHWs, namely the “global shortage of health personnel” and the capacity of member states to achieve “internationally agreed development goals” (such as the SDGs), the *WHO Global Code of Practice on the International Recruitment of Health Personnel* was devised to strengthen health systems by establishing voluntary principles and practices and improving legal frameworks “for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel.”<sup>61</sup> Although focused on the recruitment of international health personnel to serve in domestic health workforces, many of the code’s guiding principles applicable to this engagement are potentially instructive in relation to safeguarding the rights of CHWs recruited to enable the operation of overburdened national health systems. These include the application of principles of transparency and fairness in relation to the recruitment of health personnel; fair labor practices in conformity with national legislation; principles of nondiscrimination to all aspects of the employment and treatment of health personnel; appropriate induction and orientation programs to enable safe and effective practices within a health system; and opportunities and incentives to enhance knowledge, expertise, and career progression.<sup>62</sup>

Despite the apparent benefits of a more regulated and paid CHW workforce, proponents of CHWs’ health voluntarism highlight the benefits of such an approach, including a sense of altruism, social recognition, job satisfaction, peer support, and continuing education.<sup>63</sup> Others have argued that from a health systems perspective, what motivates CHWs is adequate remuneration regardless of whether it takes the form of performance-based incentives or a formalized, salaried position.<sup>64</sup> In spite of the strong ethical and moral arguments favoring the protection of CHWs’ rights, the potential impact on India’s health expenditure, particularly

within a pandemic environment, also remains unclear. In India, primary health care makes up only 44% of health spending, for an average of US\$26 per capita.<sup>65</sup> Arguably, investments in the appropriate remuneration for CHWs could “crowd out” other essential services. Further, formalizing the CHW workforce may be challenging for governments influenced by the social acceptability of salaried CHWs. Health voluntarism is tied to racial, cultural, and religious notions of health care. Such health care is overwhelmingly considered “women’s work,” which populations may perceive to be service to community rather than employment.<sup>66</sup> Some scholars have also highlighted that the extension of labor rights to CHWs could transform CHWs into government extension workers, which is distinct from the initial premise of the ASHA program, which characterizes them as social health activists capable of mobilizing around health inequities faced by their communities.<sup>67</sup> Such a shift, it is argued, could impact their role as trusted representatives of the community.

Ultimately, in the face of CHWs’ deepening poverty, increasing vulnerability, and severely limited resources, the “spirit of volunteerism” is insufficient motivation for sustaining this workforce.<sup>68</sup> The ASHA model can be reinforced through a strong domestic rights framework, and this need not entail the erosion of the benefits afforded by volunteerism. The successful operation of salaried health workers within hard-to-reach communities across India highlight that altruism and connection to community can and do exist alongside employment rights, adequate remuneration, and institutionally supported work. Innovative policy models informed by a CHW charter of rights could meet this aim by addressing insecure working conditions and building on ASHAs’ foundation of trust within the community.

## Conclusion

*[E]ven in well-functioning programs, CHWs often have little space to negotiate for themselves at work, due to their poverty, gender, lower educational levels, poor exposure and the lack of growth opportunities. It is therefore necessary to take a*

*rights- and gender-based perspective of CHW programs in order to strengthen both the CHWs and the programs.*<sup>69</sup>

A multicountry study of CHWs in low- and middle-income countries published in 2016 examined the limitations and opportunities for CHW “empowerment.” Highlighting the critical role played by CHWs in empowering communities via the promotion and facilitation of access to health services, the study demonstrates the corresponding benefit of CHW empowerment in securing this objective. Urging a move away from “an instrumentalist approach to CHWs,” which sees CHWs as a necessary supplement to a health workforce, the study found that “access to privileged medical knowledge, linking CHWs to the formal health system, and providing them an opportunity to do meaningful and impactful work” enhanced the health outcomes of the communities they served.<sup>70</sup>

At the core of CHW empowerment is the right to exercise agency, the right to safe and conducive working conditions, and the right to assert claims to accountability and redress, particularly when the design and implementation of CHW programs and work environments hamper and undermine CHW contributions. Such discrimination within the health workforce can act as a powerful barrier to health services and contribute to poor quality of care, therefore undermining India’s aspirations for achieving universal health coverage. Although local CHW programs are clearly informed by distinct historical, political, cultural, and socioeconomic influences, their common objective is to enhance the health outcomes of the communities they serve which are often remote and under-resourced. On a global level, against the backdrop of poverty, climate change, displacement, gender violence, and emerging pandemics, this aspiration is directed at the achievement of some of the SDGs and the acceleration of progress toward universal health coverage. Central to both is the effective maintenance and urgent development of sustainable CHW programs and the recruitment, training, and retention of sufficient CHWs. A human rights-based approach provides clear principles for charting rights and targeting discriminatory practices and unjust pow-

er relations at the heart of the ASHA experience. The empowerment of CHWs through the delineation of their rights “is an essential prelude to them being effective in enacting their [various] roles” and to their transformation of health systems that will “reach the unreached’ with health services, develop and support community participation and health education, and help patients to manage long-term health conditions.”<sup>71</sup>

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# Applying Human Rights and Reducing Coercion in Psychiatry following Service User-Led Education: A Qualitative Study

SUSANNA EVERY-PALMER, LEAH KININMONTH, GILES NEWTON-HOWES, AND SARAH GORDON

## Abstract

Despite the imperatives to reduce coercive practices such as substitute decision-making, seclusion, and restraint, the psychiatric profession has struggled to realize these aspirations. Education delivered by people with lived experience of mental distress can help facilitate change. We introduced a service user-led academic program for psychiatry residents focused on promoting human rights and reducing coercive practices in mental health care. Few published reports of such service user-led education exist. In this qualitative study, we analyze data exploring this new program's impact in practice. Four major themes were identified. Service user-led training was challenging but highly valued and prompted a *paradigm shift*, changing residents' thinking. Residents had *so much promise* in their early intentions to reduce coercive practices. However, numerous barriers impeded them from implementing these intentions. *Power differentials* that existed at multiple levels caused residents to experience themselves as "pawns" playing set roles *working under a system* with entrenched hierarchies, resource limitations, legislative frameworks, and public expectations operating to maintain the status quo. The apprenticeship model under which psychiatry residents work is a significant socializing influence. If only the "old paradigm" is modeled and taught, then this hinders more progressive thinking. Service user-led education should be offered more broadly.

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## Introduction

Coercive practices such as seclusion are often experienced as highly aversive by service users and cause harm.<sup>1</sup>

The United Nations Committee on the Rights of Persons with Disabilities has found that the use of seclusion and various methods of restraint, including physical, chemical, and mechanical restraints, violates the human rights of those experiencing these practices.<sup>2</sup> The committee has also advised that substitute decision-making—where another person makes a decision on someone else's behalf—should be replaced with supported decision-making, where individuals are supported in making decisions based on their own will and preferences.<sup>3</sup>

Despite the ethical and human rights imperatives to reduce coercive practices, psychiatry as a profession has struggled to realize these aspirations.<sup>4</sup> There have been few demonstrable gains in recent decades. In fact, some metrics even suggest that clinical practice is heading in the other direction. In New Zealand, where this study is based, the use of compulsory treatment orders has been increasing and key measures currently indicate that partnerships between consumers and services are declining.<sup>5</sup> There are wide variations in seclusion usage across mental health inpatient services that cannot be attributed to sociodemographic and clinical factors and are better explained by differences in practice and service delivery across the country.<sup>6</sup>

Many countries are reviewing their mental health laws and replacing them with more human rights-focused approaches. However, legislative change on its own will not drive systemic change.<sup>7</sup> Internationally, there are viable alternatives to traditional coercive practice that have led to dramatic reductions in seclusion and compulsory treatment.<sup>8</sup> Such practices require a fundamentally different philosophy that is supported by training and is appropriately resourced.<sup>9</sup> Leaders and teachers in academic institutions have an essential role in shaping such changes, including through the engagement of service users in the design and delivery of teaching programs.

While the role of service users in coproducing

mental health services has become well established (albeit variably implemented) in North America, the UK, Europe, and Australasia, the equivalent practice of coproducing psychiatric *education*, in which service users are actively involved in the design and delivery of teaching to future psychiatrists, remains in its nascency.<sup>10</sup>

The Commission on the Future of Psychiatry (a collaboration between the World Psychiatry Association and the *Lancet* to address priority areas for psychiatry) has strongly advocated for the employment of service user educators as “particularly important to teach the principles of recovery-oriented care and combat negative stereotypes.”<sup>11</sup> However, the profession has been slow to adopt this educational practice.<sup>12</sup> There are only a few published reports about service users' involvement in academic psychiatry, which contrasts unfavorably with other mental health professions, such as nursing and social work.<sup>13</sup> As a contribution to this debate, we have conducted a qualitative analysis considering the impact on practice of the first group of psychiatry residents to participate in a program aimed at supporting sustainable reductions in the use of coercive practices (such as seclusion, restraint, and forced treatment) and promoting supported decision-making. A key component of the program is that it is designed and led by service user academics. Service user academics are scholars who privilege and utilize their lived experience of mental distress and of receiving mental health services to inform their teaching and research activities.

Here we examine the trainees' experiences with the service user-led program and their perceptions of how these experiences affected their clinical practice.

## Methodology

### Setting

Since 2011, the University of Otago in New Zealand has been progressively developing a mental health academic program, called World of Difference, that is led and delivered by service users. With funding from the country's Health Promotion Agency, in

2017 this program was extended from the education of medical students to also include the education of psychiatry residents. The extension of the program to psychiatry residents was deemed necessary given their specialization in psychiatric practice, the lack of such training having been delivered hitherto, and the expressed interest of the residents in receiving such teaching as part of their training.

The curriculum is conceptualized, developed, and led by service user academics with the support of clinical colleagues within the faculty, and trained service users deliver the teaching. In terms of being service user led, the program has been fully developed, and is fully delivered, by people with lived experience of mental illness who are employed by the university. The approach is based on lessons from social psychology, showing that to provide training to combat mental health stigma and discrimination, mental health service users should be of equal status to trainees, rather than confined to the patient role.<sup>14</sup>

The program includes—but extends well beyond—the more traditional approach of solely presenting positive recovery stories in the form of personal testimonies. While such approaches can have value and have been used successfully as a tool for social-political change, they are vulnerable to being coopted or interpreted by others in a manner that can have the opposite of the intended effect in terms of exacerbating stigma and discrimination.<sup>15</sup> The University of Otago didactic teaching incorporates other elements to empower the service user voice and reduce the risk of misinterpretation. These include service user leadership in all aspects of the program, engagement in myth busting, and a focus on behavioral change. These features align with recommendations from other successful antidiscrimination initiatives for health care providers.<sup>16</sup> However, given that the lack of systematic training on human rights as it relates to mental health allows stigma and discrimination to continue in health settings, the program for psychiatry residents also has a strong human rights focus.<sup>17</sup> This is supported by use of resources from the World Health Organization's QualityRights initiative.<sup>18</sup>

The program was designed to facilitate the attitudinal shifts and changes in clinical practice required to reduce the use of coercion in psychiatry, such as seclusion, restraint, and forced treatment, and to promote supported decision-making.

### *Research design*

This study was nested within this service user-led education and research program delivered to medical students and psychiatry residents. It was informed by the service user principle of “nothing about us without us.”<sup>19</sup> In line with coproduction principles, service users managed and directed both the intervention and the data collection and analysis processes in collaboration with two of the authors, who have dual roles as practicing psychiatrists and academics.

Data were analyzed using thematic analysis.<sup>20</sup> Thematic analysis is an established method for recognizing, analyzing, and reporting emergent patterns within data. Patterns are identified iteratively through careful processes of data familiarization, data coding, theme development, and review.<sup>21</sup> We used an inductive, realist approach to data analysis, in which we reported the experiences, interpretations, and reality of the residents.<sup>22</sup> The inductive approach involves coding the data without forcing it into a preexisting coding frame or the researcher's analytic preconceptions. However, we recognized that an education program for residents led and researched by service users would generate data embedded in the interaction between medical and service user worldviews.

### *Participant recruitment*

Participants were drawn from a pool of 20 psychiatry residents enrolled in the University of Otago's Department of Psychological Medicine's psychiatry course as part of a five-year residency program. We selected residents who were in their first three years of psychiatry training. All had spent at least two years working as junior hospital doctors (“house surgeons”) before entering the residency program. The residents receive teaching from university faculty but are employed by health boards, not by the university.

### *The teaching program*

As part of the World of Difference program, psychiatry residents participated in four hours of didactic teaching and a half-day interactive workshop (delivered to groups of approximately 10 students), both of which were mandatory. They were accompanied by optional monthly one-on-one supervision with a service user (up to eight hours of individual supervision over a year). The latter is described in more depth in a perspective piece written by one of the residents and their service user supervisor.<sup>23</sup>

The didactic teaching was largely developed using the World Health Organization QualityRights initiative toolkit.<sup>24</sup> This teaching was facilitated by a service user academic (woman, in her 40s, Caucasian) and covered the concepts of recovery, with a particular focus on personal recovery (as opposed to clinical recovery).<sup>25</sup> This was supported by the “rethink recovery framework.”<sup>26</sup> The teaching explained how stereotypes, prejudice, and discrimination can negatively affect people’s recovery journeys and lead to coercive practices. In terms of human rights specifically, the teaching included a presentation of the four models of disability (charity, medical, social, and human rights); an introduction to human rights generally; an overview of the Convention on the Rights of Persons with Disabilities; an exploration of the formal and informal ways that legal capacity is denied in mental health services; the obligations deriving from article 12 of the convention as informed by General Comment 1 of the Committee on the Rights of Persons with Disabilities, including explication of the distinction between legal and mental capacity, and the requirement to replace substitute decision-making regimes with supported decision-making regimes; and the definition and key principles of supported decision-making. Details on what would be involved in the later interactive workshop were provided to residents at this time.

Three months later, residents participated in an interactive half-day workshop designed to collectively explore and identify practical ways of reducing the use of seclusion, restraint, and other

coercive practices and promoting supported decision-making. The three-month gap between the didactic teaching and the interactive workshops was purposeful in providing time for the residents to consider the potential practical application of the teaching as they engaged in clinical work. The workshops were led by three educators identifying as users of mental health services and included the service user academic who delivered the initial teaching. Two educators were women and one was a man; they were aged in their twenties, forties and sixties; two were Caucasian and one had multiracial ethnicity; and all had personally experienced forced treatment.

In the workshops, residents worked in groups to generate actions regarding (1) what steps they could take personally and in support of their service to reduce seclusion and substitute decision-making, and (2) what steps they could take personally and in support of the service to promote and realize supported decision-making. At the end of the workshop, the participants collectively created a “pledge card” summarizing the actions they had identified. The idea was that the actions were generated and owned by the trainees (rather than being “textbook”), with the aim of increasing participants’ commitment to implementing them. Copies of the pledge cards were provided to all the trainees.

### *Data collection*

Approximately five months after the workshop, residents who provided written informed consent to participate in the qualitative evaluation ( $n=11$ ) joined one of two focus groups ( $n=4$  and  $n=7$ ) to discuss their experience in the program and how they had been implementing their “pledges” in practice. The focus groups lasted three hours each and occurred at a hospital training facility between March and November 2018.

The rationale for using focus groups was to encourage open discussion among participants. With focus groups, the researcher facilitates or moderates a group discussion among participants. Unlike interviews, the researcher takes a peripher-

al, rather than a center-stage, role in the discussion. This technique is based largely on group dynamics and synergistic relationships among participants to generate data.

The focus groups were conducted by a female service user academic with a postgraduate psychology qualification. She was in her twenties and had experience facilitating focus groups. She was not involved in delivering the teaching or analyzing data. The reasons for this were to protect confidentiality; to separate the roles so as to avoid bias; and to make use of personnel from the service user team with strengths in different areas. The facilitator was selected as someone with whom there were no existing power dynamics with the residents; she did not have any employment, supervisory, or teaching relationships with them and was the same age or younger age than many. She used a semistructured interview schedule with open-ended questions supplemented with more targeted questions for deeper exploration. The discussions were recorded and transcribed verbatim.

### *Researcher background*

LK and SG are service user academics, and SEP and GNH are academic psychiatrists. All authors have interests in coproduction. As service user academics, LK and SG base their academic work on service user-led and coproduced research with authentic service user leadership in all developmental stages. They are open about their lived experience of mental illness and use that to inform their research and teaching.

### *Data management and analysis*

The data were initially analyzed by LK, SEP, and GNH, none of whom had been involved in delivering the teaching or data collection to protect confidentiality. The transcripts were de-identified prior to analysis so that none of the named researchers knew which residents participated, protecting their anonymity. The researchers independently read and coded the transcripts, and identified emergent themes, before comparing findings.

LK led the qualitative analysis, undertaking initial coding (open coding) on a line-by-line basis

using NVivo Qualitative Data Analysis software (version 12), with subsequent analysis exploring the relationships between codes so as to develop higher-order concepts. Care was taken to ensure that this interpretation of data was undertaken from within a service user worldview, whereby such interpretation is informed primarily by a lived experience of mental distress and service use.

SEP and GNH undertook independent analyses. The analyses were then compared to identify whether there were any divergent views between the service user and clinically focused perspectives in order to enrich the overall analysis and ensure triangulation.

The relationships between and within emerging categories were explored. Overarching higher-order themes were developed through discussion and debate between the four authors. We went through four iterations of integrating, refining, and writing up the merging theories, using constant comparative methods and negative case analysis. This was to increase the credibility and trustworthiness of the concepts extracted and to enrich the depth of analysis.

### *Ethics*

All participants provided their written informed consent. The study was granted ethics approval by the University of Otago's Human Ethics Committee (D17/386).

### *Funding source*

Funding for this study was provided by the New Zealand Health Promotion Agency (grant number 6192).

## Results

Eleven residents (two women and nine men) with a median age of 32 years (+/- 5 years) participated in this study. Three residents were in their first year of psychiatry training, and eight were in their second or third year. They reported varying ethnicities, which we do not describe due to their being potentially identifying. The illustrative quotations included in this paper are accompanied by their participant code in brackets (e.g., [#1]).

The major themes identified from the focus groups were as follows:

- Service user-led training prompted a *paradigm shift* and changed thinking.
- Residents *had so much promise* in their early intentions to be less restrictive but often felt thwarted in enacting these aspirations.
- *Power differentials* persisted at many different levels and impeded change.
- Residents felt trapped and constrained *working under a system*. Services and society need to be different to achieve further progress.

### *Theme one: A paradigm shift*

Service user-led training was considered powerful and engendered deep reflection—many participants reported coming away with a new paradigm. They felt that sessions presented an alternative perspective from the biomedical model that predominated at medical school and within their working environments. Insights into how it feels to experience coercive practice were considered particularly powerful in motivating residents to pursue approaches that promoted people’s right to self-determinism and reduced coercion wherever possible.

*I personally have come away from the previous sessions we had with [the service user educators] and I've really felt they have been quite powerful and have shaped my practice in a positive way, and definitely trying to promote the least restrictive means as much as possible. [#1]*

Residents felt that the training helped them think more carefully about human rights principles. They reported becoming more conscientious in formulating management plans *with* (rather than about) service users and incorporating supported decision-making where possible. The training provided skills and confidence in using supported decision-making.

*[People] may lack the capacity to decide where they need treatment, but they do have capacity to decide*

*what treatment or certain aspects of that treatment. [#5]*

*Even somebody who might seem completely delusional and really seriously psychotic can still have input. [#6]*

*[The teaching] has definitely made me think more. If I'm doing a seclusion review or thinking about the Mental Health Act, I'm now being really careful about thinking through every aspect, and from the client's perspective as well. So, it has been a really positive thing. [#11]*

Interestingly, residents made observations that the service user teaching had helped reduce their anxieties around risk.

*[If] you're giving that person the opportunity to ... take control of their care [and] if I've made a plan with a patient that they are making decisions about and making their own decisions, and if I've given my best assessment and made recommendations [then] ... if something were to go wrong, I'd feel less personally responsible. [#5]*

*This sort of training has made me more comfortable with the idea of allowing people to make unwise decisions. [#6]*

Participants recognized that some senior clinicians were “inclined to a more paternalistic approach” [#5], using compulsory treatment as an expedient way of enforcing the preferred plan in the name of “best interests” rather than engaging in shared decision-making. Previously, residents may have imitated this approach as “usual practice,” but they described now finding it troublesome and striving to do things differently. They felt that it had been “quite easy to just get swept along with the culture of what the people around you are doing” [#6] but that they were now better equipped to challenge the status quo.

Residents reported that with experience and consistently repeated messages, they were getting better at enacting these paradigm shifts.

*I think what I'm doing more is appropriately framing the individual's experience so that it makes*

*sense in their eyes ... From a personal and practice point of view, I think we're doing that a lot better. [#3]*

*I'm just getting better at that [supported decision-making] through experience I think. [#1]*

Residents reported that this different way of practicing as presented through the workshops helped them feel that their work was “of more of value to the people, the clients, that I work with” [#5].

### *Theme two: “We had so much promise”*

While participants supported using less restrictive measures wherever possible, they did not find it easy to realize this in practice. The acute inpatient unit and after-hours management of psychiatric emergencies were particularly challenging environments and situations. Participants experienced a sense of shame and guilt about failing to implement their good intentions.

*We had so much promise ... these ideas [on the pledge cards for reducing the use of seclusion] are good, but we have failed to implement a lot of them, especially in the inpatient environment. [#1]*

*I always feel a sense of failure when someone comes up to me and says, “Doctor I just got one of the people in seclusion” ... It's like, you haven't done enough to stop them from being so unwell that they end up in seclusion. [#2]*

Residents felt that their decisional authority after hours was nominal, in conflict with the goals on their pledge cards that they had been optimistic about achieving.

*It's hard for us in our position, particularly on call, to eliminate seclusion. [#5]*

They described the tensions between an ideal world (where restrictive practices are neither needed nor in existence) and the realities of operating in a complex system, with multiple players and the specter of risk hanging over them.

*We have to rely on the feedback given by the nursing staff because they are the ones who are managing*

*the patient in the ward. So if they say, “I think there is a potential risk related to this patient,” then we have to rely on that information ... I've never been consulted on whether they should start seclusion or not. I've only ever been called saying, “Can you review this person in seclusion?” [#7]*

Overall, participants thought it was difficult to envision a country where coercive practices such as seclusion could be completely eliminated. This was because of concerns about safety, systemic factors, and societal views.

“In principle” aims of minimizing seclusion and promoting least restrictive approaches were ubiquitous within participants' workplaces, but services varied in their capacity and commitment to implement these goals. It was noted as a source of pride that in at least one inpatient unit, staff exhausted all other alternatives before considering seclusion.

*I think [the staff on the inpatient unit] do a really good job. I'm really proud of it. The way they go about really just leaving seclusion as a last resort. [#1]*

However, this was not a consistent experience, and many felt that there were both cultural and systemic factors that made the elimination of restrictive practices difficult, if not impossible, giving rise to the subsequent themes.

### *Theme three: Power differentials*

Participants used the word “power” many times, but on deep analysis this was a spurious and elusive power, characterized largely by its absence. The underlying theme was not in fact power but rather powerlessness.

Residents thought that service users lacked power and viewed themselves as wielding power.

*At the end of the day, regardless of how well you engage someone, or how well you thought you've formed that relationship, there'll still be that “you've got the power to put me on medication or to force me to have this”—and no matter what, there's still a power dynamic. [#2]*

The residents felt, however, that they had very little actual power to challenge the status quo. They were acutely aware of their role as “trainees.” For context, residents cycle through six-month training rotations, so are usually the newest staff members on a team. Every three months, reports on each resident’s progress, completed by their supervisors and informed by multidisciplinary team members, are submitted to the College of Psychiatry. These reports help determine whether the residents achieve a “pass” or “fail” for each rotation. Consequently, residents experience pressure to be seen as a good team member by their new colleagues. Participants reported feeling transient, insignificant, and vulnerable in relation to the “bosses” (certified psychiatrists and managers). This meant that they were reluctant to challenge established practices.

*We are temporary staff [others nod in agreement] so we don't have a say over bigger things like training and budgeting. It's just not our place. [#8]*

Nurses were seen as having a lot of influence over trainees. For example, seclusion is initiated by nursing staff and then a resident is called to conduct a clinical review and to recommend continuation or termination of seclusion.

*A lot of the tension is with, if I can say so, with the nursing staff, who have worked there for what can sometimes feel like decades and have their own way of doing things and the way they like things. Which often tend to be quite restrictive measures. [#1]*

Residents felt that being called to review nurses’ seclusion decisions was often a rubber-stamping exercise in which they were expected to support their more experienced nursing colleagues who had initiated the seclusion.

*I mean, we're all so junior here that we at least try to and are encouraged to be subservient in some degree to the nurses because they have so much more experience than we do. [#2]*

*I realized more and more ... how insignificant I am and how much I am governed by the bosses,*

*the charge nurses; I'm a pawn. I'm definitely trying to promote the least restrictive means as much as possible ... [but] it's met with a lot of resistance, almost to the point of abuse from some of the charge nurse managers ... and they can really make my life difficult if they want to. [#1]*

Some residents also experienced the same power dynamic with the psychiatrists, finding it difficult to express their own opinions.

*I basically got abused and bullied into doing what [the on-call psychiatrist] wanted me to do. And you're so vulnerable as a registrar [resident] because that person can then be your supervisor in the next run. [#2]*

#### *Theme four: Working under a system*

Participants felt that it was unfair to ask clinicians to change their coercive practices in high-risk environments without commensurate systemic and structural changes that would support this.

*I wish we could change things; we definitely want good for clients. But certainly, we have to work under a system, in a system. And the barriers are there. That's what I feel. [#7]*

The key barriers identified included a lack of time and resources, as well as societal attitudes toward risk.

The inpatient services in which the participants were working were experiencing high occupancy and frequent bed shortages. Most inpatient service users were experiencing acute distress. Participants had identified giving people adequate time as a key tool for supported decision-making, but in practice they found implementing this very difficult.

*You've got limited time, especially if you're working with other people. I just had a massive argument in [the emergency department] last week for seeing patients too slow. You know and then they're like, "Oh, you have three more to see." And you're like, "But I'm seeing one patient at a time!" So, it's quite difficult. [#7]*

In terms of collaboratively formulating advance

directives, participants said that this took a lot of time—time that they simply did not have. Participants repeatedly used descriptors such as “difficult,” “struggle,” and “barrier” in relation to the concept of time and resources.

*Yeah, it can be quite galling when we're told to spend more time with everyone. And that we need to invest more and more. And you can't argue against that because we all know we should, but the reality is we can't [due to resourcing constraints] ... And that's quite difficult for us to balance. [#6]*

Residents also complained about insufficient time to write directly to clients to record shared decision-making, despite the obvious benefits of such approaches.

*[Supported decision-making] actually takes an awful lot of effort and time on both the team's part and the client's part to do this. [#7]*

Residents thought that those unwell enough to require seclusion often did not have the capacity to regulate behavior or make informed decisions, particularly if acutely psychotic, manic, or suffering from drug intoxication or withdrawal. In relation to use of the Mental Health Act, residents felt that it was sometimes the only way to treat someone who might not acknowledge they needed treatment—and that it was what colleagues and the public expected.

Indeed, residents reported that public expectations rested heavily on them. They considered that the public had low tolerance for mental illness, unusual behavior, and risk within the community and that the responsibility for managing these factors was perceived to sit squarely with psychiatric services. The corollary was that adverse outcomes involving mentally unwell people were generally viewed as service or clinician failings. Participants thought that eliminating seclusion and forced treatment would require changes in public opinion and legislation. Mental well-being needed to be conceptualized as a societal responsibility, not just something to be “dealt with” by mental health services. This required further investment in

community-based services to support people and changes in public opinion.

*Mad people used to exist in civilization without being incarcerated or followed up with legislation. And then if we're going to deconstruct that we'll actually be reverting back. [#2]*

## Discussion

This service user teaching is anchored in the recovery paradigm and human rights model of disability advocated by the Convention on the Rights of Persons with Disabilities, and it is interesting that participants saw this training as providing a distinct (yet valuable) alternative view to the rest of their psychiatry training. This suggests that traditional pedagogy has not caught up with more modern practices.

Psychiatry residents felt the teaching affected their thinking about the human rights of those they treat and changed the way they wanted to practice. Consistent with findings reported in other studies, the residents felt that having the human rights-focused messages repeated over time led to incremental improvements in their clinical practice.<sup>27</sup> Although their desire to implement least restrictive practices for those experiencing mental distress increased, they identified numerous barriers that prevented them from achieving this goal. They considered that the “fact” of mental illness and diminished capacity meant that the need for coercive practices persisted. However, they also believed that if services were better resourced and society became more tolerant, the need for coercive practice would diminish.

The theme of power—or rather powerlessness—came through strongly. Residents entered the program naïve but enthusiastic with “so much promise” but consequently found their autonomy to effect change to be illusory. They often perceived themselves as hapless “pawns” playing set roles within a flawed system. Entrenched hierarchies, resource limitations, legislative frameworks, and public expectations operated to maintain the status quo. The residents appreciated that this powerless-

ness extended well beyond them, impacting most heavily on service users, the most vulnerable actors in the system.

### *Strengths and weaknesses*

The strengths of this study include an in-depth analysis of the views and experiences of psychiatric residents collected half a year after participating in a service user-led education program. There are few published examples of service user-led educational programs in psychiatric education, and we are not aware of any that have also been evaluated or researched by service users.

More than half of the first tranche of residents to undergo the teaching program elected to participate in this research, providing good representation. The data were collected by a research assistant who was not involved in teaching, assessing, or working with the residents, allowing residents to speak openly about their experiences.

As is the nature of qualitative studies, our data are hypothesis generating and cannot provide “proof” of the benefits or limitations of service user teaching, but merely an account of personal experiences. The methodology and scope of the study did not allow us to observe delayed effects among the participants or ripple effects on their environments.

In line with constructivist theory, we recognize that the service user status, age, and gender of the researchers will have interacted with the experiences, knowledge, and demographics of the participants, influencing both the data generated and the coding framework applied.<sup>28</sup> As noted by Virginia Braun and Victoria Clarke, qualitative data are not coded in an epistemological vacuum.<sup>29</sup> Other research teams with different worldviews may have elicited different data or interpreted the same data in a different way.

Interestingly, our participants were uniformly positive about the value of the teaching program; their struggles were with enacting the learnings rather than with accepting the underpinning philosophy. This warrants discussion. In our experience, service user-led education in psychiatry often engenders more diverse responses than those elicited from the residents. Some other learners

have found service user-led teaching confronting, with the spectrum of responses including resistance, defensiveness, and withdrawal. We did not detect these responses—either overtly or subliminally—in this population. This may be due to population characteristics: our residents were relatively young and early in their career, a number had previous exposure to service user-led teaching through our medical student program, and the interview panel for their residency program had included a service user and questions about recovery. However, we acknowledge that our focus group methodology may have contributed to some of the uniformity. Although we had a neutral facilitator skilled at eliciting different viewpoints, it is possible that residents did not want to reveal dissenting minority views to their peers. Furthermore, residents who did not like the program may have selectively declined to participate in the research. Hence, we may not have elicited the full spectrum of views.

### *Implications*

Arguably, one of the necessary mechanisms to connect the intervention to actual outcomes is the government’s support in terms of an active commitment to its obligations under the Convention on the Rights of Persons with Disabilities. At the start of this program, there was no such explicit governmental support for the changes required for compliance with the convention. However, this has recently changed, with the New Zealand government having accepted and prioritized the recommendations of a recent inquiry to repeal and replace the country’s mental health legislation to reflect modern approaches to human rights, supported decision-making, and informed consent.<sup>30</sup> The first stage has involved the government publishing guidelines on how to apply human rights, recovery approaches, and supported decision-making under the current Mental Health Act.<sup>31</sup> The actual repeal and reform of that act is going to involve a longer-term process. However, it has also been identified that legislative change on its own will not drive systemic change.<sup>32</sup> The results of the present study support that and provide insights into the issues that such systemic change is going

to need to address and involve, as discussed in the next section.

### *Next steps*

Data should be collected to appraise whether attitudinal changes correspond to changes in practice in the medium to long term. It is also imperative to canvas the views of service users. What is their experience working with mental health staff who have undergone training such as that provided in the World of Difference program? Do such programs result in appreciable changes in practice from their perspective?

Service user-taught programs could be expanded to include skills development and an introduction to alternative practices as modeled and endorsed by fellow practitioners internationally. Trainees could be allocated to mentors who are skilled in alternatives to coercion.

Education should include the presentation of alternative approaches to care, such as those enacted in Trieste, Heidenheim, and Soteria.<sup>33</sup> Such education shows not only *that* there are different ways of engaging with service users but also *how* to implement these methods. This can overcome the lament that there are no alternatives.

No matter the level of skill and knowledge that is built, the organizational structures within which new clinicians operate can serve to undermine their best efforts. For example, it is much harder to find alternatives to restrictive practices when insufficient time is allocated to supported decision-making, when there is insufficient staffing to accommodate de-escalation, or when suboptimal facilities create environments that feed frustration and aggression.<sup>34</sup>

The example of Trieste shows that an integrated, community-based approach can be effective not only from a financial perspective but also in achieving population benefits such as reducing suicide and acute admissions, increasing employment, and reducing the number of people requiring forensic services.<sup>35</sup> Such a change requires education and commitment throughout the organizational system, with sustained leadership identified as a key factor in changing the culture in the use of restric-

tive practices.<sup>36</sup>

The World of Difference program was designed to promote practice in psychiatry that is nondiscriminatory and that upholds the human rights of service users. Psychiatry residents participating in this inaugural program reported developing alternative perspectives from the biomedical model that they saw as predominant in their working environments. Correspondingly, they described wanting to work in less restrictive ways and generated thoughtful ideas about how to put this desire into practice. However, they felt that their good intentions were often thwarted by societal and structural factors: environments and people who resisted such change.

Our participants are enmeshed in a paradigm collision—the conflicts in their experiences represent a microcosm of the larger debate occurring between the service user worldview and the traditional clinical worldview in psychiatry. The apprenticeship model under which residents work is a significant socializing influence. If only the “old paradigm” is modeled and taught, then this will hinder more progressive thinking, particularly in relation to the application of human rights in practice. As a consequence, education of the type profiled here needs to reach people at all levels throughout the service, from policy makers to managers to multidisciplinary clinicians—with service users placed squarely at the center.

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# Building the Evidence for a Rights-Based, People-Centered, Gender-Transformative Tuberculosis Response: An Analysis of the Stop TB Partnership Community, Rights, and Gender Tuberculosis Assessment

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## Abstract

The global tuberculosis (TB) response has undergone a transformation in recent years. Calls for a paradigm shift have inspired a new focus on the importance of communities, human rights, and gender in the response. This focus has led to new approaches and innovative tools to fight an age-old disease that still affects millions each year. Notable among these tools is the Stop TB Partnership's community, rights, and gender (CRG) assessment. TB civil society and community groups, in partnership with national TB programs and others, have conducted the CRG assessment in 20 countries across four regions. Using the normative right to health framework, this article analyzes the evidence base generated by this assessment to understand the communities, legal environments, and gender dynamics at the heart of the epidemic. It describes an array of issues revealed by the assessment findings, including limited access to health services, disease-based discrimination, lack of privacy protections, and the impact of patriarchal norms on women affected by TB. Finally, this article considers how to strengthen the CRG assessment and how countries affected by TB and their donors and technical partners can leverage its findings in line with the Sustainable Development Goals and the political declaration from the first-ever United Nations High-Level Meeting on Tuberculosis.

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## Introduction

The response to the global tuberculosis (TB) epidemic has undergone a transformation in recent years. Calls for a paradigm shift have inspired a new focus on the importance of communities, human rights, and gender in the response.<sup>1</sup> This focus has led to new approaches and innovative tools to fight an age-old disease. Notable among these is the community, rights, and gender (CRG) assessment developed by the Stop TB Partnership (STP), the United Nations (UN) global partnership to end TB.<sup>2</sup> Others include the Global Fund's Breaking Down Barriers initiative and STP's TB Stigma Assessment and OneImpact Community-Led Monitoring Framework.<sup>3</sup>

The CRG assessment is a qualitative research tool that prioritizes the experiences and participation of communities affected by TB, including TB key and vulnerable populations. TB key and vulnerable populations are groups at higher risk for TB or that lack access to health services due to biological, behavioral, social, or structural factors. The CRG assessment also interrogates and highlights the significance of human rights, law, and gender in the TB response. TB civil society and community groups, in partnership with national TB programs and others, have conducted the CRG assessment in 20 countries across four regions.

This article's overall aim is to examine the evidence generated by the CRG assessment to better understand the communities, legal environments, and gender dynamics at the heart of the TB epidemic. The article first describes the context and background of the global TB epidemic and response, highlights the recent emergence of the community, human rights, and gender focus, and explains the CRG assessment tool. The article then sets forth the methodology for the analysis of the CRG assessments findings. Next, it uses the normative right to health framework to analyze the assessment findings from 20 countries, identifying and describing an array of issues and common challenges. Finally, this article considers how to strengthen the CRG assessment and how countries affected by TB and their donors and technical partners can leverage its findings to end TB by 2030 in line with the politi-

cal declaration from the first-ever UN High-Level Meeting on Tuberculosis and other global plans.

## Context and background

TB is both preventable and curable. Nevertheless, it is one of the leading causes of death worldwide.<sup>4</sup> In 2020, about 10 million people fell ill with TB and more than 1.5 million died—more than 4,000 people a day (1.3 million deaths were among HIV-negative people; 214,000 deaths were among HIV-positive people).<sup>5</sup> More than four million people who got sick with TB—more than 40% of the 2020 disease incidence—were “missed,” meaning national TB programs did not identify them.<sup>6</sup> Though some of these “missing millions” may obtain testing and treatment in the private sector, many are undiagnosed and untreated. People with active TB who go undiagnosed and untreated contribute to the further spread of the disease.

The global TB burden is distributed unevenly around the world. Almost 70% of all people who fell ill with TB in 2020 were in the World Health Organization (WHO) regions of South-East Asia (43%) and Africa (25%).<sup>7</sup> Within countries, including wealthy nations with low incidence rates, often the most vulnerable, such as the homeless, migrants, and racial and ethnic minorities, are at higher risk for TB than others.<sup>8</sup>

The COVID-19 pandemic has had a devastating impact on the TB response. In May 2020, a consortium of researchers led by STP estimated that COVID-19 lockdowns and their subsequent recoveries could lead to an additional 1.4 million TB deaths between 2020 and 2025.<sup>9</sup> In March 2021, STP reported that TB detection and treatment enrollment numbers in nine countries that account for 60% of the global TB burden had fallen during the pandemic in 2020 to levels not seen since 2008—a loss of 12 years of progress.<sup>10</sup> In its 2021 *Global Tuberculosis Report*, WHO reported that although the global disease incidence remained about the same as in 2019, there was an alarming drop in 2020 in the number of people who were newly diagnosed with TB and registered in their health systems—from 7.1 million in 2019 to 5.8 million in 2020.<sup>11</sup>

This means that, compared with 2019, more than a million people who got sick with TB last year likely went undiagnosed, an 18% decline back eight years to the level in 2012.<sup>12</sup> WHO also reported an increase in TB deaths from 2019 to 2020 for the first time in 15 years, declining back four years to the level of deaths in 2017.<sup>13</sup>

### *Global plans and targets to end TB*

The Sustainable Development Goals (SDGs), WHO's End TB Strategy and Moscow Declaration to End TB, and the STP Global Plan to End TB establish global milestones, targets, and commitments to end the TB epidemic.<sup>14</sup> The Global Plan to End TB, for example, calls for a "paradigm shift" and sets three people-centered targets: reach at least 90% of all people who need TB treatment and prevention, reach at least 90% of people in TB key and vulnerable populations, and achieve at least 90% of treatment success among people diagnosed with TB or those eligible for preventive therapy.<sup>15</sup>

In 2018, the UN General Assembly held the first-ever high-level meeting on TB. The meeting produced a political declaration by which heads of UN member states committed to a set of ambitious targets to end TB by 2030.<sup>16</sup> In accordance with the SDGs, the political declaration from the UN High-Level Meeting on Tuberculosis sets a global target to successfully treat 40 million people with TB by 2022.<sup>17</sup> The declaration also commits countries to prioritize communities, human rights, and gender in their national disease responses. Among other things, countries pledged to protect and promote the right to health and access to affordable medicines, support an end to TB stigma and discrimination, enhance psychosocial support for people affected by TB, facilitate the meaningful participation of TB key and vulnerable populations, strengthen gender equality, and ensure multisectoral collaboration and accountability in their disease responses.<sup>18</sup>

### *Methodology*

This article employs the normative right to health framework to analyze the findings of the 20 CRG

assessments listed below in Table 1.

### *The CRG assessment*

STP began developing the CRG assessment in 2015 through a series of global workshops involving people affected by TB, technical experts, and representatives of civil society groups and national TB programs. The CRG assessment is one component in a suite of initiatives at STP promoting community, human rights, and gender in the TB response. These include the OneImpact Community-Led Monitoring Framework, the OneImpact mobile application that collects real-time data on human rights violations and barriers to TB services, and the Challenge Facility for Civil Society, a small grants mechanism that supports TB civil society and community groups.<sup>19</sup>

The CRG assessment is a multistakeholder participatory process comprising four primary stages: (1) inception, adaptation of the assessment protocol, and secondary data collection; (2) training and primary data collection; (3) data analysis, validation, and report writing; and (4) dissemination and action planning.<sup>20</sup> Civil society and community groups lead the process with support from STP and technical experts. In each country, the CRG assessment is sanctioned and supported by the national TB program, and researchers obtain ethical clearances when necessary, according to national standards. The geographic scope of the assessment is typically national, with a further focus on important subnational jurisdictions, such as large cities or states or jurisdictions with high rates of TB.

Secondary data collection in the CRG assessment involves a desk review of public health and social science literature and legal and policy research. Primary data collection comprises qualitative research methods, including interviews, focus group discussions, and surveys.

The CRG assessment integrates three previously separate tools: the Data for Action Framework for Tuberculosis Key, Vulnerable and Underserved Populations; the Gender Assessment Tool for National HIV and TB Responses; and the Tuberculosis Legal Environment Assessment. Of the 20

countries considered in this article, 14 conducted the integrated CRG assessment and six employed the separate tools. Table 1 lists the countries, the tools that each country implemented, and the name of the implementing organizations. The United States Agency for International Development and the Global Fund provided financial support for the 20 assessments.

### *Right to health framework*

The UN High Commissioner for Human Rights has emphasized the role of the right to health framework in “aligning law and policy with human rights, operationalizing the pledge to leave no one behind, [and promoting] accountability and participation” to achieve the health-related SDGs.<sup>21</sup> The content of the right to health framework derives from article 12 of the International Covenant on Economic, Social and Cultural Rights and General Comment 14 of the Committee on Economic, Social and Cultural Rights, the body that monitors states’ implementation of the covenant.<sup>22</sup> The mandate of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health also produces reports and other materials that contribute to the normative development of the right to health framework.<sup>23</sup>

Scholars, international institutions, and civil

society and community groups have also contributed to the conceptual development of a human rights-based approach to TB, applying and extending the right to health framework established in international law. In 2000, STP, then hosted by WHO, identified “establish[ing] TB as a human rights issue” as the number one challenge for the following year and released a normative guidance on a rights-based approach to the disease.<sup>24</sup> In the years that followed, scholars and physicians further examined and debated human rights’ role in the TB response.<sup>25</sup> In 2016, this journal published a special section on TB and the right to health in which scholars considered access to new drugs for multidrug-resistant TB, the imprisonment of people with TB, and TB in vulnerable populations, among other issues.<sup>26</sup> In 2019, TBpeople, a global group of people affected by TB, released the Declaration of the Rights of People Affected by TB with support from STP.<sup>27</sup> In 2020, the Global Coalition of TB Activists, in partnership with the Northwestern Pritzker School of Law and STP, published a technical brief for policy makers and program implementers entitled *Activating a Human Rights-Based Tuberculosis Response*.<sup>28</sup>

This article relies on seven dimensions of the right to health framework: (1) availability, accessibility, acceptability, and quality (AAAQ);

TABLE 1. Regions, countries, implementing organizations, and years of the 20 CRG assessments

Africa	Eastern Europe and Central Asia
1. Benin (IA 2020), <i>COBCUS</i> 2. Cameroon (IA 2020), <i>FIS Cameroon</i> 3. Democratic Republic of the Congo (IA 2018), <i>Club des Amis Damien</i> 4. Kenya (GA 2018, KVP 2018, LEA 2018), <i>KELIN</i> 5. Mozambique (IA 2020), <i>AMIMO</i> 6. Niger (IA 2020), <i>SongES Niger</i> 7. Nigeria (GA 2019, KVP 2019, LEA 2018), <i>Communication for Development Centre, University of Chicago Law School International Human Rights Clinic</i> 8. South Africa (IA 2019), <i>TB HIV Care</i> 9. Tanzania (GA 2019, KVP 2018, LEA 2017), <i>EANNASO</i>	13. Georgia (IA 2020), <i>New Vector, PAS Center</i> 14. Kazakhstan (IA 2020), <i>Kazakh Union of People Living with HIV, PAS Center</i> 15. Kyrgyzstan (GA 2016, LEA 2016), <i>Samanta Sokolowski, Nonna Turusbekova</i> 16. Tajikistan (IA 2020), <i>Gender and Development, Canadian HIV/AIDS Legal Network</i> 17. Ukraine (GA 2018, KVP 2018, LEA 2018), <i>Alliance for Public Health, Stop TB Partnership, UN Development Program</i>
South Asia	Southeast Asia
10. Bangladesh (IA 2018), <i>BRAC</i> 11. India (GA 2018, KVP 2018, LEA 2018), <i>REACH</i> 12. Pakistan (IA 2018), <i>APLHIV Pakistan</i>	18. Cambodia (GA 2017, KVP 2017), <i>KHANA</i> 19. Indonesia (IA 2020), <i>Spiritita Foundation</i> 20. Philippines (IA 2019), <i>ACHIEVE</i>

Note: IA = integrated CRG assessment; GA = gender assessment tool for national HIV and TB responses; KVP = data for action framework for tuberculosis key, vulnerable, and underserved populations; LEA = tuberculosis legal environment assessment. The years refer to the year each country report was published. The names in italics are of the organizations or individuals that conducted the assessments.

(2) nondiscrimination and equal treatment; (3) health-related freedoms; (4) gender perspective; (5) vulnerable and marginalized groups; (6) participation; and (7) remedies and accountability.

The rights enshrined in the International Covenant on Economic, Social and Cultural Rights, including the right to health, are generally subject to progressive realization due to states' resource constraints.<sup>29</sup> This means that states are not legally bound to immediately realize the right to health in full. Instead, they must "take steps ... to the maximum of [their] available resources" to progressively realize the right to health "by all appropriate means, including ... the adoption of legislative measures."<sup>30</sup> Notwithstanding the obligation of progressive realization, the right to health imposes certain obligations on states that are of immediate effect. These include the obligations to ensure that the right is enjoyed equally by all without discrimination of any kind and to take "deliberate, concrete and targeted" steps toward fully realizing the right.<sup>31</sup>

The AAAQ dimension of the right to health framework encompasses the right to physical and mental health facilities, goods, and services that are available, accessible, acceptable, and of good quality. Availability requires that these facilities, goods, and services be available in "sufficient quantity" in the country.<sup>32</sup> Accessibility includes nondiscrimination and physical, economic, and information accessibility.<sup>33</sup> Acceptability requires that health facilities, goods, and services be culturally appropriate, sensitive to gender and life-cycle requirements, and respectful of medical ethics, including confidentiality.<sup>34</sup> Quality requires that they be "scientifically and medically appropriate" and administered by skilled health workers.<sup>35</sup>

The nondiscrimination and equal treatment dimension comprises the prohibition against discrimination in health care and the underlying determinants of health, and a positive dimension requiring states "to provide those who do not have sufficient means with ... health insurance and health-care facilities."<sup>36</sup>

Health-related freedoms include the rights to privacy, to confidentiality, and to be free from nonconsensual medical treatment (i.e., the right to

informed consent), as well as the freedoms of association, assembly, and movement.<sup>37</sup>

The gender perspective dimension of the right to health framework encompasses states' obligation to "integrate a gender perspective in their health-related policies, planning, programmes and research," including the disaggregation of health data according to sex.<sup>38</sup> This article also includes the health concerns of transgender persons within the ambit of the gender perspective.<sup>39</sup>

The vulnerable or marginalized groups dimension comprises states' obligation to "give particular attention to all vulnerable or marginalized groups" in the process and content of their public health strategies and action plans and to ensure that health workers are "trained to recognize and respond to the specific needs of vulnerable or marginalized groups."<sup>40</sup>

The participation dimension represents the right of affected communities to participate "in all health-related decision-making at the community [and] national ... levels."<sup>41</sup>

The remedies and accountability dimension of the right to health framework embodies the importance of accountability and effective remedies for health-related human rights violations, enabled by courts and nonjudicial mechanisms at the national and international levels.<sup>42</sup>

### *Analysis methodology*

This article analyzes the CRG assessment country reports from the 20 countries listed in Table 1.<sup>43</sup> The country reports contain the CRG assessment research findings and recommendations. The civil society organizations, community groups, and technical experts that conduct the assessment write the country reports. National TB programs and other local stakeholders provide input and review and validate the findings and recommendations in each report before its publication. The authors of this article were involved in various stages of developing the CRG assessment, conducting the assessments, and drafting some of the country reports.

As detailed in Table 1, the country reports were published between 2018 to 2021 (except Kyrgyzstan, which was published in 2016). We note that some

of the relevant circumstances in the countries involved may have changed since their publication. We also note that the organizations and individuals who conducted the CRG assessment took varying approaches in each country, focusing on a range of issues and concerns. The researchers' capacities were also varied and developed over time, as later assessments benefitted from the knowledge and experience of earlier efforts.

To conduct our analysis of the CRG assessment findings, we first read each country report in full. We then focused on the sections containing the research findings to identify specific issues associated with the seven dimensions of the right to health framework. We then used various keyword searches for each dimension to find relevant information throughout the country reports.

We documented our findings with pinpoint citations to the country reports in 20 tables with seven columns for the right to health framework dimensions. We shared these tables with the implementing organizations that wrote the country reports for their review and validation. All 20 implementing organizations provided input, and we revised the tables as necessary. We then analyzed the tables one dimension at a time to identify common issues in the CRG assessment findings across the countries. Finally, we listed the common issues under the corresponding dimensions of the right to health framework and tallied the number of countries for which each issue appears in the assessment findings. The tables and lists of common issues are available upon request from the authors.

### *Limitations*

This article's analysis and the CRG assessment tool are both subject to limitations. Our analysis of the country reports produced by the CRG assessment was subject to two limitations. First, a degree of terminological inconsistency in the country reports weakened the effectiveness of keyword searches in identifying issues associated with the dimensions of the right to health framework. Second, four country reports are written in languages other than English: Benin (French), Cameroon (French), Niger (French), and Tajikistan (Russian). We employed a

three-step process to address this limitation. First, we used Google Translate to translate the entire document, after which we performed our analysis in the English translation. Second, we conducted keyword searches in the original language and then used Google Translate to translate specific passages in which the keywords appeared. Third, we engaged the reports' authors to discuss or request translations of specific passages in which keywords were located or that were of interest based on our analysis of the English translation.

The CRG assessment tool is subject to four main limitations. First, although the assessment generally employed a uniform set of qualitative research methodologies, as described above, there was some variance in the methodologies used among countries. Some assessments relied more heavily on interviews and focus groups than others, some conducted informal surveys of stakeholders, and others focused more heavily on desk research and analysis. Second, there was also meaningful variance in the nature of the disciplines and levels of expertise, training, and education among the individuals who conducted the assessments and drafted the country reports. For example, some researchers and authors were lawyers, while others were trained in the social sciences without legal education. Third, the 20 CRG assessments as a whole focused more on certain issues, conceptual frames, and dimensions of the right to health framework than others. Among these less considered issues are directly observed therapy (DOT) for TB, social protection and psychosocial support for people affected by TB, the participation of people affected by TB in the disease response, the availability and accessibility of remedies and accountability in the response, and the gender-transformative normative frame. Finally, while multisectoral engagement was a feature of the process in all 20 countries, there were nonetheless varying levels of engagement by certain stakeholders, such as national TB programs, TB doctors, and communities affected by TB.

### CRG assessment analysis

This section analyzes the CRG assessment findings

from the 20 countries in line with the seven dimensions of the right to health framework.

### *Availability, accessibility, acceptability, and quality*

The CRG assessment revealed a variety of AAAQ challenges and concerns. The stigmatizing and discriminatory treatment of people affected by TB by health workers, an acceptability issue observed in 16 countries, is the most frequently identified issue. A lack of privacy and confidentiality in TB clinics and health services, another acceptability issue, is the second most common concern, found in 15 countries. Prohibitively long distances to TB clinics, a physical accessibility challenge, appears in the assessment findings in 12 countries. In 11 countries, the assessment discovered acceptability problems with the standard TB treatment, particularly the length of treatment, treatment side effects, and the nature of DOT, all of which are also quality concerns. A low awareness and lack of access to information about TB disease and TB health services are the leading information accessibility issues, highlighted in 11 and 10 countries, respectively. The CRG assessment further revealed the limited availability of trained TB health workers in TB centers, primary health care and other clinics, and prisons in 10 countries.

Additional availability issues include a lack or limited availability of TB treatment support services, particularly counseling and other mental health care, found in nine countries. In seven countries, the assessment highlighted the limited availability of rapid molecular diagnostics for TB that are faster and more accurate than traditional sputum smear microscopy and detect resistance to first-line TB drugs. The assessment findings in seven countries uncover first-line TB drug stock-outs. In four countries, the assessment identified a lack of integration of TB care with HIV and diabetes care and opioid-substitution therapy as a challenge at the primary health care level.

The key economic accessibility barriers observed in eight countries are out-of-pocket payments for TB tests and incidental expenses associated with TB treatment, most notably transportation costs to

clinics for mandated facility-based DOT. The two principal discrimination accessibility challenges the CRG assessment identified are discriminatory treatment of TB key and vulnerable populations in health care in seven countries and discriminatory administrative barriers to health services in five countries in Eastern Europe and Central Asia. The latter includes residency and identification requirements to access TB health services, impacting mobile populations, internally displaced persons, and people with a history of incarceration. Finally, assessment findings in five countries highlight the lack of access to nutritional support during TB treatment as a major concern.

Ten countries identified additional acceptability challenges related to operational issues, including limited hours, long wait times, and overcrowding at TB clinics. These operational issues are also accessibility and quality concerns.

The primary quality issue identified in the CRG assessment findings is the limited availability of trained TB health workers in 10 countries (noted above as an availability concern). The findings in seven and six countries, respectively, also highlight the misdiagnosis or delayed diagnosis and inappropriate treatment of people with TB as major quality concerns.

### *Nondiscrimination and equal treatment*

Discrimination and stigmatizing treatment of people affected by TB are pervasive in the CRG assessment findings. In 18 of 20 countries, the assessment revealed that people affected by TB experience discrimination in health care, including when they seek TB care but also in primary health care settings. The findings in 15 countries show that people affected by TB experience employment discrimination at the hands of both employers and coworkers. In 11 countries, the findings exhibit discriminatory and stigmatizing treatment of people affected by TB in families and communities. In the family context, the assessment findings indicate that women affected by TB are sometimes divorced or abandoned because of their experience with the disease. The findings in six countries draw attention to how children and young people affected by

TB experience discrimination in education, in both schools and higher education.

Remarkably, despite the evidence of widespread discrimination against people affected by TB, the CRG assessment reveals that only one country explicitly prohibits TB-related discrimination in law. The other 19 countries lack legal prohibitions targeting discrimination against people affected by TB. The findings further highlight that the law and policies governing the TB response in two countries contain stigmatizing and discriminatory terminology. However, the assessment findings identify laws or executive decrees in some countries that address some aspects of discrimination against people with TB, including in employment. In one country, the assessment found that people affected by TB have used the courts to combat employment discrimination with some success using the constitution and other employment-related laws.

### *Health-related freedoms*

The lack of protection for the privacy and confidentiality of people affected by TB in law, policy, and practice is the central challenge to health-related freedoms identified in the CRG assessment findings. Eighteen countries highlighted various kinds of privacy concerns. These include a lack of privacy and breaches of confidentiality in health care that deter the use of TB testing and treatment services and challenge treatment adherence. The assessment revealed that most countries do not have laws or policies that specifically recognize and protect the right to privacy of people affected by TB; however, some countries have laws protecting confidentiality in health care more generally. The findings in several countries highlight privacy concerns related to TB public health activities, including contact tracing and disease notification procedures. The assessment also discovered that TB clinics' infrastructure and operational procedures impinge on privacy with exterior and interior signs and waiting room practices.

The CRG assessment findings in 13 countries also highlight concerns about the involuntary isolation and hospitalization of people with TB. The findings reveal that most of these countries

do not have laws or policies that set forth the circumstances, procedures, or protections for the isolation of people with TB. By contrast, some have laws broadly authorizing the quarantine or compulsory hospitalization of people with TB and other infectious diseases, out of line with the WHO *Ethics Guidance for the Implementation of the End TB Strategy*.<sup>44</sup> In two countries in East Africa, the assessments discovered that the arbitrary arrest, detention, or imprisonment of people with TB or multidrug-resistant TB for stopping treatment or for posing a threat to public health was common.

The assessments in six countries revealed that law or policy permits the forced testing or treatment of people affected by TB. In four countries, the assessments highlighted the lack of protection of the right to informed consent for TB treatment and testing or during the collection of personal health data for public health purposes.

The CRG assessment in nine countries discovered that criminal laws erect barriers to health services for people affected by TB, including for TB key and vulnerable populations. These findings reveal that laws criminalizing personal drug use, commercial sex work, and same-sex sexual conduct discourage health-seeking behavior among people affected by TB. In two countries, the findings further highlight that national and subnational laws criminalize the transmission of TB.

### *Gender perspective*

The CRG assessment findings shed new light on the role of gender in the TB epidemic and response. The primary issue emerging from 13 countries is the impact of patriarchal social and cultural norms, including around domestic gender roles and household finances. These findings indicate that patriarchal norms limit women's health-related decision-making autonomy, impede their access to TB health services, and increase their vulnerability to TB infection and disease. The findings in 12 countries further reveal that women affected by TB experience more frequent or more intense stigma and discrimination than men in their families and communities, sometimes leading to abuse, gender-based violence, divorce, or abandonment.

Three countries also found that women lack access to information and are less knowledgeable than men about TB disease and TB health services.

In 10 countries, the CRG assessment findings show that men affected by TB also face unique challenges. Men experience heightened risks of exposure to TB infection, reduced access to TB health services, and higher mortality rates from TB due to a host of factors, including employment insecurity, occupational exposure, labor migration, notions of masculinity, and social and behavioral factors such as smoking, excessive alcohol consumption, and problematic drug use.

In seven countries, the CRG assessment found that transgender persons and sex workers affected by TB and other members of TB key and vulnerable populations also face unique challenges using the health system because of their gender and other gender-related circumstances.

The CRG assessment discovered substantial gender-related programmatic, legal, and policy gaps in the national TB responses in 12 countries. These include the lack of a legal prohibition of gender-based discrimination in health care and the failure to consider the role of gender in TB programs, policies, guidelines, and monitoring and evaluation frameworks. The findings in eight countries further highlight the limited availability or lack of gender-sensitive TB health services, including for transgender persons, due to the lack of gender-sensitivity training for TB health workers, among other things. Eight countries also identified the lack of epidemiological and other data for TB disaggregated by gender, including for transgender persons, as a critical programmatic concern.

### *Vulnerable and marginalized groups*

Identifying groups who are especially vulnerable to TB infection or disease or who experience barriers to accessing TB health services is a unique component of the CRG assessment. The assessment in each country identifies these groups through a combination of research and consensus among national stakeholders. In all 20 countries, the CRG assessment identified new TB key and vulnerable populations for prioritization that were not pre-

viously recognized by the national TB programs. Table 2 presents a tally of the 26 unique TB key and vulnerable populations identified during the CRG assessment in the 20 countries in this analysis.

The assessment findings in 16 countries also highlight various programmatic, legal, and policy gaps and barriers that negatively impact TB key and vulnerable populations. These include an absence of policies, programs, and dedicated resources in national TB programs recognizing and prioritizing these populations in national disease responses. Relatedly, the findings in seven countries reveal that national TB programs do not collect or effectively disaggregate data for TB key and vulnerable populations to understand their size, locations, and unique vulnerabilities. In 10 countries, the findings reveal that criminal or administrative laws and policies and the fear of law enforcement deter the use of TB health services among these populations, such as people who use drugs, sex workers, undocumented migrants, and people with a history of imprisonment. The assessment findings in six countries further highlight that a lack of health services integration for people affected by TB living with HIV, who use drugs, or who have diabetes deters their use of TB health services.

### *Participation*

The CRG assessment findings expose a dearth of mobilization and meaningful engagement of people affected by TB and TB key and vulnerable populations in the national TB responses in most of the 20 countries in this analysis. The fact that reports from four countries do not discuss participation at all underscores this situation. The reports in the other 16 countries do not address participation to the same extent or in as much detail as the other issues examined in this article.

Nonetheless, the findings in 10 of the 16 countries that consider participation highlight the low number of civil society and community groups working on TB, the limited influence of such groups, and the limited financial and other support available to these groups to facilitate their meaningful participation in the TB response. The findings in eight countries further reveal that national TB pro-

grams fail to meaningfully engage people affected by TB in designing, implementing, monitoring, and evaluating TB policies and programs. The assessments in two countries discovered that gaps or barriers in law and policy hinder the meaningful participation of communities affected by TB. These gaps include the failure of legislation to recognize the right of people affected by TB to participate in health decision-making processes.

*Remedies and accountability*

The CRG assessment findings reveal that people affected by TB have limited access to justice and accountability mechanisms in the TB response. The fact that reports from three countries do not address concerns related to remedies and accountability highlights this problem. In 10 of the 17 countries that consider the issue, the assessments

found that law and policy do not establish judicially enforceable legal rights or mechanisms for people affected by TB to seek remedies for rights violations and other legal matters. Reports from these countries noted a range of issues for which remedies and accountability were out of reach. These include discrimination in employment and health care, violations of the rights to privacy and confidentiality, denial of health services, and compensation for occupational exposure to TB, including for health workers.

The assessment in nine countries discovered that people affected by TB lack access to justice due to the absence or limited availability of legal aid services. The findings in eight countries highlight that the limited use of courts by people affected by TB is due to low levels of legal literacy and knowledge about legal rights. Two countries specifically

TABLE 2. TB key and vulnerable populations identified in the CRG assessment for prioritization in national TB responses

	TB key and vulnerable population	# of countries identifying this population
1.	Prisoners and people with a history of imprisonment	18
2.	People living with HIV	15
3.	Migrants, refugees, internally displaced persons, and other mobile populations	14
4.	People who use drugs and people who inject drugs	13
5.	Health care and hospital workers	8
6.	Children	7
7.	People with diabetes	7
8.	Urban poor and people living in slums	7
9.	Elderly people	6
10.	Miners and people with silicosis	6
11.	Contacts of people with TB	4
12.	People who smoke	3
13.	Farmworkers and fishermen	3
14.	Homeless persons and people living on the streets	2
15.	Pregnant women and mothers	2
16.	Rural poor	2
17.	Sex workers	2
18.	Ethnic minorities	1
19.	Indigenous peoples	1
20.	Men who have sex with men	1
21.	Military personnel	1
22.	People with alcohol dependency	1
23.	People with disabilities	1
24.	People with mental health challenges	1
25.	Traditional healers	1
26.	Transgender persons	1

mentioned the need for alternatives to litigation, such as alternative dispute resolution and mediation, so that people affected by TB may more easily, quickly, and affordably obtain remedies and promote accountability for rights violations.

The CRG assessment findings in two countries emphasize the lack of accountability for preventable TB deaths, inappropriate medical treatment of people with TB, and other issues of serious neglect of people affected by TB, including in prisons. The findings in three countries draw attention to criminal laws that act as inappropriate and ineffective deterrents or interfere with access to remedies for people affected by TB. The reports from two countries assert that the law should not criminalize the failure of doctors, chemists, or other health workers to notify TB cases. Instead, the reports recommend that national TB programs use incentives to promote disease notification among health workers, particularly in the private sector. The assessment findings in another country reveal that laws crimi-

nizing drug use discourage people who use drugs from seeking legal services to obtain remedies for TB-related rights violations due to fear of law enforcement.

### Discussion and way forward

The political declaration from the first-ever UN High-Level Meeting on Tuberculosis contains pioneering commitments by UN member states to prioritize communities, human rights, and gender in the TB response.<sup>45</sup> Framed by a pledge to “protect[] and fulfill[] the human rights and dignity of all people,” these commitments strengthen and expand upon preexisting human rights commitments in the WHO End TB Strategy, the WHO Moscow Declaration, and the STP Global Plan to End TB.<sup>46</sup> The CRG assessment findings constitute the most robust evidence available by which to reflect on these commitments, revisit strategic priorities, and scale up investments in communities, human

FIGURE 1. Issues identified by the CRG assessment in 10 or more countries



rights, and gender.

The CRG assessment findings examined in this article highlight a broad spectrum of challenges and opportunities. Despite considerable diversity among the issues, as Figure 1 demonstrates, there is a meaningful overlap of shared challenges across the 20 countries and four regions. For example, 90% of the assessments found that people affected by TB experience stigmatizing and discriminatory treatment in health care. Seventy-five percent of the assessments revealed that people affected by TB experience employment discrimination. Despite this, 95% of the countries in this article fail to explicitly prohibit discrimination against people affected by TB in law. The assessment findings in 90% of the countries highlight various privacy concerns, including breaches in confidentiality that deter the use of TB health services. In 65% of the countries, the assessment findings indicate that patriarchal norms negatively impact women's access to TB health services and increase their vulnerability to TB infection and disease. These remarkable findings shed new light on often overlooked challenges that are critical to meeting global commitments to end TB by 2030.

This year, WHO released an updated list of countries with high burdens of TB, TB/HIV coinfection, or multidrug/rifampicin-resistant TB.<sup>47</sup> More than 30 of these high-burden countries have not yet conducted the CRG assessment. In 2020, the STP Affected Communities Delegation and the Developed and Developing Countries NGO Delegations called for all high-burden countries to conduct the CRG assessment and develop costed national action plans with detailed budgets and monitoring and evaluation frameworks for community, human rights, and gender by 2022.<sup>48</sup> They recommended that countries integrate the assessment findings into their TB national strategic plans to establish relevant targets and set national funding and intervention priorities. The STP delegations further recommended that a completed CRG assessment and corresponding national action plan be prerequisites for countries to obtain grants from the Global Fund and other donors.<sup>49</sup> In line with these recommendations, the CRG assessment

has already led to costed national action plans for community, human rights, and gender in Bangladesh, the Democratic Republic of the Congo, India, Nigeria, and Tanzania, and similar processes are forthcoming in most of the other countries in this article.<sup>50</sup>

The CRG assessment findings represent a call to action for donors and technical partners to prioritize community, human rights, and gender in their programmatic and investment priorities for TB. These institutions include WHO, STP, the Global Fund, other multilateral donors, bilateral donors, international organizations, and philanthropic foundations. The WHO Global Tuberculosis Programme should incorporate the CRG assessment findings into World Health Assembly resolutions, its influential annual *Global Tuberculosis Report* and normative guidances, and the WHO Multi-sectoral Accountability Framework to Accelerate Progress to End TB by 2030.<sup>51</sup>

As the largest international donor for TB, the Global Fund should leverage the CRG assessment findings to increase its financial support for community, human rights, and gender interventions in TB through established funding mechanisms by promoting TB community-led monitoring and developing TB indicators for human rights and gender.<sup>52</sup> The latter could be enabled within the Global Fund's 2021 Strategy Framework and operational guidance and incentivized as prerequisites for national TB grants building on the stigma indicator in the Global Fund's Performance Framework.<sup>53</sup>

The UN-hosted STP should improve the CRG assessment tool in line with this article's suggestions (see below) and seek increased donor support for its Challenge Facility for Civil Society grant program. Among other things, this program funds TB community and civil society groups to conduct the CRG assessment and implement and monitor the assessment's recommendations.<sup>54</sup> STP should also include the CRG assessment findings in its upcoming Global Plan to End TB: 2023–2030 and the next iterations of the *Governance of TB Programs* and *TB Commitments vs. TB Realities* reports due ahead of the next UN High-Level Meeting on Tuberculosis in 2023.<sup>55</sup>

As more countries—including those on the new WHO high-burden lists—focus on community, human rights, and gender, STP and partners should strengthen the CRG assessment tool and promote greater consistency in the country reports it produces. Six concrete ideas for strengthening the CRG assessment tool emerged from this article's analysis: (1) ensure that the assessment process is adaptable and capable of integrating emerging issues, such as COVID-19 and other health emergencies; (2) improve the quality and promote greater uniformity of the assessment's methodologies through enhanced guidance, training, and technical support, including for quantitative methodologies that researchers may incorporate; (3) identify and prioritize critical issues neglected in the 20 completed assessments, such as TB community participation, health governance and systems, legal aid and remedies, and psychosocial support; (4) incorporate a critical analysis of DOT—the predominant but flawed TB treatment paradigm—in favor of community-based approaches; (5) employ a gender-transformative—rather than simply a gender-sensitive—lens in the assessment; and (6) explicitly position the assessment as the start of a dialogue and process to integrate communities, human rights, and gender into national TB responses, including through costed national action plans and dedicated funding for civil society and community groups.

## Conclusion

A paradigm shift has begun in the global TB response. The emergent focus on communities, human rights, and gender has rejuvenated the fight against an age-old yet curable disease driven by social and economic disadvantage. The STP CRG assessment and its findings from the 20 countries in this article are both a product and a forceful example of these new ideas. We urge further research, discussion, and action by national TB programs, people affected by TB, scholars, and other global and national stakeholders to develop solutions to the challenges identified by the CRG assessment. Community, human rights, and gender-focused TB interventions are especially critical in light of

the unprecedented challenges of the COVID-19 pandemic. As the world quickly moves toward the conclusion of the 2030 Sustainable Development Agenda, civil society and community groups, countries affected by TB, and donors and technical partners must leverage the CRG assessment and its findings in pursuit of the targets and commitments to end TB in the political declaration from the UN High-Level Meeting on Tuberculosis and other global plans.

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## LETTER TO THE EDITOR

# Privacy, Equity, and Human Rights Challenges in Public Health Surveillance

RACHELE HENDRICKS-STURRUP AND SARA JORDAN

In the situation of a global pandemic, how can specific vulnerable groups be protected against privacy risks that are inherent to contact tracing? Over the last 19 months, this question has motivated intense discussion by bioethicists, health law and privacy scholars, technology companies, and governments. Some of the nuance of that discussion was captured within several pieces published in *Health and Human Rights Journal*, including but not limited to “Analyzing the Human Rights Impact of Increased Digital Public Health Surveillance during the COVID-19 Crisis.” These and other authors advocate for scrutiny of digital contact tracing technologies (DCTT) for two reasons: (1) the historic pattern whereby emergency public health or safety surveillance systems later became embedded as “permanent fixtures,” sometimes to the detriment of basic access to essential public services, and (2) the trend of digital health surveillance tools as harbingers of unmanaged privacy, safety, and security risks.

The Future of Privacy Forum recently grappled with pandemic privacy and equity risk in our Privacy and Equity Principles and Framework for DCTT, solidifying the perspective that

*contact tracing efforts to monitor the spread of communicable diseases in socially vulnerable groups can place those groups at risk of discrimination or ostracism at home or within their communities. Those populations may suffer the greatest, from a social and economic standpoint, and may be less likely to engage in any technology, including DCTT, that might disclose their private social affiliations and whereabouts.*

This framework argues that the protection of vulnerable persons in the midst of heightened risk requires (at least) the following commitments:

1. Be transparent about how data is used and shared.
2. Apply strong de-identification techniques and solutions.
3. Empower users through tiered opt-in/opt-out features and data minimization.
4. Acknowledge and address privacy, security, and nondiscrimination protection gaps.
5. Create equitable access to DCTT.
6. Acknowledge and address implicit bias within and across public and private settings.
7. Democratize data for public good while employing appropriate privacy safeguards.
8. Adopt privacy-by-design standards that make DCTT broadly accessible.

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Our framework identifies five real-world case scenarios where manual or digital data collection or use has conflicted with the notion of privacy as a basic human right. For instance, we found in two cases that principles 4, 6, and 8 above were not implemented by the DCTT developers or users, thus creating situations where information gained from DCTT was used to target vulnerable groups. With respect to the future, we found that without careful consideration of social vulnerabilities, such as discrimination or ostracism, DCTT implementation will be less effective when used among populations who fear disclosure of their already stigmatized private lives.

As the COVID-19 pandemic continues, new technological solutions will test the real-world application of these principles. We hope that like-minded venues, including *Health and Human Rights Journal* authors and readers, can continue to ask and answer these challenging questions with fundamental human rights, privacy, and public health in mind.