AIDS and Rights Alliance for Southern Africa
Matahari Global Solutions

Dr Tlaleng Mofokeng
Special Rapporteur on the highest attainable standard on physical and mental health

Re: Joint submission to question 10, questionnaire "Racism and the right to 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	Joint submission by ARASA and Matahari Global Solutions
Email	gdang@matahari.global
Can we attribute responses to this questionnaire to your Institution publicly*? *On OHCHR website, under the section of SR health	**Yes** No Comments (if any):

Question 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?

Response:

1. In 2021, AIDS and Rights Alliance for Southern Africa (ARASA) and Matahari Global Solutions together with Ezintsha at University of Witwatersrand began a research initiative titled "Racism in Global Health", which focuses on the experience of Black and Brown professionals in global health institutions.[1]
2. The research focus of the initiative was determined through an Inception Roundtable of 20 Black and Brown global health professionals, including academics, practitioners, healthcare providers, and activists. The Roundtable resulted in an Inception Report that documented the conversation of the

[1] Press release: Racial Diversity in Global Health Announces Advisory Committee. April 2021. https://www.matahari.global/racial-diversity-in-global-health-initiative-announces-advisory=committee

Roundtable and explored the main themes raised.[2] Research interviews with Black and Brown global health professionals, leaders of Global North global health institutions, and global health-adjacent stakeholders are ongoing.

3. While the research is global in nature and does not focus on specific country responses, we believe that it provides an important exploration of the professional and interpersonal environment in which the right to health must be realized. It also provides a normative and conceptual framework for understanding the machinations through with global health programming, interventions, and efforts are channelled. And, importantly, it provides ample evidence of how the legacy colonialism and slavery lives on in our global health architecture.
4. As we write in the inception report, "the origin of global health dates back to colonial times, when 'tropical medicine' was established in late 19th century Britain as an active tool of maintaining the Empire. Its 'usefulness' in this regard was recognized by other European states, who employed this tool in the formation and maintenance of their own empires. Structural racism was built in from the beginning."
5. This legacy impacts the structure of and access to global health institutions for Black and Brown professionals. Roundtable participants described global health included "complicated, racist, colonialist, power imbalance and led by white males […], with nods to inequality and inequity, and struggle." They also pointed to "lack of diversity in philanthropic funding and its connection to decision-making power; hiring, recruitment, and governance in global organizations; lack of diversity in thought leadership and programmatic direction; and non-diverse leadership" as major challenges.
6. The legacies of colonialism and slavery, coupled with the racism that underlines this history, are also very much alive in the language used in global health. For example, "responses overwhelmingly pointed towards implicit biases towards Black and Brown people e.g., with the term capacity building exuding expectations of low capacity and ability, in need of help, and risky for investment. Other dehumanizing aspects of terminology were also mentioned, for example calling people subjects, targets, or beneficiaries of interventions in which lives are seen as deliverables. The terms third world and developing world were also named as connected to low expectations and racial bias." This language and the inherent racist meanings are stark reminders that white supremacy culture is an everyday experience for Black and Brown people.
7. While the research is still ongoing, several themes appear to be emerging that deserve further attention. As hinted above, participants raised several challenges to creating systemic change by relying solely on actions of Black and Brown people, including those few at the leadership level.
8. The power imbalance that defines the working environment for Black and Brown people has several negative effects.
    a. These of course include impact on the personal physical and mental health of Black and Brown people, and their ability to fully enjoy their own right to physical and mental health.
    b. No accountability for racism and bias by white colleagues within organizations results in racism that these staff of global north organization

[2] All quotes from Inception Report. Racial Diversity in Global Health. From Rhetoric to Tangible Change – Pitfalls and Opportunities. https://www.matahari.global/public/files/fcf440cfaf7150da942ad16d086c97af35197471bbdffd042c63ae687d1cba6a.pdf

then carry into their communication with country office staff and local stakeholders, broadening the circle of harm.

c. This interpersonal behavior and racist framework underlying then impacts the type of programming, policy interventions, and funding decisions that are prioritized.

9. Without addressing the racism within these decision-making institutions, we will always fall short of developing the most appropriate health by not only excluding Black and Brown people from leadership positions, but also continuing to harm the Black and Brown workforce that are tasked with implementation. While on the one hand rights-based approaches have gained more ground in health policymaking, the practice and framework of our institutions simultaneously undermine the right to health. Colonialism and racism are perpetuated by upholding the status quo of global.
10. The refusal to witness, take seriously, call out and hold people accountable for all forms of racism undermines the full realization of the right to health.