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To: Committee on the Elimination of Racial Discrimination

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Ref: Issues for consideration during the thematic discussion in preparation for a General Recommendation on article 5 (e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination

Racial discrimination and the right to health

Ipas is an international organization that works in more than 20 countries across Africa, Asia, and Latin America to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion. We envision a world where everyone can make their own sexual and reproductive choices, and ultimately, determine their own future. We work with partners to make safe abortion and contraception widely available, to connect women with vital information so they can access safe services, and to advocate for safe, legal abortion. We strive to foster a legal, policy, and social environment supportive of women's rights to make their own sexual and reproductive health decisions freely and safely. To achieve its mission, Ipas collaborates with a wide range of global, regional, national, and local partners, including ministries of health, medical and professional organizations, heath and development NGOs, women's health networks, community-based organizations, legal professionals, youth groups, research organizations, and journalists.

We celebrate that UN treaty bodies, including the CERD Committee, have consistently recognized the harms of multiple and intersecting discrimination. However, more efforts are needed from treaty monitoring bodies to develop a clear and robust intersectional analysis in their views in individual complaints, concluding observations or general recommendations/comments relating to health to address persistent structural intersectional discrimination.

We aim to collaborate to this collective effort with our submission. Below we are providing relevant information to be taken into consideration by the Committee for its first draft of the General Recommendation on racial discrimination and the right to health under Article 5 (e)(iv) of the

International Convention on the Elimination of All Forms of Racial Discrimination that will be submitted to States and other stakeholders for comments. Each section of this document refers to specific questions described in the related table.

<u>*General standards in assessing risks and outcomes of racial discrimination in health*</u>

9. Does the understanding of racial discrimination as social determinant of health encompass compounded health risks and harms arising from structural discrimination?

10. Has the concept of "health equity" added value in relation to obligations under Article 5(e)(iv)? Does health equity address the systemic risks for persons subjected to racial discrimination?

11. How does structural discrimination affect obligations related to the right to health? Does structural discrimination constitute a *de facto* limitation imposed on the right to health that States should always measure in assessing indirect discrimination? What (negative and positive) obligations are placed upon States? What sort of standards (health-related, socio-economic, risk-related, or other) should States apply to assess the effect of indirect racial discrimination? Are these standards equally applicable in the adoption of special measures (affirmative action)?

High rates of preventable deaths as an expression of racial discrimination and reproductive injustice in health in laws, policies, practices, and health systems

Sexual reproductive health and rights including right to safe abortion care are expressed in international documents and international human rights treaties. State's failure to protect SRHR in the context of prevent preventable maternal deaths and injuries due to unsafe abortion represents a denial of women's human right to health and life, among others. The reform of restrictive abortion laws and the implementation of appropriate health legislation and policies are state's measures of reparation to address *de facto* racial discrimination in access to quality health care and fulfill their international human rights obligations related to the right to health to avoid preventable deaths or injuries address human rights violations.

States are responsible to guarantee equal access to health through policies, laws, and maintain functioning health systems. When they fail to do so, there is indirect intersectional discrimination against more vulnerable women, girls, and pregnant people. The concept of reproductive and racial justice draws attention to the devaluation of the lives and health of more marginalized vulnerable women, girls and pregnant people who face higher risk of dying or suffering injuries from causes considered preventable[1]. The underlying factors such as social and economic conditions, age, geographic location, migrant status, marital status, and other social determinants of health should be taken into consideration by policymakers and health authorities. Disaggregated data with the profile of victims of

[1] Yamin AE (2010) Toward transformative accountability: a proposal for rights-based approaches to maternal health in the MDGs and beyond. Sur Int J Hum Rights 7(12):95. 2010. Available at SSRN: https://ssrn.com/ abstract¼172745

multiple forms of oppression and intersectional discrimination that affect their access to quality of sexual reproductive health is central to collect to inform rights-based states' responses.

Research demonstrated evidenced based correlation between countries' restrictive abortion laws and high rates of maternal mortality and morbidity.[2] Nearly 25% of the world's women live where abortion is prohibited except on the grounds of rape, incest or to save a woman's life.[3] When access to safe legal abortion is limited and women and girls have no timely access to contraceptive methods, information on sexual and reproductive health, emergency contraception, they face unwanted pregnancies or resort to unsafe abortions, with devastating consequences for their health, lives and families. These laws and policies increase women's vulnerability to abuse, violence, health risks and further disempower them.[4]

Every woman's death is a tragedy that affects individual women, their families, and their communities. To prevent avoidable maternal deaths due to unsafe abortion, more attention must be given to the underlying causes — rooted in factors such as race, age, literacy, living conditions, economic and social inequities —that affect women's health, lives and gender equality. Preventable maternal mortality and morbidity due to unsafe abortion is placed at the end of a chain of violations of several human rights, such as: the right to education, the right to work, the right to use and access information on contraceptive methods and the right to equal access to services of sexual and reproductive health. The fact that only women, girls, and gender non-conforming people with uterus can become pregnant requires States to adopt specific measures to prevent maternal death, guaranteeing the equal access to health care without intersectional discrimination.

The perception of maternal mortality as gender and reproductive injustice makes it possible to invoke various human rights violations, either alone or together, aiming at measures for the prevention and reduction of maternal mortality. For example: the right to life, the right to racial equality and non-discrimination, the right to health, the right to liberty and security, the right to live free from gender-based violence, the right to family life, among others. A study revealed that experiences of discrimination within the healthcare setting may present a barrier to healthcare for people that are socially disadvantaged due to gender, immigration, race/ethnicity, or religion. It concluded that researchers and policymakers should consider barriers to healthcare that lie within the healthcare experience itself as potential intervention targets[5].

In June 2009, the United Nations Human Rights Council issues its first resolution on preventable maternal mortality and morbidity and human rights[6] recognized that maternal mortality and morbidity

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[2] Jewkes R et al. 2002. Prevalence of morbidity associated with abortion before and after legalization in South Africa. *British Medical Journal, 234*(1252)

[3] According to the Center for Reproductive Rights, 141 countries have some prohibition on access to abortion and of these 68 countries either prohibit abortion all together or permit it only to save the life of a woman.

[4] UNDP, 2010. *Effects of laws criminalizing women's sexuality*. http://content.undp.org/go/newsroom/2010/march/outlawing-women--effects-of-laws-criminalizing-womens sexuality.en

[5] Rivenbark, J.G., Ichou, M. Discrimination in healthcare as a barrier to care: experiences of socially disadvantaged populations in France from a nationally representative survey. *BMC Public Health* **20,** 31 (2020). https://doi.org/10.1186/s12889-019-8124-z

[6] UN Human Rights Council. Resolutions on Preventable Maternal Mortality and Morbidity and Human Rights. 11th

are pressing human rights concerns and that addressing these issues requires effective protection of the human rights of women and girls.[7] This global decision to address the issue not only from a public health but also a human rights perspective is significant and necessary since preventable death victims are mostly low-income, non-white, single mothers, living in the poor regions of their countries. These characteristics are the risk factors affecting women's ability to exercise human rights related to reproductive self-determination.[8] In countries with restrictive abortion laws, health systems have already a history of traditionally not being responsive to women's and adolescents' sexual and reproductive health needs due to gender stereotypes, intersectional discrimination, structural and political failures. Addressing root causes involve promoting change in cultural and social norms.

In July 2012, the Human Rights Council has issued a report contained the UN *Technical Guidance, which is the only inter-governmentally approved guidance on what a human-rights-based approach to health in the context of maternal mortality consists in,* aims to assist policymakers in devising, implementing, and monitoring policies and programs by providing guidance on implementing policies and programs in improving women's health and rights, as well as to reduce maternal mortality and morbidity in accordance with human rights standards. It highlights the human rights implications for multiple actors in the policymaking, implementation, and review cycle, as well as the need for robust enforcement mechanisms and international assistance and cooperation, in accordance with human rights principles such as constructive accountability and participation[9].

The CERD Committee should develop further standards regarding state's obligation to protect the right to health and address indirect racial and intersectional discrimination. For example, the obligation to enact adequate legislation and policies to guarantee equal access to quality emergency obstetric care to black women according to their specific health needs considering their socio-economic conditions. Also, policies and laws against obstetric violence and other discriminatory health practices to promote equal access to quality, adequate and timely health services directed to women, girls, and pregnant people living in poor urban or rural areas, with low socioeconomic status. These laws should contemplate temporary special measures to reach to women girls and pregnant people that face underlying causes and risk factors that put them at higher risk of dying from preventable causes. The Committee on the Elimination of Discrimination against Women (CEDAW) has established that:

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session, UN Document A/HRC/11/L.16 (June 12, 2009); 15th session, UN Document A/HRC/RES/15/17 (October 7, 2010); 18th session, UN Document A/HRC/18/L.8 (September 23, 2011); 21st session, UN Document A/HRC/21/L.10 (21 September 2012)

[7] UN Human Rights Council, Resolution 2011, ¶ 2.
[8] Cook R and Dickens B et al. 2001. *Advancing safe motherhood through human rights* Geneva: World Health Organization
[9] Yamin AE. 2010. Toward transformative accountability: A proposal for rights-based approaches to maternal health in the MDGs and beyond. *International Journal on Human Rights*. 7(12): 95.
Yamin, AE. 2009. Suffering and Powerlessness: The Significance of Promoting Participation in Rights-Based Approaches to Health. *Health and Human Rights*. 11 (1): 5-22.
Yamin, AE. 2008. Beyond Compassion: The Central Role of Accountability in Applying a Human Rights Framework to Health. *Health and Human Rights*. 10 (2): 1-20.

"12. *Certain groups of women, in addition to suffering from discrimination directed against them as women, may also suffer from multiple forms of discrimination based on additional grounds such as race, ethnic or religious identity, disability, age, class, caste or other factors. Such discrimination may affect these groups of women primarily, or to a different degree or in different ways than men. States parties may need to take specific temporary special measures to eliminate such multiple forms of discrimination against women and its compounded negative impact on them.*

13. *In addition to the Convention on the Elimination of All Forms of Discrimination against Women, other international human rights instruments and policy documents adopted in the United Nations system contain provisions on temporary special measures to support the achievement of equality."*[10]

To address indirect discrimination from laws, policies, and health practices against vulnerable groups of women such as black women and their risk of dying due to preventable causes of maternal mortality, the Committee should develop human rights standards such as health-related, socio-economic, risk-related, gender-based violence related. For example, temporary special measures can be adopted to promote equality and address the impact of indirect and structural racial and intersectional discrimination in access to health care. The Committee can suggest as temporary measures to states such as the establishment of an independent civil society mechanism to oversee formulation, design, implementation, monitoring, and evaluation of specific public policies' impact on sexual reproductive rights and health outcomes for black women and girls. This participatory accountability mechanism should allow meaningful participation of the affected groups of the population, such as black women girls, and non-conforming pregnant people and others more affected that are more vulnerable to suffer intersectional discrimination in access to health care in a certain location where death rates are higher[11].

Individual and group experiences by indigenous peoples, people of African descent, Roma, national or ethnic minorities and castes, including women, girls, and children

16. How do racial inequalities affect sexual and reproductive health and rights?

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[10] UN Committee on the Elimination of Discrimination Against Women (UN CEDAW Committee), *General recommendation No. 25, on article 4, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures*, 2004, available at: https://www.refworld.org/docid/453882a7e0.html

[11] Yamin AE, Galli B, Valongueiro S (2018) Implementing international human rights recommendations to improve obstetric care in Brazil. Int J Gynecol Obstet 143(1):114–120. https://doi.org/10.1002/ijgo.12579. Epub 2018 Jul 23. Available at: https://www.ncbi.nlm. nih.gov/pubmed/30035298

Preventable maternal mortality and related morbidity is, in fact, a complex and multifaceted social phenomenon to which states should be held accountable. Furthermore, the occurrence of most cases of preventable maternal death among black, low income, indigenous and people from vulnerable groups, reveals the disproportionate impact of intersectional discrimination both in their unequal access to quality health services during pregnancy, childbirth, postpartum and induced or spontaneous abortion and their individual health care experiences. Violations of women's human rights can be evidenced on systemic and structural discrimination. For example, by the lack of sufficient professionals, lack of equipment, lack of trained staff, as well as essential supplies and quality of obstetric emergency services to prevent the occurrence of avoidable maternal death or by individual's experience of obstetric violence and racial discrimination[12].

When policies and laws create social stigma and criminalize access to safe abortion in criminal laws countries reinforce intersectional discrimination and inequity in access to health care. High preventable maternal deaths due to unsafe abortion among black women draws the attention of government agencies to the racial, social, gender and reproductive injustice implicit in each individual avoidable case of maternal death, for which the Public Power has the responsibility to prevent and respond through non repetition measures and human rights reparations.

Patterns of high maternal mortality due to preventable causes always reflects indirect discrimination in health policies, laws, and the health system. Indirect discrimination happens when there is a policy or law that applies in the same way for everybody but has a disproportioned impact on more disadvantaged groups of people who share a protected characteristic, such as black women or girls living in poor rural or urban areas in the country. For example, as noted by the CEDAW Committee, in the case *Alyne da Silva Pimentel vs. Brazil*, her preventable maternal death revealed emblematic of patterns of intersectional discrimination in the Brazilian health system, based on socio-economic conditions, gender and race[13]. The CEDAW Committee considered that Brazil's maternal health policies did not guarantee women's access to quality care during delivery and did not meet the specific and distinctive health needs of women, particularly women from low-socioeconomic backgrounds and historically marginalized groups[14]

Alyne's case is emblematic of strategic litigation for advancing women's right to equal access to maternal health care and to address a pattern of structural intersectional discrimination within the public health system, affecting mostly black and low-income women. This case also highlighted the pattern of state's failure to promote policies and practices to address root causes and underlying social determinants of healthcare and related human rights violations. The case has also been pointed to by black feminist organizations and activists as exemplary of the persistent institutional racism and intersectional discrimination in reproductive health care against minority pregnant women living in such poor urban areas as Baixada Fluminense in the state of Rio de Janeiro. For these women, maternal death has long been considered an act of God, divine will, rather than a consequence of the lack of equal

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[12] Galli B. Human Rights Accountability for Advancement of Gender Equality and Reproductive Justice in the Sustainable Development Agenda. W. Leal Filho et al. (eds.), Gender Equality, Encyclopedia of the UN Sustainable Development Goals, https://doi.org/10.1007/978-3-319-70060-1_42-1.

[13] UN CEDAW Committee, *Alyne da Silva Pimentel Teixeira vs. Brazil*, Communication No. 17/2008, 10 of august of 2011, UN Doc. CEDAW/C/49/D/17/2008.

[14] Ibid paragraphs 7.4, 7.5 & 7.6.

access to care and therefore a matter of reproductive justice. CEDAW's decision in this case has accordingly served to challenge this normalized and entrenched social norm paradigm.[15]

This situation was even exacerbated during Covid-19 pandemic, having disproportionate effects on women, girls and pregnant people from groups already made vulnerable by persistent racial, ethnic, and socioeconomic inequalities in the context of sexual and reproductive health. For example, most basic health units, services that perform prenatal care in the public health network were redirected to Covid-19 patients, postponed consultations with pregnant women, making it difficult to access the comprehensive care necessary for this moment of the pregnancy-puerperal cycle. Referral services for sexual violence victims were shut down.

As a result, pregnant women infected with Covid-19 arrived at health services in more serious situations, which could have been avoided with equal access to health care. This situation is aggravated by a limiting scenario of access to specialized services and monitoring and leading to more deaths: 65.9% of maternal deaths occurred among black women. According to Epidemiological Bulletin No. 2 of the Ministry of Health, in 2020 the maternal mortality ratio was 59.1 deaths per thousand live births, highlighting that black woman are exposed to twice the risk of maternal deaths. High rates of preventable maternal mortality of black women are an expression of racial discrimination and reproductive injustice in Brazil.

The achievement of 2030 Sustainable Development agenda depend on governments' political will and commitment but also relies on the promotion of accountability mechanisms for full engagement of a multi-stakeholder partnership including civil society, private sector, and local authorities to comply with their international human rights obligations to prevent and protect women girls and pregnant people from racial discrimination in the realization of the right to health, including sexual reproductive health and rights[16].

12. How is intersectionality understood in the field of health? Does the compartmentalization of health allow the identification and accurate assessment of health-risks and potential violations of the prohibition of racial discrimination?

Intersectionality in sexual reproductive health rights

Black women and adolescents living in poverty in rural and other isolated areas, without having the information, means, and ability to make autonomous decisions about their sexuality and life plans, or belonging to disenfranchised groups or victims of domestic violence, suffer far more adverse health outcomes as compared to advantaged groups. Intersectionality is both a theoretical and methodological

[15] Cook (2013) Human rights and maternal health: exploring the effectiveness of the Alyne decision. J Law Med Ethics 41:103–123. https://doi.org/10.1111/jlme.12008

[16] Galli B. Human Rights Accountability for Advancement of Gender Equality and Reproductive Justice in the Sustainable Development Agenda. W. Leal Filho et al. (eds.), Gender Equality, Encyclopedia of the UN Sustainable Development Goals, https://doi.org/10.1007/978-3-319-70060-1_42-1.

'lens' that brings attention to the distribution of power in society and in analyzing how these power structures and wider social, political and economic processes shape our everyday interactions, experiences and outcomes[17].When applied to health, this approach challenges the view that our health is shaped by individual factors (such as biology, income levels, education) or singular identities (Black or Asian, refugee or internal migrant, women or men). Instead, it argues that these factors do not work in isolation but interact with each other to co-determine inequalities and shape health across contexts and populations groups. Social identities and structures of disadvantage do not simply add together but are interdependent, mutually constituting and reinforcing[18]. Policymakers and health providers need to consider multiple social realities of individuals seeking sexual reproductive health care. Also, social accountability can be used as a mechanism to assess policies for their exclusions and oppressive effects to groups of the population and hold governments accountable at local level.

The case of zika epidemic in Brazil is a good example of intersectional structural discrimination in policies and public health system affecting sexual reproductive health and rights of pregnant women. It affected mostly young, poor, black women who gave birth to children with microcephaly, living in the poorer regions of the country[19]. Because they are black, victims of racism, which is a generator of impoverishment, with precarious access to public health services, lack of public transportation, lack of sanitation, and with less means of preventing mosquitoes from bite they were the ones most affected[20]. Intersectional and comprehensive social policies and health care were needed to address their families' more basic needs and the state has failed to provide that. Epidemics like Zika and microcephaly are, above all, dimensions of intersectional discrimination and institutionalized racism[21].

Intersectionality allows us to reveal which are the people really injured by the matrix of oppressions. It is about one's individual identity in which intercepted racism participates and intersects with other structures. It is a racialized experience, giving way to the political solitude of black women, as they are social group marked by the dynamic overlapping of identities. Feminist scholars from the Global South have expressed that it is essential to understand experiences of black women and "women of color" in gender diversity, sexuality, class, embodied geographies, and subjective markings[22].

The feminist scholar Carla Akotirene discusses the concept of intersectionality as a way of embracing the experiences and intersections affecting especially black woman. The term defines a position of the black feminism in the face of the oppressions of our white cisheteropatriarchal society and European-based, undoing the idea of a global and hegemonic feminism as single voice. The intersectionality allows

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[17] Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. Stanford Law Rev 1991;43:1241–99.

[18] Kapilashrami A. What is intersectionality and what promise does it hold for advancing a rights-based sexual and reproductive health agenda? *BMJ Sexual & Reproductive Health* 2020; 46:4-7. [What is intersectionality and what promise does it hold for advancing a rights-based sexual and reproductive health agenda? (bmj.com)]

[19] Diniz et al. Zika virus infection in Brazil and human rights obligations Int J Gynecol Obstet 2017; 136: 105–110 (2016) https://DOI: 10.1002/ijgo.12018

[20] Wenham et al. Globalization and Health (2019) 15:49 https://doi.org/10.1186/s12992-019-0489-3

[21] 49. Góes, Emanuele. A nossa dor não sai no jornal: Mulheres Negras e a epidemia do Zika vírus, um ano depois. Disponível em: https://cientistasfeministas.wordpress.com/2016/10/26/a-nossa-dor-nao-sai-nojornal-mulheres-negras-e-zika-virus-um-ano-depois/.

[22] Akotirene, Carla Interseccionalidade, In Feminismos Plurais Ribeiro Djamila (coord)-- São Paulo : Sueli Carneiro ; Pólen, 2019.

feminists political criticality to understand the fluidity of subaltern identities imposed on prejudices, gender, class and race subordinations and the structuring oppressions of the matrix modern colonial from which they emerge.[23]

For example, in most countries, abortion care is the only health service that is regulated by the criminal/penal code, which not only fuels abortion-related stigma - shaming and criminalising those who seek abortion care, having a disproportionate impact on black or indigenous women and girls form communities that have been historically marginalised and are at greater risk to harassment and intimidation by law enforcers. Ipas research globally illustrates that when abortion remains in the criminal law, the most marginalized groups of women such as black and indigenous women and adolescent girls in Bolivia and Brazil suffer more harm and human rights violations in health and justice systems due to criminalization of abortion.[24]

Adopting intersectionality approach for international human rights obligations on the right to health allows states as well as UN agencies and treaty monitoring bodies to capture individual needs experiences of racial discrimination and interactions with institutions such health systems. It also reveals what are the gaps in legislation, policies that need to be addressed to create an enabling political-economic environment for the realization of people's human right to health and equity in health care, especially in crisis processes such as global epidemics, displacement, conflict, climate change and in national contexts with growing conservatism within which SRH policies are being implemented.

The Committee should further expand the concept of intersectionality applied to sexual reproductive rights to hold states accountable for discrimination and oppression affected by social, racial, gender and reproductive injustice. The Committee should provide guidance to states to ensure participatory processes engaging civil society organizations and social movements to discuss appropriate policies and reparation measures to address structural intersectional discrimination and human rights violations.

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[23] Akotirene, Carla Interseccionalidade, In Feminismos Plurais Ribeiro Djamila (coord)-- São Paulo : Sueli Carneiro ; Pólen, 2019.
[24] Kane, G., Galli, B., & Skuster, P. (2013). When abortion is a crime: The threat to vulnerable women in Latin America. Chapel Hill, NC: Ipas.