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 ☒ Other (please specify) (Youth-led Initiative)
Name of State Name of Survey Respondent	The Canadian Advisory of Women Immigrants (CAWI) - Canada CAWI's Sexual and Reproductive Health Campaign Team
Email	admin@cawicanada.com
Can we attribute responses to this questionnaire to your Institution publicly*? *On OHCHR website, under the section of SR health	Yes (circled) 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 protection. 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?

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.

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.

   Although Canada ensures universal health coverage for all, many marginalized communities continue to be excluded from good healthcare practices as well as equal access to healthcare and rights. Take the example of Samwel Uko, a Black University student and athlete in Saskatchewan, who committed suicide at Wascana Lake, Regina, SK. Before his passing, Uko tried to access emergency medical assistance from the Regina General Hospital twice due to mental health concerns, but he was forcibly escorted from the facility. This goes to show just how much racism minority communities face, particularly in a province like Saskatchewan, as well as the lack of accountability of the Saskatchewan Health Authority. Canada also does not collect race-based data, which makes it immensely difficult to address and hold higher-ups accountable for their discriminatory actions, especially in regard to racism in healthcare settings.

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.

There are many Canadian organizations and researchers (Both Indigenous and non-Indigenous) who respectfully acknowledge and use restorative justice approaches for healing and as a different form of retribution for certain criminal acts. One of CAWI's Research Assistants noted, "as part of my duties as a Research Assistant for Shift: The Project to End Domestic Violence, I have looked at organizations across Canada that use restorative justice approaches for cases of sexual violence and/or abuse and have come across Circles of Support and Accountability (CoSA) Canada, Mediation and Restorative Justice Centre, Community Justice Initiative, Antigonish Women's Resource Centre, Urban Aboriginal Voices Society, and Ma Mawi Wi Chi Itata Centre to name a few. Although these organizations specifically focus on using restorative justice approaches for cases of sexual harassment/assault, there are bound to be many more that use restorative justice approaches for other crimes as well".

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.

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.

   The Sexual Health Options, Resources, & Education Centre, or the SHORE centre, is a non-profit organization in Kitchener, Ontario which runs provides sexual health information and services to the community. The Canadian Advisory of Women Immigrants (CAWI) has previously worked with SHORE on a publicly-offered educational panel discussing the barriers to sexual health faced by immigrant and refugee women. Specifically, SHORE runs a number of Newcomer Programs which are language-specific, culturally and religiously sensitive, and offered to new immigrants, aiming to help them access support related to healthy relationships, family planning and sexual health. They strive to offer non-judgemental support, accurate information, and increased access, reducing the barriers to these resources that are often faced by newcomers. They also help to create networks of support for these communities.

   CAWI's sexual and reproductive health campaign and accompanying research project is a grassroots initiative aiming to develop better sexual health resources for immigrant women and girls. Through the development and distribution of this research and curriculum, we aim to destigmatize and educate at the

community level so that immigrant communities have access to educational opportunities regarding their sexual and reproductive health.

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."

   As a part of our own community-based research project, we found it immensely hard to engage immigrant women and girls from rural communities. Research shows that rural folks face greater challenges when it comes to accessing healthcare services as well as resources, which is why it is important to develop good practices that enable rural communities, particularly immigrants and refugees with intersectional identities, to have access to sexual and reproductive health services and resources.

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?

    The historical and ongoing legacy of colonialism on the right to health in Canada has impacted Indigenous communities most as the exploration and eventual settling of Turtle Island was traumatic, in terms of social dislocation, economic disruption, and a cycle of disease and starvation (Daschuk). Indeed, starvation and disease become a tool deliberately used against Indigenous communities to eliminate them, and today this has created long-lasting impacts on their health, causing stigma to build in regards to their perceived weak immune system. As such, Indigenous patients often are ignored by health care workers due to systemic racism, which results in a lower quality of provision of health services. The lack of reparations for colonialism and recognition of racial discrimination occurring in health care institutions continues a cycle of ignorance. It contributes to the loss of life of Indigenous people.

    Source:
    [*https://www.ohchr.org/sites/default/files/Documents/Issues/IPeoples/EMRIP/Health/UniversityManitoba.pdf&sa=D&source=docs&ust=1654142319857006&usg=AOvVaw2Og_Q0IRwrerpFDVmAd0Mz*](https://www.ohchr.org/sites/default/files/Documents/Issues/IPeoples/EMRIP/Health/UniversityManitoba.pdf&sa=D&source=docs&ust=1654142319857006&usg=AOvVaw2Og_Q0IRwrerpFDVmAd0Mz)

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

    Based on the preliminary results of CAWI's sexual and reproductive health research project, there are various suggested good practices and reparations. The immigrant women we interviewed have highlighted the importance of diversity. Diversity is important in both the practices and the people implementing the practices. Based on our community-based research, it is important for stakeholders to come from diverse backgrounds and experiences regarding decision-making and practices. By incorporating individuals from diverse backgrounds, safer spaces can be created making health education better received by youth and students. Another way diversity is important is through diversity in approaches. Good practices and reparations should focus on holistic and diverse content as well as ways of delivering that content. More specifically, when referring to the diversity of content, it is suggested that practices not be restricted by heteronormativity and gender roles and consider perspectives beyond that of Westerners. Finally, it is important to be culturally sensitive when communicating these practices and approaches to community members.

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.[2]

"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."[3]

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

[2] A/HRC/47/28, paras 87-88.
[3] Ibid para 87.

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.