

Committee on the Elimination of Racial Discrimination

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

Racial discrimination and the right to health

The Working Group of Experts on People of African People answers selected questions as follows:

Background

1. The Committee on the Elimination of Racial Discrimination decided at its 103rd session (19-29 April 2021) to prepare a 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, in light of experience obtained in the review of State reports and individual communications on this right. CERD aims at providing guidance on the legal obligations of States parties under Article 5 (e) (iv) of the Convention and defining the measures they should implement to ensure full compliance with this provision.

2. Article 5 (e)(iv) reads as follows:

“In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:

(...)

(e) Economic, social and cultural rights, in particular:

(...)

(iv) The right to public health, medical care, social security and social services;”

3. To start this process, the Committee will convene a day of general discussion at its 107th session, on 23 August 2022. The Committee is inviting State parties, national human rights institutions, civil society and grassroots organisations, academia, other relevant stakeholders (i.e., health-related entities or laboratories) and international organisations to provide relevant information to be taken into consideration by the Committee during the preparation of the first draft that will be submitted to States and other stakeholders for comments. Interested parties are invited to participate in this consultation process by providing information on any of the questions raised below, or by making submissions on any other aspects of article 5 (e)(iv) that they deem relevant.

Questions

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

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

The understanding of racial discrimination as a social determinant of health explains how racism shapes the conditions in which people grow, live, work and age that in turn affect their physical, mental and social well-being.

The formulation falls short of expressing the structural impact of racial discrimination and the disproportionate effect on its victims.

The expression - 'racial discrimination is a structural and social determinant of health, and driver of health or ethnic health inequities'¹ is more comprehensive.

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?

Health equity relates to fairness and impartiality in health. It addresses key aspects such as exposure, susceptibility to health risks, and economic accessibility.² 'Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households...'³

The key systemic risks for persons subjected to racial discrimination partly derive from unaffordability of health services. This is addressed by the concept of health equity, which obliges the state to subsidise and universalise the right to public health, medical care, social security and social services (Article 5 (e) (iv) ICERD).

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

Structural discrimination excludes marginalised persons and groups from access to even available health care and it undermines the quality and acceptability of health possibilities. The Working Group has been informed of lack of knowledge by medical practitioners on how symptoms manifest on black bodies. This partly leads to incorrect diagnoses and lack of proper health care for people of African descent. This trend is sustained by structural discrimination that constrains access of people of African descent to the medical profession and exclusive use of white models in medicine. In such cases, people treated by the same doctor, with the same expertise, get different outcomes.

Research shows that the 'softer' aspects of accessibility are as critical - whether or not the health service provider speaks the same cultural language, understands the context, has or not

¹ For example, James Stanley et al , 'The impact of racism on the future health of adults: protocol for a prospective cohort study', (2019) BMC Public Health 19 (346) 1 -10 [The impact of racism on the future health of adults: protocol for a prospective cohort study \(biomedcentral.com\)](https://doi.org/10.1186/s12916-019-1400-4).

² See COVID 19, systemic racism and global protests, Report of the Working Group of Experts on People of African Descent, A/HRC/45/44, 21 August 2020.

³ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), 11 August 2000, E/C.12/2000/4, para 12 (b).

preconceived ideas about the ailments and the quality of care that people of African descent should receive. This spans from thinking people of African descent have a higher pain threshold to them having the right to an explanation about options and treatment to even being offered more than the basics as offered to people of other races/ethnicities.

In most countries, it is expected that all adults would have health insurance, often obtained by way of contributions to schemes. Subscription to health insurance requires the requisite documented residence status, and a source of income. An unknown number of people of African descent are stranded in Western countries as asylum seekers in suspense (denied but not deported), and as undocumented migrants. The denial of regularisation of residence status leads to other vulnerabilities such as unemployment. Even in countries where health care is free, documentation is required.

States without racially disaggregated data are unable to determine the advanced populations they classify as minorities. This limits the efficacy of budgeting and support for medical research, training and health care that relates to conditions that predominantly affect those groups. The Working Group found a gap in addressing diseases like sickle cell anaemia, and fibroids among health systems of wealthy nations.

States are under an obligation to ensure equality in health care and this includes affirmative action to identify, study and develop capacity to address peculiar health needs of minority populations. 'Reducing structural health inequities required challenging systemic racism and the unequal distribution of power within society'.⁴

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 the interaction of social factors and identities such as race and gender to multiply health inequities.

Intersectionality makes a strong case for making invisible populations and would be invisible concerns visible. It supports the obligation to unveil and address the vulnerabilities of all persons. This leads to holistic health programming. Iyer and Mukherjee stated that 'By giving precise insights into who is affected and how in different settings, [intersectionality] provides a scalpel for policies rather than the current hatchet. It enables policies and programmes to identify whom to focus on, whom to protect, what exactly to promote and why. It also provides a simple way to monitor and evaluate the impact of policies and programmes on different sub-groups from the most disadvantaged through the middle layers to those with particular advantages'.⁵

Regrettably, recognising intersectionalities can work for or against people of African descent, and this is a choice that the individual or family or community has to make, and in real life continue to make so that specific contexts do NOT work against them. By implication, many people of African descent have developed a sixth sense about when to speak up and when not to optimise their health care. This capacity is predicated on other foundational competencies such as cultural literacy, etc... this is a complex area and merits more and more research...

13. Traditional medicine continues to have a very important place in certain health systems and coexists in many parts of the world with modern medicine. Certain groups exposed to racial discrimination continue to use regularly traditional medicine. How is the dialogue between modern and traditional medicine established? What status do the States give to this medicine in their health system?

⁴ Annual Report of the Working Group of Experts on People of African Descent, 25 August 2021, A/76/302, para 12.

⁵ Sen G, Iyer A, Mukherjee C. A methodology to analyse the intersections of social inequalities in health. *J Human Dev Capab.* 2009; 10: 397–415, p. <https://doi.org/10.1080/19452820903048894>.

There is an identifiable hierarchy between traditional medicine and modern medicine. What is considered traditional medicine and of limited potential transforms into modern medicine of high potency and patentable quality at the hands of corporations. Traditional medicine is an individual or community remedy but modern medicine is a structural solution.

On the other hand, we see that traditional medicine is increasingly being appropriated, and 'westernised' and sold back to communities - this is particularly true for many of the non-communicable diseases that are widespread among people of African descent such as hypertension and asthma. These traditional medicines are often housed in traditional herbs and spices that are popping up at a astonishing prices in pharmacies and the health foods sections in supermarkets. COVID-19 exposed this fact around the world as all kinds of teas were popping up in neat packages...

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

14. Apart from health indicators already established by specialised organisations, which other indicators should States adopt to measure the impact of racial discrimination on groups protected under the Convention?

The availability, affordability and accessibility and uptake of highly specialised services for chronic non-communicable diseases that are endemic among people of African descent.

15. How do women, children, persons with disabilities and LGBTQI persons within these groups experience racial discrimination intersecting with other forms of discrimination, including age?

Limited access, unhelpful, unprofessional service, assumptions about what is good enough, etc.

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

Racial inequality excludes disadvantaged groups from access to adequate reproductive health care services while rendering them susceptible to conditions that jeopardise their health. The Working Group of Experts on People African Descent has learnt of several stereotypes that constrain the care accorded to women of African descent during and after childbirth such as 'the bodies of black women are meant for childbirth', 'black bodies perceive less pain'. This causes inadequate pain management in such cases.⁶

The significance of informed consent by marginalised persons is often underrated. The Working Group has been informed of the presumption that women of African descent within a certain age range have already had a number of children and would readily acquiesce in permanent birth control procedures, such as removal of uteruses, even when done without their prior consent. This affects their right to the autonomy to determine the number of children they can have.

Consultation with groups subject to racial discrimination

19. Is there a right to consult on health with groups protected under the Convention?

Civil society, and in particular people of African descent, should be at the core and part of the process that create international treaties, or specific health commentary or guidance. Any drafting process should ensure that all relevant and technically qualified stakeholders, including people of African descent, Indigenous Peoples and local communities, civil society, academia, and the private sector are engaged during the development and implementation of any instrument to be adopted. This should extend to any facilitative, non-punitive mechanisms developed to ensure compliance with national obligations and shared objectives under the instrument (in this case pandemic prevention treaty currently being negotiated). Civil society engagement, particularly the provision of technical expertise at the invitation of Member States or Parties, has proven highly beneficial in compliance mechanisms adopted in multilateral fora addressing wildlife, trade, and crime. We recommend that

⁶ See also, Nevert Badreldin et al, Racial Disparities in Postpartum Pain Management (2019) *Obstetrics and Gynaecology* 134 (6) 1147 – 1153; Kelly M Hoffman et al, Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites, (2016) *Psychological and Cognitive Sciences* 113 (16) 4296 – 4301.

at the very least, provisions should be made within the instrument that allows for further development and refinement of compliance assistance mechanisms.

20. How should States determine the groups to be consulted?

The test should be persons who may directly or indirectly be impacted by decisions or actions of states and other actors that the states ought to have them in contemplation at the time of making those decisions or taking those actions.

21. Should States ensure the participation of groups exposed to racial discrimination in health-related processes with non-state actors and health-related corporations?

Often classified as minorities, groups that are exposed to racial discrimination are deprioritized by the profit visions of non-state actors and health related corporations. State interventions may be required to ensure an equitable approach that may be an exception. The participation of such groups would validate the role of the protection role of the state and the rights of the specific groups.

Lessons learned during the COVID-19 pandemic

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.

As public health officials design measures to prevent or mitigate the spread of COVID-19, it is imperative that we also focus on those who are living on the margins and understand the intersecting hazards and compounding forms of discrimination which create levels of vulnerability. Public officials will need to apply a somewhat differentiated approach to urban and rural areas but a commonality across the board is the importance of transparent and disaggregated data. The context of a community and its location has to be understood well, and information shared rapidly in a coordinated manner. All of this has to be done in a simultaneous manner as authorities invest in the public health system for emergencies with a view to the medium and long-term horizon.

Officials can also learn from organizations like Last Mile Health to prevent, detect and respond by rapidly expanding community health workers in the fight against COVID-19. Furthermore, it is imperative that community health workers have the protective equipment and are provided a good standard of pay to work on the frontlines in safety and dignity. We must not only focus on where the virus currently resides but take preventive action against an outbreak in communities where the virus has not yet spread. In doing so we need to think about the context, culture, and social relations within these communities, and involve them in the design of such public health solutions. Moreover, the response also has to be integrated and not just limited to one sector. It has to be combined with relief packages, and other forms of integrated assistance to those most dispossessed and excluded. This is the human rights-based approach to public health.

If we are to protect the world from future infectious diseases of zoonotic origin, much more attention needs to be given to reducing the risk of initial emergence or spillover of viruses from wildlife. The increasing frequency and extent of human and domestic animal contact with wildlife due to land-use change, live wildlife markets and trade, and weak livestock biosecurity have increased novel pathogen evolution, spillover, and spillback opportunities. Spillover events combined with ever-increasing global travel, trade, and interconnectedness mean that future consequential spillover events will occur more often and spread faster if we do not immediately reduce and ultimately eliminate the primary drivers.

As part of a precautionary approach, there should be the prohibition of such actions and practices, particularly the commercial trade in live birds and mammals for human consumption and the fragmentation of highly intact forest ecosystems. Beyond the imminent health threat they pose, these practices facilitate zoonotic pathogen spillovers and perpetuate global inequities. By degrading and emptying forests and landscapes, they deprive people of African descent, Indigenous Peoples and local communities of their rights, food security, and cultural needs. Eliminating the urban commercial trade

in wildlife (which is not a food security issue) will directly benefit these communities, which are critically dependent on accessing food from highly intact, biodiverse, and healthy landscapes.

Written submissions must be submitted to ohchr-cerd-gr37@un.org, before 1 July 2022 in one of the official working languages of the Committee: English, French or Spanish and should be limited to a maximum of 10 pages. Additional supporting materials, such as reports, academic studies, and other background materials may be annexed to the submission.