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HUMAN RIGHTS
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# Social and Economic Impact Assessment of COVID-19 in the Republic of Moldova: A Human Rights Based Approach (HRBA)

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*(OHCHR Moldova)*

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# Contents

# 1. HRBA framework

A Human Rights-Based Approach (HRBA) to any intervention, including the Social and Economic Impact Assessment of the COVID-19 Pandemic, entails due attention being given to the international human rights framework that treats *all human beings, without discrimination, as* ***rights holders***. In other words, the HRBA puts *human beings*, with their *needs, choices and preferences at the centre of any intervention*. The difference between HRBA and other approaches (such as needs-based approaches) consists of the fact that HRBA does not rely on charity or benevolence of specific actors and it empowers and gives an active role to those effected. Under the HRBA, every human right implies an identifiable ***duty bearer*** with specific ***immediate obligations (obligation not to discriminate in the realization of the right) and sometimes also progressive (when full realization of a right is achieved progressively due to resource constraints)***. However, we should note that resource constraints cannot be an excuse for failing to address rights due to a clear obligation to use **maximum available resources** for progressive realization of rights and to ensure **minimum core** enjoyment of human rights to all. HRBA entails due attention to both ***human rights principles*** and ***standards***. The elements of the HRBA are briefly substantiated below.

## Rights-Holders

Given the universal nature of human rights, every individual is a rights-holder, entitled to the same rights without distinction based on race, colour, sex, age, language, religion, political or other opinion, national or social origin, disability, property, birth or other status, such as sexual orientation, marriage status, or any other ground.

Rights-holders must have the capacity to:

- exercise rights;
- formulate claims; and
- seek redress.

## Duty-bearers

Duty-bearers include:

- primarily ***State actors and institutions at various levels of government***, and
- ***certain non-State actors,*** who have the obligation to respect, protect, promote and fulfil human rights.

Human rights responsibilities can also attach to non-State actors, such as businesses, private individuals, international organizations and civil society organizations (amongst others). Parents, for example, have explicit obligations under the Convention on the Rights of the Child. Health providers have specific responsibility to protect the right to privacy of their patients, and a duty to ensure their right to accurate information. The UN Guiding Principles on Business and Human Rights stipulate that businesses have a corporate responsibility to respect human rights, which means that business enterprises should act with due diligence to avoid infringing on the rights of others and to address adverse impacts with which they are involved.[1]

[1] For further information please see the UN Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework, A/HRC/17/31, available online at https://www.ohchr.org/Documents/Issues/Business/A-HRC-17-31_AEV.pdf

## Human Rights Obligations

Although the human rights framework puts responsibilities on a wide range of actors, state authorities are the primary duty-bearers with regard to human rights. Their obligations towards human rights are understood in three ways: obligations to **respect human rights, protect human rights and fulfil human rights**.

1. To ***respect*** human rights, means that a States must refrain from violating human rights directly in laws, policies, programmes or practices. For example, governments cannot arbitrarily deny girls the same educational opportunities and standard of medical care that it offers to boys.

2. To ***protect*** a human right means that the States must prevent violations by others (e.g. state and non-state actors including individuals, groups, institutions and corporations), and must provide affordable and accessible redress. For example, the state authorities must ensure that employers do not discriminate against employees living with HIV, and must provide avenues for redress (e.g. complaint, compensation), if individuals are subject to discrimination on the basis of their HIV status.

3. To ***fulfil*** a human right means that state authorities must take measures that move towards the full realization of rights. These measures should be legislative, administrative, budgetary, and could include other types of actions as well. The key is to create an enabling environment. For instance, taking steps to ensure a working health system and universal health coverage to all are a way of fulfilling the right to health.

The following obligations are of **immediate effect**:

- The obligation ***not to discriminate*** between different groups of people in the realization of the human rights in question;
- The obligation ***to take steps*** (including creating specific strategies and programmes) targeted deliberately towards the full realization of the human rights in question; and
- The obligation ***to monitor progress*** in the realization of human rights. Accessible mechanisms of redress should be available where rights are violated.

## Human Rights Principles

***Universality and inalienability*** – the state must pay particular attention to be sure it does not accidentally ignore or violate the human rights of any group (such as persons with disabilities, ethnic minorities, migrants, children, women). Universality means that all people have human rights, even if resource constraints imply the need for prioritization.

***Indivisibility*** and **inter-dependence** – it implies that the advancement of a human right depends on the advancement of all other human rights, and that no human right is pursued to the detriment of others (for example, procedural rights should not be prioritised at the expense of access to healthcare or access to information; access to information can have a direct impact on the right to health).

***Equality and non-discrimination –*** development interventions (or in this case research) cannot be directed solely at those currently easy to reach, such as urban populations rather than rural, otherwise existing power imbalances will simply be exacerbated. Unintentional discrimination must also be avoided. This can happen when, for example, the public at large is invited to participate in programme design (consultations or focus group discussion) but certain groups in effect are excluded from participating because they live in remote areas and cannot reach the meeting(s) or they speak a different language (persons belonging to minorities) or need reasonable accommodation (e.g. persons with disabilities) or

additional assistance to overcome barriers facing them (environmental, institutional, attitudinal) and may be excluded if targeted assistance is not provided.

Specifically, programming (or research and analysis) may need to:

- give priority to those being impacted by discrimination and disadvantage in any given context, especially those living in extreme poverty;
- strengthen capacities for data collection and analysis to ensure data is disaggregated as far as possible on the grounds of gender, age, ethnicity, disability, income, geographic location, etc.;
- advocate for temporary special measures to 'level the playing field', such as affirmative action for specific groups;
- make information available in accessible formats and minority languages; and
- foster non-discriminatory attitudes and a change in behaviour.

***Participation and inclusion*** – ensuring that national stakeholders have genuine ownership over design of the study/research: assessment, data collection, analysis, appraisal. For a process to be truly inclusive, participation should be "active, free and meaningful." Participation should be viewed as fostering critical consciousness and decision-making as the basis for active citizenship and creating safe spaces for such exchanges is of vital importance.

***Accountability and rule of law*** - accountability systems require:

- clear roles and responsibilities;
- transparent decision-making processes and decision criteria;
- access to information; and
- effective mechanisms to demand accountability.

For accountability to be effective, it needs to be demanded. Therefore, a human rights-based approach also requires an analysis of the capacities needed for rights-holders, especially the most disadvantaged, to know and claim their rights effectively.

## Human Rights Standards

Human rights standards constitute the minimum entitlements, claims and obligations against which duty-bearers at all levels of society can be held accountable.

When trying to determine what this minimum level is, turn to international human rights treaties and their 'General Comments', drafted by the bodies monitoring the implementation of the human rights treaties as they often provide useful analysis to understand the obligations of a State in regard to a specific right or group of rights.

As an example, for the right to health, the international human rights standards indicate that States are obliged to ensure that public health services, as well as medicine and health care staff:

- are made **available** to all, regardless of geographical location or economic status;
- are **acceptable** to all people irrespective of culture, gender or age; and
- are **accessible (geographically, physically, informationally, financially)** without discrimination to all groups, be they young people, refugees, women living in poverty, etc., and respect the privacy of all individuals.
- the **quality** and the skills of the health personnel, the medicines available and the equipment used should be of a consistent standard for all communities and all individuals within those communities.

These minimum standards (*availability, accessibility, acceptability and quality*) are usually referred to as the '**3AQ**'. All of the **3AQ** are necessary if the minimum standard required of specific rights is to be fulfilled.

For the purpose of the Social and Economic Impact Assessment of COVID-19 in Republic of Moldova at least the following **human rights** should be considered for further assessment of the impact that COVID-19 has had on them:

- Right to the enjoyment of the highest attainable standard of physical and mental health
- Right to education;
- Freedom from Exploitation, Violence and Abuse;
- Right to Access to Information, Participation and Freedom of Expression
- Right to Work and Related Labour Rights;
- Right to Social Security;
- Freedom of Movement;
- Right to water and sanitation;
- Right to adequate housing.

In the process of assessment of the impact of COVID -19 on the above mentioned rights, it is important that one is guided methodologically by the Check List for a Human Rights Based Approach to Socio-Economic Country Responses to COVID-19 developed by OHCHR, UNDP and DCO in July 2020.[2]

It should also be noted that the indicators in this document capture the cross-cutting human rights principles of participation, access to effective remedies, non-discrimination and equality. These principles are essential.

In conclusion, we should note that human rights are also central to the 2030 Agenda for sustainable development and its promise to leave no one behind. The 2030 Agenda, its 17 SDGs and their targets and indicators, provides a blueprint for action as we tackle the effects of the pandemic and provides the benchmarks that will tell us whether we are on the right track and accelerating towards a more sustainable and just society. The 2030 Agenda is the framework for the UN and national development action, and we can deliver on it only if we fully account for human rights and prioritize those who are most vulnerable.

# 2. Integration of HRBA elements to the Social and Economic Impact Assessment of COVID-19 in the Republic of Moldova

Mainstreaming human rights entails integrating elements of the HRBA in the process of the social and economic impact assessment. The sections below provide specific guidance for each stage envisaged by the research.

## Stage 1. Scoping

1. While defining the methodology, it is important to take into consideration the make-up and diversity of the population. Ensure that data collection sources and tools (such as questionnaires) will reach out to and will be accessible for various groups (rights-holders) including persons with *visual, hearing, intellectual and psycho-social* disabilities, linguistic minorities, detainees, individuals in institutionalized

[2] The interim version can be provided upon request by OHCHR Field Presence (and will be available online the week of 27 July.

settings, older people, persons with chronic diseases, those who are illiterate (principle of equality and non-discrimination), LGBTI persons, as well as other groups that may be at risk of being excluded from data collection.

1.2. Collect data on the enjoyment of social, economic, cultural as well as civil and political rights[3] in particular as they have a direct impact on economic and social rights in the context of COVID-19 (such as access to information, freedom of expression, freedom from violence or abuse) with due attention to multiple disaggregation of data, at least on the following grounds (principle of equality and non-discrimination):

*1) gender;*

*2) age;*

*3) disability (including by type and degree of disability);*

*4) ethnicity and language (due attention to Roma ethnic group and Russian speakers);*

*5) residence (Chisinau/urban/rural, Transnistrian region);*

*6) socio-economic status (persons with low income: below the minimum subsistence level);*

7) *citizenship (citizens, non-citizens, refugees, asylum seekers).*

Other grounds can be considered, e.g. religion, marital and family status, sexual orientation and gender identity, and political opinion based on OHCHR standard model questions for data disaggregation.

1.3. Analyse the information and identify most **affected groups** for each of the listed rights.

## Stage 2. Initial Impact Assessment

2.1. Identify human rights most impacted by the COVID-19 pandemic (human rights obligations and standards).

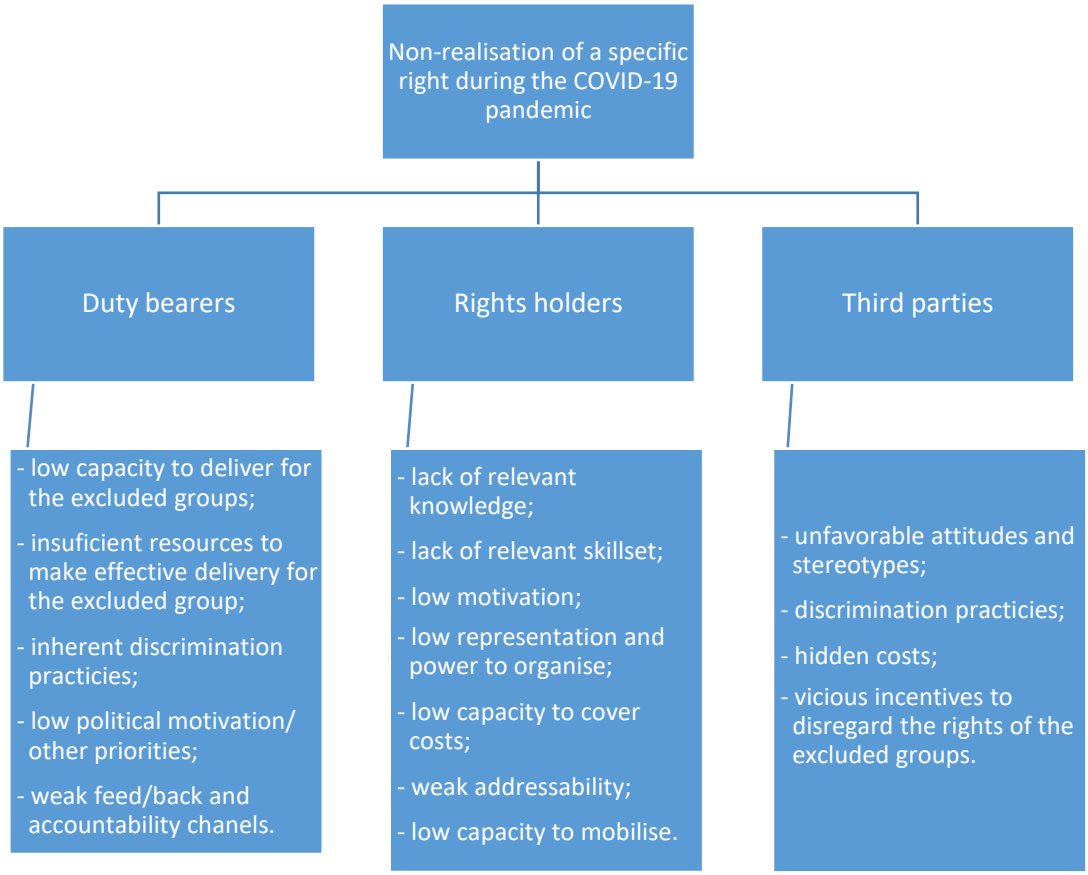
2.2. Identify the most affected groups (rights-holders) in relation to the enjoyment of specific rights (principle of equality and non-discrimination). Map the corresponding duty bearers (principle of accountability).

2.3. Conduct a causality analysis to answer the question which human rights are at stake and why, who has to do something about it, and what do they need to take action. The result of the causality analysis will be the identification of the causes of the non-realization of a specific human right by a specific group in the context of the COVID-19 Pandemic. Causal analysis shall be conducted in relation to both rights holder, duty bearers and also third parties wherever applicable (such as private sector actors/market).

Causality analysis should investigate the manifestation of a problem, immediate causes, underlying and root-causes. The analysis should also apply a gender lens and reflect on how women (including as part of specific vulnerable groups) may experience different challenges and need targeted interventions.

Examples of causes in relation to the three types of actors are provided below:

[3] We should note that many of the rights are mirrored in the SDG framework of the 2030 Agenda, therefore we should always consider possible links with the global and national SDG targets and indicators.




2.4. Develop survey questions based on human rights standards and principles (see indicators attached).

## Stage 3. Deep-Dive Data Collection

3.1. In addition to official data sources such as the data collected by the National Statistical Office, sources of information should also include data produced by the NHRI, CSOs representing vulnerable and/or affected groups (principle of equality and non-discrimination), UN entities, and other relevant stakeholders. International human rights mechanisms are also a valuable source of data and analysis.

3.2. Ensure that vulnerable/affected groups are represented in the survey that will be conducted by PWC in a proportionate manner. For instance, women represent around 52% of the population. That entails due effort to ensure that a corresponding share of women will be included in the sample of respondents. The same goes for minorities and other marginalized population groups.

3.3. Identify *immediate, underlining* and **root causes** of violations/denial of specific human rights during the COVID-19 pandemic (principle of accountability).

3.4. Consider that the lack of disaggregated data may in itself be a factor in the further marginalization or discrimination of certain groups. It would therefore be important to address this gap at a more systemic level using the results of the deep-dive. One of the possible interventions is to institutionalize the role of the NHRI in the National Statistical System, including by the NHRI and the NSO establishing a joint program/strategy to operationalize the Human Rights Based Approach to Data (HRBAD).

3.5. As the part of the exercise of the deep dive data collection further work will need to be done to develop the methods of computation, sources of data collection, disaggregation, periodicity, and limitations for each of the indicators.

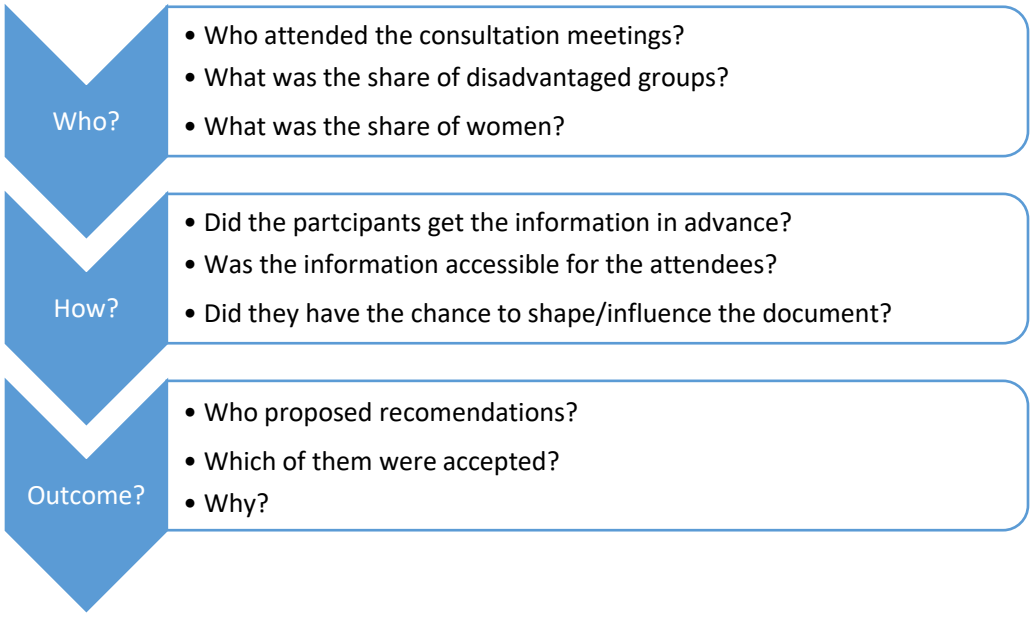
## Stage 4. Update impact assessment

4.1. Ensure that the impact assessment reflects the impact of COVID-19 on human rights, while paying specific attention to the impact of the pandemic on the most vulnerable (principle of equality and non-discrimination).

4.2. Ensure that the analysis covers the *root causes*, especially related to duty-bearers (principle of accountability) and identifies possible interventions to address them.

## Stage 5. Consultations

Ensure that vulnerable groups are consulted (principle of participation and empowerment). Key questions that should be considered are provided below:




## Stage 6. Peer review

Ensure that representatives of disadvantaged groups are part of the peer-review process (principle of participation and empowerment, equality and non-discrimination).

# 3. Human Rights Indicators relevant for the COVID-19 Social and Economic Impact Assessment

Drawing from the OHCHR guidance on human rights implementation and measurement[4], this section seeks to provide a framework for human rights indicators applicable to the COVID – 19 Social and Economic Impact Assessment in Moldova. The framework is indicative and does not pretend to be exhaustive.

In the context of this work, *a human rights indicator* is specific information on the state or condition of an object, event, activity or outcome that can be related to human rights norms and standards; that addresses and reflects human rights principles and concerns; and that can be used to assess and monitor the promotion and implementation of human rights.

There are two types of human indicators: *quantitative* and *qualitative* human rights indicators. The former category views indicators narrowly as "statistics", while the latter cover any information articulated as a narrative or in a "categorical" form.

Human rights indicators could also be categorized as *fact-based* and *judgement-based* indicators. Thus, objects, facts or events that can, in principle, be directly observed or verified (for example, weight of children, number of violent deaths, nationality of a victim) are categorized as objective indicators. Indicators based on perceptions, opinions, assessment or judgements expressed by individuals are categorized as *subjective* or *judgement-based* indicators.

Human rights indicators should be anchored in human rights standards. As a starting point, it is important that the narrative on the legal standard of a human right is transcribed into a limited number of characteristics or ***attributes*** of that right. For example, the right to the enjoyment of the highest attainable standard of physical and mental health entails *five attributes*:

1. *"sexual and reproductive health",*
2. *"child mortality and health care",*
3. *"natural and occupational environment",*
4. *"prevention, treatment and control of diseases", and*
5. *"accessibility to health facilities and essential medicines".*

Having identified the attributes, the next step is to have a consistent approach to selecting and developing indicators for the normative standards and the *obligations* related to those attributes. Duty bearers' obligations to respect, protect and fulfil human rights entail acceptance and commitment to human rights treaties (ratification and creation of institutional mechanisms for the promotion and protection of human rights), continuous efforts required to make that commitment a reality (process) and ensure increased enjoyment of human rights over time (outcomes).

In light of this conceptual framework three categories of human rights indicators will be used, namely *structural, process and outcome indicators.*

1. ***Structural indicators*** - reflect the ratification or adoption of legal instruments by a country, and the existence of basic institutional mechanisms necessary for facilitating the realisation of the concerned human right;

[4] For further information please see OHCHR (2012). *Human Rights Indicators: a Guide to Measurement and Implementation*. Available online at https://www.ohchr.org/Documents/Publications/Human_rights_indicators_en.pdf and https://www.ohchr.org/Documents/Issues/HRIndicators/SDG_Indicators_Tables.pdf.

2. ***Process indicators*** - measure duty bearers' ongoing efforts to transform their human rights commitments into the desired results;
3. ***Outcome indicators*** - capture attainments that reflect the enjoyment of a specific right at the individual and collective level in a given context.

Exploring the **principle of equality and non-discrimination**, **wherever applicable**, all indicators should be disaggregated at least by the following grounds:

*1) gender;*

*2) age;*

*3) disability (including by type and degree of disability);*

*4) ethnicity and language (due attention to Roma ethnic group and Russian speakers);*

*5) residence (Chisinau/urban/rural, Transnistrian region);*

*6) socio-economic status (persons with low income: below the minimum subsistence level);*

7) *citizenship (citizens, non-citizens, refugees, asylum seekers).*

Other grounds can be considered, e.g. religion, marital and family status, sexual orientation and gender identity, and political opinion based on OHCHR standard model questions for data disaggregation.

| Right to the enjoyment of the highest attainable standard of physical and mental health | |
|---|---|
| Structural | (**Thematic indicator 1**) Number of adopted/ implemented COVID-19 Country Preparedness and Response Plans containing systematic mapping of most vulnerable and marginalized groups and special measures for their protection and access to health services/equipment, including for: older persons, persons with disabilities, special health conditions or requiring specific health services (e.g. pregnant women, vaccination of children, people living with HIV, people using drugs); migrants (including undocumented), refugees, internally displaced persons, stateless persons, homeless, travellers, population in slums or other informal settlements, conflict affected populations; people in detention or institutionalized settings (e.g. prisoners, migrants and asylum seekers, persons in psychiatric care, geriatric care, drug rehabilitation centers etc.); minorities; LGBTI persons, women and girls who are pregnant or have given birth.<br><br>CI1.3: Health measures adopted pursuant to the International Health Regulation, that ensure human rights and dignity of international travellers (International Health Regulations, 2005)<br><br>CI1.4: ethical/human rights consistent guidelines adopted on admission/ treatment of COVID-19 patients in intensive care units<br><br>The coverage of national policy on sexual and reproductive health<br><br>Coverage of national policy on abortion and foetal sex determination |
| Process | **CI1.2:** Number/proportion of identified vulnerable/marginalized groups participating in the formulation/implementation of COVID-19 policy responses affecting them, |

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| | including through relevant representatives (e.g. community leaders, national human rights institutions, civil society organizations).<br><br>(**Thematic Indicator 2**) […] women's access to sexual and reproductive health (for instance, birth, pre- and post-natal care) and/or children immunization (e.g. DTP3) compared to the situation before the pandemic;<br><br>**CI9.2:** Recorded cases of people in detention or institutions that are unable to access treatment for COVID-19 or failure of institutions to implement precautionary measures;<br><br>Per capita government expenditure on primary health care and medicines*<br><br>Density of medical and paramedical personnel, hospital beds and other primary healthcare facilities*<br><br>Proportion of population that was extended access to affordable healthcare, including essential drugs, on a sustainable basis*<br><br>Proportion of people covered by health insurance*<br><br>Rate of refusal of medical consultations by target group*<br><br>Proportion of persons with disabilities accessing assistive devices*<br><br>Share of public expenditures on essential medicines met through international aid*<br><br>Proportion of mental health facilities inspected during the pandemic*<br><br>No. of vaccinated children during the pandemic*<br><br>Proportion of births attended by skilled personnel*<br><br>Antenatal care coverage during the pandemic (at least one visit)<br><br>Proportion of women of reproductive age using contraception<br><br>Unmet need for family planning<br><br>Medical terminations of pregnancy as a proportion of live births*<br><br>Proportion of reported cases of rape and other violence restricting women's sexual and reproductive freedom responded to effectively by Government<br><br>Number of complaints received by Human Rights Institutions during the pandemic on violation of the right to health<br><br>Number of complaints on violation of the right to health received by CSO monitoring platforms, including Promo-LEX and IDOM<br><br>Number of complaints on alleged violation of the right to health received from closed and residential institutions (penitentiary institutions, placement centres for persons with disabilities, placement centres for older people, children) |

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| | Number of patients with chronic diseases treated during the pandemic |
| Outcome | Maternal mortality rate during the pandemic*<br><br>Perinatal mortality rate during the pandemic*<br><br>Mortality rate of children under 5 during the pandemic*<br><br>Suicide rates*<br><br>Death rate associated with prevalence of communicable and non-communicable diseases (TB, HIV/AIDS, etc.)<br><br>Mortality rate of persons with disabilities<br><br>Mortality rate of older people during the pandemic<br><br>No. of people sanctioned for the violation of the right to health including malpractice, discrimination, limitation or denial of access to essential drugs.<br><br>Incidence of COVID-19 among persons with disabilities living in institutions<br><br>Incidence of COVID-19 among persons deprived of their liberty<br><br>Incidence of COVID-19 among older persons in residential institutions<br><br>Incidence of COVID-19 among people with chronic diseases |

| Right to education | |
|---|---|
| Structural | Number of policies adopted to facilitate access to education during the pandemic, with due attention to most vulnerable children, including children with disabilities, Roma, children left behind, children from vulnerable families.<br><br>Regulation on reopening adopted pursuant to meaningful consultation of rights holders, with due attention to most vulnerable |
| Process | Proportion of received complaints on the right to education investigated and adjudicated by the national human rights institution, Equality Body or courts and the proportion off these responded to by the Government*<br><br>Public expenditure on primary, secondary and higher education as proportion off gross national income; net official development assistance for education received or provided as proportion of public expenditure on education*<br><br>Proportion of parents who declared that the remote education platform was easily accessible;<br><br>Number of children who could not participate in the distance learning during the pandemic because of technical equipment or internet access; |

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| | Number of vulnerable children (parents from the poorest quintile) assisted with devices (laptops or tablets) during the pandemic or financial support to facilitate internet connection;<br><br>Number of children with Special Education Needs who benefited of individualized support in accessing distance education (adaptability).<br><br>The online education platform was accessible for children and parents with sensorial disabilities (Yes/No)<br><br>The extent to which online education platform was accessible for children and parents of linguistic minorities<br><br>Proportion of respondents who declared that information about the distance learning arrangements was clear (understandable, including for linguistic minorities and persons with learning difficulties, intellectual and hearing or visual disabilities)<br><br>Proportion of parents who requested support in order to access the remote education platform and benefitted from corresponding support (adaptability);<br><br>Proportion of respondents who declared that the educational process was adapted to their needs in the context of COVID-19 Pandemic<br><br>Proportion of respondents satisfied with the quality of education provided during the pandemic;<br><br>Proportion of respondents (parents with children with disabilities) satisfied with the quality of education during the pandemic;<br><br>Number of complaints on violation of the right to education during the pandemic;<br><br>Proportion of budget allocated to facilitate digital access for vulnerable children during the pandemic;<br><br>Proportion of respondents who declared that they were consulted with regards to re-opening of the educational institutions |
| Outcome | Proportion of children enrolled per stage of education;<br><br>Proportion of children not enrolled per stage of education;<br><br>Proportion of Roma children enrolled per stage of education;<br><br>Proportion of children with disabilities enrolled per stage of education; |

| Freedom from Exploitation, Violence and Abuse | |
|---|---|
| Structural | Number of policies adopted and implemented during the COVID-19 Pandemic designed to strengthen protection against violence, exploitation and abuse. |
| Process | (**Thematic Indicator 3**) Number of recorded cases of physical, sexual or psychological violence against women, girls and boys, elderly and LGBTI persons, including offline and online violence and violence by intimate partners, during the COVID-19 |

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| | pandemic, and proportion of these victims that have access to appropriate services and interventions.<br><br>**CI9.1:** Number/proportion of detention centres / institutions monitored by independent bodies, including National Human Rights Institutions and National Preventive Mechanisms (NPMs);<br><br>Number of complaints of domestic violence lodged by victims and investigated during the pandemic;<br><br>Number of complaints lodged and investigated on alleged abuses by personnel of psychiatric institutions and placement centres for persons with disabilities and for older persons;<br><br>Number of complaints on alleged violence against LGBTI people;<br><br>Number of complaints on alleged violence against children during the pandemic.<br><br>Number of calls on domestic violence received by service providers (disaggregated by type);<br><br>% of women who declared they knew where to submit a complaint or receive counselling if they are victims of domestic violence;<br><br>Share of women respondents who mentioned they were victim of at least one form of domestic violence during the pandemic (physical, sexual, psychological, sexual, economic);<br><br>Out of the above, % of women respondents who submitted complaints to competent authorities<br><br>Number of complaints on alleged abuses committed by staff of closed institutions received by the Ombudsperson's Institution;<br><br>Number of available places in shelters per 1000 population*<br><br>Number of adopted restraining orders*<br><br>Proportion of women men and women who think that domestic or gender based violence is accepted or tolerable*<br><br>Proportion of victims of rape who had access to emergency contraception or safe abortion<br><br>Proportion of formal investigations of law enforcement official for cases of domestic or gender based violence resulting in disciplinary action or prosecution*<br><br>Proportion of victims of violence accessing appropriate medical, psychological and legal services*<br><br>Proportion of reported cases of domestic violence where victims initiated legal action* |

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| | Proportion of expenditure on relief and emergency assistance devoted to women and child welfare. |
| Outcome | Number of perpetrators of domestic violence and abuse sanctioned during or after the pandemic.<br><br>Maternal mortality ratio and proportion of deaths due to unsafe abortions<br>Proportion of women who have experienced physical and/or sexual violence during the pandemic*<br><br>Proportion of women subjected to psychological and/or economic violence by the intimate partner*<br><br>Reported cases of deaths, rape and other incidents of violence against women that occurred in conflict, post/conflict or emergency situation*<br><br>Reported cases of violence against patients<br><br>Suicide rate by sex and age* |

| Right to Access to Information, Participation and Freedom of Expression | |
|---|---|
| Structural | Number of policies developed and adopted to facilitate access to information and freedom of expression during the pandemic.<br><br>**CI6.1:** Adoption/implementation of public information campaigns, including statements by political and civil leaders, contributing to eliminate COVID-19 associated stigma, discrimination, racism and xenophobia within the population. |
| Process | (**Thematic indicator 4**) Proportion of vulnerable groups receiving relevant COVID-19 information, including in appropriate, accessible, language and format and adapted to their specific needs (e.g. older persons, persons with disabilities, children, refugees, IDPs and migrants, minorities).<br><br>(**Thematic indicator 5**) Number of recorded acts of COVID-19 related censorship, digital shutdown, deliberate dissemination of inaccurate or misinformation; killings, detention, harassment, and other attacks against human rights defenders, journalists, bloggers, trade unionists, medical and other experts, and whistle-blowers motivated by their COVID-19 related actions.<br><br>(**Thematic indicator 6**) Number of recorded acts of discrimination, harassment, racism or xenophobia relating to COVID-19; and number of statements by public officials that engage in or fuel such acts.<br><br>Number of complaints alleging hate speech (or incitement to discrimination) against persons who tested positive on COVID-19;<br><br>Number of complaints alleging undue interference with their right to freedom of assembly during the pandemic, including right to strikes<br><br>Number of journalists and human rights activists who reported difficulties in accessing public interest information during the pandemic; |

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|---|---|
| | Number of healthcare workers who reported cases of pressure, stigma or discrimination as a result of disclosing systemic issues regarding the fight against the pandemic;<br><br>Proportion of media requests responded to by effectively by the state authorities<br><br>Number of cases of shutdown of websites/blogs and other media sites<br><br>Number of complaints by media professionals alleging hate speech and harassment given their public reporting on COVID-19<br><br>Number of complaints to National Human Rights Institutions and monitoring platforms related to freedom of expression during the pandemic and the proportion of these responded to effectively by the Government*<br><br>Proportion of judicial actions on alleged libel, defamation and slander investigated and resulting in conviction*<br><br>Proportion of quasi/judicial actions against hate speech or instigation to discrimination against people infected with COVID-19 investigated and resulting in conviction*<br><br>Number of court cases initiated by public figures against journalists in the context of COVID-19 |
| Outcome | Number of journalists who reported reprisals or political pressure for published information during the pandemic*<br><br>Number of authors of hate speech against journalists or people tested positive on COVID-19 or returned citizens/migrants from affected countries sanctioned by courts or by Equality Council<br><br>Number of authorities sanctioned by courts for failure/unwillingness to provide timely or full access to public interest information during the pandemic<br><br>Proportion of victims of hate speech who received compensation or rehabilitation*<br><br>Proportion of victims of undue interference with their right to freedom of assembly and speech who received compensation or rehabilitation<br><br>Reported cases of non-disclosure of documents, archives and administrative data of public interest<br><br>Percentage of different linguistic population groups having access to information about COVID-19 through the media broadcasts in their own language. |

| Right to Work and Related Labour Rights | |
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| Structural | (**Thematic indicator 7**) Adoption/implementation of measures to ensure occupational health and safety for those who cannot work from home or remotely, including workers in health care settings, law enforcement and civil protection officials, employees of essential businesses (supermarkets, groceries, food providers, etc.) and |

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| | related provision of adequate protective equipment, health checks, reasonable working hours, mental health and ethical support and counselling.<br><br>CI7.1: [..] adoption/implementation of national occupational safety and health plans or programmes for health workers;<br><br>Measures of mitigation of the economic impact such as subsidizing wages, providing tax relief and establishing supplementary social security and income protection programmes were implemented (Yes/No);<br><br>Special legislation or measures developed and implemented to protect parents who lost the job because of lack of child care alternatives |
| Process | Proportion of employed respondents by affected sectors, who declared that occupational health and safety was ensured when remote working was not possible<br><br>Proportion of employed respondents by affected sectors of economy who declared that protection equipment, health checks, reasonable working hours, mental health and ethical support and counselling was available at the workplace;<br><br>Proportion of confirmed COVID-19 cases among sectors not able to telecommute (eg health workers, social workers)<br><br>Proportion of respondents who declared they had lost their job during the pandemic;<br><br>Proportion of respondents who declared that they could not exercise their right to work due to the lack of alternative education and care solutions for their pre-school and primary school children.<br><br>Proportion of employed persons who reported unfair dismissals and layoffs, reduced working hours, modifications to the type of employment;<br><br>Proportion of employed respondents satisfied with the measures taken by their employer during the pandemic;<br><br>Number of complaints registered by the National Human Rights Institution and monitoring platforms related to alleged violation of labour rights;<br><br>Number of complaints on the violation of labour rights examined by courts and other competent authorities during the pandemic;<br><br>Average time spent on unpaid domestic or family care work in family business by women, men, children* during the pandemic<br><br>Proportion of informal workers shifted to formal sector employment in the pandemic*<br><br>Estimated number of labour force in the informal sector receiving some public support *<br><br>Proportion of targeted unemployed persons covered by unemployment/social security benefits |
| Outcome | CI7.2: Number of new probable and confirmed COVID-19 cases in health workers. |

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| | Number of marginalized and disadvantaged individuals, including unemployed persons, self-employed workers, workers in non-traditional forms of employment (own-account, temporary, casual workers) and migrant workers who received special attention from state authorities;<br><br>Number of employers sanctioned for violation of labour rights during the pandemic.<br><br>Reported cases of violation of the right to work, discrimination and unlawful termination of employment during the pandemic and proportion of victims who received adequate compensation.*<br><br>Proportion off workers in precarious employment (short-term, casual, seasonal workers)* |

| Right to Social Security | |
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| Structural | (**Thematic indicator 8**) Adoption/implementation of country measures, including by businesses, to ensure equal access to social protection floors to victims of COVID-19 related crisis, provision of basic income, including for workers and migrants in the informal economy, aid for affordable housing, access to food, water, health care, education (for example, alternative accessible teaching methods) and care-giving support during quarantines/lockdowns, especially for older persons, children, single parents and persons with disabilities.<br><br>CI8.1: National authorities instituted bans of evictions, rents and mortgage relief measure, or other specific measures to address housing-related impacts during the COVID-19 pandemic, including measures to ensure frontline workers with restricted mobility and homeless people have access to shelters designed and equipped to prevent COVID-19 infection and to facilitate access to healthcare; complementary post-crisis extension of mortgage freeze and rent reduction/freeze for affected persons. |
| Process | Proportion of received complaints on the right to social security investigated and adjudicated by national human rights institution or courts and the percentage of those responded to by the Government*<br><br>Proportion of targeted population appropriately informed of its entitlements and benefits during the pandemic*<br><br>Net official development assistance for implementing this right, received or provided as a proportion of public expenditure on social security and Gross National Income.*<br><br>Proportion of requests for benefits reviewed and met during the pandemic* / Number of people who registered social protection requests during the pandemic (pensions, indemnities, financial support, allocations, benefits in case of labour accidents or professional illness)<br><br>Proportion of cases or complaints concerning social security obligations of enterprises effectively responded to by the Government*<br><br>Number of individuals registered as unemployed at the Territorial Employment Agencies during the pandemic and benefitting from free medical policy insurance |

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| | Public expenditures for targeted social assistance schemes per beneficiary during the pandemic<br><br>Number of people who benefited of support in accessing basic supplies and food security (distribution of meals during schools closure, delivery of food and basic supplies to individuals, especially older people and persons with disabilities living alone and single persons that are in self-isolation)<br><br>Number of requests for social protection services that were declined by the authorities during the pandemic and corresponding reasons formulated by the national authorities<br><br>% of budget allocated for targeted social assistance*<br><br>Proportion of respondents who mentioned that they were able to access social assistance services and social protection measures and entitlements (pension, disability pension, survivor's pension, social benefits including childcare benefits, determination of disability, etc.)<br><br>Proportion of respondents who declared that they could not access social protection services although they needed to.<br><br>Proportion of respondents who declared they benefited from social community services during the pandemic, including support of social assistant, home care, social canteen services or distribution of food at home, community centres of social assistance, personal assistants, mobile teams, Respiro, etc. |
| Outcome | Proportion of population in specific situations off need receiving social assistance for food, housing, health care, education, emergency or relief services*<br><br>Proportion of population who live in extreme poverty<br><br>Proportion of population who live in absolute poverty<br><br>Proportion of population under the minimum poverty threshold before and after targeted social payments / transfers |

| Freedom of Movement | |
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| Structural | Number of policies developed and adopted during the pandemic to facilitate personal mobility and freedom of movement, with due focus on most disadvantaged groups<br><br>(**Thematic indicator 10**) State of emergency was officially proclaimed through proper legal procedures and details the rights being derogated and the duration, geographic, and material scope of application. |
| Process | Proportion of respondents with disabilities who reported that measures and assistive devices were available to facilitate their access to basic needs and services (assistive devices);<br><br>Proportion of older who reported that measures were available to facilitate their access to basic needs and services. |

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| | Proportion of respondents who reported problems in accessing basic needs and services due to lack of transportation;<br><br>Proportion of respondents who declared that lack of transportation during the pandemic did not hinder their access to goods and services;<br><br>Proportion of respondents who were satisfied with the quality of public transportation services during the pandemic;<br><br>Number of complaints regarding lack of personal mobility devices during the pandemic;<br><br>Number of complaints regarding lack of personal mobility devices in closed institutions;<br><br>Number of people who reported undue interference with their right to freedom of movement during the pandemic (i.e. older people sanctioned for going to the market);<br><br>Number of citizen who reported undue restrictions of their right to return to their home country.<br><br>CI10.1: Recorded cases of unlawful, disproportionate, unnecessary, or discriminatory restrictions or excessive measures (such as broad measures not directly linked with public health objectives and potentially violating other rights, such as the right to food or social security. |
| Outcome | Number of persons with disabilities provided with assistive mobility devices during the pandemic;<br><br>Number of older people assisted to get access to goods and services during the pandemic. |

| Right to water and sanitation | |
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| Structural | Existence of a national policy for the progressive implementation of measures, including special measures for target groups, for the right to sufficient, safe and acceptable water and sanitation. |
| Process | Number of complaints on the right to water and sanitation examined and adjudicated by the national human rights institution and the share of complaints adequately responded to by the Government.<br><br>Proportion of population that was provided sustainable access to safe, sufficient water and sanitation during the pandemic.<br><br>Proportion of population who reported difficulties in accessing safe and sufficient water supply during the pandemic. |

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| | Number and proportion of schools, hospitals and placement institutions for persons with disabilities, older people and children that were provided access to water and sanitation during the pandemic |
| Outcome | Number and share of population with access to sufficient and continuous water supply for personal and domestic uses (access to tap water).<br><br>Number and share of population with access to safe water, free from micro-organisms, chemical substances and radiological hazards that constitute a threat to a person's health (quality of water).<br><br>Number of share of people with access to safe and acceptable water within their home, or in the immediate vicinity (physical accessibility).<br><br>Number and share of population who cannot afford access to water in sufficient quantity and of sufficient quality (economic accessibility)<br><br>Profile of people without access to sufficient and safe water<br><br>Share of people who are aware the quality of drinking water, either from the well or tap water (information accessibility)<br><br>Number and proportion of schools, hospitals and placement institutions for persons with disabilities, older people and children with access to safe and sufficient water and sanitation |

| Right to adequate housing | |
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| Structural | Number of assessments (or mappings) conducted regarding specific vulnerability to COVID-19 of people living in informal settlements or overcrowded houses, with due attention to returned migrant workers, Roma, older people, persons with disabilities, refugees, asylum seekers.<br><br>Existence of a national policy for the progressive implementation of measures, including special measures for target groups, for the right to adequate housing at different levels of authorities.<br><br>*(Thematic Indicator 9). State's adoption/ implementation of alternatives to deprivation of liberty, in particular in situations of overcrowding (e.g. greater use of alternatives to pre-trial detention, commutation of sentences, early release and probation, alternative measures to immigration detention) as a COVID-19 prevention and mitigation measure.* |
| Process | Number of received complaints on the right to adequate housing investigated and adjudicated by the People's Advocate Office or courts and the proportion of these responded to effectively by the authorities.<br><br>Average time taken to settle dispute related to housing in courts<br><br>Number and proportion of evicted persons rehabilitated or resettled during the pandemic |

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| | Total public expenditure on housing reconstruction or rehabilitation of evicted persons during the pandemic<br><br>Share of public expenditure on social or community housing<br><br>Share of public expenditure on provision and maintenance of sanitation, water supply, electricity and other services of homes.<br><br>Proportion of persons with disabilities that were deinstitutionalized and placed in alternative community services (protected apartments, community houses, etc)<br><br>Proportion of population that was extended sustainable access to an improved water source, improved sanitation, electricity and waste disposal<br><br>Proportion of households that receive subsidised public housing assistance, including those in subsidised rental and subsidised owner occupied housing<br><br>Proportion of homeless people that used public or community shelters during the pandemic<br><br>Proportion of people who sold their property during the pandemic because of the need to cover costs for basic needs |
| Outcome | Proportion of population with sufficient living space and average number of persons per room among targeted households<br><br>Proportion of population living in permanent structure in compliance with construction standards<br><br>Proportion of population living in slums<br><br>Proportion of population using an improved drinking water source, sanitary facility, electricity and waste disposal<br><br>Proportion of population spending more than 50% of their monthly income or expenditure on housing<br><br>Average of homeless persons per 100000 population during the pandemic<br><br>Reported cases of forced evictions<br><br>Proportion of households with secure tenure during the pandemic<br><br>Proportion of women with title to land or property |