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**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development**

Duty to prevent exposure to the COVID-19 virus

Report of the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes*

Summary

In his report, the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes, Baskut Tuncak, addresses the issue of the duty of States to prevent exposure to hazardous substances within the context of the global crisis arising from the coronavirus disease (COVID-19) pandemic. The report was prepared pursuant to Human Rights Council resolution 36/15.

* The present report was submitted after the deadline in order to reflect the most recent developments.



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I. Introduction

1. Pandemics serve as a magnifying glass, revealing existing patterns of vulnerability, inequality and discrimination, while simultaneously exacerbating injustice and drawing attention to international human rights law obligations neglected by States. No State can meet its human rights obligations without preventing human exposure to pollutants, toxic industrial chemicals, pesticides, viruses, wastes and other hazardous substances. The most vulnerable in society are also the most likely to become victims of hazardous substances. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus responsible for coronavirus disease (COVID-19) is no exception.

2. In light of the current global crisis arising from the COVID-19 pandemic, the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes (toxics), Baskut Tuncak, reminds the international community of the State's duty to prevent exposure to hazardous substances. He identifies key challenges and issues arising from the COVID-19 crisis, highlighting underlying elements of failures by governments and businesses, and their consequences for vulnerable groups, as well as good practices and progress made in preventing such exposure and slowing the spread of the pandemic. He concludes with recommendations for various stakeholders.

3. The Special Rapporteur was also scheduled to visit the United Nations Interim Administration Mission in Kosovo in March 2020. Owing to the COVID-19 pandemic, the United Nations cancelled the visit. In light of these circumstances, the Special Rapporteur is presenting to the Human Rights Council, in addition to the present report, relevant information on access to remedies,¹ based on a case study in Kosovo.²

II. Duty to prevent exposure to the COVID-19 virus

4. Every State has a duty to prevent and minimize exposure to hazardous substances. This incumbent obligation flows clearly and implicitly from a number of recognized human rights and duties of States under international law and human rights standards. Every State has multiple binding human rights obligations that create a duty to take active measures to prevent the exposure of individuals and communities to the COVID-19 virus. It is necessary to assess the extent to which States are respecting their duty to prevent and mitigate the spread of the virus and prevent further losses and new outbreaks.

5. In his 2019 report to the General Assembly, the Special Rapporteur reminded the international community of the State's duty to prevent exposure to hazardous substances, outlining the legal basis of that duty, derived from and re-enforced by, *inter alia*, the human rights to life, health, a life with dignity, respect for bodily integrity, equality and access to an effective remedy.³ Human rights treaty bodies and national and international courts have all recognized such a duty. For example, in its general comment No. 14 (2000) on the right to the highest attainable standard of health, the Committee on Economic, Social and Cultural Rights notes that States have a duty to prevent and minimize exposure to hazardous substances to protect against preventable diseases; such substances can also contribute to disabilities.⁴ Whether at the molecular or at the population level, it is impossible to minimize exposure to hazardous substances without preventing exposure. The duty of the State to prevent exposure extends to viruses.

6. The State's duty to prevent exposure is underscored by national and international recognition of the environmental and occupational rights to life, bodily integrity, safe and

¹ See www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session45/Documents/A_HRC_45_CRP_10_EN.docx.

² References to Kosovo shall be understood to be in the context of Security Council resolution 1244 (1999).

³ A/74/480.

⁴ *Ibid.* See also the International Covenant on Economic, Social and Cultural Rights, art. 12.

healthy working conditions and a healthy environment, among many others.⁵ This duty is essential to the fulfilment of the rights to life, health, and other human rights implicated by exposure to hazardous substances.⁶ Strengthening laws and institutions to support constitutional recognition not only contributes to preventing occurrences of future pandemics, but also promotes a healthy future for generations to come. The COVID-19 pandemic has increasingly illustrated the importance of safeguarding a healthy environment and workplace as a human right.

7. The duty to prevent exposure is incumbent on every State, and every individual has the right to be protected from exposure to hazardous substances, including the COVID-19 virus. Below, the Special Rapporteur examines the extent to which States have taken this obligation to heart.

8. Certain States have exercised their duty with remarkable clarity, commitment and leadership, demonstrating good practices in their responses to, and management and prevention of, exposure to the COVID-19 virus. The measures implemented have not come without costs in terms of employment, education and mental health. However, through strong leadership and decisive action these countries have saved countless lives while reducing overall economic damage.

9. In all of the best responses, actions were taken quickly and decisively on the basis of recommendations issued by the scientific and international community that cast aside political and other objectives and focused on preventing exposure, foreseeing the tragedy of inaction. Governments of several States exercised their duty to prevent with commendable confidence and determination, illustrating what is possible in response to public health threats due to hazardous substances, including but not limited to the COVID-19 virus.

10. At the other end of the spectrum are a handful of States whose leaders completely shunned their human rights obligations to prevent exposure to the COVID-19 virus at the earliest stages. The pandemic illustrates the failure of many governments, individually and collectively, in acknowledging and upholding their duty to prevent exposure, reflected both in the entry of the COVID-19 virus into society and then its rapid spread within and beyond national borders. The reaction of most of those States was not unlike their rejection of the evidence surrounding other public health threats, such as environmental pollution, occupational health hazards and the relentless production of, use of and eventual exposure to toxic chemicals, under a false narrative of necessary evils that cannot be reduced and eliminated.

11. A pandemic of this magnitude was preventable. The failure stems from heads of governments placing economic or political interests before national health concerns. This was reflected in their absence of precautions, their sluggish responses and rejection of preventative measures, the lack of transparency, compounded by misinformation, the callous and inexcusably irresponsible statements of certain political leaders, underinvestment in health-care systems and other social protections, and poor international cooperation.

12. Obviously, efforts to prevent further exposure have been made, and not without consequences. The implementation of necessary measures, such as lockdowns and quarantines, social distancing and mass surveillance, has been paid for dearly, including in terms of aggravation of physical and mental health problems due to a lack of social interaction and physical activity, and an alarming global increase in domestic violence against women and children.⁷ Millions are losing jobs and livelihoods⁸ without access to

⁵ Ibid.

⁶ Ibid.

⁷ See www.unwomen.org/en/digital-library/publications/2020/04/issue-brief-covid-19-and-ending-violence-against-women-and-girls; www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25778&LangID=E.

⁸ See www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_743036/lang--en/index.htm and <https://unstats.un.org/unsd/ccsa/documents/covid19-report-ccsa.pdf>, p. 20.

basic services and social protection or protection of their human rights guaranteed.⁹ Students face serious limitations on the enjoyment of their right to education due to inequalities in digital access for remote learning.¹⁰ All these elements increase, directly or indirectly, vulnerability to COVID-19. It must be emphasized that the vast majority of these impacts could have been minimized had States responded appropriately to their obligation to prevent exposure and protect human rights.

13. The following section of the report illustrates the differences between States of these extremes. As the cases continue to rise in many countries, it will be essential for States to improve on the experiences of countries with earlier outbreaks in upholding the many human rights obligations that play an integral part in efforts to prevent exposure, recognizing the grave consequences of inaction.

III. Key factors in the failure to prevent exposure to the COVID-19 virus

14. The inability to stop the COVID-19 epidemic from becoming the catastrophic pandemic that it is today is a failure among States in upholding their duty to prevent exposure. In examining the development of the pandemic, and States with relative success in responding to the COVID-19 crisis as compared to those with far worse records, key elements come to light regarding the prevention of exposure. The Special Rapporteur identifies these below.

A. Environmental degradation

15. The best way to prevent exposure to zoonotic diseases such as coronaviruses is to prevent them from entering human society in the first place. While the speed at which COVID-19 disease spread across the world shocked many and found many States grossly unprepared, scientists and international authorities had been repeatedly warning governments of the grave risks of emerging infectious diseases from nature for many years. In 2005, the United Nations Environment Programme warned about the imminence of such a pandemic and the urgent need to take action.¹¹ Early warning signs were clearly visible in previous outbreaks of sudden acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), Ebola virus disease, avian influenza, Rift Valley fever virus, West Nile virus, and Zika virus disease.¹² Evidence suggests that COVID-19 is also a zoonotic disease passed on from wildlife to humans,¹³ the risk of which has been exacerbated through relentless destruction of natural habitats.

16. Emerging infectious diseases in humans are frequently caused by pathogens originating from animal hosts, and zoonotic disease outbreaks present a major challenge to global health. The number of new diseases per decade has increased nearly fourfold over the past 60 years, and since 1980, the number of outbreaks per year has more than tripled.¹⁴ Data shows that environmental degradation and land use changes are key drivers where deforestation, climate change, habitat fragmentation and destruction of biodiversity, wildlife trade, urban sprawl and an expanding agricultural frontier increase contacts between humans and wildlife, enhancing the chances of zoonoses emerging.¹⁵ Around 75

⁹ See www.humanrights.dk/sites/humanrights.dk/files/media/Covid-19%20response%20and%20recovery%20must%20build%20on%20human%20rights%20and%20SDGs%20.pdf.

¹⁰ See <https://en.unesco.org/covid19/educationresponse>.

¹¹ See <https://news.un.org/en/story/2005/02/129442-environmental-changes-are-spreading-infectious-diseases-un-study>.

¹² See https://environmentlive.unep.org/media/docs/assessments/UNEP_Frontiers_2016_report_emerging_issues_of_environmental_concern.pdf.

¹³ See www.nature.com/articles/s41591-020-0820-9.

¹⁴ See www.un.org/africarenewal/web-features/coronavirus/simple-fact-informed-hygiene-measures-africa-can-slow-covid-19-spread.

¹⁵ <https://www.ncbi.nlm.nih.gov/books/NBK215318/>.

per cent of emerging infectious diseases, such as COVID-19, originate in animals,¹⁶ moving from the wild to humans, illustrating now more than ever the critical need to enhance protection of the environment to protect human rights. Alarming, at this rate, the human-mediated introduction of infectious disease and vectors, referred to as “pathogen pollution”, is expected to continue to increase through further expansion of global travel and trade.¹⁷

17. Most States did not take early warnings to heart, as deforestation, biodiversity collapse, climate change, wildlife trade and other environmental concerns remain at critical levels across much of the world. Now we see the preventable results of ignoring these warnings: as at mid-September, close to 30 million cases of infection resulting in more than 940,000 deaths.¹⁸ Unemployment and economic collapse that could have been mitigated through sincere, early efforts to prevent exposure, are now costing countries billions of dollars each day, 98 per cent of which could have been entirely avoided by some estimates.¹⁹ These impacts are due to States failing to prevent exposure to the COVID-19 virus at the earliest point when preventive measures could have been undertaken.

18. As cases escalate, it has become increasingly clear that “people of any age with certain underlying medical conditions are at increased risk for severe illness from COVID-19”.²⁰ An important consideration is that the pre-existing health conditions referred to appear to be diseases and disabilities linked to an unhealthy environment, including at the workplace, and toxic exposures from consumer products. Diseases linked to exposure to hazardous substances, such as pollutants, pesticides, toxic chemicals in consumer products and wastes, include: kidney disease; respiratory illnesses, such as chronic obstructive pulmonary disease, pulmonary fibrosis and asthma; an immunocompromised state, such as those caused by therapies for environmental and occupational cancers; obesity; heart disease; hypertension or high blood pressure; and type 2 diabetes.²¹

19. An unhealthy environment can cause or contribute to nearly all of the pre-existing and underlying health conditions that make one extremely vulnerable to COVID-19. Air pollution, for example, causes and contributes to respiratory and cardiovascular problems that significantly increase the risk of life-threatening cases of COVID-19, mortality and overall vulnerability.²² Health officials and researchers have called for air pollution reduction following previous outbreaks of zoonotic diseases.²³ Asbestos inhalation causes debilitating respiratory diseases leading to deaths in workers and communities from COVID-19, but so too do the treatments for diseases caused by asbestos exposure, which can result in an immunocompromised state. Chronic exposure to toxic chemicals at home in food, water, air and consumer products, including certain plastics, increase the risk of developing non-communicable diseases that make individuals more vulnerable to death or serious illness from COVID-19. Similarly, exposure to toxic chemicals that affect the normal functioning of hormone systems, particularly in unborn and young children, increase the likelihood of obesity and diabetes and other health conditions later in life that can elevate the risk of death from COVID-19.²⁴

20. Inequality in socioeconomic conditions among various communities further accentuates the impacts of toxic exposures on victims. As described further below, people living in vulnerable situations, including low-income population groups, minorities and

¹⁶ See https://environmentlive.unep.org/media/docs/assessments/UNEP_Frontiers_2016_report_emerging_issues_of_environmental_concern.pdf.

¹⁷ See www.ncbi.nlm.nih.gov/books/NBK215318/.

¹⁸ See <https://coronavirus.jhu.edu/map.html>.

¹⁹ See <https://science.sciencemag.org/content/369/6502/379>.

²⁰ See www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fgroups-at-higher-risk.html.

²¹ Ibid.

²² See www.sciencedirect.com/science/article/pii/S0048969720321215 and www.theguardian.com/world/2020/aug/13/study-of-covid-deaths-in-england-is-latest-to-find-air-pollution-link.

²³ See www.who.int/gard/publications/The_Global_Impact_of_Respiratory_Disease.pdf.

²⁴ See https://apps.who.int/iris/bitstream/handle/10665/78102/WHO_HSE_PHE_IHE_2013.1_eng.pdf?sequence=1.

other marginalized communities, face more exposure to zoonotic diseases due to environmental determinants of health and social conditions, which correlate with the spread and exposure to diseases.²⁵

21. Often, the cost of prevention of disease and disability heavily outweighs the cost of treatment, and cannot be compared to the incalculable burdens of death. The overall costs of addressing the health impacts of COVID-19 are yet to be known, but it is already clear that the economic arguments of States reluctant to take measures to prevent exposure are often nonsensical and misleading and pander to financial interests.

B. Poor governance

22. Good governance systems are built on the rule of law, transparency, responsiveness, participation and inclusiveness, equity and accountability, among other pillars. Where public health challenges are poorly addressed, some of these elements are often missing. The COVID-19 pandemic is no exception. In the present section, the Special Rapporteur looks at governance systems for prevention of exposure, namely, responsiveness and inclusiveness. Transparency is addressed separately below, in sect. III.D.

23. In general, States are duty-bound to protect human rights by taking timely steps, on the basis of the technical, human and economic resources available to them, to prevent, halt and redress impacts on, *inter alia*, life, dignity and bodily integrity. Measures and restrictions on some rights can be justified to protect public health as long as those measures are lawful, strictly necessary, limited in time, subject to review, not arbitrary or discriminatory, based on scientific evidence and information, respectful of human dignity, and proportionate to achieve the objective.²⁶ Despite many States having the requisite technical, human and economic capacity, abysmal governance has led to a failure to protect human rights from exposure to the COVID-19 virus, especially at an early stage of the pandemic, which has claimed hundreds of thousands of lives and left millions of other victims, including those who have lost loved ones, in its wake.

1. Responsiveness

24. Rapid government response was common among States with good practices. Such responses were driven by many factors, predominantly effective and efficient decision-making grounded in public health available to all and the implicit recognition that the principle duty of the State in such pandemics is to prevent exposure. The duty to prevent requires States to develop capacity and preparedness to provide a prompt and effective response to public health emergencies. Acting promptly is crucial to prevent further losses and to relax containment measures earlier.

25. States that successfully prevented millions of infections were better prepared, recognizing the grave risk, at least as soon as reports emerged from China. Countries that have reported some of the lowest infection and mortality rates worldwide adopted a disease elimination strategy²⁷ at a very early stage, which allowed them to be among the first countries to be declared virus free and to relax lockdown, social distancing and other measures sooner, while still actively monitoring the response.

26. Such States adopted coherent, coordinated, and early preventative and precautionary measures, including early closing of borders, testing and tracing, self-isolation orders, effective infection-tracking systems, proper data handling, creative use of technologies, and participation and transparency in measures addressed to citizens. Many of those States quickly created task forces comprising representatives of all government ministries and, crucially, of all regional and city governments, in order to ensure coordination and effective

²⁵ See www.who.int/zoonoses/Report_Sept06.pdf; www.ncbi.nlm.nih.gov/pmc/articles/PMC5468693.

²⁶ See www.ncbi.nlm.nih.gov/pmc/articles/PMC7365536/ and www.oas.org/es/sadye/publicaciones/GUIDE_ENG.pdf.

²⁷ See www.health.govt.nz/system/files/documents/pages/aotearoa-new_zealands_covid-19_elimination_strategy-_an_overview17may.pdf.

responses at the national and subnational levels. All of this was grounded on recommendations made by the scientific and international community and driven by a recognition of the grave risks to life and health and a commitment to prevent exposure.

27. Prior funding and preparation of health systems, and coordination of interventions at the national level and through international cooperation, have played a crucial role in rapid responses by States. Public outreach campaigns to communicate key messages around prevention and containment measures have also been imperative. Best practices are characterized by transparency, information-sharing, participation and empathy, which allow States to foster public trust in leadership and institutions.

28. Given the uncertainties related to the spread and impact of the virus, precautionary measures proved to be essential. In the States with best practices, precautionary measures were translated into targeted interventions and the organization of comprehensive monitoring systems that, risk assessments permitting, allowed States to limit confinement measures and the closure of schools, while day-care establishments and basic services remained in operation. Countries with good practices also relied on information and timely preventive measures to resume activities at an earlier stage.

29. On the other hand, when the first cases were detected, a number of Governments throughout the world failed to prevent the spread of COVID-19. Some States had been increasing the risks of such a pandemic through the above-mentioned environmental harms. Some States were also inexcusably unprepared, despite repeated alerts from international authorities about the grave risks presented. While some States had been taking measures related to pandemic preparedness, others had, shockingly, eliminated key programmes in the years leading up to the COVID-19 outbreak.

30. Indeed, some Governments faced a lack of capacity and resources.²⁸ Others dithered, denying for several critical weeks the seriousness of the pandemic, derelict in their duty to prevent exposure. Even as cases were identified in their own countries, some States failed to recommend even the most basic preventive measures, and then resisted declaring a national emergency and imposing strict measures to prevent contagion. Instead of swift action, several leaders underestimated the risks, on the basis of unreasonable assumptions, such as that there would be a miraculous disappearance of the virus, and “herd immunity” theories, which, in practice, constitute death sentences for the most vulnerable. At the same time, such leaders decided, on the basis of economic fear, against introducing preventative and containment measures that would have minimized the overall economic impact in the long term.

31. In many countries, tens of thousands of suspected cases of COVID-19 went untested and untraced and infected persons freely circulated among the public for months, in full disregard of World Health Organization (WHO) recommendations. States were reluctant to impose restrictions at the outset, or were unable to maintain them for a reasonable period, for both political and economic reasons. Tracing programmes and protocols were not developed and resources were unavailable for testing to identify cases. Necessary decisions on how to isolate and protect various vulnerable groups were not taken. Such delays caused a rapid spread of the virus within and outside the borders of those States and a preventable loss of tens of thousands of lives. In several States, the numbers of cases and deaths related to the COVID-19 pandemic were pushed higher by a lack of coordination between national and regional or local governments.

32. Even taking into account the time normally needed to develop adequate testing capacity and preventative measures, the timing of most State responses has been inconsistent with the rapid emergency action demanded under the duty to prevent and under the international human rights standards applicable in the event of disasters, and with respect to risk management. Not only were States increasing the risks of such a pandemic by causing environmental harm, many were also inexcusably underinvesting in

²⁸ See www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

preparedness, despite repeated alerts from international authorities about the grave risks presented.

33. In most countries, the ability to take bold, decisive action to prevent exposure to the COVID-19 virus was made more difficult because of an underinvestment in the progressive realization of socioeconomic rights; better realization of those rights could have helped to mitigate the impact on national economies. For example, acknowledging the possibility of an outbreak similar to the SARS outbreak faced in 2003, health officials and researchers identified various measures that needed to be taken, including improving housing conditions to prevent crowding.²⁹

34. The pandemic has revealed the serious fragility of health-care systems and infrastructure worldwide, in terms of shortages of human resources and equipment. This can be attributed not only to the current disruption of global supply chains,³⁰ but also to decades of privatization of, and funding cuts to, health-care systems, which left countries and their hospitals unprepared and unequipped to manage the unforeseen crisis, causing a collapse of hospitals and considerable delays in the responses to the pandemic. In addition, a shortage of testing capacity, which hindered contact tracing, led to a proliferation of regional outbreaks, and places of concentration of infection going undetected for some time. This included places of high risk, such as hospitals and retirement homes, which also lacked protective equipment, contributing to a large increase in the number of infections registered nationally.

35. The COVID-19 pandemic is exposing the deep divide in how health care is understood in different countries. While some countries have systems that are publicly funded and almost entirely free for anyone, others, including some high-income countries, do not have universal health care, with many citizens unable to pay for treatment and private medical insurance. Once more, the economically and socially disadvantaged groups are the most affected, with limitations on access to health care. Evidence suggests that, in many countries, more centralized, solid, publicly funded systems with universal coverage and a strong chain of command and control could have responded better to the crisis. Such systems have been more suitable for scaling up testing faster, coordinating responses, pooling resources, reducing death rates and guaranteeing essential health services for all. Other human rights, such as to water and housing, have also been neglected, contributing to the inability to effectively prevent exposure among huge swaths of the population.

2. Science, policy and participation

36. The role of science in responses to the coronavirus crisis was, unsurprisingly, critical. The rejection of the science of COVID-19 has strong parallels to the rejection of the science of the deadly impacts of pollution and toxic chemicals. The cost to economies of taking late action or lifting restrictions too early has arguably been greater than what the impact would have been had strong measures been taken quickly and retained adequately.

37. With respect to exposure to hazardous substances, an overwhelming number of States are unwilling to question bogus economic arguments, cowardly citing scientific uncertainty and incomplete financial narratives to delay taking measures that are unfavourable to powerful interests, but nevertheless required to fulfil human rights and the duty owed to the public. As COVID-19 infections rose, far too many States did not heed the advice of their public health experts. Instead of following scientific advice to adopt more rigorous testing and containment measures, certain government leaders proffered disingenuous arguments in support of their approaches, particularly the economic justification of not imposing a lockdown, effectively sacrificing the lives of their citizens, in particular those in low-income and minority communities, workers and older persons.

38. Some political leaders have gone as far as to treat the virus as a “little flu”, contributing to, in their countries, the highest number of infections and deaths registered

²⁹ See www.who.int/gard/publications/The_Global_Impact_of_Respiratory_Disease.pdf.

³⁰ See www.who.int/westernpacific/internal-publications-detail/critical-shortage-or-lack-of-personal-protective-equipment-in-the-context-of-covid-19.

worldwide. They have publicly rejected recommendations by scientists and WHO, spread misinformation and downplayed the risk, contributing to the underestimation of the pandemic. Some have also called for environmental deregulation while the public is distracted by COVID-19.

39. States that had positive impacts in terms of limiting the spread of the pandemic also tended to better ensure representation of women in the decision-making process in the public sphere. Globally, women face discrimination and are underrepresented in decision-making processes, including those in response to COVID-19. Limited inclusion of women in the composition of COVID-19 crisis management bodies, such as dedicated governmental task forces and technical scientific committees, highlights systemic discrimination against women in the scientific and political/public spheres.

40. The Special Rapporteur wishes also to highlight that the duty to prevent should not translate into the adoption by States of measures that are inconsistent with human rights, nor instrumentalized in order to perpetrate human rights violations or abuses. While the measures imposed by States on individuals were onerous, the lockdowns and other extreme measures became necessary to limit contagion because of initial failures in the prevention of exposure. When they were imposed, lockdowns of course presented challenges for vulnerable communities, such as those living in extreme poverty. However, those challenges should never be an excuse for failing to prevent exposure to the maximum extent possible in such communities once the risk of contagion is apparent. Governments can and should take measures to prevent exposure, while at the same time guaranteeing adequate services, rather than using the additional collateral effects as an excuse for inaction, in violation of the rights of such vulnerable communities.

3. Rule of law and businesses

41. States may violate their obligations under international human rights law when they fail to take appropriate steps to prevent, investigate, punish, redress and remedy abuse by private actors. Independent of State efforts, and particularly where the State is unable or unwilling to exercise its duty, business enterprises have a responsibility to prevent exposure to hazardous substances resulting from their activities and/or business relationships. This responsibility is independent of whether or not adequate legislation is in place to protect human rights.³¹

42. Businesses, which through their activities can be implicated in causing or contributing to zoonotic pandemics, have a distinct role in both preventing and mitigating exposure to the COVID-19 virus. They have responsibilities to undertake human rights due diligence,³² and to assess the impacts of their operations and conduct in terms of respect for all human rights, including the rights to life and health, and to take steps to prevent, and when prevention is impossible, to mitigate, impacts, including by using the resources and leverage available to them.

43. With the COVID-19 crisis, some businesses demonstrated remarkable leadership, including by shutting down their facilities, voluntarily providing assistance or instructing workers to work remotely and facilitating remote work even before the State required them to do so. In order to overcome shortages of goods essential to prevent exposure, some converted their production facilities to make masks, sanitizing gel and ventilators. Others implemented free testing and created alliances for platforms to promote e-learning and home delivery, notably for vulnerable groups.

44. Other businesses did not uphold their responsibility to prevent exposure. This showed an inadequacy, or even absence of, governance, on the part of States with respect to the private sector. Many businesses stand accused of increasing risks to vulnerable workers in their supply chains, exacerbating immediate humanitarian suffering, and exacerbating further social inequalities and human rights abuses. Others have used obviously incorrect government statements as an excuse to fail to protect their workers and communities.

³¹ See A/74/480.

³² See the Guiding Principles on Business and Human Rights.

Certain industries, such as the alcohol, tobacco, unhealthy food and beverages, and fossil fuel industries, are a source of deep concern owing to products and practices that expose individuals to hazardous substances, which can increase the prevalence of non-communicable diseases and disabilities that heighten the risk of death from coronaviruses.³³

45. Another matter of concern has been the reckless conduct and profiteering of some business leaders, who, without any reasonable consideration for the safety and health of workers, manipulate economic fear among the public and governments. Some have deliberately prevented the implementation of protective measures, unfairly criticized some States for imposing lockdowns, publicly and privately pushed for the weakening of environmental and occupational standards, or threatened to move their facilities to other jurisdictions with weaker standards for prevention. Other companies have been accused of corruption, or involved in macabre practices of producing dangerous products and medicines, including those that are counterfeit or falsely claimed as preventing COVID-19.

C. Inequality and discrimination

46. Zoonotic diseases have historically illustrated a mismatch between global concerns and the impacts on vulnerable communities, which are often neglected.³⁴ Various studies have demonstrated that racial, ethnic and religious minorities are disproportionately affected owing to low socioeconomic status, prevalent exclusion and discrimination, placing them at higher vulnerability to infection and mortality, including due to inequalities in access to measures being taken to mitigate exposure to the COVID-19 virus.³⁵ Their situation is exacerbated by environmental conditions that are symptomatic of entrenched inequalities and structural racism.³⁶

47. The COVID-19 pandemic has exposed and in various ways, exacerbated inequalities, including through discriminatory laws and practices. Updates on the number of cases and deaths provide a daily tabulation of a pervasive problem of unequal protection from exposure to hazardous substances. The pre-existing or underlying health conditions are manifestations of social injustices, including among those living and working in unhealthy environments.

48. There have been numerous examples in which States, having created situations in which the most marginalized and vulnerable communities faced the greatest risk of death from COVID-19, then failed to ensure that those communities were appropriately protected. Such situations have been starkly apparent in high-income countries with deeply entrenched inequality. States have a heightened obligation to prevent exposure among high-risk groups, particularly given the structural discrimination those groups experienced.³⁷

1. Race, poverty and environmental injustice

49. Mandate holders of the Human Rights Council have indicated that people living in poverty are becoming poorer, increasingly dispossessed and disproportionately vulnerable to exposure as a result of the COVID-19 crisis.³⁸ Systemic racism has resulted in marginalized groups being far more likely to be in situations that increase vulnerability to

³³ See <https://ncdalliance.org/why-ncds/covid-19/map-unhealthy-industry-responses>.

³⁴ See https://environmentlive.unep.org/media/docs/assessments/UNEP_Frontiers_2016_report_emerging_issues_of_environmental_concern.pdf, p. 20.

³⁵ See www.ohchr.org/Documents/Issues/Racism/COVID-19_and_Racial_Discrimination.pdf.

³⁶ For more information, see www.ohchr.org/Documents/Issues/Racism/COVID-19_and_Racial_Discrimination.pdf.

³⁷ See, for example, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25725.

³⁸ See, for example, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25815&LangID=E.

The complete list of responses by States, national human rights institutions, civil society organizations and others to the joint questionnaire on COVID-19 impacts issued by mandate holders of the human rights council is available at: www.ohchr.org/EN/HRBodies/SP/Pages/Joint-questionnaire-COVID-19.aspx.

COVID-19, in particular with regard to substandard living conditions, pollution, unhealthy working environments, lack of access to treatment, and unaffordable insurance coverage.³⁹

50. Underlying health conditions are in many respects the manifestation of deep-rooted and multifaceted discrimination faced by racial⁴⁰ and ethnic minorities and other marginalized groups, including people of African, Asian, and Hispanic descent and indigenous peoples.⁴¹ For example, racial and ethnic minorities are more likely to live in poverty and bear the burden of health conditions such as respiratory illnesses, hypertension, cardiovascular disease, chronic stress and conditions requiring immunosuppressant treatment. The Working Group of Experts on People of African Descent has stated that the intersections of race with gender, disability, class, and sexual orientation and gender identity further add to these complexities. In States without universal health care, including high-income countries, people of African descent face significant and disproportionate barriers in accessing care.⁴²

51. The intersectionality of exposure to pollution, racial discrimination and economic inequalities is clear. The effects of this intersectionality, fuelled by widespread environmental injustice and racism, are predictable and preventable elements of the COVID-19 pandemic. Among some racial and ethnic minority groups, evidence points to higher rates of hospitalization or death from COVID-19. In one country, for example, as at 18 August 2020, age-adjusted hospitalization rates were highest among minorities – up to five times higher than the average, in one category of minorities.⁴³ In some countries, the highest levels of contagions and deaths from COVID-19 are found among migrants, given, among other things, their lack of access to medical care.⁴⁴

2. Workers

52. Poor and minority communities are at higher risk of death from the COVID-19 virus not only because of exposure where they live, but also because of greater exposure to the virus and hazardous substances at work. Health-care, food and other essential workers have been selflessly performing their jobs for society. Tragically, these risks were increased by the irresponsible conduct of some businesses and States. Many such workers were required to be present every day at work despite the pandemic, without adequate protection from exposure or access to paid sick leave. Far too often, it was lower-paid and minority workers who risked their lives during the pandemic to serve others and produce basic goods and services.

53. Every worker has a right to be protected from exposure to the COVID-19 virus and other hazardous substances at work. States have a duty to respect, protect and fulfil the right of every worker to safe and healthy working conditions, and businesses have corresponding responsibilities.⁴⁵ Every worker is essential.⁴⁶ No one should be deprived of his or her human rights because of the work he or she performs, nor should anyone feel forced to work in conditions that unnecessarily endanger health, out of fear of losing a job or a pay check.

54. Some national and multinational business enterprises, including e-commerce giants, vegetable and meat packers and mining industry actors, have been reproached for exerting

³⁹ See www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25927&LangID=E and www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?LangID=E&NewsID=25768.

⁴⁰ See www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25776&LangID=E.

⁴¹ See, for example, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?LangID=E&NewsID=25768.

⁴² *Ibid.*

⁴³ See www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html; www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

⁴⁴ See www.ohchr.org/Documents/Issues/Migration/CMWSPMJointGuidanceNoteCOVID-19Migrants.pdf.

⁴⁵ See Human Rights Council resolution 42/21. See also A/74/480 and the Guiding Principles on Business and Human Rights, principle 1.

⁴⁶ See www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25892&LangID=E.

unacceptable pressure on their employees to work. Workers were placed at grave and foreseeable risk of exposure, where they were obligated to work in unsafe working environments, lacking personal protective equipment and measures for social distancing. For example, COVID-19 outbreaks have gravely affected workers in the food industry. Evidence also shows that in some countries, the rate of COVID-19 cases among mining workers is at least twice that found among workers in various other industries.

55. An alarming number of front-line workers were not given adequate protection during peak periods of contagion in various countries and economic sectors, with businesses failing dismally to take proper screening and isolation measures to protect their workers. In particular, workers who belonged to a minority group, were older, were migrants, were women, had low incomes, had pre-existing health conditions and/or worked in the informal sector or the gig economy were not adequately protected.⁴⁷ Too often, they have been arbitrarily categorized as “essential” for mere economic reasons rather than to guarantee basic services. While businesses may be willing to apply the hierarchy of controls for toxic chemicals, some seem unwilling to recognize that the hierarchy also applies in situations of infectious disease, such as COVID-19.

56. The inability to secure personal protective equipment for health-care workers was emblematic of the depth of the failure to prepare and adequately invest in health care to protect not only the brave and selfless health-care workers, but through them also the broader community. In some countries, medical staff are still reporting significant shortages of basic protective equipment, such as masks, goggles, surgical gowns and gloves, not to mention respirators and equipment for intensive care. Remarkably, some middle-income countries were supplying excess masks and gowns to some of the wealthiest countries in the world. Medical and sanitary staff also reported a lack of training in dealing with such a pandemic.

57. Some businesses have been remarkable in prioritizing the health of their workers in the midst of the crisis, which is commendable. Deplorable, however, are those businesses that seem concerned only with profit and revenue, disregarding worker safety and health in their operations and supply chains. In many communities, the spread of COVID-19 was driven by contagion among workers.

58. All workers, including those deemed essential, have the right to remove themselves from situations they believe are hazardous,⁴⁸ which is contingent on the availability of information about the known and unknown risks of the substance or disease to which they are exposed at work. States’ obligations with regard to protecting workers must be emphasized, for it is the State’s duty to ensure that all workers have safe and healthy working conditions, whether they are an emergency doctor or a supply-chain worker. International Labour Organization estimates suggest that testing and tracing for COVID-19 is strongly associated with lower labour market disruption and can help to reduce working-hour losses by as much as 50 per cent.⁴⁹

3. Older persons

59. Early in the pandemic, it became clear, unsurprisingly, that COVID-19 is particularly lethal in older persons.⁵⁰ The biological vulnerability of older persons, combined with care and support needs or housing in high-risk facilities, created tragic situations for families around the world. Heart-wrenching tales proliferate of families unable to say goodbye to loved ones trapped in isolation, who tragically died alone.

60. The failure of numerous States to provide the protection necessary for the elderly is inexplicable. An immunity theory leaving the virus to circulate among society is a certain

⁴⁷ Ibid. See also www.ohchr.org/Documents/Issues/Migration/CMWSPMJointGuidanceNoteCOVID-19Migrants.pdf.

⁴⁸ See the Occupational Safety and Health Convention, 1981 (No. 155) of the International Labour Organization.

⁴⁹ See www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/briefingnote/wcms_745963.pdf.

⁵⁰ See www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25748.

death sentence for the elderly. Harrowing tales from around the world describe an extreme detachment of States in the face of a clear situation of extreme vulnerability. Reports proliferate of abandoned older persons, suggesting inadequate efforts to prevent exposure among those in the most vulnerable age group. In some countries, between 42 and 57 per cent of coronavirus deaths were linked to nursing homes and other residences of older persons, which horrifically became used by some local authorities as destinations of choice for people with the virus.⁵¹

4. Indigenous peoples

61. Indigenous peoples face an alarming situation as COVID-19 cases multiply.⁵² Already, COVID-19 is devastating indigenous communities, invoking the tragic history of smallpox that decimated many peoples of the Americas and elsewhere. Testing for many communities remains limited and self-isolation is often not a viable option. Illegal miners and other unwelcome outsiders continue to present an existential threat to communities, particularly those who voluntarily live in isolation.

62. Socioeconomically marginalized indigenous peoples are also at elevated risk because of lack of access to effective monitoring and early-warning systems. Lack of access to health-care services is a pervasive problem, compounded by stigmatization and discrimination. Economic realities have forced a grave choice between income and health, if such a choice exists at all. For indigenous women, who are often the main providers of food and nutrition to their families, the choice is even graver.⁵³

63. For example, Navajo Nation leaders have drawn attention to their community's per capita COVID-19 infection rates, among the highest in the United States of America. In Brazil, Yanomami communities face existential threats and a health crisis brought about by contact with illegal miners. They launched the #MinersOutCovidOut campaign to demand "the immediate expulsion of the miners from their territory, which has been the target of illegal gold mining since the 1980s", noting that as a result of activity related to the mining, 13 per cent of the Yanomami population had succumbed to, among other diseases, influenza, the measles, pneumonia and malaria, against which the tribe has little or no immunity.⁵⁴ In Ecuador, indigenous federations have alleged, in a series of lawsuits, violations of the rights to life and health, among others, following the entry of COVID-19 into their territories. The COVID-19 crisis coincided with recent oil spills, which had deprived their communities of access to clean water. A provincial court ruled that the relevant ministries must better communicate and coordinate with Waorani leaders to provide more COVID-19 tests, food and other necessities to communities, and to provide information on COVID-19 protocols for oil companies operating there.⁵⁵

5. Disabilities

64. Persons with disabilities are disproportionately at risk of exposure. In many instances they have been left behind, for example through the discontinuation of support services. Measures to prevent exposure, such as social distancing and self-isolation, may be impossible, including for those who rely on the support of others to eat, dress and bathe.

⁵¹ See www.politico.eu/article/the-silent-coronavirus-covid19-massacre-in-italy-milan-lombardy-nursing-care-homes-elderly/, and <https://eu.usatoday.com/story/news/investigations/2020/06/01/coronavirus-nursing-home-deaths-top-40-600/5273075002/>.

⁵² See www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25893&LangID=E.

⁵³ See www.un.org/development/desa/indigenouspeoples/covid-19.html.

⁵⁴ See www.rightlivelihoodaward.org/media/minersoutcovidout-yanomami-leaders-launch-global-campaign/.

⁵⁵ See <https://news.mongabay.com/2020/06/court-forces-ecuador-government-to-protect-indigenous-waorani-during-covid-19/>.

Reasonable accommodation measures are essential to enable persons with disabilities to reduce contacts and the risk of contamination.⁵⁶

D. Lack of transparency and violations of the rights to information and freedom of expression

65. Transparency is a principle of good governance and one of the most important factors in managing infectious diseases. It is a necessary precondition to prevent exposure to hazardous substances, including coronaviruses, and to the full enjoyment of human rights. The human right to be protected from exposure to the COVID-19 virus, together with other human rights, has been frustrated by a lack of transparency and large information gaps as the COVID-19 virus has spread around the world.

66. The human right to access to information is integral to and inseparable from transparency. In his 2015 report to the Human Rights Council, the Special Rapporteur stated that information was crucial to preventing human rights violations resulting from exposure to hazardous substances and wastes. Indeed, the right to information on hazardous substances and wastes would require that relevant information be timely, appropriate, available and accessible in a manner consistent with the principle of non-discrimination;⁵⁷ it must also serve to respect and protect the rights of the most vulnerable. Public health and safety information must never be confidential. This can be ensured without violating the patient's right to privacy.

67. The Special Rapporteur noted that to protect human rights affected by hazardous substances, States were duty-bound to generate, collect, assess and update information; to effectively communicate such information, particularly to those disproportionately at risk of adverse impacts; to ensure confidentiality claims were legitimate; and to engage in international cooperation to guarantee that foreign Governments had the information necessary to protect the rights of people in their territory. He also stated that in discharging their duty to conduct human rights due diligence, businesses had a responsibility to identify and assess the actual and potential adverse impacts of hazardous substances and wastes in which they might be involved, either through their own activities or as a result of their business relationships, and to communicate information to other businesses, governments and the public effectively.⁵⁸

68. Scientific progress and the protection of human rights depend on information. The Special Rapporteur in the field of cultural rights has highlighted that everyone has the right to enjoy the benefits of scientific progress and its applications.⁵⁹ The normative content of the right includes, *inter alia*, access by everyone without discrimination to the benefits of science and its applications, including scientific knowledge; participation of individuals and communities in decision-making and the related right to information; and an enabling environment fostering the conservation, development and diffusion of science and technology.⁶⁰

69. States that applied good practice approaches drew on lessons from the outbreaks of SARS, in 2003, influenza A (H1N1), in 2009, and MERS, in 2015, to develop an early policy of free testing, targeted investigations and maximum transparency. Other countries, despite registering high numbers of cases, were very transparent about efforts to reduce transmission of the virus and provided platforms to facilitate testing, tracing and dissemination of information on COVID-19, in order to increase public awareness and address misinformation. Such States generated, assessed and acted on information to protect the most vulnerable, and managed to register relatively lower death rates, showing

⁵⁶ See www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf; www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25725; www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25765&LangID=E.

⁵⁷ See A/HRC/30/40.

⁵⁸ A/HRC/30/40, paras. 99–100.

⁵⁹ See A/HRC/20/26.

⁶⁰ *Ibid.*, para. 25.

that accurate information-sharing can be the most effective means of encouraging the public to join in efforts and to take the necessary precautions. The public in some of these States, being well informed, adopted and adhered to social distancing behaviours without mandatory measures issued by any authority.

70. However, there was a lack of transparency around COVID-19 in certain States, including with regard to the first cases. It should be noted that detailed and specific due diligence duties are laid out in the International Health Regulations (2005). These obligations include duties of surveillance, monitoring, and reporting, within 24 hours of assessment, public health emergencies of international concern.⁶¹ Nevertheless, in the context of COVID-19 crisis management, WHO denounced on multiple occasions a lack of transparency and information-sharing within the international community.⁶² While there are reports that local doctors in China warned public authorities of a surge of suspected cases of a new virus in late November 2019,⁶³ the WHO Country Office in China was not informed of the outbreak of cases of “viral pneumonia” of an unknown cause until 31 December 2019. Officials of China provided WHO with information on the cluster of cases on 3 January 2020.⁶⁴ In February, WHO, referring to, among other things, “uncompromising and rigorous” measures that provided lessons for the global response, including “extremely proactive surveillance to immediately detect cases”, set out recommendations for States, the public and the international community. In March 2020, the Director-General of WHO expressed concern about, *inter alia*, the levels of State inaction and the lack of resolve in some States, urging States to activate and scale up emergency response mechanisms.⁶⁵

71. Since the beginning of the spread of COVID-19, health-care professionals in various countries have demanded transparency from public authorities, recognition of the seriousness of the disease and treatment at the source. For example, in the earliest stages they raised alarms about the spread of respiratory infections that seemed similar to prior outbreaks of viruses such as SARS.

72. Reports that States were reluctant to test at the outset of the pandemic and still remain unwilling to test at levels required to minimize further exposure to COVID-19 suggest deep disregard for the public’s right to information and the value of information in avoiding total calamity. Testing rates continue to remain at abysmal levels in some of the worst-affected countries, and reports of the inability to access tests continued for months after spikes in cases outside Asia. While resources varied among States, some States that had some of the highest levels of technical and financial resources did not position themselves to test adequately, which amounts to a multifaceted violation of their duty to protect life. Later in the pandemic, other States with fewer but still significant financial and technical resources were still not testing at adequate levels, and were relying on private donors,⁶⁶ including to ensure that testing reached the most vulnerable communities, such as low-income communities, including favelas and other slums, and were not providing necessary information on the risks to exposure.

73. The disclosure of actual rates of infection and death from COVID-19 have been deeply problematic in many States. The Special Rapporteur is concerned about allegations suggesting that various States have not disclosed the actual numbers of positive cases or deaths, representing a catastrophic risk and escalating factor with regard to the spread of the pandemic, in violation of international human rights standards and health regulations. In some cases, States have even removed websites to prevent access to information, which is completely unacceptable and only serves to further increase the risk of individuals either

⁶¹ See www.who.int/ihr/Toolkit_Legislative_Implementation.pdf?ua=1.

⁶² See www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-mission-briefing-on-covid-19---26-february-2020.

⁶³ See www.theguardian.com/world/2020/mar/13/first-covid-19-case-happened-in-november-china-government-records-show-report.

⁶⁴ See www.who.int/news-room/detail/29-06-2020-covidtimeline.

⁶⁵ See www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

⁶⁶ See www.thenewhumanitarian.org/news/2020/05/27/Brazil-coronavirus-response-community-leaders.

contracting or further spreading the coronavirus, or refraining from economic and social activities that could be done safely out of fear of the unknown.

74. Uncertainty is always a factor in science. In the case of COVID-19, across the board there was remarkable lack of precautionary measures employed by States and businesses, in relation to the cost-effective wearing of face coverings, dissemination of information about the risk of airborne spread and transparency regarding the deadly nature of the virus itself. The Rio Declaration on Environment and Development of 1992 states: “Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation.” Since the 1930s, precaution has been seen as a fundamental part of responsible development of medicines to protect public health. Yet States continue to attack the principle of precaution in debates over international trade and environmental protection. It is not a coincidence that States that have been at the forefront of arguing against the precautionary principle, including Brazil, the Russian Federation and the United States of America, have recorded among the most severe outbreaks in the pandemic to date.

75. The outbreak has also been accompanied by waves of misinformation⁶⁷ and an “infodemic” (an overabundance of information, some accurate and some not),⁶⁸ and the spread of “fake news” is putting lives at risk.⁶⁹ This includes underreporting of cases and the promotion of untested and potentially dangerous treatments. The motives for spreading disinformation are many, and include political aims, self-promotion, and attracting attention as part of a business model. Those who spread misinformation play on emotions, fears, prejudices and ignorance, and falsely claim to “bring meaning and certainty to a reality that is complex, challenging and fast-changing”.⁷⁰ Irrespective of whether the intention is malicious, “the effect of sharing falsehoods is to disinform and disempower the public with deadly potential”,⁷¹ and moves away from real solutions and long-term strategies. In order to counter rumours and ensure their own credibility, States should be more transparent, proactively disclose more data and improve access to information from official sources, in line with right-to-information laws and policies while promoting freedom of expression.

76. Other States have instrumentalized precautionary and containment measures to limit the full enjoyment of human rights, creating an environment of uncertainty and lack of trust regarding the information available on the actual risk of the disease and the necessity and proportionality of measures taken for prevention. Several States further entrenched repressive measures, including with regard to civil society, surveillance of citizens and human rights defenders, censorship, restrictions on free expression and information, and unjustified limits on public participation, civic spaces and freedom of movement,⁷² far overreaching the limits of the derogations permitted under international human rights law during health emergencies of such scale.

77. Meaningful consent cannot be achieved without information. Under article 7 of the International Covenant on Civil and Political Rights, all persons have the right not to be subjected without their free consent to medical or scientific experimentation. Within the context of COVID-19, the capacity of individuals to be fully informed and to exercise meaningful consent with respect to possible exposure to viruses, and to treatments and vaccines, including their risks, must be protected under human rights law and standards.⁷³

⁶⁷ See www.article19.org/wp-content/uploads/2020/03/Coronavirus-briefing.pdf, and www.accessnow.org/cms/assets/uploads/2020/04/Fighting-misinformation-and-defending-free-expression-during-COVID-19-recommendations-for-states-1.pdf.

⁶⁸ See www.who.int/docs/default-source/coronaviruse/situation-reports/20200202-sitrep-13-ncov-v3.pdf.

⁶⁹ See <https://news.un.org/en/story/2020/04/1061592>.

⁷⁰ *Ibid.*

⁷¹ *Ibid.*

⁷² See www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25788&LangID=E and <https://ipi.media/covid19-media-freedom-monitoring/>.

⁷³ A/64/272, para. 19; Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 8.

78. The COVID-19 crisis also requires equitable access to medicine, including with regard to any treatment and vaccines, as part of the broader effort to prevent exposure. The protection of intellectual property rights is not inherently incompatible with human rights and should never constitute a barrier to access to essential medicines or public health protection. Particular attention must be paid to States that do not have adequate resources and infrastructure for the purchase and production of vaccines and other pharmaceutical products.

E. Attacks on human rights defenders

79. Article 19 of the Universal Declaration of Human Rights and article 19 of the International Covenant on Civil and Political Rights underpin the establishment of norms protecting sources and whistle-blowers, namely, persons who bring to public knowledge otherwise undisclosed information. In this regard, in 2015, the Special Rapporteur on freedom of expression urged States and international organizations to actively promote the right of access to information, and to adopt or revise laws and practices that provide protection and confidentiality to sources and whistle-blowers, fostering the necessary political will and social environments.⁷⁴

80. Historically, a number of health-care professionals have been whistle-blowers; many were silenced by public authorities.⁷⁵ Worryingly, since the beginning of the spread of COVID-19, there have been several allegations of State censorship, for example cases in which States have limited citizens' freedom of expression and silenced doctors, scientists and other activists and health experts who have sounded warnings about the spread and severity of the pandemic and who have called for more robust State responses.⁷⁶ In some cases, authorities did not admit the seriousness of the COVID-19 outbreak and escalating transmission for several weeks or months, and disregarded WHO guidelines.

81. Human rights defenders play a critical role in minimizing the impact and transmission of infectious diseases when they are first identified and in preventing transmission of contagion in a global pandemic. They observe the disease in clinics and hospitals, tracing the illness and advising patients, politicians and government agencies with data and science.⁷⁷ In accordance with article 19 (3) of the Covenant, restrictions on freedom of expression must be provided by law and be necessary for respect of the rights or reputations of others, or for the protection of national security or of public order, or of public health or morals. Mere assertions of such interests are insufficient, and restrictions must be necessary to achieve a specified interest, and be proportionate to those objectives.

82. Health-care professionals calling for action and transparency were in some cases quickly silenced, or even criminalized for "wrongdoing" and detained by the State for spreading "false rumours".⁷⁸ Some have since died from the COVID-19 virus. Others lost their jobs during the surging pandemic for alerting media about shortages of masks and hospital equipment.⁷⁹ Public health experts and leaders in some States are being silenced and undermined by their respective Governments when exercising their role to prevent exposure. For example, key ministers have been removed after advocating for preventative

⁷⁴ See A/70/361 and www.ohchr.org/EN/Issues/FreedomOpinion/Pages/ProtectionOfSources.aspx.

⁷⁵ See www.theguardian.com/education/2020/apr/08/coronavirus-doctors-whistleblowers-history-silenced.

⁷⁶ See, for example, www.article19.org/wp-content/uploads/2020/03/Coronavirus-briefing.pdf; www.accessnow.org/cms/assets/uploads/2020/04/Fighting-misinformation-and-defending-free-expression-during-COVID-19-recommendations-for-states-1.pdf; and www.nytimes.com/2020/03/23/us/politics/coronavirus-trump-fauci.html.

⁷⁷ See www.theguardian.com/education/2020/apr/08/coronavirus-doctors-whistleblowers-history-silenced.

⁷⁸ See www.theguardian.com/world/2020/mar/20/chinese-inquiry-exonerates-coronavirus-whistleblower-doctor-li-wenliang.

⁷⁹ See www.nytimes.com/2020/04/01/opinion/coronavirus-doctors-protective-equipment.html.

measures, and leading scientists prevented from exercising their right to freedom of expression regarding their concerns about problematic strategies.⁸⁰

83. Protections against retaliation should apply in all public institutions, including those connected to national security, and effective and protective channels should be established for whistle-blowers to motivate remedial action.⁸¹ Participation and freedom of expression must be guaranteed and promoted, to fully ensure the right to information.⁸² When the State is the only source of information, the rights to information, participation and freedom of expression are inevitably prejudiced and the best solutions are seldom, if ever, realized.

F. Weak international cooperation

84. Just as States have an obligation under international human rights law to prevent transboundary pollution, they also have an obligation to prevent the spread of diseases, including COVID-19, and to prevent them from crossing their borders. Such responsibility extends to businesses and must be reflected in businesses due diligence, and has an extraterritorial dimension. As many States do not have sufficient resources to prevent exposure in pandemics such as the COVID-19 crisis, international cooperation is essential to ensure that all States have protection measures available and accessible, as a weakness in any country is a threat to all.

85. However, not only were States not taking the necessary measures in anticipation of COVID-19 spread within their borders, for many years they had been underfunding international cooperation efforts regarding public health threats, lacking international solidarity. The politically motivated attacks on WHO must be firmly denounced. All organizations can be improved, including WHO, and in due course an independent inquiry into the responses of all international bodies to the COVID-19 crisis should be undertaken. However, withdrawal of funding for WHO stands only to increase exposure to COVID-19 in low-income and some middle-income countries, with devastating results. It illustrates a complete rejection of the principle of equality enshrined in the Charter of the United Nations by its architects and callous disregard for people in Africa, Asia and Latin America, who sadly have been disparaged for far too long, with far too few consequences.

86. Given the highly contagious nature of COVID-19 and the ease by which individuals travel worldwide, any State recording cases on its territory should have directly notified and cooperated with other States from the moment there were signs that the virus was spreading rapidly by human transmission – which could have been as early as late December 2019. In compliance with their duty to prevent, States should establish solid and coordinated international cooperation,⁸³ acknowledging that the effectiveness of responses is resource dependent and a global issue. It is essential that countries learn from the past mistakes. The current crisis should reinforce the fact that our interconnected world requires global-level crisis management, multilateralism and strong international cooperation and solidarity.

87. In this regard, the Special Rapporteur wishes to pay tribute to and recognize the efforts of those lower-income countries that, despite financial constraints and resources, showed great commitment and preparation in tackling the pandemic and, in the name of international solidarity, have supplied trained doctors, ventilators and protective equipment to some of the wealthiest countries.

⁸⁰ See www.reuters.com/article/us-health-coronavirus-brazil/bolsonaro-fires-brazils-health-minister-calls-to-reopen-economy-idUSKBN21Y338.

⁸¹ See www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---sector/documents/publication/wcms_718048.pdf.

⁸² See www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25729.

⁸³ See the draft articles on the protection of persons in the event of disasters, draft art. 11.

IV. Conclusions and recommendations

88. Prevention of exposure to hazardous substances is a human rights obligation incumbent on States. While some States have addressed the grave threats of exposure to the COVID-19 virus with remarkable determination, resolve and transparency, politics, economic miscalculations and misguided motivations enabled and emboldened many Governments to reject, individually and collectively, their duty to prevent exposure. Similarly, while many businesses prioritized the public interest benefits of preventing exposure, many showed a deplorable lack of consideration for the workers and the communities in which they operate. However, in the case of COVID-19 and other hazards, it is fundamentally the duty of the State to prevent exposure.

89. For those States that have so clearly failed in their duty to prevent exposure to the virus, the failure is a multifaceted violation of their human rights obligations, including those relating to the rights to life, dignity and health. The failure often was also characterized by recurrent violations of the right to freedom of expression, including access to information. Principles of equality, non-discrimination, international cooperation and transparency, among others, were all but lost among those States.

90. Most States did not take early warnings to heart, as deforestation, biodiversity collapse, climate change, illegal wildlife trade and other environmental conditions raised the risk of the emergence of a contagion such as the COVID-19 virus. Upon the emergence of COVID-19, various States failed to act with the prudent urgency that was so clearly required. Millions of cases of infection, resulting in hundreds of thousands of preventable deaths, are a direct result. Predictably, older persons, the poor, minorities, migrants, indigenous peoples and other vulnerable groups have all suffered from the inaction of States in the face of a clear and present danger.

91. Ironically, unemployment and economic collapse, which States cited as the threats preventing them from exercising prudent and precautionary measures to prevent exposure, especially among the most vulnerable communities, are now exacerbated by the inaction of those States. Misguided fiscal policies that made prudent action to protect human rights excessively difficult have made taking such action even more costly. The negative impact on mental and physical health and on education, and increased domestic abuse, are among the effects that have been prolonged by an unwillingness to take bold action to protect life and health at the earliest stages, and then to maintain restrictions until the risks were adequately lowered. All of these problems are due to States failing to prevent exposure to the virus at the earliest point when preventive measures could have been taken.

92. Given the interconnectedness between COVID-19 and non-communicable diseases, there is an urgent need to enhance global efforts to prevent non-communicable diseases resulting from unhealthy environments, workplaces and consumer products. Strengthened efforts with regards to non-communicable diseases are necessary not only now, during the COVID-19 outbreak, but most importantly long after, focusing in particular on the most vulnerable. For example, interventions to reduce exposure to air pollution have immense potential in protecting health and contributing to reducing the burden of non-communicable diseases that exacerbate the risks related to exposure to viruses and other hazards. Strengthening environmental and health protections and promoting the human rights to a healthy and sustainable environment and to safe and healthy work would not only address non-communicable diseases and COVID-19 vulnerabilities, but also contribute to much broader societal benefits for public health, the environment and economies.

93. Transparency, responsiveness and ensuring that the most vulnerable members of society were protected from exposure proved to be key elements of good practices. Doctors, scientists and public health experts are human rights defenders whose right to freedom of expression must be respected. States have the duty to share and take into account evidence-based information from the scientific community in the

evaluation of the necessity of precautionary measures such as testing, lockdowns and restrictions. Misinformation, the silencing of public health experts, opaque decision-making, and policy driven by politics and profit rather than science have proven catastrophic. The importance of public confidence in leadership during any crisis is crucial, and sorely lacking in so many States at present.

94. For years, the Special Rapporteur has, in chorus with medical and public health experts, been warning the international community of another public health crisis – a silent pandemic – linked to chronic exposure to toxic chemicals, pollutants and other hazardous substances. Such exposure, as early as in the womb, results in diverse and nuanced adverse health impacts that often go unrecognized or underappreciated by victims, policymakers, justice systems and society at large, as the effects are latent.

95. States that responded well to COVID-19 illustrate, in many ways, what can be done to protect public health from hazardous substances. However, it cannot be ignored that many States have failed in their duty to prevent exposure to the virus, and that this failure is similar to the failure to prevent exposure to pollutants, toxic chemicals, pesticides and other hazardous substances, which kill over 12 million people, nearly 2 million children below the age of 5, every year. Parallels may be drawn with the plight of over 160 million workers who develop preventable diseases and disabilities from exposure to hazardous substances at work, which cause approximately one worker death every 30 seconds. States should recognize that the efforts made in a handful of countries to protect against COVID-19, and thereby save perhaps millions of lives, can also be made in the context of other hazardous substances that are resulting in widespread, systemic and discriminatory violations of the rights of vulnerable groups around the world.

96. Everyone is essential, and everyone has a right to be protected from exposure to hazardous substances. Patterns of discrimination and inequalities are barriers to human dignity and development. Underlying structural inequalities and pervasive discrimination must be addressed in the response to and aftermath of the COVID-19 crisis, to build back better, guided by the principles of equality, dignity and accountability and international human rights standards.

97. The Special Rapporteur recommends that States:

(a) Recognize their obligation to prevent exposure to hazardous substances, including zoonotic viruses, as part of their obligation to protect human rights, including the rights to life, health and bodily integrity;

(b) Reform the manner in which projections of economic impacts are considered in the face of public health and environmental concerns, such as zoonotic diseases, to ensure that a rights-based approach is applied;

(c) Identify and prioritize the protection of all vulnerable groups from exposure to viruses and other hazardous substances;

(d) Recognize that environmental injustice and systemic discrimination contribute to underlying health conditions, and ensure that socioeconomic mapping of rates of infection and death among vulnerable groups includes environmental and occupational exposures to hazardous substances in addition to other criteria such as income and race;

(e) Ensure that the right to safe and healthy work is constitutionally protected, and ratify all occupational safety and health conventions of the International Labour Organization;

(f) Implement the principles on human rights and the protection of workers from exposure to hazardous substances,⁸⁴ as encouraged by the Human Rights

⁸⁴ A/HRC/42/41.

Council in its resolution 42/21, including by applying them to the grave situation confronting workers in the COVID-19 pandemic;

(g) Strengthen environmental governance to address the destruction of nature as an essential measure to prevent exposure to health hazards, such as further outbreaks of zoonotic diseases, creating effective long-term collaboration between stakeholders, including policymakers and local communities;

(h) Recognize the circular economy and sustainable consumption and production as key to reducing the risks of future zoonotic diseases, and urgently undertake efforts to improve resource conservation and the detoxification of economic output;

(i) Create permanent structures for rapid responses to infectious diseases, such as tracing and tracking systems, to mitigate and contain the spread;

(j) Ensure full compliance with the International Health Regulations (2005) and international human rights standards;

(k) Ensure maximum transparency in all matters regarding public health and exposure to hazardous substances, including the COVID-19 virus, for example with respect to decision-making and levels of contagion;

(l) Ensure that everyone has access to health care, and scientific progress, as a human right, and also ensure the preparedness of health systems, including for pandemics;

(m) Recognize medical professionals and public health experts as human rights defenders, and ensure that their right to freedom of expression is respected and protected, and that effective remedies for violations are duly provided;

(n) Enhance international cooperation, including bilateral and multilateral assistance for States in need, and increase all aspects of support for WHO.

98. The Special Rapporteur recommends that businesses:

(a) Recognize that the rights to life and health, and all other human rights, take precedence over the privilege of profit-making activities, and that they stop threatening politicians and interfering in public-health decision-making;

(b) Support efforts to prevent and minimize exposure and ensure that the right to safe and healthy work is recognized in policies and practices that include, among other things, precautionary measures to protect older workers and other vulnerable groups;

(c) Implement the principles on human rights and the protection of workers from exposure to hazardous substances, as encouraged by the Human Rights Council in its resolution 42/21, and ensure that they are applied to the grave situation confronting workers in the COVID-19 pandemic;

(d) Redesign consumption patterns and production methods to conserve resources, become free of toxic substances and advance a circular economy, thereby reducing stress on natural habitats, minimizing the risk of the emergence of future zoonoses and reducing the risk of death from pollution and other contributing exposures.
