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UVODNI ESEJ / GUEST EDITORIAL

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THE COMPATIBILITY OF COVID PASSES WITH THE PROHIBITION OF DISCRIMINATION

1. Introduction

Countries all over the world are increasingly introducing Covid-19 passes – certificates of an individual's vaccination status, testing status, or recovery from the virus – and mandating their use in certain contexts, such as access to bars, restaurants, public transport and other facilities. The most prominent such example is the EU Digital Green Certificate, but with an important caveat. While that certificate was designed so as to be interoperable and valid in all EU member states, its primary purpose was to facilitate the freedom of movement between member states.[1] But within the state it is up to each government to decide for itself whether, and to what extent, the certificate would be used to regulate access to public facilities locally – France and Italy have, for instance, been using them quite extensively. Many other states (or territorial sub-divisions within states) outside the EU are adopting similar policies, with a great degree of variety in how the regulation is framed, and with a degree of convergence with regard to their technical implementation (*e.g.* through the use of smartphone apps and QR codes). Serbia is one such recent example, even if the mandated Covid pass was introduced only half-heartedly.[2]

In this editorial I will not engage in a detailed descriptive examination of how Covid passes have been implemented in individual states. Rather, my intention is to do a big picture analysis of the compatibility of such policies with the prohibition of discrimination and the principle of equality. Non-discrimination is a foundational rule of international human rights law and most domestic constitutional systems for the protec-

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1 https://www.covidpasscertificate.com/europe-digital-green-pass/.

2 See 'Serbia introduces COVID-19 passes for indoor cafes and restaurants,' *Reuters*, 20 October 2021, (https://www.reuters.com/world/europe/serbia-introduces-covid-19-passes-indoor-cafes-restaurants-2021–10–20/).

tion of fundamental rights. It is not an absolute rule, in the sense that some distinctions in treatment can be reasonably and objectively justified. And Covid passes may well be justified in most states that have used them so far, depending on how precisely they were designed and implemented. That said, the key argument I wish to make here is that lawyers and policymakers need to be especially mindful of the potential indirect discriminatory effects of Covid passes. In order to mitigate such effects, all state rules and policies need to be thoroughly scrutinized, be evidence-based and subject to oversight and judicial review. The state must gather data about the real-world effects of Covid passes, positive and negative, and subject them to ongoing, dynamic evaluation, including meaningful equality impact assessments. Finally, the positive and negative effects of Covid passes will always be variable and context-specific – they may be a great success in one country but not in another; the circumstances of each society need to be taken into account.

The essay proceeds as follows. I will first outline some basics of non-discrimination law. I will then examine the different types of Covid pass mandates. I will then discuss how Covid passes can be directly discriminatory, and finally how they can be indirectly discriminatory.

2. Non-Discrimination: The Basics

Most human rights treaties and domestic constitutions do not define the concept of discrimination, although they may refer to some of its constituent elements, *e.g.* differentiation between individuals on the basis of some personal characteristic. Similarly, most instruments do not contain an express limitations clause, *i.e.* do not state explicitly that not all distinctions on the basis of a specific characteristic are wrongful, but that some can be justified. This is nonetheless the constant jurisprudence of all human rights bodies, which broadly accept that non-discrimination claims require value judgments as to the comparability of the situations of the relevant individuals and as to the justifiability of any distinctions made (or not made) between them.[3]

Thus, distinctions in treatment will be regarded as objectively and reasonably justified if they pursue a legitimate aim and are proportionate to that aim. For example, a rich person can be taxed more than a poor one; the health care needs of a gravely ill individual can be prioritized over those of an individual who is at lesser risk; the elderly and those with comorbidities can have earlier access to Covid vaccines than the younger

3 For an example of a jurisprudential interpretation of the prohibition of discrimination, see UN Human Rights Committee, General Comment No. 18 (1989).

and the healthier. There is some terminological variance in comparative practice as to whether justified differential treatment/distinctions are not labelled as discrimination at all, or whether justified discrimination would simply not be unlawful but would still be called discrimination.

Comparative practice is also complex and contested as to the doctrinal role that discriminatory purposes and effects should play in justifiability analysis – the most difficult cases are those in which authorities enact measures with entirely good motives but which may cause disparate impact on a particular group or class of individuals. That said, there is widespread recognition that equality requires not only treating those who are alike alike, but also treating those who are different differently. Consequently, discrimination can be direct, in the sense that a measure is based on a specific characteristic, or indirect, in the sense that facially neutral measures produce effects that excessively disadvantage a particular group. States thus have to take into account – and need to justify – the indirect disparate impacts of their policies.

Consider, for example, the recent views of the UN Human Rights Committee in *Elena Genero v. Italy*.[4] The claimant in the case was an Italian female firefighter, who for 17 years performed those duties on a temporary (voluntary) basis. She then entered a competition for a permanent position. Her application was refused because she did not fulfil the minimum height requirement of 165 cm, set out in the relevant national decree.[5] This decree was on its face directly discriminatory on the basis of height. But it was also indirectly discriminatory on the basis of sex, since a substantially greater proportion of women will, when compared to men, fail to satisfy that height requirement.

Before the Committee, Italy argued that the height requirement was justified essentially as a proxy for physical competence that a firefighter needs to have to perform their job adequately. But the Committee found that explanation wanting, finding it to be unnecessary and disproportionate and resulting in indirect gender-based discrimination:

> *While acknowledging that the State party may have a legitimate interest in ensuring the effectiveness of the National Firefighters Corps and while admitting that the activities undertaken by firefighters may require certain physical conditions, the Committee notes that neither the State party nor the national administrative courts have justified the precise role that a height of 165 cm would play in the effective performance of these functions, nor that other physical attributes, such as corporal composition, muscular force and active metabolic mass, could not compensate for not meeting the existing height requirement. The Committee notes, in that*

4 UN Doc. CCPR/C/128/D/2979/2017, 28 May 2020.

5 *Ibid*., para. 2.1.

> *regard, the author's uncontested argument that she had been successfully employed as a temporary firefighter for 17 years at the time of submitting the present communication, having participated in several rescue teams during that period and having carried out the same functions as permanent staff members.*[6]

In the Covid-19 context, the lockdown measures imposed by various governments can provide a good example of both direct and (unintended) indirect discriminatory effects. Consider, for instance, the spring 2020 Serbian restrictions on the freedom of movement, imposed during a declared state of emergency and a formal derogation from the European Convention on Human Rights (ECHR) and the International Covenant on Civil and Political Rights (ICCPR). Persons older than 65 were categorically prohibited from leaving their residences (with some very minor exceptions gradually introduced over time), whereas younger individuals were subjected to curfews that were less restrictive, but still substantial. This is an example of direct differential treatment on the basis of age, which may or may not have been justified due to the greater vulnerability of the elderly to the virus. I hedge my language here only because the one institution that was supposed to assess the justifiability of this distinction, the Serbian Constitutional Court, entirely abdicated its responsibility to do so, essentially on the basis that the prohibition of age-based discrimination does not apply in a state of emergency.[7] But the lockdown measures were also indirectly discriminatory, in that some individuals were affected by them disproportionately on account of their difference – for example, children with autism or persons with disabilities whose wellbeing and access to care were significantly curtailed.[8] The Serbian government only very belatedly recognized the specific position of some of these groups by granting them partial exceptions, did so only after public pressure and was never subjected to meaningful judicial scrutiny.

Bearing all this in mind, let us turn back to Covid passes, which can also be directly or indirectly discriminatory, with or without justification. It is first important to consider the different types of such passes.

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6 *Ibid*., para. 7.5.

7 See Decision IUo-45/2020, 25 October 2020, at VI. The Court ruled that the general prohibition of discrimination in Article 21 of the Serbian Constitution was displaced by a more specific rule in Article 202(2) of the Constitution during a state of emergency, even though the text of the Constitution does not actually say so, and without examining whether any supposed derogations from the prohibition of discrimination were strictly required by the exigencies of the situation.

8 See, *e.g.*, United Nations COVID-19 Socio-Economic Impact Assessment (Serbia), Sept. 2020, (https://serbia.un.org/sites/default/files/2020–09/seia_report%20%281%29.pdf) at 28; Belgrade Centre for Human Rights, *Human Rights in Serbia January-June 2020* (2020), (http://www.bgcentar.org.rs/bgcentar/eng-lat/wp-content/uploads/2014/01/Human-Rights-in-Serbia-I-VI-2020.pdf), at 86.

3. Types of Covid Passes and Mandates

The design of Covid passes and any mandates to use them is crucial for assessing their proportionality. This requires answering at least five preliminary questions: (1) what information is contained and certified in the pass; (2) in what format; (3) in what regulatory context; (4) which public services and facilities are being restricted through the mandated use of the pass; (5) who is doing the mandating and restricting?

As for the first of these questions, the initial design choice is whether the pass will include solely information about vaccination status (as, for example, with the NHS pass in the UK), or will also include additional information, such as the result of the most recent PCR or antigen test or proof of recent recovery from a Covid infection (as is the case with the EU digital certificate). A particularly notable example is the United Arab Emirates' Al Hosn pass, which always requires periodic PCR testing to maintain its validity, but the period of validity will vary depending on the individual's vaccination status – for example, a fully vaccinated individual needs to get tested only once every 30 days in order to get a green pass, whereas an individual who received no doses of a vaccine would need to get tested every 3 days for the pass to remain valid.[9] A further issue is whether the validity of a pass also requires the individual to carry a piece of photographic ID.

Second, as for the format of a Covid pass, the key question is whether the certificate is only available digitally, normally as a smartphone app, or whether there is also some kind of paper alternative, which may be particularly helpful to the elderly and other individuals who do not have easy access to smartphones. The EU digital certificate can easily be printed out, for example, whereas the generation of a paper vaccination certificate in the UK is much more cumbersome.

Third, as for the regulatory context, the most important question is whether the Covid pass (and any mandate to have one) exists alongside a prior legal obligation to get vaccinated or not. In most countries Covid-19 vaccination is not legally mandatory and is ostensibly a matter of individual choice, or is mandatory only in specific contexts (*e.g.* for health care workers). But if the state has chosen to mandate vaccination, then the justifiability of Covid pass mandates will likely be parasitic on the justifiability of the vaccine mandate (although distinct issues remain, as we shall see). If, however, the state does not mandate vaccination, then the problem of justifying mandatory passes certifying ostensibly voluntary vacci-

9 https://u.ae/en/information-and-services/justice-safety-and-the-law/handling-the-covid-19-outbreak/the-green-pass-system.

nation is more easily separated out. Very broad and burdensome Covid pass mandates, especially when the alternatives to vaccination (such as testing) are either non-existent or cumbersome, may in effect become *de facto* vaccine mandates and their justifiability should be assessed as such. To be clear, legally mandatory vaccinations for Covid – and other diseases – can be justified, and manifestly so in specific contexts of high risk of transmission, such as for health care and care home workers. For example, the European Court of Human Rights has already examined some mandatory vaccinations for children and found them to be compatible with the right to private life.[10] My point is simply that the justifiability of vaccination mandates and Covid passes need to be carefully distinguished, especially as to their equality impacts.

Fourth, the scope of restrictions on access to public services and facilities for those without a valid Covid pass is the most important question for assessing their justifiability. Mandates that require passes only for entry to a very small number of venues and events, such as nightclubs or large concerts, impose a lower burden and are easier to justify than those that restrict access to essential public services, such as transport or education, or those that directly affect an individual's livelihood by restricting their ability to work.

Fifth, and finally, it is important to understand that mandates requiring the use of Covid passes may come from both state and private actors. Thus, for example, the state may choose to require passes for access to bars and restaurants. But even in the absence of a state mandate, the individual owners of such venues may themselves decide to require their customers to produce a pass, or may indeed require their employees to have a Covid pass in order to continue working as a health and safety measure in the workplace. Similarly, the state may mandate the use of Covid passes in schools and universities. But even in the absence of such a mandate an educational institution may decide to impose such a mandate for itself – in Serbia this was, for example, done by the University of Belgrade Faculty of Medicine, which requires staff and students to present proof of vaccination, testing or recovery in order to access its facilities.[11] In any given country there may therefore be many state and private mandates co-existing in parallel. Private mandates potentially trigger the state's positive duty of protection, requiring it to exercise due diligence to prevent unjustified discrimination by private actors, even if the state is not itself engaging in any discriminatory conduct.

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10 See *Vavřička and Others v. the Czech Republic* [GC]. nos. 47621/13 etc., 8 April 2021.

11 https://rs.n1info.com/vesti/medicinski-fakultet-u-beogradu-uveo-kovid-propusnice/.

4. Covid Passes and Direct Discrimination

How do Covid passes differentiate or discriminate directly? They clearly draw distinctions between those who possess a certificate and those who do not. But implicit in that distinction is also differentiation between the vaccinated and the non-vaccinated, even for those certificates that include information other than vaccination status, such as testing or proof of recovery. A vaccinated individual who can get a valid pass simply on that basis is clearly being treated more favourably than a non-vaccinated person who needs to get tested every few days in order to generate a valid pass.

As we have seen, the differential treatment will constitute (unlawful) discrimination if it lacks objective and reasonable justification. In principle Covid passes pursue a legitimate aim – the protection of public health – which can then be balanced against the burdens they impose on the non-vaccinated. Covid passes can benefit public health in two basic ways. First, by reducing the risk of transmission of the virus in the contexts for which they are mandated, such as public events. Second, by incentivizing the uptake of vaccination in the population, as people realize that getting vaccinated would make their lives practically easier and thus overcome any hesitancy that they might have.

The former rationale rests on the ability of vaccines to interrupt transmission, and, if combined with alternatives such as negative tests or recent recovery from infection, on a probabilistic assessment that infection would be less likely in gatherings including only individuals with a valid pass. The actual extent of any risk reduction is a difficult empirical question that is hard to answer reliably; the evidence base for the effectiveness of Covid pass regimes remains small, and they are grounded more in precaution than rigorously obtained and evaluated evidence. In particular, the emergence and subsequent dominance of the highly infectious Delta variant has certainly lowered the ability of vaccines to reduce transmission (and not all vaccines are equally potent in that regard anyway).[12] It can fairly be said that Covid passes have some effect on reducing transmission

12 See, *e.g.*, Singanayagam, A., Hakki, S., Dunning, J. *et al.*, ATACCC Study. Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study. *Lancet Infect Dis* 2021. doi:10.1016/S1473–3099(21)00648–4 (finding that 25% of vaccinated members of households of Delta Covid patients got infected with the virus, compared to 38% of unvaccinated members, and also finding that peak viral loads of vaccinated individuals with breakthrough infections were similar to those of unvaccinated individuals).

(which will likely be quite variable from context to context), but that no policymaker or expert can reliably say how large that effect actually is.

The second rationale, that of incentivizing vaccination, is likely to be more beneficial in the long run, because increased vaccination rates would reduce the overall disease burden on vaccinated individuals and society as a whole. Some may object to it ideologically as a form of paternalism. Others might point out that it would be more honest and straightforward to legally mandate vaccination as such rather than to do so *de facto*, through ostensibly softer means such as access restrictions coupled with Covid certificates. But at least empirically the introduction of Covid passes has, in fact, led to substantial increases in vaccination rates in several countries.[13]

So much for the public health advantages of Covid passes. On the other side of the proportionality equation are the various burdens that they may impose. Again, relatively low-level restrictions to non-essential services – nightclubs, cinemas, bars, restaurants – would be easier to justify in terms of harms to unvaccinated individuals than restrictions to essential services, such as education or social care. Similarly, if unvaccinated individuals can obtain a valid Covid pass through testing, restrictions would be easier to justify if testing was free of charge and widely available.

Somewhat paradoxically, however, it is precisely such lowering of the burdens on unvaccinated individuals that also lowers the effectiveness of Covid passes with regard to the second rationale above – that of incentivizing vaccination. Lesser restrictions on access or the greater availability of alternatives such as testing may reduce the inconvenience (and cost in money and time) that incentivizes vaccination. Consider, for example, how after introducing Covid passes for access to facilities such as bars and restaurants Switzerland then went on to abolish government-sponsored free antigen testing, precisely in order to incentivize vaccination – as the Swiss Federal Council put it, "it is not up to the public as a whole to finance the cost of tests for people who decide not to get vaccinated".[14]

To sum up, while there is substantial uncertainty as to the extent of public health benefits of Covid passes, especially with regard to the reduc-

13 In France, for example, "[m]ore than a million people made a vaccine appointment in the 24 hours after [President] Macron's July 12 announcement that a health pass would soon be required for public venues. Almost 10 million people got a first dose over the subsequent month." See Covid health pass prevails over French vaccine scepticism in boost for Macron, *France 24*, 14 October 2021, (https://www.france24.com/en/europe/20211014-macron-s-covid-health-pass-a-success-in-overcoming-france-s-vaccine-scepticism/).

14 Coronavirus: Free tests for those waiting for second vaccine dose, Press Release of the Federal Council, 24 September 2021, (https://www.admin.ch/gov/en/start/documentation/media-releases.msg-id-85254.html).

tion of transmission, the balance between these benefits and the restrictions imposed on the unvaccinated would generally satisfy the IHRL proportionality test, especially when bearing in mind that courts and human rights bodies would defer to state authorities and the political process on matters that require the balancing of risks when fighting a public health crisis. The French Constitutional Council has thus, for example, found the *passe sanitaire* used in France to be compatible with fundamental rights, including equality.[15]

There are therefore in my view only three types of situations in which Covid passes are likely to be found to be directly discriminatory. First, and most obviously, if such passes were to be introduced by a state that has an insufficient supply of vaccines, *i.e.* if there were people who wanted to get vaccinated but there simply were no vaccines available. As of the time of writing (November 2021) severe supply issues remain globally; most countries in Africa in particular have vaccination rates in the single digits,[16] simply because wealthier states have cornered the market. Introducing Covid passes in a country in which a substantial number of people never had the opportunity to get vaccinated would be objectively unjustified, and would directly create a divide between the privileged and the underclass.

Second, Covid passes would be directly discriminatory against the unvaccinated if three conditions were cumulatively met: (1) the overall activity of the virus in the given society was low; (2) vaccination rates were high; and (3) the restrictions on the unvaccinated remained substantial. In this scenario Covid passes would be making only a minimal benefit to public health, if any, since the baseline risk of transmission would be low anyway and since very few people could still be incentivized to get vaccinated, while the burden imposed on the unvaccinated would be significant.

Third, depending on their design, Covid passes could also be directly discriminatory against individuals who were vaccinated in a foreign country, especially those who may have been vaccinated using a shot that did not receive regulatory approval in both states. Thus, for example, the EU and the UK had to agree on a mutual recognition of vaccine certificates, even though they have been using the same vaccines, while the domestic use of foreign certificates for accessing restricted services and facilities was until then largely discretionary.[17] Or, consider all those vaccinated

15 Décision n° 2021–824 DC, 5 August 2021, (https://www.conseil-constitutionnel.fr/decision/2021/2021824DC.htm).

16 https://ourworldindata.org/covid-vaccinations?country=OWID_WRL.

17 https://www.publictechnology.net/articles/news/uk-and-eu-agree-digital-vaccine-pass-reciprocity.

with Chinese vaccines – which account for almost half of all administered doses worldwide[18] – but who may want to visit or study in states that have not approved these vaccines. While it is understandable that technical problems may impede the easy cross-border recognition of vaccine certificates, treating individuals with foreign vaccinations as legally unvaccinated serves no cognizable public health purpose in situations in which the same vaccines were approved in both states – in particular, concerns about potentially fraudulent foreign certificates can be resolved through other means. And even if the two states are using different vaccines, which may have variable effectiveness in reducing risk of serious illness, there is very little comparative evidence on any difference between vaccines in the reduction of transmission (which is one of the main goals of a Covid pass). There would be little point to revaccinating these individuals with other vaccines unless their immunity is waning, especially when there is scarcity of vaccines elsewhere. In that regard, the problem of waning immunity would be better solved by requiring boosters for the validity of the pass after a certain period (*e.g.* six months) from the completion of the main vaccination course than by simply disregarding the initial vaccinations altogether.

5. Covid Passes and Indirect Discrimination

This brings us to the indirect – most often unintended – discriminatory effects of Covid passes. Depending on the design of these passes and the specific social context, such effects can be substantial and are more likely to enable successful legal challenges to pass mandates than claims of direct discrimination. Common to all of the examples below is that they may warrant exceptions from a regime of general applicability such as a Covid pass, or at least require the active consideration of alternative or supplementary measures by the state. And again in evaluating the possible indirect effects of Covid passes it is crucial to evaluate their relationship to any relevant vaccine mandate.

The first group of individuals who may be adversely affected indirectly by a Covid pass regime is relatively small – those with specific health conditions that mean that vaccination is permanently or temporarily medically contraindicated. Such individuals may well want to have a Covid vaccine, but are simply not allowed to have it, for example because they are allergic to one of the vaccine components such as polyethylene glycol.[19] A Covid pass that functioned solely on the basis of vaccination

18 https://www.nature.com/articles/d41586–021-02796-w.

19 See, *e.g.*, the contraindication guidance from the US Centers for Disease Control, (https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-

status would clearly produce a disparate impact on such individuals (as would a vaccine mandate that contained no exemptions). Allowing for a valid certificate on the basis of testing would alleviate the disparate impact somewhat, depending on the cost, ease and availability of testing. In any event authorities must actively monitor the situation of such individuals and make any reasonable accommodations.

Second, in states that conduct vaccination along stratified priority tiers, starting with the eldest and those with comorbidities, the young will have had the shortest window of opportunity to get vaccinated. The premature introduction of a Covid pass may thus affect them disproportionately, indirectly discriminating on the basis of their age. Any exemptions for children, for example, would also be important for this assessment.

Third, for Covid pass regimes that rely heavily on smartphone apps and online tools, some groups, especially the elderly and persons with disabilities, may experience substantial difficulties in using such technologies. Easily obtaining paper certificates may, for instance, be a necessary accommodation for individuals in these circumstances.[20]

The moral intuition underlying the reasoning regarding the three examples above is that having, or lacking, a choice to get vaccinated or use the relevant technology is important in balancing the adverse impact that Covid passes may have on these individuals. It is very easy to fall into a mindset that individuals who have the ability and free choice to get vaccinated or not and choose not do so should then bear the consequences of that choice – unlike those who never had this choice, they have only themselves to blame if their life becomes more difficult. There is some truth to this position. But we should also always be mindful of how constrained that supposed freedom to choose can really be, often by objective circumstances outside any individual's control, including their belonging to a particular group.

There are numerous other categories of individuals whose ability – and choice – to get vaccinated or use a Covid pass are substantially more limited when compared to the general population. This includes the poor, and especially the homeless, whose access to vaccinations, testing and/or

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us.html#Contraindications). Temporary contraindications would cover persons undergoing some forms of cancer treatment, such as immunotherapy, or those who have pericarditis or myocarditis.

20 A good example of reasonable alternative accommodation in the context of Covid contract tracing apps is the approach taken in Singapore, where the government distributed Bluetooth tokens to children, the elderly, the disabled and other groups who could not use smartphones easily. See Singapore gives out pocket-sized device to trace coronavirus, *Reuters*, 14 September 2020, (https://www.reuters.com/article/us-health-coronavirus-singapore-idUSKBN2651OZ).

smartphones may be inadequate, particularly in the developing world. It also includes irregular migrants, who may – depending on the country in which they are located – be denied the opportunity to get vaccinated, or be unable to get a valid certificate due to their undocumented status.[21] (The homeless may be in a similar situation because they may lack a formally registered address.) The Bureau of Investigative Journalism has thus reported that "administrative barriers in at least 10 European countries are blocking access to Covid-19 vaccines for nearly four million undocumented migrants".[22] Moreover, irregular migrants may be afraid that they may be reported to immigration authorities if they go to a vaccination site, or be afraid that a smartphone app might share their data with the authorities, thus discouraging vaccination and/or the use of a Covid pass.

Similarly, individuals belonging to minority racial or ethnic groups may be systematically disadvantaged in certain societies and may harbour deep-seated mistrust of state institutions, affecting their vaccination rates and/or the use of any related Covid pass. For example, for a number of reasons vaccine hesitancy has been higher in the Black population of the United States than in the majority white population. Vaccine take-up was substantially lower among Black people for many months into the Covid-19 vaccination campaign, and improved only upon the implementation of proactive vaccination efforts, including community outreach and mobile vaccinations centres.[23] In Eastern Europe, the Roma will be in the same general position; vaccination rates are certainly lower than in the majority population, and there seems to be a complete absence of targeted vaccination campaigns and community outreach in most of the states in the region.[24] Mandating Covid passes can therefore indirectly adversely affect this group, which can only be justified if the state takes some form of remedial action to assist them.

Depending on the society in question, religious minorities may be in a similar position. They – or their leadership – may be opposed to vac-

21 See WHO, COVID-19 immunization in refugees and migrants: principles and key consideration: interim guidance, 31 August 2021, (https://apps.who.int/iris/bitstream/handle/10665/344793/WHO-2019-nCoV-immunization-refugees-and-migrants-2021.1-eng.pdf).

22 https://euobserver.com/coronavirus/152781.

23 See Nambi, N. *et al.*, Latest Data on COVID-19 Vaccinations by Race/Ethnicity, *KFF*, 3 November 2021, (https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-by-race-ethnicity/); Landry, L. *et al.*, 2021, Minority and Rural Coronavirus Insights Study (MRCIS): The Need for Targeted COVID-19 Vaccination Efforts in Minority Populations. *medRxiv*. doi:10.1101/2021.10.06.21264407, (https://www.medrxiv.org/content/10.1101/2021.10.06.21264407v1).

24 See, *e.g.*, Holt, E., 2021, COVID-19 vaccination among Roma populations in Europe, *The Lancet Microbe*, 2(7), e289. https://doi.org/10.1016/S2666–5247(21)00155–5.

cines or the use of Covid passes, severely affecting vaccination rates. One question of principle, which I will not be examining, is whether sincerely held religious beliefs should be sufficient grounds for exemptions from a vaccine mandate (and indeed whether religious beliefs on vaccines should carry more weight than similar beliefs that are not religious in character). Leaving that aside, it is simply a fact that in some societies religion can affect vaccination rates; consider Israel as but one example, where vaccination efforts substantially lagged in ultra-Orthodox Jewish communities and improved only after a sustained targeted effort and the endorsement of vaccinations by religious leaders.[25] It is simply illusory to say that people belonging to such communities can just choose to disregard the views of authoritative voices within these communities. The state must, again, take proactive measures to reduce vaccine inequities and to thereby also reduce any inequities resulting from the introduction of Covid passes.

6. Conclusion

Depending on their design, Covid passes can be useful public health interventions that may be justified under international human rights law. But great care needs to be employed by state authorities in their design and implementation. In particular, they must be mindful of both the direct and indirect discriminatory effects of these passes, and of any further consequences imposed by private actors, *e.g.* in the employment context. Many vulnerable groups may be adversely affected by such passes, and, at a minimum, reasonable remedial measures must be in place to eliminate or mitigate such effects. This is especially the case for indirect discrimination that may be intersectional, *i.e.* cover multiple grounds (such as age, income, or belonging to a minority) simultaneously, and when the restrictions on access to public services imposed through a pass are relatively high.

It is in principle legitimate for Covid passes to function as a soft form of vaccine mandates, with the goal of inducing vaccination through inconvenience. But that goal must be tempered with the harm that a Covid pass regime may cause. This includes harms to individuals who have chosen not to get vaccinated, especially if the state has refrained from directly imposing a vaccine mandate. For many of these people choice is severely

25 See Rosen, B., Waitzberg, R., Israeli, 2021, A. *et al.* Addressing vaccine hesitancy and access barriers to achieve persistent progress in Israel's COVID-19 vaccination program. *Israeli Journal Health Policy Research* 10, 43, https://doi.org/10.1186/s13584–021-00481-x; How Israel Persuaded Reluctant Ultra-Orthodox Jews To Get Vaccinated Against COVID-19, *NPR*, 22 April 2021, (https://www.npr.org/2021/04/22/988812635/how-israel-persuaded-reluctant-ultra-orthodox-jews-to-get-vaccinated-against-cov).

constrained by factors beyond their control. In particular, individuals who are victims of manipulation and disinformation, especially in the context of confused and inconsistent public health messaging from the state, can hardly be said to be exercising free choice. Even more so when it was the state itself – often through some of its highest officials – that engaged in manipulation and misinformation.

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