QUESTIONNAIRE

"Racism and the right to health"

I have the honour to address you in my capacity as Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, pursuant to Human Rights Council resolution 42/16.

I would like to invite you to respond to the questionnaire below. Submissions received will inform my next thematic report on "Racism and the right to health", which will be presented to the General Assembly in October 2022.

The questionnaire on the report is available at OHCHR website in English (original language) as well as in French, and Spanish: (https://www.ohchr.org/en/special-procedures/sr-health).

All submissions received will be published in the aforementioned website, unless it is indicated that the submission should be kept confidential.

There is a word limit of 750 words per question. Please submit the completed questionnaire to ohchr-srhealth@un.org. The deadline for submissions is: **2 June 2022.**

Tlaleng Mofokeng
Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Contact Details

Please provide your contact details in case we need to contact you in connection with this survey. Note that this is optional.

Type of Stakeholder (please select one)	☐ Member State ☐ Observer State X☐ Other (please specify) Civil society
Name of State Name of Survey Respondent	United States Action on Smoking and Health
Email	Romeo-stuppyk@ash.org
Can we attribute responses to this questionnaire to your Institution publicly*? *On OHCHR website, under the section of SR health	X Yes No Comments (if any):

Background

Within the framework of Human Rights Council resolution 42/16, the Special Rapporteur on the highest attainable standard of physical and mental health has identified racism and the right to health as one of her priorities during her tenure (See A/HRC/47/28 paras 87-94). In compliance with her mandate and in line with this priority she has decided to devote her next thematic report to the General Assembly in October 2022 to the theme of "Racism and the right to health."

Objectives of the report

The Special Rapporteur underlines that racism is a key social determinant of health and a driver of health inequities. With this report, she would like to shed light on the impact of racism and discrimination on the grounds of race, colour, descent, caste, national or ethnic origin or migrant or refugee status, on the enjoyment of the right to health. She will focus on its impact particularly on Black people, persons of African descent, Arabs and Muslims, Asians and persons of Asian descent, migrants and persons belonging to indigenous peoples and minorities and the intersection of factors such as poverty, or discrimination based on age, sex, gender identity, expression, sexual orientation, disability, migration status, health status eg HIV, Albinism etc. and the rural and urban divide.

She intends to consider the historic perspective of the impact of past and contemporary forms of racism on the right to health and on the ability of individuals and communities to realize their right to access health care, services and goods including the realization of sexual and reproductive health rights and on the ability of States to fulfill their obligations under the right to health. The focus of the report will be on the impact of racism on human dignity, life, non-discrimination, equality, the right to control one's health, including the right to be free from non-consensual medical treatment and experimentation as well their entitlement to a system of health protections. In so doing, and by adopting the anti-coloniality[1] and anti-racism frameworks, the report will expose the impact of the living legacy of past and ongoing forms of racism, apartheid, slavery coloniality and oppressive structures in the global health including the economic architecture and funding, national health systems on racialized people.

Importantly, the Special Rapporteur will adopt an intersectional approach and take into account the multiple forms of discrimination affecting persons experiencing racism and related discrimination in the context of health care. She will analyze the links between inequalities in accessing adequate health care and social disparities, sex, age, gender, poverty, class, nationality, exclusion, disability and the rural and urban divide and related systems of oppression.

The Special Rapporteur would also like to identify good practices that affirm the right to a system of health protection (i.e. health care and the underlying social determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health.

[1] Coloniality is a concept coined by Walter Mignolo around 1995,4 refers to the living legacies of European colonialism in social orders and knowledge systems, which created racial hierarchies that enable the social discrimination that has outlived formal colonialism. See A/HRC/47/28 para 9.

She seeks examples of how to combat racism and discrimination on the grounds of race, colour, descent, national or ethnic origin – in accessing health care health facilities, goods and services and the underlying determinants of health.

Key Questions

You can choose to answer all or some of the questions below. (750 words limit per question).

1. **What are the main ongoing manifestations of racism, and related forms of discrimination enabled by racism that may be prevalent in your country in the area of the right to health broadly including in underlying determinants of health, health outcomes and access to health care?**

In 2009, the United States Congress passed—and President Obama signed into law—the Family Smoking Prevention and Tobacco Control Act. This act implemented a flavor ban in cigarettes, but excluded menthol, subject to further research on the public health impacts of menthol in cigarettes.

According the Center for Diseases Control, in the United States, "non-Hispanic Black or African American people who smoke cigarettes, regardless of age, are more likely to smoke menthol cigarettes than people of other races or ethnicities who smoke cigarettes" and "in 2019, approximately 85% of non-Hispanic Black or African American adults who smoked used menthol cigarettes". It is estimated that between 1980 – 2018, 1.5 million African Americans began smoking menthol cigarettes and 157,000 African Americans died prematurely because of menthol cigarettes.[2]

In 2011, the FDA's Advisory Committee concluded that the "removal of menthol cigarettes from the marketplace would benefit public health in the United States." That same report determined that if menthol cigarettes were removed from the marketplace in 2010, then by 2020, roughly 17,000 premature deaths would have been avoided, and about 2.3 million people would not have started smoking; and by 2050, the cumulative gains would have resulted in over 300,000 premature deaths avoided, and over 9 million people that would not have started smoking.

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The negative relationship between African Americans and menthol is the direct result of a decades long campaign strategy by the tobacco industry. In 1974, a report prepared for Philip Morris stated that "Menthols in general do better among the very young, and among very young blacks…" The tobacco industry has clearly and openly used menthol to target African Americans, making it more difficult for people of African descent in the United States to "achieve the highest attainable standard of physical and mental health."

Now, 11 years since the law passed, the FDA still hasn't taken action. Action on Smoking and Health (ASH) and our colleagues at the African American Tobacco Control Leadership Council (AATCLC), joined by the American Medical Association and the National Medical Association sued the U.S. Food and Drug Administration (FDA) over their inaction on menthol cigarettes. The FDA agreed to promulgate a rule, and has just recently issued a first draft; however, the rule is far from implemented. In addition to the

[2] https://www.cdc.gov/tobacco/basic_information/tobacco_industry/menthol-cigarettes/index.html#:~:text=In%202019%20and%20in%202020,the%20federal%20government%20in%201967.

FDA, ASH and our colleagues have submitted a report to CERD and plan to ask the committee to hold the US accountable for implementing this rule as effectively and quickly as possible.

At ASH, our work is global, and we are seeing many other countries take action against menthol cigarettes. The WHO Framework Convention on Tobacco Control (FCTC) Guidelines for Articles 9 and 10 encourage countries to begin 'Prohibiting or restricting ingredients which may be used to increase palatability in tobacco products,' which includes menthol." Many countries including Canada, Ethiopia, Uganda, the European Union and others are fulfilling their obligations and protecting the right to health of their citizens by taking menthol off the market, but the United States has yet to do so.

2. **Who are the most affected people and why? Please describe existing disparities in the provision of and access to health services that affect people of different racial and ethnic origin, descent as well as other groups, such as migrants. The lack of data, analysis or health indicators in this regard may also be reflected.**

This is a dangerous and deadly reluctance to enact public health measures that will protect all Americans, but specifically the African American community. For the African American community, this would have meant that (a) by 2020, roughly 4,700 premature deaths would have been avoided, and about 461,000 African Americans would not have started smoking; and (b) by 2050, over 66,000 premature deaths would have been avoided, and over 1.6 million African Americans would not have started smoking.

3. Under the right to health, States have a special obligation to refrain from denying or limiting equal access for all persons, comprising minorities, asylum seekers and migrants including undocumented migrants, to preventive, curative and palliative health services; abstain from enforcing discriminatory practices as a State policy as well as to ensure equal access to health care and health-related services provided by third parties. Please explain how the above point is implemented in your country, what works well and not so well and illustrate with disaggregated data if possible.

4. What has been the impact of colonialism and the imposition of allopathic medicine on the availability of indigenous and traditional health knowledge systems, medicine and practices, and on the right to health more broadly in your country?]. Are health services available in your country that give due consideration and acknowledgment of, or respectfully incorporate indigenous/traditional health knowledge systems and practices, preventative care, healing practices and medicines? Please share examples of good practices.

5. **Please share examples of good legal and policy frameworks that address past or ongoing racism and racial and related forms of discrimination, specifically in relation to access to underlying determinants as well as quality health care, goods, services and facilities, including sexual and reproductive health.**

   In the case of tobacco, banning tobacco menthol products is a best practice

measure that aligns with the WHO Framework Convention on Tobacco Control as well as Target 3.a of the UN Sustainable Development Goals. As the Partial guidelines for implementation of Articles 9 and 10of the WHO Framework Convention on Tobacco Control state, "Masking tobacco smoke harshness with flavours contributes to promoting and sustaining tobacco use" and for this reason they further state that "From the perspective of public health, there is no justification for permitting the use of ingredients, such as flavouring agents, which help make tobacco products attractive. Several countries including Canada, Ethiopia and the European Union have banned menthol tobacco products. This policy applied in the U.S. would help reduce racial health disparities.[3]

6. Please share examples of public health financing, non-governmental sector funding practices, inter-agency finance solutions, medical insurance products that show manifestations of ongoing or past racism and related discrimination, at the local and global levels that impact racialized people, as well as other factors such as poverty, or discrimination based on age, sex, gender identity, expression, sexual orientation, disability, migration status, health status eg HIV, Albinism etc. and the rural and urban divide."

7. Please share good practices and examples of public health interventions resulting in adequate access (inside and outside the health sector), support knowledge production or implementation of programs that successfully address inequalities in particular the impact of racism and related racial discrimination, as well as other factors such as poverty, or discrimination based on sex, gender identity, expression, sexual orientation, disability and migration status.

8. Please share good examples and practices that enable accountability in public and private sector that enable access to justice and redress to victims of racism and discrimination on the grounds such as colour, descent, national or ethnic origin or migrant or refugee status in the provision of health care and as it intersects with factors such as poverty, or discrimination based on age, sex, gender identity, expression, sexual orientation, disability, migration status, health status eg HIV, Albinism etc. and the rural and urban divide."

9. Please share information about the sources of health financing for your country, the quantity and quality of said financing, as well as any aid or funding conditionalities, global economic policies, and austerity or other measures requested or encouraged by international financial institutions, multilateral agencies or donors, that negatively affect health systems and people's access to health in your country.

10. What are the historical and ongoing legacies and impacts of colonialism and slavery on the right to health in your country? And how has the lack of reparations for slavery, colonialism, apartheid and racial discrimination impacted the right to health in your country?

[3] https://fctc.who.int/publications/m/item/regulation-of-the-contents-of-tobacco-products-and-regulation-of-tobacco-product-disclosures#:~:text=Whereas%20Article%209%20deals%20with,governmental%20authorities%20and%20the%20public.

11. Please also share good practices and examples of reparations for racial discrimination related to the right to health violations and abuses.

Key definitions

In her first report to the Human Right Council, the Special Rapporteur echoed Prof. Charles Ngwena's reflections on racism, and noted they would extend to ethnicity as well.[4]

"In 2018, Charles Nwgena noted:

[…] Race remains an associational criterion that people often claim as part of their identity or that may be ascribed to them by others or the political community of which they are part. Race has political implications where the body politic is racialized, overtly or covertly, in the sense that racial differentiation is tethered to hierarchized essences that carry social, political and economic meanings that may be positive or negative for the racialized subject, depending on which side of the "colour line" the person falls or is deemed to fall."[5]

The International Convention on the Elimination of All Forms of Racial Discrimination defines "racial discrimination" as: "any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life." (Article 1)

The Declaration and Programme of Action adopted at the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance held in 2001 in Durban, (South Africa) by the United Nations - known as the Durban Conference urged States, individually and through international cooperation, to enhance measures to fulfil the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, with a view to eliminating disparities in health status, (…), which might result from racism, racial discrimination, xenophobia and related intolerance. (Durban Programme of Action, para. 109)

In 2009, Durban Review Conference accepted the interpretation given by the Committee on the Elimination of Racial Discrimination to the definition of the concept of racial discrimination as contained in the Convention, so as to address multiple or aggravated forms of racial discrimination, as reflected in its outcome document.

[4] A/HRC/47/28, paras 87-88.
[5] Ibid para 87.