FIGO's submission to the United Nations' Committee to Eliminate Racial Discrimination

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The International Federation of Gynecology and Obstetrics (FIGO) is a professional organisation that brings together more than 130 obstetrical and gynaecological (OBGYN) associations (working in the public and private health sector) from all over the world. FIGO's vision is that women and girls of the world achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives. FIGO is in official relations with the World Health Organization (WHO) and consultative status with the United Nations (UN).

We acknowledge the pain, anxiety and suffering of so many who have experienced racism and bias. Because of the work we do, we are deeply aware of the inequities experienced by women of colour and other minority groups, and the political and economic oppressive structures that perpetuate and maintain these inequities. The disparities we see in health and wellbeing are numerous, and we know that health and wellbeing is most often compromised **not** because of a lack of medical knowledge, but rather intersectional discrimination because of several violations of basic human rights, including the right to health.[1]

We are writing to share our evidence-based responses, that we hope will provide helpful considerations for the Committee on the Elimination of Racial Discrimination's preparation on its 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. Please find our response to your key questions below.

Questions (please note: we have kept to the question numbering as stated in CERD Committee's GR37_Question EN document)

Scope of Article 5 (e) (iv)

5. What are the features of the right under Article 5 (e) (iv), taking into account the core obligations of Article 2 ICERD? Do the prohibition and elimination of racial discrimination introduce a specific focus on socio-economic determinants establishing a core of health-related rights?

ICERD Article 2: sets a number of obligations that State parties are legally bound to implement, this includes, but is not limited to, taking proactive action to condemn and eliminate racial discrimination. Article 2 (c) states that States must review governmental, national and local policies, and amend, rescind or nullify laws and regulations, which have the effect of creating or perpetuating racial

discrimination. Such action will have a direct impact on fulfilling Article 5 e (iv) The right to public health, medical care, social security and social services.

The World Health Organisations' (WHO) Commission on Social Determinants of Health recommended three areas for critical action in order to tackle health inequity, which also have direct linkages in addressing racial discrimination.[2] The three key areas for action included: (i) improve daily living conditions - the circumstances in which people are born, grow, live, work and age; (ii) tackle the inequitable distribution of power, money and resources - the structural drivers of those conditions of daily life (for example, macroeconomic and urbanization policies and governance); and (iii) measure and understand the problem and assess the impact of action - expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health – this requires a scaled up and systematic action that is universal but proportionate to the disadvantage across the social gradient, which is necessary for effective delivery to inequities in health and will enable the promotion of healthier populations.

Evidence-based research demonstrates that social determinants, including socio-economic. can be more important than health care or lifestyle choices in influencing health outcomes. For example, numerous studies suggest that social determinants of health account for 30-55% of health outcomes, and estimates show that the contribution of sectors outside health to population health outcomes exceeds the contribution from the health sector directly.[3]

7. What is the relationship between Article 5 (e)(iv) and the definition of health in the World Health Organisation?

The right to Equality/Non-discrimination is a fundamental human right that is recognised both in Article 5 (e) (iv) and the World Health Organisation's Constitution (1946)[4] which states: 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition…Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.'

Both ICERD and WHO recognise that everyone has a right to health and this human right must be enjoyed by all, free from discrimination on any grounds, including race, age, ethnicity or other status. Non-discrimination and equality requires States to take proactive steps to redress any discriminatory law, practice (includes behaviour) or policy. Non-discrimination also recognises that certain individuals, communities and peoples can face multiple and/or intersectional discrimination that places them at a higher risk to human rights violations including right to health.[*]

The right to health as a human right creates a legal obligation on States to ensure access to timely, acceptable, and affordable health care of appropriate quality, as well as providing for the underlying determinants of health, such as the right to safe and potable water, the right to sanitation, right to food, right to housing, right to health-related information, right to education, and right to equality.[5]

[*] Multiple discrimination refers to discrimination on more than one ground when each type of discrimination operates separately. Taking the example above, a disabled woman may experience discrimination on the grounds of disability when she is unable to access a public building because it does not have an elevator. Separately she may face discrimination on the basis of gender when she receives sexual harassment online. These forms of discrimination are multiple but separate; they do not necessarily result in a specific impact because she is both disabled and a woman. If she experiences forcible sterilization because of a state policy to control reproduction of disabled women, the discrimination she experiences is due to a combination of her gender and her disability and constitutes intersectional discrimination because neither a non-disabled woman nor a disabled man would experience the same impact.

General standards in assessing risks and outcomes of racial discrimination in health

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

Globally social determinants of health are shaped and influenced by historical, political, social and economic forces and help explain the relationship between environmental conditions and individual health. Social and structural determinants of health describe environmental conditions, both physical, socio-political, that influence health outcomes. Physical conditions such as lack of access to safe housing, clean drinking water, nutritious food, and safe living environments contribute to poor health outcomes. Socio-political conditions such as institutional racism and/or sexism; police violence targeting people of colour; gender inequity; discrimination against lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals; poverty; lack of access to quality education and jobs that pay a liveable wage; and mass incarceration all inform behaviour and biological processes that ultimately influence individuals' health and the health of communities. Such social conditions not only influence individual health but also work to create cycles that perpetuate intergenerational disadvantage. For example, in the United States social and structural factors account for one third of total deaths in a year, and evidence shows that addressing social needs of individuals improves overall health.[6]

Preventable maternal mortality and disability

Maternal mortality and disability is rooted in gender injustice and intersectional inequalities. Globally, approximately 295,000 women died during and following pregnancy and childbirth in 2017. The vast majority of these deaths (94%) were of women of black, coloured or indigenous, who also have intersectional identities e.g marginalised religious, caste and/or ethnic status, often those living in poverty, in rural areas, and/or illiterate. Low resource settings: Sub-Saharan Africa and Southern Asia accounted for approximately 86% (254 000) of the estimated global maternal deaths in 2017.[7]

Progression in achieving gender/intersectional equality has been persistently elusive, as illustrated by the lack of progress made under SDG 3 target to reduce the global maternal mortality ratio (MMR) to fewer than 70 maternal deaths per 100,000 live births and 140 nationally, which has now been further compounded by COVID pandemic. A reduction in MMR is dependent on social determinants, access to and the enjoyment of social health determinants reflects the structural inequalities and avoidable differences in health status seen within and between country populations.[8] For example: states in the USA that expanded Medicaid eligibility improved the health of women of childbearing age by increasing access to preventive care; reducing adverse health outcomes before, during, and after pregnancies; and reducing incidence of maternal mortality moreover, expansion states experienced significant reductions in Black – White disparities in adverse birth outcomes shortly after the policy went into effect 32 and a 50% reduction in infant mortality, with the greatest declines among Black/African American infants.[9] In addition, a review conducted by the Organization for Economic Cooperation and Development countries concluded that (i) reforms that have increased the duration of job-protected paid parental leave have improved women's economic outcomes; (ii) access to paid parental leave around the period of childbirth appears to reduce rates of infant mortality, with breastfeeding representing one possible mechanism; and (3) more generous paid leave entitlement in countries that offer unpaid or short duration of paid leave could help families strike a balance between the competing demands of earning income and focusing on personal and family well-being.[10]

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?

Reflecting on the evidence, even in 'high income' countries it is clear urgent proactive human-rights based measures must be taken to address health inequity. For example, Black women in the UK are four times more likely to die in pregnancy and childbirth than white women, while Asian and mixed-race women are twice as likely.[11] Stillbirth rates in babies of black and black British ethnicity were more than twice those for white babies and neonatal mortality rates were 43% higher. For Asian and Asian British babies, stillbirth and neonatal mortality rates were around 60% higher than for white babies for both groups.[12] "These findings show how challenges facing the maternity system, including workforce shortages and a lack of long term consistent investment, can combine with systemic racism and structural barriers and leave women from minority ethnic backgrounds at increased risk and feeling unsafe during their maternity care," Royal College of Obstetrics and Gynecology, UK.[13]

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

Intersectionality is still a relatively new analytical framework (term coined by Kimberle Crenshaw in 1989) and both in the field of health and human rights, more advocacy, human-rights based (clinical) education and awareness programmes and campaigns need to be conducted, with relevant tools and approaches to better understand and address the impact on intersectionality and the right to health. However, there is evidence from national associations of obstetrics and gynecology that certain approaches are being employed to better understand how patient-centred care can respond to this issue, for example see a practical tool developed by the American College of Obstetricians and Gynaecologists which included: (i) Questionnaires to enable screening for social determinants of health (ii) Medical –legal partnerships this involved working with legal services and co-locating them in the same site as the clinic, which enabled patients to receive assistance with problems such as concerning racial discrimination which may link/impact right to housing, immigration challenges, and other legal matters that directly affect individuals' health, (iii) Providing interpreter services to better address language barriers that may result in conscious/unconscious biases, (iv) Supporting patients with transportation and logistics, again with the aim to avoid conscious of unconscious biases and racist attitudes/assumptions developing if patients from certain marginalised sectors of the community missed appointments or came late to appoints due to challenges with transport/logistics eg childcare.[14]

A recent piece of research conducted by FIGO's Committee for Human Rights, Refugees and Violence against Women asked about which SRHR topics were taught in medical universities. Respondents represented 143 universities in 54 countries. Of those responding, only 45.8% included determinants of SRHR.[15]

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

The United Nation's Special Rapporteur of Health Dr. Tlaleng Mofokeng report: Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic (July 2021)[16] highlighted that: 'The historical impacts of colonialism on sexual and reproductive health rights are multifaceted. Broadly, colonial regimes have seen reproduction primarily in instrumentalist terms, promoting it when it was deemed valuable for economic or political objectives and discouraging it when it was deemed undesirable. Maternal health programmes created by European colonial powers in Africa and the Caribbean in the early twentieth century, for example, were driven

largely by a perceived shortage of labour needed to work on plantations and in export industries. Colonial and postcolonial regimes, as well as many international organizations, then shifted to discouraging reproduction and promoting family planning in the mid-twentieth century, when smaller families were deemed more conducive to national economic development and global security. The connections among fertility, family size and broader social and economic development continued to be debated, strengthened by the resurgence of the rhetoric of population control in the context of climate change. In the era of climate change, it must be noted that these resurgent discourses make their way into social and policy discussions and attribute environmental destruction… European colonial regimes set in place specific laws, including restrictions on abortion and consensual same-sex acts, which remain on the books today in formerly colonized countries. Indeed, in contrast to the popular narrative that the advancement of sexual rights and abortion rights internationally are modern forms of "colonization" by the West, in fact State-sponsored homophobia, the privileging of heterosexuality and restrictions on women's rights to bodily autonomy are a more precise legacy of colonial rule. They shape contemporary geopolitics of financing, services and audit regimes for sexual and reproductive health rights which enforce power disparities in health aid between bilateral donors and implementing countries.'[17]

Taking the above into context: racial inequalities further exacerbate the risk/denial of SRHR i.e. the COVID-19 pandemic has disproportionately impacted women and girls around the world. UN agencies reported a global rise in domestic violence, studies revealed that for every 3 months the lockdown continued an additional 15 million cases of gender-based violence are expected and 13 million women are not able to access modern contraceptives and there will be an estimate of 325,000 unintended pregnancies.[18] Black, Asian or minority ethnic woman may find additional barriers and/or denials to accessing SRHR services because of under-resourcing/investment in socio-economically deprived areas (which are often disproportionately from Black, Asian, ethnic marginalised groups). These populations face obstacles to meaningfully engage and influence priorities and resource allocation. Such communities may be reluctant to reach out to statutory agencies (such as the police, social services, or housing authorities) because their fear racism, based on their lived experience with such agencies.[19] In addition, they may lack trust that accountability will be provided, even if they do raise complaints, because of the composition (white supremacy and power hierarchies eg Caste based) governing decision-making panels/processes.[20]

17. How should "informed consent" be understood under the Convention?

FIGO's Ethics Guidelines[21] set informed consent as:

The obligation to obtain the informed consent of a woman before any medical intervention is undertaken on her derives from respect for her fundamental human rights. These rights have been widely agreed on and are laid down in human rights standards.

Informed consent is a consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on: (a) the diagnostic assessment; (b) the purpose, method, likely duration and expected benefit of the proposed treatment; (c) alternative modes of treatment, including those less intrusive, and (d) possible pain or discomfort, risks and side effects of the proposed treatment. Providing this information is essential for empowering women to make decisions with their physicians, as required by the ethical principle of respect for patient autonomy.

It is the ethical obligation of the physician to ensure that the woman's human right of self-determination is met by ensuring that the process of communication is satisfactory before informed consent occurs. This means that others may become involved in her decision-making process only with her explicit permission. Consent can be withdrawn at any time. The patient should be informed about the risks of discontinuation of treatment and how these should be managed. It is important to

keep in mind that informed consent is not a signature, but a process of communication and interaction. The signed consent form documents only that the patient has authorized treatment. The opinion of children or adolescents on a medical intervention should be assessed within the limitations posed by their level of development or understanding. If a woman is unable to decide for herself because of mental incapacity or intellectual disability, she must be involved in the decision-making process to the fullest extent her capacity allows, and her best interests must be taken into account by her joint decision maker.

Stateless persons, asylum seekers, refugees, and migrants

18. How does the status of stateless persons, asylum seekers, refugees, and migrants influence the assessment of restrictions in the right to health? Do immigration policies allow for systemic deficiencies in health and how should these policies balance individual and societal risks?

FIGO advocates on a global stage for increased focus on the health and wellbeing of refugee, asylum seeker and migrant women and girls, recognising that their specific health needs do not change when they are displaced.

Example 1 Colombia: Constitutional Court of Colombia rules that Venezuelans refugees must have access SRHR care services[22]

Colombia has received approximately 1.2 million refugees since 2017, driven by the political and economic crisis in Venezuela. The healthcare needs of women in refugee and migrant populations are huge, and since March 2017, approximately 60,000 pregnant women from Venezuela have given birth in Colombia. There is an increase in cases of extreme maternal morbidity (four-fold), increase in cases of low birth weight infants and perinatal deaths (two-fold) and an increase in cases of gestational syphilis (almost five-fold comparing January 2018 and January 2019).

Women from Venezuela living in Colombia require: access to sexual and reproductive health care services to close the unmet need for modern contraceptive methods and limit unwanted or adolescent pregnancy; safe abortion and post-abortion services; protection from sexual exploitation and integrated care for sexual and gender-based violence; maternal health, antenatal care and hospital-based deliveries overseen by skilled health personnel; neonatal health care; reproductive morbidity and cancer screening, as well as midlife needs. These must be provided at primary health care level for refugees at a wider scale.

FIGO welcomes the Constitutional Court of Colombia's ruling that the healthcare system continue to provide care for Venezuelan citizens no matter their immigration status, and commends the healthcare community, which has provided more than 2 million individual services to Venezuelan citizens.

Example 2: Lebanon – Syrian refugees, especially those with inter-sectional identities, have less access to primary healthcare services than Lebanese population[23]

Lebanon is hosting 1.5 million Syrian refugees, 75% percent of whom are women and children. According to the UN High Commissioner for Refugees (UNHCR), Syrian refugees have less access to primary healthcare services than the Lebanese population. Among Syrian refugees, the individuals most at risk of discrimination are survivors of gender-based violence (GBV) individuals with disabilities, unmarried women and girls, LGBTQI persons. Although 80% of the cost of primary health care is covered by the UNHCR, use is dwindling due to collateral medical costs and humiliation experienced during clinical visits.[24] A recent study found that Syrian refugees report lack of dignity as a main barrier to their use of healthcare services; experienced mainly in the form of long

waiting times, attitudes of the medical personnel ("naming and shaming"), and the high cost of services refugees.[25] Embedding the right to human dignity in the delivery of healthcare is fundamental, and governments, donors and NGOs must ensure greater accountability when health care providers and health care systems deny the right to healthcare of vulnerable and marginalised populations.

26. How should States assess their compliance with the prohibition and elimination of racial discrimination regarding health in situations, such as deprivation of liberty?

States must facilitate quality, dignified care of incarcerated patients, obstetrician–gynaecologists and other women's health care practitioners should support efforts to improve the health care of imprisoned pregnant, postpartum, and nonpregnant individuals at the local, state, and national levels. These efforts may include the following:[26]

- work inside prisons, jails, and detention centres to provide medical care to incarcerated individuals, and consultation and training to other clinicians in these settings and correctional officers to ensure that reproductive health and pregnancy needs are being appropriately addressed and are patient-centred
- create and participate in systems that improve continuity of care after release
- advise prisons, jails, and detention facilities on guidelines and protocols that ensure comprehensive reproductive health, pregnancy, and postpartum care is provided, including the ability to initiate or continue contraception while in custody; cervical and breast cancer screening; respectful maternity care by a qualified clinician consistent with accepted clinical guidelines; access to abortion services; treatment of mental illness and substance use disorders, including access to medications for opioid use disorder; and promotion and support of breastfeeding
- advocate at organizational; hospital; and local, state, and federal levels to ensure policies and laws follow accepted clinical guidelines and evidence-based protocols; to eliminate co-pays to access health care while in custody; to restrict shackling during pregnancy, labour, and the postpartum period and work with local hospital and custody staff to ensure compliance; to ensure that menstrual products are available at no cost and in adequate supply; and to support policies and laws that decrease the number of incarcerated people and promote community-based alternatives, especially for those who are pregnant and parenting
- provide compassionate, appropriate care when incarcerated patients are treated at clinics and hospitals in the community. They should foster safe and dignified birthing environments for incarcerated people who give birth in custody and allow these individuals to have the same opportunities to bond with their newborns as nonincarcerated postpartum hospitalized people
- advocate for data collection on pregnancy and other reproductive health outcomes of incarcerated people by public agencies and through research

Global health

34. Do States have obligations under the Convention regarding global health? Have States any anti-discrimination obligation regarding the right to health outside their jurisdiction? Have States an obligation to harmonise their actions within international and regional organisations or other international agreements with their obligations under the Convention?

The 2030 Agenda for Sustainable Development, adopted by all United Nations Member States, provides an action-orientated plan for all governments to strengthen global partnerships (eg

specifically Sustainable Development Goals (SDGs) 16 and 17). People living in poverty experience a myriad of human rights violations, in order to successfully address rates of poverty, SDG strategies must be human rights compliant, the Vienna Declaration and Programme of Action sets that all human rights are universal, indivisible, interdependent and interrelated.[27]

International organisations and racial discrimination

39. How should human rights and health-related organisations enhance cross-fertilization?

The importance of having inter-disciplinary teams and representation, where there are professional clinicians (various disciplines and levels) involved from the design/concept – delivery stage is critical at the global, regional and national level to ensure shared ownership and buy-in, to agree SMART objectives with clear roles/responsibilities identified. To that end strengthen participation (includes skill-sharing, local/national knowledge and solutions) - to ensure language needs must be catered for. In order to operationalise human rights laws and policies, programmes resources must be equitable shared particularly at the national level.

FIGO can share its first-hand insights and evidence with human rights bodies, in order to harmonise calls for action and accountability from similar decision-making stakeholders e.g. governments and Ministries of Health. For example – our global statement[28] FIGO together with its partners mobilised nearly 300 global healthcare organisations to urge all governments to defend access to safe and quality abortion care when the US Supreme Court overturned the landmark Roe v Wade judgement. FIGO emphasised that supporting safe and high-quality abortion care is a demonstration of a government's commitment to reproductive and social justice, and limiting access to abortion care takes the greatest toll on the lives of women, girls and pregnant people; those living in poverty; those with marginalised racial, ethnic identities; adolescents; and those living in rural areas. A denial of abortion care further exacerbates their historical discrimination and mistreatment, and places them at the greatest risk of preventable maternal death and disability.

41. Examples on lessons learned on racial inequality and good practices in building community-centered approaches and combatting racial discrimination during the COVID-19 pandemic.

One of the lessons commonly drawn from the MDGs was the need for the SDGs to provide more disaggregated statistics and analysis to account for the most vulnerable and marginalized populations and enhance measurement of discrimination and inequalities both within and among countries.[29] The COVID-pandemic has illustrated more needs to be done, both in terms of ensuring disaggregated data of populations, but also ensuring disaggregated data among the experiences of healthcare workers' rights and entitlements, particularly the most historically marginalised due to their racial and ethnic identity etc.

Covid-19 has disproportionately affected ethnic minority groups in developed countries.[30] In the UK, people of black ethnicity have had the highest diagnosis rates, with the lowest rates observed in white British people.[31] Data up to May 2020 show 25% of patients requiring intensive care support were of black or Asian background.[32] The mortality risk from covid-19 among ethnic minority groups is twice that of white British patients after potential confounding factors such as age, sex, income, education, housing tenure, and area deprivation have been taken into account.[33] Data from covid-19 inpatients in England showed that South Asian people had the highest death rates (350 deaths/1000 compared with 290/1000 for white people).[34]

These differences are highlighted in the covid-19 cases among key workers. Although black and Asian staff represent only 21% of the NHS workforce, early analysis showed that they accounted for 63% of deaths among health and social care workers.[35]

In the US, the case and admission rates are at least 2.5 and 4.5 times higher, respectively, among black, Hispanic, and Native American populations compared with white populations.[36] The American Public Media Research Laboratory has estimated a death rate of 61.6/100 000 population for African Americans, 1.7 times greater than that of indigenous Americans and 2.3 times of white and Asian American.[37]

Some of the approaches initiated, but they need to be expanded and embedded further to strengthen access to healthcare among marginalised populations include:

- Prioritize access to free or affordable testing, medications and needed procedures, such as ventilation, for those at higher risk, including members of racial and ethnic groups who have been disproportionately affected by COVID-19.[38]
- Make wider use of mobile clinics to reach out and deliver services directly to marginalised and vulnerable communities who may be cut off from access to health services.[39]
- Distribute essential medical and preventive information in minority languages through digital and printing means.[40]
- Involve communities and their representatives and associations, in designing and implementing health programmes and projects concerning racial and ethnic groups.[41]

The rapid adoption of technology in health and care services during the COVID-19 pandemic has enhanced its potential in providing effective and efficient health care, in particular to those in underserved communities. Telemedicine abortion is one such area that has the potential for example to enable women and girls, particularly those with marginalised intersectional identities, to self-manage abortion in their homes, through online consultation with health care providers and with medicines delivered to, or collected by, the patient.[42] Telemedicine improves accessibility to health care across the board by removing many barriers, including transport, employment or care responsibilities, disability, and costs related to attending a clinic. For women and girls accessing medical abortion, telemedicine also removes barriers associated with concerns of privacy, and may also improve access due to an overall reduction in waiting time to receive treatment. Research has shown that telemedicine abortion services are particularly favoured among those for whom in-clinic visits are logistically or emotionally challenging.[43]

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