

RIGHTS IN A PANDEMIC

Lockdowns, rights and lessons from HIV in the early response to COVID-19



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Foreword

The COVID-19 crisis has upended the world. It has left everyone scared and many bereaved. It has damaged economies, weakened health systems, and hampered progress towards all the Sustainable Development Goals. It has hit the most vulnerable the hardest. Worldwide, decision-makers have found themselves in hugely challenging situations, under-prepared and under-resourced, and have had the responsibility to move fast on the basis of uncertain information. Many exemplary actions have been taken, saving lives and protecting livelihoods as governments have worked with communities to provide free emergency medical transport, extend water services, place moratoriums on evictions, provide temporary shelter, emergency food supplies or cash benefits, implement community delivery or multi-month dispensing of medicines, institute prisoner release programmes to reduce overcrowding and lessen pandemic risk, and spend millions to mitigate lost wages. Ensuring an effective response to this unfolding crisis, however, will also require learning from what has not gone right.

This is crucial for delivering on the mandate of UNAIDS and its Joint Programme. In our work on the ground, supporting governments and communities, we have seen how the COVID-19 crisis has exacerbated the difficulties faced by people living with HIV, including in accessing life-saving healthcare. We have seen too how the crisis has widened the social and economic inequalities which increase the vulnerability to HIV of marginalised groups—including adolescent girls and young women, LGBTI people, migrants, sex workers, people who use drugs, and prisoners. It is clear too that the crisis is not only a problem of a virus. In many instances, knock-on effects from the response have had an even deeper impact on marginalised groups than the virus. The defeat of AIDS depends on how the world responds to COVID-19.

Four decades of learning from HIV have demonstrated the essential relationship between human rights and public health, and so, as a home for that learning, UNAIDS has been mandated to help apply those lessons. To overcome COVID-19, and to avoid slipping back on progress in overcoming AIDS, countries will need to build COVID-19 responses rooted in respecting human rights, and hearing from the most marginalised. The purpose of this report is to help governments and other national stakeholders to do so.

This report was produced because we observed in the first phase of the COVID-19 response many cases where punitive and discriminatory approaches hurt the most vulnerable and in so doing were impeding progress in tackling COVID-19 and HIV. It is vital to study them to ensure that they are avoided in future. The examples shared in the report happen to be from sixteen countries with significant HIV prevalence and where fuller case studies could be brought together. The issues those examples highlight go *well beyond* those countries and elements described in them have been reported across the world. The illustrative examples are included not to narrow the focus of discussion down to just the countries they are from, but to illustrate approaches reflective of many countries. The examples are a snapshot from a period

between February and May 2020. In several cases governments have made very welcome steps to address the specific cases, and both the report and the progress of our work together in countries have benefitted greatly from our constructive conversations about the examples included. The purpose of sharing them in this report is not to apportion blame, but to help the world learn lessons from examples, including from examples where judicial or government action helped to rectify earlier damaging impact on rights, to support advances in the effectiveness of the response in *every country* in the world.

We are learning more about COVID-19 and about the response day by day. Learning and adapting is central to success. We invite and look forward to ongoing conversations with governments and other stakeholders to exchange experiences, strengthen plans, and continue to learn about how we can best support countries in our joint work.

What this report highlights most of all is that rather than a public health response and a rights-based response being opposing poles, public health responses are only fully effective if they are absolutely grounded in human rights and have the unwavering trust and confidence of communities. When disease transmission is between humans, human rights must be the fundamental driver of the response. Discrimination, stigmatization, and criminalization of marginalized communities are bad for the health of everyone. No one is safe until all of us are safe. When, in contrast, we ensure that no one is left behind or pushed behind, it helps us *all* move forward.

The really *good* news is that we don't need to give away our human rights in order to preserve our health. Human rights are not only intrinsic, but they are also the very means by which governments can successfully beat a pandemic. We will beat COVID-19, and we will beat AIDS, while—and indeed *by*—valuing the rights and dignity of every person. The conversations sparked by this report will help us to do so.

The Joint Programme is working shoulder-to-shoulder with governments, civil society and communities to advance a human rights-based response to the dual pandemics, HIV and COVID-19, and together we will succeed.

Winnie Byanyima
Executive Director, UNAIDS

Abbreviations and acronyms

ECOSOC	United Nations Economic and Social Council
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
ILO	International Labour Organization
IMF	International Monetary Fund
LGBTI	lesbian, gay, bisexual, transgender and intersex people
OHCHR	Office of the United Nations High Commissioner for Human Rights
PrEP	pre-exposure prophylaxis
TB	tuberculosis
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
WFP	World Food Programme
WHO	World Health Organization

Executive summary

One of the main lessons learned from the HIV response is that human rights-based approaches and community empowerment must be at the centre of any pandemic response. Discrimination, overreliance on criminal law, curtailing civil society operating space, and failing to take proactive measures to respect, protect and fulfil human rights can hamper mobilization of communities to respond to health issues—a necessary ingredient for an effective response. Overly restrictive responses—especially those that do not take the lived realities of communities into account—and violent and coercive enforcement can undermine trust rather than support compliance. The COVID-19 pandemic is one of the gravest threats facing society today. Within a short period of time, it has reached every corner of the globe and it has touched every aspect of our lives. The socioeconomic impacts of this pandemic will be deep and long-lasting, and swift and coordinated action is needed to reduce transmission and protect against the broader impacts of the virus.

At the same time, the HIV pandemic is not over. With 1.7 million new infections in 2019 and 38 million people living with HIV worldwide, we are living in a time of two parallel pandemics. Not only should the lessons from one pandemic inform the other, but the responses must mutually support each other, taking care not to harm the progress that has been made thus far.

The protection and promotion of human rights has been central to the approach and success of the HIV response. UNAIDS has a responsibility to monitor, review and provide normative guidance on human rights concerns that impact upon the HIV response in any way. The United Nations Economic and Social Council (ECOSOC), in its 2019 resolution on the UNAIDS Joint Programme, called for “a reinvigorated approach to protect human rights and promote gender equality and to address social risk factors, including gender-based violence, as well as social and economic determinants of health” (1). In 2016, the United Nations (UN) General Assembly requested the UNAIDS Joint Programme “to support Member States within its mandate in addressing the social, economic, political and structural drivers of the AIDS epidemic, including through the promotion of gender equality and the empowerment of women and human rights, in achieving multiple development outcomes” (2). This includes those related to the elimination of poverty and the provision of social protection, food security and stable housing. As the UN Secretary-General put it in his report on human rights and COVID-19, “we are all in this together,” and it is the responsibility of all agencies to support the efforts of the World Health Organization (WHO) in their own respective areas of expertise (3).

In order to fulfil this obligation, UNAIDS is drawing on lessons learned in the HIV response to review how COVID-19 public health orders that restrict movement have impacted human rights in the period leading up to mid-May, paying particular attention to people living with HIV and those most affected by HIV, including key populations (sex workers, people who use drugs, gay men and other men who have sex with men, transgender people and prisoners) and women and girls.

It therefore provides insights and recommendations that build upon and utilize the knowledge gained in the HIV response about the impacts that public health measures have on the most vulnerable.

Governments are facing enormous challenges in responding to the COVID-19 pandemic: economies are in decline, airports and borders are closed, unemployment is growing and health-care systems are overstretched. In many cases, they have responded quickly to the enormous task of protecting their populations from COVID-19 and the broader socioeconomic fallout, and they have answered the call for international solidarity and assistance by helping neighbouring and sometimes distant countries. Social protection schemes have been expanded or created, food packages have been distributed and community groups have been mobilized to ensure the continuation of health services. The International Monetary Fund (IMF) estimated that countries had mobilized approximately US\$ 9 trillion globally by 20 May (4).

As can happen when a significant new infectious disease emerges—and as was the case in the early days of the AIDS epidemic because modes of transmission were unknown—attempts to contain the spread of COVID-19 have resulted in human rights concerns and violations, despite calls for a focus on rights. This has, at least in some cases, had devastating consequences for communities that may be vulnerable to COVID-19, HIV or the broader socioeconomic consequences of the pandemic.

While some human rights may be limited for a legitimate purpose, such as protecting public health, a human rights-based approach mandates that restrictions must be lawful, necessary, proportionate, evidence-based, time-limited and—importantly—that they do not discriminate either in policy or implementation. In contexts that are constantly changing, policies must also change, as new evidence arises or human rights impacts are uncovered. Restrictions can have a disproportionate impact on marginalized or stigmatized communities, especially if they are enforced in ways that magnify stigma and discrimination. Cosponsors of the UNAIDS Joint Programme have put forward guidance and recommendations for countries on ensuring a human rights-based response. This report builds on those—and on the UNAIDS publication, *Rights in the time of COVID-19: lessons from HIV for an effective, community-led response*—to explore how lessons from the HIV response have been taken up in practice during the early response to COVID-19 and how the various lockdown policies have affected people living with or vulnerable to HIV.

Given the urgency of the situation, it was not possible to undertake a global review. Rather, the policies and practices reviewed in the 16 countries in this report should be seen as examples of a much broader global phenomenon.¹ Due to the necessity of sustaining services for HIV—and in light of UNAIDS' responsibility to monitor human rights concerns affecting people who are living with or vulnerable to HIV—the regions highlighted in this report were chosen because they contain countries with some of the highest HIV prevalence in the world.

While there are many good practices that give us reason for hope, other findings are deeply concerning. Many governments at the national and subnational levels are taking action to affirm human rights protections and empower communities. For example, some governments are extending access to water, providing social protection, adapting health service delivery, providing emergency food supplies, instructing police to hand out masks and supporting community health workers to reach those likely to be left behind.

¹ Argentina, Botswana, Brazil, Cameroon, the Central African Republic, Chile, Colombia, El Salvador, Ethiopia, Jamaica, Kenya, Malawi, Nigeria, Peru, South Africa and Uganda.

However, there have been repeated examples of rights violations, particularly early in the pandemic. The cause of rights violations can be separated into three categories:

- Those where the policy or directives themselves caused rights violations, such as failing to ensure access to transport for medical emergencies.
- A policy/implementation gap, where the policy is sound, yet implementation has resulted in rights violations, such as the disproportionate use of force by law enforcement.
- Where COVID-19 is used as a cover for other rights abuses, such as price gouging or targeting marginalized communities.

While many of the violations in the first category are rectified early on in the pandemic response, it is the second and third categories that have the potential to persist. As such, there is a need for continuous human rights monitoring and vigilance throughout the course of a pandemic.

In the period covered by this report, tens of thousands of people were reportedly arrested for violating lockdown measures and curfews in the 16 countries discussed. Key populations have been disproportionately affected, experiencing violence, exclusion and arrest under lockdown orders. Sex workers have been left out of financial support measures in most of these countries, while hundreds of people engaging in sex work have faced arrest in country after country. Gay men and other men who have sex with men and transgender people have been subject to arrest and harassment, and people who use drugs lack safe options for accessing harm reduction services. Overly broad lockdown restrictions have disproportionately affected women—for example, by making it difficult for women in labour to travel to hospitals.

Young key populations are particularly at risk of being negatively impacted. In a United Nations Development Programme (UNDP) regional project, young lesbian, gay, bisexual, transgender and intersex (LGBTI) people and people who use drugs indicated that measures taken to address COVID-19 make them more vulnerable to violence and service disruption, as they cannot rely on consent and support from family to access services, cannot access support and health services due to lockdown restrictions, and face increased violence due to prolonged confinement in homes that may not be safe (5).

This report is a snapshot in time, focusing on the very early days of the COVID-19 pandemic, from February to mid-May 2020, drawing attention to the experiences of some of the most marginalized and vulnerable communities. Since then, many countries mentioned in this report have made changes and adapted, lessons have been learned across the world, and some problems have been solved. We hope this report will generate discussion about these solutions and good practices, similar to those early good practices outlined in this report. However, the reality remains that, as we have seen in the HIV response, early responses to outbreaks and crises can significantly affect the rights and well-being of vulnerable communities, and it is important to take the time to review and analyse both the approach and the outcomes, even as we continue to respond to the pandemic.

The analysis of the early COVID-19 response in this report is grounded in internationally recognized human rights standards, recommendations from public health bodies and lessons from the HIV response. For human rights to be at the centre of national strategies to address COVID-19—as clearly outlined in this report—those responses must be continue to be reinforced and supported by international cooperation and assistance. Based on the lessons learned from the HIV response, the following are 10 immediate areas for action for governments that are looking ahead to building effective, rights-based COVID-19 responses.

Laws and enforcement

- ▶ **Avoid disproportionate, discriminatory or excessive use of criminal law:** As experiences with the criminalization of key populations and of HIV exposure, non-disclosure and transmission have shown, excessive or discriminatory use of criminal law is detrimental to a public health response. Use of criminal law as a core part of a public health response—for example, by criminalizing exposure, transmission or spread of the disease—can increase the risk of transmission and undermine education and empowerment. Tens of thousands of people have been arrested for violating COVID-19 orders in the countries reviewed, and research shows many examples of harmful overreliance on criminal laws and penalties to enforce compliance. Governments should refrain from imposing coercive and punitive approaches to responding to COVID-19; instead, they should address barriers to compliance with public health orders, support information campaigns to educate the public about COVID-19 and avoid wherever possible the use of criminal sanctions. Experience from the HIV response has demonstrated that when these punitive and coercive measures are lifted, new cases decrease, better health outcomes are achieved and human rights are protected.
- ▶ **Stop discriminatory enforcement against key populations:** Sex workers, gay men and other men who have sex with men, transgender people, and other vulnerable groups who have experienced violence have been denied access to services or been subject to discriminatory enforcement under COVID-19 lockdown orders. The history of the HIV epidemic shows that the violence, harassment and discrimination of key populations has a direct impact on internalized stigma and HIV outcomes. Governments should take immediate action to address this, including amending laws and training front-line personnel in non-discrimination.
- ▶ **Explicitly prohibit state-based violence and hold law enforcement and security forces accountable for disproportionate responses or actions when enforcing COVID-19 response measures:** This report details multiple and widespread reports of police and/or security forces using violence, including lethal force, to enforce public health measures such as curfews and the wearing of masks. As with the HIV pandemic, such approaches can divert time and resources away from a more enabling approach that ensures access to essential services, such as health care (particularly HIV services). They establish fears of arrest or violence, creating barriers to reaching such crucial services. Governments should deploy law enforcement in a manner that is consistent with international human rights law and—from the highest level down—they should: guarantee rights related to the use of force, arrest and detention, fair trial and access to justice and privacy; ensure police and security forces exercise restraint; and hold security forces accountable for abuses. Law enforcement agencies should be reminded that the prohibition against arbitrary deprivation of life, torture and other ill treatment is absolute and non-derogable at all times.

Access to services and support

- ▶ **Include reasonable exceptions to ensure that legal restrictions on movement do not prevent access to food, water, health care, shelter or other basic needs:** Most laws in the 16 countries reviewed for this report allow all people to move for food, water and health care, but in practice, overly broad lockdowns in some countries are undermining access to essential services, including access to HIV services and adequate nutrition that are essential for people living with HIV. In some cases, particularly harsh lockdown measures have led to deaths and physical harm because people could not meet basic needs. Governments should consistently allow for exceptions that reflect the complexity of basic survival and diversity of needs during public health emergencies.

- ▶ **Take proactive measures to ensure people, particularly from vulnerable groups, can access HIV treatment and prevention services and meet other basic needs:** Beyond making exceptions to movement restrictions, this report details specific measures that governments are putting in place to support the realization of the rights to health, food and clean water. The breadth and scale of the need, however, are often outpacing capacity. Many countries are seeing documented disruptions in HIV treatment or prevention, with more aggressive policy shifts needed to ensure access, particularly to harm reduction services. Governments and international financing agencies should implement diversified service delivery and accelerate emergency funding and policy shifts.
- ▶ **Rapidly reduce overcrowding in detention settings and take all steps necessary to minimize COVID-19 risk, and ensure access to health and sanitation, for people deprived of liberty:** Prison populations have an overrepresentation of people with drug dependence, HIV, tuberculosis, and hepatitis B and C, and prisoners and other incarcerated people may be at increased risk of complications from COVID-19 that goes beyond vulnerability to infection with COVID-19. Nearly all of the countries reviewed have released some people from prisons to address overcrowding and reduce the spread and risk of COVID-19 among people deprived of liberty. Several countries have reduced overcrowding significantly. In many settings, however, the releases have been too small to have a significant impact. This report details examples where ill-treatment of people in prison is likely to drive the spread of COVID-19. Testing and medical care are significant problems for many people in prison amid COVID-19. Where lockdowns cut off family and legal support, there are further rights concerns. Governments should ensure release of people at particular risk of COVID-19 where safe, people whose crimes are not recognized under international law, and any other people who can be released without compromising public safety, such as those sentenced for minor, nonviolent offences, with specific consideration given to women and children.
- ▶ **Implement measures to prevent and address gender-based violence against women, children and LGBTI people during lockdowns:** Interpersonal violence against women is associated with higher rates of HIV, while violence against LGBTI persons has been shown to impact significantly on access to HIV services and positive HIV outcomes. Nearly all countries reviewed have seen significant increases in reports of gender-based violence, and yet none of the lockdown restrictions reviewed explicitly allow people to leave home or change domiciles to escape gender-based violence. Governments should expand services and allow movement of people to escape abuse and support people seeking assistance.
- ▶ **Designate and support essential workers, including community health workers and community-led providers, journalists and lawyers:** The HIV pandemic has shown how critical journalists are to getting unrestricted, trusted information to people during a pandemic; lawyers, for creating accountability for a rights-based response; and community health workers and community-led health-care providers, for reaching marginalized people and diversifying delivery of services. Most but not all governments have designated these three groups as essential workers, although arrests and harassment have been documented in several settings. In some countries, there remain major barriers to these groups working effectively under lockdown orders. Governments should ensure these groups are designated as essential workers and are supported to be able to work safely during the pandemic.

Participation and rule of law

- ▶ **Ensure limitations on movement are specific, time-bound and evidence-based, and that governments adjust measures in response to new evidence and as problems arise:** As this report shows, many of the limitations create barriers or difficulties for people who are living with or vulnerable to HIV. It is important that those limitations are regularly reviewed and given time limits. Most public health orders in these 16 countries are time-bound and specific. Governments should periodically review public health measures to identify possible rights violations and other problems. They should adjust measures to rectify these problems and incorporate new evidence about COVID-19.
- ▶ **Create space for independent civil society and judicial accountability, ensuring continuity despite limitations on movement:** Communities and accountability mechanisms have been critical to the HIV response, removing discrimination and reaching those most likely to be left behind. Likewise, in the early days of the COVID-19 pandemic, we saw communities of people living with or vulnerable to HIV mobilizing to provide HIV and other services and support. Civil society and courts have helped improve the COVID-19 response in many countries where they are enabled to operate freely by highlighting problems experienced by communities and both offering and implementing solutions. Governments should engage communities from the beginning in all response measures. This includes consulting rapidly and widely with a range of stakeholders before imposing restrictions on movement, and creating space for civil society voices to engage with and monitor the COVID-19 response. Courts should continue to operate, as much as possible, particularly where liberty interests or the legality of public health orders are at stake.

As countries consider the coming months or years of the COVID-19 pandemic, governments will need to calibrate their responses for a pandemic that is likely to see waves of new infections and epidemics throughout the world for some time to come. This report addresses the early response to COVID-19 in the context of rapid change and evolution based on the lessons learned from the HIV response. Countries are already shifting from some of the responses reported here to new responses as the outbreak changes, while others are already reintroducing lockdown measures where there have been new waves of infections. In this context, interventions to limit the movement of people through lockdowns, stay-at-home orders, physical distancing requirements and curfews may continue to be deployed as part of the broader response to COVID-19. In doing so, urgent consideration must be given to maximizing rights-based approaches that empower and engage communities, ensure resilience and build cooperation. This report shows this will be particularly important for people living with HIV and key populations, and for securing trust for the public health response ahead.

Introduction

Pandemics are a particular type of crisis—an invisible enemy, not of our making, spanning the world, and requiring bold and decisive actions to protect the health of populations. As countries around the world respond to the COVID-19 pandemic, it is critical that the response is firmly grounded in respect for human rights.

The HIV pandemic taught the world that this imperative comes from the intrinsic value of human life and dignity, and because rights-based responses are more effective in the long run for engaging, educating and empowering communities to protect their own health, and for spreading awareness and accurate information. Rights violations can undermine trust and compliance with public health directives, economic resilience, and ultimately the success of public health efforts over time.

Although there are clear differences between COVID-19 and HIV, these principles continue to be relevant as governments seek to secure the public's consistent participation with public health advice over many months while the world waits for an effective vaccine. Interventions such as physical distancing, wearing masks, contact tracing, quarantine and isolation of people with COVID-19 are critical tools in the fight. Without careful planning of the practical implementation of these interventions early in the pandemic and an overreliance on coercion and force to promote compliance, governments may catalyse a myriad of negative consequences for people, including obstructing access to safe housing, food, water, sanitation, HIV prevention and treatment, and other life-saving medical care, all of which can impact on HIV services and prevention, and on treatment adherence and outcomes. Due to patterns of social and economic marginalization and discriminatory enforcement, these negative consequences fall most heavily on vulnerable communities, including women, LGBTI people, sex workers, homeless people, indigenous populations and people living with disabilities. For many people living with HIV, these initial COVID-19 response policies may exacerbate the stigma and challenges they already face.

Governments must act quickly, comprehensively and coherently, updating their responses based on evolving evidence to react to this rapidly spreading, highly contagious virus. Yet the urgency presents a challenge: the more rapidly and expansively governments respond, the greater the risk of rights violations that undermine public health objectives. At the same time, governments are implementing policies and programmes that protect rights—many of which are detailed in this report—to ensure access to basic services, provide safety from violence and deploy law enforcement in a protective and enabling manner.

The COVID-19 pandemic is a public health emergency—but it is far more. It is an economic crisis. A social crisis. And a human crisis that is fast becoming a human rights crisis . . . By respecting human rights in this time of crisis, we will build more effective and inclusive solutions for the emergency of today and the recovery for tomorrow.

– United Nations Secretary-General António Guterres

The UN General Assembly (6), the UN Secretary-General (3), and other human rights leaders and bodies have issued strong calls for a human rights-based response to COVID-19 and urged caution about ensuring that restrictions on movements do not create a human rights crisis (7, 8). UNAIDS and its Cosponsors have issued a range of normative advice and guidelines to help governments address COVID-19 with a human rights-based approach (9-19). In March 2020, UNAIDS published *Rights in the time of COVID-19: lessons from HIV for an effective, community-led response* to bring forward particular lessons from the HIV response (19, 20). This report builds on these normative and guidance documents to explore how they have been implemented, and how the lessons from the HIV response have been adopted in practice in the early response to COVID-19.

The focus of this report is on the very early days of the pandemic, from February through mid-May. Drawing on the lessons learned in the HIV response, the report looks at how COVID-19 public health orders restricting movement and other related aspects of the response have impacted human rights. It also looks at steps taken by governments to protect rights, with a particular focus on people living with HIV and people affected by or at risk of acquiring HIV (including key populations and women and girls). In a rapidly changing environment, this report captures only a snapshot in time, and we recognize that in many cases, countries have continuously changed and adapted their approaches and strategies in response to concerns, solving problems as they arise.

Some of these good practices are captured in the report. The first stages of a pandemic and response are critical, and it is important to reflect on and analyse these first weeks and months, even as we continue to respond to the crisis. It is our hope that this report can be used to inform action and update policy responses as COVID-19 continues to disrupt social and economic life in communities across the world.

COVID-19 has affected all regions of the world, and so the issues addressed here are globally relevant. To allow deeper analysis, the focus here is on two of the regions that contain countries with some of the highest HIV prevalence in the world: sub-Saharan Africa and Latin America and the Caribbean. It is critical to note, however, that lockdowns and human rights concerns related to them are present in countries in all regions, including in Asia and the Pacific and Europe. The geographical focus of this report, chosen to fit practical and time constraints and to focus on high-burden HIV regions, should not be interpreted to imply that concerns are more acute in, or issues are confined to, the countries explored.

Methodology

This review of policy and practice focuses on restrictions on movement and related issues during the early response to COVID-19: the laws and policies put in place, their implementation and their effects on human rights, as well as the actions taken by governments to protect human rights and ameliorate the negative consequences of lockdowns or other restrictions. In terms of the issues reviewed, the scope of this report was based on a combination of early reports of human rights concerns by communities of people who are living with or vulnerable to HIV, and the prior experience of UNAIDS with the HIV response. Of particular importance was UNAIDS' understanding of the types of human rights violations that would affect public health outcomes—in this case for both COVID-19 and HIV—which were examined in the *Rights in the time of COVID-19* publication, released earlier this year.

The methodology was developed to avoid taking time and resources away from the COVID-19 response, and to allow information-gathering during a pandemic response in contexts that featured lockdowns and other limitations on movements across the period of analysis for a report that would be published in a relatively short period of time. A global review was beyond the scope and time requirements for this project, so the report is therefore restricted to two regions: Latin America and the Caribbean and sub-Saharan Africa. These regions were chosen because they contain countries with the highest HIV prevalence.

Within each region, the following criteria were used for selecting countries:

- Ensure representation across income classifications.
- Include at least one country from each of eastern, southern, western and central Africa, South and central America, and the Caribbean.
- Ensure the majority of countries contained a UNAIDS office.

Countries were then picked at random until the above criteria were met. Ultimately, 16 countries were selected: Argentina, Botswana, Brazil, Cameroon, the Central African Republic, Chile, Colombia, El Salvador, Ethiopia, Jamaica, Kenya, Malawi, Nigeria, Peru, South Africa and Uganda.

UNAIDS partnered with the O'Neill Institute for National and Global Health Law at Georgetown University to coordinate research and drafting.

The questions were developed by drawing on the observations and recommendations contained in *Rights in the time of COVID-19* about what the HIV response has taught us about human rights concerns and how the COVID-19 pandemic could impact negatively on people who are living with or vulnerable to HIV.

Data were gathered beginning in February 2020 through 19 May 2020, with limited updates after that time. Information for each country was gathered through: (a) a qualitative questionnaire sent to human rights experts with local knowledge

of each country; (b) the review of legal documents, and reports from government, nongovernmental organizations and the media; (c) consultation with national human rights experts; and (d) observations from UNAIDS staff. Wherever possible, the relevant public sources are cited. Information was verified by experts on human rights, law and development who have experience working in the relevant countries. The draft report was then the subject of a dialogue with the 16 countries reviewed, and an invitation was extended to correct any factual errors within the document.

Although this short report cannot possibly capture the full reality of national contexts, it seeks to understand some of what is happening in relation to rights and COVID-19 in a rapidly evolving context with limited mobility. The report does not purport to provide a complete picture of each country, as it was not feasible to cover all areas of human rights concern or all actions taken by countries. It is also subject to limitations where complete data or information are not in the public domain or readily available. These include broader socioeconomic policies and support programmes rolled out by governments to address the direct and indirect effects of the pandemic; human rights concerns raised by increasing use of digital technologies in COVID-19 responses, including contact tracing, disseminating public health messages, and health care; and broader access to COVID-19-related health care during the pandemic, including current technologies such as ventilators and prospective vaccines and treatments.

Based on the review's findings related to lessons learned from the HIV response and UN human rights guidance, this report is structured around 10 key areas for action by governments as they orient in the coming months for a rights-based response to COVID-19.

Setting the scene: limiting movement of people in response to COVID-19

Countries around the world have implemented a range of measures to reduce transmission of the virus responsible for COVID-19. One of the most common measures—although it is by no means universal—is that of a lockdown that places restrictions on individual movement, such as limiting people to within a certain radius of their domicile and/or preventing them from leaving their place of residence. Some countries have instituted partial lockdowns where restrictions are at the subnational level or are only for certain times of day, such as a curfew. While restrictions on freedom of movement are permissible to achieve a legitimate aim, such as protecting public health, states still have a responsibility to ensure that such restrictions are proportionate, evidence-based and time-limited.

Of the 16 countries reviewed, 12 have issued varying degrees of lockdown or stay-at-home orders; only Cameroon, the Central African Republic and Ethiopia have not. The Government of Malawi issued a lockdown order, but it was stayed by court order before taking effect.

The lockdowns are largely nationwide, except in Brazil, where they have been issued by some state and municipal governments. Argentina, Chile, Jamaica, Kenya and Nigeria have some nationwide restrictions in place, such as curfews, combined with more extensive lockdown measures in certain areas (21–37). See Table 1 for more details.

Unlike policies for the medical quarantine of people with suspected exposure to COVID-19 or isolation of cases (both of which apply to specific individuals), lockdown orders apply to the general population. A core set of restrictions is fairly uniform across countries. Unessential businesses are closed, with their employees asked to work from home if possible. The size of gatherings and the number of people in public transit vehicles are limited. People are instructed to stay at home unless they are essential workers or engaging in permitted activities. The list of permitted activities varies across countries. All 12 countries allow people to leave home to get food or medical care. In Colombia, people are explicitly allowed exercise outdoors (38). Nigeria (39) and South Africa (40) also added exercise to the permitted activities list as they eased their lockdown restrictions.

Chile, Jamaica, Kenya, Nigeria, Peru, South Africa and Uganda have implemented nightly curfews rather than round-the-clock lockdowns. These curfews make exceptions only for essential workers and, in some cases, for people seeking emergency medical care. In Chile (26) and Kenya (30), the curfews are nationwide, but only some areas have lockdown orders in place during the day (41–43). In Nigeria (39) and South Africa (33), the curfews were put in place as part of the first phase of easing lockdowns.

Some countries have taken further steps to restrict people's movements. Uganda banned the use of transport without official permission (44). In Botswana (23), Chile (45) and El Salvador (46), people were required to register or request permission before they left home. In Chile, people were allowed three hours of shopping for essential goods twice a week, and five hours or 24 hours (depending on

how far they must travel) to attend the funeral of an immediate family member (47). In Argentina, people were required to register if they wished to travel further than one kilometre from their home (48). The Government of the City of Buenos Aires initially required people over the age of 70 years to register before leaving home and to call a hotline, whose operators would inform them of the dangers posed by COVID-19 and attempt to dissuade them from leaving; a judge declared this measure discriminatory and overturned it, and so the Government downgraded it to a recommendation (49, 50). In parts of Colombia (51), El Salvador (46), Jamaica (52) and Peru (53, 54), people have been allowed out only on certain days of the week, with days sometimes assigned based on gender or national identity number. Cameroon (34), the Central African Republic (36), Ethiopia (37) and Malawi (55) have not instituted general lockdown orders, but they have implemented some more specific restrictions. All four countries closed schools and limited the size of gatherings (although in Malawi, the limit is 100 people). Cameroon ordered bars and restaurants to close at 6 pm, while the Central African Republic closed bars and restaurants entirely, except for takeaway services (35, 36).

Table 1. Overview of lockdown measures adopted and lockdown enforcement as of 15 May 2020 ^A

Country	Measures implemented	Exemptions for seeking food, medical care, exercise and caregiving	Registration or permission required to leave home?	Masks required in public?	Reports of arrests or use of violence to enforce lockdowns or other restrictions/ requirements?
Nationwide lockdown					
Argentina	Some nationwide measures; more severe lockdowns in some parts of country	Food, medical care, caregiving	Yes	Yes	Yes
Botswana	Nationwide lockdown	Food, medical care	Yes	Yes	Yes
Brazil	Lockdown in some parts of country	Food, medical care, caregiving	No	Yes	No
Cameroon	No lockdown or curfew	N/A	N/A	Yes	Yes
Central African Republic	No lockdown or curfew	N/A	N/A	Recommended but not required	Yes
Chile	Some nationwide measures, including curfew; more severe lockdowns in some parts of country	Food, medical care (permission or registration may be needed), caregiving	Yes	Yes	Yes
Colombia	Nationwide lockdown	Food, medical care, exercise, caregiving	People allowed out on certain days (in some parts of country)	Yes	Yes
El Salvador	Nationwide lockdown	Food, medical care (permission or registration may be needed), caregiving	Yes; people allowed out only on certain days	Yes	Yes

Country	Measures implemented	Exemptions for seeking food, medical care, exercise and caregiving	Registration or permission required to leave home?	Masks required in public?	Reports of arrests or use of violence to enforce lockdowns or other restrictions/requirements?
Ethiopia	No lockdown or curfew	N/A	N/A	Yes	Yes
Jamaica	Some nationwide measures, including curfew; more severe lockdowns in some parts of country	Food, medical care	People allowed out only on certain days in some parts of country under specific lockdown	Yes	Yes
Kenya	Some nationwide measures, including curfew and restrictions on movement between counties; more severe lockdowns in some parts of country	Food, medical care (permission or registration may be needed)	No, except during curfew hours	Yes	Yes
Malawi	No lockdown or curfew	N/A	N/A	No	Yes
Nigeria	Some nationwide measures, including curfew; more severe lockdowns in some parts of country	Food, medical care	No	Yes	Yes
Peru	Nationwide lockdown, including curfew	Food, medical care, caregiving	People allowed out only on certain days	Yes	Yes
South Africa	Nationwide lockdown, including curfew	Food, medical care	No	Yes	Yes
Uganda	Nationwide lockdown, including curfew	Food, medical care (permission or registration may be needed)	Yes	Yes	Yes

^a This table describes lockdown measures that have been adopted at any point during the COVID-19 pandemic. Some may no longer be in effect.

COVID-19 public health orders and human rights

The COVID-19 pandemic is an exceptional time, and international human rights law permits governments to temporarily limit the exercise of some human rights for the compelling and legitimate purpose to protect lives and public health. Lessons from the HIV response reaffirm the imperative to follow key principles when applying rights-limiting measures—namely that these measures must be lawful, necessary, proportionate, non-discriminatory and limited to achieving a legitimate aim. The requirement of proportionality means the restrictions must be appropriate to achieve their function (effective), the least intrusive and least restrictive to achieve their protective function, and proportionate to the interest being protected (56).

Recognizing that these limitations and restrictions are impacting the HIV response and people who are living with and vulnerable to HIV, UNAIDS recommended that countries ensure that any enforced limitations on individual movement are “carefully assessed, including their effectiveness and whether more proportionate measures are available” (19). In reviewing information gathered for this report, particularly on the impact on people who are living with or vulnerable to HIV, 10 key areas of human rights concerns emerged that are applicable both to communities of people who are living with and vulnerable to HIV and to the broader population. UNAIDS has drawn on its own experience and that of international human rights bodies and experts to provide key recommendations for each area of concern. It is hoped that the following lessons from HIV can be taken up more clearly in the months ahead.

Avoid disproportionate, discriminatory or excessive use of criminal law

Efforts to halt HIV transmission by criminalizing behaviours and activities have proven ineffective, driving people away from critical services and undermining the trust that communities have in authorities. UNAIDS has argued that the excessive or discriminatory application of criminal laws “risks undermining public health and human rights” (57).

Hundreds of thousands of people around the world have been arrested for violating COVID-19 orders (58). Globally, many countries have introduced new criminal offences or relied on existing criminal laws—such as manslaughter or endangering the health of others—to enforce compliance (59). The use of criminal law for public health ends is, in most cases, a disproportionate and ineffective response that is vulnerable to arbitrary and discriminatory implementation. Governments should presume communities’ desire to comply with sound public health advisories if they are well-informed and supported to do so. Wherever possible, governments should plan for and seek to address barriers to compliance rather than impose criminal penalties or other punitive measures, particularly where detention in unhygienic and overcrowded conditions may worsen a health emergency.

The Office of the United Nations High Commissioner for Human Rights (OHCHR) has made clear that “deprivation of liberty must be reasonable, necessary and proportionate in the circumstances, even in a state of emergency” (60). When assessing the appropriateness of detaining a person, governments should “pay specific attention to the public health implications of overcrowding in places of detention and to the particular risks to detainees created by the COVID-19 emergency” (60). Using criminal law to fight COVID-19 poses significant perils associated with arrests and detention to arrestees, police officers and staff of the justice system; it also deflects critical time, human resources and limited budgets from measures that more effectively respond to the pandemic, including education, testing, tracing, treatment, temporary isolation, and supporting people to more effectively and safely reduce physical interaction. A reliance on criminal laws can also distract from government support for measures that would assist populations at risk to stay home, such as provision of medicines, HIV prevention and treatment, food, water or alternative shelter. Reliance on criminal penalties to enforce curfews and physical distancing guidelines can lead to discriminatory outcomes where people without access to reliable information, clean water or safe shelter are most likely to face arrest and detention. The pandemic can also intensify the disproportionate negative impact of administrative penalties, such as fines. OHCHR has cautioned governments that “in assessing the appropriate sum of a fine, consideration should be given to the individual circumstances, including gender specific impacts. This is particularly relevant for people not in paid employment or those not generating income because of the emergency measures” (60).

There is a real risk of the discriminatory application and impact of such criminal laws. In the HIV response, the disproportionate impact of criminal laws and law enforcement practices on key and vulnerable populations has been widely documented (61). As the United Nations Office on Drugs and Crime (UNODC) has pointed out, this applies equally under COVID-19: “specific populations such as LGBTI persons or other groups are at risk of use of force violations by police and security providers” (13).

In the 16 countries reviewed, tens of thousands of people have been arrested for violating lockdown orders, which fits with findings across UN agencies of hundreds of thousands of people arrested in recent months (62-71). Eleven of the 12 countries with lockdowns have reported arrests relating to COVID-19 restrictions, using short-term detention and fines as a deterrent and a way to punish people suspected of failing to comply with COVID-19 risk mitigation behaviours (see Table 1).

We have also seen the discriminatory impact of criminal laws and enforcement measures on key populations. Chile has reportedly arrested more than 1200 people for violating its curfew orders (63). Although Ethiopia has not implemented a lockdown on movement, according to the Ethiopian Human Rights Commission, the five-month state of emergency in response to COVID-19 established new, broadly worded crimes and criminal penalties of up to three years imprisonment or a fine of up to 200 000 Ethiopian Birr (US\$ 5750) for violating physical distancing standards, including shaking hands and being in public without covering one’s nose and mouth (68). These new criminal provisions led to the arrest and temporary detainment of more than 2800 people (69, 70). According to media reports, Cameroon has arrested and detained hundreds of people for not wearing masks in public and issued fines. This has meant that people who could not pay fines remained in jail longer than those who could pay (71).

Food distribution sites need to be managed carefully because they tend to draw crowds, potentially increasing the risk of COVID-19 transmission. Attempts to manage these sites through punitive laws are disproportionate, can lead to unjustified use

of force, and fail to assist in finding other solutions for delivering food and other basic resources. For example, the Government of Uganda stated that politicians who sought to distribute food aid to needy people would be charged with attempted murder, allegedly because physical proximity during distribution could lead to COVID-19 transmission (72). Complying with that order, security forces arrested and severely beat a member of parliament who was handing out food to community members in his area. He sustained serious injuries and was ultimately released on police bond from detention to seek emergency medical treatment (73). All charges have since been dropped (74).

Police officers, however, can play a constructive role in the response. In Mombasa, Kenya, one governor worked with police to hand out masks to people at checkpoints rather than arrest them for not wearing masks (75). Likewise, several Brazilian states have instructed authorities to prioritize educating the public about the importance of the new restrictions before resorting to sanctions (76, 77).

Government efforts should work to respond to the lived reality of people's lives and focus on disseminating accurate information and educating the public about COVID-19 risks and transmission. While there is urgency to ensure communities abide by physical distancing and other COVID-19 response measures to stem transmission, an overreliance on criminal sanctions risks a raft of human rights violations that undermine efforts to curtail the pandemic and exacerbate pre-existing social challenges of poverty, prison overcrowding and inadequate access to accurate information. If and when police officers are on the front lines of the COVID-19 response, they should be trained in supporting community education and empowerment efforts, given clear instructions on when and how to use and not use their law enforcement powers, and supplied with enough personal protective equipment to carry out their duties without risk to themselves or the communities they serve.

An overreliance on criminal sanctions also impedes governments' understanding of why people are breaching COVID-19-related best practices and their ability to support communities to comply willingly. Many people have needs—such as access to medicines, including HIV prevention and treatment, and clean water or food—that make remaining at home extremely difficult. The practical economic and social costs of poverty in a pandemic should always be factored into government planning and buttress governmental ability to provide measures to support a range of urgent needs so that compliance is possible.

Governments should be—and many are, as detailed later in this report—working with communities to implement policies and programmes that support people's urgent needs and make it possible for them to comply with COVID-19 prevention measures.

Stop discriminatory enforcement against key populations

From the history of the HIV epidemic, we have seen how stigma and discrimination negatively affects people's physical and mental health and social support . . . Combat all forms of stigma and discrimination, including those based on race, social contacts, profession (healthcare workers), and those directed towards marginalized groups that prevent them from accessing care . . . Use of criminal laws in a public health emergency is often broad-sweeping and vague and they run the risk of being deployed in an arbitrary or discriminatory manner.

– Joint United Nations Programme on HIV/AIDS (19)

In many countries around the world, gay men and other men who have sex with men, transgender people, people who use drugs, sex workers, and other socially and economically marginalized groups vulnerable to HIV—including women and girls, people in informal settlements, indigenous groups, young people, and migrants and refugees—are experiencing discriminatory impacts under COVID-19 lockdown orders (78, 79). Governments should take immediate action to address stigma and discrimination, including amending laws and training front-line personnel in non-discrimination.

As we have seen in the HIV response, the effects of coercive or restrictive public health measures and the burden of their enforcement falls disproportionately on some groups and communities, often those who are already vulnerable or marginalized. This can have negative effects on HIV programmes and outcomes, such as increasing stigma and discrimination, pushing the HIV epidemic underground, removing the ability of sex workers to negotiate safer sex, and creating barriers to prevention, testing and treatment. When stigma and discrimination are reduced and an enabling legal approach is taken, HIV outcomes improve (61).

Under COVID-19, this is playing out in many countries worldwide—not because the law is consistently written in a discriminatory manner, but because its effects are foreseeably unequal or enforced in ways that reinforce social structures of stigma and discrimination. Discrimination, whether direct or indirect, is unlawful under international human rights law and can drive people away from seeking needed health care in crises and ultimately curtail effective responses. The effects on marginalized communities are systemic rather than coincidental, and they must be addressed as such. UNAIDS (19), the United Nations Educational, Scientific and Cultural Organization (UNESCO) (18), OHCHR (8) and other organizations have called on governments to take immediate action to address stigma, xenophobia and other forms of discrimination, including by amending laws and training front-line personnel in non-discrimination.

Sex workers have been particularly vulnerable to arrest and mistreatment under COVID-19. With their income at risk or entirely eliminated, and often ineligible for financial support due to the legal status of their work, many sex workers report having to choose between physical distancing and meeting basic needs, with many sex workers arrested globally (78, 79). In this context, UNAIDS and the Global Network of Sex Work Projects have called for an immediate halt to arrests and prosecutions of sex workers, "moving away from punitive measures and criminalization towards reaching and serving those most in need" (80).

The review found that this global trend is also reflected within the 16 focus countries of this report, with punitive measures used against sex workers in at least four of them. In Cameroon, more than 50 sex workers were reportedly arrested in Yaoundé for entering hotels in violation of isolation orders (81). In Kenya, more than 50 sex workers were reportedly arrested for violating lockdown orders, including 24 reportedly arrested in one raid in Makueni county (82, 83). In Uganda, civil society organizations reported that at least 117 sex workers, bartenders and other vulnerable women have been arrested for violating lockdown, including 71 within a single day of raids in Kampala, Kasese, Lira, Masaka, Mbale, Nakasongola, Oyamu and Wakiso (84). They were subsequently released (85). Rights groups in El Salvador report sex workers being among the hundreds of people arrested for violating lockdown orders (86).

In countries and regions—including Europe and Asia and the Pacific, both of which were beyond our research scope—there have been similar reports of arrests, but there also have been examples of governments supporting and working with sex workers to address the challenges of COVID-19 (87, 88). For instance, some sex workers have been enlisted to conduct contact tracing (89), while in some countries where sex work is not criminalized, they have been able to access financial assistance alongside other workers, thus eliminating the conflict between basic needs and compliance with public health directives (90, 91). In Argentina, the Ministry of Social Development launched an online registry for informal workers to access social benefits; initially, this included sex workers, but sex work was then removed as an eligible category. At the time of writing, the registry was taken down while the Government undertakes consultations on the matter (92). There have been some positive developments from civil society as well, such as in Botswana, where the nongovernmental organization Sisonke has been distributing food aid to sex workers, addressing the key driver of lost income (93, 94).

LGBTI people have found themselves disproportionately impacted by enforcement measures in some countries. In Peru between 3 and 10 April 2020, mobility outside the home was segregated by gender, which created particular problems for transgender people (95). The Government of Peru specifically noted that people should follow the policy based on their self-identification, yet there were several reports of LGBTI people being attacked or humiliated by state agents during the gender-specific lockdown, including abuse of transgender and other gender-diverse people (96-98). In response, the Peruvian Government passed a legislative decree to protect against discrimination by law enforcement on the basis of gender identity and sexual orientation (among other bases), and it drew attention to the regulations for the use of force by the police and armed forces (99).

Under COVID-19 restrictions, Ugandan officials arrested at least 23 LGBTI youth who were living in a safehouse on 29 March. Of those arrested, 19 were eventually charged with violating physical distancing orders and officially accused of committing a “negligent act likely to spread an infectious disease” under the criminal code, allegedly because of the total number of people living in the house (100, 101). They were denied bail and were unable to see their lawyers while in detention. They were never tested for COVID-19 during their detention. Significant efforts from civil society eventually secured their release on 19 May, and all charges were dropped. A court later ordered compensation for the rights violations of those arrested and charged (100, 102). In Jamaica, UNAIDS has heard testimonials from gay men and other men who have sex with men living on the streets who have been receiving harassment from security forces to comply with the curfew (103). The higher rates of homelessness among LGBTI persons due to stigma and discrimination within families is a global phenomenon, which means that targeting or harassing homeless persons has a discriminatory impact on LGBTI persons (104, 105).

Explicitly prohibit state-based violence, and hold law enforcement and security forces accountable for disproportionate responses or actions when enforcing COVID-19 response measures

In most cases, lockdown measures are accompanied by powers of enforcement that—if excessive, overused or used in a discriminatory manner—could have serious consequences for the public, in terms of their rights to be free from arbitrary detention, violence and discrimination, their right to access services, and their right to health.

From very early in the COVID-19 pandemic, there have been reports from across the world of the excessive and disproportionate use of force in enforcing lockdowns, curfews and other restrictions or requirements (such as wearing a mask) (62). The review found these same trends in the countries reviewed for this report, with many examples of law enforcement and/or security forces using violence, including lethal force, to enforce COVID-19 transmission reduction measures.

From the highest level down, governments should: guarantee rights related to the use of force, arrest and detention, fair trial and access to justice and privacy; ensure law enforcement and security forces exercise restraint; and hold them accountable for abuses (60, 106). Under the principles of international law, law enforcement officials should apply nonviolent means before resorting to the use of force, use force only in proportion to the seriousness of the offence, and use lethal force only when strictly unavoidable to protect life. No country should permit or condone brutality, such as beatings, humiliation or killings, under the guise of enforcement of physical distancing, curfews or other behaviour modification, such as wearing a mask in public. Arbitrary deprivation of life, torture, and inhumane or degrading treatment are banned under international human rights law at all times, in all places (107). OHCHR has weighed in extensively on this issue in the context of COVID-19 and states: “Law enforcement officials may use force only when strictly necessary and to the extent required for the performance of their duty and only when less harmful measures have proven to be clearly ineffective” (60). As noted by a number of UN human rights experts, “breaking a curfew, or any restriction on freedom of movement, cannot justify resorting to excessive use of force by the police; under no circumstances should it lead to the use of lethal force” (108).

We have seen in the HIV response that education, consent, engagement and community empowerment are the most effective ways to achieve compliance, and yet state-based violence not only persists but has in many cases increased with the onset of COVID-19. As noted above, this can have a disproportionate impact on key and other vulnerable populations by increasing stigma, sending people underground and driving them away from services. It also can divert time and resources away from a more enabling approach that ensures access to essential services, such as health care (particularly HIV services), and it can make people fearful of leaving their homes because of the potential for arrest or violence, thus creating further barriers to reaching these crucial services (64).

Examples of this global phenomenon were found in a number of the countries reviewed. Police enforcing the curfew in Kenya reportedly killed at least six people (109-111). Nigeria’s National Human Rights Commission, an independent body that was monitoring human rights in law enforcement activities relating to COVID-19, including setting up special hotlines to receive reports, reported that between 30 March and 13 April, there were eight incidents of extrajudicial killings perpetrated by the police force, army and the Nigerian Correctional Service, resulting in 18 deaths (112, 113).

Law enforcement officials have relied on unlawful enforcement tactics, such as beatings, extortion and humiliating alleged transgressors, in some cases in ways that may exacerbate the risks of COVID-19 transmission. In South Africa, there have been multiple reports of excessive use of force by police and other security forces. As of 8 May, the Independent Police Investigating Directorate is investigating 376 reports of allegations of abuse of police power (114, 115). In El Salvador, a video on social media showed police beating an 80-year-old man for allegedly failing to respect the quarantine, and there have been other reports of police abuses (67). In Mombasa, according to media reports, Kenyan police officers forced crowds of people to lie down together, in some cases on top of each other, and beat them for allegedly violating curfew (116). In Uganda, civil activists decried multiple incidents of brutality in curfew enforcement in several locations across the country, including Elegu, Kampala and Lira, particularly by members of the police and local defense units (117-119). Sixteen security personnel were reportedly arrested in Elegu. At the time of writing, six army officers have been sentenced to six months in prison and the police officers are awaiting a court verdict (120, 121).

In some instances, government officials have issued formal apologies for brutality and conducted isolated arrests of abusive security forces. Given the practical constraints of the ongoing pandemic and the urgent need for basic livelihoods, it is unclear whether survivors of such abuses will be able to seek justice or compensation. If left unchecked, countries may end up inadvertently allowing the pandemic to erode or destroy future trust and confidence in government public health efforts, further impeding the fight against the pandemic.

UNODC and UNDP released guidelines on ensuring access to justice in the context of COVID-19, noting “protocols and training are required for police and security personnel, including border authorities, to ensure the respect for dignity and rights of people in the context of implementing emergency regulations and quarantine rules, including adopting a gender-sensitive and child-friendly approach. This will be particularly relevant in the treatment of marginalized groups that may be constrained in their ability to follow quarantine rules (such as day labourers, migrant workers, street vendors, sex workers, or homeless persons)” (13).

Include reasonable exceptions to ensure legal restrictions on movement do not prevent access to food, health care, shelter or other basic needs

All public health orders reviewed officially allow people to move for food and health care (except during curfew hours), but not to shelter. Emergency medical care is supposed to be accessible at all times, but in practice, overly broad lockdowns in some contexts have undermined access and led directly to deaths and physical harm. Governments should consistently allow for exceptions that reflect the complexity of basic survival and the diversity of needs during public health emergencies within and across borders.

UNAIDS warns that where public health measures restrict people’s movements, governments must “put in place exceptions where necessary for vulnerable groups and to ameliorate the consequences of such restrictions” (19). Specifically, governments must take appropriate measures, including making targeted exceptions to lockdown restrictions, to ensure lockdowns do not “deprive people of food, medication or housing” (19). This is particularly important for populations at higher risk, such as older people, who may be subject to stricter stay-at-home rules than the general public.

Continued access to health care is, of course, critical for the HIV response, including HIV-specific services for prevention, testing and treatment, sexual and reproductive health and rights services, integrated tuberculosis services and broader health services for comorbidities. Service interruptions can have significant detrimental impacts on the mental and physical well-being of individuals, and on the HIV response as a whole. This was demonstrated in recent modelling on interruptions to HIV services during the COVID-19 pandemic (122). Likewise, food is critical, not only for general nutrition and well-being, but for people living with HIV, whose medication must be taken with food. There have been reports of people not being able to take their HIV medication due to a lack of food (123).

Across most of the countries we reviewed, governments have largely made appropriate exceptions in public health orders and laws to allow people to access food and health care, but not shelter. In practice, however, examples exist in many countries of challenges imposed by public health orders on people's ability to meet these basic needs, particularly among vulnerable groups. These examples reflect a global trend of difficulties experienced by vulnerable groups in accessing essential health care, shelter and food due to lockdown measures, despite exemptions to restrictions (124–126).

Health care

Globally, communities are facing barriers to accessing health care due to lockdown measures. For example, the United Nations Population Fund (UNFPA) has warned in a *Lancet* article that there potentially will be thousands of deaths worldwide from unsafe abortions and complicated births due to inadequate access to emergency care; it also suggested that mobility restrictions have prevented people from accessing sexual and reproductive health clinics (127). All 12 countries with lockdowns have explicit exceptions in their regulations to allow people to purchase food and essential goods. In Chile, Kenya and Uganda, however, lockdown measures initially did not contain explicit exceptions allowing people to seek emergency medical care as needed, in some cases requiring them to first register or request official permission to do so. In Colombia, El Salvador, Kenya and Uganda curfews or travel restrictions are reportedly created barriers to people seeking medical care, sometimes with tragic results.

Uganda's lockdown order, for instance, required people to seek special permission from a resident district commissioner to travel in private vehicles, even to hospitals in cases of emergency (44). Reports indicate that the officials who can provide this authorization are often absent and unreachable, and the public vehicles that take people to the hospital are too few and take too long to arrive (128). According to reports from nongovernmental organizations, at least 11 pregnant women have died since the ban came into effect, some while walking to reach a hospital (128), and the media have reported that multiple infants and children have died (129). The President of Uganda has acknowledged the problem (128), and he has issued a directive indicating that resident district commissioners should put in place a response system so that they do not have to issue the permissions themselves. Uganda also has made efforts to increase the number of public vehicles to take people to hospitals (44). On 20 April, the Government of Uganda declared "visibly pregnant women" should be allowed to travel without permits—but this exception does not help other people who need urgent care, including women in the early stages of pregnancy who require medical care.

Additionally, although Ugandan health workers are legally allowed to travel to work, the ban on private vehicles is making it difficult for them to do so. Though essential workers can travel, they require a permit to do so. The Ugandan Medical Association

reports that there have been delays in receiving these permits and that, in the interim, doctors who drive without them have been beaten, arrested and tortured (130, 131). As a result, Uganda's health-care workers "are taking extraordinary measures to get to work, commuting by foot, bicycle and in at least one case by canoe" (130).

In El Salvador, the media have reported that shutting down public transport initially created many obstacles for essential workers, including health-care workers, to reaching their workplaces, and for people seeking food and medical care. After this decree was challenged in court, the Government reactivated public transport for health-care workers (132-134), and it provided free transport to and from hospital for anyone with a chronic disease (e.g., cancer, HIV and diabetes), but not for pregnant women (132-135).

Kenya required people to seek official permission to leave home during curfew, even for medical emergencies (30). A nongovernmental organization survey found that 58.5% of Kenyans in 12 counties were unable to access emergency medical care during curfew hours due to closures of community health centres, lack of transport to hospitals, and fear of police harassment for being out after curfew (136). People living in informal settlements were especially affected because they were initially unsure about what to do if they fell sick at night and how they could obtain official permission or escort to the hospital, calling attention to the need for (at a minimum) clear public communication (137). Other reports indicate that violent curfew enforcement by police officers has interfered with people's ability to find transport to hospitals after curfew, particularly in rural areas (138). According to one report, police beat a motorbike taxi driver to death after he took a woman in labour to the hospital during curfew hours (139). In response, the Kenyan Government has partnered with civil society and the private sector, including taxi company Bolt, to create the Wheels for Life programme, which provides pregnant women and other people who need emergency care with free, officially sanctioned transport to hospitals during curfew hours (140, 141). The reach of this programme outside urban areas is not clear, however, and respondents to one survey have reported that emergency response teams fear going into some areas at night (136).

Food and health care for high-risk and vulnerable people

Governments have a particular obligation to ensure that people in higher risk groups, and people in need of special assistance due to lockdown restrictions, are able to access food, medical care and other essentials. Certain groups, including people in prison, older people, and people living with chronic health conditions and disabilities, are at higher risk from COVID-19 due to their particular circumstances. Very often, these people rely on caregivers, whether family, friends or health and social workers, for day-to-day support, and they may not be able to obtain food, take medication or bathe without assistance. WHO has reminded governments that these groups warrant specific consideration to preserve their dignity and well-being during lockdowns (142, 143).

Governments around the world are strongly advising older people and people with health vulnerabilities to stay at home. Some countries, including Argentina (49, 144), Chile (26, 145), Colombia (146) and Jamaica (147), have introduced stricter restrictions for these groups than for the general public. Of the 12 countries with lockdowns, only six included specific exemptions explicitly allowing people to provide assistance to family members and neighbours in need: Argentina (148), Brazil (149), Chile (47), Colombia (150), El Salvador (151) and Peru (152). Jamaica has no such exemption, but the Government has created a helpline that seniors (who are mandated to stay home) can call for help accessing food, medicine and other essential supplies (153). The city of Buenos Aires, Argentina, has done the same (49).

Botswana has a lockdown exemption allowing people to assist elderly or sick people to obtain medical care or social protection packages, but not to purchase food (23).

Early in the COVID-19 pandemic, the Government of Uganda ordered people not to use personal or family vehicles, including for transport to hospitals, as this might spread the virus (43). According to the Government, this ban was in response to individuals using their private vehicles as taxis once public transport was halted. Instead, people were instructed to wait for an official vehicle to transport them. The lack of available vehicles caused significant and sometimes fatal consequences (44). In one case, a nurse reportedly wheeled a patient two kilometres from a local clinic to the hospital after waiting more than four hours for an ambulance (154).

Marginalized communities and communities often left behind, including some indigenous populations, have seen a lack of COVID-19-specific information and services in some cases. The National Organization of Andean and Amazon Indigenous Women of Peru reported that in addition to ongoing problems in Peru's health policies towards indigenous peoples, understaffed facilities in remote sites and lack of access to adequate information, especially in local languages, have been critical issues (155, 156).

Shelter

Lockdown restrictions can leave people displaced, with nowhere to go and no provisions made for them in law. Across the world, populations living with or vulnerable to HIV—such as key populations, migrants, women and girls, and economically disadvantaged groups—all face specific issues of discrimination, violence or stigma that can leave them at higher risk of homelessness and/or in need of alternative, safe forms of shelter (5, 104, 105, 157-159).

During lockdowns, there have been evictions and demolitions of informal housing, placing people in precarious situations from a public health and legal perspective, and prompting the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context to issue a statement prohibiting evictions during the pandemic (124). As described under Recommendation 2, sex workers and LGBTI youth are facing the loss of safe housing or even arrest when staying in a shelter. For LGBTI people, family homes may not be a safe place to live, and other options may not be available. In Uganda, the 23 people arrested for breaching COVID-19 restrictions were doing so because they had nowhere else to live (101).

In the countries reviewed, there are similar examples of evictions and loss of shelter. UN Special Rapporteurs have received reports from Kenya about mass evictions, despite the Government's announcement that it would establish a moratorium banning them during the COVID-19 crisis. Around 8000 people were forcibly removed from Kariobangi and their houses flattened, despite a court order restraining authorities from conducting the eviction (160). In South Africa, there have been repeated reports of demolitions by local governments in the Cape Town (161, 162) and eThekweni (163) metropolitan areas, despite the national government issuing regulations stipulating that evictions during COVID-19 are unlawful (164).

In Peru, hundreds of thousands of people who travelled to Lima for work have lost their means of support and can no longer afford to remain in the city. When the Peruvian Government shut down interprovincial transport in March, it gave people only one day to return home (165, 166). Regional governments have been allowed to arrange transportation to bring people home, and the national government has arranged some temporary shelter and provisions for people who are unable

to leave, but in early May, the waiting list for transport still contained more than 170 000 people. Many attempting to return home have no choice but to walk. Reports describe convoys of hundreds of people trekking for hundreds of hours “up the hair-raising Central Highway” into the Andes (165-167).

In Chile, public transport is still running, even in the municipalities with lockdowns. Regulations allow people caught behind cordons sanitaires to return home, provided they agree to be quarantined for 14 days after arrival (26, 47, 168).

Take proactive measures to ensure people, particularly from vulnerable groups, can access HIV treatment and prevention services and meet other basic needs

Beyond making exceptions to movement restrictions, this report details specific measures governments are putting in place to support the realization of the rights to health, food and clean water. Globally, countries are seeing documented disruptions in HIV treatment or prevention (122, 169-172). Countries are expanding differentiated service delivery options, but more aggressive policy shifts are needed to ensure access, particularly to harm reduction services. Countries are improving access to water and food through distribution and placing temporary regulations and restrictions on the private sector. The breadth and scale of the need, however, are often outpacing capacity. Governments and international financing agencies should implement diversified service delivery and speed up emergency funding and policy shifts.

Including exceptions to movement orders is necessary, but proactive efforts are also required to create alternative avenues for accessing basic needs while complying with public health advice. A full review of the range of socioeconomic policies and supports that governments are putting into place is beyond the scope of this report, but we note three particularly urgent areas for action amid early responses to COVID-19: access to HIV services, water and food. International human rights law obligates governments to protect, respect and fulfil these as rights, including non-discrimination in the enjoyment of the right to health. WHO has advised governments to develop a “plan to safely maintain essential health services” during the COVID-19 response (143). Likewise, guidance from the International Labour Organization and the UN calls on governments to provide “targeted social assistance for the most marginalized and vulnerable” to ensure the availability of food, water and sanitation (106, 173).

Preserving and extending access to HIV treatment and prevention services, including harm reduction

UNAIDS and WHO have warned of the real risk that access to vital HIV, tuberculosis and harm reduction services may be disrupted during the COVID-19 pandemic (19, 174-176). Interruptions in HIV and tuberculosis treatment are particularly dangerous, since they can lead to treatment failure and HIV and tuberculosis transmission. “Where public transport may be halted and business operations shut down, access to medicines and services—including antiretroviral therapy, pre-exposure prophylaxis, opioid substitution therapy, sterile needles and syringes and other harm reduction services, mental health care and medication for other chronic conditions—must continue uninterrupted” (19). Disruptions to prevention and treatment services could also have disastrous effects. A UNAIDS and WHO modelling study of COVID-19-related service interruptions estimated that a six-month disruption of antiretroviral therapy could lead to more than 500 000 additional deaths from AIDS-related illnesses (122).

The multisectoral approach that has been key to progress in the HIV response will again be critical, both in ensuring the continuation of HIV services and for pursuing the broader COVID-19 response. Governments must work with communities to find solutions for people who cannot access treatment and harm reduction services. All HIV services, including harm reduction services, should be defined as “essential services” that save lives, and they must remain open, with workers classified as essential health-care personnel.

Reports from across the globe indicate that COVID-19 is creating significant barriers to accessing HIV services. A study undertaken by UNAIDS, the LGBT+ Foundation, the Johns Hopkins Bloomberg School of Public Health and others looked at the experiences of more than 20 000 LGBTI persons in 138 countries and found that 21% had experienced “interrupted or restricted access” to refills of antiretroviral therapy, and 42% of those had less than a one-month supply on hand. It also found disruptions to pre-exposure prophylaxis (PrEP) supply and HIV testing, and that racial and ethnic minorities had lower access to HIV services (170). A survey by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) showed that 85% of HIV programmes reported disruptions to service delivery, with 18% showing high or very high disruptions. Qualitative data indicate that lockdowns, restrictions on gatherings of people and transport stoppages are the main reasons that activities have been cancelled or delayed (171). WHO reported on 6 July that 36 countries—home to 45% of people receiving antiretroviral therapy—had reported disruptions in the provision of treatment since April (172).

Data gathered by UNAIDS for this report show similar interruptions in HIV prevention and treatment services in 11 of the 16 countries reviewed: Argentina, Botswana, Brazil, Cameroon, Chile, El Salvador, Jamaica, Nigeria, Peru, South Africa and Uganda (178). There have been disruptions to condom distribution in Botswana, Cameroon, El Salvador, Jamaica, Peru and Uganda; to PrEP in Peru and Uganda; to self-testing in Uganda; and to prevention of vertical transmission services in Cameroon, El Salvador and Uganda (178). In Argentina, Brazil, Chile, El Salvador, Peru, South Africa and Uganda, facilities where people access HIV treatment have been closed or had their hours reduced, or facility space and staff members have been reassigned to the COVID-19 response (178). In some parts of Brazil, the cancellation of medical appointments for new patients at the beginning of the COVID-19 pandemic created an obstacle for people starting PrEP (179).

On an individual level, lockdown restrictions (including reductions in public transit services) and people’s fears of entering health-care settings where they might be exposed to the virus that causes COVID-19, are making it more difficult for people living with HIV to pick up their medicines (180). For example, in Gauteng province, South Africa, the Department of Health reports just under 11 000 people have not picked up their antiretroviral medicines since the country’s lockdown began, a 20% reduction in medicine collections (181).

Table 2. Service delivery policies for antiretroviral medicines during the COVID-19 pandemic, 15 May 2020 ^A

Country	Service delivery policy
Argentina	One-month dispensing policy; most people receive one-month supply
Botswana	Three-month dispensing policy; most people receive two-month supply
Brazil	Three-month dispensing; most people receive three-month supply Community antiretroviral therapy distribution pilot programmes
Cameroon	Three-month dispensing policy; many people receive one-month supply Community antiretroviral therapy distribution nationwide
Central African Republic	Three-month dispensing policy, but geographically limited; most people receive one-month supply Community antiretroviral therapy distribution policy but not currently implemented
Chile	One-month dispensing policy; most people receive one month, though there are reported cases of people only receiving 10 days (180) Community antiretroviral therapy distribution through public health centres pilot programmes being planned in response to COVID-19 ^B
Colombia	Three-month dispensing policy; most people receive three-month supply
El Salvador	Two-month dispensing policy Community antiretroviral therapy distribution pilot programmes, but geographically limited
Ethiopia	Six-month dispensing; most people receive three-month supply Community antiretroviral therapy distribution nationwide
Jamaica	Three-month dispensing policy; most people receive one-month supply
Kenya	Three-month dispensing; most people receive three-month supply Community antiretroviral therapy distribution nationwide, but limited implementation
Malawi	Six-month dispensing; most people receive six-month supply
Nigeria	Three-month dispensing policy; most people receive three-month supply Community antiretroviral therapy distribution nationwide
Peru	Three-month dispensing policy
South Africa	Three-month dispensing policy; most people receive two-month supply Community antiretroviral therapy distribution nationwide
Uganda	Three-month dispensing policy; many people receive two-month supply Community antiretroviral therapy distribution pilot programmes

^A All data from UNAIDS portal unless otherwise noted.

^B Cádiz P. "Debes ir a un hospital y exponerte para tener medicación": vivir con VIH en tiempos de COVID-19. In: T13 [Internet]. 1 June 2020 (<https://www.t13.cl/noticia/nacional/coronavirus-vih-medicamentos-hospitalrelatos-01-06-20>).

To address the problems of access during COVID-19 lockdowns and physical distancing efforts, UNAIDS and WHO recommend that “a people-centred approach to access to medicines must be maintained throughout the outbreak” (19, 174). This approach, which falls under the banner of “differentiated service delivery,” encompasses a set of strategies designed to minimize the number of trips that people living with HIV have to make to clinics, and make services more readily available in the community, with the double advantage of helping people stay at home and reducing demand on the health system (182). Two of the main strategies are providing people living with HIV with a three- or six-month supply of antiretroviral medicines (multimonth dispensing) and enabling people living with HIV to pick up their medicines at convenient locations in the community or have their medicines delivered to them (community antiretroviral therapy distribution) (19).

According to UNAIDS data, as highlighted in Table 2, five countries have community antiretroviral therapy distribution policies that are being implemented nationwide: Cameroon, Ethiopia, Kenya (not fully implemented in village settings), Nigeria and South Africa (178). The Central African Republic has adopted a community antiretroviral therapy distribution policy, although this is not yet being implemented. Brazil, El Salvador and Uganda are piloting community antiretroviral therapy in some places (178). Botswana, Brazil, Cameroon, the Central African Republic, El Salvador, Ethiopia, Kenya, Peru, South Africa and Uganda have multimonth dispensing for HIV treatment (178). In March 2020, the Chilean Government announced that it would move to multimonth dispensing for the first time, although this has not been implemented systematically (178, 180, 183, 184).

Many countries report that supply chain problems are a major obstacle to fully implementing multimonth dispensing, with COVID-19 exacerbating these issues, such as in South Africa, which was transitioning to a new first-line HIV treatment regimen when the outbreak happened (178). Countries that do not offer multimonth dispensing cite supply chain problems as the major reason for not doing so. In some cases, this may mean that multimonth dispensing is available in some parts of a country but not others, or for some treatment regimens but not others.

Having differentiated service delivery policies does not guarantee that people living with HIV can access those services. In addition to supply chain problems, communication breakdowns between health officials and pharmacies and the stresses that the COVID-19 response is placing on the health system create barriers to access at the local level (180, 183, 185). In Chile, one woman reportedly heard the Ministry of Health’s statement that she should be able to receive multiple months of medication, but when she went to the local hospital, “they told me that it’s a lie and that because I am from [this area] I have to come every month to look for my medications” (180). Chilean activists are mobilizing to address the problem. One man filed an appeal for protection with the Court of Appeals in Santiago to order the Ministry of Health to fulfil its promise to provide multimonth dispensing (183). The National Network of Indigenous People Living with HIV issued an open letter to the Minister of Health complaining about stock-outs and the lack of HIV services and asking for a dialogue to solve the situation (186). A nongovernmental organization has set up an observatory to monitor access since the lockdown started to antiretroviral medicines and HIV-related services for people living with HIV (187).

An online survey undertaken by UNAIDS of 2300 people in 28 countries in Latin America and the Caribbean found that seven in 10 respondents do not currently have enough antiretroviral medicines for a lockdown of more than 60 days. Five in 10 respondents reported difficulties in obtaining antiretroviral therapy during the pandemic. There is also an indication that fear of HIV-related stigma and discrimination

is increasing: the same survey found that 56% of respondents believed they could experience physical, psychological or verbal violence due to living with HIV in the midst of the COVID-19 pandemic. Fear of HIV-related discrimination also caused three in 10 respondents to stop accessing services in the midst of lockdowns (188).

Communities are uniting to find solutions. In Ethiopia, people living with HIV worked with the Government to expand multimonth dispensing and introduce community antiretroviral therapy distribution policies that allow people who are deemed, according to current evidence, to be at lower risk of acquiring COVID-19 to collect medications for other people. The Government has agreed to this in the guidance, although it had not yet been implemented (178). In Nigeria, treatment access groups are coordinating and using motorbike riders with travel permits to deliver medicines to people who live far away from treatment centres (178). In Lagos, Nigeria, advocates are working to ensure that people from other states and countries who cannot get home due to border closures are able to get medicine refills (178). In Kenya, Peru and Uganda, communities have set up virtual peer support groups to promote adherence and help people obtain their medications (178).

Continuity in access to harm reduction services is critical, and more proactive responses are needed. Although there are reports of expanded flexibility in opioid substitution therapy, according to UNAIDS data, none of the 16 countries we reviewed allows take-home doses of opioids in response to the COVID-19 pandemic, and only South Africa is permitting secondary distribution or distribution of large volumes in needle-syringe programmes (178). Enrolment in South Africa's opioid substitution therapy programmes has increased since the start of the lockdowns, with one programme in Pretoria adding more than 600 people (189, 190).

Government action to ensure access to HIV services

Since the onset of the COVID-19 pandemic, governments have taken a wide variety of measures to ensure the continuity of HIV services and safe access to them. Two are mentioned above: multimonth dispensing and community distribution. In addition, a number of governments have informed UNAIDS of various approaches taken in the past few months to reduce disruptions to services. What follows is a small selection of those policies, as they were communicated to UNAIDS.

In **Botswana**, in addition to existing social services, the Government reports that it undertook a comprehensive assessment of households to determine food relief requirements, particularly those in the informal sector, leading to the employment of 952 social workers on a temporary basis. At the time of writing, 537 466 households have been assessed countrywide; of those, 426 740 have been recommended for food relief, while 429 255 have already been assisted with food hampers (toiletries inclusive).

Brazil has taken measures to ensure the continuity of HIV services, including: (a) extending the validity dates of antiretroviral medicine forms; (b) implementing telemedicine services; (c) beginning to offer HIV tests for patients with respiratory syndromes; (d) recommending that people

living with HIV who have undetectable viral loads reduce the frequency of their consultations; (e) offering antiretroviral therapy for foreigners unable to return to their countries of origin due to travel restrictions related to the COVID-19 pandemic; and (f) beginning to coordinate the national expansion of self-testing with states and municipalities.

In **Chile**, pharmacies in public hospitals have been reorganized and moved to other spaces to ensure the continuity of antiretroviral therapy provision, and monitoring has been undertaken to ensure all antiretroviral medicines continue to be dispensed, with 33 of 44 centres dispensing for two to three months at a time. Chile is also piloting community antiretroviral medicine distribution through public health centres or home delivery.

In **Colombia**, the National Government has provided subsidies of more than US\$ 270 million for electricity and natural gas for the poorest households. It has also suspended the execution of eviction orders and provided financial relief for more than 300 000 families, which have been given financial relief for housing.

The Government of **El Salvador** is providing free antiretroviral medicine for two months and extending the dates and repeats of prescriptions to reduce trips to the hospital. It has instituted home delivery of antiretroviral medicines through a variety of mechanisms, and it is providing food support for families in need and free antiretroviral medicines for foreigners who are unable to travel home due to the lockdown.

Jamaica has created new homeless shelters for those in need during this time, and it has found innovative ways to prevent and respond to child abuse, including through alternative modes of outreach using social media, virtual engagements and community motorcades.

In **Peru**, immediate measures were taken to ensure the continuity of care for people living with HIV and their access to antiretroviral therapy, including three-month dispensing and the creation of six new HIV treatment centres. It has also prioritized the identification of respiratory infections and the handling of suspected cases of COVID-19 among users of HIV services.

In **Uganda**, the National Task Force prioritized providing food to the most vulnerable communities living in Kampala, including people living with HIV. The Ugandan AIDS Council also engaged District Task Forces to include people living with HIV as members, ensuring they are partners—and not just beneficiaries—of HIV and COVID-19 services.

Access to food

Nutrition and HIV are strongly related to each other. For people living with HIV, malnutrition and food insecurity reduce HIV treatment adherence: this impacts both their health and increases their risk of transmitting HIV, because stopping treatment can increase a person's viral load, thus increasing their chance of transmitting the virus. Food insecurity can also increase HIV risk behaviours, potentially putting people at increased risk of acquiring HIV (191). Argentina (192, 193), Botswana (93, 194), Chile (195, 196), Colombia (197), El Salvador (198), Nigeria (199), South Africa (200, 201), Uganda (202), and some local governments in Brazil have introduced or expanded food distribution programmes (203). Nigeria provided a two-month supply of food to people residing in camps for internally displaced people; in Lagos State, the Government has partnered with civil society to provide food and necessary items to vulnerable groups, including women, young people and more than 1250 households of people living with HIV (204).

Botswana (93) and Uganda (44) have said they are prioritizing food distribution to vulnerable families or people who have lost work due to the lockdowns. Argentina, Botswana, El Salvador, Malawi and Nigeria have taken steps to stabilize food prices, such as by imposing price controls (205-209).

Unfortunately, as is the case everywhere, the need for assistance is outstripping the scale of the problem. Globally, the World Food Programme (WFP) has stated that this is the largest humanitarian response in its history, but it has only received 9% of its stated required total funding to provide essential food assistance (210). The Red Cross has commended food distribution efforts in Kampala, Uganda, but in northern Uganda, there are reports that more than 1000 people living with HIV have abandoned treatment due to lack of food (202, 211). On 18 May, in response to street protests over a lack of food, the President of Chile announced the Government would deliver a "historic" 2.5 million baskets of food and cleaning supplies to vulnerable communities, including people living with HIV and key populations, within two weeks (212, 213). As of 11 June 2020, the Government had reported delivering more than 1 215 000 boxes, including more than 130 000 delivered in one day (214, 215). Colombia has seen similar protests, followed by similar pledges from its Government to scale up assistance to reach the estimated 750 000 people who are going hungry (216). But hunger moves faster than aid: across the country, people who need food hang red cloths from their windows and wait; in some cities, the cloths blanket entire neighbourhoods (217). Distribution of large-scale relief requires careful monitoring and oversight. In Uganda, four officials from the Office of the Prime Minister were arrested for procuring food at inflated prices (218). In South Africa, more than 100 national groups came together to raise concerns about corruption and call for greater transparency in the COVID-19 response (219). On 23 July, the President of South Africa announced that an operation hub had been created to investigate allegations of COVID-19-related corruption (220).

COVID-19 has represented a real threat to indigenous populations in Latin America. Lockdown measures in El Salvador reportedly prevented indigenous people from farming for livelihood or selling their agricultural products at local markets (221). In addition, in Colombia, Amnesty International reported that even with a governmental mandate to provide food to indigenous people during a "state of economic, social and ecological emergency," several weeks after the quarantine was imposed many communities stated they had received no support from government authorities, despite their strict compliance with isolation measures (222, 223).

According to media reports, the Government of Brazil has not adequately responded to indigenous people's requests for pandemic aid to be delivered to their isolated

communities in a safe manner, leaving them with no alternative but to travel to cities to obtain social benefits and then return to the forest, taking the virus with them. The Government, however, has reported providing food baskets and other supplies to a number of villages, in addition to other support for indigenous populations (224–226).² After indigenous rights organizations and six political parties filed a petition with the Brazilian Supreme Court, a judge ordered the Federal Government to make emergency measures to protect indigenous communities (227, 228).

Access to water

WHO emphasizes that COVID-19 infection prevention measures such as frequent handwashing are “dependent on access to safely managed water, sanitation and hygiene (WASH), particularly for vulnerable communities” (143). For people living with HIV, access to clean water and sanitation can be critical, particularly in relation to opportunistic infections and the effectiveness of treatment (229). Despite this, 2.2 billion persons globally do not have access to safe water services, 4.2 billion do not have safely managed sanitation services, and 3 billion lack basic handwashing facilities (230). In the regions reviewed for this report, a quarter of the people in Latin America and the Caribbean and 40% of people in sub-Saharan Africa lack reliable access to a safe water supply (231, 232). This problem is particularly acute for people who live in informal settlements and people with disabilities (231–234). This crisis is being exacerbated by ongoing droughts in southern Africa and parts of South America (231, 235).

The governments of Chile (236), Colombia (237), El Salvador (238), Jamaica (239), Peru (240) and Uganda (44) have declared that water companies may not suspend people’s services for non-payment of bills. Argentina (241), Botswana (205, 242, 243), parts of Brazil (231, 240), Colombia (231, 237), El Salvador (231), Malawi (235), Peru (231), South Africa (235) and Uganda (205) are working to expand their water supplies, such as by distributing water through tankers or offering financial assistance to help people pay their water bills. Brazilian utility company Companhia de Saneamento de Minas Gerais is easing drought rationing to ensure continuous water supplies (231). The South African Government is providing temporary homeless shelters that meet necessary hygiene standards, and it has also distributed 77 000 water tanks and 1200 water trucks to villages and townships across the country (235, 243). Malawi’s COVID-19 response has planned to allocate US\$ 5.6 million towards longer term water distribution solutions, including repair of existing water sources and construction of new solar-powered sources (235).

The human right of access to clean water is particularly imperilled when people must compete with the agriculture industry for limited water supplies. In Colombia, COVID-19 has prompted the Government to redirect some of the water usually allocated for agriculture to increase the human water supply (235). In the parched agricultural region of Petorca, Chile, however, families were restricted to 50 litres of water per day—half of the WHO recommended amount (244–246). The Chilean Government has acknowledged the problem, and in early April, it announced it would increase the daily water supply to 100 litres; this plan was reportedly later abandoned. In response, civil society activists have petitioned the Inter-American Commission on Human Rights to intervene (247).

² For more information, please also see: Freitas H. Indígenas pedem ao STF que governo adote medidas para proteger povos isolados. In: Jota [Internet]. 30 June 2020 (<https://www.jota.info/stf/do-supremo/indigenas-pedem-ao-stf-que-governo-adote-medidas-para-proteger-povos-isolados-30062020>).

Rapidly reduce overcrowding in detention settings and take all steps necessary to minimize COVID-19 risk, and ensure access to health and sanitation, for people deprived of liberty

Nearly all of the countries reviewed for this report have released some people from prisons to address overcrowding and reduce the spread and risks of COVID-19 among people deprived of liberty. Some countries have reduced overcrowding significantly, but in many settings, the releases have been too small to have a significant impact. This report details examples where ill-treatment of people in prison is likely to drive the spread of COVID-19. Testing and medical care are significant problems for many people in prison during the pandemic. Where lockdowns cut off family support, there are further rights concerns. Governments should ensure release of people at particular risk of COVID-19 where possible, people whose crimes are not recognized under international law, and any other people who can be released without compromising public safety, such as those sentenced for minor nonviolent offences, with specific consideration given to women and children.

In March 2020, the UN Secretary-General stated that because of the serious risks of COVID-19, imprisonment should be a last resort during the pandemic (248). Since then, UN experts have underlined how COVID-19 has “heightened vulnerability of prisoners and other people deprived of liberty” and encouraged governments to take all appropriate public health measures to address COVID-19 in prisons (249). OHCHR, UNAIDS, UNODC and WHO have urged governments to create release mechanisms for people at particular risk of COVID-19, such as older people and people with pre-existing health conditions, and others who could be released without compromising public safety (249). It is essential to abide by international human rights standards on the treatment of prisoners (249-252). The obligation to ensure health, safety and dignity applies “irrespective of any state of emergency” (249). In many prisons, physical distancing, handwashing and access to disinfectant are difficult or impossible, and personal protective equipment for prisoners and staff is in short supply. As noted by OHCHR, UNAIDS, UNODC and WHO, “prison populations have an overrepresentation of people with substance use disorders, HIV, tuberculosis (TB) and hepatitis B and C compared to the general population. The rate of infection of diseases in such a confined population is also higher than among the general population. Beyond the normal infectivity of the COVID-19 pandemic, people with substance use disorders, HIV, hepatitis and TB may be at increased risk of complications from COVID-19” (249).

Overcrowding constitutes an insurmountable obstacle for preventing, preparing for or responding to COVID-19 . . . We urge political leaders to consider limiting the deprivation of liberty, including pretrial detention, to a measure of last resort, particularly in the case of overcrowding, and to enhance efforts to resort to non-custodial measures.

– UNODC, WHO, UNAIDS and OHCHR (249)

Despite the many calls for the release of prisoners, one study estimates that while 109 countries had adopted decongestion policies by June 2020, only 639 000 prisoners had been released globally, representing only 5.8% of the global prison population (253). In 15 of the 16 countries reviewed for this report, governments, through executive or judicial action, have released people from prisons to reduce overcrowding and stem COVID-19 transmission; El Salvador is the exception (254-256). The Ethiopian Government reported releasing 40 000 people from prisons as of May 2020 (257). The Supreme Court judicial prosecutor in Chile reported that a third of the country's prison population had been released as of June 2020 (258). Efforts in some contexts have been slow, however, and often not at a scale commensurate with the magnitude of overcrowding. In Brazil, judges released 30 000 people early in the pandemic, but this represented only 4% of the overall prison population (259). In Nigeria, the interior minister called for a "massive decongestion" of the country's extremely overcrowded prisons in March (260). Civil society organizations have complained about the sluggish speed of the process of selecting and releasing people from prisons (261).

Where releases have occurred, civil society groups have noted that women have been largely absent from the releases. For example, Penal Reform International noted that in Nigeria, only one of 2600 people released was a woman (262).

UNODC has indicated justice system officials should make decisions that contribute to reducing incarceration rates during the pandemic, including allowing alternatives to pretrial loss of liberty, the commutation or suspension of sentences, and other legal mechanisms (263). Many people have been detained, however, for violating curfew orders or failing to wear masks. Reports indicate that thousands of Salvadorans have been arrested and detained for an indefinite period of time for violating lockdown measures, even though the decrees establish 14-day containment as a sanction (249, 264, 265). This has continued, even though the Supreme Court ruled this to be unconstitutional (266, 267).

The El Salvador Ombudsperson's Office reports that people were being held in overcrowded detention centres (268). Detainees lack appropriate access to food, water and medical treatment; many are being forced to sleep on the ground; and there are no measures in place to separate higher risk people from other detainees (67). The Government of El Salvador announced that people held in these centres will not be a priority for testing, even though this is a criterion for their release from detention (269). El Salvador also exacerbated the risks of COVID-19 transmission in prisons. In April 2020, in response to a wave of gang-related homicides, Salvadoran authorities initiated a crackdown in several of the country's prisons, forcing people to crowd together on the ground, photos of which were shared publicly by authorities. OHCHR has said this "could amount to cruel, inhuman or degrading treatment, and could also exacerbate the already precarious hygiene conditions" (270).

The UN Secretary-General and other experts have underscored the importance of a gender-responsive approach to addressing COVID-19 among people in prisons and other closed settings (248, 249). In many countries, people in prison are reliant on family visits for basic necessities, which may impact women more directly. Many countries have disproportionately high incarceration rates of prisoners with disabilities, particularly intellectual and psychosocial disabilities. Countries should work to ensure that prisoners with disabilities have access to legal avenues for release due to COVID-19 vulnerability, if applicable, and continuity of access to medical care and other services (271).

It is crucial to ensure access to COVID-19 testing in prisons around the world to efficiently address hotspots when they occur and to ensure adequate access to

treatment. In many prison systems around the world, too few clinical or medical staff are available for the overall number of people in prisons, and decisions regarding access to medical care are often left to people without appropriate training. For people in prisons to receive the same standard of health as mandated by the United Nations Standards on the Treatment of Prisoners (“Mandela Rules”), timely access to medical care and testing remain critical (250).

Implement measures to prevent and address gender-based violence against women, children and lesbian, gay, bisexual, transgender and intersex people during lockdowns

Nearly all countries have seen significant increases in reports of gender-based violence, and yet none of the lockdown restrictions we reviewed explicitly allow people to leave home or change domiciles to escape such violence. Governments should expand services, allow the movement of people to escape abuse and support people seeking assistance. UNAIDS, UNESCO, UNFPA and WHO have warned that the pandemic is intensifying the risk of gender-based violence (9, 272-274). Closed schools and work-from-home orders keep people in constant close proximity to their abusers, while increased fear, anxiety, stress, economic pressure and social dislocation can put women and children and other vulnerable people at increased risk of abuse (274-276). Intimate partner violence in areas of high HIV prevalence is associated with women being 50% more likely to be HIV-positive. Meanwhile, men who are perpetrators of violence against women tend to be at higher risk of HIV themselves, and to use condoms less frequently, thus increasing the risk of HIV transmission. Abuse during pregnancy also makes it less likely that women will seek HIV testing or services to prevent vertical transmission to newborns. In addition, being HIV-positive is a trigger for violence, with women living with HIV frequently reporting experiences of violence or fear of violence, including from intimate partners, and such situations will only be exacerbated by the COVID-19 pandemic and the related lockdowns (277).

UNFPA warns: “as systems that protect women and girls, including community structures, may weaken or break down, specific measures should be implemented to protect women and girls from the risk of intimate partner violence with the changing dynamics of risk imposed by COVID-19 . . . Obstacles and barriers must be addressed, enabling women’s and girls’ access to services, including psychosocial support services, especially for those subject to violence or who may be at risk of violence in quarantine . . . Gender-based violence referral pathways must be updated to reflect changes in available care facilities, while key communities and service providers must be informed about those updated pathways” (9).

According to the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), emerging data indicate that all types of violence against women and girls, particularly domestic violence, have intensified since the outbreak of COVID-19 across the globe, with increases in calls to domestic violence hotlines in many countries and limited access to support (277). For the countries in this review, all 12 countries with lockdowns have recorded increases in gender-based violence, reflecting the broader global trend (279-296).

Given the challenge of timely information collection, the true situation is likely to be much worse than we know. In most of these countries, reported incidents have increased by 40-70%, with even greater spikes in certain municipalities, including Bogotá, Colombia (225%) and Providencia, Santiago, Chile, which has a population of just over 140 000 people (500%) (283). The Central African Republic, which does not have a full lockdown, has seen a 24% increase in reports of gender-based

violence cases (297). Additionally, Botswana (298), Kenya (299), Peru (284, 293) and Uganda (300) have recorded increased incidents of child sex abuse. There are also concerns that lockdown measures may be making it more difficult to report situations of abuse. Although official records in Jamaica show a decline in reports of child sex abuse, for example, experts working for national child welfare institutions are concerned that while reports continue to come in through WhatsApp and toll-free lines, children could be in situations where the pathways for identifying or reporting abuse are currently less accessible due to the closure of schools, and that abuse is most likely taking place at home or at the hands of relatives (288, 301).

Government lockdown policies that designate days to leave the home by gender have also led to additional discrimination, harassment and violence by private and public actors. In Colombia, there were reports of transgender people unable to access public services because they were out on the day that corresponds to their gender identity rather than the gender marker on their identity documents (302, 303). The Colombia rights group Red Comunitaria Trans said it had received 18 discrimination complaints since the measure began, including complaints of violence against transgender people out on the “wrong” day (304).

In some countries, there are promising signs that awareness of gender-based violence as a pervasive problem is during lockdowns. For example, a Colombian nongovernmental organization describes how “neighbours began reporting cases of violence like never before . . . This has never happened. I just hope that this never goes back to being hidden, that violence against women becomes a public issue because of this surge” (284). On 30 March, Argentine people took to their balconies, banging pots and flying purple handkerchiefs for women and children experiencing gender-based violence (304).

Governments are aware of the problem and are making efforts to address it. In the Central African Republic and Jamaica, UNAIDS is working with national governments and other UN agencies to prioritize gender-based violence in their COVID-19 response programmes. Argentina (305), Colombia (306), Peru (307) and South Africa (308) have taken steps to prioritize and strengthen the responses of the police and protective authorities and to expedite judicial proceedings against abusers. Argentina (309), Botswana (310), Chile (311), El Salvador (312, 313), Kenya (314), Nigeria (291), Peru (307) and South Africa (315) have strengthened gender-based violence reporting systems by expanding hotlines and offering new WhatsApp, text or email reporting options for women who cannot make a phone call within earshot of their abusers. Argentina (304) and Chile (316) have set up code word-based reporting systems, where a woman can go into a pharmacy and ask for a “red facemask” or a “facemask19” and the pharmacist will call for help. The Bogotá Secretariat for Women partnered with FENALCO, the National Trade Federation of Colombia, to create a “safe spaces” strategy, where women can report gender-based violence in supermarkets (317).

The impact of COVID-19 on services to aid survivors who report gender-based violence is less clear. Nor did any of the countries we reviewed have explicit provisions in their lockdown orders allowing people to leave home or relocate to a different residence if they felt unsafe. In most cases, it does not appear that governments intend to prevent people from seeking safety—but that message is not necessarily getting through. One Colombian nongovernmental organization reports that as soon as the lockdown started, it began getting texts from women saying “my husband is beating me up, but I’m not allowed to leave” (284). Gender-based violence shelters were open and operating in Chile (316), Peru (318) and South Africa (319, 320), but we could not determine whether the same was true for the other countries we reviewed. Peru is

guaranteeing the provision of urgent care to people experiencing gender-based violence as a priority (321). The Buenos Aires Government has said it will pay for transfer, new lodgings and medical costs for survivors of gender-based violence (321).

Even where emergency centres and shelters are operating, the COVID-19 pandemic creates a host of new challenges. In South Africa, at the time of writing, in order to be admitted to a shelter, a survivor must first be tested for the novel coronavirus and await their results in a quarantine hospital (320). Once admitted, survivors may not be released from the facility for the duration of the lockdown, visits were not allowed, and family reunification and interaction programmes have been suspended (319). These policies may be necessary to protect shelter residents from COVID-19, but they may also dissuade survivors from seeking help.

The dangers and hardships of lockdowns are particularly acute for members of the LGBTI community, especially youth, who may be forced to remain in or return to homes where they are unsafe and unaccepted. As well as physical dangers, nongovernmental organization and media reports reveal the extreme psychological and emotional toll that lockdowns are taking on LGBTI youth. For example, a young Brazilian woman described her experience in her parents' home: "Being a lesbian made them so disappointed in me that no matter what I do, it's never enough. I feel like I'm watching my life go by through somebody else's eyes—because I'm not who they want me to be, but I also can't be myself when I'm in their house" (322). In Nigeria, one LGBTI organization described how it has been overwhelmed by calls from people needing support; although most requested food and monetary support, "some people just requested that they don't really need anything, they just need someone to talk to" (322).

Designate and support essential workers, including community health workers and community-led service providers, journalists and lawyers

The HIV and COVID-19 pandemics have shown how journalists are critical to providing people with unrestricted, trusted information, and the COVID-19 pandemic has highlighted the impact of lockdown measures on communities, such as key populations and people living with HIV. It also has illustrated the importance of lawyers for ensuring accountability for a rights-based response, of community health workers and community-led service providers for reaching marginalized people (including key populations and other people vulnerable to HIV), and of diversifying delivery of services, including those for HIV. Most, but not all, governments have designated these three groups as essential workers, although arrests and harassment have been documented in several settings. In some countries, there remain major barriers to these groups working effectively under lockdown orders. Governments should ensure they are designated as essential workers and are supported to work safely during the pandemic. This report has already detailed the importance of each of these groups to ensuring the protection of key populations and other vulnerable groups, and the role they play in the continuation of services, from representing LGBTI youth arrested in Uganda, to providing safe access to HIV prevention and treatment services, to drawing international attention to violence and discrimination faced by sex workers and transgender persons.

During lockdowns and other periods of limitations on movement, governments are making critical decisions about which categories of people are designated as essential and how they will be supported to carry out important functions in the disease response. Community health workers and community-led service providers, lawyers and journalists are not always considered essential, but they provide

particularly important support for a rights-based response. OHCHR, UNAIDS, UNODC, WHO and other UN agencies have called on governments to categorize these groups as essential workers (13, 249, 323, 324). As outlined in Table 3, countries have taken a variety of approaches to designating these workers as essential.

Table 3. Designation of community health workers, journalists and lawyers as essential workers, 15 May 2020

Country	Community health workers	Journalists	Lawyers
Argentina	Yes	Some	No
Botswana	Yes	Yes	Yes
Brazil	Yes	Yes	No
Cameroon	N/A	N/A	N/A
Central African Republic	N/A	N/A	N/A
Chile	No	Yes	No
Colombia	Yes	Yes	No
El Salvador	Yes	Yes	Yes
Ethiopia	N/A	N/A	N/A
Jamaica	Yes	Yes	Yes
Kenya	Yes	Yes	No
Malawi	N/A	N/A	N/A
Nigeria	Yes	Yes	Some
Peru	Yes	Yes	Some
South Africa	Yes	Yes	Yes
Uganda	Yes	Yes	No

Community health workers and community-led services

Community health workers, health promoters, home health aides and health-service providers from community-led organizations play a critical role in supporting health and rights in the HIV response, particularly in reaching those who are the most marginalized and left behind. It is essential that this approach is carried over into the COVID-19 response, both for people living with and affected by HIV and the broader population.

The World Health Assembly resolution called on Member States to include exceptions in restrictions on the movement of people for “community health workers to fulfil their duties” (325). Health professionals are essential workers under public health orders in all countries we reviewed; however, community health workers and community-led service providers often lack official recognition, credentials or certification guaranteeing them recognition. Some are public employees, but others are less formally employed in the private or nongovernmental sector—and thus their status, and the protections and equipment they receive, are far more tenuous if they are not explicitly exempted from limitations on movement. Community health workers and community-led service providers are particularly critical in the realization of the right to health under lockdown for people with less access to health care because of age, rural geography, lack of transport or immigration status—not only for COVID-19, but also for the distribution of HIV medicines and other critical health services, including for sexual and reproductive health. Other service providers from community-led organizations may not be recognized as community health workers, and yet “community organizations have an unparalleled depth of experience in creating and delivering responses to health and human rights crises within their communities. The many community-led networks and groups that emerged to respond to HIV possess immense practical experience, organizational strength and unparalleled community access for facilitating the delivery of life-saving support, and for influencing people’s real-life practices to better protect their health” (325). UNAIDS has recommended that governments include “the workforce of community-led health-care services into the lists of essential service providers and treat them as equivalent to health-care providers” (325).

Decrees in Argentina (326), Brazil (327), Chile, Colombia (328) and El Salvador (28) broadly cover people working in health, which presumably includes community health workers and similar roles (such as health promoters). In Peru, all people working in health services can request a Special Labor Pass (329). South Africa explicitly exempts all health workers in the public and private sectors from the lockdown order (330) and has mobilized 28 000 community health workers to lead screening, testing and contact tracing efforts, but there have been extensive reports that health workers lack personal protective equipment (331–333), with particular concern for community health workers (334). In Nigeria, the President’s COVID-19 Regulations (335) explicitly exempt all organizations involved in health care, while the local order allows for movement to deliver medical supplies (336). The Nigerian polio infrastructure has been mobilized for COVID-19 contact tracing, including hundreds of disease notification and surveillance officers and more than 50 000 community informants for community sensitization and case reporting (337). Additionally, the HIV structure, community volunteers and other relevant agencies were mobilized for community engagement, risk communication and contact tracing (338).

Journalists

Access to information and transparency is critical to a rights-based response. People need accurate information about health, and governments need information about what is happening in communities in order to calibrate effective policy responses. They play a key role in ensuring that the experiences of people living with HIV, key populations, and women and girls are brought to light so that action can be taken to correct violations. The critical principles of accountability of a government to its people and participation of communities in decision-making are premised on transparent information. All of these require journalists to be designated as essential workers under public health orders and for governments to refrain from restricting their movement and access to information. Freelance journalists in particular often lack official credentials, making it hard for them to navigate police checks and limitations under curfews and lockdowns (339). The UN Secretary-General has “urged governments to protect journalists and others who work in media, and to uphold press freedom,” warning that COVID-19 response measures should not be abused as an excuse to impede journalists’ ability to do their work (323).

While there is no global database of which countries have designated journalists as essential workers, the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression called on countries to designate journalists as essential in April 2020, noting that there have been numerous reports globally of journalists and media workers experiencing intimidation, detention, questioning and other forms of repression (340). Most, but not all, countries have designated journalists as essential workers. In Uganda, for example, the President explicitly mentioned that “the media people and journalists are very important to this country” in his order designating all media as essential— although reports of violence and harassment continue (241, 242).

In El Salvador, early executive orders failed to explicitly include journalists, but this was addressed in more recent ministerial orders (343). In a Presidential Decree, Brazil recognizes broadly as essential activities “telecommunications and internet” and “sound and image broadcasting,” so workers from these sectors would be allowed to go out if the country were to implement a national lockdown (344). At the state level, Maranhão, for example, does not mention journalists but excludes workers in “telecommunication services,” “postal services and internet” and “social communication services” from the lockdown (24). Peru excludes workers from “telecommunication and call centre services” and “sound and image broadcasting services” (149).

Journalists have, however, reportedly faced arrest and mistreatment under newly expanded police powers during the pandemic in a range of countries throughout the world (345–348). Concerns about journalist mistreatment were raised by the Committee to Protect Journalists in the arrest of South African journalist Paul Nthoba in the Free State. Nthoba was charged with obstructing law enforcement under the country’s Disaster Management Act (349, 350). In Kenya, nongovernmental organizations have reported a rise in reports of attacks on journalists in recent months, with at least 22 documented in March and April 2020 by the organization Article 19, and concerns raised by a range of human rights groups about journalists arrested for violating curfew laws, even though they are officially exempted (351). The Association of Journalists of El Salvador reported several examples of journalists from the Christian Radio and Television Network and Radio La Voz de Mi Gente being harassed or prevented from reporting by security forces because of the lockdown order (352, 353). It is notable that governments in all of these countries have been responsive to complaints and have revised rules, laws or procedures.

Lawyers and legal services

As the recent joint UN statement on prisons and COVID-19 noted, the right to legal representation must continue to be fully respected during public health emergencies (249). Doing so requires not only that the judiciary continues to function, but that lawyers and legal services be allowed to continue to operate effectively, travel as needed, and perform their functions as essential services. As described in the final recommendation, courts and lawyers have been critical to ensuring the defense of human rights during the COVID-19 pandemic, including for key populations and other vulnerable groups. In Botswana, “legal practitioners” are explicitly included under the definition of “essential services” (23). In Jamaica, the public health order allows “any attorney-at-law attending at police stations or lock-ups, or appearing before a court . . . or attending to a client of the attorney-at law in the case of an emergency arising due to the SARS-CoV-2 (coronavirus COVID-19) pandemic” (354).

In many countries, the position of lawyers were much less clear, which can be a barrier to effective legal services. For example, in Argentina, “personnel of the justice services on duty” (22), and in El Salvador, “legislators and staff of the Legislative Assembly” (28) were exempt from lockdowns; however, lawyers were not explicitly mentioned.

In Chile, lawyers were not part of the exceptions established by the national government, but to “attend to a judicial hearing in which a lawyer must be to comply with the law” is one of the reasons people can argue to access the “temporary permit to move about during the quarantine” (47, 168).

In Kenya and Uganda, the governments did not include lawyers in the definition of “essential workers,” even as hundreds of people in both countries were being arrested and detained for violations of lockdown measures and courts were continuing to operate in limited ways. This profoundly hampered or removed access to counsel for many people in need to legal support. For example, in Uganda, the ban on all public and private transport meant that lawyers could not use any transport means except walking or cycling to reach their clients. On some occasions, officials have denied lawyers access to their clients in prison, citing the lockdown as a rationale (346). In one case, the High Court of Uganda found that this practice violated clients’ constitutional rights and awarded them each 5 million Ugandan shillings (US\$ 1350) in damages (356).

The Kenya Law Society petitioned the Constitutional Court in April and obtained an order from the court including lawyers as essential workers. The judge specifically found that lawyers “can be extra vigilant when the State is exercising emergency powers and offer legal aid to those in need” (357). In Uganda, the situation left lawyers vulnerable to arrest for doing their jobs during the most restrictive time of the lockdown. Ugandan lawyers sued the state on constitutional grounds, but while the court process was under way, the Government announced that the Uganda Law Society should designate 30 lawyers countrywide who could receive the permission stickers required to use private transport and provide services as essential workers. This allows only 1 lawyer per 1.4 million Ugandans, however, creating devastating inequities in access to legal help (358). In Argentina, the Public Bar Association of the Federal Capital appealed for legal protection, as lawyers have not been part of the exceptions mentioned in any of the national decrees regulating lockdowns (359).

Where lawyers have had the ability to operate, they have been able to: innovate; ensure timely, fair and effective court processes, despite the challenges of COVID-19; and work to assist and monitor the important work around decongestion of prisons, which are hotspots in many countries for the spread of the COVID-19. For example, in South Africa, public interest law organizations came together to establish a hotline for free legal advice during COVID-19 restrictions (360).

Ensure limitations on movement are specific, time-bound and evidence-based, and that governments adjust measures in response to new evidence and as problems arise

Most public health orders in these 16 countries are time-bound and specific. Governments should periodically review public health measures to ensure they are proportionate, necessary and legitimate and to identify possible rights violations and problems in addition to those identified above. They should adjust measures to rectify these problems and incorporate new evidence about COVID-19. Failure to do so can lead to the continuation of the negative impacts of lockdowns, including LGBTI youth staying in unsafe family situations, disruptions or barriers to accessing food, shelter or health services (including HIV services), and sex workers continuing to face arrest.

At the 73rd World Health Assembly, Member States resolved to “ensure that restrictions on the movement of persons . . . in the context of COVID-19 are ‘temporary and specific’ and ‘time-bound’” (361). OHCHR advises that governments can respect these obligations by ensuring that policies limiting individuals’ movements have built-in review and expiration dates (60). This means that governments must proactively decide to extend the restrictions if necessary; otherwise, the law automatically reverts to its prior state and people can fully exercise their rights.

Most countries have constructed their lockdown policies in this way, including Argentina (22), Botswana (23), Colombia (27), El Salvador (28), Jamaica (29), Kenya (30), Nigeria (31), Peru (32), South Africa (33) and Uganda (34). In Brazil, the Federal Government has not instituted lockdowns, but lockdowns have been instituted at the state and subnational levels (24, 25). Chile stands out since it implemented its nationwide curfew (which lasts from 10 pm until 5 am) indefinitely, with no review date specified in law (26).

Problems can arise, however, when orders are of such short duration that successive orders result in confusion and lack of time for governments or the judiciary to assess them. For example, in El Salvador, the Constitutional Chamber of the Supreme Court has been admitting cases for legal revision of several of the restrictions included in the executive decrees, but it has been unable to keep up with rapid changes in policies (362–364). Human rights law mandates that governments review restrictions to assess their effectiveness. If measures that restrict people’s rights are not effective from a public health standpoint, then they can no longer be justified. It may not be practicable to conduct a rigorous policy evaluation in the midst of a quickly evolving pandemic, but one way that governments can act on this obligation and ensure effective policies is by updating them as new scientific information and evidence from community and other sources become available (365).

For example, between early April and early May 2020, Argentina, Botswana, Cameroon, Chile, Colombia, El Salvador, Ethiopia, Jamaica, Kenya, Nigeria, Peru, South Africa and Uganda adopted new policies requiring people to wear facemasks in public (366–370). Facemasks are also required in some parts of Brazil (77, 371) and recommended (but not required) in the Central African Republic (372). The Government of Uganda has said it will provide facemasks free of charge for the entire population, but implementing this commitment has been slow, with distribution beginning on 10 June 2020 (373). Only Malawi has no official facemask policy.

While addressing the public health crisis, lockdown policies limit freedom and impose heavy economic and social tolls. Governments can honour their human rights commitments by revising lockdown measures to address unforeseen problems and ameliorate unintentional consequences, especially for vulnerable groups—but

we found relatively few examples of governments doing so. Peru initially allowed people to leave home only on specific days of the week, depending on their gender: women on Tuesdays, Thursdays and Saturdays, and men on Mondays, Wednesdays and Fridays (95, 374). This measure was abandoned after eight days when policy-makers realized it was not effective (375, 376); the country also added a lockdown exception to allow people with intellectual and psychosocial disabilities and a companion to leave home and spend time outdoors more frequently (377, 378). Argentina (379, 380) and Chile (47, 381) have similar exceptions. In Argentina, children were initially required to stay with one parent, but restrictions were amended to allow children to travel between the homes of parents who share custody (382). In Uganda, under pressure from civic groups, the Government amended movement restrictions to allow pregnant women to seek care without official permission.

Create space for independent civil society and judicial accountability, ensuring continuity despite limitations on movement

Civil society, particularly community-led organizations, and courts in many of the countries reviewed, have helped improve the COVID-19 response where they are enabled to operate freely by highlighting problems experienced by communities and both offering and implementing solutions. Governments should include community-led organizations in their decision-making bodies, including those focused on gender, equity and human rights, to ensure COVID-19 policies are designed to support the range of service providers and activities necessary for an effective and equitable response. This should be before imposing restrictions on movement and should create space for civil society voices to engage with and monitor the COVID-19 response. Courts should also continue to operate as much as possible to hear cases where rights issues, particularly liberty interests, are at stake and cases are related to the legality or constitutionality of the government's COVID-19 response.

No country or government can solve the crisis alone; civil society organizations, particularly community-led organizations, should be seen as strategic partners in the fight against the pandemic. I am thus concerned by the information I have received from online consultations with civil society around the world, suggesting several worrying trends and limitations, including on civil society's ability to support an effective response.

–United Nations Special Rapporteur on the rights to freedom of peaceful assembly and of association (383)

One of the key lessons of the HIV response has been that civil society advocacy and public interest legal efforts, especially those led by and for communities most affected, play a key role in responding to the pandemic. They increase the potential for accountability, provide a platform for authentic community voices, and bring critical information to light for governments about what is and is not working to advance public health. Engagement with civil society builds trust, ensures suitability and effectiveness, helps to avoid indirect or unintended harms, and ensures the frequent sharing of information. We have also seen this during the COVID-19 pandemic.

The UN Special Rapporteur on the rights to freedom of peaceful assembly and of association has underscored this, stating “no country or government can solve the crisis alone; civil society organizations should be seen as strategic partners in the fight against the pandemic” (383). A joint statement by UN agencies calls on governments to “guarantee meaningful participation of all sectors of society and diverse civil society actors in decision-making processes on COVID-19 response” (106).

Such independent scrutiny is especially critical now, as governments rush to address the pandemic, planning outside regular channels, often without past experience to draw on, complex and multifaceted virus mitigation measures. Consultations with and participation of civil society on government task forces is an important step—but it is not sufficient. Civil society should have the space and freedom to use a wide range of tools, without fear of reprisals, to bring expertise to bear and be a credible partner to affected communities and governments. From the perspective of HIV, for example, it would be critical to have representation from communities of people who are living with or vulnerable to HIV—including key populations, women and girls, and migrants—so that they can flag the specific or disproportionate impacts that lockdown measures are having on their communities, and so that they can suggest alternatives and indicate where existing community structures can be mobilized quickly for the COVID-19 response. However, research by WHO indicates that “civil society is hardly involved in national government decision-making nor its response efforts, and that female representation in COVID-19 decision-making entities is particularly paltry” (384).

In a number of countries, civic campaigns are highlighting the serious threat of rights violations prompted by disproportionately broad public health orders, and in some instances, these campaigns have prompted life-saving policy and practice changes. For example, in Uganda, a campaign by civil society and human rights organizations was able to document multiple cases of the devastating consequences of the severely restrictive lockdown on access to medical care for pregnant women and children (385, 386). The campaign ultimately contributed to shifting World Bank policies and a change in the Government of Uganda's policy approach to the issue. Building on this success, organizations have pressed for more expansive access to health care for other vulnerable groups, such as people living with HIV or tuberculosis, and people with other chronic illnesses (387).

In Santiago, Chile, civil society groups urgently warned of a problem of hunger as protests broke out over lack of access to food (212, 388, 389). As mentioned above, in response, President Piñera announced five measures to support the most vulnerable people, including the delivery of 2.5 million baskets of food and essential products (214).

Activists have been able to provide critical insights on proposed measures, helping to shape COVID-19 response legislation. For example, in Nigeria, civic groups came together to provide law-makers with a legal analysis of the pending Infectious Diseases Bill 2020 submitted to the House of Representatives. The groups raised specific concerns over the bill granting broad, overreaching powers to public health officials, including the Minister of Health and the Director General of the National Center for Disease Control (390). The groups argued that a provision allowing the Director General to “stop any meeting” on public health grounds lacked statutory safeguards and was prone to abuse, and “effectively deprives aggrieved persons the right to fair hearing” (391).

Civic activism has paved the way for public interest litigation that has buttressed a country's rights-based responses. Kenyan lawyers were able to receive a designation from the judiciary to be deemed “essential workers” (392).

Such a designation has allowed lawyers to work in a myriad of areas to support an effective response, including advocating for victims and survivors of abuse and discrimination. In Malawi, a coalition of human rights organizations won a court injunction on 17 April 2020 against government plans to impose a lockdown without first ensuring that vulnerable people had access to food, water and other basic needs. The Government withdrew its appeal of the injunction on 23 April 2020 and announced a new aid programme for 1 million people and small businesses affected by the pandemic (393). While opposing a lockdown order until protections are in place, civil society groups have nonetheless called on the Government to move quickly to establish a rights-based plan to enforce distancing guidelines—particularly during an election campaign that is drawing large crowds (394, 395).

Conclusion

We know from our experiences with HIV that public health approaches that are not in line with human rights can undermine a pandemic response. Efforts should be made to ensure that lessons learned about human rights and community engagement in dealing with epidemics such as HIV and Ebola are not forgotten and are included in the design of the ongoing response to COVID-19, not only to ensure an effective COVID-19 response, but also to avoid undermining other ongoing public health efforts, including the HIV response. This 16-country review of policy responses restricting the movement of people as a strategy to halt COVID-19 finds that current responses in many countries have resulted in significant breaches of rights, including of people who are living with or vulnerable to HIV—some of which have already cost lives. Discriminatory enforcement, violence, overly restrictive lockdown orders, prison overcrowding and overreliance on criminal law enforcement are harmful in and of themselves, disproportionately impact key populations and are likely to undermine public health strategies and community trust in government.

The actions of some states show that rights-based responses to COVID-19 that also support the HIV response and communities are possible. Many states have made clear provision in public health orders for people to address their basic needs; taken proactive measures to address access to HIV treatment, food and water; expanded gender-based violence programming; designated community health workers and community-led service providers, journalists and lawyers as essential workers to help build and support community-based and community-led responses; and made space for civil society and judicial action to improve accountability and effectiveness of the COVID-19 response.

As governments and communities in countries around the world consider the coming months or years of the COVID-19 pandemic, there is an opportunity to calibrate responses for a pandemic likely to see waves of new infections and epidemics throughout the world for some time to come. In this context, non-pharmaceutical interventions, including legal interventions to limit the movement of people, will continue to be used to varying degrees to fight the disease that, at this point, has neither a vaccine nor highly effective, widely available treatments. In doing so, urgent consideration must be given to maximizing rights-based approaches that empower communities and build cooperation, not simply at the local and national levels, but internationally. In times of crisis, such as a pandemic, the protection of rights is everyone's responsibility, requiring international cooperation and assistance to support national responses that are grounded in human rights.

In the *Rights in the time of COVID-19* report, the final recommendation was "to be kind" (19). This was not an idle recommendation but a key element of a successful response. We are in a time of emergency, panic and fear. It is tempting to respond with strength and force rather than help and cooperation; easier to blame and stigmatize rather than empathize and support. To do the former is to risk human rights violations, as we have seen, and an ineffective response. To do the latter is to succeed.

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