INTERVIEW

Making Human Rights Relevant to Social Struggles during Covid-19: An Interview with Alicia Yamin

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Covid-19 is causing harm around the world, with states having adopted measures in response. Would you consider these measures effective and consistent with respect for human rights?

I am currently running a global symposium at Harvard Law School looking at the rule of law in global responses to Covid-19 and different country analyses. This crisis has challenged the traditional understanding and organisation of democratic institutions in ways we have rarely seen. Most of the legal measures instituted have been done through decree, federal order or states of exception or emergency, triggered under constitutions or legislation.

Due to the virus emerging with such rapidity, with dire health implications, there has definitely been a shift in response from normative, legislative oversight and judicial backstopping to a much more concentrated executive power, which was already a trend we were seeing before the pandemic – and we have yet to see the [full] extent of this.

Public health (and economic) measures are notoriously utilitarian and blunt, and so the effects on different populations are not often taken into account. This has been evident in the US, where the virus is not striking everybody equally, but instead social determinants and inequalities have largely influenced who contracts the disease, as well as the effects of the governmental responses of lockdown. It is also evident elsewhere. For example, not everybody is able to maintain a livelihood during lockdown. Migrant workers, prisoners, people in institutions, women who have been exposed to greater increases of domestic violence, and persons with disabilities, are marginalised groups experiencing vulnerabilities during this pandemic.

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The effects of Covid-19 on the health-care sector would seem to differ between developed and developing countries. How would you relate this to inequalities in access to health care and related services?

It is proving to be more complicated than 'developed versus developing countries'. Generally, countries with more resources and health-system capacity are going to fare better, with the capacity for additional mitigation of economic and, in turn, other health effects such as childhood nutrition and starvation.

However, this pandemic has highlighted [how disastrous the response has been in] countries where health systems are privatised or designed around a specialised system of hospital care, with little investment in public health, including the US … [I]n countries with much lower income contexts, such as Kerala in India or Cuba, we have seen much greater containment measures, where the use of tried and true basic testing and contact tracing measures and community-based primary care strategies, with a backdrop of social equality and social protection, have fared better.

This pandemic has reaffirmed that the way you organise your public health system is really important for addressing pandemics and in times of normalcy. The US has proven that although it is the richest country in the world, it has done an absolutely miserable job in managing this crisis. Therefore, it is not just about having resources but how these resources are deployed and organised.

How would you assess the impact of Covid-19 on the enjoyment of sexual and reproductive health and the rights of vulnerable and marginalised groups?

The impacts have been absolutely terrible across the board. There has been a 'shadow pandemic' of domestic violence, which was entirely predictable. All the work that has been done in trying to get domestic violence recognised and treated as torture, cruel and degrading treatment, along with General Comment No. 35 from [the] Committee on Convention on the Elimination of all forms of Discrimination Against Women (CEDAW Committee), noting that it has risen to the level of ***jus cogens***, has essentially been belied by the treatment during this pandemic.

We are witnessing women literally being locked up with their torturers and abusers, as well as children. Women are also largely reliant on the health system, [and] contraception has become more difficult to access, as well as antenatal and delivery care. There has also been a huge spike of cases, in the economic north, where women are being refused support partners during delivery, and where women have been induced to give birth and get out of the hospital quickly, or induced to have an emergency caesarean and then kicked out of hospital – this is extreme obstetric violence and abuse. There has also been the shameless use of this pandemic to legally restrict or de facto restrict access to abortion.

The LGBTQIA communities have also fared badly; sexual reassignment surgery has been delayed, and this population is also likely to be let go from jobs, are the last ones who will receive mental and health support services if they are needed under these conditions, and they are also facing increasing violence.

HIV and AIDS treatment across Sub-Saharan Africa has also been set back years by this pandemic, including [treatment of] sex workers and the LGBTQIA populations who rely on these public programmes.

Efforts are ongoing to find a vaccine for Covid-19. How do we ensure that this process adheres to ethical human rights standards and, more importantly, how do we ensure these vaccines are not out of reach of poor countries in Africa?

The consensus view of ethicists is that the first people to get a safe and effective vaccine should be those who are most vulnerable, such as people with underlying medical conditions, including HIV and AIDS, cancer, etc. They have the most clinical benefit to gain. Second, the consensus view among moral

philosophers and human rights lawyers is that the vaccine must be treated as a public good, and so it cannot be held hostage to intellectual property rules or private profits. It cannot be used in a politicised way by the Trump administration in the US.

In this respect, [the] distribution of an eventual vaccine would also need to take in account the lack of resources and vulnerabilities, in sub-Saharan Africa and other [regions], where it's not just [a case of] paying for a vaccine, but also for establishing or strengthening supply chains.

As the world continues to tackle Covid-19, are there lessons we can learn from the way Ebola and HIV/AIDS were addressed in Africa?

The first lesson is that you have to work with the people who are being directly affected. It is not just a matter of bringing in experts from an international body who tell people what to do. It requires conversations with the people in communities, them voicing their concerns and trying to deliberate with them [as to] what is the best way forward. I've seen this over 30 years of maternal health struggles – the reality is that health systems are really bad at talking to people instead of at them.

The second lesson is that people are different and have different needs, and there is no space for one-size-fits-all strategies. The third lesson is the critical role of contact tracing. Partners in Health, who have been extremely active in the Ebola outbreak and the HIV and AIDS pandemic in Africa, [are] now in charge of contact tracing for Covid-19 in the state of Massachusetts, where I live now. Recognising the standard that everything is usually done right in the north and should be imposed in the south is a misconception – lessons are now being learnt from sub-Saharan Africa and being applied in the US.

However, there is one thing that should ***not*** be learned from the HIV and AIDS pandemic. While we learned a lot about the stigmatisation of populations and non-discrimination, it also led to the adoption of targeted and vertical approaches in health systems.

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I would hate to see health systems in Africa now investing in ventilators and expanding intensive care units: this not going to increase public health equity. Public health measures like getting on top of this early [are] what [are] going to increase public health equity, and preparedness for pandemics generally. In the US, there are hospital conglomerates with tons of equipment and specialists – but not public health systems – and this has been one of the biggest problems.

Over the years your work has focused on a rights-based approach to health and addressing inequalities in access to health care. Do you think there have been positive developments in this regard in the last decade?

It will be easier to answer this subsequently with Question 10. The reason I wrote ***When Misfortune Becomes Injustice*** stems from when I was in law school. All of us who have dedicated ourselves to economic and social rights (and in my case, health rights in particular) had three main goals.

The first goal was to show that economic and social rights, including health, were real legal rights which could be enforced by courts. While courts do not always issue judgments in ways which enhance equity

and public learning, significant progress has been made in this regard. The second issue was that it was not immediately apparent what these rights mean, including the right to health, regulations, policies and constitutional design. For example, the right to health is not simply the right to be healthy, to medical care, [but is about] what it means for a state to level the playing field – there has also been progress in this realm, although there is still a limited perspective when it comes to human rights-based approaches.

The third goal was to show that the realisation of economic and social rights could actually lead to more egalitarian social orders, which are genuinely better, fairer and inclusive. In this regard, it is when misfortune becomes injustice – a quote from an opinion by Justice A Sachs – ... that we have largely failed. While we have achieved real significant change at a normative level and in people's lives, we have failed in achieving the larger objective. The focus was on expanding the social contract to different kinds of people, including marginalised and vulnerable populations. However, at the same time the rules of global economic governance were becoming increasingly intrusive. Neo-liberalism was sweeping across the world, there was the privatisation of basic social services, taxation regimes were changing dramatically, there was the financialisation of economies, and intellectual property acted a mass transfer from the global south to the global north.

South Africa is a good example of how, toward the end of apartheid, the country was under-borrowed, and the World Bank and International Monetary Fund were eager to get a cut and encouraged South Africa to borrow money. In the initial stage of post-apartheid [South Africa], there was this idea that there can be redistribution through growth, and while this was a reasonable aspiration, this did not work in South Africa. Politics became increasingly dysfunctional to the point when it was kleptocratic and performative. By the time Jacob Zuma was president, the executive branch largely had impunity from domestic accountability and South Africa is not alone.

There has been a toxic synergy between pushed adjustment policies and opportunities of international financial institutions from cronyism and consolidation of executive power. This has led to certain people getting extremely rich and other people [having] been left out. You cannot have a democracy where that kind of inequality exists, in South Africa or anywhere. Extreme income and wealth inequality is just as toxic as violations of civil and political rights such as racial discrimination. When the people who are making the policies don't need to live by any of the effects – in health, education, security – this cannot coexist with meaningful democracy. And then, enter Covid-19 against this background.

What would you suggest to the international community, especially governments of developing countries, as regards preparedness for addressing pandemics like this in the future?

We need to invest more in multilateral institutions, including the World Health Organization. There were many pandemic-preparedness assessment scenarios, including critiques after the Ebola outbreak, of which most were not implemented. The International Health Regulations were significantly rewritten after SARS and needs to be rewritten again. However, we are seeing how fragile the post-World War II reality is. The fact that Trump can independently decide to withdraw funding to the World Trade Organisation and World Health Organization because he feels it is unfair to China, has highlighted how easy it is to shift power within these institutions.

Therefore, while we need to invest in these institutions, we should also ensure they are rebuilt better and more justly. These multilateral institutions have been run by the donor countries and now private philanthropic capitalists like Bill Gates, who are even less accountable. It is not fair, especially for Africa, which loses so much more in outflows than it receives in aid. This system needs to be restructured, and this pandemic has brought this to the surface.

It should not be responded to with the 'normal' human rights approach, which often does little to assist on the ground. The formalistic approach of calling on human rights institutions in Geneva means little at grassroots level. I believe we need to make human rights relevant to social struggles – we need

to make this about re-democratisation, much more than [about] the highly legalistic approaches we have become accustomed to. And that's what I say in the book.

Do you think courts can play an important role in addressing some of the challenges posed by Covid-19?

Courts have largely played an ancillary role thus far. At times they have invalidated police arrests or fining people, but they have been largely reticent about invalidating restrictive orders. One place where courts have played an important role is in Brazil, where President Bolsonaro has stated that Covid-19 is a 'little flu', [which] has resulted in them having one of the highest numbers of deaths. He has tried to clamp down on the restrictions that states and municipalities have imposed in their territories, and the Supreme Federal Tribunal has said that would be unconstitutional.

This pandemic has also highlighted the stresses of our democratic institutions and all of the tools of deliberation and reason that we relied on. It is imperative that how we come out on the other end is not only aimed at the least amount of lives and livelihoods lost, but [at having] the semblance of the rule of law intact and democracy hopefully renewed. If not, it is going to be a pretty bleak dystopia that awaits us [at] the other end of this horrific pandemic**.**

Can you tell us more about your recent book, When Misfortune Becomes Injustice, and what the motivation for it was?

The motivation behind the book was mentioned earlier, but the title [comes from] … an opinion piece by Justice A Sachs, stating that 'it is precisely the function of constitutional protection to convert misfortune to be endured and justice to be remedied'. It is relevant now because in many ways illness and sickness [are] conceived of as misfortune, but there is a lot of structural injustice adding to who gets to live, who gets to die, who gets to keep a job, or house, etc.

What is your opinion on how we can ensure that the emergency measures states are taking now are not abused after the pandemic and are in line with human rights standards?

Some emergency measures expire after 30 days, 90 days, or some limited period and require legislative action to extend or modify. Others shockingly still require sunset clauses to be put into them to ensure we don't see temporary states of exception become permanent. I do believe some restrictions, such as lockdowns, will end at different rates in different contexts, and freedom of movement will be largely restored. But take, for example, the surveillance and use of technology for tracing – is this going to be removed after the pandemic? The abuse of such technology should be a big concern for human rights lawyers and activists because it can so easily be abused.

It is also interesting how different countries have imposed measures. In South Africa the selling of alcohol and tobacco has been completely prohibited, even with the big black market and opportunity for police corruption and extortion. In the US it would be absolutely impossible. Alcohol and tobacco are considered essential commodities during the pandemic. However, where are the lines drawn? Some kind of exercise is permitted, such as golf, others not. What is considered arbitrary? What are the justifications? The pandemic also challenges us to balance different kinds of evidence.

This is a huge challenge for democracy and the way we have thought about human rights and the right to health. Too often human rights experts have developed the right to health as though it were a modular exercise untethered from all of those necessary trade-off considerations and [an] understanding that these rights are enjoyed in social contexts. It is important to stay vigilant about the connections between population health, health systems and democracy – now and in the post-pandemic future.