

Human rights considerations with regard to pandemic influenza

The last decade has seen a number of major health scares around potential outbreaks of some form of pandemic influenza. The development of responses to HIV/ AIDS established new standards in the way people were treated, including confidentiality, informed consent to testing and so on. Older, more coercive public health responses to communicable disease such as those seen in response to sexually transmitted disease in the 19th Century were generally rejected. However, the 2003 Severe Acute Respiratory Syndrome outbreak in China broke with that trend. Involuntary testing and detention were common. The avian influenza scare, predominantly in Viet Nam in 2003/ 2004, saw relatively small numbers of reported human infections. However, forced culling of birds and restrictions on movement of agricultural produce was employed. The recent swine flu scare in 2009 resulted in forced quarantines in a number of different countries, both developing and industrialized.

All three scares had serious economic impacts. These included impact on tourism, restrictions in market access and slowdown of general economic activity. In all three, there was also a degree of panic about the availability of antivirals, mainly Oseltamivir and Zenamivir (Tamiflu and Relenza), and issues around stockpiling and access. In all three cases major infection requiring large-scale use of antivirals did not occur, meaning that there is not yet experience of how access to antivirals would be prioritized in the case of widespread severe infection.

Based on the experience in China, Viet Nam and Mexico, key human rights questions for consideration in the context of public health imperatives include¹:

1. How can testing, quarantining and restrictions on movement be done in a way that respects human rights? Involuntary testing is a violation of personal integrity, while the right to freedom of movement and from arbitrary detention are central to the ICCPR. Related questions include acceptable limits on detention, the boundaries of restrictions on freedom of movement, protection of confidentiality with regard to testing, conditions of confinement (including, in the case of children, educational provision for those quarantined). More broadly, there are issues of economic compensation for those who have been quarantined: for the poor in developing countries, ten days away from employment and income can be devastating for their families.
2. How can access to healthcare and medication be prioritized? We have not yet experienced a situation where limited access to doctors, hospital beds and drugs is addressed. But it is clear that in the event of pandemic influenza there will need to be rationing, not only in terms of who gets access to medicines, but also in terms of how the competing needs of different geographical areas are reconciled, and the needs of patients with other conditions are balanced with those of new influenza patients. The potential for discriminatory patterns of access is high.

¹ The attached “Checklist for Pandemic Influenza Preparedness and Response Plans” is a useful resource to identifying groups which may be disproportionately affected, or excluded from pandemic flu responses.

3. What are the obligations of States Parties in terms of planning and preparedness for children?
The CRC creates an obligation to have in place the best possible preparedness measures to protect all children without discrimination from an influenza outbreak. To what extent are preparedness measures meeting such requirements, including their explicit reference to such governmental public health obligations? In the case of children, the obligation to take steps to minimize disruption with regard to education is significant: some countries preparedness measures include consideration of ways to deliver education in a situation where children were told to stay at home. For example, UNICEF in Viet Nam is developing Pandemic Preparedness for School Administrators guidelines together with the Government and partners.
4. How can responses be tailored for the needs of all? This includes making sure that public health information is available in different languages and that public health measures more broadly are customized to be culturally appropriate for minority and indigenous groups. It also means not discriminating against non-citizens, such as migrants, refugees and asylum seekers. It means seeking out and ensuring that children in institutions, in juvenile detention, and in migratory agricultural camps receive information and treatment.
5. How can the economic impacts of influenza, including influenza scares, be mitigated for the most vulnerable and marginalized? None of SARS, avian influenza or to date, swine flu, had enormous impacts in terms of public health. However, each had major economic impacts. These included the costs to the poultry industry in Viet Nam, and the tourism industry in Mexico. Perhaps less obvious was the distortion of prices of other types of food. For example, in Viet Nam the culling of poultry caused a major increase in prices of meat and fish, pricing these sources of protein out of the diets of many poor families, with significant implications for children's nutritional status. One possible conclusion is that a prerequisite for addressing the economic impacts of the poor is some form of relatively rapid surveillance system which identifies areas where deteriorating economic conditions are having severe consequences. Nutritional or food security surveillance systems might be one way to address this.

Overall, while we have as yet not seen a pandemic influenza outbreak with severe health impacts, there are many reasons based on past experience to identify a number of questions which from a human rights point of view need to be asked in the context of preparedness planning. Asking these questions, contextualizing them within a human rights framework, and putting them on the agenda of the international human rights mechanisms should be at the centre of our thinking as we prepare for a severe pandemic influenza outbreak in the short to medium term.

Our communication should stress not only health measures to be taken, but the clear message that no child or his/her family should be discriminated against due to their health and H1N1 status, their age, ethnic or geographic origin, their migratory status or nationality. The response to the H1N1 pandemic must protect the rights of girls, boys and adolescents and ensure that there is no discrimination in access to treatment, and that those whose livelihoods are disproportionately affected are compensated.