



RACISM AND THE RIGHT TO HEALTH

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

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1. INTRODUCTION

We the call from the Committee on the Elimination of Racial Discrimination for comments on the Draft General comment No. 37 on racial discrimination and the right to health in advance of the Day of General Discussion. The comments and observations in this document should not be seen as an exhaustive list of issues but include priority suggestions on ways in which key provisions in the draft General Comment can be strengthened.

2. BARRIERS TO ACCESSING HEALTH FACED BY GROUPS FACING RACIAL DISCRIMINATION

People subject to racism face multiple barriers in accessing timely and quality health care. Often, these barriers are the result of not only a person or group's race, colour, descent, ethnic or national origin, but also a combination of other factors, such as their gender, sexuality, income, citizenship, employment-status, and presence of a health condition or disability. Other treaty bodies have explicitly recognized the need to tackle multiple and intersecting forms of discrimination to achieve substantive equality. According to the Committee on Persons with Disabilities, for example, "Multiple discrimination" 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'.¹

In Libya, for example, pre-existing discrimination against ethnic minority groups such as the Tabu and Tuareg create additional barriers to their access to healthcare, as they do not possess identity documents or family identity booklets to prove Libyan citizenship, necessary to access the free public health system. The lack of documentation has also had serious economic consequences, and many cannot afford to privately pay for medical expenses.² In Namibia, the San people face significant barriers to access healthcare. San peoples are the only ethnic group in Namibia whose health status has declined since independence in 1990.³ The remote location of many San communities has impacted their access to healthcare. Although most rural Namibians face similar distance-related barriers to accessing healthcare facilities, the San's multiple socio-economic challenges including the lack of education, financial means and poor access to public transport exacerbated their inability to access healthcare facilities, which in some cases were 80kms away. The government has failed to prioritize the provision of mobile health outreach and extension services in the most remote areas. Primary healthcare facilities in Namibia are under-resourced in terms of physical infrastructure, personnel and material resources such as medications and equipment. The language barrier between San patients and their healthcare providers, majority of whom are neither San nor fluent in any San languages was another major obstacle standing in the way of the San peoples' realization of the right to health. Furthermore, while the Namibian government acknowledge Indigenous San people's health disparities and vulnerability to TB and MDR-TB, there is a pervasive lack of national health and epidemiological data on Indigenous San peoples.

In the USA, American Indian and Alaska Native women who survive sexual violence often do not receive adequate and timely sexual assault forensic examinations (including a rape kit), which are vital for a successful prosecution. This failure is caused in part by the federal government's severe underfunding of the Indian Health Service (IHS, the main and sometimes sole healthcare provider for American Indians

¹ Committee on the Rights of Persons with Disabilities, General comment No.6 on equality and non-discrimination, CRPD/C/GC/6, 26 April 2018, <https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no6-equality-and-non-discrimination>, Para 19, <https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no6-equality-and-non-discrimination>

² Amnesty International, Libya: Historic discrimination threatens right to health of minorities in the south amid COVID-19, April 20, 2020, <https://www.amnesty.org/en/latest/news/2020/04/libya-historic-discrimination-threatens-right-to-health-of-minorities-in-the-south-amid-covid19/>. This report also noted that members of both communities are also potentially more at risk of contracted COVID-19, in case there is an outbreak, as they live in impoverished and densely populated neighborhoods such as Taouiri in Sabha, where social distancing is essentially impossible

³ African Commission on Human and Peoples' Rights & International Work Group for Indigenous Affairs. (2008) Report of The African Commission's Working Group on Indigenous Populations/Communities: Mission to The Republic of Namibia, p 89, https://www.iwgia.org/images/publications/ACHPR_Namibia_UK.pdf

and Alaskan Natives), IHS understaffing, a lack of clarity within the IHS on the availability of rape kits or trained professionals who can administer the exam, and policies resulting in major geographical gaps in post-rape care. Additionally, IHS policy on sexual assault response protocols have not been fully implemented and are not adequately monitored. The IHS is not adequately keeping track of each facility's spending, decision-making or self-assessment and it does not have data on tribal facilities, suggesting that if there was a severe shortage of rape kits, as Indigenous advocates suggest, the IHS itself might not be aware of this. These barriers result in many survivors being overwhelmed by the emotional and logistical difficulties involved in accessing post-rape care, often giving up when faced with needing to go to a second hospital or clinic after being unable to access the closest IHS facility. Survivors who must seek treatment at non-Native health facilities also face non-culturally sensitive care and, at times, discriminatory treatment. The end result is that Indigenous women in the USA receive unequal and inadequate post-rape because of their Indigenous status.⁴

People subject to racism can also experience forced and coerced sterilization.⁵ Forced sterilization occurs when a person is sterilized without their knowledge or informed consent. Coerced sterilization is when people give their consent to be sterilized, but on the basis of incorrect information or other coercive tactics such as intimidation, or that conditions are attached to sterilization, such as financial incentives or access to health services. Forced and coerced sterilization violate the rights to equality, non-discrimination, physical integrity, health, privacy, information, family, and security, and constitutes violence against women. In some cases, this constitutes torture or cruel, inhuman or degrading treatment or may be a violation of the right to life. Forced or coerced sterilization of Indigenous women is also an assault on the cultural integrity of societies that have already endured grave human rights violations, including forced assimilation.⁶

Recommendations

States should ensure that efforts to address racial discrimination in health care, health inequalities, and barriers to health based on race, colour, descent, ethnic or national origin also consider and address multiple and intersecting forms of discrimination. They should

- *Put in place specific measures to ensure that people subject to multiple and intersecting forms of discrimination, including based on race, colour, descent, ethnic or national origin can achieve equality*
- *Ensure there are effective legal remedies and sanctions in relation to all forms of discriminations, including intersectional discrimination, in civil, administrative and criminal proceedings*

3. LACK OF SOCIAL DETERMINANTS OF HEALTH DUE TO RACIAL DISCRIMINATION AND STRUCTURAL INEQUALITY

The right to health includes a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying social determinants of health, such as food and

⁴ Amnesty International, USA: The never-ending maze: Continued failure to protect Indigenous women from sexual violence in the USA, AMR 51/5484/2022, <https://www.amnesty.org/en/documents/amr51/5484/2022/en/>

⁵ See for example: Amnesty International, Peru: Order to indict Fujimori is a milestone in search for justice for victims of forced sterilization, April 28, 2018, <https://www.amnesty.org/en/latest/news/2018/04/peru-order-to-indict-fujimori-is-a-milestone-in-search-for-justice-for-victims-of-forced-sterilization/>; Amnesty International, Sterilization of Indigenous Women without Consent, <https://www.amnesty.ca/what-we-do/indigenous-peoples/sterilizationwithoutconsent/#:~:text=sterilization%20of%20indigenous%20women%20without%20consent&text=Amnesty%20international%20is%20advocating%20alongside,and%20ensure%20justice%20for%20survivors>

⁶ Measures to prevent births within national, ethnic, racial, or religious groups are explicated prohibited by the Convention on the Prevention and Punishment of the Crime of Genocide as well as one of the specific elements of the crime of genocide in the Rome Statute of the International Criminal Court. Convention on the Prevention and Punishment of the Crime of Genocide, Article 2 (d). See also, UN Declaration on the Rights of Indigenous Peoples, Article 8.2; Rome Statute, Article 6(d): Imposing measures intended to prevent births within the group

nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.⁷ The Committee on Economic, Social and Cultural Rights (CESCR) also lists social factors essential to good health such as education, economic development and gender equity.⁸ Any discrimination in access to the underlying determinants of health, as well as to means and entitlements for their procurement is prohibited.⁹ Access to these determinants often reflect structural inequality and institutional discrimination which drive/perpetuate racial health disparities.¹⁰ Groups subject to racism often face barriers due to discrimination and structural inequalities in accessing the underlying determinants of health, which contributes to their experience of poorer health outcomes and long-term health inequalities. Inequalities in the access to the social determinants themselves are often linked to racial and other intersecting forms of discrimination, as detailed in the examples below. In several countries, key information on access to health care, and health status, is not collected or disaggregated by race, descent, ethnic or national origin, making it harder to understand what challenges exist and how to formulate policies to address them.

For example, in Sweden, European Union (EU) citizens from Eastern Europe, most of whom identify as Roma, are currently living in desperate and dangerous situations in Swedish cities and towns. Many EU citizen Roma people have left structural discrimination and “anti-Gypsyism” in their home countries, mainly Romania and Bulgaria, coming to Sweden to try to make a living for themselves and their families. Those without housing and a regular income are categorized as “vulnerable EU citizens” in Sweden. Inadequate legal and policy frameworks mean that many in this group fall through the cracks in Sweden, with serious consequences for their health and lives. Many faced obstacles in accessing the necessary health care and treatment from the medical system in Sweden. These obstacles include challenges accessing subsidized health care due to vague laws and high costs of health care.¹¹

Colonial policies, including those that reflect racial segregation, combined with government failures to address stark inequalities in the public health system's infrastructure and resources continue to impact people's access to health care. In South Africa, for example, those in the poorest and most marginalized communities, including women, girls and people living with HIV, and sex workers, continue to experience physical, and economic barriers to accessing their right to health.¹² Access to safe abortion is especially challenging in areas of poverty and rural communities due to large distances to health facilities and the high costs of transport to reach them and ongoing failures to provide accessible information on which public health facilities provide abortion services.¹³

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.¹⁴ 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. For example, the criminalization of drug-related offences such as the use, possession and cultivation of drugs for one's own personal and private purposes has deterred people from seeking help with drug dependence and related health problems; it has led to riskier methods of drug use, which increases the risks in HIV infections and other diseases; and it has led to the proliferation of unsafe and harmful drugs being sold on the illicit market.¹⁵ The criminalization of some aspects of sex work results in poorer health outcome 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.¹⁶ 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.¹⁷

⁷ CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12), UN Doc. E/C.12/2000/4, para. 4

⁸ CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12), UN Doc. E/C.12/2000/4, para. 16.

⁹ CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12), UN Doc. E/C.12/2000/4, para. 18

¹⁰ See for example Amnesty International, Unequal and Lethal: Five key actions to recover from the human rights crisis unleashed by the pandemic in Latin America and the Caribbean, AMR 01/5483/2022, <https://www.amnesty.org/es/documents/amr01/5483/2022/es/>

¹¹ Amnesty International, Sweden: A cold welcome: Human rights of Roma and other 'vulnerable EU citizens' at risk, EUR 42/9403/2018, <https://www.amnesty.org/en/documents/eur42/9403/2018/en/>

¹² Amnesty International, South Africa: Barriers to safe and legal abortion in South Africa, AFR 53/5423/2017, <https://www.amnesty.org/en/documents/afr53/5423/2017/en/>

¹³ Amnesty International, South Africa Submission to the UN Committee on Economic, Social and Cultural 64th Session, 24 September - 12 October 2018. AFR 53/8980/2018

¹⁴ Amnesty International, There is no help for our community: The impact of states' Covid-19 responses on groups affected by unjust criminalization, POL 30/5477/2022, <https://www.amnesty.org/en/documents/pol30/5477/2022/en/>

¹⁵ Amnesty International, Substance Abuses. The human cost of Cambodia's anti-drug campaign, ASA 23/2220/2020

¹⁶ Amnesty International, “We live in a violent system”. Structural violence against sex-workers in Ireland, EUR 29/5156/2022, <https://www.amnesty.org/en/documents/eur29/5156/2022/en/>

¹⁷ Amnesty International, Body Politics: a primer on criminalization of sexuality and reproduction, POL40/7763/2018, [amnesty.org/en/documents/pol40/7763/2018/en](https://www.amnesty.org/en/documents/pol40/7763/2018/en/)

This criminalization also has a particular gender component. The threat of criminal punishment or civil sanctions for drug use during pregnancy is a reality for many women in the USA, particularly for those who are already marginalized due to multiple, intersecting factors including poverty, racial and ethnic discrimination, and a lack of access to health care.¹⁸ Laws and policies that criminalise women's conduct during pregnancy, which disproportionately affect women from racialised communities, drive pregnant women away from health care, in particular vital prenatal care and drug treatment.¹⁹ In addition to negatively impacting women's access to health care, these laws erode women's trust in health care providers who may test them for drugs without their knowledge or consent or report them to child welfare or law enforcement officials. As such, punitive policies targeting pregnant women create direct barriers to women's access to care in violation of the human right to health.²⁰

The criminalization of abortion has a disproportionate impact on women, girls and all people who can become pregnant, who face multiple and intersecting forms of discrimination, particularly those from racialised and marginalised communities. Criminalisation of abortion compels people in need of abortion to travel for accessing lawful services or to resort to unsafe, clandestine and/or illegal abortions. It also reinforces abortion-related stigma and discrimination.²¹ International human rights bodies have long stated that to comply with human rights obligations, states should fully decriminalize abortion, liberalize restrictive laws and remove barriers that hinder access to safe abortion.²² Unequal access to social determinants of health also impact women and girls access to sexual and reproductive health.²³ In Nepal, for example, higher uterine prolapse prevalence is linked to higher levels of gender discrimination affecting access to both social determinants of health and treatment. There are also disparities among ethnic and caste groups and higher rates are reported among women who suffer intersectional discrimination based on their caste, gender, and poverty.²⁴ Similarly, in Peru, social factors can create barriers and negatively impact Indigenous women's access to maternal health care that result in disproportionately high rates of Indigenous maternal mortality and morbidity.²⁵

Recommendations

- *States should put in place processes to understand the range of barriers that racialised groups face in accessing healthcare and the underlying determinants of health and take urgent steps to remove them.*
- *States should put in place positive measures to address these concerns and ensure that such measures are adequately resourced and funded as matter of priority. Where necessary they should also strengthen legal and policy frameworks to address racism in the private sector.*
- *States should collect health-related data, including on health outcomes, access to health services, access to social determinants of health, and the financial impact of health expenditure, and ensure that this is disaggregated on the grounds of race, colour, descent, ethnic or national origin,*

¹⁸ Amnesty International, Criminalizing pregnancy: policing pregnant women who use drugs in the USA, 2017, (AI Index: AMR 51/6203/2017), available at: <https://www.amnesty.org/en/documents/amr51/6203/2017/en/>

¹⁹ Amnesty International, USA: Tennessee 'Fetal Assault' Law a Threat to Women's Health and Human Rights, 2016 (AI Index: AMR 51/3623/2016), available at: <https://www.amnesty.org/en/documents/amr51/3623/2016/en/>

²⁰ The UN Special Rapporteur on the Right to Health has affirmed that criminalization of conduct during pregnancy impedes access to health care goods and services, infringing the right to health of pregnant women, and has called for states to suspend the application of "existing criminal laws to various forms of conduct during pregnancy."²⁰ WHO, UBODC and UNIADS has also expressed a position that "[e]ffective pharmacotherapy treatment of opioid dependence can substantially improve obstetric, perinatal and neonatal outcomes".

²¹ Amnesty International and partners have highlighted this impact in a submission to the Supreme Court of the United States on the *Dobbs v. Jackson Women's Health Organization* case. The Texas law SB8 introducing near total abortion ban, which directly affects seven million women of reproductive age in the state of Texas, USA, has similar impact. But its disproportionate impact falls on people of low income, including teenagers, people of colour, migrants and refugees, who already struggle to access healthcare. See Brief of amici curiae Human Rights watch, Global Justice Center, and Amnesty International In Support of Respondents, 10 September 2021, https://www.supremecourt.gov/DocketPDF/19/19-1392/192874/20210920162148560_Dobbs_9_20_Clean.pdf; Amnesty International, USA: Federal and state lawmakers must protect access to abortion after extreme ban in Texas, 15 September 2021, <https://www.amnesty.org/en/latest/news/2021/09/usa-federal-and-state-lawmakers-must-protect-access-to-abortion-after-extreme-ban-in-texas/>

²² UN Human Rights Committee, General Comment 36 (Article 6: Right to Life), 2018, UN Doc. CCPR/C/GC/36, para. 8; CESCR, General Comment 22 (2016) on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), 2016, UN Doc. E/C.12/GC/22, para. 28; UN Committee on the Rights of the Child (CRC) Committee, General Comment 20 (2016) on the implementation of the rights of the child during adolescence, 2016, UN Doc. CRC/C/GC/20, para. 60.

²³ Amnesty International, Deadly Delivery: The Maternal Health Care Crisis in the USA, AMR 51/007/2010, <https://www.amnesty.org/en/documents/amr51/007/2010/en/>

²⁴ Amnesty International, Unnecessary burden: Gender discrimination and uterine prolapse in Nepal, 2014 (AI Index: ASA 31/001/2014), available at: <https://www.amnesty.org/en/documents/asa31/001/2014/en/>

²⁵ Amnesty International, Fatal flaws – barriers to maternal health in Peru, 2009 (AI Index: AMR 46/008/2009), available at: <https://www.amnesty.org/en/documents/AMR46/008/2009/en/>

and other prohibited grounds of discrimination, including gender, gender identity, sexual orientation, disability-status, ethnicity, and nationality, among others.

4. THE IMPACT OF COERCIVE MEASURES TO PROTECT PUBLIC HEALTH ON GROUPS FACING RACIAL DISCRIMINATION, WITH A FOCUS ON WHAT HAPPENED DURING THE PANDEMIC

In the context of the COVID-19 pandemic, several countries introduced measures to protect public health, including ‘lock-downs’, quarantines, compulsory testing, and use of law enforcement agencies to enforce these public health rules. In many instances these measures further stigmatized racialized groups, disproportionately impacted them and contributed to entrench institutional racism. These measures were often ineffective to protect the right to health of racialized groups and other marginalized communities and rather had a punitive impact on them. Criminalization and coercive measures in relation to enforcement of health policies place a heavy responsibility on individuals to manage their health risks and do not take account of structural inequalities and discrimination in access to the resources needed to comply effectively.

Coercive measures to protect public health increase the number of interactions between law enforcement officers and groups facing intersecting discriminations. In view of the systemic human rights concerns regarding racial discrimination in law enforcement globally, 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.

In some European countries, there were human rights concerns in the application of measures to counter the COVID-19 pandemic including institutional racism and discrimination in law enforcement.²⁶ The use of coercive measures to protect public health in Europe has had a disproportionate impact on racialized groups already subject to discriminatory identity checks and unlawful use of force prior to the pandemic. Coercive approaches contradict evidence-based public health best practice, and often target disadvantaged communities which are marginalized, impoverished or at risk of discrimination, resulting in increased stigma and fear, and thwarting trust in authorities.

In Slovakia, there was concern that conducting targeted testing in Roma settlements – in the context of the COVID-19 pandemic - without providing Roma the necessary means to protect themselves would only add to stigmatisation and prejudice they already face.²⁷ Inadequacies around the social determinants of health in Roma communities made it harder for them to follow public health recommendations. For example, a long-standing problem is the lack of access to water and sanitation in informal settlements where a majority of the Roma live.²⁸ There has not been any significant progress in ensuring access to water and sanitation since then and segregated Roma settlements are particularly affected.

There were similar concerns about the treatment of Roma communities in Bulgaria during the COVID-19 pandemic. Reports indicated that the government had imposed measures, including mandatory quarantines, targeting Roma settlements. The government did not apply these measures to other groups or the general population. Such selective application, in the absence of evidence that less restrictive alternatives were considered, raised questions over compliance of these measures with the obligation to prohibit discrimination under the European Convention on Human Rights and the European Union’s Race Equality Directive. There was also concern that mandatory quarantines had disproportionately affected Roma living in poverty. Restrictions on their freedom of movement severely affected their ability to engage in work, including informal work, on which many families depend, exposing them to increased poverty and further social exclusion. With limited savings and lack of adequate support, many struggled to sustain themselves through the quarantine period without an income.²⁹

²⁶ Amnesty International, Europe: Policing the pandemic: Human rights violations in the enforcement of COVID-19 measures in Europe, EUR 01/2511/2020, <https://www.amnesty.org/en/documents/eur01/2511/2020/en/>

²⁷ Amnesty International, Slovakia: Roma must not be further stigmatised during COVID-19, EUR 72/2110/2020, <https://www.amnesty.org/en/documents/eur72/2110/2020/en/>

²⁸ Amnesty International, Slovakia: Roma must not be further stigmatised during COVID-19, EUR 72/2110/2020, <https://www.amnesty.org/en/documents/eur72/2110/2020/en/> - According to the 2013 Atlas of Romani Communities in Slovakia, approximately 23% of Roma settlements lack access to any public water supply.

²⁹ Amnesty International, Quarantines of Roma Settlements in Bulgaria and Slovakia Require Urgent Attention, 18 May 2020, <https://www.amnesty.eu/news/quarantines-of-roma-settlements-in-bulgaria-and-slovakia-require-urgent-attention/>

Recommendations

- 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, criminalised and marginalized groups and individuals.
- States should enable and support people to adhere to public health measures. The coercive enforcement of measures to protect public health should be considered only as last resort. States should in particular avoid the use of criminal sanctions to protect public health. Racialised, criminalised and marginalized communities and individuals should not be penalized or otherwise sanctioned solely for not having the necessary resources and conditions to comply with public health restrictions.
- 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.

5. INTERNATIONAL COOPERATION AND ASSISTANCE AND ITS IMPACT ON RACISM IN HEALTH

a. Vaccine inequality and concerns around ICA during COVID

The Committee has already noted how “the vast majority of COVID-19 vaccines have been administered in high- and upper-middle-income countries”, which has created “a pattern of unequal distribution within and between countries that ... further deepens structural inequalities affecting vulnerable groups protected under the Convention”.³⁰ Global vaccine inequality will have particular impact on people in certain countries, not just in terms of their right to health, but also other economic and social rights. In East Africa, for example, governments were unable to roll out timely, predictable and therefore effective mass vaccination campaigns. Several countries in East Africa, the Horn and Great Lakes maintained strict measures aimed at preventing the spread of Covid-19 much longer than in countries where vaccine supply has been plentiful. This has risks to the rights to health, education, and an adequate standard of living.³¹

Recommendation

- States must cooperate globally and remove any potential barriers to ensure that vaccines and treatments for COVID-19 are developed, manufactured in sufficient supply, and then distributed in a timely and inclusive manner around the globe. This obligation includes providing technical and financial assistance to other states, as well as refraining from behaviours including bilateral deals that could compromise the ability of other states to do so, which includes “hoarding” of vaccines beyond what is needed for priority, at-risk populations. Intellectual property rights should not prevent any countries from upholding the right to health.

b. Impact of financial policies

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

³⁰ Committee on the Elimination of Racial Discrimination, Statement on the lack of equitable and non-discriminatory access to COVID-19 vaccines, Statement 2 (2022), 11-29 April 2022

³¹ Amnesty International, East Africa: “Address the access issue and the pandemic will be managed tomorrow”: Global vaccine inequity’s impact in East Africa, 14 December 2021, <https://www.amnesty.org/en/documents/afr04/5084/2021/en/>. See also Amnesty International, Covid-19: Vaccination programmes across the world must adapt to reach the most marginalized, 17 December 2021, <https://www.amnesty.org/en/latest/news/2021/12/covid-19-vaccination-programmes-across-the-world-must-adapt-to-reach-the-most-marginalized/>

impact people from marginalised groups more, and in distinct ways.³² In many instances international financial institutions, multilateral agencies and donors play a role in how these measures were developed and implemented. In Spain, for example, federal government introduced austerity measures in the aftermath of the economic crisis that began in 2008. The exclusion of adult irregular migrants from freely receiving many aspects of health care was one of the most controversial aspects of the RDL 16/2012, one of the austerity measures introduced. From 2012, it is estimated that almost 750,000 migrants were excluded from free public health coverage. Several regional governments in Spain disagreed with this decision, and restored access to health care for irregular migrants, within their jurisdiction. However, some health care centres continued to charge for emergency services or deny access to health care for people who should have been covered. The discrepancy in rules at the national and regional level on access acted as a deterrent: many people did not seek health care they were entitled to, thinking they would be turned away.³³

Recommendation

- *States should ensure that any austerity measures introduced during economic crises are not discriminatory, mitigate the inequalities that can emerge in times of crisis, and ensure that the rights of disadvantaged and marginalized individuals and groups – including racialised groups - are not disproportionately affected.*

6. CONCLUSIONS

We have made recommendations to address the barriers that people face in accessing the highest attainable standard of health free from discrimination based on race, colour, descent, ethnic or national origin and intersectional forms of discrimination. In addition to those listed above, some key overarching calls include:

- *States must ensure that any policies and measures are developed with the meaningful participation of all people affected by them.*
- *States should ensure that legal systems and health systems have effective accountability mechanisms in place to address direct and indirect discrimination based on race, colour, descent, ethnic or national origin and intersectional discrimination, and linked human rights violations, including clear legal prohibitions against these forms of discrimination.*

³² For example, Amnesty International's report in Spain showed how austerity measures had a particular and disproportionate impact on people with lower incomes, and especially on people with chronic health conditions, people with disabilities, older persons, and people accessing mental health care. Amnesty International, Spain: Wrong prescription: The impact of austerity measures on the right to health in Spain, EUR 41/8136/2018, <https://www.amnesty.org/en/documents/eur41/8136/2018/en/>

³³ Amnesty International, Spain: Wrong prescription: The impact of austerity measures on the right to health in Spain, EUR 41/8136/2018, <https://www.amnesty.org/en/documents/eur41/8136/2018/en/>

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RACISM AND THE RIGHT TO HEALTH

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

This submission to Committee on the Elimination of Racial Discrimination on racism and the right to health covers the following themes: barriers to accessing health faced by groups facing racial discrimination, lack of social determinants of health due to racial discrimination and structural inequality, the impact of coercive measures to protect public health on groups facing racial discrimination, with a focus on what happened during the pandemic, and international cooperation and assistance and its impact on racism in health. It is based on Amnesty International's research on these issues across countries. It also provides some conclusions and key recommendations.