WHO’s initial written submission to inform the thematic discussion 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

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1. WHO Approach to the Right to Health and Related Determinants of Health
2. WHO’s mission to promote health, keep the world safe, and serve the vulnerable is based on Sustainable Development Goal (SDG) 3 and the associated Triple Billion Goals in WHO’s 13th  General Programme of Work, 2019 – 2025 (GPW13).[[1]](#footnote-2) GPW13 stresses the importance of the impactful integration of gender, equity and human rights as critical for progress on the 13 SDG 3 targets, SDG 5 on Gender Equality and Women’s Empowerment and achieving the central pledge of the 2030 Agenda: Leave No One Behind (LNOB), a commitment which is grounded in the normative framework of international human rights and operationally directed to reaching the furthest behind first.[[2]](#footnote-3) In addition, WHO contributes to SDG, as well as other health-related goals and targets, anchored by a rigorous approach to public health evidence, international human rights and its constitutional mandate to advance the right to health, without discrimination.[[3]](#footnote-4)
3. The WHO Constitution (1948) affirms that “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”. Other provisions of the interpretive preamble define the right to health as, ‘not merely the absence of disease or infirmity, but a complete state of physical and mental health and well-being’ and provide additional principles on the right to health, which informed the development of General Comment 14 on Article 12 of the International Covenant on Economic, Social and Cultural Rights, the four essential elements of availability, accessibility, acceptability and quality, associated criteria, and additional guidance on the need to address health inequities among women, girls, marginalized groups and populations in vulnerable contexts, including humanitarian settings.[[4]](#footnote-5)
4. Beyond the UNGA 2015 resolution on the 2030 Agenda for Sustainable Development, WHO is also guided on the right to health and related human rights by relevant UN General Assembly and World Health Assembly resolutions and Political Declarations on, *inter alia*, Universal Health Coverage[[5]](#footnote-6) and the Astana Declaration on Primary Health Care,[[6]](#footnote-7) which foreground progress in these core WHO technical areas in providing guidance to governments at all levels to meet their responsibility in guaranteeing the right to health to health for all. The declarations commit to ensuring optimal health laws, policies and services through meaningful participation of civil society organizations and communities, particularly underserved and marginalized communities.
5. Relevant World Health Assembly (WHA) resolutions also guide the WHO Secretariat’s normative role in integrating public health evidence, the right to health, gender equality, health equity, and underlying rights to adequate, nutritious food, clean water and sanitation, occupational health and safety for the health workforce and the right to accessible health services, information and programmes on a nondiscriminatory basis. WHA 60.25: Strategy for integrating gender analysis and actions into the work of WHO;[[7]](#footnote-8) WHA 74.16: Action on the Social Determinants of Health to address economic, social and environmental drivers of health inequities and gender inequality, building on the findings and recommendations of the Commission on Social Determinants of Heath;[[8]](#footnote-9) WHA 69/11: Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control.[[9]](#footnote-10)
6. WHO works across the three levels of the organization (HQ, Regional and Country Offices)and with other UN entities, civil society organizations and technical experts to ensure a joined-up, consistent and coordinated approach to incorporate the cross-cutting SDG principles of a human rights-based approach, gender equality and Leave No One Behind commitment, including operational guidance to address structural drivers of inequality and disadvantage that result in health and social inequality. This includes contributing to interagency platforms to develop SDG normative guidance, that incorporate the Human Rights-Based Approach to Development Cooperation, Gender Equality and Women’s Empowerment and LNOB analyses in UN Common Country Analyses and the Development Cooperation Frameworks negotiated with Member States, the foundation of the 2030 Agenda.[[10]](#footnote-11)
7. WHO explicitly adopts a multisectoral “whole of society, whole of government” Health in All Policies approach to address the social, environmental, economic and commercial determinants of health, including systemic racism and other structural and institutional drivers of health inequities, through the development of normative products, including guidelines, other normative and standard-setting products, and capacity-building trainings on technical products, addressing Structural Racial and Ethnicity-based Discrimination, delivered to UN Country Teams to inform Development Cooperation Frameworks and bilateral WHO Country Strategic Support Plans.[[11]](#footnote-12)
   1. Right to Health Standards in International Law and WHO Conventions & Regulations
8. In its guidelines and other normative and standard-setting technical products and policy briefs, WHO incorporates a rigorous approach to public health research and evidence reviews, informed by the right to health and health-related rights standards and principles, including sexual and reproductive health rights, based on the scope and content of the provisions and associated General Comments issued by UN human rights mechanisms. These include the Committee on Economic, Social and Cultural rights (Article 12),[[12]](#footnote-13) including its General Comment on Non-Discrimination in the enjoyment of the right to health and other social and economic rights,[[13]](#footnote-14) and other international human rights treaties, including, inter alia, the Convention on the Elimination of All Forms of Discrimination against Women (Article 7), the Convention on the Rights of the Child (Article 13), International Convention on Eliminating All Forms of Racial Discrimination and the Committee on Eliminating All Forms of Discrimination Against Women (CEDAW), including in specific technical areas such as CEDAW General Recommendation 33 on gender-based violence.[[14]](#footnote-15) In addition, WHO’s engagement with Human Rights Council Special Procedures thematic mandate-holders provides additional opportunities to both inform WHO Normative guidance and standard-setting technical products and advise Special Rapporteurs on specific technical areas of work relevant to their Calls for Input and reports to the HRC and UNGA.
9. Human Rights Standards in WHO Legal Instruments and Normative Guidance
   1. International Health Regulations and Framework Convention on Tobacco Control
10. The International Health Regulations, Article 3.1, requires that the implementation of public health measures pursuant to IHR provisions comply with international human rights and fundamental freedoms, and (Articles 44-45) on the least restrictive public health measures necessary in compliance with international human rights standards related to international travel and mobility.[[15]](#footnote-16)
11. The WHO Framework Convention on Tobacco Control (FCTC) is an international treaty that reaffirms the right of all people to the highest standard of health, recalling the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, as well as the preamble to the Constitution of the World Health Organization, supra.[[16]](#footnote-17)
12. The Preamble of the WHO FCTC states that Parties to the Convention are ‘Deeply concerned about the high levels of smoking and other forms of tobacco consumption by indigenous peoples’.[[17]](#footnote-18) The prevalence of tobacco use amongst indigenous peoples is higher in some places than amongst the general population, often with disproportionately detrimental impacts on their health, economic and cultural well-being.[[18]](#footnote-19)
13. Target 3.a of the Sustainable Development Goals (SDGs) specifically calls for strengthening implementation of the WHO FCTC, as the treaty is considered an accelerator for sustainable development overall.[[19]](#footnote-20)
14. Tobacco use is one of the biggest public health threats and causes more than 8 million deaths per year, with over 80% of the world’s 1.3 billion tobacco users live in low-and middle-income countries.[[20]](#footnote-21) Marginalized and vulnerable populations- including, people in low-and middle-income communities, women, children, racial and ethnic minorities, LGBTIQ+ persons, and indigenous peoples, bear a disproportionate burden of tobacco-related harm.[[21]](#footnote-22)
    1. Sexual and Reproductive Health Rights
15. Multiple and intersecting forms of discrimination against women’s sexual and reproductive rights, including racial and ethnic discrimination, as well as structural discrimination faced by Indigenous peoples has been documented by researchers, suggesting that the struggle for reproductive justice is not only a fight for gender equality but also an anti-racist agenda in WHO’s normative guidance on sexual and reproductive health issues.
16. Historically, women have been disproportionately subjected to forced, coerced and otherwise involuntary sterilization, especially in connection with coercive population policies. Indigenous peoples and ethnic minority women are particularly vulnerable to acts of violence, including coercive sterilization. Some countries have in their population policies specifically targeted indigenous and ethnic minority women from the most deprived sectors of society for sterilization without their consent. Often indigenous and ethnic minority women and girls, in all their diversity, are not provided with a full choice of contraceptive methods. Moreover, information relating to their sexual and reproductive rights is often not made available in accessible formats.[[22]](#footnote-23)
17. Recent evidence reviews conducted by WHO on access to abortion care suggests similar multiple, intersecting forms of discrimination experienced by women seeking health care. The WHO Abortion care guideline states that:

…abortion should be fully decriminalized. Regulatory, policy and programmatic barriers – as well as barriers in practice – that hinder access to, and timely provision of quality abortion care should be removed. These include grounds-based approaches, gestational age limits, mandatory waiting periods, third-party authorization requirements and provider restrictions. States should also protect access to and continuity of abortion care against barriers created by conscientious objection.[[23]](#footnote-24)

1. Studies suggest that some of these barriers disproportionately impact certain groups. For example, Hispanic and African descent minors may be disproportionately impacted by mandatory waiting periods, and where mandatory waiting periods have an effect on birth rates, this effect disproportionately impacts people of African descent, especially when requiring two visits. Increased birth rates associated with parental consent laws are disproportionately experienced by teens of African descent. Minors requesting abortion by judicial bypass compared with parental consent vary significantly, but minors obtaining abortion under judicial bypass as compared with parental consent are significantly more likely to be racial or ethnic minorities and of low socioeconomic status. Additional information on the evidence and incorporation of the multiple human rights issues engaged in access to abortion services are available in the law and policy Evidence-to-Decision tables in the background materials to the Abortion Care Guideline and Annex A: Key Human Rights Standards on Abortion.[[24]](#footnote-25),[[25]](#footnote-26)
   1. Migrant Health Programme

12. Racial and ethnic minorities may be particularly vulnerable to being forcibly displaced within their country or forced to migrate, both of which make them vulnerable to becoming stateless. Equality and non-discrimination in the right to health includes prohibiting discrimination based on health, racial or ethnic identity or legal status. However, discriminatory policies based on racial or migrant status often result in exclusion from health care services and health systems more broadly.[[26]](#footnote-27)

1. Migrant or refugee status is often as a barrier to accessing healthcare, with migrant groups (especially those in transit/without formal status) unable to access health care, or only able to access emergency healthcare. The COVID-19 pandemic exacerbated the already dire working, living and transiting conditions, conditions that are primarily rooted in structural, political, social, and economic determinants, contributing to a negative effect on migrant physical and emotional well-being.[[27]](#footnote-28)
2. Direct or indirect forms of discrimination of migrant populations influence migrants’ ability to enjoy the highest attainable standard of health and well-being. With global reports of increased discrimination of people on the move during COVID-19, the WHO’s AparTogether survey (2020) also demonstrated that, on average participants perceived the same degree, or deterioration, in discrimination during the pandemic.[[28]](#footnote-29)
3. Racism and xenophobia are important components in the discrimination against migrants, refugees and ethnic minorities. National policies and programmes need to be planned and implemented with due regard for the human rights of persons belonging to ethnic and racial minorities using an intersectoral approach to addressing marginalized communities, as emphasized in the research and findings of the recently released Global Report on Migration and Health in order to reduce health inequalities in the light of international human rights obligations, for which governments are the prime duty-bearer.[[29]](#footnote-30)
   1. Racial and Ethnic Minority health in the context of Persons with disabilities
4. The United Nations Disability Inclusion Strategy (UNDIS) provides a platform for the transformation of the UN system to ensure that persons with disabilities are included through all aspects of the work of the UN[[30]](#footnote-31). Given the proportion of the world’s population that experience disability (15%), it will be important to integrate the UNDIS progress and consider the issues experienced by persons with disabilities both as a distinctive cultural group, and in relation to intersectionality (persons with disabilities among other ethnic/cultural/linguistic minorities) in the forthcoming report by Special Rapporteur on Minorities.
5. Persons with disabilities include those with long-term impairments which in interaction with barriers, may hinder their full and effective participation in society on an equal basis as others[[31]](#footnote-32).

21. Persons with disabilities who belong to national racial, ethnic, religious and linguistic minorities can face multiple and compounding discrimination. That is, they can be neglected by mainstream disability rights movement, as well as the advocacy movements of their national, ethnic, religious or linguistic group. For example, Indigenous persons with disabilities can face multiple discrimination, and often lack awareness and knowledge about disability, including lacking the knowledge about accessing social protection mechanisms that could benefit them.[[32]](#footnote-33)

* 1. WHO Regional Office of the Americas (AMRO/Pan-American Health Organization)

1. The WHO regional office for the Americas (PAHO) has prioritized ethnicity as a cross-cutting theme for PAHO, in addition to gender, equity and human rights. This is reflected in different guidelines, projects and initiatives at all levels of PAHO. In September 2017, at the 29th Pan American Sanitary Conference (69th Session of the Regional Committee of WHO for the Americas), PAHO Member States unanimously approved the Policy on Ethnicity and Health.**[[33]](#footnote-34)** With this policy, Member States agreed to guarantee an intercultural approach to health and the equitable treatment of indigenous peoples, Afro-descendants, Roma populations, and members of other ethnic groups. Representatives from indigenous peoples, Afro-descendants, and Roma populations, ministries of health, and multilateral organizations participated in the development of this policy and committed to supporting its implementation, the first formal policy to adopt an intercultural approach to address health inequities.
2. As a follow up to this important achievement for the PAHO region, in 2019, a Strategy and Plan of Action on Ethnicity and Health was approved unanimously by all Member States to prioritize actions ensuring that all communities have access, without discrimination, to comprehensive, appropriate, timely, and quality health services. [[34]](#footnote-35)
3. Implementation of rights-based, equity-oriented technical products & trainings
   1. Gender, Equity and Rights Capacity-Building and Trainings
4. WHO co-organized with UNESCO a high-level and cross-UN Frontier Dialogue on tackling structural racial and ethnicity-based discrimination in building forward better from COVID-19. This was done with a dedicated interagency steering group under the umbrella of the UNSDG Task1 Team on Leaving No One Behind and Human Rights. WHO commissioned Harvard university to co-author a final outcome document as a resource for all UNCTs. [[35]](#footnote-36)
5. In 2022, WHO has convened three Community of Practices for UNCTs on areas such as criminal justice, indigenous languages, and country work on people of African descent, alongside dedicated sessions for reporting back progress from UNCTs involved in the October 2021 training. In Q4 2022 it is also convening a Sensitization Session on Training Approaches for Tackling Racial Discrimination and Strengthening the Protection of Minorities to increase the capacity of UN staff in addressing racial discrimination and protecting minorities.
6. WHO produced a research brief on “Strengthening primary health care to tackle racial discrimination, promote intercultural services and reduce health inequities” (publication forthcoming). WHO outlines 14 strategic and operational levers for policy-makers to strengthen PHC. Within each lever, the brief presents multiple potential entry points for targeted actions to address racial discrimination in health, foster intercultural care, and reduce health inequities experienced by indigenous peoples as well as people of African descent, Roma and other ethnic and linguistic minorities.
   1. Pan-American Health Organization/Americas Regional Office
7. Other measures adopted in the region of the Americas, include promotion of differentiated approaches in health and tackling discrimination, such as:

* [Health Plan for Afro-descendant youth in the LAC Region](https://www.paho.org/en/documents/health-plan-afro-descendant-youth-latin-america-and-caribbean). PAHO provided technical support to Afro-descendant youth in the region in the development of a health plan with the priorities identified by youth.[[36]](#footnote-37)
* In the context of the COVID-19 pandemic, it is important to highlight the [Considerations on Indigenous Peoples, Afro-descendants and other ethnic groups during the COVID-19 pandemic](https://iris.paho.org/handle/10665.2/52251). This technical report includes some of the concerns expressed by afro-descendant people in the region, through PAHO country offices. [[37]](#footnote-38)
* At the sub-regional level, PAHO is working at the South and Central American levels to address the health of afro-descendant populations. In this regard, a health plan addressing the health of Afro-descendant population in the South American region was developed with ORAS CONHU (“Organismo Andino de Salud”) and is being implemented in 2022. In Central America, a project has been developed to address the health situation of afro-descendant and indigenous peoples as well as the policies in place to address them, with emphasis on access to health and health outcomes in women and girls.
* In 2022, PAHO produced a methodology on knowledge dialogues aimed at improving access to health services and building intercultural health, with emphasis on solving previously raised problems and their causes, promoting mutual understanding and the creation of solid links through the participation and empowerment of indigenous peoples, Roma populations, and Afro-descendants.[[38]](#footnote-39)
  1. WHO Regional Office in Europe (EURO)

1. The WHO regional office for EURO produced a quarterly Roma Inclusion newsletter to share information and resources relevant for Roma inclusion, and thereby support current efforts to strengthen the different components of national Roma integration strategies or policy measures in the EU and action plans for the Decade of Roma Inclusion.[[39]](#footnote-40)
2. WHO/EURO has also produced a Toolkit on social participation which includes methods for ensuring the social participation of Roma populations in the design, implementation, monitoring and evaluation of policies and programmes to improve their health, available in English and [Română.](https://www.euro.who.int/__data/assets/pdf_file/0018/351360/Toolkit-social-participation_en_ro_FINAL_final.pdf)[[40]](#footnote-41)
3. WHO/EURO has also produced Roma case studies on different aspects of Roma health care at the national and regional level, including:

* Roma health mediation in Romania to improve the health status of Roma and their access to health care services - Case studies series No. 1;[[41]](#footnote-42) Review and reorientation of the health programme for health protection of mothers and children in the former Yugoslav Republic of Macedonia - Case study series No. 2;[[42]](#footnote-43)  Review and reorientation of the Serbian national programme for early detection of cervical cancer towards greater health equity - Case study series No. 3;[[43]](#footnote-44) Brief on how health systems can address health inequities linked to migration and ethnicity produced through the WHO/European Commission equity project.[[44]](#footnote-45)
  1. FCTC Implementation: Tobacco and Racial and ethnic minorities and Indigenous peoples

1. The WHO FCTC recognizes the vulnerability and promotes tailored and inclusive measures for the protection of specific groups in the face of the tobacco threat, namely women and young girls, children and adolescents, indigenous individuals and communities, and economically vulnerable households, including tobacco growers and farmers.
2. Tobacco companies misappropriate indigenous traditions and symbols in marketing, target flavoured products to marginalized and vulnerable populations, and promote electronic nicotine delivery-systems and heated tobacco products among indigenous peoples.[[45]](#footnote-46) The Guiding Principles of the WHO FCTC highlight the need for Parties to take measures to promote the participation of indigenous individuals and communities in the development, implementation and evaluation of tobacco control programmes that are socially and culturally appropriate.[[46]](#footnote-47) This principle cuts across all WHO FCTC provisions, supporting Parties to develop, strengthen and adjust tobacco control measures to their specific domestic contexts, for example:

* **Article 6: Price and tax measures to reduce the demand for tobacco.** Evidence shows that price and tax measures are an effective and important means of reducing tobacco consumption. However, in some cases, research has shown that indigenous peoples developed innovative tobacco-related practices to continue to smoke, despite the rising costs of tobacco.[[47]](#footnote-48) In other instances, indigenous tobacco use may be less affected by tax measures due to tax exemptions.[[48]](#footnote-49) [[49]](#footnote-50) These challenges may suggest in some settings the need to strengthen cessation and uptake prevention programmes for indigenous peoples.[[50]](#footnote-51)
* **Article 9 and 10: Regulation of the contents of tobacco products and tobacco product disclosures:** The Partial Guidelines for implementation of Articles 9 and 10 of the WHO FCTC state that masking tobacco smoke harshness with flavours contributes to promoting and sustaining tobacco use. The Parties are recommended to prohibit and restrict ingredients that increase the palatability of tobacco products.[[51]](#footnote-52) There is documented evidence of the tobacco industry’s efforts to promote menthol cigarettes at the point of sale, and in at least one country, studies have observed more outdoor and retail menthol advertisements in neighbourhoods along racial lines.[[52]](#footnote-53) As a result of the foregoing, some jurisdictions have banned menthol and other flavoured tobacco products: European Union (2020), Brazil (2012), Canada (2017), Ethiopia (2015), Moldova (2015).[[53]](#footnote-54)
* **Article 13: Tobacco advertising, promotion and sponsorship:** Article 13 of the WHO FCTC obliges Parties to undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship, or restrictions. Tobacco industry marketing practices have included misappropriating and misrepresenting indigenous traditions, symbols and culture to hook marginalized and vulnerable populations on deadly products. This practice should be prohibited as part of a comprehensive ban under Article 13 of the WHO FCTC. Further, implementation of plain or standardized packaging of tobacco products will assist in the disassociation of indigenous traditions, symbols, and cultural imagery. As a further example, a tobacco product manufacturer during the Black Lives Matter movement, announced a donation of $5 million “to address systemic racism faced by Black Americans and advance social and economic equity”.[[54]](#footnote-55) The WHO FCTC defines tobacco sponsorship as “any form of contribution to any event, activity or individual with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly”. Accordingly, Parties to the WHO FCTC should prohibit such activities in accordance with Article 13 of the WHO FCTC.
  + 1. FCTC Policy Recommendations

1. Policy recommendations from the FCTC including advocating that countries which have not ratified the WHO FCTC should take the necessary steps for ratification;

* Countries should implement and enforce a comprehensive ban on tobacco advertising, promotion and sponsorship;[[55]](#footnote-56)
* Countries should implement provisions of the WHO FCTC, and tobacco control measures more generally, in ways that take account of health disparities between racial groups;
* In relation to indigenous peoples: (i) Collect indigenous-specific tobacco use data to build momentum for reducing the high prevalence of commercial tobacco use among indigenous peoples; and (i) Recommend countries take measures to promote the participation of indigenous individuals and communities in the development, implementation and evaluation of tobacco control programmes that are socially and culturally appropriate to their needs and perspectives.

1. WHO will continue supporting efforts and initiatives, in coordination with Member States, UN system actors, private sector, civil society, and philanthropic organizations to address structural drivers of health inequities among racial and ethnic minorities and Indigenous peoples to accelerate progress on WHO’s SDG 3 targets and related health and human rights SDGs to achieve health for all.

1. WHO. Thirteenth General Programme of Work 2019-2023. Available at <https://www.who.int/about/what-we-do/thirteenth-general-programme-of-work-2019---2023> [↑](#footnote-ref-2)
2. United Nations General Assembly. Transforming Our World: The 2030 Agenda for Sustainable Development. UN Doc A/Res/70/1. New York, 21 October 2015, paras 10, 18 – 20. ([https://www.un.org/ga/A/RES/70/1](https://www.un.org/ga/A/RES/70/1&Lang=E)). [↑](#footnote-ref-3)
3. WHO Constitution. 1946. Entry into force 7 April 1948 ([https://www.who.int/governance/constitution](https://www.who.int/about/governance/constitution)). [↑](#footnote-ref-4)
4. Committee on Economic, Social and Cultural Rights (CESR). General Comment No. 14: The Right to Health, UN Doc. E/C.12/2000/4. OHCHR, 2000, Geneva ([https://tbinternet.ohchr.org/\_layouts/15/treatybodyexternal](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en); CESCR. General Comment 22: Article 14 on Sexual and Reproductive Health Rights. OHCHR, 1 May 2016, Geneva ([https://www.ohchr.org/en/documents/general-comment-no-22-2016](https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no-22-2016-right-sexual-and)). [↑](#footnote-ref-5)
5. UNGA. Political Declaration of the High-Level Meeting on Universal Health Coverage. UNGA Res 74/2, 18 October 2019, New York ([https://documents-dds-ny.un.org/doc/UNDOC/GEN/N19](https://documents-dds-ny.un.org/doc/UNDOC/GEN/N19/311/84/PDF/N1931184.pdf?OpenElement)). [↑](#footnote-ref-6)
6. WHO. Declaration of Astana. WHO, October 2018, Geneva (<https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>). [↑](#footnote-ref-7)
7. World Health Assembly (WHA). Res 60/19: Strategy on integrating gender analysis and actions into the work of WHO. WHO, May 2007, Geneva (<https://apps.who.int/gb/ebwha/pdf_files/WHA60/A60_19-en.pdf>). [↑](#footnote-ref-8)
8. WHA. Res.74/16: Social Determinants of Health. WHO, May 2021 ([WHA74/A74\_R16-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R16-en.pdf)). [↑](#footnote-ref-9)
9. WHA. Res. 69/11 (<https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_11-en.pdf>). [↑](#footnote-ref-10)
10. UNSDG. Operationalizing Leave No One Behind: Good Practice Note for UN Country Teams. March 2022 ([https://unsdg.un.org/leaving-no-one-behind-unsdg-operational-guide-un-country-teams](https://unsdg.un.org/resources/leaving-no-one-behind-unsdg-operational-guide-un-country-teams).l)). [↑](#footnote-ref-11)
11. WHO. Frontier dialogue consultations on addressing structural racial and ethnicity-based discrimination. WHO, 2021, Geneva ([https://www.who.intfrontier-dialogue-consultations](https://www.who.int/publications/m/item/frontier-dialogue-consultations-on-addressing-structural-racial-and-ethnicity-based-discrimination)). [↑](#footnote-ref-12)
12. CESCR, General Comment No. 14: the right to health, *supra* FN 4; CESCR. General Comment No. 22: the right to sexual and reproductive health. UN Doc C.12/GC/22. OHCHR, 2016, Geneva ([https://tbinternet.ohchr.org/\_layouts/15/treatybodyexternal/Download.aspx](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f22&Lang=en)). [↑](#footnote-ref-13)
13. CESCR General Comment 14, 20 and 22, *supra* FN 4. [↑](#footnote-ref-14)
14. Committee on the Elimination of All forms of Discrimination Against Women (CEDAW). General Recommendation 35 on Gender-Based Violence. OHCHR, 2017, Geneva ([https://www.ohchr.org/en/general-recommendation-no-35-2017-gender-based](https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-recommendation-no-35-2017-gender-based)). [↑](#footnote-ref-15)
15. WHO. International Health Regulations, 3rd ed. WHO, 2015, Geneva ( [↑](#footnote-ref-16)
16. WHO. Framework Convention on Tobacco Control. <https://fctc.who.int/publications/i/item/9241591013> [↑](#footnote-ref-17)
17. *ibid,* Preamble  [↑](#footnote-ref-18)
18. New South Wales, Australia, the smoking rate in 2018-19 among Aboriginal people was 26.4% i.e. more than double of the rate for non-Aboriginal people, which was 10.1% (<https://www.health.nsw.gov.au/tobacco/Pages/aboriginal-communities-smoking.aspx>); New Zealand, the smoking rate in 2019-20 amongst Māori adults was 31.4%, compared to 13.4% amongst non- Māori adults ([https://www.health.govt.nz](https://www.health.govt.nz2025#:~:text=Progress%20to%20Smokefree%202025&text=The%20current%20smoking%20rate%20of,40.2%20percent%20in%202011%2F12)); Canada, smoking rates are 2.5 times higher among Inuit, and higher among First Nations people overall (<https://www.canada.ca/en/public-health/services/publications/science-research-data/inequalities-smoking-infographic.html>); United States, African American people usually start smoking at an older age than white people but are more likely to die from smoking-related disease (<https://www.cdc.gov/tobacco/health-equity/african-american/health-burden.html>). [↑](#footnote-ref-19)
19. Convention Secretariat and the United Nations Development Programme, ‘*WHO Framework Convention on Tobacco Control: an accelerator for sustainable development*’ (2017), https://fctc.who.int/publications/m/item/the-who-framework-convention-on-tobacco-control-an-accelerator-for-sustainable-development [↑](#footnote-ref-20)
20. WHO, Tobacco: Overview, <https://www.who.int/news-room/fact-sheets/detail/tobacco> [↑](#footnote-ref-21)
21. See Kristen Emory, Francisco Bucting, et al, *‘Lesbian, Gay, Bisexual, and Transgender (LGBT) view it differently than non-LGBT: exposure to tobacco-related couponing, e-cigarette advertisements, and anti-tobacco messages on social and traditional media’,* Nicotine Tob Res. (2019)*,* Vol. [21] 4, 513-522, doi: 10.1093/ntr/nty049; Shervin Assari, Mohsen Bazargan, ‘*Education Level and Cigarette Smoking: Diminished Returns of Lesbian, Gay and Bisexual Individuals*’, Behav Sci (Basel) (2019), Vol. 9(10), 103,. [↑](#footnote-ref-22)
22. WHO. Eliminating forced, coercive and otherwise involuntary sterilization: an interagency statement. OHCHR, UN Women/UNAIDS/UNDP/UNFPA/UNICEF/WHO, 2014. At: <https://apps.who.int/iris/handle/10665/112848>. [↑](#footnote-ref-23)
23. WHO. Abortion Care Guideline. World Health Organization, 8 March 2022, Geneva. (<https://cdn.who.int/reproductive-health/abortion/supplementary-material-1.pdf>). [↑](#footnote-ref-24)
24. WHO. Abortion Care Guideline, Supplementary Material 1: Evidence to Decision Frameworks for Law and Policy Recommendations. World Health Organization, 8 March 2022, Geneva. At: [https://cdn.who.int/reproductive-health/abortion/supplementary-materials](https://cdn.who.int/media/docs/default-source/reproductive-health/abortion/supplementary-material-1.pdf?sfvrsn=5bc94f18_7). [↑](#footnote-ref-25)
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