COVID-19 in the Global South

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The notion of universal human rights, applicable to all and promoted as an answer to future global peace, security and sustainability after World War Two, continues to be a work in progress in a deeply divided and unequal world. Attempts to establish international human rights standards and enforcement mechanisms by the UN and then other regional bodies such as the Council of Europe (CoE) have been beset by a range of different obstacles. Different cultures, ideologies and socioeconomic contexts, geopolitical rivalries and the unequal distribution of power and wealth globally all influence the establishment of ‘rights’ and their realisability. In the Global South, the legacy of colonialism and ongoing neocolonialism have often contributed to weak states, dictatorial rulers and gross inequalities, exacerbated by a dominating global market system. In such circumstances, even the most basic human rights – such as the rights to life, health and education – have been denied to large sections of the population. Massive global inequalities exist in access to rights – whether civil and political, but especially social and economic. It is therefore not surprising that as states have struggled to cope with the COVID-19 pandemic, human rights concerns have emerged in terms of what governments have and have not done, and how global institutions have fared in ensuring human rights protections in the global community. This chapter explores some of the impacts of the COVID-19 pandemic.
pandemic on international human rights globally and on the whole notion of the universality of human rights.

**Human rights protection and COVID-19**

When COVID-19 was declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organization (WHO) on 30 January 2020, governments reacted differently and at varying paces in response. Measures taken, or not, were informed by a mixture of political, economic and ideological influences weighed against sometimes conflicting advice from national and international scientific advisers. Concerns for the impact on the economy, education, mental health and normal life had to be weighed against the need to contain the spread of a deadly new virus about which the world knew very little and for which there was no cure or vaccine. Lockdown of the economy, education, childcare, leisure facilities, as well as restrictions on movement, social distancing and quarantine, challenged individual rights’ protections in the name of the right to life and health of the society, and particularly of those most susceptible to the virus.

Concerns for the rights of citizens at nation state level overrode ideas about international solidarity. Narrow national responses led to the unilateral closure of borders in many states to prevent the inflow of people from elsewhere, including the cancellation of the European Union’s (EU) programme to resettle refugees from Syria. The notion of ‘free’ trade was shelved as governments prevented the export of or used their economic power to corner the market for respirators, personal protective equipment (PPE) and drugs. In July 2020, the US cornered almost all the global supply of Remdisivir – the most promising drug to emerge at the time in the fight against the virus. At the same time, the EU Commission announced that it was in discussions with the drug’s producers, the US company Gilead, ‘to reserve doses of Remdisiver for EU member states’ (*Irish Times*, 6 July 2020: 12). This of course led to concerns by those states, particularly in the Global South, who may not have the economic clout to challenge rich states in the marketplace for
the necessary drugs and equipment to fight the virus. It also raised questions about who would have access (and when, and to what extent) to any vaccine that might be produced at a future date. US President Trump, for example, made it clear that he intended to ensure that Americans would get access to any potential new vaccine before anyone else in the world. Such pharmaceutical protectionism would have a catastrophic effect on many countries in the Global South unable to prepare for this pandemic without appropriate medical resources.

Globally, concerns were also raised about the potential use of the pandemic as an excuse by some states to curtail hard-won freedoms. Human Rights Watch (HRW), for example, listed 111 countries where it said that governments had used the crisis to introduce media suppression, controls on civil society, or legislation that was intended to silence oppositional voices. Lockdown became an excuse in some countries to adopt emergency powers or martial law decrees, or to monitor populations under the guise of limiting contagion. It also opened the window for the suppression of ethnic minorities and permitted political persecution to thrive on a wide scale (HRW, 2020).

Although restrictive regulations are undoubtedly necessary at times of public health emergencies, some governments used the opportunity to circumvent or change human rights legislation. While states are allowed under international human rights law to derogate from many of the rights in a time of emergency, the extent of restrictions to rights should be appropriate to the particular circumstances at that time and should be lifted when the emergency dissipates. There are always concerns though that once restrictions on rights are in place it may be difficult to get them removed in the future as states become comfortable with this ‘new normal’. The 2015 imposition of emergency decree laws in Turkey, for example, showed that: ‘...the longer the emergency regime lasts, ... the lesser justification there is for treating a situation as exceptional in nature with the consequence that it cannot be addressed by application of normal legal tools’ (Venice Commission, 2016: 41).
Rights violations have become widespread in the Global South since the announcement of the pandemic. President Duterte of the Philippines, for example, threatened to shoot anyone violating his pandemic restrictions and public animal cages were erected for public humiliation; in South Africa, the police enforced violations of restrictions with beatings, water cannons, rubber bullets and mass imprisonment; in India, migrant workers were lined up and sprayed with disinfectant; others had ‘keep away from me’ forcibly written on their foreheads; 15 people were shot dead by police enforcing the curfew in Kenya; in Iran, Amnesty International reported 36 killings of prisoners protesting about health concerns around the virus (Delvac, 2020: 1). Fundamentally, what has been challenged in many countries has been the right to liberty. Under the restrictions imposed during the pandemic, restraints have been placed on whole populations in terms of what they can and cannot do, where they can travel, shop or spend leisure time, who they can be in contact with and how closely and for how long. In particular, restrictions have been placed on the most vulnerable: the elderly, the ill, those with underlying health issues and those in need of institutional care. Health protection and public safety have been the primary concerns, but proportionality is important, as is the rebuilding of rights-focused approaches post-COVID-19.

A thin line exists between the need to protect communities from the spread of the virus and the right to freedom of movement and behaviour. In some countries, such as the US where the primacy of individual freedom and limited government regulation is promoted, the conflict between individual rights and the collective rights of communities to good health has precipitated the spread of the virus. As a result, the deleterious effects of the pandemic have been most severe on the rights to healthcare, education, freedom from hunger, and so on.

The welfare states which emerged after World War Two in many European countries, with comprehensive public health services, free education systems, income and other social protections, were not replicated in most of the Global South or indeed even in rich countries such as the US. When the pandemic emerged, while some health services (such as in
Germany) appeared better prepared than others, many, even among those with comprehensive welfare systems, struggled to cope. Lack of adequate supplies of PPE, respirators, medical staff, drugs, hospital facilities and testing capabilities were experienced throughout Europe with some health facilities overwhelmed with the numbers infected. That so many healthcare workers and elderly residents of care homes were to die was an indictment of both the lack of preparedness of some states and the virulence of the virus. In the US, the lack of a comprehensive public health service and a reluctance to interfere in the market or individual rights for the collective good, alongside poor political leadership, meant that one of the richest countries in the world suffered the most in terms of total deaths throughout much of 2020. In particular, it was the poor, the disadvantaged, the elderly and ethnic minorities that bore the brunt of this.

It emerged early in the pandemic that large numbers of workers in specific employment sectors, such as the meatpacking industry, were contracting the virus. Dependent on mostly migrant labour, on poor wages and living and working under congested conditions, this raised questions about work practices and conditions in such industries. It also raised questions about the effectiveness of travel controls supposedly established to prevent the spread of the virus from state to state. Bus drivers, care workers and taxi drivers were also groups especially affected by the virus. When states began to lockdown to try and curtail the spread of the virus, those first to lose their jobs were often those who were in low-income employment or with precarious contracts – those with little or no labour rights. As the lockdown restrictions start to be lifted and economies begin to function again, it is those same workers that will most likely suffer the most in the accompanying global recession.

In the Global South, the impact of disruption to global trade has added to economic precarity. Prior to the pandemic there were already more than 820 million people who went to bed hungry in the world. Quarantine regulations, partial port closures, border closures and travel restrictions causing disruption to the global food market will exacerbate this. ‘Well-nourished citizens in wealthy countries may weather a
couple of months without some fresh or imported produce, but in the developing world, a child malnourished at a young age will be stunted for life’ (Dongyu Qu, 2020).

Most states were quick to close schools and colleges early on in the pandemic, believing that young people were possible ‘super-spreaders’ of the virus. Education went online, to a greater or lesser degree. This in turn reinforced already existing educational inequalities for those on lower incomes or with learning difficulties. Lack of access to computers, the web, reliable broadband, dedicated technology for personal educational purposes, space, educational support, and the general environment in which education takes place, are all issues. The closure of schools also meant there were no school meals for millions of children across the world – 85 million in Latin America and the Caribbean alone (Dongyu Qu, 2020). The right to education has been put into question on a global scale.

The response of international organizations

One may well ask, where have the international institutions been during this pandemic, and to what extent have they been able to marshal a global response which protects the rights of all? The WHO, set up as an agency of the UN in 1948 with the task of promoting global health and organizing international responses to global health emergencies, announced the pandemic on 11 March 2020. At the time there were already 118,000 cases of the coronavirus illness in over 110 countries and territories around the world, and in retrospect it admitted that it had been too slow on the announcement since the first cases were identified in the Chinese city of Wuhan on 31 December 2019. One major problem had been the lack of information about and understanding of the new virus, which led to slow and confused reporting from countries affected. The WHO set in motion a global COVID-19 Strategic Preparedness and Response Plan which identified the major actions countries needed to take and the resources needed to carry them out. This continues to be updated in line with scientific evidence from around the world. Although not a
human rights oversight body, the WHO has been heavily involved, prior to the pandemic, in the promotion of the right to health globally and the UN Sustainable Development Goals (SDGs), especially Goal 3 relating to attempts to promote health. In more recent times, it has attempted to provide a coordination role in the dissemination of information which may help prevent the spread of the virus, and in the promotion of the development of treatments and vaccines to combat it. Ironically, in the middle of the crisis, US President Trump launched several public attacks on the WHO for what appeared to be domestic political reasons, announcing that the US was withdrawing from the WHO – the only UN state ever to do so – and removing its funding by 2021.

In terms of international human rights law during the pandemic, there are a number of oversight bodies in existence in relation to various civil and political rights, as well as the social, economic and cultural rights contained in the various UN rights treaties. The most obvious oversight role is that held by the UN Office of the High Commissioner on Human Rights (OHCHR) and the monitoring committees associated with each of the human rights covenants and conventions. Their role is mainly to report on rights abuses and progress towards both the protection and promotion of rights in each state which has ratified these treaties. Their oversight role is mainly one of persuasion rather than enforcement. There is also the International Court of Justice (ICJ) at the Hague, whose role it is to give judicial opinions on aspects of international law, but again it has no enforcement powers. The only UN body with the ability to enforce human rights is the UN Security Council. It can potentially invoke UN economic sanctions and even war; however, historically, such decisions have usually been more influenced by the national and geopolitical interests of the big powers rather than concerns about universal human rights protections.

The UN did introduce a US$2 billion COVID-19 Global Humanitarian Response Plan across 51 countries in the Global South to strengthen health services and combat the spread of the virus. It also highlighted a number of specific groups as being vulnerable to political interference in human rights standards, including persons in detention; women;
lesbian, gay, bisexual, and transgender (LGBT) persons; and migrants, all groups that – in light of widespread derogation of human rights conventions – were being harassed or abused in many states across the Global North and South (OHCHR, 2020: 3). Nevertheless, the UN also recognized that some rights, such as the right to movement, needed to be curtailed in order to protect other more fundamental rights, the right to life and the right to health.

Conclusion

The COVID-19 pandemic has resulted in exceptional circumstances for populations around the globe. The imposition of emergency powers and curfews have placed immense pressures on the architecture of human rights protection, which coupled with recent derogations and reversals globally has complicated the drive for human rights-based approaches to international development. The urgency of rebuilding is critical for the lives of billions of people, but particularly the most susceptible to human rights abuses: minority ethnic groups, women, LGBT communities, the elderly and sick. International coordination and cooperation need to remain central for reestablishing the consensus on the importance of human rights across all societies. The Council of Europe offers some internationalized conscience to easing out of this emergency situation, with forward thinking that is globally applicable:

Even after the acute phase of the crisis, our societies will have to find the means to repair the social and economic damage and further enhance trust in our democratic institutions. Among other things, a broad reflection will need to be initiated on the protection of the most vulnerable individuals and groups in our societies and about the means to safeguard their rights in a more sustainable and solidary governance model.

(Council of Europe, 7 April 2020: 9)
The pandemic has raised questions about a range of other rights, such as the right to health, education, income, freedom from hunger. Indeed, some of the actions and inactions of states may well have contributed to disproportionate levels of deaths and severe illness among some sections of society. For example, why was it that many older people in care homes, frontline healthcare staff and unequal numbers from ethnic minorities died in societies with comprehensive public healthcare systems? Why was public healthcare withdrawn in many regions of the Global South? Decisions by some states also potentially targeted certain minorities as ‘problem’ groups. Questions also remain as to whether it was appropriate or humane to force elderly people or those with underlying health problems to self-isolate and restrict their freedom to associate, even when they were very ill or dying, often while others in the general population were free to move around.

With the rush of nation states to protect their own interests, their establishments and that of their own citizens, concepts of human rights, which are supposed to be universal to all humans and provided globally, have often been lost. However, at the least, the continuing existence of international bodies, such as the WHO and the OHCHR, provide some level of hope that in a world less afraid and recovering from the pandemic, concepts and actions of global solidarity will return.

References


