How Communication Impacts the Right to Health: COVID-19 Seen Through a Lens of Vulnerability

Timothy Affonso

Abstract
The COVID-19 pandemic has affected the global community in a sudden and unpredictable manner. As such, it becomes essential that States engage in immediate effective communication of public health messaging to ensure that persons are aware of the ways in which they can protect themselves from contracting the virus. In this vein, guidance has been offered to States on how to effectively engage in public health communication strategies by the international human rights regime which sets out the standards for right to health. These standards recognize that the right to health includes a dimension for health communication. However, the vulnerabilities, which exist in some groups in society, make generic health communication ineffective in achieving the goal of protection from COVID-19. Furthermore, the pandemic highlighted the lack of compliance by States with their right to health obligations. It is this disconnect between the de jure human rights obligations and the de facto compliance by States with those obligations that will be explored in this paper. The paper will set out the different formulations of the right to health in specific international human rights treaties and compare the text of the treaties with the actual health messaging initiatives by States during the pandemic. There will also be an identification of ways in which States may more appropriately tailor their communications strategies to align with the international standards for the right to health. This exercise will highlight the connection between effective public health communication and improved health outcomes for the public and the important role the international human rights framework plays in this paradigm. The paper will demonstrate the need for a tailored approach to health communication when dealing with socially vulnerable groups using the guidance which can be offered by the international human rights treaties in realizing the right to health for the public.

1The University of the West Indies at St Augustine, St Augustine, Tunapuna-Piarco, Trinidad and Tobago

Corresponding Author:
Timothy Affonso, The University of the West Indies at St Augustine, St Augustine, Tunapuna-Piarco, Trinidad and Tobago.
Email: timothyaffonso@hotmail.com
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Introduction
The recent “2019 Novel Coronavirus” global pandemica has realized significant illness, strain on the medical resources of nations, and widespread death. Healthcare, at a national level, has been placed under severe stress. While there is a great deal of understanding of the pressure placed on national resources by this pandemic, the reaction by States must be seen in light of a recognized right to health in international law.

The right to health is not a new concept, nor is it purely aspirational. It can be traced to the latter half of the 20th century and finds its recognition in many international human rights treaties. If States had endeavored to realize their international obligations when the international duties first arose, the pandemic would not have impaired the right but would have been confronted by States with an institutional framework guided by their international obligations. Therefore, the unpredictable and unexpected nature of the pandemic does not make the right sacrificial at the expense of urgency. However, in times of global challenges, the most vulnerable tend to be de-prioritized for utilitarian policy implementation.

The main international human rights treaties which address the right to health are as follows: (i) The International Covenant on Economic, Social, and Cultural Rights;2 (ii) The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW);3 (iii) The Convention on the Elimination of All Forms of Racial Discrimination (CERD);4 and (iv) The Convention on the Rights of the Child (CRC).5 These treaties can be considered the hallmark of the human rights treaty system. There are differences in the articulation of the right to health in each of these treaties, most significantly, in respect to the breadth of the right contemplated. These treaties will be addressed, in turn, in this paper, with careful attention being paid to the different constructs of the right and the degrees of compliance with those formulations, specifically looking at the impact of COVID-19.

What must be noted is that the international legal regime has developed the boundaries of the right to include non-discrimination in access to health facilities and services; physical accessibility; economic accessibility (affordability); and information accessibility.6 It is the aim of this paper to examine these legal boundaries of the right to health under the various human rights treaties previously identified, with particular reference to the component of the right to health that addresses the public health information dissemination to vulnerable groups and assess whether the response to the threat has been consistent with the parameters of the right. The response will confront the way in which education and information reach those who need it most. It must also be highlighted that the paper will address the rights, not only from the right holder’s perspective (the citizen), but also from the point of view of the duty bearer (the State).
After a review of the international standards of the right to health, it will be possible to conclude that there is a disconnect between the normative content of the international human rights health framework and the actual enforcement of the right by States. Taking a look at the vulnerable groups of women, persons of color and children, through the lens of human rights treaty law, it will become clear that public health messaging needs to be tailored to the unique requirements of each audience to be effective. The thorough analysis of the human rights treaty regime, as it relates to the right to health, will identify the ways in which States can adapt their health messaging apparatus to cater to those most in need of health information, particularly during a global pandemic.

**The International Covenant on Economic, Social, and Cultural Rights**

The [ICESCR](https://en.wikipedia.org/wiki/International_Covenant_on_Economic,_Social,_and_Cultural_Rights) articulates the clearest formulation of the right to healthcare in the following terms in Article 12:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   (a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
   (b) The improvement of all aspects of environmental and industrial hygiene;
   (c) The prevention, treatment, and control of epidemic, endemic, occupational, and other diseases;
   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

As provided for in the [ICESCR](https://en.wikipedia.org/wiki/International_Covenant_on_Economic,_Social,_and_Cultural_Rights), the right to health includes not only physical, but also mental health set in a context of a State’s resources. This qualification must be seen in the language of Article 12(1) which sets the right against the background of “attainable” standards of health. In addition, of particular importance to the present discussion is Article 12(2)(c) which speaks of States Parties’ duties, in general terms, in the prevention, treatment, and control of “other diseases.” It can be argued that COVID-19 is captured by the language of this Article, sufficient to trigger State responsibility.

Furthermore, General Comment 147 of the Committee on Economic, Social, and Cultural Rights sets outs, in much greater detail, the scope of the right to health. This offers guidance to States Parties on how the right is to be realized. This guidance is broken down into three components of the obligation. These obligations are (i) to respect the right and not interfere with the enjoyment of the right; (ii) to protect the right from third party intervention; and (iii) to fulfil the right through an adoption of appropriate legislative, administrative, budgetary, judicial, promotional, and other measures toward the full realization of the right to health.
In light of this formulation of the elements of the right, the breadth of the right has been described as operating on a spectrum. At a minimum, it could mean a right to conditions that protect health in the population. At most, it could also include the provision of medical care for the diagnosis and treatment of disease and injury for those unable to pay. Relevant to this paper, we currently see with the threat of COVID-19 that there is a development of the boundaries of the right to health to include the right to access accurate information about the nature of the threat and the means to protect one’s self, one’s family, and one’s community.

The United Nations High Commissioner for Human Rights (HCHR) has recently added clarity to this dimension of the right when it was stated that human health depends not only on readily accessible healthcare. It also depends on the right to freedom of expression, which includes the right to seek, receive, and impart information and ideas of all kinds, regardless of frontiers, through any media, applies to everyone, everywhere, and may only be subject to narrow restrictions.

In this regard, the HCHR issued a statement in March 2020 setting out five communication deliverables under the internationally recognized right to health. First, governments are under an obligation to provide truthful information about the nature of the threat posed by the Coronavirus. Second, the role of Internet was seen as being critical in a time of crisis and essential to the access of information. Third, governments were duty-bound to make exceptional efforts to protect the work of journalists and to robustly implement their freedom of information laws to ensure that all individuals, especially journalists, have access to information. Fourth, governments were expected to address disinformation. Finally, States were urged to monitor their use of surveillance technology in the protection of patients’ information and journalistic sources.

Perhaps the need to provide this clarity to this aspect of the right was made necessary by some of the statements made by President Trump in his handling of the pandemic. The significant influence that President Trump has on his listening and viewing audience make his statements particularly impactful. However, when public statements are made recommending the use of untested medicine; UV rays; or disinfectants as possible cures for COVID-19, the full breadth of the right to health needed to be restated. In fact, after the statement in which disinfectants were suggested as a possible cure for COVID-19, poison control centers across the United States of America (USA) received increased calls from citizens verifying the proposed treatment. As such, not only can it be categorized as irresponsible for a non-medical professional to recommend medical treatment but the right to health, as embodied in the ICESCR, demands that it not be done. In fact, the provision of information that is not reliable and that prevents persons from being able to adequately safeguard themselves from contracting and treating illness is a violation of the right to health.

As it relates to the three-prong obligation built into the international human right to health, the provision of accurate information relates to the respecting of the right and not impairing its enjoyment. It is therefore necessary to recognize that the overarching public health apparatus and strategy are not just arbitrary political decisions but legal
obligations under international law. What is most interesting is that beyond the broad-brush approach to public health education and information, the duty imposed on States is made even more specific depending on which vulnerability is being targeted by governments. It is in this context that attention will now to be turned to the specialized international human rights treaties, with a view of identifying the role information access plays in safeguarding the right to health for these vulnerable social groups.

**The Convention on the Elimination of All Forms of Discrimination Against Women**

The CEDAW uniquely provides for the right to health for women. The recitals to the Convention recognize that the axes of oppression of women intersect both access and the quality of healthcare they receive. It undergirds the fact that women are not homogeneous and require different forms of support as it relates to cultural, linguistic, and economic differences.

To this end, the right to health is reflected in CEDAW as it relates to family planning, working conditions, reproduction, and access. These Convention Articles are specific to women and girls and address health from a perspective of gender equality. However, it should be noted that COVID-19 has demonstrated a discriminatory impact on the right to health for women and girls and has widened the poverty gap between women and men, highlighting the economic impact of policies on this sector of society. In fact, the United Nations Entity for Gender Equality and the Empowerment of Women has provided a Policy Brief in which it provides that:

> The pandemic is deepening pre-existing inequalities, exposing vulnerabilities in social, political and economic systems which are in turn amplifying the impacts of the pandemic.

Getting to a more granular expression of the threat faced by women as a result of COVID-19, the Committee on CEDAW issued a Call for Joint Action in the following words:

>[. . .] the consequences of the current crisis ha[ve] impacted women in a disproportionate and more severe manner. Women have experienced multiple and compounded forms of discrimination while on the front lines of responses, at home, in the health workforce and in various sectors of production.

Because of pre-existing gender inequalities, deep-rooted discrimination and feminized poverty, the multifaceted consequences of the current crisis have impacted women more than men, while at the same time placing increased responsibilities on women’s shoulders.

Media reports have shown that incidents of discrimination against women and girls and domestic and gender-based violence have risen due to domestic tensions resulting from confinement, often in poor housing conditions, pressure of accompanying children during home schooling and job losses by women and men.
There is therefore a need to provide equity in the public health discourse relating to women and girls. Moreover, there are social consequences of a lockdown which existed in a patriarchal pre-COVID-19 world and which have been exacerbated due to increased unemployment. With the increased vulnerability of women because of their unique placement in society, even their access to information unfairly prejudices them in their ability to safeguard themselves from the virus. On this point, the Committee on Economic, Social, and Cultural Rights in its General Comment 14 expressed that the right to health extends to underlying determinants of health which include the “access to health-related education and information.” It is in this context that the way in which States communicate health-related information to its population is not a discretionary public relations initiative but a legal obligation grounded in international law. Moreover, it cannot be ignored that women make up approximately 70% of health and social workers putting them at greater risk. This is all the more relevant, when one looks at the USA, as women make up nearly nine out of ten nurses and nursing assistants, most respiratory therapists, a majority of pharmacists, and an overwhelming majority of pharmacy aides and technicians. This therefore means that the protection of the health of women at the workplace is directly threatened by the pandemic. This is what is referred to as the gendered impact of COVID-19 and makes the consequence of poor public health communication to tailor to this audience a matter of life and death. As such, couched in the language of law, there is a need to integrate gender into the COVID-19 risk communication and community engagement response.

However, it is a fact that there are challenges faced by women and girls in accessing health-related information. Gender inequity, especially in the use of technology, may also restrict women’s access to information, limiting their exposure to campaigns disseminating essential health messages. In many instances, national-, community-, and local-level responses to COVID-19 may also not include women in leadership and decision-making roles. Layered over this systemic inequity is the failure to communicate COVID-19 health information to culturally and linguistically diverse communities. It is made more unfortunate when we see that public health campaigns require a tailored approach to women taking into account their non-homogeneity. This approach is rarely realized.

There have been attempts by some States to recognize the need to address the vulnerability of women in their public health communication strategy. For example, Pakistan implemented a program which disseminated information to marginalized transgendered people about COVID-19 prevention. Libya and Lesotho utilized the emergence of telemedicine and established a gender-based mental health hotline with success which was used in the context of COVID-19. New Zealand decriminalized sex work to allow for healthy practices for women in the industry. Also, in an attempt to address the disproportionate impact that COVID-19 and stay-at-home orders had on adolescent girls and young women, the UNESCO has adopted a campaign for eastern and southern Africa to prevent and address early and unwanted pregnancies.

While there are laudable approaches to the dissemination of information to women surrounding COVID-19, the global response to the COVID-19 pandemic has revealed
shortcomings in the communications strategy of life-saving medical information. An approach that focusses on public health communications must include the diversity of women from perspectives of age, class, economic status, medical conditions, cultural and linguistic backgrounds, race, and ethnicity. Any strategy which does not adopt an all-encompassing approach will undermine the right to health and its ultimate goal of safeguarding the health of the global population.

The communications strategy for information dissemination targeted at women and girls must approach the communication remembering that the message must include information that is relevant to the needs of the target audience. To this end, there have been consistent proposals to include women in the communications apparatus at decision-making levels to ensure that the concerns of women and girls are identified and articulated by those affected by the threats or risks. It is important to recognize that the unique obstacles faced by women in accessing information relative to their health and the COVID-19 virus is compounded when race is added to the complexity of a gender discussion. Attention will now be turned to the issue of race as a factor to be addressed in the protection of the right to health.

The Convention on the Elimination of All Forms of Racial Discrimination

From a vantage point of the CERD, the right to public health is to be free from racial discrimination. This point is noteworthy as the statistics show a sad reality for racial minorities and morbidity rates. Based on research conducted in March 2021 in the USA, indigenous persons (Native Americans) were three times more likely to die from COVID-19 than a white American. Pacific Islanders were 2.6 times more likely and Latinos and Blacks were 2.4 and two times more likely than White Americans to die from the virus. This is made even more startling when one considers that in March 2020, “Black Americans made up twenty-five percent of deaths from COVID-19 in the USA though they make up a little under thirteen percent of the USA population.” This is not to say that access to healthcare is being discriminatorily provided, per se, but that the social construct in the USA makes black Americans more prone to contracting the virus. As was stated by Danyelle Solomon, the Vice President of the Race and Ethnicity Program at the Centre for American Progress:

National emergencies, pandemics, epidemics, what they do is they spotlight inequality,” Solomon said. “What we see in COVID-19 is no different. It’s highlighting racial disparities at every single level that have been with our society for a very long time.

This highlighting of inequality was similarly predicted in the United Kingdom where it was stated that,

in the short term, ethnic inequalities are likely to manifest from the COVID-19 crisis [. . .] through exposure to infection and health risks, including mortality.
In fact, even the Centre for Disease Control and Prevention provided that while the effects of COVID-19 on the health of racial and ethnic minority groups are still emerging, the current data suggest a disproportionate burden of illness and death among racial and ethnic minority groups.\textsuperscript{48} Therefore, looking at the right to health through a lens of racial equality, it is not only the access component of the right that is being negatively affected but similarly the prevention dimension. This is seen quite glaringly in Mississippi which has one of the highest death rates in the USA with American Indians/Native Americans being described as “most likely to contract and die from COVID-19”.\textsuperscript{49} In New York, both Hispanics and blacks more than doubled the deaths of white Americans.\textsuperscript{50}

The foregoing data show that the pandemic is affecting some races differently. However, that fact, by itself, is not a violation of the \textbf{CERD}. However, when the inequality is institutionalized in a society, then the disproportionate impact of the virus on some racial minorities is not accidental but a man-made construct. Furthermore, persons from some racial backgrounds face multiple barriers to accessing healthcare which include cultural differences, language barriers, educational, and income gaps.\textsuperscript{51} As reported in the Lancet Medical Journal, over a year into the COVID-19 pandemic, the Black, Asian, Minority Ethnic (BAME) communities in the UK and elsewhere continue[d] to be disproportionately burdened by COVID-19-associated morbidity and mortality.\textsuperscript{52} It has been even advanced that vaccine hesitancy and low rates of vaccination among the BAME community are a direct result of misinformation and poor messaging strategies toward this group.\textsuperscript{53}

What must be noted is that the issue of racial discrimination may not be a deliberate targeted goal of the public health mechanism within a State, but without careful conscious planning, racial inequity in information dissemination may be a resultant effect. Culturally appropriate COVID-19 information and messaging platforms are urgently required to overcome the shortcomings of a deficient public awareness campaign which does not tailor to the needs of racially disparate groups. This messaging must be clear, in both style and content, conveying simple, easy to understand, visual, consistent, and generic to all communities, ethnic groups, cultures, and faiths.\textsuperscript{54} And as it relates to avenues for dissemination of information, the use of local radio, TV, and social media which operate actively during religious events and festivals such as Christmas, Hanukah, Diwali, Eid, Ramadan Holy, Shivaratri, and Baisakhi, may prove particularly useful. Communities propagate messages effectively internally, so it would be beneficial if restrictions are announced in a timely fashion prior to festivals or events.\textsuperscript{55}

The failure to implement a public health awareness mechanism which caters to the communication needs of racial groups could constitute a breach of the right to be free from discrimination. Where the discriminatory treatment affects the boundaries of the right to health, then it would also be possible to assert that there is a violation of the right to health.

As a logical next step, it is necessary to highlight that as a subset of the axes of oppression characterized by gender, race, ethnicity, social class, and economic standing is the most vulnerable: children, who exist as a minority in a minority. Their unique requirements in the right to health discourse will now be addressed.
The Convention on the Rights of the Child

The risks faced by children, as a result of COVID-19, make the right to health, as constructed in the CRC, very relevant. As was stated by Henrietta Fore, the Executive Director of United Nations International Children’s Education Fund (UNICEF),

Not only are children and young people contracting COVID-19, they are also among its most severely impacted victims. Unless we act now to address the pandemic’s impacts on children, the echoes of COVID-19 will permanently damage our shared future. […] Prior to the COVID-19 crisis, 32 per cent of children worldwide with pneumonia symptoms were not being taken to a health provider. What will happen when COVID-19 hits in full force? We’re already seeing disruptions in immunization services, threatening outbreaks of diseases for which there already exists a vaccine, such as polio, measles and cholera.56

This demonstrates that the level of protection which ought to be afforded to children, outside of a pandemic, is not being realized. In reality, COVID-19 only shines a light on the gaps in protection and to the extent that these gaps negatively affect the right to access healthcare or the right to treatment itself, States are in contravention of their obligations under the CRC.

The CRC speaks to the right to health with a child-centric approach and the intersectionality of the rights of children and health is also seen in the numerous articulations of the right in the CRC. In fact, the CRC provides for the right to health in the context of care institutions;57 access to information related to physical and mental health;58 care for the disabled;59 and a general right to health and treatment of illness.60 This means that the components of the right to health which demand access to health information must be extended to children in their own unique context.

Based on a joint report by UNICEF, The World Health Organization, and the International Federation of the Red Cross, it was concluded that “having information and facts about COVID-19 will help diminish […] fears and anxieties around the disease and support their ability to cope with any secondary impacts in their lives.”61 To this end, it has been advanced that an effective tool in complying with the information dissemination component of the right to health relative to children is the use of technology to communicate and coordinate effectively.62 The uniqueness of the challenges faced by children in information gathering is that in most situations they receive the information through their parents in the form of secondary information. Therefore, the spread of misinformation via social media, by previously trusted news outlets, and through word-of-mouth serves only to increase parental anxiety and uncertainty.63 It is the duty of healthcare providers trained to understand evidence-based medicine to dissect and disseminate factual information to parents and families yearning for accurate health information.64

Therefore, in overcoming the obstacles faced by all other minorities, there will also be a transitive benefit which will inure to children among that group. That would also apply equally to persons who exist outside of the vulnerable groupings identified.
Conclusion

In looking at the international human rights treaty regime, it is possible to clearly see that the right to health includes the essential components of health education and public health dissemination of information. The role of public health communication is not only a component of the right to health in international law, but also reflects a legal duty imposed on States. This duty is not discretionary but mandatory and demands modification, depending on the group which is being targeted.

What can be seen is that the COVID-19 pandemic most significantly showed up the failure to “fulfil” the right. It is not that there is no access to healthcare simpliciter but that the structure of the society perpetuates a cycle in which some groups are more prone to contract the virus and possibly die. There is a clear recognition that the public health communication strategy and apparatus need to be aligned to the unique needs of the group being targeted with an understanding that a one-size-fits-all approach is not appropriate. When one examines the boundaries of the right embodied in treaty law and the practical application of its content in the COVID-19 pandemic, it can be concluded that there exists an entire layer of social victims who are precariously placed in harm’s way. Their placement is directly as a result of their vulnerability in society. As such, those who were meant to benefit from the right to health when it mattered most appear to be those who are completely forgotten.

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Author Biography

**Dr. Timothy Affonso** is the Dean (Acting) of the Faculty Law at the University of the West Indies (UWI), St. Augustine Campus. Before this appointment, he was the Deputy Dean (LLB and Programme Development) and Lecturer. He is an attorney-at-law with over 16 years’ experience in civil and criminal litigation. He holds a Bachelor of Laws Degree; a Legal Education Certificate from the Hugh Wooding Law School; a Masters of Law Degree in Public Law and Human Rights from the University College London and a Doctor of Philosophy in Public International Law and International Human Rights Law from the UWI, Cave Hill Campus. He also has a Post-Graduate Certificate, with Distinction in University Teaching.