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**Promotion and protection of human rights: human rights questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms**

## **Right of everyone to the enjoyment of the highest attainable standard of physical and mental health**

### **Note by the Secretary-General**

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, submitted in accordance with Human Rights Council resolutions 6/29 and [42/16](#).

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\* [A/77/150](#).



## **Report by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health**

### **Racism and the right to health**

#### *Summary*

In her second report to the General Assembly, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, focuses on the impact of racism on human dignity, life, non-discrimination, equality, the right to control one's health and body, and the entitlement to a system of health protection. She analyses the impact of racism and discrimination, in particular on Black people, people of African descent, migrants, indigenous peoples and minorities, and the intersection of factors at play, such as poverty, and discrimination based on age, sex, gender identity, expression, sexual orientation, disability, migration status, health status and location in rural or urban communities.

Using the frameworks of intersectionality, anti-coloniality and anti-racism, the Special Rapporteur examines the global health impact on racialized people of the living legacy of past and ongoing forms of racism, apartheid, slavery, coloniality and oppressive structures. In addition, she clarifies the legal framework that applies to various population groups affected by racism and draws attention to specific measures recommended to States. She also identifies good practices that affirm the right to a system of health protection in which people have equal opportunities to enjoy the highest attainable standard of health and provides examples of reparations for racial discrimination related to violations and abuses of the right to health.

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## I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health agrees with the High Commissioner for Human Rights that systemic racial discrimination extends beyond any expression of individual hatred.<sup>1</sup> She recognizes that it results from bias in multiple systems and public policy institutions, and is also crystalized in laws. Both separately and together, these factors perpetuate and reinforce barriers to equality.

2. The focus of the present report is on the impact of racism on human dignity, life, non-discrimination, equality, the right to control one's health and body, including the right to freedom from non-consensual medical treatment and experimentation, and the entitlement to a system of health protection.<sup>2</sup> On the basis of anti-coloniality and anti-racism frameworks, the report exposes the global health impact on racialized people of the living legacy of past and ongoing forms of racism, apartheid, slavery, coloniality<sup>3</sup> and oppressive structures, including the global economic architecture, funding mechanisms and national health systems.

3. The Special Rapporteur underlines the fact that racism is a key social determinant of health and a driver of health inequities. She considers from a historical perspective the impact of past and contemporary forms of racism on the right to health and on the ability of individuals and communities to realize their rights to underlying determinants of health, such as access to health care, services and goods, including with respect to sexual and reproductive health. She also sheds light on the impact of racism and discrimination, in particular on Black people, persons of African descent, migrants and indigenous peoples and minorities, and the intersection of factors at play, such as poverty, and discrimination based on age, sex, gender identity, expression, sexual orientation, disability, migration status, health status (e.g. HIV/AIDS) and location in rural or urban communities.

4. The Special Rapporteur identifies good practices for affirming the right to a system of health protection, including to health care and underlying social determinants of health, whereby people have equal opportunities to enjoy the highest attainable standard of health. She also provides examples of how to end racism and discrimination on the grounds of race, colour, descent, national or ethnic origin with regard to access to underlying determinants of health, social protections and health-care facilities, goods and services.

## II. Racism and substantive equality

5. The main proposal made by the Special Rapporteur is to operationalize the right to health in an attempt to foster substantive equality, in line with the peace, security, development and human rights agenda of the United Nations.

6. In the report, she asserts that intersectionality is the bridge to substantive equality and must be placed at the centre of the operationalization of the right to health. This requires an unequivocal commitment to the realization of the universal

<sup>1</sup> Office of the United Nations High Commissioner for Human Rights (OHCHR), "Seminal United Nations report offers an agenda to dismantle systemic racism", 29 June 2021.

<sup>2</sup> OHCHR, "About the right to health and human rights". See also [A/HRC/35/21](#), para. 31; [A/HRC/35/21](#); and the Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 8.

<sup>3</sup> Zaneta M. Thayer and Christopher W. Kuzawa, "Biological memories of past environments: epigenetic pathways to health disparities", *Epigenetics*, vol. 6, No. 7 (July 2011).

principles of human rights enshrined in the main international human rights norms and standards (see sect. IV).

7. The health consequences of racism and discrimination can be persistent and passed from one generation to the next through the body's "biological memory" of harmful experiences.<sup>4</sup> Rooted in colonialism, slavery and other historical power imbalances, racism continues to manifest itself in poor and preventable health outcomes worldwide, such as glaring disparities in maternal mortality and morbidity, and higher risk levels of communicable and non-communicable diseases. Racial discrimination is also institutionalized in underlying determinants of health, such as education, employment and housing. In addition to being linked to poverty, racism is present in multiple localities and leads to exceedingly high rates of police brutality, poor access to justice and recourse, mass incarceration, exposure to toxic environmental pollutants and a lack of access to housing, education, employment, health care, and healthy food.<sup>5</sup>

8. Related adverse health outcomes are well supported by available data. It has been largely documented that racism leads to increased rates of mortality and morbidity.<sup>6</sup> However, a number of other health outcomes affected by racism are challenging to measure because of widespread and concerning gaps in data collection.<sup>7</sup> The full picture of the impact of racism on the right to health cannot be discerned without disaggregating health data by race,<sup>8</sup> ethnicity, gender, age, sexual orientation, gender identity, disability, rural or urban location, among other factors.

### III. Methodology

9. The present report is based on the analysis of existing international human rights laws and standards, as well as on information received about racism and the right to health from different stakeholders and relevant literature.

10. Since the beginning of her term on 1 August 2020, the Special Rapporteur has initiated or joined at least three press releases/media statements directly linked to racism.

11. In preparing the present report, the mandate holder issued a call for submissions, inviting relevant stakeholders to share their experiences and policies. She expresses her appreciation to all those who contributed to the report.<sup>9</sup>

### IV. Legal framework

12. Racism can have a severe impact on the exercise of the right to the enjoyment of the highest attainable standard of physical and mental health, including the right

<sup>4</sup> Ayesha Khan, "Racism, not race, is a risk factor for infectious diseases", *Infectious Diseases Society of America*, 3 August 2020.

<sup>5</sup> Mohammad S. Razai and others, "Mitigating ethnic disparities in COVID-19 and beyond", *BMJ*, vol. 372 (15 January 2021); Sharrelle Barber, "Death by racism", *The Lancet Infectious Diseases*, vol. 20, No. 8 (August 2020); Michelle A. Albert and others, "Perceptions of race/ethnic discrimination in relation to mortality among Black women: results from the Black women's health study", *Archives of Internal Medicine*, vol. 170, No. 10 (24 May 2010).

<sup>6</sup> Pan American Health Organization, "Why data disaggregation is key during a pandemic", 13 April 2020; OHCHR, "International human rights standards and recommendations relevant to the disaggregation of Sustainable Development Goal indicators", working document (9 April 2018).

<sup>7</sup> Rhonda Vonshay Sharpe, "Disaggregating data by race allows for more accurate research", *Nature Human Behaviour*, vol. 3, No. 12 (2019).

<sup>8</sup> For the submissions received, see XXX.

<sup>9</sup> Committee on the Elimination of Racial Discrimination, general recommendation No. 29 (2002).

to sexual and reproductive health. Racism may also lead to violations of other human rights, including civil, political, economic, social, cultural and environmental rights and can, in the worst cases, lead to the death of people belonging to marginalized population groups.

13. The main international human rights instruments (the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and the Convention on the Rights of Persons with Disabilities) refer to race as a reason not to discriminate.

14. The International Convention on the Elimination of All Forms of Racial Discrimination includes concrete examples of racial discrimination and a clarification that racial discrimination should be understood as “any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life”.<sup>10</sup> Article 5, paragraph (e) (iv), of the Convention refers to the need to prohibit and eliminate racial discrimination in order to guarantee the right to public health and medical care. The Committee places particular emphasis on and provides recommendations, including in relation to the right to health, regarding certain population groups that experience racism or racial discrimination such as Roma,<sup>11</sup> people of African descent,<sup>12</sup> indigenous peoples,<sup>13</sup> migrants, refugees and asylum seekers<sup>14</sup> and ethnic minorities,<sup>15</sup> as well as members of communities based on forms of social stratification, such as caste and analogous systems of inherited status.<sup>16</sup>

15. In addition to falling into the above-mentioned categories, sex and gender also intersect with other factors of discrimination. The Committee on the Elimination of Discrimination against Women emphasizes that “discrimination against women based on sex and/or gender is often inextricably linked with and compounded by other factors that affect women, such as race, ethnicity, religion or belief, health, age, class, caste, being lesbian, bisexual or transgender and other status” and that “gender-related claims to asylum may intersect with other proscribed grounds of discrimination, including age, race, ethnicity/nationality, religion, health, class, caste, being lesbian, bisexual or transgender and other status”.<sup>17</sup>

<sup>10</sup> International Convention on the Elimination of All Forms of Racial Discrimination, art. 1, para. 1.

<sup>11</sup> Committee on the Elimination of Racial Discrimination, general recommendation No. 34 (2011).

<sup>12</sup> Committee on the Elimination of Racial Discrimination, general recommendation No. 24 (1999), paras. 1–3.

<sup>13</sup> Ibid.

<sup>14</sup> With regard to non-citizens, the Committee on the Elimination of Racial Discrimination clarified that States have the obligation to also report on “foreigners”. See Committee on the Elimination of Racial Discrimination general recommendations No. 11 (1993) and No. 30 (2004); and the International Convention on the Elimination of All Forms of Racial Discrimination, art. 1.2. See also: CERD/C/CHL/CO/22-23, para. 32; CERD/C/USA/CO/7-9, para. 15; CERD/C/CZE/CO/12-13, para. 23; and CERD/C/CZE/CO/12-13, para. 24.

<sup>15</sup> See CERD/C/ISR/CO/17-19, paras. 32 and 38; and CERD/C/CHN/CO/14-17, paras. 28–29.

<sup>16</sup> Committee on the Elimination of Racial Discrimination, general recommendation No. 27 (2000). See also: CERD/C/HUN/CO/18-25, para. 20; CERD/C/CZE/CO/12-13, para. 15 (c); CERD/C/LTU/CO/9-10, para. 18; and CERD/C/HUN/CO/18-25, para. 20.

<sup>17</sup> Committee on the Elimination of Discrimination against Women, general recommendation No. 32 (2014).

16. The Committee on the Elimination of Discrimination against Women calls on Governments to pay particular attention to women belonging to vulnerable and disadvantaged groups, such as migrant, refugee and indigenous women and women with physical or mental disabilities.<sup>18</sup> The Committee recommends that States take measures within their territories to eliminate poverty among communities of persons of African descent and remove barriers to escaping poverty, including in housing, health, education and employment.<sup>19</sup> The Committee also expressed concern about the consequences that the world financial and economic crisis could have on the situation of persons belonging to the most vulnerable groups, mainly racial and ethnic groups, leading to an aggravation of the discrimination that they might suffer.<sup>20</sup> In August 2020, it also emphasized that the pandemic was having significant adverse impacts on the right to non-discrimination and equality.<sup>21</sup>

17. With regard to the right to health,<sup>22</sup> the Committee on Economic, Social and Cultural Rights has indicated that the right was closely related to and dependent upon the realization of other human rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination and equality.<sup>23</sup> The Committee has clarified that anyone whose right to health has been violated should have access to appropriate judicial and other remedies, and is entitled to adequate reparations, including “restitution, compensation, satisfaction or guarantees of non-repetition.”<sup>24</sup>

18. The Durban Declaration and Programme of Action include specific measures to combat racism, racial discrimination, xenophobia and related intolerance and requests for States to ensure the right to health and health care to people of African descent, indigenous women and girls, migrants, people belonging to national or ethnic, religious and linguistic minorities, foreigners and migrant workers.<sup>25</sup> They also contain guidance for States on the type of data to collect, which should be disaggregated and take into account economic and social indicators, including health and health status, infant and maternal mortality, life expectancy and mental and physical health care, “in order to elaborate targeted social and economic development policies with a view to closing the existing gaps in social and economic conditions.”<sup>26</sup> In the Programme of Action, States are urged to establish national programmes to promote the access of victims or potential victims of racial discrimination to basic social services, including basic health care, and to eliminate disparities.<sup>27</sup>

19. Concerning the right to health more specifically, States are urged to enhance measures to fulfil the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, with a view to eliminating disparities in health status that might result from racism, racial discrimination, xenophobia and related intolerance.<sup>28</sup>

<sup>18</sup> Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999), para. 6.

<sup>19</sup> Committee on the Elimination of Racial Discrimination, general recommendation No. 34 (2016).

<sup>20</sup> Committee on the Elimination of Racial Discrimination, general recommendation No. 33 (2009).

<sup>21</sup> Committee on the Elimination of Racial Discrimination, “Statement on the coronavirus (COVID-19) pandemic and its implications under the International Convention on the Elimination of All Forms of Racial Discrimination” (2020).

<sup>22</sup> See International Covenant on Economic, Social and Cultural Rights, art. 12, which is linked to art. 2.2. on non-discrimination and equal treatment.

<sup>23</sup> Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 3.

<sup>24</sup> *Ibid.*, para. 59.

<sup>25</sup> Durban Declaration and Programme of Action, paras. 5, 18, 29, 30 (g), 49 and 81.

<sup>26</sup> *Ibid.*, para. 92 (c).

<sup>27</sup> *Ibid.*, paras. 100–101.

<sup>28</sup> *Ibid.*, para. 109. See also paras. 110–111.

20. It is specified in Sustainable Development Goal 3 that good health and well-being are essential to sustainable development. The Special Rapporteur emphasizes in particular targets 3.C, on the need to increase health financing in developing countries, and 3.D, on strengthening the capacity of all countries for early warning, risk reduction and management of national and global health risks. Both targets are essential. She also recalls the report of the Secretary-General entitled “Our Common Agenda” (A/75/982) and the “key proposals across the 12 commitments”, including the commitment to leave no one behind, which relates to the proposal for a new era for universal social protection, including health care; the commitment to protect our planet, which relates to the right to a healthy environment; and the commitment to be prepared, which relates to global public health.

21. The Special Rapporteur agrees that States should eradicate hunger and poverty; ensure food and nutritional security, and access to affordable, safe, efficacious and quality medicines, as well as to safe drinking water, sanitation, employment, decent work and social protection; and protect the environment and deliver equitable economic growth through resolute action on social determinants of health across all sectors and at all levels.<sup>29</sup>

## V. Ongoing manifestations of racism and related forms of discrimination in underlying determinants of health

22. The concept of epistemic injustice, or injustice related to knowledge,<sup>30</sup> whereby someone’s knowledge or experience is not taken seriously or considered credible on the basis of an analysis of power and associated stereotypes, has increasingly been applied in the context of health care.<sup>31</sup> A distinction is made between two types of epistemic injustice: testimonial injustice, in which someone’s pain, experience or trauma is discounted by people in a position of power,<sup>32</sup> and hermeneutical injustice, in which the naming and articulation of suffering is prevented by a gap in (dominant) knowledge and ideas, arising from stereotypes and the dismissal of the authority of marginalized groups’ experiences.<sup>33</sup> These injustices “can be systematic, especially if, as in the case of racism and sexism, the stereotypes and prejudices are deeply entrenched in the social world”.<sup>34</sup>

23. The Special Rapporteur has reviewed the existing literature on the barriers faced by indigenous peoples to enjoyment of the right to health. It can be confirmed that language is a major component of discrimination in various countries, including Argentina (A/HRC/21/47/Add.2, para. 110), Australia (A/HRC/36/46/Add.2, para. 56), the Congo (A/HRC/18/35/Add.5, para. 23), Namibia (A/HRC/24/41/Add.1, para. 95), Panama (A/HRC/27/52/Add.1, paras. 74–75) and Sri Lanka (A/HRC/34/53/Add.3, para. 59). Ongoing research has also shown that inadequate cultural adaptation in the delivery of health services can create a barrier to the enjoyment of the right to health for indigenous peoples in various countries, including Botswana (A/HRC/15/37/Add.2,

<sup>29</sup> World Health Organization (WHO), sixty-fifth World Health Assembly, Outcome of the World Conference on Social Determinants of Health.

<sup>30</sup> Miranda Fricker, *Epistemic Injustice: Power and the Ethics of Knowing* (Oxford, Oxford University Press, 2011).

<sup>31</sup> Eleanor Alexandra Byrne, “Striking the balance with epistemic injustice in healthcare: the case of chronic fatigue syndrome/myalgic encephalomyelitis”, *Medicine, Health Care and Philosophy*, vol. 23, No. 3 (2020), pp. 371–379.

<sup>32</sup> Rupa Marya and Raj Patel, *Inflamed: Deep Medicine and the Anatomy of Injustice* (New York, Farrar, Straus and Giroux, 2021), p. 193.

<sup>33</sup> *Ibid.*, pp. 193–194.

<sup>34</sup> Ian James Kidd and Havi Carel, “Epistemic injustice and illness”, *Journal of Applied Philosophy*, vol. 34, No. 2 (February 2017), p. 177.



para. 81), Chile (E/CN.4/2004/80/Add.3, para. 78), Colombia (E/CN.4/2005/88/Add.2, para. 110), the Congo (A/HRC/18/35/Add.5, para. 74), Ecuador (A/HRC/42/37/Add.1, para. 103), and Honduras (A/HRC/33/42/Add.2, para. 102). Moreover, information relating to the sexual and reproductive rights of indigenous peoples is often not made available in accessible formats and in indigenous languages.<sup>35</sup> This language barrier exacerbates both testimonial and hermeneutical injustice. The Special Rapporteur regrets that there have been a limited number of submissions investigating the situation in European countries.

### Education

24. Disparities in poverty are also tied to structural racism pervasive in education systems,<sup>36</sup> and adults with a lower educational attainment have poorer health outcomes and lifespans than their more educated peers.<sup>37</sup> It is crucial to recognize the link between meaningful education, health-seeking behaviours and, ultimately, outcomes. Members of racial and ethnic minorities are also more likely to report being victims of bullying by their peers which has a huge impact on their physical and mental health.<sup>38</sup>

25. The increasing recognition of the deep impact of systemic oppressions on mental health is important, and the data available seems to be only the tip of the iceberg. As one civil society organization stated during the forty-fourth session of the Human Rights Council, “to be well, we also need to be free and living in a just world. There is no mental health in a violent world.”<sup>39</sup>

### Segregation

26. Residential segregation is a powerful predictor of health and well-being, since residents of communities in which public health services are inaccessible face higher rates of preterm birth, cancer, tuberculosis and depression.<sup>40</sup> In its submission, Switzerland, for example, recognizes that data on race and ethnicity have never been collected in public statistics, and that it has therefore not been possible to determine which ethnic or racialized groups have been more subjected to exclusion and differences in access to health care due to racism.<sup>41</sup>

27. In comparison with predominantly white neighbourhoods, communities predominantly composed of people of African descent are more exposed to environmental toxins, air pollutants and carcinogens, which contributes to higher rates of pulmonary diseases and lower birth weights. Those communities also bear a disproportionate burden of the increasing risks of housing instability as a result of climate crises like flooding, wildfires and extreme heat (A/64/255).

<sup>35</sup> WHO and others, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: an Interagency Statement* (Geneva, 2014).

<sup>36</sup> Cecilia Barbiero and Martha K. Ferede, “A future we can all live with: how education can address and eradicate racism”, United Nations Educational, Scientific and Cultural Organization (UNESCO), 29 June 2020.

<sup>37</sup> Viju Ragupathi and Wullianallur Ragupathi, “The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015”, *Archives of Public Health*, No. 20 (6 April 2020).

<sup>38</sup> Chardée A. Galán and others, “Exploration of experiences and perpetration of identity-based bullying among adolescents by race/ethnicity and other marginalized identities”, *Jama Network Open*, vol. 4, No. 7 (23 July 2021).

<sup>39</sup> See [www.sexualrightsinitiative.org/resources/hrc-44-statement-interactive-dialogue-special-rapporteur-right-health](http://www.sexualrightsinitiative.org/resources/hrc-44-statement-interactive-dialogue-special-rapporteur-right-health).

<sup>40</sup> Michael R. Kramer and Carol R Hogue, “Is segregation bad for your health?”, *Epidemiologic Reviews*, vol. 31 (23 May 2009), pp. 178–194.

<sup>41</sup> Submission by Switzerland.

## Migration

28. In addition to the various pathways for structural racism described above, migration itself can be considered a determinant of health impacted by racism that may be embedded in countries' immigration laws, policies, institutions and practices, which often subject migrants to dangerous conditions or impose obstacles to health services and resources.

29. In 2021, the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance submitted a report highlighting how digital technologies were being deployed to advance xenophobic and racially discriminatory treatment and exclusion of migrants, refugees, and stateless persons (A/HRC/48/76). The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health also agreed with the Special Rapporteur on extreme poverty and human rights, who had indicated that there was a “diversity crisis in the artificial intelligence sector across gender and race” and that those designing artificial intelligence systems in general, as well as those focused on the welfare state, were “overwhelmingly white, male, well-off and from the global North” (A/74/493).

30. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health agrees with this analysis and recalls that migrant or refugee status is often a barrier to access to health care, especially for migrants in transit or undocumented migrants, who do not have access to health care and preventive health care, or have access to only emergency health care. Migrant or refugee status is therefore ineffective in the long term as it may cost more for the health system than inclusive policies.<sup>42</sup> In Switzerland, data show that regions with a higher rate of socioeconomic deprivation, and/or of immigration, have a higher rate of avoidable hospitalizations and avoidable rehospitalizations.<sup>43</sup> In Italy, persistent barriers, including administrative ones, fears related to unfamiliarity with the health system, language and intercultural barriers in Roma settlements are documented.<sup>44</sup>

31. The coronavirus disease (COVID-19) pandemic has exacerbated the already dire working, living and transit conditions, which are primarily rooted in structural, political, social and economic determinants, and has had a negative effect on migrant physical and emotional well-being.<sup>45</sup>

## Sexual and reproductive health rights

32. Maternal mortality and morbidity statistics illustrate the intersectionality between race and gender, as well as revealing stark disparities along racial lines in outcomes for births.<sup>46</sup> The Special Rapporteur remains concerned that even in the most comprehensive global data, many vulnerable populations are not represented and are therefore invisible. Moreover, even for countries with good overall progress indicators, the national-level data often mask extreme disparities that exist between population groups within these countries.<sup>47</sup>

<sup>42</sup> Kayvan Bozorgmehr and Oliver Razum, “Effect of restricting access to health care on health expenditures among asylum-seekers and refugees: a quasi-experimental study in Germany, 1994–2013”, *PLOS One*, vol. 10, No. 7 (22 July 2015).

<sup>43</sup> Submission by Switzerland.

<sup>44</sup> Submission by Italy.

<sup>45</sup> Miriam Orcutt and others, “Global call to action for inclusion of migrants and refugees in the COVID-19 response”, *Lancet*, vol. 395, No. 10235 (23 April 2020); and WHO, “Refugee and migrant health”, fact sheet, 2022.

<sup>46</sup> Maria J. Small, Terrence K. Allen and Haywood L. Brown, “Global disparities in maternal morbidity and mortality”, *Seminars in Perinatology*, vol. 41, No. 5 (August 2017).

<sup>47</sup> WHO and others, *Trends in Maternal Mortality 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (Geneva, WHO, 2019).

33. In its report entitled “Women and Girls of African Descent: Human Rights Achievements and Challenges”, the Office of the United Nations High Commissioner for Human Rights (OHCHR) highlighted the negative impact of the exclusion of women of African descent from quality sexual and reproductive health services.<sup>48</sup> The report also indicated that their exclusion was “due to a combination of structurally discriminatory factors, such as poverty, the low availability of quality health services and a lack of culturally acceptable health services, as well as direct discrimination, stigmatization and racism within health facilities”.<sup>49</sup> This broad problem affects many groups other than people of African descent, such as in India, where marginalized women and girls often lack access to family planning services.<sup>50</sup> Girls and women with disabilities have no awareness of their sexual and reproductive rights, are at a heightened risk of involuntary sterilization and remain a target in some countries because of population control policies aimed at indigenous women and members of ethnic minorities. This is one of the clearest reasons why human rights principles should permeate and find expression in programme design, implementation and service delivery.

34. Coercion in health care is a common experience for racialized people,<sup>51</sup> including in the form of population control and other coercive population policies. In complete violation of the rules on informed consent and other ethical standards, there has been violent experimentation on racialized people throughout the history of medicine. Pregnant women from lower-income communities who are HIV-positive and rely solely on State-funded health care have been specifically targeted. Media coverage of forced sterilizations of women based on HIV status requires a nuanced understanding of the “intersection of their gender, race and class which renders them more vulnerable to forced and coerced sterilization”.<sup>52</sup> In some European countries, Roma women have been forcibly sterilized and targeted on the basis of a combination of racist, sexist, classist and ableist stereotypes.<sup>53</sup>

35. The Special Rapporteur agrees that “we need to reconsider the meaning of reproductive liberty to take into account its relationship to racial oppression.”<sup>54</sup> For example, in South Africa, access to health services continues to be affected by spatial injustice, which reflects a combination of racial segregation, colonial and apartheid repression and the Government’s failure to address stark inequalities in the infrastructure and resources of the public health system.<sup>55</sup> In the United States of America, in particular since the Supreme Court rescinded federal protections for abortion, criminal sanctions for pregnancy outcomes and behaviour during pregnancy will increase dramatically. For that reason, the Special Rapporteur prepared a brief of selected United Nations mandate holders as *amici curiae* in the United States Supreme

<sup>48</sup> United Nations and OHCHR, “Women and girls of African descent: human rights achievements and challenges”, 2018.

<sup>49</sup> Ibid.

<sup>50</sup> Y.K. Sandhya, *Examining the Family Planning Programme in India: Findings from Civil Society Monitoring Initiatives between 2015–2018* (Sahayog, National Alliance for Maternal Health and Human Rights and Asian-Pacific Resource and Research Centre for Women, 2018).

<sup>51</sup> See Dharmi Kapadia and others, *Ethnic Inequalities in Health Care: A Rapid Evidence Review* (NHS Race and Health Observatory 2022), p. 22.

<sup>52</sup> Ann Strode, Sethembiso Mthembu and Zaynab Essack, “‘She made up a choice for me’: 22 HIV-positive women’s experiences of involuntary sterilization in two South African provinces”, *Reproductive Health Matters*, vol. 20, supplement No. 39 (2012), p. 63.

<sup>53</sup> Gwendolyn Albert and Marek Szilvasi, “Intersectional discrimination of Romani women forcibly sterilized in the former Czechoslovakia and Czech Republic”, *Health and Human Rights Journal*, vol. 19, No. 2 (December 2017). See also CEDAW/C/36/D/4/2004.

<sup>54</sup> Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (Vintage, 29 December 1998).

<sup>55</sup> Amnesty International, “Barriers to safe and legal abortion in South Africa”, 2017.

Court in support of the defendant,<sup>56</sup> given that the country's criminal legal system already disproportionately polices women and girls of African descent, which is the population group that suffers the most from increased surveillance and criminalization.<sup>57</sup>

36. As had been detailed in the mandate holder's report (A/76/172, para. 6), many former colonized countries still carry the legacy of the European colonial regimes through their present-day restrictive abortion laws. However, telemedicine and self-managed abortion frameworks provide women and girls with the opportunity to manage their own access to abortion, which can have a significant impact, in particular on the lives of marginalized women. The International Federation of Gynaecology and Obstetrics shared its evidence with the Government of the United Kingdom of Great Britain and Northern Ireland and, along with its partners, contributed to the permanent adoption in March 2022 by the United Kingdom Parliament of telemedicine in abortion cases.<sup>58</sup>

37. Globally, approximately 295,000 women died during and following pregnancy and childbirth in 2017. Maternal mortality rates are rooted in gender injustice and intersectional inequalities. In the United Kingdom of Great Britain and Northern Ireland, Black women are four times more likely, and Asian women twice as likely, to die in childbirth than white women.<sup>59</sup> Issues related to negative experiences, interactions marked by racist stereotypes and discrimination, and the State's treatment of women who are undocumented or seeking asylum, were among the factors contributing to racialized and migrant women's access to and experience of maternal health care.<sup>60</sup> There are also ethnic inequalities in access to perinatal mental health support.<sup>61</sup> The Committee on the Elimination of Discrimination against Women has found that the State "failed to provide timely, non-discriminatory and appropriate maternal health services to the victim", a woman of African descent of low-socioeconomic background and a member of a historically marginalized group (CEDAW/C/49/D/17/2008).

### **Imprisonment of women**

38. Since Black women are nearly twice as likely to be incarcerated as white women, they are also disproportionately subjected to shackling. In a 2018 study of perinatal nurses in the United States, it was found that 82.9 per cent of those who worked with incarcerated pregnant patients reported that their incarcerated patients were shackled "sometimes" or "all the time".<sup>62</sup>

39. The practice is a direct legacy of the subjugation and confinement of Black women during slavery, as well as in the racist post-Civil War carceral systems that have influenced modern prison policies<sup>63</sup> in the United States and beyond. As Winnie

<sup>56</sup> Supreme Court of the United States of America, *Thomas E. Dobbs, State Health Officer of the Mississippi Department of Health, et al. v. Jackson Women's Health Organization, et al.*, Case No. 19-1392, Brief of United Nations mandate holders as amici curiae in support of respondents, 20 September 2021. Available at [https://www.supremecourt.gov/DocketPDF/19/19-1392/193045/20210920163400578\\_19-1392%20bsac%20United%20Nations%20Mandate%20Holders.pdf](https://www.supremecourt.gov/DocketPDF/19/19-1392/193045/20210920163400578_19-1392%20bsac%20United%20Nations%20Mandate%20Holders.pdf).

<sup>57</sup> National Association of Criminal Defense Lawyers, *Abortion in America: How Legislative Overreach is Turning Reproductive Rights into Criminal Wrongs* (Washington, D.C., 2021).

<sup>58</sup> International Federation of Gynaecology and Obstetrics, "FIGO endorses the permanent adoption of telemedicine abortion services", 18 March 2021; and Kapadia and others, *Ethnic Inequalities in Healthcare*, p. 22.

<sup>59</sup> Kapadia and others, *Ethnic Inequalities in Healthcare*, p. 22.

<sup>60</sup> *Ibid.*, pp. 48–53.

<sup>61</sup> *Ibid.*, p. 57.

<sup>62</sup> Lorie S. Goshin and others, "Perinatal nurses' experiences with and knowledge of the care of incarcerated women during pregnancy and the postpartum period", *Journal of Obstetric, Gynaecologic, and Neonatal Nursing*, vol. 48, No. 1 (January 2019).

<sup>63</sup> Priscilla A. Ocen, "Punishing pregnancy: race, incarceration, and the shackling of pregnant prisoners", *California Law Review*, vol. 100, No. 5 (October 2012).

Madikizela-Mandela recalled on the many ways in which imprisonment under the apartheid regime had affected her: “the years of imprisonment hardened me ... I no longer have the emotion of fear ... There is no longer anything I can fear. There is nothing the Government has not done to me. There isn’t any pain I haven’t known.”<sup>64</sup>

40. Since 2000, the world prison population has grown by 20 per cent.<sup>65</sup> The female prison population has increased by 50 per cent.<sup>66</sup> In 2020, over 11 million people were imprisoned worldwide, the highest number ever recorded.<sup>67</sup> Punitive drug policies and laws continue to drive this mass incarceration: one in five people in prison globally, 2.5 million people, were detained because of drug offences,<sup>68</sup> and the proportion is even higher among women.<sup>69</sup> The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that between 56 and 90 per cent of people who inject drugs will be incarcerated at some stage in their lifetime.<sup>70</sup>

### **Police brutality and the criminal justice system**

41. In the United States, the murder of George Floyd on 25 May 2020 by police officers incited mass protests worldwide, leading to the Human Rights Council adopting a resolution in which it called on the United Nations High Commissioner for Human Rights to report on systemic racism by law enforcement agencies and the impact on international human rights.<sup>71</sup> The High Commissioner highlighted the fact that studies showed that “intergenerational trauma caused by racism passed down over centuries has negative health consequences on some people of African descent” and that repeated racist microaggressions and commonplace experiences of racism caused further stress and trauma and disproportionately impacted the health of people of African descent, in particular their mental health (A/HRC/47/CRP.1, para. 28). United Nations human rights mechanisms have highlighted “issues of racial profiling and the disproportionate impact of police harassment, verbal abuse and abuse of power, discriminatory stop-and-search, ill-treatment, arbitrary arrests, excessive use of force against people of African descent by law enforcement in some States, and broad impunity for such violations” (ibid.). Undeniably, these activities often amount to violations of the right to health, with policing and incarceration both having a profound direct impact on health (e.g. deaths and non-fatal injuries from police violence and the rampant spread of infectious diseases in prisons) and indirect effects, including higher rates of trauma, anxiety, acute stress and hypertension among highly policed communities (ibid.).

42. The Working Group of Experts on People of African Descent highlighted the fact that racial disparities in the criminal justice system “reflect harmful stereotypes grounded in the historical legacies of the global trafficking in enslaved Africans, colonization, and the ways in which modern social narratives evolved from rhetoric designed to justify these institutions and the exploitation of people of African descent” (ibid.).

43. In addition to police encounters, racism extends to virtually every aspect of the criminal justice system. Africans and people of African descent are disproportionately represented in prisons in many countries, including Brazil, Colombia, Ecuador, Italy,

<sup>64</sup> Nelson Mandela Foundation, “Winnie Madikizela-Mandela (26 September 1936–2 April 2018)”, 3 April 2018.

<sup>65</sup> Institute for Criminal Policy Research, “World prison populations list”, 12th ed., 2015.

<sup>66</sup> Ibid.

<sup>67</sup> Penal Reform International and Thailand Institute of Justice, *Global Prison Trends 2020*, 2nd ed. (2020).

<sup>68</sup> *World Drug Report 2021* (United Nations publication, 2021).

<sup>69</sup> Penal Reform International, *Global Prison Trends 2015* (London, 2015); and *World Drug Report 2018: Women and Drugs* (United Nations publication, 2018).

<sup>70</sup> UNAIDS, “GAP Report 2014: People who inject drugs”, 2014.

<sup>71</sup> Human Rights Council resolution [43/1](#) and [A/HRC/47/53](#).

Portugal and the United States (ibid.), and experience harsher outcomes in terms of bail, prosecutions, convictions, sentence length and capital punishment.

### **Role of industry and business**

44. Corporate and business practices can create or deepen racial disparities in health, with an impact on a range of health outcomes, including cardiovascular diseases, chronic respiratory diseases and cancer. Building on the social determinants of health framework, these practices can be better understood as commercial determinants of health<sup>72</sup> which are defined by the World Health Organization (WHO) as “conditions, actions and omissions by corporate actors that affect health”.<sup>73</sup>

45. The global tobacco industry has deep ties to colonialism and slavery, with legacies continuing even today. For decades, tobacco companies have aggressively targeted certain populations.<sup>74</sup> In July 2022, the Special Rapporteur joined a communication sent to seven tobacco companies and four Governments, including of the country in which violations were alleged to have occurred and of countries in which the companies are headquartered, regarding allegations of trafficking in persons for the purposes of forced labour, which has affected tenant farmers and their families in tobacco farms. The mandate holders drew attention to the fact that trafficking and forced labour can negatively impact physical and mental health and that exposure to toxic chemicals can have an adverse impact on human health, including reproductive health.<sup>75</sup>

46. Power asymmetries also dominate food systems both within and among countries, and this has a disproportionate impact on certain communities that are subjected to aggressive marketing, often lack access to nutritious and affordable food options and face high rates of food insecurity.<sup>76</sup> People in the global South who have been dispossessed of land for generations are now particularly exposed to the aggressive marketing techniques of food and beverage companies whose products contain a combination of fat, salt, sugar and additives that are associated with risk factors of noncommunicable diseases.<sup>77</sup> Structural inequities in the food systems have led to higher rates of diet-related chronic diseases, such as diabetes and cardiovascular diseases.<sup>78</sup>

## **VI. History of medicine and links to racism**

47. Colonialism is heavily reliant on the creation of hierarchy, with white supremacy egregiously fashioning itself as the way to move through life.<sup>79</sup> Colonialism and racism have also shaped the medical norms of what is considered “healthy” and have led to the resulting stigmatization of monitoring and surveillance. White supremacy has led to the creation of systems like body mass index, a standard for health based primarily on

<sup>72</sup> Ilona Kickbusch, Luke Allen and Christian Franz, “The commercial determinants of health”, *The Lancet: Global Health*, vol. 4, No. 12 (2016).

<sup>73</sup> WHO, “Commercial determinants of health”, 5 November 2021.

<sup>74</sup> See Kelsey Romeo-Stuppy and others, “Tobacco industry: a barrier to social justice”, *Tobacco Control*, vol. 31, No. 2 (2022).

<sup>75</sup> See communications Nos. GBR 8/2022; JPN 1/2022; MWI, 2/2022; USA 10/2022; OTH 46/2022; OTH 45/2022; OTH 44/2022; OTH 43/2022; OTH 42/2022; OTH 41/2022; and OTH 47/2022.

<sup>76</sup> Maywa Montenegro de Wit and others, “Editorial: resetting power in global food governance: the UN Food Systems Summit”, *Development*, vol. 64, Nos. 3–4 (December 2021); and the Food and Agriculture Organization of the United Nations, *The State of Food Security and Nutrition in the World: Safeguarding against Economic Slowdowns and Downturns* (Rome, 2019).

<sup>77</sup> C.A. Monteiro and others, “Ultra-processed products are becoming dominant in the global food system”, *Obesity Reviews*, vol. 14, supplement 2 (November 2013).

<sup>78</sup> Matthew J. Belanger and others, “COVID-19 and disparities in nutrition and obesity”, *New England Journal of Medicine*, vol. 383, No. e69 (2020).

<sup>79</sup> Sylvia Tamale, *Decolonization and Afro-Feminism* (Ottawa, Canada, Daraja Press, 2020).

Caucasian European men that has been weaponized against the mostly Black and indigenous bodies who fall outside the purported standards of health.<sup>80</sup>

48. In elite sport, discrimination in the form of “sex testing” and current testosterone-based versions of this are vehicles for racist ideas about sex characteristics, physiology and the associations between hegemonic femininity with whiteness.<sup>81</sup> In the past decade, exclusively women have been targeted by race and gender discrimination in sport (A/HRC/44/26) in the so-called global South, for example, in India, South Africa and Uganda.<sup>82</sup> On 8 October 2021, in an amicus brief to the European Court of Human Rights, the Special Rapporteur asserted that global athletics organizations had violated the principles of human dignity, equality, autonomy and physical and psychological integrity.<sup>83</sup>

49. One of the legacies of white supremacist conspiracy theories and pseudoscience to justify slavery, colonization and exploitation is the claim that racialized people, in particular Black people, do not feel pain,<sup>84</sup> and this racial bias has led to inaccurate pain diagnoses and treatment recommendations. Acknowledging implicit bias and taking actions to break down institutional barriers are the first steps to eliminating pervasive racial disparities in health care and improving the outcomes for patients.<sup>85</sup>

50. The Special Rapporteur warns that coloniality continues and is supported by the media, the medical-industrial complex, the prison-industrial complex and, to a great extent, education systems, which all work to maintain former colonies exactly how the colonizers want them to be run.<sup>86</sup>

51. The ongoing legacy of white supremacist colonialism is evident in media reporting, as well as in the border control measures taken throughout the various waves of COVID-19. More recently, UNAIDS has called out the racist international media coverage of monkeypox.<sup>87</sup>

52. Conversations about vaccine hesitancy during the COVID-19 pandemic have been conducted in a way that has demanded an erasure of the history of experimenting on Black enslaved people.<sup>88</sup>

53. The Special Rapporteur remains concerned by the lack of empathy in public health information and its dissemination, as well as by the fact that it does not take into account broader structures of the oppression, mistrust, lived realities and histories of people.

<sup>80</sup> Sabrina Strings, *Fearing the Black Body: The Racial Origins of Fat Phobia* (New York, New York University Press, 2019).

<sup>81</sup> Katrina Karkazis and others, “Out of bounds? A critique of the new policies on hyperandrogenism in elite female athletes”, *The American Journal of Bioethics*, vol. 12, No. 7 (2012); and Human Rights Watch, *They’re Chasing Us Away from Sport: Human Rights Violations in Sex Testing of Elite Women Athletes* (2020).

<sup>82</sup> Karkazis and others, 2020; and Human Rights Watch, *They’re Chasing Us Away from Sport*.

<sup>83</sup> See “Third party intervention/amici curiae brief by the case of Mokgadi Caster Semenya v. Switzerland”, available at [www.ohchr.org/en/special-procedures/sr-health/comments-legislation-and-policy](http://www.ohchr.org/en/special-procedures/sr-health/comments-legislation-and-policy).

<sup>84</sup> Kelly M. Hoffman and others, “Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between Blacks and whites”, *Proceedings of the National Academy of Sciences of the United States of America*, vol. 113, No. 16 (2016).

<sup>85</sup> The Henry J. Kaiser Family Foundation, “National survey of physicians part I: doctors on disparities in medical care”, March 2002.

<sup>86</sup> Kehinde Andrews, “British education does perpetuate racism”, video part 5 of 6, 29 April 2017. Available at [www.youtube.com/watch?v=lfFmRy7PrNs](http://www.youtube.com/watch?v=lfFmRy7PrNs).

<sup>87</sup> UNAIDS, “UNAIDS warns that stigmatizing language on Monkeypox jeopardises public health”, 22 May 2022.

<sup>88</sup> See [www.tuskegee.edu/about-us/centers-of-excellence/bioethics-center/about-the-usphs-syphilis-study](http://www.tuskegee.edu/about-us/centers-of-excellence/bioethics-center/about-the-usphs-syphilis-study).

54. In a previous report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the former Special Rapporteur, Anand Grover, emphasized that it continued to be questionable “whether conducting clinical trials in developing countries can ever be considered ethical, especially when using placebos despite the existence of appropriate non-placebo interventions” (A/64/272, para. 40). As was the case with COVID-19 vaccines, some of the clinical trials did not guarantee access to the medicine in the country in question or result in patent exceptions that would benefit that country.

55. Medicine also has the prescriptive power to label people as non-compliant with treatment along racial lines, even though non-compliance is often a manifestation of power imbalances between, on the one hand, systems and institutions and, on the other hand, patients.

56. Owing to racism, poverty, trauma, fear of violence or repercussions, lack of transportation, or any of the other numerous barriers and requirements made by institutional structures with regard to access to services, the best or only choice might be non-compliance.<sup>89</sup> The former Special Rapporteur also stated that “the burden of managing and coping with the systemic damage caused by ignoring the determinants of health has fallen on individuals” and that “these individuals then turn to a mental health-care sector that often lacks adequate resources and appropriate approaches to cope with collective failures” (A/HRC/41/34, para. 7).

## VII. Impact of colonialism on the availability of indigenous and traditional health knowledge systems, medicine and practices

57. Rooted in imperial conceptions and hierarchies distinguishing between “legitimate” and “non-legitimate” knowledge,<sup>90</sup> the targeting of medicine in the colonies was a deliberate strategy put forward by European colonial powers for domination.<sup>91</sup> Colonial States used both civil and criminal laws to suppress or marginalize most African therapeutics, targeting in particular those who challenged individualistic and materialist conceptions of health.<sup>92</sup>

58. This suppression, undermining and marginalization of traditional and indigenous knowledge systems and medicine has wide-ranging health impacts. Intellectual property also enables the colonial theft of indigenous peoples’ traditional knowledge and genetic resources<sup>93</sup> by allowing patenting and profiteering from the intellectual property and value extracted from global South people and communities, along with the ancestral knowledge associated with them. This threatens food sovereignty and indigenous cultural heritage in the process.<sup>94</sup>

59. Healing materials, knowledge and practices of indigenous communities were for a long time labelled as unmodern and ineffective, and their use was often regulated

<sup>89</sup> Priscilla A. Ocen, “Punishing pregnancy”.

<sup>90</sup> Ingrid Waldron, “The marginalization of African indigenous healing traditions within western medicine: reconciling ideological tensions and contradictions along the epistemological terrain”, *Women’s Health and Urban Life*, vol. 9, No. 1 (2010), p. 51.

<sup>91</sup> Marya and Patel, *Inflamed*, p. 17.

<sup>92</sup> Helen Tilley, “Medicine, empires, and ethics in colonial Africa”, *AMA Journal of Ethics*, vol. 18, No. 7 (July 2016), p. 748.

<sup>93</sup> Martin Fredriksson, “Dilemmas of protection: decolonizing the regulation of genetic resources as cultural heritage”, *International Journal of Heritage Studies*, vol. 27, No. 7 (2021).

<sup>94</sup> Martin Khor, “Why life forms should not be patented”, Third World Network, October 2000; and Third World Network, “TRIPS Council addresses patents on life forms and access to medicines”, 5 March 2010.



or even criminalized by colonial and post-colonial States.<sup>95</sup> With the expansion of intellectual property rights towards the end of the twentieth century, as well as Western scientific bias, whereby knowledge is considered to exist only if it is formalized or privately owned, pharmaceutical companies have sought to patent traditional herbs and materials used for their medicinal properties.<sup>96</sup>

60. These efforts of co-optation are intimately linked to monocultural ideologies, genetic modification technologies, and, more broadly, to monopolies. The sociocultural manifestations of the Western consumerist appropriation of indigenous knowledges are to be found in the takeover and monetization of yoga, meditation and other culturally rooted practices by middle class white people in the global North.<sup>97</sup>

## VIII. Health financing and global aid

61. Across the globe, health systems are funded in various ways, including through taxes, out-of-pocket expenditure and donor funding. In areas of what has been categorized as the global South, donor funding through Governments, multilateral donors and philanthropy are some of the main ways in which health systems are financed.<sup>98</sup>

62. Donor funding is a significant source of health financing, accounting for an average of 30 per cent of health spending in low-income countries and over half of health spending in four low-income countries.<sup>99</sup> Unfortunately, however, with aid flowing between colonial powers and formerly colonized regions, racist and imperialist practices continue to influence the global health financing and foreign aid sector.<sup>100</sup>

63. The reminder by the Independent Expert on foreign debt and human rights, particularly economic, social and cultural rights, that “human rights require resources” (A/HRC/49/47, paras. 22–28) goes to the heart of the issue of the absence of reparations for colonialism. In view of States’ obligation to guarantee the right to health “to the maximum of their available resources”,<sup>101</sup> consideration should be given to the racist reasons why some States have ample resources while others are hamstrung by a history of colonial dispossession and exploitation, followed by neo-colonial capitalist domination. It is for these reasons that the Special Rapporteur continues to focus on the decolonization of global health funding.

64. Aid, therefore, although an important aspect of financing health systems across the globe, is associated with challenges like austerity, high interest rates, trade liberalization, privatization and open capital market requirements that further marginalize developing countries.<sup>102</sup>

65. It is the obligation of the State to ensure the accessibility, availability, acceptability and quality of health care. If any one or more of the elements is not realized,

<sup>95</sup> Emilie Cloatre, “Traditional medicines, law and the (dis)ordering of temporalities”, in *Law and Time*, Siân M. Beynon-Jones and Emily Grabham, eds. (Oxon, United Kingdom of Great Britain and Northern Ireland, Routledge, 2019).

<sup>96</sup> Vandana Shiva, *Biopiracy: The Plunder of Nature and Knowledge* (Berkeley, California, North Atlantic Books, 1999).

<sup>97</sup> Maryann Auger, “Westernization and cultural appropriation in yoga”, An Injustice!, 10 September 2021.

<sup>98</sup> WHO, *New Perspectives on Global Health Spending for Universal Health Coverage* (Geneva, 2017).

<sup>99</sup> Ibid.

<sup>100</sup> Peter O’ Dowd, “Global public health, colonialism, and why so many people die of preventable diseases”, Wbur, 9 March 2021.

<sup>101</sup> International Covenant on Economic, Social and Cultural Rights, art. 2 (1); and OHCHR and WHO, *The Right to Health*, Fact Sheet No. 31 (2008).

<sup>102</sup> Ibid.

discrimination and inequality thrive. The Special Rapporteur is concerned that maladministration, corruption and the mismanagement of resources can lead to the collapse of public health systems and, in turn, to increased privatization, which at its extreme may lead to divesture in public health and racialized abuses that are classed, gendered and ableist. She is also concerned by structural adjustments and the austerity measures already taken by some Governments to the detriment of public health.<sup>103</sup>

66. Through discriminatory practices, such as race-based premiums, redlining, rates based on big data, lack of minority representation in the insurance sector, credit-based insurance scores, discriminatory pricing, longer waiting periods, higher charges for conditions that are more prevalent among certain groups and the offering of lower private insurance reimbursement rates to physicians in urban areas with a large minority population, racialized people have been structurally prevented from access to timely and quality health care.<sup>104</sup>

67. Insurers advance fatphobia by denying coverage of certain health-care services to those outside the perceived acceptable weight standards and the ideas that society has in mind of how a body should be.<sup>105</sup> The Special Rapporteur asserts that the legacy of white supremacist hierarchal approaches is prevalent in health insurance. Health insurance is not affordable for many racialized people, which has meant that the number of uninsured and underinsured people has been unacceptably high in this social group.<sup>106</sup>

## IX. Good practices in public health interventions

68. Ending racism has become a central component of many global efforts to advance health and other human rights, for example, through the agenda towards transformative change for racial justice and equality (A/HRC/47/53, annex) and the 2030 Agenda for Sustainable Development at the universal level, and the Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance at the regional level. The European Union Anti-racism Action Plan 2020–2025 encourages countries to adopt legislation to promote racial equity in health care, employment, education and housing.

69. To mitigate the impact of racism on the provision of health care and services, in its ruling C-882 of 2011, the Colombian Constitutional Court highlighted the right of ethnic communities to use and produce traditional medicines and preserve their medicinal plants, animals and minerals.

70. In South Africa, one of the aims of the National Action Plan to Combat Racism, Racial Discrimination, Xenophobia and Related Intolerance, adopted in 2019, is to “promote human dignity through the promotion and protection of human rights”. Sweden has established a national plan to combat racism, similar forms of hostility and hate crime,<sup>107</sup> and Norway has enacted the Action Plan against Racism and Discrimination on the Grounds of Ethnicity and Religion 2020–2023. Several Latin

<sup>103</sup> Submissions by Amnesty International and the Sexual Rights Initiative.

<sup>104</sup> Jim Probasco, “The insurance industry confronts its own racism”, Investopedia, 23 June 2022.

<sup>105</sup> Marilyn Wann, “Foreword: fat studies – an invitation to revolution” (p. xi); and Dan Burgard, “What is ‘health at every size?’” (pp. 42 and 53), both in *The Fat Studies Reader*, Esther Rothblum and Sondra Solovay, eds. (New York, New York University Press, 2009).

<sup>106</sup> Jamila Taylor, “Racism, inequality, and health care for African Americans”, The Century Foundation, 19 December 2019.

<sup>107</sup> Government Offices of Sweden, *A comprehensive approach to combat racism and hate crime: National plan to combat racism, similar forms of hostility and hate crime* (2017).

American countries, including Brazil,<sup>108</sup> Costa Rica,<sup>109</sup> Honduras<sup>110</sup> and Peru,<sup>111</sup> have adopted plans and policies geared towards addressing racial disparities in health.

71. In Switzerland, asylum seekers and undocumented migrants living in the country for more than three months have various levels of access to health insurance, and subsidies for premiums are granted or can be requested by those of modest economic status. In some cantons, people who do not have a residence permit and/or for whom no tax data are available are not eligible for reduced premiums.<sup>112</sup> All cantons inform migrant populations about the functioning and particularities of the Swiss health system within the context of the strategy for strengthening early childhood development.<sup>113</sup>

72. The Special Rapporteur notes that Act No. 19/2020 adopted by the Spanish Government on the health-care system provides for non-discrimination in formal access to health services on various grounds, including sex, race, origin and religion. The Act provides for the duty of the authorities to implement health adequacy programmes, as well as training and awareness-raising plans for health personnel, among various actions for equal treatment and the prevention of discrimination.<sup>114</sup>

73. Some promising opportunities, such as the recent adoption of a policy by the American Medical Association in which racism was declared a public health threat, indicate that structural, systemic and interpersonal forms of racism and bias exist across all social determinants of health and medical research. This policy encourages technological innovators to tease out the implications of racial bias in medical algorithms and similar innovations.<sup>115</sup>

74. In Argentina, the National Directorate of Sexual and Reproductive Health has worked on a framework of training projects from a rights and intercultural approach for health agents and local health promoters in cases of sexual violence in primary care.<sup>116</sup>

75. In Brazil, the National Policy for the Integral Health of the Black Population, besides indicating the diseases that most affect the Black population, includes specific objectives to incorporate the theme of combating gender and sexual orientation discrimination, with an emphasis on the intersections with the health of the Black population.<sup>117</sup>

76. While needle and syringe programmes are available in most countries in Eurasia, North America and Western Europe, they are severely lacking in the majority of countries in other regions. An unfavourable drug policy environment hinders the implementation of harm reduction services in many countries in Asia, Latin America, the Caribbean, the Middle East and Africa.<sup>118</sup>

<sup>108</sup> Brazil, Ministério da Saúde, *Política Nacional de Saúde Integral da População Negra: Uma Política do SUS* (2013).

<sup>109</sup> Costa Rica, Ministerio de Salud, *Plan Nacional de Salud para Personan Afrodescendientes 2018–2021* (2018).

<sup>110</sup> The United Nations Development Programme (UNDP) and others, *Política Nacional contra el Racismo y la Discriminación Racial 2014–2022* (2014).

<sup>111</sup> Peru, *Política Sectorial de Salud Intercultural*. See <https://web.ins.gob.pe/sites/default/files/Archivos/censi/observatorio/politica-sectorial/Pol%C3%ADtica%20de%20Salud%20Intercultural.pdf>.

<sup>112</sup> Submission by Switzerland.

<sup>113</sup> Ibid.

<sup>114</sup> Submission by Spain.

<sup>115</sup> American Medical Association, National Medical Association and National Hispanic Medical Association, “The Commission to end health disparities: unifying efforts to achieve quality care for all Americans”, 2004.

<sup>116</sup> Submission by Argentina.

<sup>117</sup> Submission by Brazil.

<sup>118</sup> Ibid.

77. Denver, United States, has been running a programme to send medics and clinicians, instead of the police, in response to emergency calls related to mental health, homelessness and addiction. As a result, people in crisis in Denver have received help without having to talk to police on 748 occasions. No one was arrested, and people received health care and opportunities to heal instead.<sup>119</sup> The Special Rapporteur highlights this as an example of a multisectoral response that ensures access to appropriate care for communities disproportionately targeted by drug law enforcement.

78. The Colombian Constitutional Court, in its ruling T-128 of 2022, recognized Afro-Colombian midwives of the Pacific coast as health providers and ordered the Ministry of Health to include them in the health system and ensure that they benefited from measures established to help health providers during the COVID-19 pandemic, such as prioritization for vaccination and certain economic rewards.<sup>120</sup>

79. The Special Rapporteur notes that in the submissions received, few good practices resulting in adequate access had been highlighted, or initiatives to support knowledge production or the implementation of programmes within and outside the health sector.

80. An example of an intervention related to access to health care is that in 2015, Italy adopted a document aimed at offering indications on interventions and actions to foster the promotion and protection of the health of Roma and Sinti communities.<sup>121</sup>

81. Another example of the successful inclusion of people with an immigrant background in a health initiative is the way in which information has been disseminated during the COVID-19 pandemic. In the Netherlands, press conferences were translated into eight languages and always included a sign language interpreter. Posters, flyers and signs were also translated to provide easier access to information.<sup>122</sup> An organization has also arranged support meetings to inform undocumented refugees of their rights to health care.<sup>123</sup>

82. Through administrative decree No. 1953 of 2014, Colombia created the intercultural indigenous health system, a set of policies, norms, principles, resources, institutions and procedures based on a collective understanding of life in which ancestral wisdom is considered a fundamental guide, in harmony with Mother Earth and according to the cosmovision of each people.<sup>124</sup>

## **X. Examples of reparations for racial discrimination related to violations and abuses of the right to health**

83. A limited amount of data and few submissions were received by the mandate holder on reparations for racial discrimination related to violations and abuses of the right to health.

84. The mandate holder agrees with the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance in her assertion that “reparations for slavery and colonialism include not only justice and accountability for historic wrongs, but also the eradication of persisting structures of racial inequality,

<sup>119</sup> Elise Schmelzer, “Call police for a woman who is changing clothes in an alley? A new programme in Denver sends mental health professionals instead”, *The Denver Post*, 7 September 2020.

<sup>120</sup> Submission by the International Planned Parenthood Federation.

<sup>121</sup> Submission by Italy.

<sup>122</sup> See [www.pharos.nl/corona-virus-begrijpelijke-voorlichting/begrijpelijke-informatie-over-het-nieuwe-coronavirus/](http://www.pharos.nl/corona-virus-begrijpelijke-voorlichting/begrijpelijke-informatie-over-het-nieuwe-coronavirus/).

<sup>123</sup> Submission by the Stichting Choice for Youth and Sexuality.

<sup>124</sup> Submission by the International Planned Parenthood Federation.

subordination and discrimination that were built under slavery and colonialism to deprive non-whites of their fundamental human rights” (A/74/321, para. 7).

85. In many countries and contexts, judicial measures are often the primary way in which violations of the right to health are addressed. The Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence has noted that given the lack of effective response to violations of human rights law stemming from colonialism and other forms of oppressive systems, as well as the realization that those violations continue to have negative effects today, the components and tools developed by transitional justice over the past 40 years offer lessons and experiences that could be useful in responding to the legacy of these violations (A/76/180, para. 4).

86. The groundbreaking case of *Laxmi Mandal v. Deen Dayal Harinagar Hospital and Others*<sup>125</sup> represented the first time in history that a Government was held accountable for preventable maternal death. The final judgment combined the individual cases of two women: Shanti Devi, a scheduled caste Dalit woman who was internally displaced and living in poverty, and Fatima, a homeless Muslim woman living in poverty. In the judgment, not only were reparations awarded to the family of the deceased Shanti Devi and to the applicant Fatima, but also clear instructions were provided on synthesizing various programmes, schemes and entitlements in order to remove barriers and burdens, such as documentation to prove that one is below the poverty threshold, which is a challenge to obtain and a further burden for women and girls.<sup>126</sup>

87. In the wake of formal Government apologies for the harm caused by colonial policies, the Australian Government has launched reparations programmes to provide monetary compensation to “stolen generation” survivors who were removed from their families as children and suffered abuse and trauma at the hands of State or church agencies.<sup>127</sup> These programmes vary by state but seek to address the trauma and harm that resulted from the removal of Aboriginal children from their families, communities, culture, identity and language.

88. The Inter-American System of Human Rights stands out for having established a system of integral reparations, providing an array of measures and remedies that States must adopt in specific cases to provide redress and restore human dignity.<sup>128</sup> The Inter-American Court of Human Rights can utilize the full range of reparations under international law,<sup>129</sup> and reparation judgments handed down by the Court have encompassed both individual and collective matters. For example, it has ruled in favour of financial compensation, medical attention and scholarships at the individual level, and legislative amendments, human rights education and the reform of schools and other institutions at the collective level.<sup>130</sup>

<sup>125</sup> Jameen Kaur, “The role of litigation in ensuring women’s reproductive rights: an analysis of the Shanti Devi judgement in India”, *Reproductive Health Matters*, vol. 20, No. 39 (2012). It was also cited in a book co-edited by former Special Rapporteur of Health, Paul Hunt. See Paul Hunt and Tony Gray, eds., *Maternal Mortality, Human Rights and Accountability* (London, Routledge, 2013).

<sup>126</sup> Submission by the International Federation of Gynaecology and Obstetrics.

<sup>127</sup> See [www.aboriginalaffairs.nsw.gov.au/healing-and-reparations/stolen-generations](http://www.aboriginalaffairs.nsw.gov.au/healing-and-reparations/stolen-generations); and [www.niaa.gov.au/indigenous-affairs/community-safety/national-redress-scheme/territories-stolen-generations-redress-scheme](http://www.niaa.gov.au/indigenous-affairs/community-safety/national-redress-scheme/territories-stolen-generations-redress-scheme).

<sup>128</sup> Douglas Cassel, “The expanding scope and impact of reparations awarded by the Inter-American Court of Human Rights”, *Revista do Instituto Brasileiro de Direitos Humanos*, vol. 7, No. 7 (2006–2007).

<sup>129</sup> American Convention on Human Rights, art. 63.1.

<sup>130</sup> Jorge E. Calderón Gamboa, *La Evolución de la ‘Reparación Integral’ en la Jurisprudencia de la Corte Interamericana de Derechos Humanos* (Comisión Nacional de los Derechos Humanos, 2013).

## XI. Conclusions and recommendations

89. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health agrees with the agenda towards transformative change for racial justice and equality, a four-point agenda for ending systemic racism and human rights violations by law enforcement against Africans and people of African descent. She encourages this model to be considered when dealing with the right to abuses and violations of the right to health, namely: step up, to stop denying and start dismantling racism; pursue justice, to end impunity and build trust; listen up, so that people of African descent are heard; and redress past legacies, take special measures and deliver reparatory justice.

90. She also supports the recommendations of the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance to fully implement international human rights legal obligations on the provision of reparations for racially discriminatory violations of human rights and adopt a structural and comprehensive approach to reparations that accounts for individual and group historical wrongs, as well as the persisting structures of racial inequality, discrimination and subordination that have slavery and colonialism as their root causes (A/74/321, paras. 56–57).

91. Similarly, the Special Rapporteur on the rights of indigenous peoples has emphasized that measures should be developed to train indigenous health-care workers to incorporate traditional medicine into the delivery of health services, and to increase the participation of indigenous communities in designing health services that are responsive to their needs, including in cases related to reproductive health and rights.<sup>131</sup>

92. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health supports the removal of all laws and policies criminalizing or otherwise punishing abortion, contraception, adolescent sexuality, same-sex conduct and sex work.<sup>132</sup> WHO, in its newly updated *Abortion Care Guideline*, recommends full decriminalization of abortion, drawing on evidence that it found that grounds-based laws and abortion laws based on gestational limits act as barriers to access to safe and quality abortion care.<sup>133</sup>

93. Informed consent is a critical component of the right to health and it must be respected, together with all ethical and professional standards.

94. It is important to recognize and ensure the full realization of the right to enjoy the benefits of scientific progress and its applications<sup>134</sup> by ensuring equitable access to COVID-19 diagnostics, therapeutics and vaccines, as well as to modern methods of contraceptives and assisted fertility for marginalized populations.

95. The COVID-19 epidemic has drawn attention to the urgent need for strategic, equitable investments in public health infrastructure. The Special Rapporteur agrees with calls for a bold reimagining of public health policies and practices, pandemic preparedness, international solidarity and the extent to which human rights are respected, fulfilled and protected, which will ultimately determine the success of the pandemic response.

<sup>131</sup> See A/HRC/18/35/Add.5; E/CN.4/2004/80/Add.3; E/CN.4/2005/88/Add.2; A/HRC/42/37/Add.1; A/HRC/33/42/Add.2; and A/HRC/18/35/Add.5.

<sup>132</sup> A/HRC/14/20 and A/66/254.

<sup>133</sup> WHO, *Abortion Care Guideline* (Geneva, 2022).

<sup>134</sup> See, for instance, Committee on Economic, Social and Cultural Rights, general comment No. 25 (2020), including paras. 69, 70 and 83.

96. **Acceptable health requires an urgent focus on ensuring an end to the demonization and belittling of indigenous and traditional health, and instead promotes an inclusive approach that is respectful and seeks to understand and support integration into primary health care.**
97. **Specific ongoing research into the multiple and intersecting impacts of racism on health is required. Disaggregated data are critical to understanding not only the impacts of racism on health and of structural discrimination on certain communities, but also to informing budgeting and expenditure on preventative, curative and palliative measures, which are key to an adequate response. Disaggregated data are also critical to accomplishing the Call to Action for Human Rights, the report of the Secretary-General entitled “Our Common Agenda”, the Sustainable Development Goals and the principle of leaving no one behind.**<sup>135</sup>
98. **The Special Rapporteur underscores the need for Governments to intentionally create budgets and research lines dedicated to uncovering the epidemiological risks associated with being subjected to racism throughout one’s life<sup>136</sup> and urges “health-care institutions, physician practices and academic medical centres to recognize, address and mitigate the effects of racism on patients, providers, international medical graduates and populations”.**<sup>137</sup>
99. **It is important to focus on neglected diseases and therapeutic options for conditions that predominantly affect those living in the so-called global South, while ensuring that we do not blame individual Black people, people of African descent, indigenous people and other racialized persons for the ways in which racism is manifested on their bodies.**
100. **To truly decolonize aid, the structure of the current system of financing and how priorities have been set must be re-examined.**<sup>138</sup> **Donor States, international financial institutions and other creditors and donors should apply a human rights-based approach, and a gender and health perspective, and ensure that financial and other assistance is sustainable, designed with the meaningful participation of rights holders and does not depend on any conditionality, such as austerity measures, privatization and structural adjustments.**<sup>139</sup>
101. **The Special Rapporteur recommends that the good practices, public health policy and interventions highlighted in the present report be implemented in relevant contexts by States, and that progress be monitored with the necessary agility of health systems to affirm the right to a system of health protection that provides equality of opportunity for people to enjoy the highest attainable standard of physical and mental health.**
102. **An intersectional rights-based approach to ending racism as a determinant of health must urgently be adopted to move towards substantive equality and restore the dignity of all people.**

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<sup>135</sup> See <https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind>.

<sup>136</sup> American Medical Association, National Medical Association and National Hispanic Medical Association, “The Commission to end health disparities”.

<sup>137</sup> Ibid.

<sup>138</sup> Ibid.

<sup>139</sup> See, for example, A/67/302, para. 28; and Juan Pablo Bohoslavsky, “COVID-19: urgent appeal for a human rights response to the economic recession”, 15 April 2020, p. 12. This was part of the recommendations made by 354 organizations and 643 individuals in a joint statement on abortion delivered at the Human Rights Council in September 2020, see [www.sexualrightsinitiative.org/resources/hrc-45-joint-civil-society-statement-abortion](http://www.sexualrightsinitiative.org/resources/hrc-45-joint-civil-society-statement-abortion).