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## Current Concerns Bridging Health and Human Rights: From the Global to the Local

by Professor Sofia Gruskin

### Introduction

**W**ith the overturn of *Roe v. Wade* here in the United States and the COVID-19 pandemic still seriously affecting folks everywhere in the world, whether or not we ALL still see it as a priority—with monkeypox, with Ebola, and the parade of horrible that goes on and on—we are at a crossroads, not only in terms of these specific issues but what they are showing us about the commitment, or lack thereof, of our governments, but also of the rest of us, to doing something about it.

To try to help frame this conversation, which will focus a bit on both COVID-19 and abortion, I would like to say a few things about health and about human rights that seem key. Health is political. But so are human rights. Even as human rights are meant to transcend politics, the erosion of rights protections in the name of public health that we have seen in the past few years, both here in the United States and in the rest of the world, is nothing, if not political. It is also a reflection of the inequalities within and across all of our societies—fault lines that have always been there but somehow, it seems, may not have been seen by everyone quite so clearly. This is a public health emergency, but it is equally a human rights emergency.

A key lesson the last few years have taught us is that for those of us privileged enough to be in these conversations, we also have to be willing to situate ourselves in these conversations in ways that perhaps were not as stark before, especially a white, cisgender woman like myself who lives in Los Angeles, who claims to be engaged in global health. We have to genuinely acknowledge and address our own positions and our own privilege that allow us to be in these conversations.

### The Basics: Health and Human Rights

In contextualizing human rights, it is important to recognize that human rights as we know them today—for whatever problems there are with how they

may play out in practice—grew out of crises, out of the recognition of the need for some basic societal and international legal rules applicable to the actions of governments everywhere, for everyone, at all times, within which the world can operate. Human rights call on us to challenge the distribution of power and to value everyone equally. This requires us not only to interrogate but to address the historical reasons for the economic, social, cultural, and political backdrop to the massive and entrenched systems of inequality that perpetuate in our societies.

By human rights, I mean what the United Nations (UN) means, in that they are internationally agreed upon and are about the relationship between the individual and the state. They are not about what people as people do to one another, and sadly, from a legal perspective, they are also not, at least not yet, about the actions or inactions of multinational corporations like pharmaceutical companies. And human rights law, then, is what the governments of the world have agreed with one another about what their legal obligations are to promote and protect our rights as humans. Obviously, that is a floor and not a ceiling in terms of where we want things to be. Every country in the world, including the United States, has ratified one, some, or all of the human rights treaties, which makes them a common standard across all countries. While the United States has only ratified the International Covenant on Civil and Political Rights (ICCPR), the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), and the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), these are nonetheless legally binding obligations. The international committee that monitor government compliance with CERD has quite recently pronounced on the United States, and made some very helpful points in relation to both COVID-19 and access to abortion services that can be relevant to advocacy moving forward.

Global health is another key concept to define.

Global health moves us past looking at health problems only in relation to our own country, our own city, or our own experiences. Global health is also not about health concerns that are “out there.” It is about the connections between what happens in Los Angeles with what is happening in all parts of the world. Importantly, for context on international organizations and roles, the UN is the primary actor responsible for coordinating collective action in both health and human rights. For health, the key player is the World Health Organization (WHO), which is responsible for setting unified standards for health.

Bringing human rights and health together can happen primarily in three ways. One can look at the impact of health policies and programs on human rights and ask, do those policies burden rights, or do they benefit rights? The second way is to look at the effects of human rights violations and evaluate how these impact health. The third way concerns the interdependence of health and human rights and how they are mutually reinforcing. Essentially, the promotion and protection of both health and human rights are ultimately going to lead to the best outcomes for people’s well-being, and conversely, their neglect or violation results in worse outcomes. It is worth noting in this respect that the human rights framework recognizes that it can be considered legitimate to restrict rights for the sake of public health. Interfering with freedom of movement when instituting quarantine or isolation for COVID when the pandemic was just starting is an example of a restriction on rights that could be necessary for the public good and could, therefore, be considered legitimate in public health terms and under international human rights law, so long as it met the following criteria:

- The restriction is provided for and carried out in accordance with the law;
- It is in the interest of a legitimate objective of general interest;
- It is strictly necessary in a democratic society to achieve the objective;
- There are no less intrusive and restrictive means available to reach the same objective; and
- The restriction is not imposed arbitrarily, i.e., in an unreasonable or otherwise discriminatory manner.

Much of what is done in public health relies on law and directives, which can be assessed from both a health and a rights perspective using these criteria.

## COVID-19 as an Example

Focusing on public health directives requires thinking of what makes sense from a public health perspective but being, nonetheless, attuned to the economic, social, cultural, and political backdrop within which they occur. In the context of COVID, for example, consider physical distancing, the notion that people must remain six feet apart. While this generically makes sense in health terms, what sense this makes for people who live, and spend all aspects of

their lives, in extremely overcrowded conditions is unclear. How can one maintain six feet of distance when, for example, you live in a crowded room where people sleep in shifts as there is no room for everyone to lie down at once? Thus, the issue to consider for all medical and public health directives is not only the evidence of effectiveness or what makes sense clinically but also what sorts of resources are needed for these to be relevant and accessible for ALL people, no matter how poor or vulnerable. Much of this, therefore, goes beyond simply the purview of a department of health and requires attention to the broader societal context, including the social and other services that fall within the responsibility of the government.

While all health issues are different, nonetheless, the ways in which public health directives are meant to come down are intended to require a number of steps and things to be put in place. First, there is supposed to be the science and evidence behind the decision (which is a key point we need to think about in terms of what happened with COVID as well as the spate of abortion directives coming down). Then, the decision has to be written out in some form and reviewed, the regulation has to be passed by a body with the authority to do so, resources have to be allocated, the tests or vaccines or services then have to be distributed, and those responsible for implementing the directive have to be trained. In each case, one has to consider what part of government is or should be made responsible for implementation. Is it the health department? Is it the police? Is it the military? Finally, the directive has to be communicated to the general public, and there must be some monitoring and evaluation in place to determine if the directive is having its desired effect.

A wide-ranging set of regulations were passed across the world in the name of COVID, and it is worth considering these from a dual public health and human rights lens to determine their legitimacy in health and rights terms and, ultimately, their effectiveness. Whether it is the detention of thousands of people by the police in crowded cells for ostensibly not complying with the quarantine orders in place or the hundreds of people around the globe charged under new emergency laws passed in the name of COVID that punish people for potential or perceived COVID-19 exposure, each of these directives needs to be reviewed to ensure they were effective in public health terms and, importantly, that they did not result in discriminatory actions taken only against already poor and marginalized people.

A particularly relevant issue that has been raised is the use of phone applications for contact tracing, introduced as part of the COVID response in many places. Ongoing questions need to be raised as to what it means that these data were and are being collected; what is happening with the data gathered; who is it going to; who should have access to this information; and what does it mean for monitoring people’s movements and contacts over and above the specifics of COVID? Is it acceptable if the application is now used by governments to generally track people’s

personal health status, contacts, and lifestyle choices in the name of public health, even as the virus is no longer an immediate threat? For how long is it acceptable for governments to be storing these data, and how much are they responsible, for example, for safeguarding the data against hackers? And importantly, for all of this, who should decide?

These are only a few of the many issues COVID has raised that must remain central to bringing health and human rights together moving forward.

## Abortion as an Example

To place what has happened in the United States at the federal level with the Dobbs decision and the spate of actions happening within states in context, it is worth paying attention to what is happening in all parts of the world in terms of legal access. In 2022, close to 75 countries allow abortion essentially on request, with some varieties, and then about 125 countries have some types of restriction but allow abortion, for example, to save the life of the mother, in the case of rape or incest, because of physical or mental health concerns, on broad social or economic grounds, and in relation to fetal viability and impairment. Most countries have been, based on public health evidence, whittling away at their restrictions and moving closer to seeing abortion as a medical procedure (full stop). In fact, over the last 20 years, the majority of the world has been making abortion safer by reducing restrictions, while only the United States, Poland, and El Salvador keep legally making abortion harder to access.

The WHO has recently revised its Safe Abortion Guidance and notes, in particular, as relevant to what is currently happening in the United States, that people should receive the care they need without financial hardship, and this includes abortion as a part of universal health coverage; that this is necessary so that people do not have to resort to unsafe abortion; and that on public health grounds there is a need for legal, administrative, political and judicial environments that facilitate quality abortion care.

The data are clear that making abortion less legally accessible does not reduce the number of abortions, it simply reduces the number of safe abortions. Globally, there are already millions of people seeking unsafe abortions, and the resulting morbidities have long been of great concern. If there are already 20 million pregnant people needing (but not always receiving) medical care for complications from unsafe abortion around the world, it is scary to think how much this number will grow in several years with the more recent changes in the United States.

The Center for Reproductive Rights and the Guttmacher Institute have done very important work in tracking the present legal situation in the United States since the Dobbs decision. The range of bans and restrictions is overwhelming, with many states having in place myriad and inconsistent restrictions, with tremendous variability even between states that are

geographically close to one another. The legal restrictions in place comprise everything, including: physician and/or hospital requirements; gestational limits; prohibition of the use of public funds and/or of private insurance; the right of refusal by provider or institution; state-mandated “counseling” and waiting periods; mandated parental involvement; Targeted Regulation of Abortion Providers (TRAP) laws that single-out physicians who provide abortion care; and criminalization of self-managed abortion. The list goes on and on, and in each case, the specifics are quite different from state to state, even when a law may have the same name and is ostensibly regulating in the same thing.

Problematic provisions vary from state to state, but they abound, including those that authorize members of the public to sue abortion providers, as well as people who they think have helped others access abortion care. To note, additionally, several states have passed “heartbeat” laws that ban abortion once any cardiac activity can be detected on an ultrasound scan. Those laws would effectively ban abortions at about six weeks of pregnancy, if not before, even as most people are not even aware they are pregnant at that point. Many states have included prison sentences for doctors who perform an abortion. In some states, a person performing an abortion faces a minimum penalty of five years in prison. The maximum penalty is life. Conversely, several states have enshrined the right to access abortion in their state constitutions in order to make explicit that the state cannot deny or interfere with a person’s reproductive freedom, including their decision whether or not to have an abortion. The point is simply that it is a crazy time for an individual pregnant person living in the United States. If you are pregnant and seeking an abortion, the variability of what is allowable is incredibly hard to navigate, and I fear it is only getting worse. This state-by-state approach is clearly of great concern for the years to come. All major medical associations in the United States have called out the harms of this approach brought on by the Dobbs decision and the need for safe and legal abortion. And importantly, the CERD has called out the racialized aspects of abortion in this country and specifically called on the federal government to mitigate the risks faced by women seeking an abortion and by health providers assisting them, and to ensure that they are not subjected to criminal penalties. So, this is important, very current, and very useful for advocacy and for action against some of the current complicated legal landscape.

## Moving Forward

There are many actions being taken these days by governments in the name of public health. I would like to suggest that in each case, whether COVID or abortion or any other health issue, when we hear or read about government-mandated regulations justified in the name of public health, that we interrogate: What was the evidence base for the decision? How is it being



financed? What are its human rights impacts? Who should be responsible for enforcing the law, and with what training and with what resources and support to ensure it is done correctly? And, given the rationale for such measures is ostensibly that they are necessary for health, that the question be asked in each case, how effective is the directive not just in political terms but truly in public health terms?

It is undeniable that human rights matter for public health responses and that they can offer a useful framework for assessment and for action. Specifically, they provide a framework for how we look at and engage with the economic, social, cultural, and political backdrop to these sorts of public health emergencies, and with the use and misuse of law in how these sorts of health issues are addressed. This means, purely at a practical level, ensuring that our responses to health issues seek to optimize both public health and human rights. It is the right thing to do, but it is also the most effective and can lead to better outcomes. As a society, we should not have to keep relearning this whenever there is a new global health crisis.

What will it take to move forward? First, we have to be vigilant in addressing actions taken in the name of public health that have clearly overstepped the bounds of what is actually in the interest of the public's health. And there is work for all of us here, whatever our discipline. These new harmful COVID laws and abortion restrictions will need to be legally challenged; some of this is starting to happen, but this will need to be a focus in the next few years. And we need to be working with communities to directly address the harmful impacts of these laws on people's lives, as well as documenting their impacts on health and well-being. Second, as we all know, more health emergencies are right around the corner, so we need to think about what this all means for training: the training of lawyers but also of physicians and folks in public health for how to operate in these challenging environments, as well as the police for how they can minimize harms in carrying out their legal mandates, and for judges, to understand the medical and public health evidence alongside people's lived experiences as necessary to address the harms of these bad laws and overturn them.

If the last few years have shown us anything, it is that public health directives are increasingly hard to separate from politics. And we need to be vigilant about this and what this means for our work and for our lives. We also need to watch the ways in which the meaning of national security is being recast: what does it mean that health and security have become so intertwined? It is not a reach to say that COVID has allowed the architecture of surveillance and social control to expand in the name of public health. The potential harms are real, and something we need to think about going forward.

And finally, there are a few issues to be addressed in the immediate. First, in terms of COVID, we have to

address the inequitable access to COVID-19 vaccines that exists. We cannot pretend COVID is over just because, for many of us in the United States, we are starting to be able to "get back to business." Vaccines are often thought of as a tool to achieve global equity, and yet this pandemic has shown that many wealthy countries, not just the United States, did not pursue an equity approach to vaccine acquisition and distribution. Further, what is being called vaccine diplomacy became a means of cementing spheres of influence, with rich countries donating vaccines first to the countries they see as strategic partners. It should not even need to be said, but the pandemic will only come to an end if the virus is tackled everywhere in the world, and equitable access to vaccines is essential for this to happen.

Second, in terms of abortion, there is a normative force to the United States' human rights obligations as concerns access to safe and effective abortion services. Human rights can give legitimacy and solidarity to the kind of social movement action needed to foster political change. There is no question that in this moment, we need new strategies and to build new alliances, and that means moving beyond working in silos, and it means connecting to the range of folks who are engaged in the fight for health equity, not just those who work in our specific domains.

In all of our countries and communities, if we really want to build momentum towards social change, we have to take a hard look at the last few years. To be clear, these issues have always been here, but there is no getting around the long-term effects of all that is happening now in all of our communities, the deepening of the divisions between the haves and the have-nots, and specifically, within this country, the growing differences for health and well-being that exist depending on what state we live in. These inequalities will impact the world for decades to come. There is no getting around it.

On scientific, humanitarian and human rights grounds, we need a major collective effort to create a comprehensive, equitable global approach to addressing health and human rights, based on true global human solidarity—this is not just a nice idea, it is a necessity. And I hope we can work together to help make this a reality.