**Racial discrimination and the right to health**

Dear Committee

We write to request the Committee to address the impact of police violence – targeted primarily against Black people, Indigenous communities, people of African descent, and other groups discriminated against on the basis of their race or ethnicity - on the right to public health as set out in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination.

Special Rapporteur Dr Mofokeng, in her thematic report on ‘Violence and its impact on the right to health’ (A/HRC/50/28) stressed that ‘Violence is a major obstacle in the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ adding that the obligation to respect the right to health ‘requires that States refrain from directly or indirectly interfering with the right to health, such as … refraining from engaging in police brutality.’

The violations of the right to health that arise from racist policing practices relate to several questions set out by the Committee and listed below this submission, **particularly questions 5, 6, 7, 8, 9, and 11,** but since this submission relates to one issue – human rights violations by law enforcement officers against people of African descent, Black people, Indigenous people, and other racial and ethnic minorities - we are addressing it as a separate aspect not specifically addressed in the list of questions, above.

There is strong evidence that excessive use of force and other forms of police violence compromises the physical and mental health of residents of targeted communities, and that these risks are clearly foreseeable and avoidable. Police violence also contributes to structural discrimination that impacts on residents’ right to health because routine, sustained and extreme police violence poses severe challenges to all aspects of community life - schools, nurseries, getting to work, getting home again, shopping, social events – and this in turn impacts on health.

We believe that the impact of police violence on the health of residents of targeted communities is so serious that the Committee should address it specifically in its upcoming General Recommendation on Article 5. Such an approach would help strengthen the work of the UN Agenda towards transformative change for racial justice and equality in law enforcement that was established in the wake of the killing of George Floyd.

**Who we are:**

We are a group of human rights defenders working to challenge and raise awareness of racist policing practices, especially racist police violence, and their impact on human rights, including the economic, social and cultural rights protected by Article 5 of the CERD Convention, especially violations of Article 5 (iv) on the right to public health. Three members of our group - Ana Paula Oliveira, Bruna da Silva and Vanessa Francisco Sales - are mothers whose children were killed by police and who now campaign for accountability and for a safer healthier world in which everyone can live with dignity and in which all children can develop healthily both physically and mentally free from state violence. They shared their testimonies on the impact of police violence on their mental health at a Human Rights Council side event held on 21st June 2022 (available here <https://vimeo.com/724563708/41baf7eb02>) and in a film *It Marked My Life A Lot* (available at <https://vimeo.com/720351861>; and with Portuguese captions at <https://vimeo.com/720832298>).

**Legal Context: The Right to Health Encompasses a Right to the Social Determinants of Health**

The Human Rights Council in its report A/HRC/32/18 on mental health and human rights, reaffirmed that ‘all human rights are universal, indivisible, interrelated, interdependent and mutually reinforcing’ that ‘all human beings are born free and equal in dignity and rights, and recognizing that these rights derive from the inherent dignity of the human person.’ The Council also expressed concern ‘at the instances of multiple, intersecting and aggravated forms of discrimination, stigma, violence and abuses that affect the enjoyment of human rights in the context of mental health’ and recalled ‘how important it is for States to adopt, implement, update, strengthen or monitor, as appropriate, laws, policies and practices to eradicate any form of discrimination, stigma, violence and abuse in this regard.’

It is indisputable that good public health is dependent on structural social determinants such as access to clean water, nutritious food, and a healthy environment in which to live and work and in which children can develop physically and mentally. As noted in question 5 of this call, a high proportion of state parties to the International Convention on the Elimination of Racial Discrimination are also parties to the International Convention on Economic Social and Cultural Rights (ICESCR). The ICESCR committee, is clear that the right to health includes a right to the social determinants of health as stated in General Comment 14 (E/C.12/2000/4). Likewise, the WHO Commission on the Social Determinants of Health stated in its 2008 report that:

the high burden of illness responsible for appalling premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age. In their turn, poor and unequal living conditions are the consequence of poor social policies and programmes, unfair economic arrangements, and bad politics. Action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies. Policies and programmes must embrace all the key sectors of society not just the health sector. …Communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being and that are protective of the natural environment are essential for health equity.

Successive Special Rapporteurs on the right to health have affirmed this view. Sixteen years ago, former Special Rapporteur Paul Hunt (2002-2008) stated in his 2006 report E/CN.4/2006/48 that:

The right to health can be understood as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. …A health system cannot simply be understood in terms of an individual’s access to doctors, medicines, safe drinking water and adequate sanitation. The social and economic conditions of the population served by a health system have a dramatic impact upon the population’s health. Known as the social determinants of health, these are the conditions, such as poverty and unemployment, which may make people ill in the first place. When the Special Rapporteur talks about the underlying determinants of health, he is not referring only to determinants such as safe drinking water and adequate sanitation, but also to the social determinants of health.

Former Special Rapporteur Anand Grove stated in his 2013 report A/68/297 that States are required to:

address marginalization arising from social, political and economic exclusion; discrimination against persons belonging to or perceived to belong to a specific community; vulnerability due to ill-health; and conflict strategies that deliberately render certain communities vulnerable. These factors, individually or in combination, may expose certain groups to multiple vulnerabilities and an increased risk of violation of their right to health. Recognizing the diverse vulnerabilities in different communities and empowering them to participate in all decision-making processes that affect their health enable States to fulfil their obligation under the right to health during conflict and also promotes a sustainable recovery from conflict.

The former UN Special Rapporteur on the right to health, Dainius Puras, (2014-2020) drew attention to the need for states to respect, protect and fulfil the right to mental as well as physical health, noting in his report A/HRC/44/48 of April 2020, ‘there is no health without mental health,’ and ‘there can be no good mental health without human rights.’ He went on to say that since the right to health encompasses the social determinants of health, ‘States must facilitate, provide and promote conditions in which mental health and well-being can be realized; that requires the provision of interventions that can protect populations from key risk factors for poor mental health.’

In the same report Professor Puras stressed that:

Solidarity, collective activism and shared commitments to responding to global challenges are a powerful means of confronting helplessness and powerlessness, building resilience (and resistance) and promoting well-being. Having their collective voices heard is a potent antidote to power asymmetries and injustice. States must take all measures to ensure that this civic space is protected and flourishes as a key indicator for compliance with the right to health.

State violence, including violent law enforcement methods, threatens civic spaces and undermines their ability to flourish.

In April 2021, in her first report, A/HRC/47/28, Dr. Mofokeng, UN Special Rapporteur on the right to health (2010-), stressed that the right to health includes ‘the psychosocial elements that promote individual and social well-being,’ noting that ‘adverse health outcomes are not only about individual predisposition or genetics, but also about oppressive systems that established racial hierarchies, which enable enduring social discrimination beyond formal colonial structures and continue to perpetuate health inequalities.’ She continued:

Eliminating discrimination in practice requires paying sufficient attention to groups of individuals that suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations. This is a necessary measure to ensure a nuanced understanding and the use of collective power to win freedom for all oppressed people. The Special Rapporteur will advocate for the application of the right to health framework to deepen understanding of the negative impact of coloniality, racism and the oppressive structures embedded in the global health architecture, which disproportionately affects Black people, indigenous communities and other groups who are racially discriminated against in the global South.

The Committee will be aware that in many parts of the world, police violence and use of excessive force in policing, including militarised approaches that were once used only in exceptional circumstances, have become normalised and that these law enforcement approaches disproportionately affect the same groups addressed by Dr Mofokeng in her report A/HRC/47/28 - Black People, indigenous communities and other groups who are racially discriminated against, especially in the global South as a result of its history of colonial oppression and exploitation. It is therefore appropriate and timely that the CERD committee addresses the impact of violent policing, especially militarised policing, which has its roots in slavery and colonialism, within the frame of the right to public health – in addition to the other human rights violations, such as violations of the right to life, to liberty, and the rights of children e.g., to development and education, that routinely ensue from excessively violent policing.

Lieblich and Shinar argue that police militarization ‘is based on a presumption of the citizen as a threat…the deployment of militarized police, marks the policed community as an enemy, and thereby excludes it from the body politic.’[[1]](#footnote-1)In a recent interview Dr Mofokeng stated that:

it is absolutely important to understand the issue of social determinants of health as non-negotiables …I don’t think people quite understand the underlying structural discrimination and systemic issues that lie at the core of why certain people do not actually realise those rights…And I would like to look at the issue of police brutality and policing methods as to why were the policing [methods] needed in the first place. Many countries have imported what people call the slavery time, or the slavery era, where slaves were having to be controlled and policed in terms of where they can go, where they can’t go, but also it was about protecting of white peoples’ property. The racism and the racist methods of policing do have their roots there. And no wonder that many of these communities…that are marginalised, Black communities, communities of people of African descent, migrant communities, refugees...feel that they are not free. <https://vimeo.com/manage/videos/718402073>

**The Impact of Police Violence on the Right to Health**

As High Commissioner Bachelet observed in her 2021 report A/HRC/47/53 on racial justice and equality, militarised policing may create conditions akin to ‘war zones’ - with police routinely fir**i**ngfrom helicopters and from armoured vehicles in densely populated residential areas. Many of the communities policed in this way have large populations of racial, ethnic, or religious minorities. In her recent report A/HRC/50/28 on *Violence and its impact on the right to health,* Dr Mofokeng stated that:

Structural violence is a subtle and quite often invisible form of violence normalized through laws, policies and the institutionalization of certain practices that have their roots in legacies of colonialism, racism, apartheid and structural socioeconomic inequalities. It creates unjust barriers that are socially and systemically designed to marginalize individuals and populations across the race, class and gender divide, thereby limiting the realization of the right to health for many populations…. An intersectional and rights-based approach to violence that addresses the root causes of such violence, including the binary conceptualization of gender and heteronormative norms, and patriarchal, racist, ableist and capitalist oppression and determinants of health in law and practice, is urgently needed.

Police violence falls into a unique category of urban violence because the police have a duty to protect and they have a state-sanctioned authority to use force for this purpose: if this authority is abused, trust is undermined. A substantial body of research by psychologists has found that use of excessive force by police is associated with high levels of compromised mental health in the communities that are policed in this way, and in the police forces deployed; but this research is inadequately reflected in the work of human rights committees or in the work of the human rights lawyers and NGOs who represent victims. There is a tendency for human rights lawyers and human rights fora to focus on police shootings, murder and rape (generally the most salient criteria from the perspective of a criminal law case). This understandable but it is important not to neglect the more widespread violence inflicted without visible external wounds on women and children as a result of violent policing - particularly where there is strong evidence that the impact of police violence on these rights was predictable. De Vylder, Link, and Fedina have observed that, whilst death is the most severe health outcome of police violence, the mental health effects ‘may be less visible yet much more pervasive and, potentially, more impactful when considered across an entire community or population.’[[2]](#footnote-2)

This submission is relevant to all situations and countries with racist policing practices, especially those in which excessive use of force and other forms of police violence, are common practice. We draw your attention to Brazil in particular, which has the highest rate of police killings in the world. The murders of Dom Phillips and Bruno Pereira in the north of Brazil and congresswoman Marielle Franco from Rio de Janeiro are high profile examples of an extremely violent policy of repression. Police violence in Brazil largely takes the form of militarised operations in which entire neighbourhoods (always poor ones in which the majority population is Black) are occupied by military police or the army, for five or six days, sometimes much longer. Heavily armoured vehicles, mounted with cannon guns, are stationed at street corners and the neighbourhoods are strafed with sniper fire from helicopters. When operations are taking place residents cannot leave their houses even to buy bread or to go to work without risking their lives, children cannot go to school.[[3]](#footnote-3) Civil police officer, Janaina Matos reports that ‘it has become normal’ for police ‘to enter a territory and treat the population as if it were a war enemy…Brazil’s security policy is not aiming to guarantee security for everyone, but just for an elite while oppressing the larger part of the population, especially the black people.’[[4]](#footnote-4) Human Rights Watch reports that more than three quarters of the close to 9000 people shot by Rio police in the last decade were Black.[[5]](#footnote-5) The police themselves are also affected: a 2021 report found that post-traumatic stress disorder may be chronic among Rio police due to ‘violent incidents in which they experience trauma directly and depressing incidents which require direct professional action in the aftermath of violent events;’ police suicide rates are well above the population rates.[[6]](#footnote-6)

Whilst it is mostly young men that are shot by police it is not only men that are killed. Christen Smith argues that ‘Black women are dying slowly from police violence, particularly after losing a child or parent in a police killing. If police violence is a social disease, then Black women are more likely to die of it.’[[7]](#footnote-7) Ana Paula Oliviera, who founded Mothers of Manguinhos after her son Johnatha was killed, reported that one of the mothers in the group, Janaina whose thirteen-year-old son Cristian was shot by police ‘while playing ball in that field, ended up dying like many other mothers who get sick and die of sadness and depression.’[[8]](#footnote-8) Other mothers speak of the mental health challenges they face after their children are killed and the impact on their other children; as Ana Paula said in a webinar in 2021 they lose ‘the best of their mother’ as she struggles with grief, the fight to memorialise their children and against the criminalisation of their children since the police always claim that the child was involved in crime and somehow their death was their own fault.[[9]](#footnote-9)

The Oswaldo Cruz Foundation (Fiocruz) reports that Rio’s favelas ‘where the majority of the population is Black, are subjected to an extremely violent public security policy’ and this, along with violence by the gangs, is a leading causal factor in the high levels of depression, anxiety, nervousness, and post-traumatic stress disorders such as nightmares, hypervigilance, flashback, emotional anaesthesia, and withdrawal from social life seen amongst residents.[[10]](#footnote-10) Valcler Rangel, chief of staff at argues that the frequency and scale of militarised policing operations in Rio’s favelas ‘has literally stopped the movement of people in those territories, children who go to school, people who go to medical care, people who leave for work, people who go out for fun, stop doing these activities which has a whole consequence for life and for mental health.’ [[11]](#footnote-11) Koller, a psychoanalyst at Brazil’s *National Observatory on Mental Health, Justice and Human Rights,* reports that increasingly entire communities in Rioare affected by police violence and that this has resulted in a marked ‘increase in deaths from suicide, excessive consumption of alcohol or drugs, cancer… denoting levels of psychological distress with almost epidemic characteristics.’[[12]](#footnote-12)

Children’s rights to a healthy development, mental health and education are routinely violated as direct result of militarised policing operations. ’Cris dos Pazeres, reports, ‘When there is a police operation, we throw everyone on the floor and wait for it to pass. These children will live for days in trauma, with sleep disturbance, hearing shots that are not there.’[[13]](#footnote-13)A teacher, Luciana Gomes, reports:

A police operation starts, children stay locked up, with no right to play, this right to play is taken from all children in all favelas. I think that this is a violation, maybe the biggest, due to the impact it has on their lives, they can't go out with friends, they can’t have the learning they need…This is rape, you take away this right from a child, the right to be in school, she is there in her right and these violent operations come and they don't even want to know.[[14]](#footnote-14)

Earlier this year Dr Mofokeng said that:

If you are a child or an adolescent who is living in a community that is ravaged by poverty, food insecurity, crime, and now the added layer, right, of having elected leaders, people in governance, then using police methods that actually tell you, you don’t belong here, you’re not meant to be here, we don’t value your life. So where do people go? It’s no wonder that no one feels free… <https://vimeo.com/718399165>

Diagram

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**This is a child’s drawing of her house in Rio de Janeiro’s Maré favela. She says ‘I don’t like the helicopter because it shoots down, and people die. This is wrong.**

In her most recent thematic report as Special Rapporteur on the right to health (A/HRC/50/28), Dr Mofokeng stated that ‘The right to health is an important part of the robust human rights framework that aims to prevent violence and protect everyone from all its forms and ensure accountability and redress.’

Bearing this in mind, we request you consider our proposal to address state violence, especially violence by law enforcement officers, as a specific issue that entails obligations under Article 5 (iv) of the Convention on the Elimination of Racial Discrimination in addition to, and distinct from, relevant obligations that arise under other provisions of the treaty.

Thank you for your attention

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**ADDENDUM: THE COMMITTEE’S LIST OF QUESTIONS**

*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?

6. What is the relationship between Article 5 (e)(iv) and Article 12 of the International Covenant on Economic, Social and Cultural Rights, as interpreted by the Committee on Economic, Social and Cultural Rights, considering the ratification status of both instruments?

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

8. What is the relationship between Article 5(e)(iv) and other rights of Article 5 ICERD, such as the prohibition and elimination of racial discrimination in the right to just and favourable conditions of work, the right to housing, the right to education and training, or with civil and political rights, such as the right to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution, the right to freedom of movement and residence, and the right of privacy.

*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?

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

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

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?

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?

*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?

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

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

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

*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?

*Consultation with groups subject to racial discrimination*

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

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

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

*Identifying and measuring the effect of racial discrimination: statistics, artificial intelligence*

*and big data*

22. What kind of statistics and indicators should the States develop and standardise to monitor their laws and policies? What sort of studies are needed to evaluate the impact of racial discrimination in the right to health? Apart from health studies, which fields need to be under scrutiny and which authorities need to be coordinated?

23. How does structural racial discrimination in health manifest in emerging technologies? How does digitalisation affect persons and groups protected under the Convention?

24. Which proxies, not subject to scrutiny today under anti-discrimination law, especially in relation to AI and big data, should be considered suspect of hiding or leading to racial discrimination in the right to health? How are these proxies connected to health-related procedures? How should new technologies prevent bias but keep the focus on the racial element to identify the risks?

25. How should availability of data on intersectionality be pursued?

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

*Health-related coercive measures and racial discrimination*

27. How should States identify health practices as coercive taking into account structural racial discrimination?

28. How should States strike a balance between the prohibition and elimination of racial discrimination and coercive measures in health? Does racial discrimination establish or blurs borderlines between informed consent and coercion?

29. How should States assess the overrepresentation in mental health facilities of persons belonging to communities protected under the Convention?

30. How should States respond to potentially harmful traditional cultural practices?

31. How should the requirements of legality, precaution, necessity, and proportionality be understood?

*Private actors*

32. How should States classify actors interfering with the prohibition of racial discrimination in health? Is the division between public and private actors sufficient or should actors follow a typology reflecting their role in health?

33. Taking into account the UN Guiding Principles on Business and Human Rights, what sort of standards should States adopt in matters involving private parties and to promote respect for human rights by private parties?

*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?

*Monitoring and accountability*

35. What sort of mechanisms and institutions should States involve at national level in preventing, monitoring, and remedying racial discrimination in health? How persons and groups protected under the Convention should be involved?

36. How should accountability for violations by all parties concerned be regulated? How should responsibility be distributed?

37. Which standards should these processes apply to identify and redress racial discrimination in health? How should States apply the principles of transparency, participation and empowerment while respecting and protecting privacy rights?

*International organisations and racial discrimination*

38. How should the United Nations and its agencies and programmes, directly or indirectly involved, contribute to advancing the prohibition of racial discrimination?

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

40. Which institutional, operational, and other measures should these agencies adopt to prevent and prohibit the perpetuation of racial inequalities?

*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.

1. E. Lieblich and A. Shinar, (2018) ‘The Case Against Police Militarization’ 23 Mich. J. of Race & Law 105, [↑](#footnote-ref-1)
2. J. De Vylder et al. ‘Impact of Police Violence on Mental Health’ 110 AJPH11, 1704 [↑](#footnote-ref-2)
3. G. Martins, ‘Remoções e Militarização do Espaço Favelado nos últimos Dez Anos de Megaeventos no RJ’, in O.M. Françozo, *Clínica Política: a experiência do Centro de Estudos em Reparação Psíquica “lá em Acari”* (2018). [↑](#footnote-ref-3)
4. *It Marked My Life A Lot* (2022, 40 mins) <https://vimeo.com/720351861> [↑](#footnote-ref-4)
5. C. Munos, ‘Brazil suffers its own scourge of police brutality’ Human Rights Watch 3/06/20, hrw.org/news [↑](#footnote-ref-5)
6. F. Campos ‘Post-Traumatic Stress Disorder in the Military Police of Rio de Janeiro’ 2021 [*IJERPH*](https://www.mdpi.com/journal/ijerph) 18(5):2594 [↑](#footnote-ref-6)
7. C. Smith, ‘Lingering Trauma in Brazil: Police Violence Against Black Women’ (2018) 50 NACLA Report 369 [↑](#footnote-ref-7)
8. *It Marked My Life A Lot* (2022, 40 mins) <https://vimeo.com/720351861> [↑](#footnote-ref-8)
9. Ibid [↑](#footnote-ref-9)
10. Mendes Lages Ribeiro, M. Matos Silva, F. Serpeloni (2020) *Notes on Armed Violence and Mental Health in Rio de Janeiro / RJ / Brazil* (Department of Studies on Violence and Health, Fiocruz), page 6. [↑](#footnote-ref-10)
11. Ibid [↑](#footnote-ref-11)
12. T. Kolker, ‘Atenção psicossocial a afetados pela violência de Estado,’ in O.M. Françozo, *Clínica Política: a experiência do Centro de Estudos em Reparação Psíquica “lá em Acari”* (2018), pages 161-163 [↑](#footnote-ref-12)
13. *It Marked My Life A Lot* (Brazil/Northern Ireland 2022) <https://vimeo.com/720351861> [↑](#footnote-ref-13)
14. Ibid [↑](#footnote-ref-14)