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Human Right Violations in the 2018 Ebola Outbreak: What can Improve in Covid-19 Isolation Protocols?

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Abstract

Amidst the wake of the Ebola virus disease (EVD) that has been ravaging parts of Africa, severalisolative measures are followed to halt the spread of the epidemic. Many of these measures are yet drastic and directly affect the fundamental rights of individuals involved. The EVD outbreaks open a big discussion on public health and human rights. This article focuses on the human rights violated in the battle of EVD and considers how these are similar, yet can be avoided in the management of COVID-19.

Keywords: Ebola; Isolation; Human rights; COVID-19

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Introduction

After decades of relative obscurity, it was between 2013 and 2016 when West Africa experienced the largest ever outbreak of Ebola Virus Disease (EBV) [1]. In the absence of registered treatments to control this lethal condition, the World Health Organization (WHO) coordinated and supported research to stimulate identification of interventions that could control the outbreak and improve future control efforts. Simultaneously, the World Health Organization Research Ethics Review Committee (WHO-ERC) was deeply involved in reviews and ethics discussions. It reviewed 24 new and 22 amended protocols for research studies including interventional and observational studies [2]. Despite the coordinated support offered by both national (Mano River Union, MRU) and international entities (WHO, United Nations, World Bank), numerous were the reports suggesting that EVD management lead to multiple human right violations and immoral handling of EVD suspected patients [3,4].

With various disciplines; likewise in medical care, it is human rights declarations that superiorly reflect the legal frameworks as the universal preferred approach to regulate one's freedom. It is such legal frameworks that are adhered to for the sake of public wellbeing and set the limits of intervening on others' freedom. The case of the West African management of the 2014 EVD outbreak though, was a reality where beneficence overruled the respect for individual autonomy and hence lead to a misbalance caused by less beneficial caregiving and more basic human right abuse.

Counting one by one the violations that occurred or were present during the 2014 EVD outbreak, though impractical, proves how most of them were an aftermath of patients' isolation. The 'traditional' quarantine isolation recommended by the WHO, seemed and still seems the most effective way to control the dispersion of the virus. However, some measures adopted in Guinea, Liberia, and Sierra Leone, the three west African countries worst affected by EVD, go beyond these principles.[4] On August 2014, these three countries announced the enforcement of a mass quarantine in vast forest areas around their common borders that were considered the epicentre of the outbreak [5]. The measure was implemented despite evidence that the virus had already passed outside of the quarantined zones. All aforementioned countries prepared their national legislation in such a way that enforced the legal dominance, making it officially legal to withhold a citizen not because one was under arrest, but because one was suspected of having contracted the virus.

Medical anthropologists called this structural violence [6]. If we fail to recognize such social injustices, what breakthroughs will bring change? As JM Mann once reclaimed, protecting the public's health and respecting human rights are synergistic not incompatible. And though initially, it was the international debate over appropriate treatment of persons with HIV/AIDS in the 1980s that gave rise to such observations, this message applies equally in modern outbreaks such as the EVD one(s).

Legal aspects involved

Since the 2014 EVD outbreak though was not just a biomedical tsunami, but accompanied an enormous sociological wave of disparity, there were a series of legal frameworks that were

instantly put in practice. Medical law is indeed a critical tool of public health emergency preparedness and its response to EVD was immediate. Nonetheless, invoking states of emergency can be precarious. Ideally, emergency laws clearly direct preparedness and response efforts. In actuality, they typically do not provide precise legal guidance. Framed in broad (and sometimes vague) statutory or regulatory language, emergency laws offer more of a menu of legal powers and options rather than a definitive guide for action.

For all 194 WHO member states globally, the starting point is international law – the laws governing the relationship and interactions of sovereign nations. After the 2014 EVD outbreak being declared an international public health emergency, the WHO issued temporary recommendations that were to be followed by all the member states [7]. The WHO also declared that there should be no international travel of Ebola cases or persons in close contact with them, unless the travel is part of an "appropriate medical evacuation." As a result, all WHO member states agreed upon the International Health Regulations by consensus as a balance between their sovereign rights and a shared commitment to limit the international spread of disease. Control of Ebola and other contagious disease is, first of all, a matter of each nation's quarantine and isolation laws as well as its public health infrastructure and capability.

Amongst the states with the highest level of preparedness both with regards to suspected Ebola cases were the United States (US). The US has well-developed laws enabling health professionals to respond quickly to EVD outbreaks. In addition to serving medical functions for the benefit of the patient, isolation and quarantine authority is derived from the right of the state to take action affecting individuals for the benefit of society. The unique brand of federalism in the US divides quarantine authority between states and the federal government [8]. If EVD is suspected or identified in a person arriving at the U.S. border or port of entry, the federal CDC may issue a federal isolation or quarantine order [9]. Federal regulations also allow the CDC to take measures to limit the spread of the disease from one state into another, including anytime the CDC Director determines that the actions taken by the health authorities of a state are insufficient to prevent the spread of it.Prompted by the potential spread of avian flu (which, unlike EVD, can be spread through the air), in 2005 the CDC announced regulations that would have would have granted the federal government a power of "provisional quarantine" to confine airline passengers involuntarily for up to three days if they exhibit symptoms of certain infectious diseases (EVD included)[10]. Federal officials would also have been able to quarantine passengers exposed to people with those symptoms.

In the same lines, contact tracing inevitably compromises privacy rights about a patient's condition. Public health officers have statutory authority to reveal a patient's EVD condition to those potentially exposed, although the patient's name or other identifying information generally may not be disclosed publicly [11]. Hospitals and private healthcare providers are obligated to inform local public health departments when they diagnose EVD and may be required to provide the names of the patient's potential contacts that they know about.

Additionally, while not traditionally viewed as part of public health law, the immigration and border control laws of individual nations are directly relevant to the threat of EVD. In the US, immigration and border control officers may refuse according to the law to admit any non-U.S. citizen infected with EVD. U.S. citizens, on the other hand, cannot be refused re-entry into the country, although officials can order immediate isolation for treatment at their arrival point, and can prohibit air travel for the period during which a sick patient could easily spread the disease [12,13]. The same legal authority applies with respect to the US sovereign borders. States or the federal government can prohibit travel of ill persons until their disease is no longer contagious, using the quarantine and isolation authority noted above. When repatriating foreign nationals who have been ordered to leave the United States, federal law requires that ill patients receive treatment until they are non-contagious before they may be released. The Department of Homeland Security has implemented enhanced screening at points of entry [14]. Border patrol agents have been told to ask travelers about possible exposure to the virus and to be on the lookout for anyone with a fever, headache, sore throat, diarrhea, vomiting, stomach pain, rash or red eyes. Finally, arriving passengers at five major U.S. airports are to be checked for fever if they have travelled from West Africa.

In brief, a quarantine or isolation order does not require advance approval from a court, but violation of a quarantine order can result in arrest and involuntary confinement. Furthermore, quarantine orders may require home or institutional confinement, and cooperation with treatment, testing, and monitoring. Legal frameworks also state that state governments are under no obligation to compensate quarantined persons for lost income, business disruption, and other economic harms.Without affirmative legal direction, however, come flexible interpretations of human rights and liberties. In Liberia, the government initially set up a diverse Ebola Task Force, whose large size and organizational challenges handicapped its effectiveness [15]. Other frameworks and policies extend from the use of public health powers to control the spread of Ebola through social distancing measures. Use of isolation, quarantine, cordon sanitaire, curfews, closures, travel restrictions, and other techniques in response to emerging infectious conditions were on historical and legal grounds prescribed not only in West Africa, but in many countries globally [16].

Concerning a condition such as EVD, which can infect and kill over half its victims in relatively short periods, limiting the movement of those infected, exposed, or merely in the area may arguably be imposed as a last-resort effort to control its spread. When such measures are used overzealously or applied too extensively however, they may unjustifiably violate human rights and liberties.

Protocols and facilities contributing to human right violations

Once the WHO declared a public health emergency of international concern, standards for surveillance and response to the disease were set and followed at a transnational level

[17]. This consequently and very directly first impacted the infected individuals, those at high-risk of contracting EVD and finally the caregivers and their sources of aid.More specifically, patients were not allowed to move according to own will and were kept separately apart. These isolated patients were only to interact with their caregiver for the basics. It was at this point, where another dimension of human right violations unfolded. The management of a pregnant woman and her child rose a series of queries. According the WHO recommendations, supposing that a suspected or (post)-confirmed woman in pregnancy will give birth - there are no reports of newborn survival beyond the neonatal phase, since EVD presents many obstetrics complications- the neonate is to be managed with the same procedures as its mother for 21 days at least [18]. This handling, not just merely deprives the child of its mother and its required breastfeeding, but results in a major violation of the first article of human rights; the one to be born free but of article 25 as well, stating motherhood and childhood are entitled to special care and assistance.

On the contrary, patients' rights are not the only ones being jeopardized. In the case of all aforementioned MRU countries, Bartsch et al describes how EVD management consumes a vast majority of the national budgets in order to control and eliminate the imminent danger of a wider spread, thus deteriorating the level of medical care other patients receive (i.e., outpatient visits, malaria patients, worm infected patients)[19].In addition, to the financial burden that EVD management bears, isolation rooms and segregated healthcare units demand space which is otherwise uneasily available, subsequently diverting the availability of space, workforce, and other essential life-sustaining services accessible for non-Ebola patients in need. This in turn, shines a light on both article 25 and article 21 and imputes EVD management in West African countries of denying individuals the right to a standard of living adequate for the health and well-being of themselves and the right of equal access to public service in their country respectively. In Liberia, surveys surrounding all 21 government hospitals located in all 15 districts of the country showed how the majority of households (57%) reported that it was very difficult or impossible to obtain health care during the 2014 EVD epidemic [20].

Further to the above, application of isolation and segregation measures resulting or not in quarantine, do not always yield favorable outcomes. In line with the WHO, quarantine has been established for high-risk contacts on the grounds of avoiding any risk of diagnostic delay. While this recommendation suggests a reasonable and proportional measure, it is more than frequently abused on grounds of time sparing and early prevention by not differentiating individuals according to risk but merely placing all (symptomatic and asymptomatic) contacts in mandatory isolation. Although, scientific evidence shows that asymptomatic persons are not contagious and that the risk of spread is low during the early febrile phase of illness, people are still being forcefully 'prophylactically' placed in quarantine [21]. Such individuals -or rather- non patients are being unfairly treated because of and only due to 'suspicious' community behaviors. It is these same people that cannot encounter family members, friends, or other social circles freely and are victimized under the violation of article 12 where no one shall be subjected to arbitrary interference nor to attacks upon their privacy, family or home. With an example of Nigeria, a case of imported EVD on August 8, 2014 resulted in placing 5 contact cases in containment with daily visits by caregivers while visitors were restricted to the front porch of the unit [22].

In a like manner, on August 19, 2014, it was reported that Liberia implemented a longly debated nightly curfew and initiated a roadblock in a slum of 50000 persons with razor wire and patrols in order to prohibit any departures [23]. This continued stigmatization of (infected and/or non-infected) individuals could have not been more discriminatory and was undoubtedly a violation of article 7; all are entitled to equal protection against any incision of discrimination.

Comparing ebola management to COVID-19 management: what can we learn?

The fear caused by the EVD outbreak in 2014, which was projected to have infected more than 20000 people, is understandable [24]. However, the disproportionate measures adopted in some of the affected countries as mentioned above are a cause for major concern. When parallelizing the tuberculosis (TB) epidemic and its course throughout the last decades, it is evident how the breakthrough of the BCG panacea at the relentless spread of TB was only brought forward some 40 years after the deadliest TB chronicle [25]. One could argue that Coronavirus disease (COVID-19), extremely contagious, might endure a similar passage of surveillance over the years. Of course, COVID-19 is not EVD. Yet, a few main points from the historical management of EVD may aid the response to thecurrent outbreak of COVID-19. Community educational programs, public engagement, further knowledge about patient stigmatism and the deterioration on patients' psychological evaluation as well as the need to diversify and divide funds of the national budget accordingly are just a few ways that EVD management can set the foundations towards a better management of the COVID-19 outbreak. This represents a more comprehensive and coherent framework than traditional biomedical approaches and should be considered an integral component of the public health toolbox.

In addition to the millions that have been committed from globally advocating entities, multiple health agencies have sought to address medical issues centered on a future CODID-19 outbreak; with the biggest focus being on the development experimental vaccinations as a potential treatment [26]. As far as legal responses are concerned, these should be ones promoting effective public health responses and respect for the health and human rights of populations. Compulsory public health interventions, approval and administration of experimental drugs or vaccines, and allocation of finite resources might solve the biomedical puzzle, but require difficult choices in law and policy. Crafting legal decisions in real-time emergencies is neither easy nor predictable, but it is essential to controlling epidemics and saving lives.

If we are to learn anything from the EVD outbreak, it is that health systems must be strengthened as a whole, and that we should step out of our 'disease-specific silos'. Globally, TB is leading the way in this respect; the new WHO 'End TB Strategy' advocates for

a broad multi-sector response, including not only health systems strengthening but also accountability from other ministries such as finance, social welfare and mining [27]. As multiple nations begin rebuilding their health systems, there is an opportunity to revolutionize how healthcare responds to lethal infections while placing human well-being above suffering.

Conclusion

Given the above we conclude that according to current investigations, a number of human right violations not only are considered mandatory, but are also regulated in a wide range of legal declarations which fluctuate from a simple recommendation to an official regulation; not to mention the possibility of law. In all hope, as time will tell and the production of new vaccines will proceed along with progressive healthcare technology, individuals will be able to feel and be more free even at times of being infected with a lethal infectious disease, without having their human rights jeopardized. In addition to the above violations, another factor should be clarified. One that underlines the fact that in less economically developed countries (with a degraded healthcare system in comparison to developed ones), more violations are observed in terms of quantity and more significant in terms of quality, because of the lack of targeted investments on healthcare infrastructure or because of investments on a specific disease framework such as COVID-19 may have exactly the opposite effects of controlling another disease such as EVD and vice versa. Once public health emergency laws and policies offer options for action, those options should be applied in consistency with basic human rights aside from acting out of mere non-maleficence. On both an international and a domestic basis, actions related to the management of EVD and COVID-19 must (1) advocate public health science; (2) aim to protect patients, their families and healthcare givers; and (3) respect human rights. Only then may Ebola (and currently COVID-19) be conquered successfully.

In the webs of COVID-19 significance, medical experts amongst all the other involved parties (legal advisors/sociologists/economists/anthropologists etc) hold the majority of the responsibility on deciding what and how changes will be implemented in practice. Until a holistic approach will dictate concrete, ethical and legal guidelines, it is the care givers that act at a baseline level, decide how management will be handled and what sacrifices will be done according to or bypassing ethical standards. These very same care givers are the ones to also convey how in times of addressing an epidemic, the human right to health together with many others compete with the human right to safety and lead to global health diplomacy. After all, the role of the health professional is not merely to treat or prevent the symptoms of one's patients, but to sound the alarm and advocate for change. Rightfully or not, our societal position gives our voices great credibility in upholding human amelioration (by often placing ourselves in danger).

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