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PRACTICAL GUIDE

TO INCLUSIVE AND
RIGHTS-BASED
RESPONSES TO
COVID-19

IN THE AMERICAS

SECRETARIAT FOR ACCESS TO RIGHTS AND EQUITY
DEPARTMENT OF SOCIAL INCLUSION

WOMEN – OLDER PERSONS – PERSONS WITH DISABILITIES – PEOPLE OF AFRICAN DESCENT – INDIGENOUS PEOPLES – LGBTIQ PEOPLE
INTERNALLY DISPLACED PERSONS – MIGRANTS – ASYLUM-SEEKERS AND REFUGEES – PERSONS DEPRIVED OF LIBERTY
PERSONS LIVING IN POVERTY AND EXTREME POVERTY – CHILDREN AND ADOLESCENTS

**LUIS ALMAGRO
SECRETARY GENERAL OF THE OAS**

**NESTOR MENDEZ
ASSISTANT SECRETARY GENERAL**

**GASTÃO ALVES DE TOLEDO
SECRETARY FOR ACCESS TO RIGHTS AND
EQUITY**

**BETILDE MUÑOZ-POGOSSIAN
DIRECTOR OF THE DEPARTMENT OF
SOCIAL INCLUSION**

Secretariat for Access to Rights and Equity Practical Guide to Inclusive and Rights-based Responses to COVID-19 in the Americas

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Graphic design: Esperanza A Ramos, Officer DSI/SARE

Coordination: Pamela Molina, Consultant DSI/SARE

OAS Cataloging-in-Publication Data

Secretariat for Access to Rights and Equity (SARE):

PRACTICAL GUIDE TO INCLUSIVE AND RIGHTS-BASED RESPONSES TO COVID-19 IN THE AMERICAS

[Published by the General Secretariat of the Organization of American States].

(OAS. Official documents; OEA / Ser.D / XXVI.16)

1. Access to rights and equity. 2. Social inclusion 3. Pandemic. 5. COVID-19.
6. Economic, Social and Cultural Rights. 7. Human Rights and Groups in Situation of Vulnerability
I. Organization of American States. Secretariat for Access to Rights and Equity. Department of Social Inclusion.



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FOREWORD¹



Luis Almagro Lemes
OAS Secretary General

1 This section includes a close-up photo of the OAS Secretary General, smiling.

Health is a right, necessary to guarantee the right to life, and safeguarding that right is essential to preserving public order. In the Americas, we have come together in the past to face threats to the values we treasure as inalienable rights, such as democracy, security, human rights, and integral development, and we have collectively committed to protecting the rights of all people, including the right to life and the right to health. The COVID-19 pandemic poses huge challenges for us at the national and regional levels, but it also provides a new opportunity to come together as a region to defend these values. It is especially an opportunity for us to reaffirm the basic principle that united us when the OAS was established and that is reflected in the **American Declaration on the Rights and Duties of Man**: that all people *"are born free and equal, in dignity and in rights, and, being endowed by nature with reason and conscience, they should conduct themselves fraternally."*

This pandemic affects all of us directly and indirectly. However, for people in situations of vulnerability, with limited or sometimes no access to medical care, goods and services, the extent of the impact is much broader; and it could, very likely, widen the gaps in their access to basic economic, social, and cultural rights, considering that these groups of people are victims of multiple and intersectional discrimination, and that such discrimination is exacerbated in crisis situations. We are referring to those who are poor and marginalized, many of whom are also members of other groups in situations of vulnerability, such as indigenous peoples, people of African descent, older persons, persons with disabilities, migrants, refugees, LGBTI persons, children, adolescents, and women. Multiple and intersectional discrimination that has become the norm in our countries limits their access to and enjoyment of basic rights, and, in emergencies, this limitation and exclusion are exacerbated. As a result, they are far less likely to survive the pandemic. Emphasis must be placed on these populations that require special support because their circumstances create even more hurdles to overcoming the situation, especially for those experiencing inequity, gender inequality, and unequal access to economic and social rights.

Today more than ever, the region requires an active OAS with clarity and capacity to lead and, above all, an OAS capable of understanding the rights of people in today's new contexts, and of supporting states in guaranteeing and respecting those rights. This is precisely what this **Practical Guide to Inclusive and Rights-Based Responses to COVID-19 in the Americas** has to offer.

We know that political systems are going to suffer, that our social fabric is going to be strained, but we cannot emerge from this situation less democratic or with our peoples' rights diminished. Let us use this challenging moment as a unique opportunity to look at ourselves as an Organization, look at ourselves as a region, reinforce the values that we believe are essential for life and human development, and ensure that the most excluded citizens in our societies will, from now on, never again be excluded or left behind.

Luis Almagro
Secretary General of the OAS

EXECUTIVE SUMMARY

01 WHY THIS GUIDE?

Because, in the face of crises and emergencies, it is vital to include a human rights perspective in responses. Vulnerable groups face major obstacles to accessing and benefiting from prevention, mitigation, and health care policies due to structural barriers of inequality.

To offer guidelines to the countries of the Americas for crafting and implementing inclusive and accessible, human rights-based responses to a pandemic that is unprecedented in the region and in the world as a whole.

WHAT NEEDS TO BE DONE TO MAKE RESPONSES TO THE HEALTH EMERGENCY TRULY INCLUSIVE?

02 Think about them with a human rights focus, paying particular attention to groups in vulnerable situations. What works for these people will work for all citizens. Each person's health impacts the health of humanity.

Develop and mainstream accessible and inclusive information and communication.

Design and implement accessible health measures with a rights-based approach.

Design and implement measures targeting the most vulnerable population to reduce economic impacts.

KEY ELEMENTS OF AN INTEGRAL RESPONSE TO THE EMERGENCY:

Cross-cutting measures

Universal accessibility

Intersectional focus of the response

03

CORE FEATURES OF A HUMAN RIGHTS-BASED APPROACH:

04

This means that all state policies, strategies, and responses should be geared to advancing full exercise of human rights by the population, as envisaged in inter-American and international treaties regarding the human rights of groups in situations of vulnerability and to eradicating all forms of discrimination and intolerance.

PRINCIPLES GOVERNING A HUMAN RIGHTS-BASED APPROACH:

05

Non-discrimination

Availability: of goods, services, spaces.

Accessibility: physical, of information and communications, mobility, economic (affordability), of infrastructure, and so on.

Acceptability: free and informed consent, moral safeguards, and respect for human integrity, and for cultural, linguistic, gender-related, bio-psychosocial, and age factors.

WHICH GROUPS ARE IN SITUATIONS OF VULNERABILITY OR "IN VULNERABLE CIRCUMSTANCES"?

06

Groups of people who, based on nationality; age; sex; sexual orientation; gender identity and expression; language; religion; cultural identity; political opinions or opinions of any kind; social origin; socioeconomic status; educational level; migrant, refugee, repatriate, stateless or internally displaced status; disability; genetic characteristics; bio-psycho-social condition, or any other condition have been discriminated against and the recognition, enjoyment or exercise of their rights have been denied or violated.¹

1

Taken from: *Inter-American Convention against all Forms of Discrimination and Intolerance*, OAS.

WHAT DOES AN INTERSECTIONAL APPROACH MEAN?

07

Addressing in political responses, in a simultaneous and comprehensive manner, the complex, irreducible, varied and variable effects which ensue when multiple axes of inequality and differentiation – economic, political, cultural, bio-psycho-social, subjective and experiential – intersect in historically specific contexts, producing unique and indivisible effects.²

2

Avtar Brah: Ain't I A Woman? Revisiting Intesectionality (2004). Taken from : <https://vc.bridgew.edu/cgi/viewcontent.cgi?article=1543&context=jjws>

INTRODUCTION:

INEQUALITY AND THE COVID-19 PANDEMIC IN THE AMERICAS³

COVID-19 is an infectious-contagious respiratory disease caused by the SARS-COV-2 virus, first detected in the province of Wuhan, China, in December 2019. In a matter of three months, it spread to the rest of the world, registering at the end of March 2020, 754,948 people infected by the virus in 202 countries, and having claimed the lives of 36,571 people,⁴ according to the World Health Organization (WHO). Due to the magnitude of the spread of contagion, the WHO declared it a pandemic on March 11, 2020.

In the Americas, the Pan American Health Organization (PAHO) documented the existence of 188,842 confirmed cases, and 3,554 deaths⁵ on the same date, with a presence in all the countries of our Hemisphere. This global pandemic is becoming the most important crisis that the world has faced in recent times, with variations in countries' responses to the emergency.

The pandemic has also tested governments in the region, revealing weaknesses in the public health and social protection systems, and has the potential to not only be a health pandemic but also to become a social pandemic. Even so, the countries of the Americas have responded with agility and pragmatism, and with a wide range of measures to *contain*

³ Prepared by Betilde Muñoz-Pogossian, Ph.D., Director of the Department of Social Inclusion, Secretariat for Access to Rights and Equity of the OAS.

⁴ World Health Organization (WHO), Coronavirus COVID-19 Situation Dashboard. Available at: <https://experience.arcgis.com/experience/685d0ace521648f8a5beeee1b9125cd> (access on March 31, 2020).

⁵ Pan American Health Organization (PAHO), Cumulative confirmed COVID-19 cases reported by countries and territories in the Americas. Available at: <https://who.maps.arcgis.com/apps/webappviewer/index.html?id=2203b04c3a5f486685a15482a0d97a87&extent=-20656313.6818%2C-3596> (access on March 31, 2020).

the virus and *mitigate* the consequences⁶ of contagion. These include avoiding shortages of basic goods, providing special lines of credit to companies to ensure wage payment, freezing bills for basic services, prohibiting service suspension for non-payment to providers, increasing social spending through the expansion of direct monetary transfers to households without wages, or families in poverty, as well as delivering food packages to families and students who only had access to adequate food through schools. The response also includes the measure that is having the most impact on our coexistence as societies: home quarantining or isolation or social distancing.

COVID-19 is not only directly and indirectly affecting the health of hundreds of thousands of people and national health systems; the effects of the infection and the aforementioned measures are also having serious impacts on the suspension of classes in schools and universities, the closing of borders, limitations on transit and free mobility of people, and the loss and suspension of jobs and livelihoods of thousands of workers. The pandemic has also caused the destabilization of the world economy, including that of the countries of the Americas, in addition to the physical and psychological impacts on everybody's lives. At the same time, in a Hemisphere marked by *inequality*, the effects on the right to health, and all areas of human rights, have more pronounced impacts, and end up affecting people in situations of vulnerability in specific ways.

Faced with this crisis, the countries of the region have a legal framework for the protection of human rights that provides certainty and sets a roadmap for what must be done to guarantee the full enjoyment of the right to health and the protection of all facets of people's rights in the context of the current pandemic. The **American Declaration of the Rights and Duties of Man** (1948) establishes in Article XI that all people have the right to the preservation of their health through health and social measures, relating to food, clothing, housing and medical care, to the extent permitted by public and community resources. The **American Convention on Human Rights**, or Pact of San José, Costa Rica (1969), also singles out as a condition of the rule of law by which democratic institutions are governed, the guarantee of rights to all persons without distinction, including the basic conditions needed to uphold them. Thus, the rights to health preservation and equal access to well-being, social protection, and work, in addition to the right to life -and to a decent life-, among others, are contemplated in these instruments.

For its part, the **Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights -Protocol of San Salvador-** (1988) directly addresses the right to health, at the physical, mental, and social level, and generates the obligation of States to recognize health as a *public good* and particularly to adopt a series of measures to guarantee that right. These measures range from the guarantee that primary health care is within the reach of all people, the extension of the benefits of health services to all individuals subject to the State's jurisdiction, universal immunization against the

⁶ Social protection measures implemented by SICA countries in the wake of the crisis generated by COVID-19 (I), available at: <https://www.sisca.int/ocades-text/formacion/1-publicaciones/serie-de-infografias/desarrollo-proteccion-e-inclusion-social/covid-19-medidas-implementadas-por-los-paises-de-la-region-sica/1183-covid-19-medidas-de-proteccion-social-implementadas-por-los-paises-de-la-region-sica/file>.

principal infectious diseases, prevention and treatment of endemic diseases, education of the population on the prevention and treatment of health problems, as well as satisfaction of the health needs of the highest risk groups that are more vulnerable due to poverty.

Equally important for states is the need to consider the minimum conditions for exercising the right to health, as envisaged in the jurisprudence of the system, that is to say, availability, accessibility, acceptability and quality.⁷ In other words, it is key for states “to provide timely, appropriate health care and treatment, and to ensure that all healthcare establishments, goods, and services are accessible without discrimination, and must adapt their responses to circumstances such as those posed by the current pandemic by adhering closely to the pro persona principle, to ensure that timely, appropriate care for the population prevails over any other pattern or interest of a public or private nature”, while urging that there should be a special focus on people’s mental health given the psychological effects of this pandemic.

Another instrument that can help guide the actions of states in this social emergency is the **Social Charter of the Americas and its Plan of Action**. These documents reaffirm that the enjoyment of the highest attainable degree of health, without discrimination, is one of the fundamental rights of every human being. In both documents, the OAS member States recognize that the right to health is a fundamental condition for social inclusion and cohesion, integral development, and economic growth with equity, but they prioritize comprehensiveness when addressing the other facets of economic, social, cultural and environmental rights, such as the right to food, housing, employment and social security, among other rights that have also been impaired in connection with this pandemic.

In addition to establishing obligations for the member States of the Organization, these instruments set the tone for the design of *public policy responses with a human rights approach* to the emergency. After all, the human rights focus in the formulation of public policies is primarily “to adopt, as the framework of reference for their actions, the principles and standards that recognize the fundamental rights enshrined in both international instruments and national constitutions and regulatory frameworks.”⁸

The principles of *equality and non-discrimination*⁹ are also essential in tackling this crisis, especially in a regional context characterized by inequality and social exclusion. This consists of guaranteeing access to the right to health and to all the other rights contemplated in international and inter-American legal instruments that have been affected by the COVID-19 crisis, for the entire population. Objective and reasonable criteria based on equal opportunities to bridge the inequality gap must be used and arbitrary differences in treatment avoided; especially differences in treatment based on expressly prohibited and

7 The IACHR and OSRESCER Urge States to Guarantee Comprehensive Protection for Human Rights and Public Health during the COVID-19 Pandemic! Available at: http://www.oas.org/IACHR/media_center/PReleases/2020/060.asp⁷

8 Public policies with a human rights approach, available at: <https://www.oas.org/en/iachr/reports/pdfs/PublicPolicyHR.pdf>. UNFPA, “The human rights-based approach” available at: <https://www.unfpa.org/human-rights-based-approach>

9 Progress Indicators for the Measuring Rights in the Protocol of San Salvador. Available at: http://www.oas.org/en/sedi/pub/progress_indicators.pdf

discriminatory factors, such as race, ethnicity, gender, religion or social origin, bio-psycho-social conditions, or for reasons associated with the unequal distribution of resources and opportunities.¹⁰

It is also vital that states take the *right to information* into consideration in managing the crisis caused by the pandemic. Indeed, it is incumbent upon states to generate a legal framework that ensures the exercise of this right, especially in the current context, considering the minimum requirements, such as the principle of maximum transparency of information, the presumption of disclosure of meetings and key documents, broad definitions of the type of accessible information, short deadlines and reasonable costs,¹¹ among others. In this context, having reliable and updated statistical information on the pandemic (confirmed cases, cases under observation, deaths) is essential to eliminate or reduce the possibility of citizens being informed by disinformation or false or *fake news*. For states to better manage this crisis, it is important that people receive information and are kept informed of the seriousness of the situation, of the measures that are being adopted, and of the preventive measures that they must take, and that this information be accessible to all people without distinction, including persons with disabilities, indigenous peoples, and older persons, among others.

A cross-cutting feature of the analysis contained in this Practical Guide and the recommendations it makes is the concept of intersectionality, which is essential for fully grasping the challenges faced by people as a result of the pandemic and for developing responses. In other words, in the analysis of the pandemic and its effects and in the responses to it, it is vital to take into account the intersection of a variety of factors (age, sex, gender identity, race, ethnicity, disability, and so on) that coexist and may, together, curtail or nullify the enjoyment of people's rights.

The express purpose of this Practical Guide is to provide guidance to states on the instruments of the inter-American regulatory framework that help manage the current pandemic and to promote the principles of equality and non-discrimination in public policy responses to this global emergency. This Practical Guide offers a series of tools for devising responses that take into account the particular situation of certain historically excluded groups in our societies that we have called “groups in vulnerable circumstances” or “in situations of vulnerability.”¹²

The first section, by Alejandra Mora Mora, Executive Secretary of the Inter-American Commission of Women (CIM), focuses on the situation of **women** in the region, who are on the frontline of care and containment of the pandemic, both in public and private spaces.

10 *Ibid.*

11 *Ibid.*

12 Groups in a Situation of Vulnerability refers to the group of people who due to race, color, lineage or national or ethnic origin, cultural identity, religion, age, sex, sexual orientation, gender identity and expression, migratory, refugee, returnee, stateless or internally displaced person status, disability, genetic characteristics, or bio-psycho-social or any other conditions, have historically been discriminated against and have had the recognition, enjoyment or exercise of their rights denied or violated (definition based on the Inter-American Convention against All Forms of Discrimination and Intolerance. Available at: http://www.oas.org/en/sla/dil/inter_american_treaties_A-69_discrimination_intolerance.asp)

For their part, Adriana Rovira and Robert Perez, specialists in the rights of older persons, address the situation of this group deemed by the World Health Organization to be at highest risk from the virus.

Pamela Molina, a Specialist in the Vulnerable Groups Section of the Department of Social Inclusion, explores the challenges that this pandemic poses for generating responses that include **persons with disabilities**, prioritizing some recommendations that guarantee, among others, the right to information and the right to health and contemplate the principles of inclusion and accessibility, so that the latter can become a reality. The impact of this pandemic on indigenous peoples and Afro-descendant populations is a dimension that must also be a priority in state responses, since they are in a heightened situation of vulnerability due to the exacerbation of the gaps in poverty and inequality and the access difficulties they normally face in exercising their rights, including the right to health. Roberto Rojas, Head of the Groups in Situations of Vulnerability Section of the Department of Social Inclusion reviews the particular challenges of **Afro-descendant Populations** and offers some recommendations to manage the effects of the pandemic on this population. Focusing on the ethno-racial dimension, Daniel Sánchez, Government Expert for the Government of Peru in the Working Group of the Protocol of San Salvador (GTPSS), delves into the particular needs of **Indigenous Peoples** in times of pandemic and the potential exacerbation of their vulnerable situation.

Lesbian, gay, bisexual, trans and intersex (LGBTI) persons in the Americas face stigma and discrimination in society in general and in the health sector in particular. The President of the Working Group of the Protocol of San Salvador (WGPSS) and Government Expert for Uruguay, Andrés Scagliola, outlines the main obstacles LGBTI people face in exercising their right to health, paying particular attention to the COVID-19 context, and offers some recommendations for states to keep in mind.

Migrants and refugees are especially vulnerable to this disease, because many of them have difficulties accessing decent health care and health programs due to their nationality or immigration status. In many cases, they also face challenges with complying with social distancing measures due to overcrowding or the need to work in the informal economy. Alvaro Botero, Coordinator of the OAS-UNHCR Unit on Forced Displacement of the Department of Social Inclusion, reviews some of the challenges, and highlights key recommendations for dealing with this group, particularly in the context of a health emergency.

Rafael del Castillo, Technical Secretary of the WGPSS, assesses how the pandemic affects **persons deprived of liberty**, and outlines some recommendations on how to protect their right to health. Sara Mía Noguera, Head of the Equity Promotion Section of the Department of Social Inclusion, reviews the particular vulnerabilities, in this emergency situation, of **persons living in poverty**. She also includes concrete recommendations that could be implemented within existing social security systems in the region. Finally, another segment of the population hit by some of the measures adopted and requiring specific responses to safeguard their right to health and education are children and adolescents. Agustín Salvia, a Researcher and Independent Expert in the WGPSS and Ianina Tuñón, a Researcher, examine some of those impacts on children and present useful recommendations for addressing their particular plight. It is important to note that, although in this case children

and adolescents close to the authors were consulted, so far this segment of the population has not been consulted on a large scale or asked for its views, a process that is expected to begin in the near future.

The OAS General Secretariat, through its Department of Social Inclusion, thanks each of these authors for their valuable contributions to this Practical Guide and Pamela Molina, in particular, for her work in coordinating and editing contributions, as well as officers Esperanza Ramos, Mariette Vidal, and Rafael Del Castillo, for their support in the preparation of this document.

It is clear that the threat and uncertainty generated by the current global pandemic cannot be addressed by any country individually. If this unprecedented emergency is teaching us anything, it is that the health of the region and the world depend on the quality of each citizen's access to health. And that each human being pertains to multiple social categories and identities which must be addressed by public policies as a whole, in an intersectional way, for responses to be truly effective.

The emergency caused by COVID-19 also appeals to the sense of solidarity and cooperation that has characterized the region. For that reason, the OAS wants to contribute with this Practical Guide, conscious of the need to share all the information that is useful and necessary to further enhance states' responses. To that end, too, we **make our knowledge and tools available, based on the inter-American legal instruments signed and ratified by the member states, to articulate the responses more effectively and comprehensively, based on the principles of transversality, intersectionality, inclusion and collaboration.** Although it creates major challenges with respect to guaranteeing rights, this pandemic should also create opportunities to guarantee **more rights for more people.** For this purpose, the OAS General Secretariat places itself at their disposal.

RECOMMENDED MATERIALS:

- 01** OAS Charter¹³
- 02** American Declaration on the Rights and Duties of Man¹⁴
- 03** American Convention on Human Rights¹⁵
- 04** Protocol of San Salvador¹⁶
- 05** Social Charter of the Americas¹⁷ and its Plan of Action¹⁸
- 06** Progress Indicators for Measuring Rights under the Protocol of San Salvador¹⁹

¹³ Available at: http://www.oas.org/en/sla/dil/inter_american_treaties_A-41_charter_OAS.asp

¹⁴ Available at: <https://www.cidh.oas.org/Basicos/English/Basic2.american%20Declaration.htm>

¹⁵ Available at: <https://www.cidh.oas.org/basicos/english/basic3.american%20convention.htm>

¹⁶ Available at: <https://www.oas.org/juridico/english/treaties/a-52.html>

¹⁷ Available at: https://www.oas.org/en/media_center/press_release.asp?sCodigo=E-206/12

¹⁸ Available at: http://www.oas.org/en/sedi/dsi/docs/Soc-Charter_AG06884E04.doc

¹⁹ Available at: http://www.oas.org/en/sedi/pub/progress_indicators.pdf

CHAPTER I:

WOMEN, GENDER EQUALITY, AND COVID-19²⁰

Once again, the mark of feminism: interpret in a political way what appears as the everyday. (Feminism Now, Amelia Valcárcel)

In general terms, there is a global recognition of the importance of incorporating gender equality in responses to emergencies, disasters, and any other type of crisis. The *Sendai Framework for Disaster Risk Reduction 2015-2030* clearly stipulates consideration of gender equality in disaster risk reduction, emergency preparedness, and humanitarian aid actions.

Effective implementation of the recommendations of health authorities around the world on the COVID-19 pandemic will be the key to the success of containing this crisis. However, the participation and leadership of women is essential for the effective implementation of these recommendations.

1. THE SITUATION OF WOMEN IN THE AMERICAS AND COVID-19

The experience of other epidemics such as SARS, Ebola, or measles confirms that there are differentiated impacts on men and women of any crisis, including a health crisis -not only biologically, but also socially, economically, and politically. Although in biological terms, preliminary data indicate a lower mortality rate in women than in men, women face a higher risk of infection associated both with their role in health service centers and in jobs in the informal economy and in the service industry. In addition to the risk of infection, women also face the disproportionate burden of

²⁰ Prepared by Alejandra Mora Mora, Executive Secretary of the Inter-American Commission of Women (CIM).

unpaid work placed upon them, including caring for families, as well as their increased vulnerability to the economic crisis and fallouts from it.

The countries of the Americas are adopting specific policies and measures aligned with the general recommendations of entities such as the World Health Organization (WHO), which include essential measures such as, among others, distancing or social isolation, the closing of schools, the reduction or elimination of any activity in public spaces, the closing of non-essential business activities, and even quarantine. Although these measures are necessary to reduce the impact and scope of the pandemic, they largely depend on the differentiated contribution of women to maintain and sustain the social and family fabric. If no additional measures are taken to mitigate their impact, current measures will deepen inequalities of all kinds and undermine women's independence.

At times when companies close, where domestic service is dispensed with, and small and medium-sized companies are unable to sustain operating costs and laying off personnel, it is women who are most affected, since their jobs are often precarious, temporary, and largely without social security. Although men will also be affected in this sense, in the case of women, their loss of economic autonomy is directly related to a greater vulnerability to situations of dependency, violence, discrimination, and exclusion at multiple levels due to their gender. In this sense, states must **promote policies and programs to minimize the economic impact on women in the informal sector and those in a situation of economic precariousness due to the pandemic.**

According to the United Nations, 87,000 women were intentionally killed worldwide in 2017, and of that number, more than 50,000 were murdered by their partners, former partners, or a member of their family. The WHO notes that 30% of women in the Americas have suffered physical or sexual violence from their partner, and that 38% of women are killed by their partner or a former partner. Prolonged coexistence exacerbates situations of violence, especially in combination with stress and fear of loss of income or adverse economic situations, and the home can become the most insecure place when women and children are in confinement along with their attackers.

2. RECOMMENDATIONS FOR A GENDER-BASED EMERGENCY RESPONSE

It is essential that public measures of distancing and isolation consider **family-work balance for those who must continue to attend to their professional and work responsibilities**, particularly in the case of single-parent households, and in light of the closure of educational and childcare centers. It is important to **promote policies on co-responsibility and the equitable distribution of domestic work and care**, so that women can continue participating in their productive activities, even with the increase in housework due to the pandemic.

Similarly, during isolation and quarantine, **the incorporation of alternative measures for the prevention, care, and assistance for victims of various manifestations of gender violence in domestic settings is required, including services adapted for**

women with disabilities (especially deaf and blind women) and shelters for women and their children who are at risk or homeless, as well as specific measures for women refugees and victims of trafficking.

It is also essential that the **measures to combat COVID-19 consider those who are on the frontline of care, and take into account and spotlight their particular needs.** According to a study by the Inter-American Development Bank (IDB), in Latin America and the Caribbean half of the doctors and more than 80% of the nursing staff are women, the highest percentage in the world. As an extension of gender roles, nursing, geriatrics, and care services for dependent people are increasingly the domain of women. Nevertheless, **men tend to occupy the highest decision-making positions: in 2015, globally, only 27% of Ministries of Health were headed by women, and in our region, currently, only 8 Ministries of Health are led by women ministers.**

Despite their role at the center of families and communities and their ability to identify and warn about worrying health trends, women are not in leadership or decision-making positions related to preparedness, response, recovery, or mitigation of the crisis. There is evidence in multiple sectors that **parity in decision-making has resulted in greater plurality of options in addressing problems and better proposed solutions.** The participation of women, their leadership, and the breadth of their perspectives show that there are no gender-neutral policies and that the perspective and specific needs and interests of half of the population must have a voice of their own, which is even more fundamental for managing this crisis. In this sense, **it is essential to consider the National Mechanisms for the Advancement of Women as well as women in government positions of leadership and experts on gender issues in decision-making processes to address this pandemic situation and other effects.**

It is essential that the perspective of women, particularly women without a voice, be present and heard at decision-making tables on the immediate and long-term responses to COVID-19, particularly on the issue of their physical and economic autonomy. This crisis will present enormous challenges for women and their children and will reinforce the social division of labor that continues to perpetuate gender inequality. But this crisis can also be a moment of transformation and an opportunity to challenge traditional political, economic, and social dynamics, recognizing the experience and knowledge of women in protecting the health of families and communities, and adding the feminine perspective and contributions at this unprecedented juncture, calling for inclusive and equal leadership at all levels.

RECOMMENDED MATERIALS:

- 01** **Coronavirus: A worldwide pandemic that affects women differently²¹**
- 02** **UN Women. Checklist for response to COVID-19²²**
- 03** **The Atlantic. The Coronavirus is a Disaster for Feminism (March 19th 2020)²³**
- 04** **The Lancet. "COVID-19: the gendered impacts of the outbreak." Vol. 395, # 10227, (March 14th 2020)²⁴**
- 05** **UNISDR. Sendai Framework for Disaster Risk Reduction 2015-2030²⁵**

²¹ Available at: <https://dialogocim.wordpress.com/2020/03/18/coronavirus-una-pandemia-mundial-que-afecta-diferenciadamente-a-las-mujeres/>

²² Available at: <https://www.unwomen.org/en/news/stories/2020/3/news-checklist-for-covid-19-response-by-ded-regner>

²³ Available at: <https://www.theatlantic.com/international/archive/2020/03/feminism-womens-rights-coronavirus-covid19/608302/>

²⁴ Available at: [https://www.thelancet.com/journals/lancet/issue/vol395no10227/PIIS0140-6736\(20\)X0011-0](https://www.thelancet.com/journals/lancet/issue/vol395no10227/PIIS0140-6736(20)X0011-0)

²⁵ Available at: https://www.unisdr.org/files/43291_spanishsendaiframeworkfordisasterri.pdf

CHAPTER II:

CONSIDERATIONS FOR AN INCLUSIVE RESPONSE FOR OLDER PERSONS TO THE COVID-19 PANDEMIC IN THE AMERICAS²⁶

1. OLDER PERSONS IN THE AMERICAS

The population of the Americas is aging at an accelerated rate, with a marked increase in the aging index, although with differences between subregions: while between 2010 and 2015, Canada, Cuba, Puerto Rico, and Martinique showed aging indexes above 100 (they have more people over 60 years of age than under 15), countries like Belize, Guatemala, Haiti, and Honduras show an aging rate of around 20 persons over 60 for every 100 persons less than 15 years old (United Nations 2017).

Among older people, the group which is growing the fastest is that of people 80 years old and older, which is known as aging of the aging, with a very strong surge expected as of 2025 (United Nations, 2017).

These situations are already posing a series of unprecedented challenges for the health, social security, and care systems of the region, with respect to guaranteeing the rights of older people. The way in which states understand their role in the distribution of social welfare is essential for the implementation of basic services and health systems that are accessible and equitable for the population. Old age is not only a stage of life, but is directly linked to the right to a prolonged life which is based on access to services and to equality and dignity in life.

²⁶ Prepared by Adriana Rovira, Social Psychologist and University Professor and Researcher in older persons and human rights, and Robert Perez, Doctor in Community Mental Health and Co-coordinator of the Interdisciplinary Center on Aging at the University of the Republic of Uruguay.

2. WHAT DO WE KNOW ABOUT THE PANDEMIC AND OLDER PERSONS?

The recent outbreak of the new coronavirus (SARS-CoV-2) and its rapid expansion throughout the world means that we still do not have clear evidence on the scope of this pandemic. Although there are not yet enough data to analyze the mortality rate of this virus in general, and in the Americas in particular, the experience of countries where the spread of the virus has reached advanced stages indicates that the highest mortality rate occurs among older people. This is the case in Italy where, although no deaths of persons under 30 years old have been reported among infected people, the mortality rate for the 30-59 age range is 1.1%, increasing to 11.5% for the 60-79 age range, and to 24% for those over 80 years old.²⁷ Something similar is taking place in China, where the mortality rate of people with COVID-19 is 3.6% for the 60-69 age range, 8% for the 70-79 age range and 14.8% for those over 80 years old.²⁸ Beyond the analysis that will need to be done to determine whether mortality is due to the biological effect of the virus in certain living organisms or to the responses of health systems, or both, it is clear that older persons are one of the groups most at risk of developing severe forms of this disease. The biological changes linked to age, as well as the increase in other pathologies, clearly facilitate this process.²⁹

It is reasonable to suppose that in the Americas this situation will continue and become even more marked especially in countries that have not yet been able to develop advanced health, social security, and care systems. Moreover, older persons are not a homogeneous group and therefore, in addition to age, other vulnerabilities will coexist at different levels in the context of the pandemic: someone who has his or her basic needs satisfied (housing, food, health, education, income, affection, etc.), will not be affected in the same way as someone who does not and who will become part of an especially vulnerable subgroup within that group already at risk. The same is true of older persons who are institutionalized and/or have mental disorders, cognitive impairment, or dementia: another highly vulnerable group. An additional factor faced by this group is social stigma, which is a violation of rights that can erode people's dignity and even threaten their lives.

In order to protect older persons from contagion, the most effective measure thus far taken by governments to prevent or delay it has been physical or social distancing: a remedy that may, however, also negatively impact the mental health of this vulnerable group facing imminent risk from the pandemic, and cause them anxiety, depression, stress, isolation, and so on.³⁰ It is therefore essential to monitor and assess those effects on mental health, not as an individual phenomenon but as part of a social construct impacting people, with a view to generating social and community mitigation strategies. This is particularly important when people are placed in institutions, in which it is vital to monitor respect for their human rights in social distancing situations.

27 COVID-19 Taskforce, 2020

28 The Novel Coronavirus Pneumonia Emergency Response Epidemiology Team, 2020.

29 Malone et. Al., 2020; WHO, 2020.

30 (WHO, 2020).

3. LEGAL FRAMEWORK: OLDER PERSONS IN THE HUMAN RIGHTS AGENDA

Although older persons are mentioned in various universal and regional generic mechanisms for the protection of rights, it is only in the past decade, with the adoption of the **Inter-American Convention on Protecting the Human Rights of Older Persons** (OAS) in 2015, that specific attention has been drawn to this population. Based on this instrument, old age is considered to be 60 years and older. Given the size of this population, it will be necessary to identify which segments within it age in a context of structural inequality, and which ones will need to be cared for as a priority, especially in the context of the pandemic.³¹

The core importance that needs to be attached to the right to health of older persons is clear. But it is impossible to talk about health if there are no guarantees for the protection of human rights, so that, even in emergency situations, those rights must be construed in a broad and comprehensive manner, in which the key factor is a decent life. That is precisely why Article 6 (*Right to life and dignity in old age*) of the Convention on Protecting the Human Rights of Older Persons (OAS, 2015) protects, on an equal footing, “effective enjoyment of the right of life and the right to live with dignity in old age until the end of [...] life.”

4. RECOMMENDATIONS TO STATES ON TAKING OLDER PEOPLE INTO CONSIDERATION IN THEIR RESPONSES TO THE COVID-19 PANDEMIC

- Given that older people are a special priority in the context of COVID-19, provide the state resources needed to meet preventive and assistance requirements of older people.
- Provide guidelines and information to health and social welfare teams on protection of the rights of older people, with special emphasis on combating stigma.
- Generate, and create protocols for prevention and control mechanisms in social and health services to prevent negligent or prejudiced actions that impair protection of older persons’ right to health and dignity.
- Generate statistical information taking older persons into account with a view to ascertaining, and systematically recording, how they have been affected by COVID-19 and the intervention procedures that were carried out.
- States must guarantee that the rights of older persons are fully respected, placing special emphasis on their right to health, dignity, and involvement in the different aspects and measures to be taken that impact their lives.

31 In relation to this, the *Inter-American Convention on Protecting the Human Rights of Older Persons*, Article 5 *Equality and non-discrimination or reasons of age* is recommended.

- Provide accurate and adequate information to older persons, according to their circumstances, for decision-making and evaluation of health and social risk situations. This means taking whatever steps are needed to include Deaf persons, hard of hearing persons, and people with cognitive disabilities or mental health problems.
- Take whatever steps are needed to ensure that under no circumstances is the right to health imposed over a person's right to dignity.
- Pay special heed to persons in situations of structural inequality and discrimination for belonging to LGBTBI groups, particularly the segments of the population mentioned in Article 5 of the Inter-American Convention on Protecting the Human Rights of Older Persons.
- Generate processes to control and monitor the prices of essential items for the elderly, since during a health emergency those costs may increase.
- Physical or social distancing measures should not, under any circumstances, lead to social isolation, deprivation of personal freedom of movement, and restrictions on communication with third parties, all of which must be prohibited.
- Promote special measures to protect against violence, abuse, and mistreatment, paying particular heed to the fact that "stay-at-home" recommendations may lead to isolation and exacerbate domestic violence.
- Older persons under full-time institutional care require special protection. Surveillance and coordination are needed to safeguard the rights of older persons, including their right to health and dignity.
- Social isolation measures and deprivation of liberty of older persons under full-time care services should be prohibited and punished.
- Pay special heed to the situation of older persons with diminished autonomy, who need to be helped with essential day-to-day tasks. Provide care for those who have temporarily or permanently lost their personal care support network.
- A key recommendation is to not stop essential services for the protection of the rights of older persons, such as legal aid, payment of pensions and retirement benefits, access to social benefits, and so on.

- Given the social and economic constraints associated with the health emergency, administrative and bureaucratic mechanisms need to be put in place to ensure economic security for older persons, facilitating adequate access to their pensions and other income. It needs to be borne in mind that not all older people are familiar with electronic systems, so it is essential to maintain in-person services for them.
- Take actions to ensure older persons' access to enough food, especially fresh food, which is vital for their health.

RECOMMENDED MATERIALS:

01 Inter-American Convention on Protecting the Rights of Older Persons³²

02 Independent Expert Mechanism on the enjoyment of all human rights by older persons. Resolution 24/20 2013. United Nations³³

03 Huenchan, Sandra and José M. Guzmán. 2006. "Economic Security and Poverty in Old Age: Tensions, Expressions and Challenges for Policies", Meeting of Experts on Population and Poverty in Latin America and the Caribbean, November 14 and 15, 2006, Santiago, Chile. Organized by the Economic Commission for Latin America and the Caribbean, CELADE-Population Division, under the auspices of the United Nations Population Fund (UNFPA)³⁴

04 Huenchuán, Sandra (ed.). 2009. Aging, human rights and public policies. Santiago de Chile: ECLAC³⁵

³² Available at: http://www.oas.org/en/sla/dil/inter_american_treaties_a-70_human_rights_older_persons.asp

³³ Available at: <https://www.ohchr.org/en/issues/olderpersons/ie/pages/ieolderpersons.aspx>

³⁴ Available at: https://www.cepal.org/celade/noticias/paginas/5/27255/huenchuan_guzman.pdf

³⁵ Available at: https://www.cepal.org/celade/noticias/paginas/5/27255/huenchuan_guzman.pdf

- 05** Malone, M., Hogan, T., Perry, A., Biese, K., Bonner, A., Pagel, P. & Unroe, K. (2020) COVID-19 in Older Adults: Key Points for Emergency Department Providers. *Journal of Geriatric Emergency Medicine*. 1 (4): 1-11
- 06** United Nations. Department of Economic and Social Affairs, Population Division. *The demographic situation in the world 2017. Concise report*. NY; 2017³⁶
- 07** Task force COVID-19 (2020). *Epidemic COVID-19, National update: March 23, 2020*. Department of Infectious Diseases and IT Service, Higher Health Institute, Italy³⁷
- 08** The Novel Coronavirus Pneumonia Emergency Response Epidemiology Team (2020) *The Epidemiological Characteristics of an Outbreak of 2019 Novel Coronavirus Diseases (COVID-19) - China, 2020*. Chinese Center for Disease Control and Prevention 2 (X): 1-10³⁸
- 09** World Health Organization (2020). *Mental health and psychological resilience during the COVID-19 pandemic*.³⁹

³⁶ Available at: <https://www.un.org/en/development/desa/population/publications/pdf/trends/Concise%20Report%20on%20the%20World%20Population%20Situation%202014/es/pdf>

³⁷ Available at: https://www.epicentro.iss.it/coronavirus/bollettino/Bollettino-sorveglianza-integrata-COVID-19_26-marzo%202020.pdf

³⁸ Available at: <http://www.ourphn.org.au/wp-content/uploads/20200225-Article-COVID-19.pdf>

³⁹ Available at: <https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/3/mental-health-and-psychological-resilience-during-the-covid-19-pandemic>

CHAPTER III:

TOWARDS AN INCLUSIVE RESPONSE FOR PERSONS WITH DISABILITIES IN THE FACE OF THE COVID-19 EMERGENCY⁴⁰

1. SITUATION OF PERSONS WITH DISABILITIES IN THE AMERICAS: STIGMATIZATION, ACCESS BARRIERS, DISCRIMINATION, AND INVISIBILITY

In the current context resulting from the COVID-19 pandemic, persons with disabilities is one of the groups that is most seriously neglected, especially because of the absence of **accessibility mechanisms** that reduce the barriers surrounding them on a daily basis and make prevention and care measures more effective. Recommendations that seem obvious and easy to follow, like constantly washing hands, avoiding touching surfaces, or maintaining social distance, constitute a huge barrier for persons with disabilities. There are persons whose disability prevents them from washing their hands by themselves or accessing the tap or sanitizer; there are people who need to touch surfaces to gather information about their environment in order to function, and persons who use their hands to move around; all of whom are therefore at high risk of being infected and unable to precisely follow World Health Organization (WHO) guidelines. Even instructions on how to wash hands properly may also be inaccessible, in many cases, to persons with visual disabilities. These are only a few examples.

According to the latest official statistics available from the World Bank and the World Health Organization, more than a billion people in the world have a disability.⁴¹ That is, one in seven persons. In the Americas, this represents approximately 85 million

⁴⁰ Prepared by Pamela Molina, Disability Specialist, Department of Social Inclusion, Secretariat for Access to Rights and Equity of the OAS.

⁴¹ Cf. World Report on Disability. World Health Organization (WHO) and World Bank (WB), 2011. Available at: https://www.who.int/disabilities/world_report/2011/report.pdf

people. In addition, as indicated by the United Nations Economic Commission for Latin America and the Caribbean (ECLAC),⁴² women, Afro-descendant populations, indigenous peoples, older adults, and families living in poverty are more likely to acquire a disability. If all of this were not enough, persons with disabilities have to deal with the **stigma associated** with their corporality (embodiment) and diversity (supposed inability, unproductiveness, handicap, dangerousness).

We can distinguish **three main groups of barriers** faced by persons with disabilities and which put them at high risk during this health emergency:

- **Barriers to prevention measures:** no or little access to preventive public health information; barriers to executing a large part of the recommendations for prevention (access to hygiene resources, mobility, dependence on physical contact with the environment, difficulties in maintaining social distancing due to dependence on personal assistants, or because they are in a psychiatric or other type of institution, deprived of liberty and/or in conditions of poverty and overcrowding).
- **Barriers to risk minimization and control measures:** the implementation of quarantines, curfews, or similar restrictive measures can mean interruptions in vital services for many persons with disabilities, as well as for older adults, and limit the exercise of basic rights such as access to food, hygiene, and communications, leading to abandonment, isolation, and risk of forced institutionalization, as well as of being victims of abuse and violence. For many persons with disabilities, support and assistance personnel are as vital as the air they breathe.
- **Barriers to health care and attention measures:** if they become infected with COVID-19, persons with disabilities may face additional barriers to seeking medical attention, due to communication and mobility difficulties. Also, they could be more likely to be at risk of being more seriously ill because of health problems related to their kind of disability. In addition to this, persons with disabilities around the world already face discrimination and negligence from health care personnel who consider disability a variable to justify not prioritizing health care for them in a context of scarce resources and personnel. This current criterion becomes a violation of the inalienable right to health and life and is an act of serious discrimination on the basis of disability.

42 Cf. Social Panorama of Latin America and the Caribbean: the situation of people with disabilities. CEPAL, 2012. Available at: <https://www.cepal.org/es/publicaciones/1247-panorama-social-america-latina-2012>

2. THE SPECIFIC MANDATORY OR RELEVANT LEGAL AND PROGRAMMATIC FRAMEWORK FOR STATES IN THE REGION

The **United Nations Convention on the Rights of Persons with Disabilities** (UN-CRPD, 2006), signed and ratified by the majority of the OAS member states reaffirms in its Article 25 on **Health** the right of persons with disabilities to enjoy the highest possible level of health, without discrimination on the basis of disability.⁴³

For its part, the **Inter-American Convention for the Elimination of All Forms of Discrimination against Persons with Disabilities (CIADDIS-OAS)**, signed and ratified by 19 member states of the OAS; and the **Program of Action for the Decade of the Americas for the Rights and Dignity of Persons with Disabilities (PAD-OEA, 2016-2026)** emphasize the right to prevention, access, and health care for people with disabilities, without discrimination. In particular, it should be noted that the PAD, in its **Goal 2**, on **Health**, establishes the duty of the OAS member states to broaden, enhance, and ensure access of persons with disabilities to health services [...], on an equal footing with other persons and ensuring that existing services mainstream the disability perspective and, when relevant, [...] that of other groups in situations of vulnerability and/or who have been historically discriminated against. In its **Goal 13**, on emergency, catastrophic, and disaster situations, the PAD establishes that states must guarantee the integral management of person with disabilities in situations of risk, taking into account their needs before, during, and after the emergency, including their [support tools] or personal assistance measures as a means to safeguard their autonomy, displacement, and independence. Finally, **Goal # 3 of the 2030 Agenda**: "Ensure healthy lives and promote well-being for all at all ages", in section 3.8. reaffirms the duty of States to: "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". Goals 1, 2, 4, 5, 6, 8, 10, 11, 16 and 17 are also relevant.⁴⁴

3. RECOMMENDATIONS: UNTIL INCLUSION AND ACCESSIBILITY BECOME A HABIT!

a. In the framework of information and communication policies:

- All public health information before, during and after the emergency, must be regularly disseminated **in a variety of formats accessible** to persons with disabilities at the same time and through the same channels as for

⁴³ Cfr. United Nations Convention on the Rights of Persons with Disabilities: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>. See also Article 25, others directly interrelated with human rights in emergency situations: Article 4, 5, 9, 10, 11, 12, 14, 15, 16, 17 and 19, among others.

⁴⁴ Cfr. Sustainable Development Goals: <https://sustainabledevelopment.un.org/?menu=1300>

the rest of the population. This implies that all audible communication must be available in visual materials (sign language, subtitles), and all visual information must be available in audio formats, such as audio-description, audio-text, tactile methods, augmented communication, and other alternative communication formats. There must be plain language versions, pictograms, and infographics for people with intellectual disabilities or neuro diversities.⁴⁵

- Sign language interpretation must be carried out by trained and neutral professionals, recognized by the national Deaf community, who are, together with the authorities, reporting on the situation including on television. Small boxes are not effective. It is important to consider that the Deaf community is heterogeneous and, therefore, subtitles and sign language for reporting in emergency situations should be used together.⁴⁶
- Make information and communication technologies (ICT) and assistive technologies that promote communication and autonomy of individuals in emergency situations available to public services and persons with disabilities -such as video chats for the use of interpreters in health services, cellular applications to detect infections, location indicators, emergency hotlines, phone numbers to get basic supplies delivered, programs to describe environments to blind people, read labels, and so on-.⁴⁷
- Sign language interpreters and personal assistants, guide-interpreters for persons who are blind or with low vision, among others, working in healthcare and emergency situations must receive the same health, hygiene, and safety protections as other personnel working on COVID-19.
- Persons with multiple disabilities, who depend on personal assistants to access information, such as deafblind people and other kind of multiple disabilities have to be taken into consideration. The former, for example, require tactile interpreters, which involves twice as many care measures available for them.

⁴⁵ Examples of use of simple language to deliver self-care information during the Emergency can be found at: <https://www.facebook.com/Copidisgcba/videos/235746131154622/UzpfSTc5NTYONTA4NDoxMDE2MzYwNzUyNzczMDA4NQ?/id=795645084>. Pictograms (Argentina): <https://www.facebook.com/318014794882002/post/3494120850604698/?sfnsn=scwspmo&extid=cbp6MKhnfXg0V> Gtx.

⁴⁶ Examples of accessible audiovisual information (Argentina): <https://www.facebook.com/AgenciaNacionaldeDiscapacidad/videos/vb.318014794882002/2495492690555902/?Type=2&theater>. Examples of information campaigns for deaf people and sign language interpreters in Chile: <https://www.youtube.com/watch?v=WlCUMpEDNc> and https://www.youtube.com/watch?v=DNIB2HL_7EQ & feature =youtu.be.

⁴⁷ In Peru, a WhatsApp service telephone number was created so that deaf or hard-of-hearing people who have doubts about the emergency or feel symptoms and need guidance, can communicate directly and autonomously with health services. Example of a video call service for deaf people in Argentina in response to the crisis: <https://www.facebook>

b. Within the framework of contagion control and mitigation policies:

- In the case of quarantines, curfews, and home restrictions, the needs of support providers, personal assistants, and caregivers of persons with disabilities must be met, as well as those of persons on the autism spectrum, neuro-diversities, or with psychosocial disabilities - for whom contact with the environment and open spaces is essential to remain calm - and specific policies must be established to allow for their mobility and continued services. Personal assistance and care services for persons with disabilities should never be interrupted.⁴⁸
- Additional protective measures should be adopted for persons with disabilities in specific situations, such as:
 - Disinfecting entrance doors reserved for wheelchairs, ramp and stair handrails and doorknobs for people with reduced mobility.
 - Prioritization of persons with disabilities and older adults in the delivery of protective gloves, antibacterial soap, and antibacterial wipes, among others, as they require them more frequently since they use their hands to move around and interact with the environment.
 - Consider home tests for the virus, prioritizing persons with disabilities, their personal and family assistants, and older persons.
 - Blind people and people with a low vision must also rely on support networks for purchases and other processes which need to be done outside their home, in order to prevent risks of transmission. States must ensure that these support networks exist and are activated in emergencies like the current one.
- Establish communication and coordination policies with community support networks and intermediary care services for persons with disabilities and older adults in emergency situations, to ensure continuity, advice, and support in the context of public policy responses to the emergency.⁴⁹
- The COVID-19 crisis and confinement measures can generate fear and anxiety. Psychosocial and therapeutic care should not be interrupted during these periods. An example of public policy could be to authorize by law remote psychiatric and psychological support, among other professional

⁴⁸ Example of issuance of free passes certificates for people with disabilities as a State policy (Argentina): <https://www.boletinoficial.gob.ar/detalleAviso/primera/227248/20200329>. In the United Arab Emirates, an online application system was established to obtain a circulation permit for personal assistants and to maintain the continuity of service during quarantines; the same for people with disabilities requiring contact with the exterior.

⁴⁹ It is also possible for States to organize volunteer networks for these purposes (for example: civil society initiatives in Argentina I-E, and COALIVI, an organization of blind people in Colombia)

services, which could also be covered by social protection policies.⁵⁰

- All preparedness and response plans should be inclusive and accessible to women with disabilities, including a gender perspective, and must take into consideration their greater exposure to gender violence due to home isolation. States must be aware of this risk and generate management, prevention, and support policies.
- The number of people in institutions should be progressively reduced, and transition to community-based outpatient services should take place. Under no circumstances should a person be forced to take psychosocial medication or receive a treatment in the name of the emergency situation or quarantine.
- Under no circumstances should institutionalization and abandonment due to disability be authorized. Persons with disabilities should not be institutionalized as a consequence of quarantine measures or any other reason, and especially without their free and informed consent.
- Personal assistants, support workers, or interpreters who continue to provide their services during quarantines should be proactively tested for COVID-19 to minimize the risk of spreading the virus to persons with disabilities.
- Remote work or education services must be equally accessible to employees/students with disabilities, with a cross-cutting perspective.
- Decision makers should consider that business restrictions disproportionately impact persons with reduced mobility and other disabilities. A best practice in terms of allowing for alternatives is, for example, the case of Australia, Argentina and the United States where specific store hours are scheduled especially for persons with disabilities and older persons.
- Any support program for groups in situations of vulnerability, including freezing personal debt payments, employment alternatives and socio-economic aid, **must include the disability variable in an intersectional manner.**⁵¹

c. In the framework of health care and attention policies during the emergency

- It is necessary to train all local and national health services personnel in effective, accessible, and affordable care and communication regarding persons with disabilities, with a focus on human rights and equity.
- Persons with disabilities who need health services due to COVID-19, such as

⁵⁰ An example of a civil society initiative in Argentina: <https://www.facebook.com/109326287204778/posts/156408842496522/>.

⁵¹ For example, cash distribution measures may not be a good option for many persons with disabilities, as they may not be able to find the items they need due to accessibility barriers. For state financial assistance measures in emergencies, the most effective way to help is to deliver food baskets and essential goods and to provide affordable or cost-free and accessible basic services, including, where necessary, home delivery services.

hospitalization, ventilators, and so on, cannot be deferred or omitted due to their disability. From a public policy perspective, it is essential to clearly prioritize human life and human dignity, first and foremost, equally and without distinctions of any kind due to disability or age.

d. Planning and preparedness policies for future emergencies

- It is essential to generate statistics broken down by groups in situations of vulnerability, including persons with disabilities, in order to collect evidence needed to enhance the planning of responses to future health and other emergencies. A best practice in this regard is the use of virtual surveys, through platforms such as Survey Monkey or others, to facilitate the production of unpublished and approximate data in the context of crises.
- Before, during, and after emergencies, states must engage in close consultation and collaboration with civil society organizations of the region representing persons with disabilities who must actively participate in the entire process of proposal, design, approval, and monitoring of public policy responses and solutions to crises.⁵²

⁵² Before, during and after emergencies, develop specific protocols for inclusive responses for persons with disabilities, the effectiveness of which can be evaluated. Example of an inclusive disability protocol prepared by the Government of India: <https://www.outlookindia.com/newscroll/covid19-govt-issues-comprehensive-disability-guidelines/1782164>.

RECOMMENDED MATERIALS:

- 01** Declaration of regional and international organizations of persons with psychosocial disabilities including recommendations in the context of the COVID-19 pandemic⁵³
- 02** Regional Risk Communication and Community Engagement (RCCE): COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement⁵⁴
- 03** Human Rights Watch: Protect Rights of People with Disabilities During COVID-19: Ensure Access to Information, Essential Services for Those Most at Risk⁵⁵
- 04** COVID-19: Who protects persons with disabilities? United Nations expert alert⁵⁶
- 05** International Disability Alliance: Survey on COVID-19 and People with disabilities⁵⁷
- 06** International Disability Alliance: COVID-19 and the Disability Movement⁵⁸

⁵³ Available at: http://www.chrusp.org/home/covid19?fbclid=IwAR3khdA24xvgSODK5IBVluuzHB GqOifFGnnapelPE_xg6T4nXLYKBUOR6g.

⁵⁴ Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/COVID_19_CommunityEngagement_130320.pdf.

⁵⁵ Available at: <https://www.hrw.org/news/2020/03/26/protect-rights-people-disabilities-during-covid-19#>.

⁵⁶ Available at: https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25725&LangID=S&fbclid=IwAR0ts1XjRGvdIcb0__a6MDpMQoiRVAaQQGvIFHXhw7ljmXIKq6IFnkYfE7U.

⁵⁷ Available at: https://docs.google.com/forms/d/e/1FAIpQLSeESduS_RXj_mGtK3d BmJrIN9x9AcVYqk7EEVowq_Zo4zdBA/viewform.

⁵⁸ Available at: <http://www.internationaldisabilityalliance.org/en/content/covid19-and-the-movement-of-disability>.

CHAPTER IV:

COVID-19 AND THE POPULATION OF AFRICAN DESCENT⁵⁹

1. THE SITUATION OF THE POPULATION OF AFRICAN DESCENT IN THE AMERICAS AND THE IMPORTANCE OF ITS INCLUSION IN POLICY RESPONSES

According to various international and regional organizations, around 200 million persons of African descent⁶⁰ live in the Americas and most of them are in a situation of vulnerability; this is a consequence of poverty, underdevelopment, social exclusion, and economic inequalities, which are closely linked to racism, racial discrimination, xenophobia and related practices of intolerance.

In this context, the United Nations and other regional organizations, such as the Organization of American States (OAS),⁶¹ have repeatedly expressed concerns regarding the inclusion, respect for human rights and the needs of people of African descent. Furthermore, the United Nations and OAS General Assemblies have adopted a series of resolutions and action plans to promote recognition, justice, and development of this important population. Worth highlighting in this regard are the **International Decade for People of African Descent** (2015-2024) at the United Nations and the **Plan of Action for the Decade for Persons of African Descent in the Americas** (2016-2025) at the OAS.

⁵⁹ Prepared by Roberto Rojas Dávila, Head of the Vulnerable Groups Section of the Department of Social Inclusion, OAS Secretariat for Access to Rights and Equity.

⁶⁰ People of African descent are those who live in the Americas and wherever there is an African diaspora as a consequence of slavery and of having been historically denied the exercise of their fundamental rights

⁶¹ Through its General Secretariat, as well as the Inter-American Commission and Court of Human Rights, and the Summits of the Americas Process.

2. RELATED INTER-AMERICAN LEGAL FRAMEWORK

The population of African descent is addressed in the following inter-American instruments, among others:

- American Declaration of the Rights and Duties of Man;
- Charter of the Organization of American States;
- American Convention on Human Rights;
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights - Protocol of San Salvador;
- Declaration of the Conference of the Americas, Preparatory to the III World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance - Declaration of Santiago;
- Inter-American Democratic Charter;
- Social Charter of the Americas;
- Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance;
- Inter-American Convention against all Forms of Discrimination and Intolerance;
- Plan of Action for the Decade for People of African Descent in the Americas (2016-2025).

3. RELEVANT ASPECTS AND RECOMMENDATIONS

Given the historical situation of discrimination and social exclusion of the majority of the Afro-descendant population in the Americas, COVID-19 has a disproportionate impact on this group because most of the measures adopted by the countries of the region do not have a differential approach nor do they have an inclusive, transversal, and intersectional perspective.

In relation to the right to health, the Pan American Health Organization (PAHO) affirms that the Afro-descendant population suffers the consequences of significant gaps in health due to determining socioeconomic factors resulting from the discrimination and historical exclusion they have suffered. Likewise, it points out that information systems do not collect sufficient data regarding the variable of ethnicity, leading to a lack of disaggregated data to allow a precise identification of the specific dimensions of this population's health. In addition, it considers that this situation of invisibility and exclusion of persons of African descent represents a challenge with regard to achieving the Sustainable Development Goals (SDGs) relating to health, such as those having to do with universal access to health and universal health coverage, tuberculosis, malaria,

and mental health, among others.⁶²

On the other hand, in relation to the social distancing measures ordered by various states in the region, it is important that they take into account, as indicated by the World Bank, the persistence of poverty gaps between Afro-descendants and non-Afro-descendants. Likewise, the Bank points out that, in general, persons of African descent have higher levels of unemployment in all countries and, among those who do have a job, a higher proportion of them work in low-skilled employment and are also more likely to have precarious jobs in a majority of countries.⁶³

Similarly, it is important that states take into account, as ECLAC points out, the disadvantages in access to basic services, drinking water, and sanitation by people of African descent in relation to the rest of the population.⁶⁴ It is also important that they take into account the habitability of homes, since ECLAC has been able to confirm that in most countries the percentage of people of African descent living in overcrowded homes is higher than that of non-Afro-descendants, both in urban and rural areas.⁶⁵

Likewise, it is important to bear in mind that, as indicated by the World Bank, the Afro-descendant population has significantly lower levels of education in most countries; particularly in primary education in rural areas.⁶⁶

Finally, it is of utmost importance that when implementing measures in response to COVID-19, states guarantee the principle of equality and non-discrimination, take into account ethnic, cultural, and linguistic diversity, and incorporate a focus on gender and intersectionality.

62 Pan American Health Organization. *Ethnicity and Health Policy*. Washington D.C., 2017.

63 World Bank. *People of African Descent in Latin America*. Washington D.C., 2018.

64 Economic Commission for Latin America and the Caribbean. *Situation of people of African descent in Latin America and challenges of policies to guarantee their rights*. Santiago, Chile, 2017.

65 Ibid.

66 World Bank. *People of African Descent in Latin America*. Washington D.C., 2018.

RECOMMENDED MATERIALS:

- 01** World Bank. **People of African descent in Latin America: Towards a framework of inclusion.** Washington D.C., 2018⁶⁷
- 02** ECLAC. **Situation of people of African descent in Latin America and policy challenges to guarantee their rights.** Santiago, Chile, 2017⁶⁸
- 03** IACHR. **The Situation of People of African Descent in the Americas.** Washington D.C., 2011⁶⁹
- 04** OAS. **Protection Standards for People of African Descent in the Inter-American System: A Brief Introduction.** Washington D.C., 2011⁷⁰
- 05** OAS. **Plan of Action for the Decade for People of African Descent in the Americas (2016-2025)**⁷¹
- 06** United Nations. **International Decade for People of African Descent (2015-2024)**⁷²
- 07** OPS. **Ethnicity and Health Policy.** Washington D.C, 2017⁷³
- 08** PAHO. **Strategy and Plan of Action on Ethnicity and Health (2019-2025).** Washington D.C., 2019⁷⁴

⁶⁷ Available at: <http://documentos.bancomundial.org/curated/es/316161533724728187/pdf/129298-7820181730-51-AfrodescendientesenLatinoamerica.pdf>.

⁶⁸ Available at: https://lac.unfpa.org/sites/default/files/pub-pdf/S1701063_es.pdf.

⁶⁹ Available at: http://www.oas.org/es/cidh/afrodescendientes/docs/pdf/AFROS_2011_ESP.pdf

⁷⁰ Available at: http://www.oas.org/dil/esp/publicaciones_estandares_de_proteccion_afrodescendientes_2011.pdf.

⁷¹ Available at: <https://www.oas.org/en/sare/documents/res-2891-16-en.pdf>

⁷² Available at: <https://www.un.org/en/observances/decade-people-african-descent>

⁷³ Available at: https://www.paho.org/hq/index.php?option=com_docman&view=download&category_slug=paho-who-mandates-strategies-6353&alias=47099-policy-on-ethnicity-and-health&Itemid=270&lang=en

⁷⁴ Available at: <https://iris.paho.org/handle/10665.2/51744>

CHAPTER V:

PREVENTION, CONTAINMENT, AND MITIGATION OF COVID-19 IN INDIGENOUS POPULATIONS⁷⁵

1. THE SITUATION OF INDIGENOUS POPULATIONS AND THE IMPORTANCE OF A DIFFERENTIATED RESPONSE

The states of the region have been taking a series of exceptional measures to deal with the COVID-19 pandemic. These measures generate differentiated impacts among populations, especially groups in situations of vulnerability, including indigenous peoples. There are around 826 indigenous peoples in the region, with a total population of approximately 45 million.⁷⁶ There is also a known presence of indigenous peoples in a situation of voluntary isolation or initial contact in Bolivia, Brazil, Colombia, Ecuador, Paraguay, Peru, and Venezuela.⁷⁷ It is impossible to know how many indigenous populations or people remain in isolation, but some refer to approximately 200 villages and 10,000 people.⁷⁸

Starting in the 15th century and to this day, epidemics have had a great impact on

⁷⁵ This document was prepared by Daniel Sánchez, Representative of the Government of Peru on the Working Group of the Protocol of San Salvador (GTPSS), with the close collaboration of anthropologist Dulce Morán Anticona, a Specialist on Indigenous Issues and Advisor to the Ministry of Justice and Human Rights of Peru.

⁷⁶ Fabiana Del Popolo (ed.): *Indigenous peoples in America (Abya Yala): challenges for equality in diversity*. CEPAL Books, No. 151 (LC / PUB.2017 / 26), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC), 2017, p. 467.

⁷⁷ Villages in isolation are towns that do not maintain regular contact with the majority population, and who also generally avoid all kinds of contacts with people outside their group. The towns in initial contact are towns that maintain intermittent or sporadic contact with the majority non-indigenous population. Cf. IACHR, *Indigenous Peoples in Voluntary Isolation and Initial Contact in the Americas*. OEA / Ser.L / V / II. Doc. 47/13 December 30, 2013, pp. 4 and 5.

⁷⁸ *Idem*, pp. 5, 6 and 7.

the health and life of indigenous peoples.⁷⁹ Indeed, as a result of historical exclusion and discrimination, they have higher rates of poverty compared to the non-indigenous population,⁸⁰ limited access to health services,⁸¹ and poor health conditions,⁸² putting them at high risk during epidemics, which can cause harm not only to their life and integrity, but also to the cultural survival of these groups.⁸³ That is why a differentiated approach is important.

Indigenous peoples in voluntary isolation and initial contact require special attention. These groups find themselves in a situation of extreme health, demographic and territorial vulnerability. The transmission of diseases through contact is one of the most serious threats to survival since this population does not have immune defenses against relatively common diseases, and contagion can have tragic consequences. This is why this group requires particular attention in connection with the highly transmissible coronavirus COVID-19.

2. INTER-AMERICAN LEGAL FRAMEWORK ON INDIGENOUS PEOPLES

The American Declaration on the Rights of Indigenous Peoples, consistent with ILO Convention 169 and the United Nations Declaration on the Rights of Indigenous Peoples, recognizes the right, both collective and individual, of indigenous peoples to enjoy the highest level of physical, mental and spiritual health. The three instruments coincide in indicating that, as part of this fundamental right, they have the right to maintain their own health systems and practices and to access without discrimination all social and health services, which must be administered in coordination with the peoples concerned and be culturally appropriate.

Similarly, the Inter-American Court of Human Rights has set out the standards for the

⁷⁹ Fabiana del Popolo (ed.), op.cit., p. 281.

⁸⁰ For example, in Mexico, of the 7.4 million people living in extreme poverty, 60% are indigenous. A similar situation is observed in Guatemala where the departments with the largest number of indigenous populations have the highest poverty rates. Cf. IACHR, *Indigenous women and their human rights in the Americas*. OEA / Ser.L / V / II. Doc. 44/17, 2017, paras. 185 and 213.

⁸¹ Health facilities tend to be located far from communities and also have a severe shortage or lack of medicines, supplies and medical supplies; they do not provide culturally relevant services, nor do they have health professionals trained in an intercultural approach. (Cf. Ibid., par. 199; IACHR, *Situation of the human rights of indigenous and tribal peoples of the Panamazonía*. OEA / Ser.L / V / II. Doc. 176/19, September 29, 2019, par. 302).

⁸² For example, Brazil, Chile, Mexico, Paraguay, Peru and Venezuela have higher rates of tuberculosis in the case of the indigenous population than in the rest of the population (Cf. Fabiana del Popolo, op.cit., p. 295). In Mexico, the risk of maternal death is nine times greater than among non-indigenous people (Cf. PAHO, Strategy and Plan of Action on Ethnicity and Health 2019 -2025, 57th. Directing Council, 71st Session of the Regional Committee WHO, CD57 / 13, Rev. 1, October 3, 2019, p. 7). In Canada the Inuit suicide rate is approximately 11 times higher than the national average. (Cf. United Nations, Report of the Special Rapporteur on the rights of indigenous peoples, Victoria Tauli Corpuz, August 6, 2015, A / HRC / 30/41, para. 29). In Venezuela, 10% of the members of the Warao people are likely to have HIV (Cf. IACHR, 2019, par. 160).

⁸³ In 2018, the IACHR reported that the Yanomami on the border of Venezuela and Brazil are seriously affected by outbreaks of measles and malaria related to the arrival of illegal miners, so they could be completely extinguished if the necessary measures are not taken. Cf. IACHR. Ibid., par. 153.

right to health that indigenous peoples enjoy through the right to a decent life, which implies that states have the obligation to adopt effective measures to guarantee the minimum living conditions compatible with human dignity. In the *Yakye Axa v. Paraguay* case, the Court noted that the residents of this town lived in poverty and did not have access to clean water or sanitary services,⁸⁴ and it declared the state responsible for not having taken concrete measures to reverse those conditions.⁸⁵ Likewise, in the *Xákmok Kásek v. Paraguay* case, the Court noted that, despite having received assistance from the state, it was not enough to protect the right to a decent life of this town's residents,⁸⁶ hence constituting a violation of their right to life.⁸⁷

3. RECOMMENDATIONS REGARDING KEY ASPECTS TO CONSIDER FOR CULTURALLY APPROPRIATE RESPONSES

In light of the foregoing, and in the framework of the COVID-19 pandemic, following are recommendations regarding relevant aspects that states need to take into account:

- Keep citizens and representative indigenous organizations informed of the extraordinary measures adopted by states and coordinate, in advance, with the local authorities those to be implemented within their indigenous lands and territories.
- Ensure that disaggregated sociocultural and epidemiological information on indigenous peoples is available, for example, on the prevalence of chronic diseases in indigenous peoples as a risk factor, in order to improve COVID-19 prevention, management, and containment measures. To achieve this, it is recommended that ethnicity variables be incorporated in the administrative health records used in connection with this pandemic.
- The preventive and care measures adopted and implemented must be culturally and linguistically appropriate, must take into account the practices and customs of the indigenous peoples that live in national territories, and must guarantee the use of methodologies and tools that allow the transmission of information in native languages, relevant to their culture, in a clear and simple way.
- Use the physical and/or technological means or supports available, that are most used and accessible to indigenous peoples, to disseminate the measures to be implemented.
- Culturally contextualize the measures adopted by states, using the concepts, messages, and indications that are pertinent to the social, cultural, and

⁸⁴ I/A Court H.R., *Case of the Yakye Axa Indigenous Community v. Paraguay. Merits, reparations and costs.* Judgment of June 17, 2005, par. 164.

⁸⁵ *Ibid.*, par. 176.

⁸⁶ I/A Court H.R. *Case of the Xákmok Kásek Indigenous Community v. Paraguay. Merits, Reparations and Costs.* Judgment of August 24, 2010, par. 214.

⁸⁷ *Ibid.*, par. 217.

economic reality of indigenous peoples. Likewise, consider the geographical and climatological conditions of the places where indigenous peoples live in order to ensure the relevance and effectiveness of the measures adopted.

- Indigenous women are in a situation of greater vulnerability to COVID-19 as they experience various forms of exclusion and discrimination within and outside their community; therefore, it must be guaranteed that the prevention and containment measures adopted by states guarantee their right to health under equal conditions.
- Guarantee access of Indigenous populations and strengthen the operational capacity of the first-tier health care facilities of indigenous peoples for the prevention, management, and containment of the pandemic, guaranteeing the availability of personnel, medicines, supplies, and medical equipment.
- Provide intercultural training to health personnel so that the preventive actions and care provided are culturally relevant and free from all types of discrimination.
- Guarantee that health personnel and other state agents who enter indigenous territories are in optimal health and are not carriers of COVID-19.
- Guarantee access to regular basic education for indigenous children and adolescents through appropriate means in order to strengthen the development of healthy practices and habits that prevent COVID-19 as well as other diseases affecting indigenous populations.
- Adopt measures that guarantee food security and access to basic hygiene items for indigenous peoples who may be affected by compulsory social isolation measures (quarantines).
- In the case of indigenous peoples in isolation and initial contact, suspend the exceptional authorizations to enter reserves intended to protect this population with the exception of activities that the health sector requires. Likewise, carry out epidemiological surveillance of populations living around the territories of these peoples, effectively creating a "ring of sanitary protection."⁸⁸ Also, intensify the sanitary security protocols for cases of members of the indigenous peoples in a situation of initial contact who are treated in various health units, as well as for their ground and/or air transfers to and from their settlements.

88 OHCHR. *Protection Guidelines for Indigenous Peoples in Isolation and Initial Contact in the Amazon Region, El Gran Chaco and the Eastern Region of Paraguay*. Geneva, 2012, para. 62.

RECOMMENDED MATERIALS:

01 **Ministerial Resolution No. 109-2020-MC**, through which various actions of the Peruvian Ministry of Culture are approved for the attention of indigenous peoples in the framework of the National Health Emergency due to the existence of Covid-19.⁸⁹

02 **Report on the Human Rights Situation of the Indigenous and Tribal Peoples of the Pan-Amazon Region**. Through this report, the IACHR addresses the problems of the peoples that inhabit that region in light of the standards of the inter-American human rights system.⁹⁰

03 **The defense of the right of the indigenous peoples of the Amazon to intercultural health**. Through this document, the Peruvian Ombudsman recommends a set of measures for the State to improve health care, with an intercultural approach, towards indigenous people.⁹¹

⁸⁹ Available at: https://cdn.www.gob.pe/uploads/document/file/571914/RM_109-2020-MC.pdf.

⁹⁰ Available at: <http://www.oas.org/en/iachr/reports/pdfs/Panamazonia2019-en.pdf>

⁹¹ Available at: <https://www.defensoria.gob.pe/wp-content/uploads/2018/05/Informe-Defensorial-N-169.pdf>

CAPÍTULO VI:

LGBTQI PEOPLE AND COVID-19 IN THE AMERICAS⁹²

The coronavirus pandemic is spreading through the most unequal region in the world. This cannot be ignored. Deep socio-economic differences coexist with situations of vulnerability along various axes of discrimination, leaving huge gaps in access to social rights across the Americas.

Faced with this, states, on the one hand, can respond by reproducing these inequalities. Or, on the other hand, they can take this opportunity to respond according to international and inter-American human rights standards -in line with their international commitments- and seek to reverse existing gaps by fighting inequalities and pre-existing sources of discrimination.

Responding from a human rights perspective⁹³ implies incorporating in that response the principles affirming the indivisibility and interdependence of those rights. It is essential, but not enough, to act in relation to the right to health; what is needed is a comprehensive response, which includes the right to education; to work and to social security; to adequate food and to housing and basic services (as part of the right to a healthy environment).

The same perspective must be taken into account when defining social distancing measures.⁹⁴

It is reasonable to think that an answer based on this perspective can only be forged

⁹² Prepared by Andrés Scagliola, Political Scientist and Government Expert, President of the Working Group of the Protocol of San Salvador.

⁹³ Similarly, the response must have a gender focus to understand the unequal impact of the pandemic not only on health but also on access and enjoyment of fundamental human rights in men and women. For example, the response can have a strong impact on the burden of care in the home, as well as on situations of gender violence.

⁹⁴ See Syracuse Principles on the limitation of fundamental rights.

on the basis of an Emergency or Contingency Plan, with transparent information and guaranteeing, as much as possible, social participation, and not on the basis of a succession of cumulative, often contradictory, measures focusing on persons whose rights, historically, have often been violated, such as LGBTQI (lesbian, gay, bisexual, trans, queer and intersex) people, amongst others.

1. THE SITUATION OF THE LGBTQI POPULATION IN THE AMERICAS

The non-heterosexual population has been estimated at 5% to 10% of the total population. The lack of incorporation of the categories of sexual characteristics, sexual orientation, gender identity and gender expression in official records, surveys and censuses, makes this number difficult to assess.⁹⁵ Also, the fact that there are countries in the Caribbean that still criminalize homosexuality and where social stigma persists despite contexts of legality and even recognition of full equality of rights, impairs the accuracy of any measuring instrument.

A small part of the total population is trans (transvestite, transgender, transsexual).⁹⁶ It is a small but important group, given the extreme situation of social exclusion in which it lives. In fact, the Americas is the most violent region in the world when it comes to trans people. The lack of access to and enjoyment of their human rights, in addition to the violence which ends in death in hundreds of cases every year, makes their life expectancy approximately half that of the rest of the population.

2. JUSTIFICATION

For LGBTQI persons, stigma and prejudice represent an often-insurmountable barrier to their rights. The same is true of their right to health.

Homosexual men (and this could apply to all men who have sex with men) and trans women are among the priority groups in the response to HIV due to their over-representation in percentage terms among persons living with the virus. The stigma surrounding HIV (which in some contexts is compounded by criminalization) means that many do not have access to tests and therefore to the treatments needed to be able to

⁹⁵ In Uruguay, same-sex couples are surveyed by the National Household Survey (although their underrepresentation in the measurement is still palpable) and only in the next round of censuses will the category "gender identity", inclusive of trans people, be included by mandate of Law 19684, -if political conditions do not alter it-. This would undoubtedly be a fundamental step for the visibility of this population and its living conditions and the design of public policies, given that "what is not counted does not count." Progress with respect to the trans people category is slow, but a space for it in administrative records is gradually being forged.

⁹⁶ In the only country of the region in which an exhaustive survey of trans people was carried out, Uruguay, it was possible to identify almost 1,000 people (approximately 0.03% of the total population). This is the Trans Census of the Ministry of Social Development in 2016. The authors argue that despite their efforts, not all of the population was surveyed because people under 18 years old were not considered, among other things. The estimate of social organizations is that there are 3,000 trans people in Uruguay, which would represent a figure close to 0.1% of the total population.

live with the virus as a chronic disease. Let us remember that persons with HIV who do not have access to treatments and thus to undetectable viral load and control of their CD4 cells are more exposed to death by coronavirus.

But the gap in access to health is not limited to this. Throughout the region, the difficulties of making sexual orientation openly visible also lead to inadequate diagnoses and care strategies for this population. Also, care for trans persons is absolutely deficient in relation to specific health issues (hormonal treatments, complications from the use of liquid silicone to modify their bodies according to hegemonic female aesthetic patterns, exposure to sexually transmitted diseases in the case of sex workers, consequences of daily violence and abuse, depression due to daily discrimination, just to name a few). The compensatory strategy of offering some '*friendly*' health services, mainly by LGBTQI organizations and social groups and some states, fails to close the enormous gaps which these populations endure.

Understanding the interdependence and indivisibility of the right to health with other social rights, the situation becomes much more complex. According to the few sources of information that exist in various countries in the region, LGBTQI persons (and, in particular, trans persons) show strong gaps in access to the right to food, housing and basic services, education, work, and social security.

Finally, one cannot look at the homosexual, bisexual and trans populations of our countries without an intersectional approach. LGBTQI people are affected by other types of inequality that expose them to particularly complex situations of discrimination in terms of their intersectionality. To mention some particularly relevant intersectional situations in the face of this pandemic: trans sex workers who - in the context of the legality or illegality of their activity - have been left without economic income; homosexual and trans people with HIV without confirmation of their serological status or without access to antiretrovirals; LGBTQI migrants who often find lack of support from their co-nationals in host countries due to homophobic culture or even face deportation risks due to their irregular status, which prevents them from accessing basic health services; older homosexual people with smaller social support networks than the rest of their generation (loneliness in gay men is extreme); homosexual and trans persons deprived of liberty and subjected to daily abuse; LGBTQI people with disabilities, such as deaf people, with difficulties in accessing information; or children and adolescents who, due to their atypical sexuality, face violence from their parents and relatives as well as from their communities.

3. KEY INSTRUMENTS IN THE INTER-AMERICAN LEGAL FRAMEWORK

Along with the American Declaration of the Rights and Duties of Man of 1948 (Article 11) and the American Convention on Human Rights of 1969 (Article 26, on progressive development, and Article 29, on its interpretation in light of other international treaties), the 1988 Protocol of San Salvador on economic, social, cultural and environmental rights (which in its Article 10 refers to the right to health) forms part of the basic framework for the elaboration of a response to the coronavirus pandemic with a focus

on the human rights standards in the region.⁹⁷ Based on the aforementioned article of the Protocol, this approach considers health as a public good (paragraph 2), and one that should be equally enjoyed by everyone (paragraph 2 b) and by the most affected social groups (paragraph 2 f) to enjoy equally.⁹⁸

In this scenario, the Progress Indicators of the Protocol of San Salvador, developed from a human rights perspective by the Working Group of the Protocol, the monitoring committee of this binding instrument, are a useful tool for monitoring responses to the pandemic by States Parties. The 85 indicators of the right to health, for example, relate to three transversal categories: the *transposition* of the right (and the incorporation into domestic legislation of international commitments); the *financial context and budgetary commitment* required to guarantee this right; as well as the *state capacities generated*. Similarly, through the battery of indicators, cross-cutting human rights principles such as: *equality and non-discrimination*; *access to justice*; and *access to information and participation* are highlighted.

The Working Group of the Protocol of San Salvador -in a timely manner in light of the coronavirus pandemic- generated a proposal for the analysis of progress indicators -also of the right to health- from an LGBTI transversal perspective.⁹⁹ It is today a relevant tool, both for civil society and for the States Parties, so that the response to this challenge reaffirms the basic principle that *we are born free and equal in dignity*.

Also, to protect the rights of LGBTQI people and older persons, states must progress in the signing and ratification of the inter-American conventions *Against All Forms of Discrimination and Intolerance* and *on Protecting the Human Rights of Older Persons*, which explicitly mention sexual orientation, gender identity, and gender expressions as prohibited grounds of discrimination.

4. RECOMMENDATIONS: RELEVANT ASPECTS FOR THE RESPONSE TO COVID-19

As previously stated, the response to the coronavirus pandemic requires a plan - going beyond the time limits imposed by the crisis and the complexity of consultation that social distancing implies. This, in relation to LGBTQI people, should cover at least three priority axes: information, support, and assistance.

⁹⁷ Inter-American standards lead us to understand: the right to health in a broad sense (linked, for example, to the rights to work and housing); health care based on informed consent and access to information; access to health services based on to the principles of accessibility and availability; and, based on the definitions of the Commission and the Inter-American Court of Human Rights, the state responsibility that derives from the violation of this right.

⁹⁸ In turn, Chapter 3 of the 2012 *Social Charter of the Americas* refers to the response to emerging infectious diseases, and in Chapter 5, to the necessary solidarity and cooperation between states. Both chapters are key references for building the response to the coronavirus pandemic.

⁹⁹ Elaborated for the Working Group of the Protocol of San Salvador by Juan Pablo Delgado and Andrés Scagliola.

First, guaranteeing LGBTQI people relevant, timely and pertinent information. It is important to generate content with relevant information -with an intersectional perspective- accounting for inequalities that especially exacerbate situations of violation of rights of LGBTQI people (mentioned above). Many times, this information is not available due to the persistence of heteronormative perspectives in the mass media.

Second, together with the information, generating timely support strategies for LGBTQI people from a distance. A suitable approach is the opening of a telephone line to advise and direct people to resources and services based on a protocol defined and coordinated with public institutions and social organizations.

Third, guaranteeing direct assistance to LGBTQI people -particularly trans persons- who are most vulnerable, guaranteeing the right to food and the right to health through the provision of hygiene and food products directly or through monetary transfers. Likewise, it is important to promote the creation of social support networks together with organizations and social groups, with special attention to older people, persons with HIV, trans persons, migrants, and LGBTQI children and adolescents exposed to situations of domestic violence.

To conclude, it is essential to bear in mind both the Yogyakarta (2006) and Yogyakarta plus 10 (2017) Principles which provide a transversal reading of the sexual and gender diversity of international human rights law, and of the commitments undertaken by states, as well as the recent "Statement by Independent Experts, Special Rapporteurs and United Nations Working Groups on COVID-19" that includes LGBTQI people.

There can be no other purpose in responding to this pandemic than that ***no one be left behind.***

RECOMMENDED MATERIALS:

- 01** Inter-American Convention Against All Forms of Discrimination and Intolerance¹⁰⁰
- 02** Inter-American Convention on Protecting the Human Rights of Older Persons¹⁰¹
- 03** Human Rights Indicators. Guidelines for measurement and application¹⁰²
- 04** Measuring all gaps. Guide for the operationalization of the Indicators of the Protocol of San Salvador from a LGBTI Transversal Perspective¹⁰³
- 05** Advisory opinion 24/17 of the Inter-American Court of Human Rights¹⁰⁴
- 06** Yogyakarta Principles¹⁰⁵
- 07** Yogyakarta Principles plus 10¹⁰⁶
- 08** Statement by Independent Experts, Special Rapporteurs and United Nations Working Groups on COVID-19¹⁰⁷

¹⁰⁰ Available at: http://www.oas.org/en/sla/dil/inter_american_treaties_A-69_discrimination_intolerance.asp.

¹⁰¹ Available at: http://www.oas.org/en/sla/dil/inter_american_treaties_a-70_human_rights_older_persons.asp.

¹⁰² Available at: https://www.ohchr.org/Documents/Publications/Human_rights_indicators_en.pdf

¹⁰³ Available at: http://www.oas.org/es/sadye/inclusion-social/protocolo-ssv/Guia_Operacionalizacion_Indicadores.pdf

¹⁰⁴ Available at: https://www.escr-net.org/sites/default/files/caselaw/judgment_iacthr.pdf

¹⁰⁵ Available at: <https://yogyakartaprinciples.org/principles-en/>

¹⁰⁶ Available at: <http://yogyakartaprinciples.org/principles-en/yp10/>

¹⁰⁷ Available at: <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25746&LangID=E>

CHAPTER VII:

CONSIDERATIONS FOR A RESPONSE TO COVID-19 THAT IS INCLUSIVE OF INTERNALLY DISPLACED PEOPLE, MIGRANTS, ASYLUM SEEKERS, AND REFUGEES IN THE AMERICAS¹⁰⁸

1. BRIEF OVERVIEW OF THE SITUATION IN THE AMERICAS

According to the United Nations, by 2019 there were an estimated 272 million international migrants worldwide, representing 3.5% of the world's population. In the Americas, there were an estimated 70.3 million international migrants, 58.6 million of these in North America and 11.7 million in Latin America and the Caribbean. At the same time, according to the United Nations High Commissioner for Refugees (UNHCR), in the countries of the Americas there were close to 8.1 million internally displaced persons, more than 1.3 million asylum seekers, more than 643 thousand refugees and persons in a refugee-like situation, and 23,900 returnees by the end of 2018.

In recent years, the Americas has witnessed various migratory crises caused by a number of factors, including political, socioeconomic, environmental factors, and high levels of violence from both state and non-state actors, such as organized crime groups, drug cartels, gangs, *guerrillas*, illegal organizations dedicated to extractive activities, mining and the exploitation of natural resources; as well as domestic and gender violence against women and lesbian, gay, bisexual, trans, and intersex (LGBTI) persons.

Some of the main mixed migratory movements and migratory crises in the region

¹⁰⁸ Prepared by Álvaro Botero Navarro, Coordinator of the Refugee and Forced Displacement Unit of the Department of Social Inclusion of the OAS Secretariat for Access to Rights and Equity and Member and Rapporteur of the Committee for the Protection of the Rights of All Migrant Workers and their Relatives (CMW) of the United Nations.

currently and in recent years have to do with the massive migration of Venezuelan migrants and refugees; migration and so-called migrant caravans from countries of the Northern Triangle of Central America (El Salvador, Guatemala and Honduras) and the historical, but also in many cases forced, migration of Mexican people to the United States; the forced migration of Nicaraguan people which has largely been directed towards Costa Rica; the serious situation of internal displacements and forced international migration of Colombian people who have to flee as a consequence of various forms of violence, some of them still connected to the armed conflict, the so-called war on drugs, as well as the lack of security regarding the ownership of land and natural resources; the historical migration of Haitian and Cuban people; the migration of Peruvians and Bolivians mainly to Argentina and Chile. In addition to all the aforementioned is the situation of extra-continental migrants from African countries and the Middle East who cross various countries in South and Central America with the goal of reaching the United States.

In the course of a few years, the situation of Venezuelan migrants and refugees has become the second largest migration crisis after Syria and the largest on record in the recent history of the Americas. By March 2020, it was estimated that there were more than 4.9 million Venezuelan migrants and refugees, most of them in South American countries. In a context where many countries worldwide tighten their migration and asylum policies and even adopt preventive measures, it is worth highlighting the role of many countries in the region that have granted more than 2.5 million residence permits or migratory alternatives for entry and regular stay to Venezuelan people.

Migration as a multicausal phenomenon implies that often various factors of expulsion and attraction converge when people decide to migrate. People and groups in situations of vulnerability have the least capacity to mitigate or adapt to the factors underlying their decision to migrate. As a consequence of the lack of regular migration channels, a significant percentage of international migrants, asylum seekers and refugees, particularly those living in poverty or on low incomes, have to migrate irregularly, which exposes them to greater vulnerability in terms of discrimination, various forms of violence, as well as measures approximating criminalization, such as detention and deportation by immigration authorities, and obstacles in access to health services, employment, education and justice.

In the context of what is an unprecedented global crisis, such as the one generated by the spread of COVID-19, internally displaced persons, migrants, asylum seekers, refugees, returnees and deportees are in a situation of enhanced vulnerability as a consequence of the direct and indirect effects that this pandemic can have on them and their families. In many countries of the Americas, significant percentages of the population work and depend on precarious jobs, street jobs and earn their livelihood on a day-to-day basis. In this context, COVID-19 and its effects on access to employment, health, housing and livelihoods are already having serious impacts on migrants, asylum seekers and refugees in various countries in the region. In turn, the impacts of the isolation, quarantine, physical and social distancing measures, restrictions on free movement, and the closings of borders that are being adopted by states in the region to

counter the spread of COVID-19, on the economy and way of life of numerous people will be a determining factor in many people's decision to migrate in the near future.

Frequently, migrants and refugees face barriers to accessing health services and social security for reasons related to their immigration status, language and cultural barriers, costs, lack of access to information, discrimination and xenophobia. Three quarters of refugees and many of the world's migrants are in developing countries, where health systems have limited capacities or are already overwhelmed. In addition, these people live with the fear, real or assumed, of being placed in immigration detention and deported to their country of origin where they may be at high risk of infection or where the health system is not solid enough to monitor the number of people infected and to provide health care in accordance with international and inter-American norms and standards.

Within the context generated by the COVID-19 pandemic, migrants, asylum seekers and refugees are in a situation of greater vulnerability, since they may be deprived of their liberty in immigration detention centers, confined to camps or illegal settlements or living in crowded urban areas with poor sanitation and inaccessible or overburdened health services. In turn, the migrant care centers, shelters or immigration detention centers in which many of these people are located are often overcrowded, without sufficient personnel, and in many cases lack health services or protocols that provide adequate care to COVID-19 carriers.

At the same time, one of the great contributions and risks that migrants and refugees are facing in the context of this crisis has to do with the jobs they do, including some where they are at high risk of getting COVID-19. These are jobs being done, in the midst of the various social distancing measures adopted by states to combat COVID-19, by migrant doctors, nurses, scientists working on the development of vaccines, agricultural workers, home delivery workers, couriers, packers, and others to help address the multiple effects that the COVID-19 pandemic is having and ensure that essential services continue to be provided for the rest of society.

2. LEGAL FRAMEWORK: THE HUMAN RIGHTS OF INTERNALLY DISPLACED PERSONS, MIGRANTS, ASYLUM SEEKERS, AND REFUGEES IN THE INTER-AMERICAN SYSTEM

The legal framework in the Inter-American System for the protection of the human rights of internally displaced persons, migrants, asylum seekers, refugees, returnees, and deportees is comprised of the **American Declaration of the Rights and Duties of Man** of 1948, the **American Convention on Human Rights** of 1969, and the **Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights "Protocol of San Salvador"** of 1988. Additionally, on December 7, 2019, the Inter-American Commission on Human Rights, under the auspices of its Rapporteurship on the Rights of Migrants, adopted the **Inter-American Principles on the Human Rights of all Migrants, Refugees, Stateless Persons and Victims of Human Trafficking** with the aim of guiding OAS member states in their duties to respect, protect, promote and guarantee the human rights of all people regardless of

their nationality or migration status, including migrants, refugees, stateless persons and victims of human trafficking. Furthermore, these Principles serve as a guide to state authorities in the development of legislation, regulations, administrative decisions, public policies, practices, programs, and relevant jurisprudence.

These international instruments have also been shaped by international refugee law, which is made up of the 1951 **Convention on the Status of Refugees**, the **Protocol Relating to the Status of Refugees**, and the 1984 **Cartagena Declaration on Refugees**; and international law of stateless persons, which includes the **Convention relating to the Status of Stateless Persons** and the **Convention on the Reduction of Statelessness**; and the **Guiding Principles on Internal Displacement**.

3. RECOMMENDATIONS

COVID-19 represents an unprecedented challenge for States, the international community, and the daily life of all people. In order to not leave anyone behind in the responses that are being developed, approaches that are tailored to international and inter-American norms and standards for the protection of human rights are required. In this regard, the following recommendations are intended to contribute to the development of public policies and to the responses that states must adopt to face the direct and indirect impacts that COVID-19 has on migrants, asylum-seekers, refugees, deportees and returnees, and their host communities:

- Guarantee that measures legitimately geared to protecting public health and that imply restrictions or curtailments of the right to freedom of movement are carried out in such a way that they are temporarily limited, have defined objectives, and are strictly necessary and proportional to the objective pursued.
- Guarantee that people who require international protection can access the territory of the country in which they seek protection, as well as guarantee the right to seek and receive asylum, the principle of non-refoulement, including the prohibition on rejection at the border.
- Ensure continuity of the procedures for recognition of refugee status under the principles of due process. In particular, states must avoid excessive delays in the resolution of cases, as well as implement measures to continue with the different stages of the procedure that do not require the applicant to be there in person provided that they do not limit the rights of the person seeking asylum.
- Guarantee the right of every person to return to their country of nationality. This obligation must be compatible with international health standards and the guidelines issued by the national health authorities, and must cover, in accordance with the conditions of each State, protection measures, access to information and assistance. In addition, the measures adopted by

States for the return of their nationals must prioritize people in situations of vulnerability and guarantee their safety.

- Integrate migrants and refugees in the national plans that states have created to prevent and combat COVID-19, so that they are provided with protection together with the host communities. It should be considered that migrants and refugees have, in many cases, difficulties in accessing decent health care and health programs due to their nationality or immigration status. This should include ensuring equitable access to information, testing and medical care for all migrants and refugees, regardless of their immigration status, as well as establishing firewalls to separate migration control activities from the capacity of migrants and refugees to access health, education, justice, and other essential services.
- Take the necessary steps to guarantee the protection of personal data and information provided while migrants or asylum seekers access health services. States, in accordance with the right to privacy, should not require that health or other social services provide, exchange, or share information about the immigration status of these people with immigration authorities.
- Include within social programs offered to migrants, particularly those who do not have access to social protection or paid sick leave, the possibility to benefit from vouchers or temporary financial aid, subject to the state resources available.
- Take measures to allow for extensions of work visas and other appropriate measures to alleviate the difficulties faced by migrant workers and their families due to the closure of companies, and to ensure continued protection of their human rights, including their labor rights.
- Avoid containment and other measures to reduce the COVID-19 pandemic based on discriminatory justifications. States must recognize that even general policies can have discriminatory effects if they have a disproportionate impact on individuals or groups in vulnerable situations.
- Adopt urgent international cooperation measures to support and help host countries to strengthen services, both for migrants and refugees and for local communities, and include them in national surveillance, prevention, and response agreements.
- Prevent and combat xenophobic speech and, in particular, discourse aimed at associating COVID-19 with migrants, foreigners, or nationals of a particular country.
- Include provisions for internally displaced persons, migrants, asylum seekers, refugees, and their host communities within economic recovery measures, as they will also be affected by the economic impact of COVID-19, due to loss of income, restrictions on circulation, reduced access to employment and livelihoods, and inflation.

We live in times unprecedented in the recent history of humanity, which is why it is essential that the responses developed by States, to combat the global threat and crisis that COVID-19 has generated, are rooted in multilateralism, international cooperation, and solidarity. COVID-19 has proven to be a virus that does not discriminate with respect to the origin, situation or condition of the more than 920 thousand confirmed cases and the more than 46 thousand deaths that it had caused as of April 1, 2020. In turn, this disease has shown, if anything, how interconnected we are as a human species. That is why responses should focus on the preservation of life, regardless of national origin, migratory situation or statelessness, and on ensuring the effective safeguards for human rights norms and standards.

RECOMMENDED MATERIALS:

- 01 Bachelet, Michelle and Grandi, Filippo, **The coronavirus outbreak is a test for our values, systems and humanity**, March 12, 2020¹⁰⁹
- 02 United Nations High Commissioner for Refugees, **Key Legal Considerations on access to territory for persons in need of international protection in the context of the COVID-19 response**, March 16, 2020¹¹⁰
- 03 Constitutional Court of Ecuador, **Constitutional opinion of the state of emergency for the COVID-19 pandemic**, March 19, 2020¹¹¹
- 04 Migration Policy Institute, **Coronavirus Is Spreading across Borders, But It Is Not a Migration Problem**, March 2020¹¹²
- 05 United Nations Coordinated Appeal, **Global Humanitarian Response Plan Covid-19**, April-December 2020¹¹³

¹⁰⁹ Available at: <https://www.unhcr.org/news/latest/2020/3/5e69eea54/coronavirus-outbreak-test-systems-values-humanity.html>

¹¹⁰ Available at: <https://www.refworld.org/pdfid/5e7132834.pdf>

¹¹¹ Available at: [https://doc.corteconstitucional.gob.ec:8080/alfresco/d/d/workspace/SpaceStore/0753708f-17ba-4a7b-a818-d93769a77b3a/Dictamen_1-20-EE-20_\(0001-20-EE\).pdf](https://doc.corteconstitucional.gob.ec:8080/alfresco/d/d/workspace/SpaceStore/0753708f-17ba-4a7b-a818-d93769a77b3a/Dictamen_1-20-EE-20_(0001-20-EE).pdf)

¹¹² Available at: <https://www.migrationpolicy.org/news/coronavirus-not-a-migration-problem>

¹¹³ Available at: <https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf>

06 United Nations Network on Migration, **COVID-19 does not discriminate; Nor does our response**, March 20, 2020¹¹⁴

07 United Nations Human Rights Treaty Bodies, **United Nations Human Rights Treaty Bodies call for human rights approach in fighting COVID-19**, 24 March 2020¹¹⁵

08 OHCHR, IOM, UNHCR and WHO, **Joint Press Release: The rights and health of refugees, migrants and stateless persons must be protected in response to COVID-19**. March 31, 2020¹¹⁶

09 UNHCR and IOM, **Joint Communiqué UNHCR and IOM: Refugees and Migrants from Venezuela during the COVID-19 Crisis: As needs soar, more inclusive measures and aid are essential**, April 1, 2020¹¹⁷

¹¹⁴ Available at: <https://www.unicef.org/press-releases/covid-19-does-not-discriminate-nor-should-our-response>

¹¹⁵ Available at: <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25742&LangID=E>

¹¹⁶ Available at: <https://www.who.int/news-room/detail/31-03-2020-ohchr-iom-unhcr-and-who-joint-press-release-the-rights-and-health-of-refugees-migrants-and-stateless-must-be-protected-in-covid-19-response>

¹¹⁷ Available at: <https://www.unhcr.org/news/press/2020/4/5e844e354/refugees-migrants-venezuela-during-covid-19-crisis-needs-soar-inclusive.html>

CHAPTER VIII:

THE PROTECTION OF PERSONS DEPRIVED OF LIBERTY DURING THE COVID-19 PANDEMIC¹¹⁸

1. THE SITUATION OF PERSONS DEPRIVED OF LIBERTY¹¹⁹ AND THE IMPORTANCE OF A DIFFERENTIATED RESPONSE

Currently there are approximately 11.1 million people deprived of liberty in the world; 3.9 million (35%) of them are in the Americas.¹²⁰ In the region, 40% of people deprived of liberty are in pre-trial detention¹²¹ and 5% are women.¹²² Some of the most serious problems faced by the region's prison systems are poor prison conditions, the absence of specific measures for the protection of vulnerable groups, and the overcrowding and overpopulation of prisons.¹²³ With respect to overcrowding, it is important to note that

¹¹⁸ Prepared by Rafael del Castillo e Melo Silva, Officer of the Department of Social Inclusion of the OAS Secretariat for Access to Rights and Equity and Technical Secretary of the Working Group on the Protocol of San Salvador.

¹¹⁹ For the purposes of this Guide, the term “persons deprived of liberty”, when used with respect to statistics, refers only to persons detained in the prison system. In other parts of the text, the term is used in a broad sense and refers to any person who is in the custody of the State or of a private institution that acts with the authorization of the State, including centers for the hospitalization of people with mental disabilities (intellectual or psychosocial).

¹²⁰ World Prison Brief, Institute for Crime & Justice Policy Research. Statistical information available at: <https://www.prisonstudies.org/world-prison-brief-data>. See the search engine “*Highest to Lowest - Prison Population Total*”. For the purposes of calculating the number of persons deprived of liberty in the Americas, no information was used on the territories of European countries in the region, but the figures for Puerto Rico and the Virgin Islands of the United States of America were used independently, in order to follow the same methodology as that used in the World Prison Brief.

¹²¹ Ibid. See the search engine “*Highest to Lowest - Pre-trial detainees / remand prisoners*”.

¹²² Ibid. See the search engine “*Highest to Lowest - Female prisoners (percentage of prison population)*”. This figure does not take into account the percentage of women deprived of liberty in Cuba, as the source does not provide this information.

¹²³ IACHR, *Report on the Human Rights of Persons Deprived of Liberty in the Americas*, 2011, p. 1. (hereinafter, “Report on the human rights of persons deprived of liberty in the Americas.” See also the IACHR country reports

the average occupation rate of prisons in the region is 153.5%, with three countries in the region being among the five countries in the world with the highest overcrowding.¹²⁴

Persons deprived of liberty are in a situation of greater vulnerability due to the spread of COVID-19 than the general population, given that they live in confined spaces with many other people for prolonged periods of time.¹²⁵ Overcrowding promotes the spread of diseases, makes it difficult to access basic and health services in prisons, and constitutes a risk factor for the occurrence of calamities.¹²⁶ So far, many countries of the region have recommended social distancing as a measure to prevent and/or decrease the spread of COVID-19. However, the physical separation and self-isolation of these people, given the conditions in which they live, are practically impossible, as are hygiene and hand-washing¹²⁷ recommendations, and governments must act urgently to protect the health and safety of persons deprived of liberty.¹²⁸

Evidence to date suggests that two groups of people are at increased risk of severe conditions attributed to the COVID-19 disease: older persons and those with pre-existing medical conditions (such as cardiovascular diseases, diabetes, chronic respiratory diseases, and cancer¹²⁹). Persons deprived of liberty also face other factors that increase their risk of contracting COVID-19, such as being in poorer health conditions and having a weakened immune system due to stress, malnutrition, or the prevalence or coexistence of other diseases such as tuberculosis or other viral blood diseases.¹³⁰

Past experiences show that prisons, jails, and other detention centers, where people are very close to one another, can act as a source of infection, amplification and spread of infectious diseases, both inside and outside these establishments, which is why taking care of the health of persons deprived of liberty is widely considered as a way to also

and on reports on its on-site visits that also contain information on detention conditions in these countries. Available at: <http://www.oas.org/es/cidh/ppl/informes/pais.asp>.

124 World Prison Brief, Institute for Crime & Justice Policy Research. See the search engine "*Highest to Lowest - Occupancy level (based on official capacity)*".

125 Regional Office for Europe of the World Health Organization. *Preparedness, prevention and control of COVID-19 in prisons and other places of detention Interim guidance*. March 15, 2020, p. 1 (hereinafter "*Preparedness, prevention and control of COVID-19 in prisons and other places of detention Interim guidance*")

126 *Report on the human rights of persons deprived of liberty in the Americas*, p. 7.

127 It is important to note that the inter-American system has determined that the States must adopt measures to ensure that persons deprived of liberty have access to sufficient and safe water to meet their individual daily needs, including the consumption of drinking water when required, as well as for personal hygiene. I/A Court H.R. *Case of Vélez Loor v. Panama. Preliminary Exceptions, Merits, Reparations and Costs*. Judgment of November 23, 2010. Series C No. 2183, paras. 215 and 216.

128 *Statement by Michelle Bachelet, United Nations High Commissioner for Human Rights on COVID-19 and persons deprived of liberty (hereinafter "OHCHR Declaration")*. March 25, 2020. Available at: <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25745&LangID=E>

129 Pan American Health Organization, *Response to the COVID-19 outbreak in the Region of the Americas*. March 26, 2020. Available at: <https://www.paho.org/en/documents/respuesta-al-brote-covid-19-region-americas>.

CHAPTER VIII.

130 *Preparedness, prevention and control of COVID-19 in prisons and other places of detention. Interim guidance*, p. 2

take care of public health.¹³¹

2. STANDARDS AND LEGAL FRAMEWORK REGARDING PERSONS DEPRIVED OF FREEDOM

The inter-American human rights system has established that states are in a special position as guarantors of all the rights of persons in their custody.¹³² Based on this duty, states must ensure the health of these people, which must be understood as “the enjoyment of the highest possible level of physical, mental, and social well-being, including, amongst other aspects, adequate medical, psychiatric, and dental care; permanent availability of suitable and impartial medical personnel; access to free and appropriate treatment and medication; implementation of programs for health education and promotion, immunization, prevention and treatment of infectious, endemic, and other diseases; and special measures to meet the particular health needs of persons deprived of liberty belonging to vulnerable or high risk groups, such as: older persons, women, children, persons with disabilities, people living with HIV-AIDS, tuberculosis, and persons with terminal diseases.”¹³³

States must also ensure that “the health services provided in places of deprivation of liberty operate in close coordination with the public health system, so that public health policies and practices are incorporated in places of deprivation of liberty.”¹³⁴

Given that health is a public good, in conjunction with the duty to offer health services to persons deprived of liberty in order to protect their life and physical and mental integrity, the State is responsible for supervising and monitoring the health services they are provided in State-authorized private institutions, such as private prisons, centers for the internment of people with mental disabilities, and detention centers for migrants.¹³⁵

States’ responses to the COVID-19 pandemic will require financial resources, and it is

¹³¹ *Preparedness, prevention and control of COVID-19 in prisons and other places of detention. Interim guidance*, p. 1

¹³² I/A Court H.R. *Vera Vera case and other v. Ecuador. Preliminary Exception, Merits, Reparations and Costs*. Judgment of May 19, 2011. Series C No. 226, par. 42. See also the Report on the human rights of persons deprived of liberty in the Americas, in particular chapter II on “the position of guarantor of the State vis-à-vis persons deprived of liberty”.

¹³³ IACHR, *Principles and Good Practices on the Protection of Persons Deprived of Liberty in the Americas*, approved by the IACHR through Resolution 1/08 at its 131st regular session, held from March 3-14, 2008 (hereinafter “Principles and Good Practices on the Protection of Persons Deprived of Liberty in the Americas”), Principle X. See also I/A Court H.R. *Case of Mendoza et al. v. Argentina. Preliminary Exceptions, Merits and Reparations*. Judgment of May 14, 2013. Series C No. 260, par. 189 (“This Court has established that the State has the obligation, as guarantor of the health of the persons in its custody, to provide detainees with regular medical examinations and adequate medical treatment when required”).

¹³⁴ *Idem*.

¹³⁵ Regarding the duty to inspect and supervise private institutions, see I/A Court H.R. *Ximenes Lopes case. Brazil*. Judgment of July 4, 2006. Series C No. 149, paras. 95-99 and 138-140. I/A Court H.R. *Case of Suárez Peralta vs. Ecuador. Preliminary Exceptions, Merits, Reparations and Costs*. Judgment of May 21, 2013. Series C No. 261, paras. 144-145. See also *Report on the Human Rights of Persons Deprived of Liberty in the Americas*, par. 56.

important to remember that “States cannot claim financial difficulties to justify detention conditions that do not comply with the relevant minimum international standards and that fail to respect the inherent dignity of the human being.”¹³⁶ Furthermore, it is important to guarantee that persons deprived of liberty have access to health services of the same quality as the services offered to the general population, without suffering discrimination due to their condition and situation.¹³⁷

It is important to note that, in addition to the instruments of the Inter-American System referred to in the introduction of this Guide,¹³⁸ the **Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas** are specifically relevant to dealing with the rights of these persons. In addition, the organs of the inter-American system have also referred to rights instruments of other systems to define the standards of the inter-American system in relation to the human rights of persons deprived of liberty. The Inter-American Court of Human Rights, for example, has referred to, the **Standard Minimum Rules for the Treatment of Prisoners**, the **Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment**, and the **United Nations Rules for the Protection of Juveniles Deprived of their Liberty**, among others.¹³⁹

3. RECOMMENDATIONS ON RELEVANT ASPECTS TO BE TAKEN INTO CONSIDERATION FOR RESPONSES RELATED TO PERSONS UNDER THE CUSTODY OF THE STATE

In light of the foregoing, and in the framework of the COVID-19 pandemic, recommendations are made below on the relevant aspects to be taken into consideration by states. This is not an exhaustive list and at the end of the chapter other publications are recommended that may help the State prepare its response to COVID-19 in relation to persons deprived of liberty:

- Adopt measures that drastically reduce the prison population and have an immediate impact on the overpopulation and overcrowding situation, which in turn will enable people who remain deprived of liberty to implement physical distancing measures.¹⁴⁰ These measures could be: the immediate release of people who are particularly at risk, such as older persons and people with other diseases; the release of low-risk offenders; the early release of people

¹³⁶ I/A Court H.R. Case of Pacheco Teruel et al. v. Honduras. Merits, Reparations and Costs. Judgment of April 27, 2012. Series C No. 241, par. 67.

¹³⁷ Preparedness, prevention and control of COVID-19 in prisons and other places of detention. Interim guidance, p. 3

¹³⁸ The American Declaration of the Rights and Duties of Man, the American Convention on Human Rights, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), and the Social Charter of the Americas and its Action Plan.

¹³⁹ See for example, I/A Court H.R. Case of Pacheco Teruel et al. V. Honduras. Merits, Reparations and Costs. Judgment of April 27, 2012. Series C No. 241, para. 67, footnote 60.

¹⁴⁰ OHCHR statement.

who have served almost all of their sentences; and the granting of temporary exit permits.

- Implement special measures to protect people who remain deprived of liberty and are in a group at greater risk of becoming infected by COVID-19.
- Consider detention and deprivation of liberty as a measure of last resort¹⁴¹ and, use it only when necessary, to ensure that interruption of public services will not prevent a detainee from being brought, without delay, before a judge or other official authorized by law to exercise judicial functions¹⁴².
- Avoid using arrest and possible imprisonment as a form of punishment for those who decide not to strictly adhere to the instructions of confinement and physical distancing ordered by the State as part of its response to the COVID-19 pandemic. Rather than helping to decrease overpopulation and overcrowding, this may exacerbate the dire situation in prisons.¹⁴³ Furthermore, there is a risk that these people may have contracted the disease outside the prison or jail.
- Adopt alternative sanctions to deprivation of liberty for those in pretrial detention. People in pretrial detention currently represent 40% of all persons deprived of liberty in the Americas.¹⁴⁴
- Ensure that any restrictive measure adopted regarding persons deprived of liberty with the objective of preventing the spread of COVID-19 is legal, necessary, proportional, in accordance with human dignity, and temporary. Persons deprived of liberty should receive detailed information on these measures in a language they understand.¹⁴⁵
- Promote coordination and collaboration between health and security sectors to ensure that prevention and treatment policies applied to people under state custody are adequate and in accordance with the public health strategy adopted to combat the pandemic.¹⁴⁶
- Take into account that persons deprived of liberty may belong to other groups in vulnerable situations (indigenous peoples, women, adolescents, persons with disabilities, migrants, elderly people, and so on) who require additional

141 Ibid.

142 Article 7.5 of the *American Convention on Human Rights*.

143 OHCHR statement.

144 It is recommended to use the guidelines established by the IACHR in the *Practical Guide to Reduce Pretrial Detention*. Available at: <http://www.oas.org/es/cidh/informes/pdfs/GUIA-PrisionPreventiva.pdf>

145 *European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Statement of principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (COVID-19) pandemic*. March 20, 2020. Available at: <https://rm.coe.int/16809cfa4b>

146 *Preparedness, prevention and control of COVID-19 in prisons and other places of detention. Interim guidance*, March 15, 2020, pp. 1 and 8. See also Principles and Good Practices on the Protection of Persons Deprived of Liberty in the Americas, Principle XI.

protection measures depending on their particular needs.

- Monitor and ensure that the health services and practices of private institutions keeping people in custody are in accordance with the guidelines and quality of services required by the state response to COVID-19 for people deprived of liberty.
- Guarantee that no one is prevented from accessing the prevention and treatment measures provided for in the state response to COVID-19 by gangs who “control” prisons or by state officials charging ‘fees’.¹⁴⁷
- Implement measures that avoid stigmatization or marginalization of people or groups that can be considered carriers of COVID-19.
- Considering that contact with the outside world is important for the mental health of persons deprived of liberty, take measures to ensure contact with their families, either in person with the implementation of special protocols adapted to the current context or through virtual means.¹⁴⁸
- Allow the national and international bodies responsible for monitoring prisons, jails, and other institutions where the State maintains people in custody to continue to exercise their functions and to have access to these places.¹⁴⁹

¹⁴⁷ Regarding this problem, see *Report on the Human Rights of Persons Deprived of Liberty in the Americas*, paras. 540-542.

¹⁴⁸ *Preparedness, prevention and control of COVID-19 in prisons and other places of detention Interim guidance*, p. 3

¹⁴⁹ *Ibid.* p. 5.

RECOMMENDED MATERIALS:

01 **places of detention. Interim guidance.**¹⁵⁰ This report from the Regional Office for Europe of the World Health Organization (WHO) contains interim guidelines for the elaboration of a state response to prevent the spread of COVID-19 to persons deprived of liberty and offer treatment to those who are infected.

02 **Health in prisons: A WHO guide to the essentials in prison health.**¹⁵¹ This WHO guide contains expert recommendations on measures to be taken by prison systems to reduce the public health risks associated with deprivation of liberty. The publication takes into account human rights standards related to health services in prisons and discusses measures that can be taken to protect the health of persons deprived of liberty and of officers.

03 **Inter-Agency Standing Committee Interim Guidance: COVID-19: Focus on Persons Deprived of Their Liberty.**¹⁵² This OHCHR and WHO publication contains interim guidelines to ensure the right to health of persons deprived of their liberty during the COVID-19 pandemic in accordance with human rights standards.

¹⁵⁰ Available at: http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf

¹⁵¹ Available at: http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf

¹⁵² Available at: <https://interagencystandingcommittee.org/other/iasc-interim-guidance-covid-19-focus-persons-deprived-their-liberty-developed-ohchr-and-who>

04 Pan American Health Organization. Tuberculosis and COVID-19 Information Note. March 28, 2020. This publication contains information on the risks faced by people suffering from tuberculosis in the face of the COVID-19 pandemic, which is relevant because many people deprived of liberty still suffer from this disease.¹⁵³

05 Good governance for prison health in the 21st century: A policy brief on the organization of prison health.¹⁵⁴ This publication by the United Nations Office on Drugs and Crime (UNODC) and the WHO Regional Office for Europe advises States on how they should organize health services for persons deprived of liberty taking into account the human rights standards of the European system. It is relevant to the context of the Americas since many standards coincide.

06 Report on the human rights of persons deprived of liberty in the Americas.¹⁵⁵ This IACHR report contains information on the main standards of the inter-American human rights system relating to persons deprived of liberty, including the obligations of states to guarantee the life, physical and mental integrity, and health of those persons.

¹⁵³ Available at: <https://www.paho.org/en/documents/information-note-tuberculosis-and-covid-19>

¹⁵⁴ Available at: http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf

¹⁵⁵ Available at: <https://www.oas.org/en/iachr/pdl/docs/pdf/PPL2011eng.pdf>

07 IACHR, Principles and Good Practices on the Protection of Persons Deprived of Liberty in the Americas.¹⁵⁶ Contains the principles that must guide the actions of the States in relation to persons deprived of liberty in the Americas.

08 Statement of principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (COVID-19) pandemic.¹⁵⁷ Statement of Principles of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment in relation to the health of persons deprived of liberty during the COVID-19 pandemic.

09 Standard Minimum Rules for the Treatment of Prisoners.¹⁵⁸ Adopted by the First United Nations Congress on Crime Prevention and Offender Treatment, held in Geneva in 1955, and approved by the Economic and Social Council in its resolutions 663C (XXIV) of July 31, 1957 and 2076 (LXII) May 13, 1977.

10 Set of Principles for the protection of all persons subjected to any form of arrest or imprisonment.¹⁵⁹ Adopted by the United Nations General Assembly in its resolution 43/173, of December 9, 1988.

¹⁵⁶ Available at: <https://www.oas.org/en/iachr/mandate/Basics/principles-best-practices-protection-persons-deprived-liberty-americas.pdf>

¹⁵⁷ Available at: <https://www.coe.int/en/web/cpt/-/covid-19-council-of-europe-anti-torture-committee-issues-statement-of-principles-relating-to-the-treatment-of-persons-deprived-of-their-liberty->

¹⁵⁸ Available at: <https://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx>

¹⁵⁹ Available at: <https://www.ohchr.org/Documents/ProfessionalInterest/bodyprinciples.pdf>

CHAPTER IX:

PREVENTION, CONTAINMENT AND MITIGATION OF COVID-19 FOR PERSONS LIVING IN POVERTY AND EXTREME POVERTY¹⁶⁰

1. THE SITUATION OF PEOPLE LIVING IN POVERTY AND EXTREME POVERTY AND THE IMPORTANCE OF A DIFFERENTIATED RESPONSE

In 2018, there were 185 million people living in poverty in the Americas, representing approximately 30.1% of the population of the region, of which 66 million, approximately 10.7% of the population, lived in extreme poverty. Data published by the Economic Commission for Latin America and the Caribbean (ECLAC) indicated that by 2019 the poverty rate at the regional level would increase to 30.8% and extreme poverty to 11.5%.¹⁶¹

But poverty in the region affects specific social groups in particular, and studies have shown that the incidence of poverty and extreme poverty is higher "among rural residents, children and adolescents, women, indigenous people and the Afro-descendant population, among other groups".¹⁶²

2. INTER-AMERICAN LEGAL FRAMEWORK

In the inter-American legal system, there are several instruments establishing the

¹⁶⁰ Prepared by Sara Mia Noguera, Head of the Equity Promotion Section of the Department of Social Inclusion, Secretariat for Access to Rights and Equity of the OAS.

¹⁶¹ CEPAL, *Social Panorama of Latin America* 2019, p. 96. Available at: <https://repositorio.cepal.org/handle/11362/44989>

¹⁶² For example, "the incidence of poverty reaches rates higher than 40% among rural residents, children and adolescents from 0 to 14 years old, the unemployed population and indigenous people". Source: ECLAC, *Social Panorama of Latin America* 2019, p. 18.

obligation of states to guarantee rights that are directly related to overcoming poverty. Some of the most important are: **the American Declaration of the Rights and Duties of Man** of 1948, which contains a series of rights that are closely related to overcoming poverty; the **American Convention on Human Rights** of 1969, which points out that economic, social and cultural rights, and civil and political rights are indivisible, and its **Additional Protocol on Economic, Social and Cultural Rights, "Protocol of San Salvador"**, of 1988, which guarantees rights closely linked to overcoming poverty, such as the right to work, health, social security, food, education and a healthy environment.

In addition, there are other relevant instruments, such as the **Inter-American Democratic Charter** in which states undertake to implement the necessary actions to reduce poverty and eradicate extreme poverty, highlighting the link between poverty and democracy, and the **Social Charter of the Americas** in which states commit to combat poverty, reduce inequities, and promote social inclusion, as necessary actions to achieve integral development in the Hemisphere.¹⁶³

In addition to these instruments, both the IACHR and the Inter-American Court of Human Rights have developed standards and jurisprudence on persons in situation of poverty and extreme poverty and the exercise of fundamental human rights such as the right to health. In the framework of the Individual Petitions and Cases system, "both the Commission and the Court have observed how poverty, marginalization and exclusion can lead to human rights violations, constitute aggravating circumstances or be a consequence of these violations".¹⁶⁴

3. JUSTIFICATION: WHY IS IT IMPORTANT TO TAKE THEM INTO ACCOUNT IN THE RESPONSES TO THE PANDEMIC?

While it is true that the disease caused by the new coronavirus (COVID-19) represents a threat to the population worldwide, government actions in response to the pandemic must take into account the particular vulnerability of people living in poverty and extreme poverty. For example, this is evidenced by the particular difficulties that the poorest people face in implementing the basic recommendations aimed at preventing the spread of the virus, such as: regularly washing hands using soap, social distancing, staying at home and isolating family members who have symptoms of COVID-19.

These basic measures are practically impossible to fulfill for persons living in poverty and extreme poverty considering that approximately 25.7% of the population in the region does not have access to drinking water¹⁶⁵ and 37.6% live in dwellings without sewage

¹⁶³ IACHR, *Report on Poverty and Human Rights of the Inter-American Commission on Human Rights*, p. 51.

Available at: <https://www.oas.org/en/iachr/reports/pdfs/Poverty-HumanRights2017.pdf>

¹⁶⁴ *Ibid*, p. 55.

¹⁶⁵ WHO and UNICEF, *Joint Water and Sanitation Monitoring Program*.

disposal.¹⁶⁶ Data for some countries in the region also show that overcrowding¹⁶⁷ is a frequent problem in the poorest households.¹⁶⁸

Not only do these conditions make it more difficult for people living in poverty to prevent the spread of the virus; their situation worsens if we consider that, upon contracting the virus, factors associated with their living conditions, such as the lack of adequate food, malnutrition, and some diseases prevalent among this population, such as cardiovascular disease, diabetes, and respiratory diseases such as tuberculosis, significantly decrease their chances of recovery.

Social distancing measures, such as “quarantining,” needed to contain the pandemic, may have unexpected consequences, such as the loss of work that can be particularly devastating for people who are in a vulnerable economic situation since they generally have no savings and cannot count on basic social protection, such as unemployment insurance, pension, medical insurance, and so on.¹⁶⁹ It is important to keep in mind that ECLAC data between 2014–2018 show that labor income, including wages and income from self-employment, was the factor that most influenced the changes in poverty rates during that period. Thus, for example, “in Brazil, a country that experienced an increase in poverty, the decrease in labor income was the factor that most affected the contraction of income in low-income households”.¹⁷⁰

In addition, the areas where the poorest people live, particularly rural areas, are characterized by precarious and, in some cases non-existent, health services, which significantly hampers identification, monitoring, and treatment of people with the new Coronavirus disease, all of which are key factors in preventing deaths caused by the virus.

4. RECOMMENDATIONS ON RELEVANT ASPECTS TO TAKE INTO ACCOUNT IN RESPONSES TO THE COVID-19 PANDEMIC

- Government policies and actions to prevent and contain the COVID-19 pandemic must be “intersectional”; that is to say, be oriented to address the multiple discriminations that people living in poverty and extreme poverty experience, and their impact on access to fundamental human rights, such as

¹⁶⁶ Figures available at: <https://estadisticas.cepal.org/cepalstat/portada.html?idioma=english>

¹⁶⁷ In Latin America, overcrowding is generally measured based on the relationship between the number of people and the number of rooms available (or potentially usable) to sleep in a dwelling. Source: <https://www.cepal.org/sites/default/files/presentations/2017-05-pablo-villatoro.pdf>.

¹⁶⁸ IDB, Housing, *What's Next? From thinking the Unit to Building the City*, p. 79. Available at: https://publications.iadb.org/publications/spanish/document/Vivienda_Qué_viene_de_pensar_la_unidad_a_construir_la_ciudad.pdf

¹⁶⁹ In 2017, at the regional level, only 23.8% of the economically active people from the lower strata were affiliates or contributors to a pension system. See ECLAC, *Social Panorama of Latin America*, p. 78.

¹⁷⁰ CEPAL, *Social Panorama of Latin America*, p. 115.

the right to health.

- It is essential that people living poverty and extreme poverty be guaranteed free access to COVID-19 tests. Free medical care and treatment should also be given to persons who have contracted the virus. In order to do this, mobile health clinics where COVID-19 tests can be opened and primary medical care provided could be provided.
- Close coordination between municipalities in rural areas should be considered to ensure that people living in the most isolated areas where health services are precarious, or non-existent, can receive timely medical attention. This coordination may involve actions such as the creation of "municipal consortia" to provide primary health care to persons from municipalities where there are no health services in municipalities that have hospitals and health centers.
- In urban areas, the activation of primary care systems for home visits could be considered, through which a health professional (doctor or nurse) is deployed, accompanied by a social worker, to visit families in more vulnerable circumstances to identify not just the state of health of family members but also to verify conditions and hygiene in the home (the availability of soap, drinking water, and so on). These visits could also be key to identifying cases of domestic violence which, as several organizations have already warned, could increase as a result of the restrictive measures adopted to contain the spread of the virus. (see the section in this Guide on Women, Gender Equality and COVID-19).
- Measures for the protection of income levels also need to be taken into account. Possible options to explore include "universal basic income" which could be adopted on a temporary basis, ensuring that these benefits reach the most vulnerable families. In some countries of the region that have social programs, such as conditional cash transfers, this could be done through a temporary increase of those transfers. The most important challenge of these types of measures is to ensure that they reach the most vulnerable families who are not necessarily registered in the registry of beneficiaries of social programs, as well as families who do not have access to the banking system. Another one that can be considered is to coordinate the distribution of the "basic temporary income" with organizations that work directly in the poorest areas, such as civil society organizations and community-based organizations.
- The particular vulnerability of people living on the streets deserves special attention.¹⁷¹ It is essential to ensure that COVID-19 awareness programs reach these people, that they can access COVID-19 tests, and are directed to care centers where they can receive medical assistance.

¹⁷¹ These people live in an unhealthy street environment, their incomes are affected by the lack of people on the streets, and they generally have no family support. In addition, the growing demand for support in shelters prevents them from receiving timely support.

- Consideration should also be given to the implementation of psychosocial assistance programs aimed at providing tools and support to people living in vulnerable situations to overcome the most common psychological consequences of the pandemic, including mourning for the loss of relatives, anxiety, stress, and depression.
- Taking into account that in low-income households, women perform most of the unpaid domestic work, including caring for dependents (children, sick people, t older persons, and persons with disabilities, among others), this health crisis highlights the pressing need for developing or extending national care systems and the incorporation of women into the labor market. This is also key to strengthening the family's income and increasing resilience to unexpected crises, such as pandemics, and the unexpected loss of employment of a family member. In the longer term, this is also key to facilitating social and economic mobility.

It is important to keep in mind that every crisis also represents an opportunity. From this perspective, the global COVID-19 pandemic and the emergency measures put in place to deal with this crisis present governments with a new opportunity to explore easing their fiscal rules and limitations in a responsible manner; to finally prioritize the establishment of comprehensive social protection systems that enable our societies; and to, not only, be better prepared to face future crises, but also to achieve the global sustainable development goals of eradicating poverty and inequality.

RECOMMENDED MATERIALS:

01 **Report on Poverty and Human Rights of the Inter-American Commission on Human Rights.** This report addresses the impacts of poverty on the enjoyment and exercise of human rights and seeks to open the doors to the development of the legal framework governing the international responsibility of States for poverty and extreme poverty.¹⁷²

02 **Social Panorama of Latin America, 2019** (LC/PUB.2019/22-P/Rev.1) of the Economic Commission for Latin America and the Caribbean (ECLAC), Santiago, 2019. This document analyzes trends in income inequality, poverty and social spending in Latin America and includes an analysis of migration in the region.¹⁷³

03 **Response to the COVID-19 outbreak in the Americas Region.** This document describes the priority lines of action recommended by the Pan American Health Organization to address the disease caused by the new Coronavirus in the Americas.¹⁷⁴

¹⁷² Available at: <https://www.oas.org/en/iachr/reports/pdfs/Poverty-HumanRights2017.pdf>

¹⁷³ Available at: <https://www.cepal.org/en/publications/44989-social-panorama-latin-america-2019>

¹⁷⁴ Available at: <https://www.paho.org/en/documents/response-covid-19-outbreak-region-americas>

04 **Beazley R., Solórzano A. and Barca V. (2019). Reactive social protection against emergencies in Latin America and the Caribbean: Main findings and recommendations. In this report,** Oxford Policy Management in collaboration with the World Food Program address the question: What factors make national social protection systems more reactive to emergencies? They also offer a series of specific recommendations for the countries of the region.¹⁷⁵

¹⁷⁵ Available at: <https://es.wfp.org/publicaciones/estudio-sobre-proteccion-social-reactiva-ante-emergencias-en-america-latina-y-el>

CHAPTER X:

EARLY CHILDHOOD, EDUCATION, AND SOCIAL ASSISTANCE IN THE COVID-19 ERA¹⁷⁶

1. EDUCATING AND FEEDING CHILDREN IN A SOCIAL ISOLATION CONTEXT

The social distancing and quarantine measures in force in many countries hit by COVID-19 have confined families to their homes and forced them to find new ways of living together and connecting with their social environment. While distance learning through digital media is becoming the practice to continue children's education, it is mostly available in countries which possess well developed educational institutions and programs, and extensive internet access. Distance learning is thus becoming generally accessible to a high-income social minority.

All over the world, children and adolescents' education happens mostly in schools, with families playing an important, but subsidiary role in curricular activities. Indeed, the education that school-age children receive at school is vital when it comes to assimilating content. Responses to the COVID-19 outbreak included class suspensions. This has posed a new challenge for families: mothers and fathers have had to take over the role of educators in the home, and are the ones leading the process of pedagogical and curricular training of their children.

¹⁷⁶ Written by Agustín Salvia, Researcher at Argentina's National Scientific and Technical Research Council (CONICET) and Independent Expert in the Working Group on the Protocol of San Salvador, and Ianina Tuñón, Lead Researcher at the Argentine Catholic University's Infancy Social Debt Barometer (Social Debt Observatory, ODSA-UCA). In collaboration with Enzo Rave, Research Assistant at ODSA-UCA.

The fact that children and adolescents cannot continue their education in school classrooms has also challenged traditional teaching methods and has forced families to play a major role in the learning process of their children. Helping out with homework and school assignments, something that used to be done quickly and as an additional task among many others in the home, has now taken prominence and required families to tap into available didactic materials, also online, to support children's educational progress. This, however, is not applicable to the most vulnerable households that have limited access to computer equipment and internet and where parents do not have the educational level to support their children. In other words, these challenges brought by the pandemic are compounded with the already-existing ones that limited children's educational attainments in vulnerable households. Even in households equipped with the appropriate technology for distance learning, there may clearly be limitations for educating children and adolescents, such as lack of familiarity with the proper use of the technological tools or other psychological and relational impediments exacerbated by social isolation.

In other words, today's circumstances redefine and widen a set of preexisting inequality gaps: households' digital and human capital gaps in a broad sense (educational and psychosocial health) are already a barrier to equalizing the curricular education provided to all the children and adolescents continuing their studies at home.

Another constraint that cannot be ignored in this diagnostic assessment is the size of available living space. Overcrowding or lack of space is a major obstacle to doing homework and is probably also detrimental to the quality and strength of human bonds within households. Even though overcrowding pre-dates COVID-19, during quarantines it becomes a permanent feature of family life. The current social context increases the likelihood of domestic violence, of which children and adolescents are often the main victims.

Similarly, in the current context of class suspensions, inequality gaps in education exponentially widen between families with and those without paid care options. For that reason, States are attempting to take steps to mitigate these tensions, albeit with mixed success and for periods of time that remain uncertain. It seems clear that schools have not been able to adapt to the pace of the measures imposed by the pandemic, given the lack of substantive reforms in the educational systems of the region.

However, in the Americas, apart from their traditional role, schools today also fulfill another function, perhaps even more essential in terms of sustaining life, than its traditional role as the guarantor of social reproduction and citizen training. For years now, schools have become sources of food for children and adolescents. This amended role of the educational institution challenges us to consider the relationship between education and social inequality.

A particularly challenging issue is that as a result of food insecurity, many families rely on educational, and other institutions, to obtain food. In the current context, schools' food assistance function for children is not there anymore, as the risk of contagion

takes precedence over food insecurity. In that context, homeless children pose a specific problem, as they require not only food assistance but a comprehensive social protection system as well. In the scenario triggered by the COVID-19 pandemic, these dimensions are particularly worrisome, not so much due to the number of infected persons in the region, but rather due to the consequences that the protective measures being adopted by governments may have on the most vulnerable segments of society if states do not respond quickly and prioritize them on their agenda.

Finally, it is important to pinpoint certain cross-cutting vulnerabilities for all children and adolescents during quarantines and social isolation measures. One of the main needs of this age group is to socialize with peers, and practice sports and engage in other physical activities, and play. In fact, these constitute children's and adolescents' rights. One internationally influential benchmark in this respect is the U.S. Department of Health and Human Services' Physical Activity Guidelines for Americans (2008). The section on children and adolescents in those Guidelines recommends 60 or more minutes a day of physical activity. A lack of physical activity and the opportunity to socialize with peer groups in face-to-face activities may impair children's and adolescents' physical health (overweight, obesity, immune system disorders, etc.); emotional health (anxiety, depression, mood disorders, etc.); and mental health (distractedness, sleep disorders, etc.).

It is also important to consider the particular situation of children and adolescents with divorced parents who shared custody rights or have made other family arrangements. It is crucial to protect their visiting rights to see each of their parents.

2. REGULATORY FRAMEWORK AND LEGAL PROTECTION OF CHILDREN

Children's human and social development is safeguarded by rights embodied in numerous international regulatory instruments generated by multilateral consensus, beginning with those that became consolidated as universal and general frameworks for the protection of human rights, such as the **Universal Declaration of Human Rights** (United Nations, 1948), the **International Covenant on Economic, Social and Cultural Rights** (United Nations, 1966); and the **Convention on the Rights of the Child** (United Nations, 1989)

More specifically, and at the inter-American level, States have a duty to grant special protection to children and adolescents, as established in the following instruments:

- Article VII of the **American Declaration of the Rights and Duties of Man** (1948) provides that "*All women, during pregnancy and the nursing period, and all children have the right to special protection, care and aid.*"
- The **American Convention on Human Rights** (OAS, 1969) protects the right of the child in Article 19, which establishes that "*Every minor child has the right to the measures of protection required by his condition as a minor on the*

part of his family, society, and the state."

- Article 16 of the **Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights** (OAS, 1988) ratifies what the American Convention on Human Rights has to say about the Rights of the Child and adds that (...) "*every child has the right to free and compulsory education, at least in the elementary phase, and to continue his training at higher levels of the educational system.*"

Specifically regarding nutrition, Article 24 of the Convention on the Rights of the Child (United Nations, 1989) establishes that the States Parties recognize the right of the child *to the enjoyment of the highest attainable standard of health* and commits States to taking a series of measures including "*To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution.*" Likewise, Article 28 of the Convention recognizes the right of the child to education and explicitly states that it is a duty of states to "*Make educational and vocational information and guidance available and accessible to all children [...and] take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity (...).*" It is also important to note that Articles 7, 13, 17, 18, and 31 of the Convention establish the right of the child to participate in cultural life, sports, and technology.

3. RECOMMENDATIONS TO STATES REGARDING RESPONSES TO THE COVID-19 PANDEMIC THAT TAKE INTO ACCOUNT CHILDREN AND ADOLESCENTS

To assist this process, several international organizations, such as FAO,¹⁷⁷ UNICEF, WHO, IFRC,¹⁷⁸ and others have compiled a set of key messages and actions for COVID-19 Prevention and Control in Schools and other educational facilities, as well as for parents, caregivers, community members, students and children.

Likewise, FAO (2020) has issued a series of recommendations regarding the pandemic, geared to facilitating the availability of food and its access for households¹:

- It proposes food distribution to the most vulnerable families (preferably fresh food delivery, and if possible, locally produced), at previously established delivery times. To that end, it recommends the use of digital tools (georeferenced applications) to improve communication regarding access points for food deliveries, distribution times, and recommendations for the proper use of food.

¹⁷⁷ Source: United Nations Food and Agriculture Organization. Available at <http://www.fao.org/home/en/>

¹⁷⁸ Source: UNICEF, WHO AND IFRC Key Messages and Actions for COVID-19 Prevention and Control in Schools March 2020 Available at: https://www.who.int/docs/default-source/coronaviruse/key-messages-and-actions-for-covid-19-prevention-and-control-in-schools-march-2020.pdf?sfvrsn=baf81d52_4

- Also proposed is the delivery of emergency essential food rations to the most vulnerable communities and territories in coordination with authorized government agencies or international cooperation.
- Redistribution of food from school feeding programs through donations to entities responsible for providing food assistance (such as food banks, social organizations, non-governmental organizations, churches, local clubs, etc.) during the emergency response phase.
- Increase in the economic allocation of social protection programs (such as income transfers) by an amount corresponding to the cost of food rations delivered by school feeding programs.
- Exemption from taxes on basic food for families with school-age children, especially for workers in the most affected economic sectors.

The continuity of educational processes through schooling partly depends on the strategies that families can devise, the strategies that arise in educational facilities, and the synergies that can be forged within the educational community, including families.

Once the quarantine and social distancing measures end, and schools reopen, every precaution must be taken to ensure student safety and health. While they remain closed due to isolation, children's routines for personal hygiene, sleep time, clothing, mealtimes, and also, the time and timing of homework must be continued.

Should social distancing measures continue, these will probably be harder for the most vulnerable families to follow due to their greater material deprivation, greater exposure to psychological stress, and limited space availability in their homes. In such cases, the above listed recommendations and especially those proposed by the FAO with respect to access to food and income transfers to households become a priority. It is also vital in those cases to expand the psychosocial dimension of protection systems for children and adolescents and their principal caregivers.

In situations involving prolonged social isolation, the use of digital or on-line learning strategies is recommended, along with the assignment of reading materials and exercises to be done at home. Television and radio programs and podcasts with academic content are also useful. Also recommended is daily or weekly monitoring by teachers of activities performed by their students at home, along with the monitoring of their overall situation, so as to detect any rights violations that may be occurring. Another suggestion is to update or create accelerated education strategies (UNICEF, WHO, and IFRC, 2020, p. 5).

In addition, a broad set of recommendations have been made for school environments at each education level, regarding prevention measures associated with hygiene and health practices. Other recommendations promote preventive practices among students, such as hand washing and social distancing. In other words, the goal is to

foster safe school environments, with respect to hygiene (constant disinfecting) and the personal hygiene habits of students, teachers, and non-teaching staff (through information and by setting an example). One important warning regards the need to avoid stigmatizing and discriminating against others during these prevention-related training and awareness-raising processes (UNICEF, WHO, and IFRC, 2020).

All these recommendations will be more difficult to implement within families and school environments in vulnerable communities. It is thus important to work in partnership with other public health and social services, with a view to ensuring that medical exams are carried out; that access to food and psychological support is provided; and that any child abuse and other violations of the human rights of children with disabilities or in other types of vulnerable situations are reported.

It is also important to take into consideration the multiple vulnerabilities to which children may be exposed in connection with domestic exploitation (caring for the sick or the elderly, or others) and domestic violence exacerbated by overcrowding and the tensions typically associated with additional shortages in a context in which adult providers have less work and income. It is recommended that awareness-raising campaigns be stepped up, including publication of the telephone numbers available for reporting and requesting help in cases of child abuse, violence, and exploitation, as well as to report and protect homeless children.

Mass campaigns are also needed to stress the importance of social distancing in situations where people live together and interact with one another in public spaces, with a view to eventually being able to ease up on quarantines and allow children to go outside the house for games and recreational physical activities in parks and squares in major cities. Another recommendation is to plan alternative arrangements for achieving social distancing within physical education courses at school and avoiding the suspension of those crucial educational stimuli that are deemed to be priorities and that only happen in the classroom (UNESCO, 2015).

Consideration also needs to be given, within the exceptions made in times of quarantines, to making arrangements for the transportation of children and adolescents, their parents, and principal caregivers in emergency situations.

RECOMMENDED MATERIALS:

- 01 OHCHR. **Coronavirus: Human rights need to be front and centre in response, says Bachelet.** March 2020¹⁷⁹
- 02 OHCHR. **The coronavirus outbreak is a test of our systems, values and humanity.** March 2020¹⁸⁰
- 03 World Bank (2006). **Development and the Next Generation. World Development Report, 2007.** Washington, D.C. World Bank.¹⁸¹
- 04 ECLAC and UNICEF (2014). **Children's Rights in the Digital Age.** Santiago, Chile: ECLAC.¹⁸²
- 05 Inter-American Commission on Human Rights (2013). **The Right of Boys and Girls to a Family. Alternative care. Ending Institutionalization in the Americas.** Washington, D.C. OAS.¹⁸³
- 06 FAO **A battle plan for ensuring global food supplies during the COVID-19 crisis.** March 2020¹⁸⁴
- 07 Jorge, E., and González, M. C. (2017). *Estilos de crianza parental. Una revisión teórica. Informes psicológicos*, Vol. 17, No. 2, pp. 39-66.¹⁸⁵
- 08 Mazzola, Roxana (2020). *Desigualdades en niños y niñas en América Latina frente a la pandemia del Coronavirus. Equidad para la Infancia*, March, 2020.¹⁸⁶

¹⁷⁹ Available at <https://www.ohchr.org/SP/NewsEvents/Pages/Media.aspx?IsMediaPageSP=true&LangID=E>

¹⁸⁰ Available at <https://www.unhcr.org/news/latest/2020/3/5e69eea54/coronavirus-outbreak-test-systems-values-humanity.html>

¹⁸¹ Available at <https://openknowledge.worldbank.org/handle/10986/5989>

¹⁸² Available at https://repositorio.cepal.org/bitstream/handle/11362/37337/Challenges18_ECLAC_UNICEF_en.pdf

¹⁸³ Available at <https://www.oas.org/en/iachr/children/docs/pdf/Report-Right-to-family.pdf>

¹⁸⁴ Available at <http://www.fao.org/news/story/en/item/1268059/icode/>

¹⁸⁵ Available at <https://dialnet.unirioja.es/servlet/articulo?codigo=7044268>

¹⁸⁶ Available at <http://equidadparalainfancia.org/2020/03/desigualdades-en-ninos-y-ninas-en-america-latina-frente-a-la-pandemia-coronavirus/>

09

UNITED NATIONS. **Alarming high' number of children malnourished worldwide: UNICEF report.** October 2019.¹⁸⁷

10

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CONTRIBUTORS¹⁹⁴

Is the Coordinator of the Unit on Refugees and Forced Displacement of the Secretariat for Access to Rights and Equity (SARE) of the OAS and Member and Rapporteur of the Committee for the Protection of the Rights of All Migrant Workers and their Families (CMW, in its acronym in English) of the United Nation (UN). He is also an Assistant Professor at American University (United States). He has a law degree from the University of the North (Colombia) and a Master's Degree in Advanced Studies in Human Rights from the Carlos III University of Madrid (Spain). Previously, he worked at the Inter-American Commission on Human Rights (IACHR), with civil society organizations and as a consultant to UNDP and SEGIB.



**ÁLVARO BOTERO
NAVARRO**



**RAFAEL DEL CASTILLO E
MELO SILVA**

Is an officer of the Secretariat for Access to Rights and Equity (SARE) of the OAS and Technical Secretary of the Working Group of the Protocol of San Salvador. He has a law degree from the Pontifical Catholic University of Campinas (Brazil) and a master's degree in Advanced Studies in Human Rights from the Carlos III University of Madrid (Spain). Before joining the SARE team, he worked for several years on issues of criminal rights, criminal due process and persons deprived of liberty at the International Criminal Court, the Special Court for Sierra Leone, the International Criminal Tribunal for Rwanda and the Inter-American Commission on Human Rights.

Bachelor of Humanities from the University of Chile and Master of Science in Disability and Human Development from the University of Illinois at Chicago, USA. She participated directly in the process of elaborating and adopting the United Nations Convention on the Rights of Persons with Disabilities. She has published several articles on the subject internationally. She was an Assistant Professor of the Master's Program in International Development at Gallaudet University, in Washington, D.C. She currently works as a Specialist on Rights of Persons with Disabilities in the Department of Social Inclusion of the OAS Secretariat for Access to Rights and Equity.



PAMELA MOLINA



**ALEJANDRA MORA
MORA**

Executive Secretary of the Inter-American Commission of Women (CIM) of the OAS

Jurist, feminist, researcher, Costa Rican politician and activist for the human rights of women. She was Minister for the Status of Women, President of the National Institute of Women (INAMU) from 2014 to 2018 and Director of the Ombudsperson's Office of Costa Rica until August 2019. She graduated in Law from the University of Costa Rica in 1989. She completed specialization courses at the University of Lund and Raul Wallenberg of Sweden in 1997. She obtained her Master's Degree in Constitutional Law from the Distance State University of Costa Rica in 2004 and a Postgraduate Degree in Human Rights at the University of Chile in 2007. Author of a book and multiple articles on the human rights of women. Alejandra Mora Mora began her work as Executive Secretary of the CIM/OAS on August 16, 2019.

Is Director of the Department of Social Inclusion of the OAS Secretariat for Access to Rights and Equity. She holds a PhD in Political Science from Florida International University, Miami, FL and a Master's Degree in International Relations from the University of South Florida, Tampa, FL. From the Department of Social Inclusion, she leads the efforts of the GS/OAS in the area of inclusion of populations in situations of vulnerability, and the promotion of the full exercise of their human rights. She is the author of various publications and opinion columns on issues of human rights, equity and social inclusion, democracy, and migration and refuge in the Americas, among others.



**BETILDE MUÑOZ-
POGOSSIAN**



SARA MÍA NOGUERA

Is the Head of the Equity Promotion Section of the Department of Social Inclusion of the OAS Secretariat for Access to Rights and Equity. She has a degree in International Studies, with an emphasis on the Latin American region, from the Georgia Southern University, United States. She holds a Master's Degree in International Human Rights Law from the United Nations University for Peace of Costa Rica. She manages the social development portfolio, including the Meeting of Ministers and High-Level Authorities on Social Development, the Inter-American Social Protection Network and the Technical Secretariat of the Working Group of the Protocol of San Salvador. She also coordinates cooperation and technical activities to strengthen government capacities to effectively implement public policies and initiatives to promote social development. For the past ten years, she has been an officer of the OAS, working on issues related to the promotion of democracy, women's political participation, human rights, and development cooperation.

PhD in Community Mental Health from the National University of Lanús, Argentina. Master in Mental Health and Psychologist from the University of the Republic, Uruguay. Full Professor of the Institute of Social Psychology, Faculty of Psychology, University of the Republic. Co-coordinator of the Interdisciplinary Center on Aging. Level 1 Researcher National System of Researchers of Uruguay.



**ROBERT PÉREZ-
FERNÁNDE**



ROBERTO ROJAS DÁVILA

Head of the Groups in Situations of Vulnerability Section of the OAS Department of Social Inclusion. He is a lawyer and has a postgraduate degree in Social Management from the Pontifical Catholic University of Peru, Master's in International, Human Rights and Humanitarian Law from the American University -Washington College of Law, and candidate for a doctorate in Citizenship and Human Rights from the University of Barcelona.

Master's in Social Psychology and Bachelor of Psychology from the University of the Republic of Uruguay. A government expert who participated in the OAS Committee of Experts that drafted the Inter-American Convention on Protecting the Human Rights of Older Persons. Director of the National Institute for the Elderly of Uruguay 2011-2019. University Professor and Researcher in older people and human rights.



ADRIANA ROVIRA



**DANIEL SÁNCHEZ
VELÁSQUEZ**

Government expert on the OAS Working Group of the Protocol of San Salvador. Deputy Minister of Human Rights of Peru. Specialist in the rights of indigenous peoples and transitional processes. Author of various publications on Constitutional Law, Human Rights and the Law of Indigenous peoples.

Principal Researcher at Argentina's National Scientific and Technical Research Council (CONICET). Sociologist. M.A. in Political and Social Sciences and Ph.D. in Social Sciences. Director of Research at the Argentine Catholic University's Social Debt Observatory (ODSA-UCA). Director of the Structural Change and Social Inequality program at the Research Institute at the Social Sciences Faculty of the University of Buenos Aires. Coordinator of the CLACSO Working Group on Structural Heterogeneity and Inequality in Latin America. Expert in the Working Group of the Protocol of San Salvador. GTPSS).



AGUSTÍN SALVIA



**ANDRÉS
SCAGLIOLA**

Is an expert and President of the Working Group of the Protocol of San Salvador on economic, social, cultural and environmental rights. Political scientist, with postgraduate studies in government, administration and public policy at the University of the Republic (Montevideo) and the Autonomous University of Barcelona. He was National Director of Social Policies of the Ministry of Social Development (MIDES) under the José Mujica government (2010-2015). He is Executive Coordinator of the Secretariat for Diversity of the Municipality of Montevideo for the period 2015-2020. He led the pilot project "Intersectionality in metropolitan LGBTI policies" of the World Association of Major Metropolises (2017-2019). He is general coordinator of RE (civil association in formation dedicated to the themes of Human Rights, Diversity, Migration and Culture).

Sociologist. M.A. in Social Science Research. Doctorate in Social Sciences from the Social Sciences Faculty at the University of Buenos Aires. Coordinator and Lead Researcher at the Argentine Catholic University's Infancy Social Debt Barometer and PICTO 2017-0061, in connection with the Argentine Social Debt Observatory. Certified Researcher of the National Ministry of Education. Full-time professor at the Universidad Nacional de la Matanza and undergraduate and post-graduate professor at Argentina's Catholic University and the Tres de Febrero National University.



IANINA TUÑÓN

**ORGANIZATION OF AMERICAN STATES
SECRETARIAT FOR ACCESS TO RIGHTS AND EQUITY
DEPARTMENT OF SOCIAL INCLUSION**

MAY 2020



**17th St. and Constitution Ave., NW
Washington, D.C., 20006-4499
United States of America**



Emails

Secretariat for Access to Rights and Equity: **SADyE@oas.org**
Department of Social Inclusion: **DIS@oas.org**