

# RACIAL DISCRIMINATION IN THE ENJOYMENT OF THE RIGHT TO HEALTH

## OBSERVATIONS ON DRAFT GENERAL RECOMMENDATION N°37 BY THE COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION

Amnesty International welcomes the call from the Committee on the Elimination of Racial Discrimination for comments on the Draft General recommendation No. 37 (2023) on Racial discrimination in the enjoyment of the right to health.<sup>1</sup> The comments below should not be seen as an exhaustive list of issues but include priority suggestions on ways in which key provisions in the draft General Recommendation can be strengthened. Amnesty International's recommendations are based on a prior submission to the Committee on this draft General Recommendation and should be read in conjunction with that document.<sup>2</sup>

## 1.1 GENERAL RECOMMENDATIONS

1. The draft General Recommendation acknowledges the need to address racial discrimination in the enjoyment of the right to health. The text and recommendations should clearly explain the many insidious ways that racism harms the right to health – including the ways the experience of racism causes stress (e.g. allostatic load) that contributes to poor outcomes, the ways that it shapes access to the social determinants of health, the ways it influences access to health services and the effectiveness (and harm) of contact with the health system, and the ways that racist policies and behaviour can directly and immediately harm health (e.g. police violence), among others.<sup>3</sup> These factors are inter-related, but acknowledging each is key to the articulation of state obligations to end racial discrimination. Systemic racism and structural racial inequalities have a negative impact on health, reinforce racial bias, and perpetuate racial discrimination, requiring robust and specific recommendations. We recommend adding language to the legislative and policy related measures in Paras 38 – 43 that strengthen the obligation to fulfil the right to health from a comprehensive approach that goes beyond protection against racial discrimination to address racism as a social determinant of health.
2. We welcome the references in the draft General Recommendation to intersectionality. These should be strengthened. Intersectionality should be used in the text, particularly the recommendations, as a perspective of analysis which makes underlying structural factors and root causes behind poorer health outcomes for racialised groups explicit and makes the barriers to access to social determinants of health for people affected by racial discrimination clearer. We recommend adding language to para. 18 that brings an intersectional lens and highlights that the barriers should be understood with an intersectional approach, including the perspective of disability, minority languages, and challenges faced by Indigenous Peoples. The recommendations sections should also be revised with this in mind.
3. The draft General Recommendation would benefit from using the language and concepts already developed by other UN treaty bodies and special procedures in several places. For example, in para. 9, instead of the text “Treating these cases solely as gender-based discrimination ... accordingly racial discrimination”, it would be good to reference understandings of multiple

<sup>1</sup> <https://www.ohchr.org/en/calls-for-input/2023/call-contributions-draft-general-recommendation-ndeg37-racial-discrimination>

<sup>2</sup> Amnesty International, Racism and the right to health: Preliminary observations on the Draft General recommendation n°37 by the Committee on the Elimination of Racial Discrimination, 30 June 2022, IOR 40/5785/2022, <https://www.amnesty.org/en/documents/ior40/5785/2022/en/>

<sup>3</sup> David R. Williams, Jourdyn A. Lawrence, and Brigette A. Davis, “Racism and Health: evidence and needed research”, April 2019, Annual Review of Public Health, Volume 40, pp. 105-125. David R. Williams, “Race, socioeconomic status, and health the added effects of racism and discrimination”, February 2006, Volume 896, Issue 1, pp. 173-188.

and intersecting forms of discrimination developed by the Committee on the Rights of Persons with Disabilities.<sup>4</sup> Similarly, instead of solely referring to ‘family planning’, we recommend using ‘family planning and access to contraception’ throughout. We recommend that references to ‘maternal mortality’ should be followed by ‘and morbidity’ in all instances, since it has been acknowledged that actions are urgently needed to target, prevent, and reduce both. ‘Indigenous Peoples’ should be capitalized throughout the text, in line with the United Nations Editorial Manual, and ‘Indigenous communities’ should not be used. References to ‘caste’ should be replaced by ‘people discriminated on the basis of work and descent’. References to participation should include the qualifier ‘meaningful’ or ‘effective’.

4. The draft General Recommendation identifies specific groups and protected characteristics who often experience discrimination in several places but omits explicit references to some protected characteristics and discriminated groups. All lists of discriminated groups and protected characteristics in the text should include explicit reference to sexual orientation, gender identity, citizenship, employment status, presence of a health condition, sex workers, and people who use drugs (for example, Paras 9, 12, 20, 30 and 38) in addition to those listed. The text of the draft General Recommendation could also be strengthened by highlighting the issues faced by Indigenous Peoples, including by recognizing the particular rights of Indigenous Peoples to self-government, effective participation in decisions that affect them, and free, prior and informed consent, in several parts of the draft General Recommendation, including Paras 14, 27, 28 and 29; and reference Indigenous Peoples’ representative institutions in para. 26.
5. It would be important to explicitly recognize the negative impact of criminalization on access to healthcare and health outcomes for groups experiencing racial discrimination through the text. For example, the text does not include any reference to the impact of drug policies on the right to health nor the disproportionate impact it has had on racialized people. People experiencing racial discrimination are often disproportionately impacted by unjust criminal laws that violate human rights, including the right to the highest attainable standard of health. The text should reflect the impact of this and recommend that states decriminalize specific behaviours, including abortion-related offences, all aspects of sex work, and the use, possession, and cultivation of all drugs for personal use. The General Recommendation should also acknowledge that the overrepresentation of racial minorities in the criminal justice system is an effect of systemic racism, and the fact that people in prison often lack access to healthcare, including sexual and reproductive health care, is a clear consequence of this.

## 1.2 SPECIFIC RECOMMENDATIONS

Para. 5 should acknowledge how, during the Covid-19 pandemic, several countries introduced measures to “protect public health”, which had disproportionate and adverse impacts on racialized groups. We recommend adding text at the end of the paragraph that reflect that during the Covid-19 pandemic, states used criminalization and coercive measures to enforce public health policies, which in many instances further stigmatized racialized groups, disproportionately impacted them and contributed to entrench institutional racism. The involvement of police and criminal justice systems in coercive health measures presents a particular risk for discriminated groups and contradict with public health objectives. These legacies of colonialism also featured in state interference with Indigenous Peoples’ right to develop their own health systems and regulate public health within their communities, as well as the failure of states to ensure the effective participation and free, prior, and informed consent of Indigenous Peoples in the development of the emergency response, and health policy more broadly.

Para. 12 should be substantially revised for clarity and to ensure it fully represents existing international legal standards. We suggest adding “adequate and sufficient food and access to sexual and reproductive health services, goods and information” in para. 12 (a) (ii). We also recommend adding the following text in Para 12 (b) (ii): “for example in the underfunding of Indigenous Peoples’ self-administered health services”. It is unclear why para. 12 (b) (iii) mentions certain groups and not others, hence it would be good clarify that these are just examples. Para. 12 (b) (iv) mentions “Interpersonal and institutional bias”; we recommend amending to clarify by replacing it with “harmful racial stereotypes and prejudices”. In para. 12 (b) (v), we recommend replacing “including” with “for example”, to clearly indicate that the illustration is an example of possible harm. In para. 12 (b) (vii), we recommend adding that “lack of information includes the failure to translate health information into Indigenous and minority languages”; and, in para. 12 (c) that “lack of recognition and criminalization of Indigenous medicine also undermined their health and education systems and by extension their governments”.

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<sup>4</sup> Discrimination can be based on a single characteristic, such as disability or gender, or on multiple and/or intersecting characteristics. “Intersectional discrimination” occurs when a person with a disability or associated to disability suffers discrimination of any form on the basis of disability, combined with, colour, sex, language, religion, ethnic, gender or other status. Intersectional discrimination can appear as direct or indirect discrimination, denial of reasonable accommodation or harassment. For example, while the denial of access to general health-related information due to inaccessible format affects all persons on the basis of disability, the denial to a blind woman of access to family planning services restricts her rights based on the intersection of her gender and disability. In many cases, it is difficult to separate these grounds. States parties must address multiple and intersectional discrimination against persons with disabilities. “Multiple discrimination” according to the Committee is a situation where a person can experience discrimination on two or several grounds, in the sense that discrimination is compounded or aggravated. Intersectional discrimination refers to a situation where several grounds operate and interact with each other at the same time in such a way that they are inseparable and thereby expose relevant individuals to unique types of disadvantage and discrimination.

We recommend that Para 15 is expanded to address the disproportionate impact on racialized and ethnic minorities and Indigenous Peoples, due to their socio-economic situation, cultural norms, the psychological damage caused by colonialism and slavery, inter-generational impacts and trauma, and geographical location, which in many cases is intrinsically tied to colonialist land alienation.

In line with the suggestion mentioned above to acknowledge the experience of people who use drugs, we suggest adding text in para. 17 that reflects that subjecting people to mandatory drug testing, which disproportionately affects people protected under the Convention, infringes on the right to privacy and may also constitute a violation of the right to physical integrity;<sup>5</sup> and in para. 19, that compulsory detention regimes in the name of drug treatment and rehabilitation are a violation of the right to health and have been found to be inherently arbitrary. The criminalization of the use and possession of drugs for personal use, which has exacerbated discriminatory practices against people protected under the Convention, has deterred people from seeking medical care and has worsened the risks and harms associated with drug use.<sup>6</sup> In this context, it would also be good to note that women and girl athletes should not be forced, coerced or otherwise pressured into undergoing unnecessary, humiliating and harmful medical interventions, that derive from and perpetuate stigma and discrimination on the basis of race and gender, in order to participate in women's events in competitive sports.<sup>7</sup>

In para. 21, we recommend that you replace “women suffering from mental health illness” with “women with psychosocial disabilities”, to avoid language that stigmatizes persons with disabilities.

To reflect how racialized groups experience disproportionate impacts of unjust criminalization, we recommend adding a paragraph, after para. 20, addressing that racialised communities are also disproportionately targeted with unjust criminalisation, i.e. criminal sanctions or punitive laws, policies or regulations that have the effect of punishing people because of their identities, work, health, choices and decisions or socio-economic status. Furthermore, unjust criminalization is a driver of poor health outcomes and is linked to violations of the right to health, among other rights. The misuse of criminal law has a negative impact on health outcomes. The criminalization of some aspects of sex work results in poorer health outcomes for sex workers who may rely on strategies to avoid criminalization that put their health at risk or face additional barriers to report violence and abuse, especially when the threat of criminalization is compounded with migration status. Moreover, unjust criminalization can compromise individuals' access to care by allowing, and in some cases encouraging, discrimination against them in the provision of services by healthcare workers.

We recommend that para. 22 be substantially revised to protect the full range of sexual and reproductive health and rights, reflecting current human rights standards, as follows: “Persons within the purview of the Convention are at a higher risk of unwanted pregnancies and of lacking the means to overcome socioeconomic and other barriers to access to safe abortion. They also have limited access to contraception and sexual and reproductive health information, goods and services. Laws, rulings and practices nullifying in law and in practice access of women and all persons with reproductive capacity protected under the Convention to safe and legal abortion have a disproportionate impact on the sexual and reproductive health and rights of groups and minorities within the purview of the Convention, in particular those with low incomes.<sup>8</sup> Safe, legal and effective access to abortion is part of the right to control one's health and body and the rights to health and life of the persons protected under the Convention.<sup>9</sup> States should recognize and eliminate the effects of racial discrimination on sexual and reproductive health and combat stigmatization, marginalization, and disadvantage of women protected under the Convention. Failing to recognize the impact of racially motivated sexual violence, hindering access of groups within the purview of the Convention to information and programmes on involuntary pregnancies, comprehensive sexual and reproductive health services, goods and information including access to full range of contraceptive methods, and programmes on comprehensive sexuality education, amongst other social determinants of sexual and reproductive health, stigmatizing and criminalizing the role of midwives belonging to these groups and, finally, criminalizing abortion and punishing people seeking, providing or facilitating access to abortion depicts a chain of causation where racial discrimination operates both as a separate health risk and as structural social determinant.”

We also recommend adding specific language after Para 22 on how stigma affects racialized groups and addressing the structures of racial inequity that have a detrimental impact on health by adding text, such as ‘Eliminating racial discrimination requires states to consider how stigma can impact people covered by the Convention, including deterring them from seeking timely health care. It also requires states to clearly acknowledge and address the structural and systemic structures of racial inequity that have a detrimental impact on health’.

We are concerned that the recommendations focus on states' obligations to respect and protect, but do not elaborate on their obligation to fulfil aspects of the right to health in a substantive way. We also consider it to be important for the recommendations to go beyond criminal and punitive approaches (such as prohibition of racial discrimination) and look at removing the structural issues through

<sup>5</sup> Working Group on Arbitrary Detention, “Study on arbitrary detention relating to drug policies”, 18 May 2021, UN Doc. A/HRC/47/40, para. 10.

<sup>6</sup> WGAD, A/HRC/47/40; Report of the Working Group on Arbitrary Detention, 10 July 2015, UN Doc. A/HRC/30/36, para. 74; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, UN Doc. A/65/255, para. 32; ILO, OHCHR, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UN Women, WFP, WHO and UNAIDS, “Joint statement on compulsory drug detention and rehabilitation centres”, March 2012; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, UN Doc. A/65/255, para. 26; Office of the High Commissioner on Human Rights, “Study on the impact of the world drug problem on the enjoyment of human rights”, 4 September 2015, UN Doc. A/HRC/30/65, para. 26

<sup>7</sup> UNHRC Resolution, Elimination of discrimination against women and girls in sport, A/HRC/40/L.10/Rev.1 Human Rights Documents (ohchr.org)

<sup>8</sup> CERD/C/USA/CO/10-12, para. 35; CERD/C/BRA/CO/18-20, para. 16 (b).

<sup>9</sup> Abortion care guideline, Annex A. Key international human rights standards on abortion, World Health Organisation 2022.

positive action policies in addition to decriminalizing health services and conduct which disproportionately affects racialised and marginalized groups.

We recommend that para. 37 be revised to provide more detail about states' obligations to fulfil, including the proactive steps they need to take to address structural barriers and enable and support people experiencing racial discrimination to have equal access to health care. This paragraph should also extend to the social determinants of health.

We recommend adding, in para 38, that States should ensure that all measures to protect public health, including in the context of the COVID-19 pandemic and of future pandemics, are designed and implemented in a strictly proportionate and non-discriminatory manner, and accompanied with safeguards to mitigate any disproportionate effects that such measures may have on racialised, criminalized and marginalized groups and individuals. States should repeal existing laws and refrain from introducing new laws that criminalize or penalize directly or in practice the various actions and decisions of people who are marginalized and that have a negative impact on their human rights, particularly their right to health. Such legislation should require the participation and free, prior, and informed consent of Indigenous Peoples, as well as a recognition of their right to develop and maintain their own health systems, including public health systems.

We also recommend adding a para. 39 (v) that address recommendations for racial discrimination in the context of the social determinants of health, by clarifying that States should put in place processes to understand the range of barriers that racialised groups face in accessing the social determinants of health, put in place positive measures to address these concerns, and ensure that such measures are adequately resourced and funded as a matter of priority. Any measure taken should not favour or reinforce disease stereotyping and bias. In para 40, we suggest replacing the word "modern" with "western".

Para 40 rightly recognises the importance of not reporting undocumented migrants. This should be applied to all forms of unjust criminalization, particularly in countries where sexuality, gender identity, adolescent sexual activity, sex work or drug use are criminalized; forms of criminalisation that affect racialized groups disproportionately. We also recommend that the first sentence of Para 40 replace 'gender-based and culturally sensitive practices' with 'gender-responsive, disability and culturally sensitive practices'.

In Para 44, we recommend amending the list of prohibited grounds of discrimination to include: "Data should be disaggregated by any information about race, colour, descent, or national or ethnic origin and indigeneity, in conjunction with all prohibited grounds of discrimination, including sexual orientation, gender identity, gender, age, disability, migratory and any other status". In Para 45, we suggest adding: "states should review health budgets to ensure that the budget allocations and expenditures are proportionate to population and seek to address disparities that prevent racialized groups from enjoying the highest attainable standard of health". It is also very important that this section recognizes that disaggregated data collection programmes must be developed with the full and effective participation of the affected groups, and respect principles of Indigenous data sovereignty, including that all data collected with regard to Indigenous Peoples must remain their intellectual property, and only be used with their free, prior and informed consent. In Para 47, we suggest adding "and Indigenous" while describing which authorities should be involved.

At the end of Para 51, we recommend including, 'Such campaigns as well as health and public health information more broadly should be translated into Indigenous and minority languages', to ensure these are accessible to a broader audience.

In the section on Accountability, there should be a reference (and accompanying recommendation) to the need for full and effective consultations with impacted groups regarding reparations for slavery and colonialism, given the impacts of these on mental and physical health of racialized people including Indigenous peoples.

We suggest adding an additional Para 66 to clarify references to international cooperation to also note how financial policies pursued by states and the international community can negatively impact racialized groups, for example by adding that 'Certain financial policies which are implemented when countries are in economic crisis place further risks on the rights of groups protected by this Convention. In many countries, for example, austerity measures tend to impact people from marginalised groups more, and in distinct ways. In many instances international financial institutions, multilateral agencies and donors play a role in how these measures were developed and implemented. States should ensure that any austerity measures introduced during economic crises are not discriminatory, mitigate the inequalities that can emerge and/or deepen in times of crisis, and ensure that the rights of disadvantaged and marginalized individuals and groups – including racialised groups - are not disproportionately affected'.