



WP 2 Reclaiming Human Rights for Effective Epidemic Control: Lessons from COVID-19 – a suggested policy approach for the EU

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INTRODUCTION	3
PROBLEM STATEMENT	3
PRINCIPLES OF DISEASE CONTROL	4
RECOMMENDATIONS.....	5
CONCLUSION	6
REFERENCES.....	6

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Introduction

COVID-19 pandemic underscores the scope of HRJUST. Globally, more than 7 million confirmed deaths have been reported, while excess mortality estimates suggest the true toll may exceed 14–15 million deaths between 2020 and 2022¹.

At the same time, the global economy contracted by approximately 3.1% in 2020, representing the deepest recession since the Second World War². These impacts were unevenly distributed, with low- and middle-income countries experiencing sharper economic shocks and slower recoveries.

The International Labour Organization estimated that global working hours declined by 8.8% in 2020, equivalent to the loss of 255 million full-time jobs, disproportionately affecting informal workers, migrants, and women³.

¹ World Health Organization (2022). *Global excess deaths associated with COVID-19*.

² International Monetary Fund (2021). *World Economic Outlook*

³ ILO (2021). *ILO Monitor: COVID-19 and the world of work*

Problem Statement

Epidemics, migration, climate, and gender are not independent domains of human rights; rather, they intersect and shape each other's outcomes. The COVID-19 pandemic clearly demonstrated how these interactions influence both the spread of disease and its social and economic consequences. International travel, largely driven in the early phase by wealthier populations, contributed to the rapid global spread of COVID-19. However, the impact of containment measures—particularly travel restrictions and lockdowns—fell disproportionately on poorer countries and vulnerable population groups within countries. This pattern is not unique to COVID-19. Diseases such as dengue may be introduced through global mobility, yet their impact is most severe in communities with limited access to health services. Even in high-income regions, including parts of Europe, preparedness for emerging or re-emerging diseases such as dengue or other tropical conditions remains inadequate.

Epidemic responses tend to amplify existing inequalities.¹ Marginalised communities, migrants, and informal workers often experience reduced access to essential services while bearing the greatest economic and social burden of public health measures. These populations, particularly those who are socially disadvantaged and have limited or no alternatives, are most affected by disruptions in livelihoods and healthcare access.

Gender is another critical dimension shaping epidemic outcomes. During COVID-19, women in many settings experienced higher exposure due to caregiving roles and overcrowded living conditions.

Although mortality rates were often lower among women, they faced increased vulnerability to infection in confined environments, disruption of essential services such as maternal and reproductive healthcare, and heightened risks of violence and economic loss. These gendered impacts underscore the need to go beyond mortality indicators and adopt a broader understanding of equity in epidemic responses.

At the same time, COVID-19 revealed a significant shift in the role of human rights. Traditionally, human rights have functioned as a mechanism to protect individuals from State overreach. During COVID-19, however, they were increasingly revoked by States to justify restrictive measures in the name of public health. This phenomenon, described as Human Rights Justifications (HRJ), represents a transition from human rights as tools of accountability to instruments of governance, often prioritising population-level objectives over individual protections.

Principles of Disease Control

Experience from epidemic control over the past century demonstrates that when the rights of infected, affected, and vulnerable populations are compromised, overall disease control is weakened.ⁱⁱ Coercive measures tend to increase stigma, discourage individuals from seeking testing or treatment, and create distrust between communities and public authorities. As a result, disease transmission may become more difficult to control.

The global response to HIV/AIDS marked a fundamental departure from this pattern. Under the leadership of UNAIDS, a rights-based approach was developed that actively involved marginalised communities in decision-making and programme implementationⁱⁱⁱ. This approach emphasised voluntary testing, confidentiality, dignity, and non-discrimination. By recognising affected populations as partners rather than targets of intervention, the HIV response improved access to treatment, increased uptake of prevention services, and strengthened trust between communities and health systems. It demonstrated clearly that protecting human rights enhances, rather than undermines, public health outcomes.

The foundation of this approach lies in medical ethics. The long-standing ethical principles of medical practice emphasise equal treatment of all individuals, irrespective of their legal or social status^{iv}. The commitment to dignity, non-discrimination, and care for all aligns closely with the holistic definition of health advanced by the World Health Organization, which includes physical, mental, and social well-being. These principles provide a strong basis for non-coercive, trust-based epidemic responses.

Evidence from both HIV and COVID-19 further supports the link between rights-based approaches and public health effectiveness^v. Community engagement, voluntary participation, and transparency have been shown to improve compliance and sustainability of interventions. In contrast, coercive measures, while sometimes necessary in the early stages of an epidemic, may undermine trust and have limited long-term effectiveness. Modelling studies during COVID-19 suggested that targeted, community-based strategies—such as early detection, regular screening, and localised isolation—could achieve outcomes comparable to large-scale lockdowns associated with colossal violations of human rights and associated social and economic costs^{vi}.

A key tension in epidemic control lies in balancing individual rights with collective health objectives. During COVID-19, there was a marked shift toward prioritising a collective right to health, often at the expense of individual protections. While collective considerations are inherent to public health,

excessive reliance on this framing can justify disproportionate restrictions and marginalise vulnerable populations. Human rights frameworks were originally designed to protect individuals, particularly minorities, against the power of the State and the majority. In health practice, ethical obligations often require that care be provided irrespective of legal or administrative constraints, reinforcing the primacy of individual rights even within collective strategies.

Epidemic responses typically evolve through stages: an initial crisis phase characterised by rapid decision-making under uncertainty; a normalisation phase where measures are adapted and accepted; and an institutionalisation phase where temporary measures become embedded in systems. The greatest risks to human rights arise during the transition from normalisation to institutionalisation, when emergency measures risk becoming permanent without adequate scrutiny.

Recommendations

Future epidemic responses must begin by reaffirming the primary role of human rights as mechanisms of accountability. Human rights should serve to constrain State power and protect individuals, rather than being used primarily to justify restrictive measures. A clear distinction must be maintained between rights as accountability and rights as justification.

Public health interventions should be calibrated, proportionate, and evidence-based. Uniform, large-scale coercive measures should be replaced with context-specific strategies informed by epidemiological data and local conditions. Greater emphasis should be placed on early detection, community engagement, and targeted interventions that minimise disruption while maintaining effectiveness.

Community engagement must be institutionalised as a core component of epidemic preparedness and response. Organisations representing people with lived experience play a crucial role in bridging the gap between the State and affected populations. They act as buffers that can absorb human rights shocks, ensure access to services, and enhance trust. Their involvement should extend beyond observation to active participation in policy formulation, service design, and programme implementation well before any epidemic hits.

Ensuring equity in service delivery is essential. Continuous access to essential health and social services must be maintained for all populations, including migrants, informal workers, and marginalised groups, irrespective of their legal status. Services should be designed to ensure accessibility, availability, and acceptability, particularly for those with limited options.

Gender-sensitive approaches must be integrated into all aspects of epidemic response. Monitoring should go beyond mortality to capture indirect impacts on women and vulnerable groups, including access to services, economic effects, and exposure to violence. Protecting and advancing gender equality must remain a priority.

The European Union has a critical role to play in shaping a rights-based approach to epidemic control in a multipolar world. It should develop common standards for rights-based public health interventions, strengthen cross-border coordination, and ensure that human rights remain central to health governance. The EU can also lead in promoting balanced approaches that integrate human rights, public health evidence, and social considerations.

At the global level, the World Health Organization must be strengthened to play a more independent and authoritative role. This includes enhancing its financial autonomy, ensuring that scientific and community expertise informs decision-making, and enabling it to advocate for non-coercive, evidence-based approaches without undue political or financial influence.

There is also a need to establish centres of excellence at regional and global levels that can generate innovative and humane epidemic control strategies, support WHO as collaborating centres, and provide real-time guidance to policymakers. These centres should integrate expertise from public health, social sciences, and affected communities.

Finally, epidemic governance must adapt to the realities of a multipolar world. Divergent national approaches during COVID-19 highlighted the challenges of coordination, credibility and the erosion of multilateralism. Future frameworks must promote collaboration, ensure equitable participation of all countries, and provide support irrespective of economic or political status.

Conclusion

The COVID-19 pandemic has highlighted a critical shift in the relationship between human rights and epidemic control. While the HIV/AIDS response demonstrated that rights-based approaches can enhance both equity and effectiveness, COVID-19 revealed a reversion toward coercive, State-centric models often justified through human rights language – collective versus individual rights- itself.

Future epidemic preparedness must restore the balance between public health and human rights by integrating medical ethics, community engagement, and evidence-based interventions. Only by reaffirming human rights as a foundation of accountability, rather than a malleable tool of justification, can epidemic responses achieve both effectiveness and legitimacy while protecting human dignity.

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