Introduction

We all have been affected by the current COVID-19 pandemic. However, the impact of the pandemic and its consequences are felt differently depending on our status as individuals and as members of society. While some try to adapt to working online, homeschooling their children and ordering food via Instacart, others have no choice but to be exposed to the virus while keeping society functioning. Our different social identities and the social groups we belong to determine our inclusion within society and, by extension, our vulnerability to epidemics.

COVID-19 is killing people on a large scale. As of October 10, 2020, more than 7.7 million people across every state in the United States and its four territories had tested positive for COVID-19. According to the *New York Times* database, at least 213,876 people with the virus have died in the United States.[1] However, these alarming numbers give us only half of the picture; a closer look at data by different social identities (such as class, gender, age, race, and medical history) shows that minorities have been disproportionally affected by the pandemic. These minorities in the United States are not having their right to health fulfilled.

According to the World Health Organization's report *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, "poor and unequal living conditions are the consequences of deeper structural conditions that together fashion the way societies are organized—poor social policies and programs, unfair economic arrangements, and bad politics."[2] This toxic combination of factors as they play out during this time of crisis, and as early news on the effect of the COVID-19 pandemic pointed out, is disproportionately affecting African American communities in the United States. I recognize that the pandemic has had and is having devastating effects on other minorities as well, but space does not permit this essay to explore the impact on other minority groups.

Employing a human rights lens in this analysis helps us translate needs and social problems into rights, focusing our attention on the broader sociopolitical structural context as the cause of the social problems. Human rights highlight the inherent dignity and worth of all people, who are the primary rights-holders.[3] Governments (and other social actors, such as

corporations) are the duty-bearers, and as such have the obligation to respect, protect, and fulfill human rights.[4] Human rights cannot be separated from the societal contexts in which they are recognized, claimed, enforced, and fulfilled. Specifically, social rights, which include the right to health, can become important tools for advancing people's citizenship and enhancing their ability to participate as active members of society.[5] Such an understanding of social rights calls our attention to the concept of equality, which requires that we place a greater emphasis on "solidarity" and the "collective."[6] Furthermore, in order to generate equality, solidarity, and social integration, the fulfillment of social rights is not optional.[7] In order to fulfill social integration, social policies need to reflect a commitment to respect and protect the most vulnerable individuals and to create the conditions for the fulfillment of economic and social rights for all.

Disproportional impact of COVID-19 on African Americans

As noted by Samuel Dickman et al.:

economic inequality in the US has been increasing for decades and is now among the highest in developed countries ... As economic inequality in the US has deepened, so too has inequality in health. Both overall and government health spending are higher in the US than in other countries, yet inadequate insurance coverage, high-cost sharing by patients, and geographical barriers restrict access to care for many.[8]

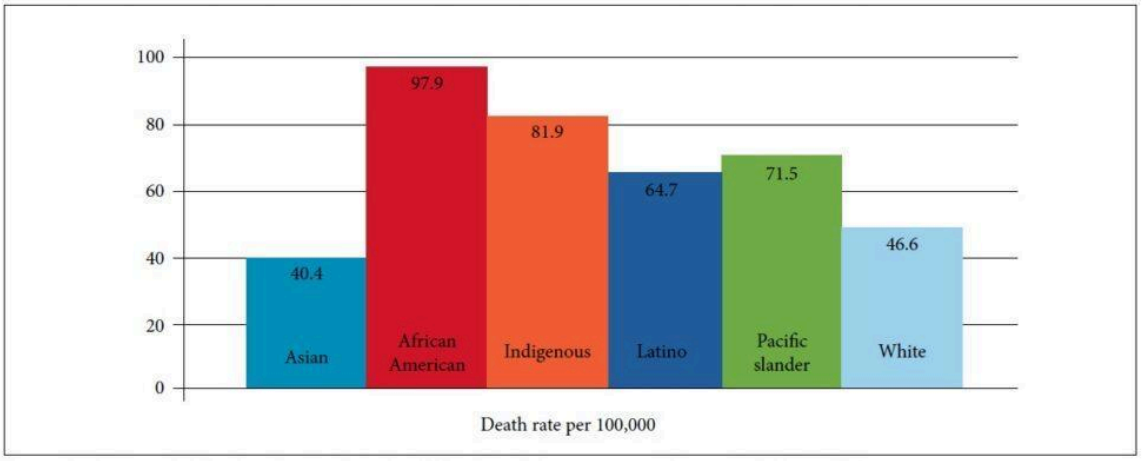
For instance, according to the Kaiser Family Foundation, in 2018, 11.7% of African Americans in the United States had no health insurance, compared to 7.5% of whites.[9]

Prior to the Affordable Care Act—enacted into law in 2010—about 20% of African Americans were uninsured. This act helped lower the uninsured rate among nonelderly African Americans by more than one-third between 2013 and 2016, from 18.9% to 11.7%. However, even after the law's passage, African Americans have higher uninsured rates than whites (7.5%) and Asian Americans (6.3%).[10] The uninsured are far more likely than the insured to forgo needed medical visits, tests, treatments, and medications because of cost.

As the COVID-19 virus made its way throughout the United States, testing kits were distributed equally among labs across the 50 states, without consideration of population density or actual needs for testing in those states. An opportunity to stop the spread of the virus during its early stages was missed, with serious consequences for many Americans. Although there is a dearth of race-disaggregated data on the number of people tested, the data that are available highlight African Americans' overall lack of access to testing. For example, in Kansas, as of June 27, according to the COVID Racial Data Tracker, out of 94,780 tests, only 4,854 were from black Americans and 50,070 were from whites. However, blacks make up almost a third of the state's COVID-19 deaths (59 of 208). And while in Illinois the total numbers of confirmed cases among blacks and whites were almost even, the test numbers show a different picture: 220,968 whites were tested, compared to only 78,650 blacks.[11]

Similarly, American Public Media reported on the COVID-19 mortality rate by race/ethnicity through July 21, 2020, including Washington, DC, and 45 states (see figure 1). These data, while showing an alarming death rate for all races, demonstrate how minorities are hit harder and how, among minority groups, the African American population in many states bears the brunt of the pandemic's health impact.

FIGURE 1. COVID-19 deaths per 100,000 people by race/ethnicity, through September 10, 2020



Source: APM Research Lab, September 10, 2020. Available at https://www.apmresearchlab.org/COVID/deaths-by-race.

Approximately 97.9 out of every 100,000 African Americans have died from COVID-19, a mortality rate that is a third higher than that for Latinos (64.7 per 100,000), and more than double than that for whites (46.6 per 100,000) and Asians (40.4 per 100,000). The

overrepresentation of African Americans among confirmed COVID-19 cases and number of deaths underscores the fact that the coronavirus pandemic, far from being an equalizer, is amplifying or even worsening existing social inequalities tied to race, class, and access to the health care system.

Considering how African Americans and other minorities are overrepresented among those getting infected and dying from COVID-19, experts recommend that more testing be done in minority communities and that more medical services be provided.[12] Although the law requires insurers to cover testing for patients who go to their doctor's office or who visit urgent care or emergency rooms, patients are fearful of ending up with a bill if their visit does not result in a COVID test. Furthermore, minority patients who lack insurance or are underinsured are less likely to be tested for COVID-19, even when experiencing alarming symptoms. These inequitable outcomes suggest the importance of increasing the number of testing centers and contact tracing in communities where African Americans and other minorities reside; providing testing beyond symptomatic individuals; ensuring that high-risk communities receive more health care workers; strengthening social provision programs to address the immediate needs of this population (such as food security, housing, and access to medicines); and providing financial protection for currently uninsured workers.

Social determinants of health and the pandemic's impact on African Americans' health outcomes

In international human rights law, the right to health is a claim to a set of social arrangements—norms, institutions, laws, and enabling environment—that can best secure the enjoyment of this right. The International Covenant on Economic, Social and Cultural Rights sets out the core provision relating to the right to health under international law (article 12).[13] The United Nations Committee on Economic, Social and Cultural Rights is the body responsible for interpreting the covenant.[14] In 2000, the committee adopted a general comment on the right to health recognizing that the right to health is closely related to and dependent on the realization of other human rights.[15] In addition, this general comment interprets the right to health as an inclusive right extending not only to timely and appropriate health care but also to the determinants of health.[16] I will reflect on four determinants of

health—racism and discrimination, poverty, residential segregation, and underlying medical conditions—that have a significant impact on the health outcomes of African Americans.

Racism and discrimination

In spite of growing interest in understanding the association between the social determinants of health and health outcomes, for a long time many academics, policy makers, elected officials, and others were reluctant to identify racism as one of the root causes of racial health inequities.[17] To date, many of the studies conducted to investigate the effect of racism on health have focused mainly on interpersonal racial and ethnic discrimination, with comparatively less emphasis on investigating the health outcomes of structural racism.[18] The latter involves interconnected institutions whose linkages are historically rooted and culturally reinforced.[19] In the context of the COVID-19 pandemic, acts of discrimination are taking place in a variety of contexts (for example, social, political, and historical). In some ways, the pandemic has exposed existing racism and discrimination.

Poverty (low-wage jobs, insurance coverage, homelessness, and jails and prisons)

Data drawn from the 2018 Current Population Survey to assess the characteristics of low-income families by race and ethnicity shows that of the 7.5 million low-income families with children in the United States, 20.8% were black or African American (while their percentage of the population in 2018 was only 13.4%).[20] Low-income racial and ethnic minorities tend to live in densely populated areas and multigenerational households. These living conditions make it difficult for low-income families to take necessary precautions for their safety and the safety of their loved ones on a regular basis.[21] This fact becomes even more crucial during a pandemic.

Low-wage jobs: The types of work where people in some racial and ethnic groups are overrepresented can also contribute to their risk of getting sick with COVID-19. Nearly 40% of African American workers, more than seven million, are low-wage workers and have jobs that deny them even a single paid sick day. Workers without paid sick leave might be more

likely to continue to work even when they are sick.[22] This can increase workers' exposure to other workers who may be infected with the COVID-19 virus.

Similarly, the Centers for Disease Control has noted that many African Americans who hold low-wage but essential jobs (such as food service, public transit, and health care) are required to continue to interact with the public, despite outbreaks in their communities, which exposes them to higher risks of COVID-19 infection. According to the Centers for Disease Control, nearly a quarter of employed Hispanic and black or African American workers are employed in service industry jobs, compared to 16% of non-Hispanic whites. Blacks or African Americans make up 12% of all employed workers but account for 30% of licensed practical and licensed vocational nurses, who face significant exposure to the coronavirus.[23]

In 2018, 45% of low-wage workers relied on an employer for health insurance. This situation forces low-wage workers to continue to go to work even when they are not feeling well. Some employers allow their workers to be absent only when they test positive for COVID-19. Given the way the virus spreads, by the time a person knows they are infected, they have likely already infected many others in close contact with them both at home and at work.[24]

Homelessness: Staying home is not an option for the homeless. African Americans, despite making up just 13% of the US population, account for about 40% of the nation's homeless population, according to the Annual Homeless Assessment Report to Congress.[25] Given that people experiencing homelessness often live in close quarters, have compromised immune systems, and are aging, they are exceptionally vulnerable to communicable diseases—including the coronavirus that causes COVID-19.

Jails and prisons: Nearly 2.2 million people are in US jails and prisons, the highest rate in the world. According to the US Bureau of Justice, in 2018, the imprisonment rate among black men was 5.8 times that of white men, while the imprisonment rate among black women was 1.8 times the rate among white women.[26] This overrepresentation of African Americans in

US jails and prisons is another indicator of the social and economic inequality affecting this population.

According to the Committee on Economic, Social and Cultural Rights' General Comment 14, "states are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons—including prisoners or detainees, minorities, asylum seekers and illegal immigrants—to preventive, curative, and palliative health services."[27] Moreover, "states have an obligation to ensure medical care for prisoners at least equivalent to that available to the general population."[28] However, there has been a very limited response to preventing transmission of the virus within detention facilities, which cannot achieve the physical distancing needed to effectively prevent the spread of COVID-19.[29]

Residential segregation

Segregation affects people's access to healthy foods and green space. It can also increase excess exposure to pollution and environmental hazards, which in turn increases the risk for diabetes and heart and kidney diseases.[30] African Americans living in impoverished, segregated neighborhoods may live farther away from grocery stores, hospitals, and other medical facilities.[31] These and other social and economic inequalities, more so than any genetic or biological predisposition, have also led to higher rates of African Americans contracting the coronavirus. To this effect, sociologist Robert Sampson states that the coronavirus is exposing class and race-based vulnerabilities. He refers to this factor as "toxic inequality," especially the clustering of COVID-19 cases by community, and reminds us that African Americans, even if they are at the same level of income or poverty as white Americans or Latino Americans, are much more likely to live in neighborhoods that have concentrated poverty, polluted environments, lead exposure, higher rates of incarceration, and higher rates of violence.[32]

Many of these factors lead to long-term health consequences. The pandemic is concentrating in urban areas with high population density, which are, for the most part, neighborhoods where marginalized and minority individuals live. In times of COVID-19, these

concentrations place a high burden on the residents and on already stressed hospitals in these regions. Strategies most recommended to control the spread of COVID-19—social distancing and frequent hand washing—are not always practical for those who are incarcerated or for the millions who live in highly dense communities with precarious or insecure housing, poor sanitation, and limited access to clean water.

Underlying health conditions

African Americans have historically been disproportionately diagnosed with chronic diseases such as asthma, hypertension and diabetes—underlying conditions that may make COVID-19 more lethal. Perhaps there has never been a pandemic that has brought these disparities so vividly into focus.

Doctor Anthony Fauci, an immunologist who has been the director of the National Institute of Allergy and Infectious Diseases since 1984, has noted that "it is not that [African Americans] are getting infected more often. It's that when they do get infected, their underlying medical conditions … wind them up in the ICU and ultimately give them a higher death rate."[33]

One of the highest risk factors for COVID-19-related death among African Americans is hypertension. A recent study by Khansa Ahmad et al. analyzed the correlation between poverty and cardiovascular diseases, an indicator of why so many black lives are lost in the current health crisis. The authors note that the American health care system has not yet been able to address the higher propensity of lower socioeconomic classes to suffer from cardiovascular disease.[34] Besides having higher prevalence of chronic conditions compared to whites, African Americans experience higher death rates. These trends existed prior to COVID-19, but this pandemic has made them more visible and worrisome.

Addressing the impact of COVID-19 on African Americans: A human rights-based approach

The racially disparate death rate and socioeconomic impact of the COVID-19 pandemic and the discriminatory enforcement of pandemic-related restrictions stand in stark contrast to the

United States' commitment to eliminate all forms of racial discrimination. In 1965, the United States signed the International Convention on the Elimination of All Forms of Racial Discrimination, which it ratified in 1994. Article 2 of the convention contains fundamental obligations of state parties, which are further elaborated in articles 5, 6, and 7.[35] Article 2 of the convention stipulates that "each State Party shall take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists" and that "each State Party shall prohibit and bring to an end, by all appropriate means, including legislation as required by circumstances, racial discrimination by any persons, group or organization."[36]

Perhaps this crisis will not only greatly affect the health of our most vulnerable community members but also focus public attention on their rights and safety—or lack thereof. Disparate COVID-19 mortality rates among the African American population reflect longstanding inequalities rooted in systemic and pervasive problems in the United States (for example, racism and the inadequacy of the country's health care system). As noted by Audrey Chapman, "the purpose of a human right is to frame public policies and private behaviors so as to protect and promote the human dignity and welfare of all members and groups within society, particularly those who are vulnerable and poor, and to effectively implement them."[37] A deeper awareness of inequity and the role of social determinants demonstrates the importance of using right to health paradigms in response to the pandemic.

The Committee on Economic, Social and Cultural Rights has proposed some guidelines regarding states' obligation to fulfill economic and social rights: availability, accessibility, acceptability, and quality. These four interrelated elements are essential to the right to health. They serve as a framework to evaluate states' performance in relation to their obligation to fulfill these rights. In the context of this pandemic, it is worthwhile to raise the following questions: What can governments and nonstate actors do to avoid further marginalizing or stigmatizing this and other vulnerable populations? How can health justice and human rights-based approaches ground an effective response to the pandemic now and build a better world afterward? What can be done to ensure that responses to COVID-19 are respectful of

the rights of African Americans? These questions demand targeted responses not just in treatment but also in prevention. The following are just some initial reflections:

First, we need to keep in mind that treating people with respect and human dignity is a fundamental obligation, and the first step in a health crisis. This includes the recognition of the inherent dignity of people, the right to self-determination, and equality for all individuals. A commitment to cure and prevent COVID-19 infections must be accompanied by a renewed commitment to restore justice and equity.

Second, we need to strike a balance between mitigation strategies and the protection of civil liberties, without destroying the economy and material supports of society, especially as they relate to minorities and vulnerable populations. As stated in the Siracusa Principles, "[state restrictions] are only justified when they support a legitimate aim and are: provided for by law, strictly necessary, proportionate, of limited duration, and subject to review against abusive applications."[38] Therefore, decisions about individual and collective isolation and quarantine must follow standards of fair and equal treatment and avoid stigma and discrimination against individuals or groups. Vulnerable populations require direct consideration with regard to the development of policies that can also protect and secure their inalienable rights.

Third, long-term solutions require properly identifying and addressing the underlying obstacles to the fulfillment of the right to health, particularly as they affect the most vulnerable. For example, we need to design policies aimed at providing universal health coverage, paid family leave, and sick leave. We need to reduce food insecurity, provide housing, and ensure that our actions protect the climate. Moreover, we need to strengthen mental health and substance abuse services, since this pandemic is affecting people's mental health and exacerbating ongoing issues with mental health and chemical dependency. As noted earlier, violations of the human rights principles of equality and nondiscrimination were already present in US society prior to the pandemic. However, the pandemic has caused "an unprecedented combination of adversities which presents a serious threat to the mental health of entire populations, and especially to groups in vulnerable situations."[39] As Dainius Pūras has noted, "the best way to promote good mental health is to invest in

protective environments in all settings."[40] These actions should take place as we engage in thoughtful conversations that allow us to assess the situation, to plan and implement necessary interventions, and to evaluate their effectiveness.

Finally, it is important that we collect meaningful, systematic, and disaggregated data by race, age, gender, and class. Such data are useful not only for promoting public trust but for understanding the full impact of this pandemic and how different systems of inequality intersect, affecting the lived experiences of minority groups and beyond. It is also important that such data be made widely available, so as to enhance public awareness of the problem and inform interventions and public policies.

Conclusion

In 1966, Dr. Martin Luther King Jr. said, "Of all forms of inequality, injustice in health is the most shocking and inhuman."[41] More than 54 years later, African Americans still suffer from injustices that are at the basis of income and health disparities. We know from previous experiences that epidemics place increased demands on scarce resources and enormous stress on social and economic systems.

A deeper understanding of the social determinants of health in the context of the current crisis, and of the role that these factors play in mediating the impact of the COVID-19 pandemic on African Americans' health outcomes, increases our awareness of the indivisibility of all human rights and the collective dimension of the right to health. We need a more explicit equity agenda that encompasses both formal and substantive equality.[42] Besides nondiscrimination and equality, participation and accountability are equally crucial.

Unfortunately, as suggested by the limited available data, African American communities and other minorities in the United States are bearing the brunt of the current pandemic. The COVID-19 crisis has served to unmask higher vulnerabilities and exposure among people of color. A thorough reflection on how to close this gap needs to start immediately. Given that the COVID-19 pandemic is more than just a health crisis—it is disrupting and affecting every aspect of life (including family life, education, finances, and agricultural production)—it

requires a multisectoral approach. We need to build stronger partnerships among the health care sector and other social and economic sectors. Working collaboratively to address the many interconnected issues that have emerged or become visible during this pandemic—particularly as they affect marginalized and vulnerable populations—offers a more effective strategy.

Moreover, as Delan Devakumar et al. have noted:

the strength of a healthcare system is inseparable from broader social systems that surround it. Health protection relies not only on a well-functioning health system with universal coverage, which the US could highly benefit from, but also on social inclusion, justice, and solidarity. In the absence of these factors, inequalities are magnified and scapegoating persists, with discrimination remaining long after.[43]

This current public health crisis demonstrates that we are all interconnected and that our well-being is contingent on that of others. A renewed and healthy society is possible only if governments and public authorities commit to reducing vulnerability and the impact of ill-health by taking steps to respect, protect, and fulfill the right to health.[44] It requires that government and nongovernment actors establish policies and programs that promote the right to health in practice.[45] It calls for a shared commitment to justice and equality for all.

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References

[1] "Coronavirus in the U.S.: Latest map and case count," *New York Times* (October 10, 2020). Available at https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html.

[2] World Health Organization Commission on the Social Determinants of Health, *Closing the gap in a generation: Health equity through action on the social determinants of health* (Geneva: World Health Organization, 2008), p. 1.

[3] S. Hertel and L. Minkler, *Economic rights: Conceptual, measurement, and policy issues* (New York: Cambridge University Press, 2007); S. Hertel and K. Libal, *Human rights in the United States: Beyond exceptionalism* (Cambridge: Cambridge University Press, 2011); D. Forsythe, *Human rights in international relations*, 2nd edition (Cambridge: Cambridge University Press, 2006).

[4] Danish Institute for Human Rights, *National action plans on business and human rights* (Copenhagen: Danish Institute for Human Rights, 2014).

[5] J. R. Blau and A. Moncada, *Human rights: Beyond the liberal vision* (Lanham, MD: Rowman and Littlefield, 2005).

[6] J. R. Blau. "Human rights: What the United States might learn from the rest of the world and, yes, from American sociology," *Sociological Forum* 31/4 (2016), pp. 1126–1139; K. G. Young and A. Sen, *The future of economic and social rights* (New York: Cambridge University Press, 2019).

[7] Young and Sen (see note 6).

[8] S. Dickman, D. Himmelstein, and S. Woolhandler, “Inequality and the health-care system in the USA,” *Lancet*, 389/10077 (2017), p. 1431.

[9] S. Artega, K. Orgera, and A. Damico, “Changes in health insurance coverage and health status by race and ethnicity, 2010–2018 since the ACA,” *KFF* (March 5, 2020). Available at https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/.

[10] H. Sohn, “Racial and ethnic disparities in health insurance coverage: Dynamics of gaining and losing coverage over the life-course,” *Population Research and Policy Review* 36/2 (2017), pp. 181–201.

[11] Atlantic Monthly Group, *COVID tracking project*. Available at https://covidtracking.com.

[12] “Why the African American community is being hit hard by COVID-19,” *Healthline* (April 13, 2020). Available at https://www.healthline.com/health-news/covid-19-affecting-people-of-color#What-can-be-done?.

[13] World Health Organization, *25 questions and answers on health and human rights* (Albany: World Health Organization, 2002).

[14] Ibid; Hertel and Libal (see note 3).

[15] Ibid.

[16] Ibid.

[17] Z. Bailey, N. Krieger, M. Agénor et al., “Structural racism and health inequities in the USA: Evidence and interventions,” *Lancet* 389/10077 (2017), pp. 1453–1463.

[18] Ibid.

[19] Ibid.

[20] US Census. Available at https://www.census.gov/library/publications/2019/demo/p60-266.html.

[21] M. Simms, K. Fortuny, and E. Henderson, *Racial and ethnic disparities among low-income families* (Washington, D.C.: Urban Institute Publications, 2009).

[22] Ibid.

[23] Centers for Disease Control and Prevention, *Health Equity Considerations and Racial and Ethnic Minority Groups* (2020). Available at https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.

[24] Artega et al. (see note 9).

[25] K. Allen, "More than 50% of homeless families are black, government report finds," *ABC News* (January 22, 2020). Available at https://abcnews.go.com/US/50-homeless-families-black-government-report-finds/story?id=68433643.

[26] A. Carson, *Prisoners in 2018* (US Department of Justice, 2020). Available at https://www.bjs.gov/content/pub/pdf/p18.pdf.

[27] United Nations Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000).

[28] J. J. Amon, "COVID-19 and detention," *Health and Human Rights* 22/1 (2020), pp. 367–370.

[29] Ibid.

[30] L. Pirtle and N. Whitney, “Racial capitalism: A fundamental cause of novel coronavirus (COVID-19) pandemic inequities in the United States,” *Health Education and Behavior* 47/4 (2020), pp. 504–508.

[31] Ibid; R. Sampson, “The neighborhood context of well-being,” *Perspectives in Biology and Medicine* 46/3 (2003), pp. S53–S64.

[32] C. Walsh, “Covid-19 targets communities of color,” *Harvard Gazette* (April 14, 2020). Available at https://news.harvard.edu/gazette/story/2020/04/health-care-disparities-in-the-age-of-coronavirus/.

[33] B. Lovelace Jr., “White House officials worry the coronavirus is hitting African Americans worse than others,” *CNBC News* (April 7, 2020). Available at https://www.cnbc.com/2020/04/07/white-house-officials-worry-the-coronavirus-is-hitting-african-americans-worse-than-others.html.

[34] K. Ahmad, E. W. Chen, U. Nazir, et al., “Regional variation in the association of poverty and heart failure mortality in the 3135 counties of the United States,” *Journal of the American Heart Association* 8/18 (2019).

[35] D. Desierto, “We can’t breathe: UN OHCHR experts issue joint statement and call for reparations” (EJIL Talk), *Blog of the European Journal of International Law* (June 5, 2020). Available at https://www.ejiltalk.org/we-cant-breathe-un-ohchr-experts-issue-joint-statement-and-call-for-reparations/.

[36] International Convention on the Elimination of All Forms of Racial Discrimination, G. A. Res. 2106 (XX) (1965), art. 2.

[37] A. Chapman, *Global health, human rights and the challenge of neoliberal policies* (Cambridge: Cambridge University Press, 2016), p. 17.

[38] N. Sun, "Applying Siracusa: A call for a general comment on public health emergencies," *Health and Human Rights Journal* (April 23, 2020).

[39] D. Pūras, "COVID-19 and mental health: Challenges ahead demand changes," *Health and Human Rights Journal* (May 14, 2020).

[40] Ibid.

[41] M. Luther King Jr, "Presentation at the Second National Convention of the Medical Committee for Human Rights," Chicago, March 25, 1966.

[42] Chapman (see note 35).

[43] D. Devakumar, G. Shannon, S. Bhopal, and I. Abubakar, "Racism and discrimination in COVID-19 responses," *Lancet* 395/10231 (2020), p. 1194.

[44] World Health Organization (see note 12).

[45] Ibid.