The Veil of the COVID-19 Vaccination Certificates: Ignorance of Poverty, Injustice towards the Poor

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Socioeconomic disadvantages are amplified by the COVID-19 pandemic all over the world. Public actions and omissions severely affect the poor, alongside their precarious living, health and working conditions. As we slowly prepare for the aftermath of the pandemic, thanks to the progression of the vaccination, especially in developed countries, certain measures taken in this context, more specifically the 'vaccination certificates', are likely particularly to affect the poor, who usually also belong to other vulnerable groups such as ethnic minorities or single parents, and could eventually constitute for them a state of permanent quarantine. In this contribution, I argue that COVID-19 vaccination certificates are a slippery slope towards exclusion and stigmatisation of the poor through a bureaucratic system based on privileges which raises important questions in light of the fundamental rights of the people who reside at society's margins, struggling to conform to the 'phantom of normalcy'.

I. Introduction

As the COVID-19 vaccine rollout continues apace, and hope slowly returns that we are on our way back to some sort of 'normalcy,' many critical public health policy questions remain unanswered. One body of initiatives aimed at resuming normal life and raising concerns are the various vaccination certificates. These certificates would enable people to travel and access services upon presentation of a certificate showing that its bearer has been vaccinated. In some cases, an alternative would be to present a certificate of recovery (proving that the person has acquired some immunity) or a test certificate (proving that she has received a negative test result), valid only for a short period.[1] Some countries, such as Israel – the world champion of vaccination–with its digital green pass,[2] New York City with its digital vaccine pass,[3] and Denmark through it 'coronapas',[4]

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[1] See for example: Article 3(a) 'Proposal on a framework for the issuance, verification and acceptance of interoperable certificates on vaccination, testing and recovery to facilitate free movement during the COVID-19 pandemic (Digital Green Certificate)' COM(2021)130 final, Brussels, 17 March 2021.
[2] See the official website about the Greenpass: https://corona.health.gov.il/en/directives/green-pass-info/ [accessed 12 April 2021].
[3] See the official website about the Excelsior Pass: https://covid19vaccine.health.ny.gov/excelsior-pass [accessed 12 April 2021].
[4] Euronews, 'Denmark among first in Europe to introduce COVID pass scheme' (6 April 2021).

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have already implemented their own vaccine certificates. The EU is currently discussing the 'Digital Green Certificates' to facilitate free movement.[5]

In this context some authors have considered vaccine certificates as 'immediate policies that offer reasonable leeway for balancing protection of public health with a return to prepandemic life' and that 'current circumstances' demand.[6] It is difficult with this stance. If vaccination programmes are to protect the whole population, including the poor, the system of vaccination certificates itself is exclusionary, because of its difficult access for the least socioeconomically priviledged people who will not be able to return to prepandemic life (II). More specifically, I argue in this paper that the system of vaccination certificates is likely to put poor people in a perpetual state of lock down (III), discriminating against them (IV) and casting some serious doubts about its proportionality (V). Indeed, if by definition such a certificate system is based on privileges conferring special rights to the bearers, these privileges will in fact mainly be granted to socioeconomically privileged people who are more likely to get vaccinated, are not 'essential' workers likely to see the exercise of their job conditioned by such a certificate, have a stable legal status, are likely to encounter fewer difficulties in dealing with the administrative vagaries linked to the granting of such certificates etc., as the experience of the 'Green Pass' in Israel has already showed.[7]

The present contribution will mainly deal with the consequences of such certificates for the socioeconomically underprivileged within developed countries, where vaccination has been generally been much faster than in most developing countries, and where the introduction of such certificates is on policy agendas where they have not already been implemented. I will focus more specifically on EU countries and will also borrow some exemples from Israel, the US and the UK. Although I do not deal with it in my paper, it is important to bear in mind that such certificates also have important consequences in terms of global inequalities as they add barriers to migration and travel, especially between the poorer and richer world regions, an issue which is addressed by Martina Tazzioli and Jouni Häkli in the present special issue.[8]

II. Difficult access for the poor

Socioeconomically disadvantaged people are the most affected by the COVID-19 crisis due to higher exposure to the virus, which is in turn driven by a variety of socio-economic factors.[9] Several studies have shown the same phenomenon in the context of previous pandemics, such as the

[5] Proposal for a Digital Green Certificate regulation, supra note 1. On this proposal, see the contribution of Dimitry V. Kochenov and Jacquelyn D. Veraldi, 'The Commission against the internal market and EU citizens: Trying to shoot down Sputnik with the "Digital Green Certificate"?', in this issue.

[6] Mark A. Hall, David M. Studdert, 'Vaccine Passport' Certification – Policy and Ethical Considerations [2021] *NEJM*.

[7] Einat Albin et al., 'The Israeli "Green Pass": Promoting Vaccination from a Human Right and Equity Perspective', in the present issue.

[8] Martina Tazzioli and Jouni Häkli, in this special issue.

[9] Bo Burström, Wenjing Tao, 'Social determinants of health and inequalities in COVID-19' [2020] 30 *Eur. J. Public Health* 4, 617–618; Jay Patel, 'Poverty, inequality and COVID-19: the forgotten vulnerable' [2020] 183 *Public Health*, 110–111; Richard Blundell, 'COVID-19 and Inequalities' [2020] 41 *Fiscal Sudies* 2, 311-313; Clare Bambra et al., 'The COVID-19 pandemic and health inequalities' [2020] *J Epidemiol Community Health*, 1–5.

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Spanish flu of 1918, which mainly affected the working class whether that was in India, Norway or the United States.[10] It was no different with the H1N1 flu of 2009.[11]

First, socioeconomically disadvantaged people are among the 'at-risk' groups because of their over-representation among people suffering from cardiovascular disease, diabetes, cancer and chronic disease;[12]Second, their living conditions make them more vulnerable to the virus;[13] Third, when they are employed, these people are more commonly exposed to the virus because of the nature of their work;[14] Fourth, they have greater difficulty accessing the health system;[15] Fifth, measures taken by public authorities in the context of lockdown measures[16] have *de facto* hit people who live in cramped, unsanitary, overcrowded housing without green space more severely, including people who find themselves in social and human distress;[17] and, workers who are undeclared or hired in the informal sectors – overrepresented among irregular migrants – have been left without income and social protection. In addition, poor people have also been targeted by the police in terms of sanctions for non-compliance with lockdown[18] and and likely particularly to be affected by financial penalties for non-respect of the lockdown.[19]

Making a vaccination programme widely available constitutes an international obligation for public authorities, including under Article 12(2)c) of the International Covenant for Economic, Social and Cultural Rights, which enshrines the right to prevention, treatment and control of disease, including the implementation or enhancement of immunization programmes and other infectious

[10] Bambra et al., *supra* note 9, 1–5; Edgar Sydenstricker, 'The incidence of influenza among persons of different economic status during the epidemic of 1918: commentary' [1931] 36 *Public Health Reports* 4, 154-170.
[11] Bambra et al., *supra* note 9, 1–5.
[12] Bambra et al., *supra* note 9 ; Burström, Tao, *supra* note 9, 617–618.
[13] Bambra et al., *supra* note 9; Mohamed Buheji et al., 'The Extent of COVID-19 Pandemic Socioeconomic Impact on Global Poverty. A Global Integrative Multidisciplinary Review' [2020] 10 *Am. J. Econ.* 4, 220.
[14] Konstantinos Pouliakas, Jiri Branka, '*EU jobs at highest risk of Covid-19 social distancing: Is the pandemic exacerbating the labour market divide?'* [2020] Cedefop working paper; Lazaro Gamio, 'The Workers Who Face the Greatest Coronavirus Risk', *NYTimes* (15 March 2020).
[15] Virginia Hernanz et al., *'Take-up of Welfare Benefits in OECD countries: a review of the evidence'*, [2004] OECD Social, Employment and Migration Working papers no. 17; Ben Baumberg, The stigma of claiming benefits: A quantitative study [2016] 45 *J. Soc. Policy* 2, 181–199; Michael Fuchs et al., 'Falling through the social safety net? Analysing non-take-up of minimum income benefit and monetary social assistance in Austria' [2020] *Soc Policy Adm*. 54, 827– 843; Sylvain Chareyron, Patrick Domingues, 'Take-up of Social Assistance Benefits: the Case of the French Homeless' [2018] 64 *Rev. Income Wealth* 1, 170-191.
[16] Elisabeth Beaunoyer et al., 'COVID-19 and digital inequalities: Reciprocal impacts and mitigation strategies' [2020] 111 *Comput. Hum. Behav.*, 1-9; Mads Meier Jæger, Ea Hoppe Blaabæk, 'Inequality in learning opportunities during Covid-19: Evidence from library takeout' [2020] 68 *Res. Soc. Stratif. Mobil.*, 1-5.; Special Rapporteur on Extreme Poverty and Human Rights, *Looking Back to Look Ahead: A Rights-based Approach to Social Protection in the Post-COVID-19 Economic Recovery* [2020] United Nations, para. 44.
[17] Richard Armitage, Laura Nellums, 'The COVID-19 response must be disability inclusive' [2020] 5 *The Lancet*; Stéphanie Hennette-Vauchez, 'L'urgence (pas) pour tou(te)s'[2020] *La Revue des droits de l'homme*.
[18] Sophie Body-Gendrot, 'Police marginality, racial logics and discrimination in the banlieues of France' [2010] 33 *Ethn. Racial Stud.* 4, 656-674; Fabien Jobard et al., 'Mesurer les discriminations selon l'apparence: une analyse des contrôles d'identité à Paris' [2012] 3 *Population* 67, 423-451; Amnesty International, *Policing the Pandemic Human Rights Violations in the Enforcement of COVID-19 Measures in Europe* [2020] 5.
[19] Toby Helm et al., '£10,000 fines warning for failing to self-isolate as England Covid infections soar' *The Guardian* (20 September 2020).

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disease control strategies.[20] The European Committee for Social Rights has also recalled that 'States Parties must operate widely accessible immunization programmes. They must maintain high coverage rates not only to reduce the incidence of these diseases, but also to neutralize the reservoir of the virus and thus achieve the goals set by WHO to eradicate several infectious diseases'.[21] More generally, the ECtHR has recently recognised that 'vaccination is one of the most successful and cost-effective health interventions'[22] echoing the World Health Organization's (WHO) position on COVID-19 according to which 'vaccines are one of the most effective tools for protecting people against COVID-19'.[23]

Against this background, if vaccines against COVID-19 appear as an urgent and important remedy to protect the socioeconomically underprivileged people more heavily affected than the rest of the population, the vaccination certificates are likely to exclude them. The ways such certificates work and the conditions they impose differ from one country, city or region to another and many are still blurred and uncertain. However, before these certificates become a common practice all over the world, especially in developing countries, it is urgent to highlight the danger they present for the fundamental rights of the poor, who are less likely to gain access to and then benefit from such certificates. Indeed, poor people are among the sections of the population who are the least vaccinated,[24] not only because of practical and administrative obstacles[25], but also because of their higher vaccination hesitancy and their mistrust in the health system, which is partly explained by their experience of long-standing discrimination, as poor people usually belong to minorities and discriminated groups.[26] This is, for instance, the case for the Roma community in Hungary[27] but also black people in the UK[28] and the US,[29] and the Bedouin community in the South of Israel[30] in the context of COVID-19, confirming studies carried out previously according to which low-skilled and poor people tend to be less commonly vaccinated, although they are among the 'at-risk' groups.[31] In addition, many Western countries do not include irregular migrants in the

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[20] Article 12(2)c) International Covenant for Economic, Social and Cultural Rights and General Comment n°14 of the Committee on Economic, Social and Cultural Rights, *The right to the highest attainable standard of health* (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 [2000], para. 16. See also see Article 11(3)d) European Social Charter and European Committee for Social Rights

[21] European Social Charter and European Committee for Social Rights, Conclusions XV-2, Belgium, Article 11-3, 31 December 2001.

[22] *Vavricka and Others v. the Czech Republic* app no 47621/13 and five other applications (ECHR, 8 April 2021). para. 277.

[23] WHO, 'COVID-19 and mandatory vaccination: Ethical considerations and caveats', Policy brief, 13 April 2021.

[24] Patrick Peretti-Watel, 'Attitudes toward vaccination and the H1N1 vaccine: Poor people's unfounded fears or legitimate concerns of the elite?' [2014] 109 *Soc Sci Med,* 10-18.

[25] Dakota Gruener, 'Immunity Certificates: If We Must Have Them, We Must Do It Right' [2020] COVID-19 Rapid Response Impact Initiative - White Paper 12, Edmond J. Safra Centre for Ethics – Harvard University; Le défenseur des droits, *Les refus de soins opposés aux bénéficiaires de la CMU-C, de l'ACS et de l'AME*, [2014] 14.

[26] Vanessa Gamble, Under the shadow of Tuskegee: African Americans and health care [1997] 87 *Am J Public Health*, 1773-8.

[27] Marton Dunai, 'Falling like flies': Hungary's Roma community pleads for COVID help', *Reuters* (31 March 2021(.

[28] Mohammad Razai et al., 'Covid-19 vaccine hesitancy among ethnic minority groups (2021) 372 *BMJ* 513, 1-2.

[29] Laura Bogart et al., 'COVID-19 Related Medical Mistrust, Health Impacts, and Potential Vaccine Hesitancy Among Black Americans Living With HIV' [2021] 86 *J Acquir Immune Defic Syndr*. 2, 200-207.

[30] Albin et al., *supra* note 7.

[31] Elise Paul et al., 'Attitudes towards vaccines and intention to vaccinate against COVID-19: Implications for public health communications' [2021] *The Lancet Regional Health – Europe*, 1-5; Michaël Schwarzinger et al., 'COVID-19 vaccine hesitancy in a representative working-age population in France: a survey experiment based on vaccine

vaccination plans, making a whole group of people – already in the shadow – *de facto* out of any health protection.[32] Finally, the digital divide is another obstacle likely to make it difficult for the poor to access certificates.[33] Although, for the present these certificates appear to be being made available digitally and in paper, in the event that only the former form becomes the norm, poor people who do not have the necessary digital resources will not be able to use them.[34] Even if these certificates continue to be accessible on paper and digitally, other parts of the administrative process will normally be conducted online, which amounts to an additional obstacle. In other words, the lack of access to technology and digital skills is likely to perpetuate poverty, restricting social mobility[35] and, in the case of vaccination certificates, physical mobility *tout court*. All the above mentioned difficulties are likely to be persistent through time since repeated vaccinations may be required as the virus evolves, as explained by WHO.[36]

III. A perpetual state of lockdown for the poor

Most certificates are public in nature and cover cross-border travel for which poor people are less likely to be affected, especially within the EU, where tertiary graduates are generally more mobile than the rest of the population.[37] However, low-skilled people (more likely to be socioeconomically underprivileged), especially from Eastern Europe, still move across-borders.[38] Therefore, when they need to travel, these socioeconomically underprivileged people are likely to encounter more difficulties overcoming the barriers of the vaccination certificates, which derails their life or work projects, for the reasons I explained in the previous section: either because they are not vaccinated and/or because they were unable to get a vaccination certificates for administrative reasons.

More importantly, beyond the question of cross-border travel, the vaccination certificate is also likely to be used by public and private actors for other purposes, either because the law says so or because of gaps in the regulation regarding these certificates, as is the case in Israel regarding labour law: because there is no regulation or collective agreements dealing with the case of unvaccinated workers, some employers took advantage of this vacuum to place entry restrictions for their unvaccinated workers or even by terminating their employment contracts.[39] The fact that poor people are less likely to benefit from a certificate also carries with it the risk that they will be

characteristics' (2021) 6 *Lancet Public Health*, 210–21; Amy Schoenfeld Walker, 'Pandemic's Racial Disparities Persist in Vaccine Rollout' *NYTimes* (5 March 2021).

[32] PICUM, *The COVID-19 Vaccines and Undocumented Migrants: What are European countries doing?* [2021].

[33] Jan A.G.M. Van Dijk, Digital Divide: Impact of Access, in Patrick Rössler, Cynthia A. Hoffner and Liesbet Zoonen (eds.), The International Encyclopedia of Media Effects [2017]. It overlaps with a urban/rural divide and a age gap (Eurostat, 'Digital Economy and Digital Economy Statistics a Regional *Level'*, [2021]), as well as gender gap (ITUpublications, 'Measuring Digital Development, Facts and Figures' [2019]).

[34] Gruener *supra* note 25; Andrew Perrin, Erika Turner, 'Smartphones help blacks, Hispanics bridge some – but not all – digital gaps with whites' [2019] *Pew Research Center*.

[35] Jeffrey James, 'Confronting the scarcity of digital skills among the poor in developing countries' [2021] 39 *Dev Policy Rev*., 327-330 (concerning the question of smartphones in developing countries). As for an example of how the digital divide is likely to affect poverty, see: Isabella Mingo, Roberta Bracciale, 'The Matthew Effect in the Italian Digital Context: The Progressive Marginalisation of the "Poor"' [2018] *Soc Indic Res* 135, 629–659.

[36] WHO, *supra* note 23, 2.

[37] Eurostats, EU citizens living in another Member States – Statistical Overview [2021].

[38] *Ibid.*

[39] Albin et al., *supra* note 7.

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excluded from increasingly many services in society. Even more critically, if such certificates concern access to *certain* services – such as swimming pools, museums, restaurants, events, hairdressers, cinemas etc. – in most countries which have so far implemented this type of certificate, it is reasonable to fear that over time, such certificates will become more general: certificates are likely to be even more problematic if they are required to benefit from other services, such as nurseries, schools, social services, administrative services, supermarkets etc., with a deterrent effect on the most marginalized populations. As a matter of fact, whether limited to certain services or generally, the vaccination certificate system in Western societies amounts to an indirect vaccination obligation, imposing on those who are not in possession of such a certificate a perpetual state of lockdown.

Furthermore, aside from the question of how the scope of the certificates will disadvantage the poor, the certificate system itself raises the important issue of the 'non-take-up' phenomenon as regards the poor population. The 'non-take-up' phenomenon describes a situation where people who have rights on paper do not claim them or benefit from them in practice. Even where many private and public services remain available to people who do not possess certificates, they will still constitute an additional invisible barrier likely to drive people not to claim the social benefits and rights they are entitled to, exacerbating the phenomenon of 'non-take-up'. In 2004, there was between 40% to 80% of non-take-up in OECD countries and recent studies have shown that it remains very high.[40] This issue of 'non-take-up' has been confirmed in the context of the pandemic and the measures put in place by governments to help poor people because of complex procedures and bureaucratic jargon.[41] The causes of 'non-take-up' are diverse, including a lack of information, transparency, institutional barriers, the complexity of the procedures and stigma.[42] The difficulty of 'receiving' a certificate even once a person has been vaccinated should not be overlooked in light of the non-take-up issue. The administrative obstacles, especially for poor people are real and this administrative requirement might be a new barrier for them, especially when these certificates expire after a period, as they do in Israel. In addition, it has been shown that stigma plays a role in this non-take-up phenomenon,[43] and that such stigma is likely to be intensified for people who do not have a vaccination certificate – even where it is not required as such – likely to exacerbate the situation of 'non-take-up'.

IV. A discriminatory and stereotyping tool against the poor

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[40] See *supra* note 15.

[41] Special Rapporteur on Extreme Poverty and Human Rights *supra* note 16, para. 20.

[42] Administrative costs involving long periods spent queuing, filling forms, and obligations to report detailed information and provide extensive documentation to the welfare agencies appear to play an important role in non-take-up.

[43] While stigma plays a role, the literature seems divided on the magnitude of its impact. See Fuchs et al., *supra* note note 15. See also Hilke Kayser, Joachim Frick, 'Take it or leave it: (non-)take-up behavior of social assistance in Germany' [2000] 121 *J Appl Soc Sci* 1, 27–58; Jennifer Stube, Karl Kronebusch, 'Stigma and other determinants of participation in TANF and Medicaid' [2004] 23 *J Policy Anal Manag* 3, 509–530; Baumberg, *supra* note 15; Oliver Hümbelin, 'Non-Take-Up of Social Assistance: Regional Differences and the Role of Social Norms' [2019] 45 *Swiss Journal of Sociology* 1, 7–33 (claiming that stigma plays an important role) and see also Kerstin Bruckmeier and Jürgen Wiemers, 'A New targeting: a new take-up?'[2012] 43 *Empir Econ*, 565–580. Janet Currie, 'The Take-Up of Social Benefits' [2004] *IZA Discussion Papers*, No. 1103, Institute for the Study of Labor (claiming that stigma plays a role, but more more limited role).

Against this background, vaccination certificates are likely to discriminate against poor people, especially indirectly, since while they appear to be 'neutral' measures applied to the entire population, their consequences are much worse for the poor because they are overrepresented among people who will not be in possession of such a certificate, not only as regards their mobility, but more importantly regarding the access to services and rights as explained in the previous section. Moreover, where criminal and administrative sanctions can be imposed for the failure to obtain or present a certificate, as in Denmark, the fact that the rich and the poor have to pay the same fine might be regarded as indirect discrimination since it is likely to affect poor people much more than the more privileged classes, especially where custodial sentences are available in the case of non-payment, as in Germany, Switzerland or in the USA.[44]

Frthermore, poor people who are particularly affected by these vaccination certificates are likely to fall into situations of intersectional or additive discriminations:[45] poor families 'with a migration background',[46] single women and mothers overexposed to poverty and over-represented in low-paid jobs,[47] Roma, people of colors etc. In other words, people are likely to be discriminated against by the vaccination certificate system not only on the ground of their socioeconomic underprivileged situation, but also on the basis of other characteristics such as ethnic origin, race or gender which intersect or add up to their situation of precariousness. Indeed, one the one hand, 'status-based discrimination is frequently closely correlated with socioeconomic disadvantage'[48] since '[g]roups which suffer from discrimination on status grounds [gender, race …] are disproportionately represented among people living in poverty'.[49] On the other hand, poor people themselves are subjected to stereotyping, prejudice, stigma and discrimination because of their precarious situations.[50] In this regard, poverty is not only a consequence but also a cause of discrimination, creating a vicious cycle. As a matter of fact, an intersectional or additive approach of discrimination which includes, among others, status grounds related to the socioeconomic situation is particularly important when assessing the legality of the measures justified by public health protection in the context of the pandemic – especially the vaccination certificates –,

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[44] Motali Nagrecha, 'The Limits of Fairer Fines: Lessons From Germany' (Criminal Justice Policy Program, Harvard Law School, 2020). See also: *Lăcătuş v. Switzerland*, app no 14065/15 (ECHR, 19 January 2021). This question has been much more documented and researched in the United States: Neil L. Sobol, 'Charging the Poor: Criminal Justice Debt & Modern-Day Debtors' Prisons' [2016] 75 *Md L Rev* 486; Torie Atkinson, 'A Fine Scheme: How Municipal Fines Become Crushing Debt in the Shadow of the New Debtors' Prisons' [2016] 51 *Harv C R -C L L Rev* 189; Note, 'Fining the Indigent' (1971) 71 *Colum L Rev* 1281; Thomas B. Harvey, 'Jailing the Poor' [2017] 42 *Hum Rts* 16.

[45] Sarah Hannett, 'Equality at the Intersections: The Legislative and Judicial Failure to Tackle Multiple Discrimination' [2003] 23 *Oxf J Leg Stud*, 65; Kimberley Crenshaw, 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics' [1989] 8 *U Chi Legal F* 1, 139-167; Shreya Atrey, 'The Intersectional Case of Poverty in Discrimination law' [2018] 18 *Human Rights Law Review* 411.

[46] Lucinda Platt, Ross Warwick, 'Are some ethnic groups more vulnerable to COVID-19 than others?' [2020] *The IFS Deaton Review*.

[47] Hennette-Vauchez *supra* note 17.

[48] Sandra Fredman, 'Redistribution and Recognition: Reconciling Inequalities' [2007] 23 *S Afr J Hum Right,* 214-215.

[49] Sandra Fredman*,* 'The Potential and Limits of an Equal Rights Paradigm in Addressing Poverty' [2011] 3 *Stellenbosch Law Review* 567 .

[50] Sarah Ganty, 'Poverty as Misrecognition: What Role for Anti-discrimination Law in Europe?', *Human Rights Law Review* [2021] (forthcoming).

because it is a way to recognise that 'privilege and disadvantage migrate across identity categories'.[51]

More importantly, vaccination certificates also raise important issue of stereotyping and stigma against the poor. Many examples show that beyond the disadvantages that the poor and undereducated face, they are also victims of stereotyping and stigma, which can be defined as 'beliefs about the characteristics of groups of people' which are predominantly negative.[52] Stereotypes 'serve to maintain existing power relationships; they are control mechanisms. Stereotypes uphold a symbolic and real hierarchy between "us" and "them"'.[53] As for the COVID-19 situation more specifically, several reports have shown that the stereotyping of poor people and minorities is exacerbated in times of pandemic. Indeed, as Earnshaw explains, we tend to believe that bad things happen to people we view as 'bad', a phenomenon called the 'just-world fallacy'.[54] Many new manifestations of stereoptypes and discrimination have also been observed since the identification of COVID-19. Xenophobia was first directed against people regarded as having 'spread' the virus around the world.[55] Then, essential workers such as health workers and populations facing stereotypes and discrimination previously to the pandemic (e.g. people with HIV, sexual minorities, sex workers, migrants, Rom etc.) were subjected to further stereotypes and verbal and physical abuse.[56] These people are over-represented among socioeconomically disadvantaged populations and their socioeconomic situation contributes in turn to the stereotypes and prejudices of which they are victims. In this context, requirements for vaccination certificates are likely to exacerbate the stigmatisation and stereotyping of the poor, even when they have a certificate. The attitudes expressed in stereotypes and stigma towards them can also trigger and worsen their own mistrust and isolation, resulting in an even higher risk of 'non-take-up', putting in danger their health and the wellbeing of the society in general. Indeed, stigma and stereotypes during a pandemic pose a threat to everyone. Research on HIV, Ebola, Hansen's disease, Hepatitis B[57] and other infectious disease shows that stereotypes undermines efforts to find and treat diseases. People who fear being socially excluded if they are sick are less likely to get tested or seek treatment if they have symptoms,[58] and a vaccination certificate, whatever the extent of the obligations it represents, will act as a catalyst for this stigma, whether they are real or 'only' internalised by the most vulnerable groups of our society.

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[51] Martha Albertson Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' [2008] 20 *Yale J.L. & Feminism* 1, 21. As for the proportionality question, see below Section IV.

[52] Alexandra Timmer, 'Toward an Anti-Stereotyping Approach for the European Court of Human Rights' [2011] 11 *Human Rights Law Review* 4, 714.

[53] *Ibid.,* 715. See also: Human Rights Council United-Nations General Assembly, Final Draft of the Guiding Principles on Extreme Poverty and Human Rights, Submitted by the Special Rapporteur on Extreme Poverty and Human Rights, Magdalena Sepúlveda Carmona [2012] A/HRC/21/39, 4–8.

[54] Valery Earnshaw, 'Don't Let Fear of Covid-19 Turn into Stigma' [2020] *Harvard Business Review*; Lenore Manderson, Susan Levine, 'COVID-19, Risk, Fear, and Fall-out' [2020] 39 *Medical Anthropology* 5, 367-370.

[55] Amnesty international, 'Mesures prises face à la COVID-19 et obligations des états en matière de droits humains : observations préliminaires' [2020].

[56] UNAIDS, 'Addressing stigma and discrimination in the COVID-19 response' [2020]; Remus Creţan, Duncan Light, 'COVID-19 in Romania: transnational labour, geopolitics, and the Roma 'outsiders'' [2020] 61 *Eurasian Geogr. Econ.* 4-5, 559-572.

[57] Jolynne Mokaya J et al., 'A blind spot? Confronting the stigma of hepatitis B virus (HBV) infection - A systematic review' [2018] 21 *Wellcome Open Res* 3, 29.

[58] Earnshaw *supra* note 54.

V. Doubtful proportionality as regards the poor

The obligation to possess a vaccination certificate to gain access to public and private services, especially if it becomes general at some point, would make the situation of the poor untenable, especially if they become subject to fines, as in Denmark, for non-respect of such obligations.[59] The interference in the fundamental rights of these people is real and manyfold and raises many concerns, not only in terms of discrimination as previously explained, but also because it is likely to affect most of their rights – political, civil and socioeconomic.

In this context, the proportionality of vaccination certificates which conditions movement, but more importantly access to public and private services and work needs to be generally questioned.[60] Indeed, although the aim of protection of public health pursued by this system of certificates can certainly be considered legitimate, the need for such an indirect vaccination obligation to achieve this goal and its *stricto sensu* proportionality are far from obvious in light of the situation of socioeconomically underprivileged people: are all the activities conditioned by vaccination certificates likely to increase the public health risk if a section of the population participating in them are not vaccinated? If so, are there not less intrusive measures than certificates to achieve the same aim, for instance the combination of distancing policies and an information campaign on vaccination? Are most of the individuals reluctant to be vaccinated? When dealing with the question of the necessity of mandatory vaccination in general, the WHO stated that such an obligation should be imposed only 'if […] [it] would increase the prevention of significant risks of morbidity and mortality and/or promote significant and unequivocal public health benefits', if 'a substantial portion of individuals are able but unwilling to be vaccinated and this is likely to result in significant risks of harm' and after having tried to address the concerns of these persons proactively.[61] It is only in these circumstances, according to the WHO, that such an obligation 'may be considered "necessary" to achieve public health objectives'. As for the vaccination certificates system, as an indirect obligation of vaccination, the conditions stated by the WHO have not been demonstrated so far, which casts important doubts on the proportionality of such a system. In addition, beyond the certificate system itself, there remains some doubts about the vaccines themselves, as recalled by the WHO: 'a number of scientific unknowns remain concerning the effectiveness of COVID-19 vaccines: efficacy in preventing disease and limiting transmission, including for variants of SARS-CoV-2; duration of protection offered by vaccination; timing of booster doses; whether vaccination offers protection against asymptomatic infection […]'.[62] In short the vaccination certificate system is even more questionable as there is incomplete data available showing that making COVID-19 vaccination indirectly mandatory through the system of certificates would actually achieve the goal of protecting public health. As a consequence, giving the importance of the rights at stake and the potential disastrous consequences for the poor,

[59] The fine imposed amounts to EUR 330.

[60] Aharon Barak, *Proportionality, Constitutional Rights and their Limitations* [2012] 131; Vicky Jackson, 'Proportionality and Equality' in Vicky Jackson and Mark Tushnet (eds.), *Proportionality and Equality in Proportionality, New Frontiers, New Challenges* [2017] 175.

[61] WHO, *supra* note 23, 2.

[62] WHO, Interim position paper: considerations regarding proof of COVID-19 vaccination for international travellers, 5 February 2021. In the same vein, the organization has opposed the immunity certification: Teck Chuan Voo et al., 'Immunity certification for COVID-19: ethical considerations' [2020] *Bulletin of the World Health Organiz*ation.

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it is doubtful that the benefits – if any – of such a certificates system for society outweigh the individual costs for precarious people.

A recent judgment by the European Court of Human Rights (ECtHR) has dealt with this question of proportionality – although only in light of the right to a private and family life (Article 8 ECHR) – in the context of the compulsory administration of nine different vaccines for children in the Czech Republic. Parents who did not comply were respectively fined and prohibited from benefiting from nursery services for their kids.[63] In other words, the case concerned the indirect obligations to be vaccinated – i.e. obligations which do not directly impose an involuntary medical treatment[64] – such as in the case of a vaccination certificate. The Court judged that such measures did not violate the right to private and family life, without engaging with the questions raised under the right to education and the freedom of thought, conscience and religion.[65] The ECtHR appears to leave a very wide margin of appreciation to the states. As critical commentators have pointed out, as well as Judge Wojtyczek in his dissenting opinion, if it is important for the Court to take a strong stance about vaccination, its decision is mainly based on 'strong value judgments without a sufficient factual basis'[66] and its reasoning lacks coherence,[67] especially as to the necessity of the sanctions imposed on parents in light of the aim of public health protection.

This case cannot be entirely transposed to the vaccination certificate system, however, as it mainly concerned the protection of very young children: the best-interests of the child was central to this case, while it has been shown that children are barely affected by COVID-19. Moreover, this ruling was only limited to nurseries – the fact that schools were not concerned played an important role in the Court's reasoning in light of the concept of 'social solidarity' – i.e. not contaminating other children. In addition, the Court did not tackle the flip-side of the social solidarity aspect: the parents' poverty is likely to be significantly affected by fines or the fact that nursery care was rendered unavailable to them, but this question was unfortunately marginal in the arguments brought by the applicant.[68] As a consequence, the question of conditioning the fundamental rights of the poor through an indirect vaccination obligation remains open before the ECtHR. In any case, this judgement cannot be interpreted by the Council of Europe Member States as a green light to condition work, public and private services to the possession of such certificates, especially when it comes to socioeconomically underprivileged people, since the proportionality of such measures could be seriously questioned, as I have just explained.

VI. Conclusion

As Hershkoof and Cohen rightly put, 'Society tries to impose on poor people – as it does on all those whom it stigmatizes – implicit conditions on how they may relate to members of the

[63] *Vavřička and Others v. the Czech Republic supra* note 22.
[64] The margin of appreciation of the state is also wide when it comes to a direct compulsory vaccination, though: *Solomakhin v. Ukraine* app no 24429/03 (ECHR, 15 March 2012); *Boffa and others v. San-Marino* app no 26536/95 (ECHR,15 January 1998).
[65] *Vavřička and Others v. the Czech Republic supra* note 22.
[66] Disstenting opinion of Judge Wojtyczek in *Vavřička and Others v. the Czech Republic supra* note 22, para. 18.
[67] Zuzana Vikarská, 'Is Compulsary Vaccination Compulsary?', *VerfBlog*, (12 April 2021).
[68] *Vavřička and Others v. the Czech Republic supra* note 22, para 162.

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mainstream'.[69] Vaccination certificates constitute the paradigmatic example of such 'phantom normalcy',[70] which is likely to have important consequences for poor people already weakened by the pandemic, thus further crystalizing their underprivileged status. In this situation, it is essential that in their assessment of the proportionality of the certificates – especially under the necessity test – courts take into account the situation of these people who are made increasingly 'invisible' and might be condemned to live in a permanent state of lockdown, parked in their shelters. As recalled by the UN Committee on Economic, Social and Cultural Rights, there is a clear link between fundamental rights in general and the right to health: 'The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights […] These and other rights and freedoms address integral components of the right to health'.[71] In other words, we cannot consider the right to health in a *vacuum* since all the other fundamental rights – including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement – are essential to the realisation and respect of the right to health. As a consequence, in the case of people less likely to be vaccinated and to get the vaccination certificates, whether it is for accessibility, administrative, hesitancy, mistrust or other reasons, it is essential for public authorities to take into account the exclusionary dimension that the lack of vaccination certificate will have, especially for vulnerable socioeconomically disadvantaged groups who have a long history of discrimination, because it raises issues under many of their fundamental rights directly linked to their right to health. In any case, instead of putting effort, energy and money in developing exclusionary and discriminatory measures like the vaccination certificates, it seems to me much more constructive and productive to put in place a programme of prevention and education to combat COVID-19, including through vaccination.

Arundhati Roy has powerfully written: 'Historically, pandemics have forced humans to break with the past and imagine their world anew […] We can choose to walk through it, dragging the carcasses of our prejudice and hatred, our avarice, our data banks and dead ideas, our dead rivers and smoky skies behind us. Or we can walk through lightly, with little luggage, ready to imagine another world. And ready to fight for it'.[72] Sadly, by adopting this vaccination certificates system, the most powerful people in this world seemed to have opted for the first option, the perpetuation of inequalities and stigma, against the margins of our society.

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[69] Helen Hershkoff, Adam S. Cohen, 'The First Amendment and the Right to Beg' [1991 104 *Harv. L. Rev.* 4, 912.
[70] See references note 40 above.
[71] Comment n°14 of the Committee on Economic, Social and Cultural Rights *supra* note 20 para. 3.
[72] Arundhati Roy, 'The pandemic is a portal', *Financial Times* (3 avril 2020).