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

Racism and Right to health

2 June 2022

Submitting organisations:

Harm Reduction International (HRI) is a leading non-governmental organisation dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

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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): Civil Society Organisation
Name of State Name of Survey Respondent	Global Colleen Daniels, on behalf of Harm Reduction International
Email	Colleen.daniels@hri.global

Can we attribute responses to this questionnaire to your Institution publicly*? *On OHCHR website, under the section of SR health	Yes 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,

[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.

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.

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?

Drug control has been used to uphold colonial power structures around the world. The 'colonization of drug control' refers to the use of drug control by states in Europe and America to advance and sustain the systematic exploitation of people, land and resources and the racialized hierarchies, which were established under colonial control and continue to dominate today.

Current drug policies have contributed to an increase in drug-related deaths, overdoses and sustained transnational criminal enterprises at the expense of the lives of people who use drugs, their families and greater society.

Overarching structural problems also negatively affect access to health and harm reduction services. Criminalisation, racism and discrimination against Indigenous, Black and brown people results in low household incomes, unemployment, food insecurity, poor housing and lower levels of education. This, in turn, results not only in worse health outcomes for these communities but also in people from these communities disengaging or actively avoiding health services.

Structural inequalities negatively impact the health of Indigenous people both in Australia and New Zealand. In New Zealand, such factors include social deprivation, poverty, the quality of housing and household crowding, which could contribute to inequalities in rates of most infectious diseases – COVID-19 included.[i]

Since 2000, the world prison population has grown by 20 percent.[2] The female prison population has increased by 50 percent.[3] Over 11 million people are imprisoned worldwide today, the highest number ever recorded.[4] Punitive drug policies and laws

2 Walmsley, R. / World Prison Brief (2015), 'World Prison Populations List' [pdf].
3 Ibid.
4 Penal Reform International (2020), 'Global Prison Trends 2020' [pdf].

continue to drive this mass incarceration: 1 in 5 people in prison globally – 2.5 million people – are detained because of drug offenses[5], and the proportion is even higher among women.[6] [7] UNAIDS estimates that 56-90 percent of people who inject drugs will be incarcerated at some stage in their lifetime.[8] In 1980, 580,900 people were arrested on drug-related charges in the U.S. By 2014, that number had increased to 1.56 million. Nearly half of the 186,000 people serving time in federal prisons in the US are incarcerated on drug-related charges.

Black, Brown, and Indigenous people are overrepresented in the world's prisons. Higher arrest and incarceration rates for these communities do not reflect a higher prevalence of drug use; rather they reflect law enforcement's greater focus and greater use of violence and force in urban areas, lower-income communities and communities of color.[9]

The consequences of incarceration can transcend individuals and even generations. Incarceration of a parent or breadwinner can impact a family's income and ability to fulfill its basic needs. The negative consequences of incarceration are more severe and long lasting for women – impacting health, finances, social stability, family and personal relationships. Negative consequences for children can extend to social exclusion, educational attainment, housing status and health.[10] [11] [12] These effects are compounded in the social groups that are more likely to experience incarceration, reinforcing pre-existing inequalities related to race, nationality and class.

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.

Globally, Black, Brown and Indigenous peoples are disproportionately targeted for drug law enforcement and face discrimination across the criminal system. These communities face higher arrest, prosecution and incarceration rates for drug offenses than other communities, such as majority populations, despite similar rates of drug use and selling among (and between) different races.

In the United States, COVID-19 in correctional settings has disproportionately impacted Black and Hispanic individuals. In the US, there is also evidence of racial disparity in access, with Black clients 77% less likely to be prescribed buprenorphine than white clients.

5 UNODC (2021), 'World Drug Report 2021' [pdf].
6 Penal Reform International (2015), 'Global Prison Trends 2015' [pdf].
7 UNODC (2018), 'World Drug Report 2018: Women and Drugs' [pdf].
8 UNAIDS (2014), 'GAP Report 2014: People left behind: People who inject drugs' [pdf].
9 Drug Policy Alliance, 'Race and the Drug War' [web page, accessed October 2021].
10 Gatti, U., Tremblay, RE., and Vitaro, F. (2009), 'Iatrogenic effect of juvenile justice', Journal of Child Psychology and Psychiatry, 50 (8), 991–998; Gilman, AB. (2015), 'Incarceration and the life course: Predictors, correlates, and consequences of juvenile incarceration' [Ph.D Thesis].
11 Gilman, AB., Hill, KG., and Hawkins, JD. (2015), 'When is a youth's debt to society paid? Examining the long-term consequences of juvenile incarceration for adult functioning, Journal of Developmental and Life-Course Criminology, 1(1), 33-47.
12 Doherty, EE. et al. (2016), 'Examining the consequences of the "prevalent life events" of arrest and incarceration among an urban African-American cohort', Justice Quarterly, 33(6), 970-999.

In Canada, there is a lack of tailored services for women, Indigenous communities and young,[ii] [iii] while young people who use drugs were reported as a subpopulation for whom OAT is unavailable in Switzerland.[iv] Hepatitis C incidence is five times higher among Indigenous people,[v] in part due to their overrepresentation in vulnerable populations such as people who inject drugs, people in detention and those with unstable housing.[vi] According to the latest available data, cases of active tuberculosis increased by 2.6% from 2016 to 2017. TB incidence was highest among Indigenous people at 21.5 cases per 100,000, and alarmingly high among those identifying as Inuit at 205.8 cases per 100,000.[vii] No data is available on prevalence among people who use or inject drugs.

Indigenous peoples in Oceania, specifically Aboriginal and Torres Strait Islander people in Australia and the Māori population in New Zealand, are disproportionately affected by the harms of drug use, and consistently experience worse health outcomes than other ethnic groups in the region.[viii] [ix] [x] [xi] This inequality has persisted since the arrival of European settlers and the beginning of colonialism,[105] with newly imposed health care systems focusing primarily to serve those of European descent.

Furthermore, Māori people consistently experience barriers when accessing health services, from discriminatory behaviour and inadequate information provision to practical barriers like costs and travel challenges, resulting in Māori people disengaging or actively avoiding health services. Factors contributing to worse health outcomes in Aboriginal and Torres Strait Islander people include higher prevalence of low household incomes, unemployment, food insecurity, poorer housing and lower level of education compared to the non-Indigenous population. The lack of accessibility to culturally appropriate health services is also apparent. Though there are government-funded Indigenous-specific primary health care services in Australia, the low rate in specialist service use reflects difficulties in accessing these services for many Aboriginal and Torres Strait Islander people. [xii]

It has been recognised in New Zealand that Māori people have specific health needs, and the Māori Health Strategy was adopted in 2014. However, racism and discrimination across the health system was raised as a key issue when the Māori Health Action Plan 2020–2025 was developed.Inequalities are reflected in higher burden of drug related infectious diseases, for example hepatitis C prevalence is higher among Aboriginal and Torres Strait Islander people who inject drugs compared to non-Indigenous people who inject drugs. However, research in Australia found that factors associated with hepatitis C infection were the same for Indigenous and non-Indigenous people who inject drugs - imprisonment, sharing injecting equipment in prison - but the extent of exposure to these factors differed. In particular, incarceration rates are higher for Indigenous people in both countries. In Australia, Aboriginal and Torres Strait Islander people represented 28% of the prisoner population in 2019, while accounting for 3.3% of the general population. In New Zealand in 2019, 52% of the prison population was Māori people, while they represented 16.5% of the general population.[xiii]

Prevalence of drug use in general is also higher among Indigenous peoples. In New Zealand, Māori people are more likely to have used cannabis and amphetamines in the past year than non-Māori people and, in Australia, last year prevalence of cannabis is

1.9 times higher, while last year prevalence of amphetamines is 2.3 times higher among Aboriginal and Torres Strait Islander Australians than non-Indigenous Australians.[116] Also, the proportion of NSP clients reporting an Aboriginal and/or Torres Strait Islander background in Australia increased significantly over the past five years, from 14% in 2015 to 22% in 2019.[xiv]

According to the national NSP survey data, the HIV prevalence rate among Aboriginal and Torres Strait Islander respondents was stable between 2014 to 2018. However, it was higher among this population compared to other respondents (3.6% and 1.1% respectively in 2018).

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 2001, Portugal enacted one of the most extensive drug law reforms by decriminalizing the personal use and possession of *all* illicit drugs, while retaining criminal sanctions for activities such as trafficking. The Portuguese Government focused efforts on treatment and harm reduction. The change in policy resulted in no significant increase in rates of drug use but did lead to a fall in new HIV infections among people who inject drugs (from 1,575 in 2000 to just 78 in 2013), and a fall in drug-induced mortality, from 80 deaths in 2001 to just 16 in 2012.[13]

Decriminalization is the central building block on which a new drug policy can be built. It would eliminate all criminal and administrative penalties, reduce the number of people in prison and prioritize health and safety over punishment for drug use. Experiences of decriminalization to date have demonstrated its role in reducing the adverse health, social and economic impact of drug policy on people who use drugs and society as a whole. The International Network of People who Use Drugs calls for:

13 Transform Drug Policy (13 May, 2021), 'Drug Decriminalisation in Portugal: Setting the Record Straight' [web article, accessed October 2021].

All models of decriminalisation [to] **fully decriminalise** people who use drugs, including: the removal of all administrative sanctions and mechanisms of monitoring, surveillance, coercion and punishment for use and possession of drugs; removing the use of arbitrary quantity thresholds or threshold amounts that result in criminal records; ensuring that operational police fully understand policy and legislative changes associated with full decriminalisation; and establishing independent and ongoing monitoring for criminal justice systems.[14]

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."

Every year, USD 100 billion is spent on global drug law enforcement, roughly 750 times more than the amount invested in life-saving services for people who use drugs.[15] To decolonize drug policy, funds must be redirected away from the institutions that uphold racist, discriminatory policies and disrupt the white supremacist system created in service of colonial violence.[16] Calls for funding to be redirected from ineffective, punitive drug law enforcement to social, health and other community services must be heeded if drug policy reform is to address the root causes of the harms created by the war on drugs.[17]

In 2019, the total budget for harm reduction in Thailand was estimated to be USD 1.7 million; in contrast, the Thai government allocated around 1,500 times this amount to drug law enforcement activities.[18] Drug law enforcement expenditure in Thailand is USD 1.8 billion. In Indonesia, drug law enforcement is estimated to be USD 250 million, of which USD 81 million is for prison costs for drug-related offenses and USD 31 million for prison costs for possession for personal use. The Drug Enforcement Administration in the US, which cost US tax-payers USD 3.136 billion[19] in the financial year 2019, is an organization that militarizes police in the US as well as other countries, such as South Africa, to enforce drug control policy.

Harm reduction interventions that seek to reduce the negative health and social harms of drug use and drug policy are drastically under-implemented and underfunded. Fewer than half of the 179 countries where injection drug use occurs implement needle and syringe programs (NSPs). Even in those countries that do, coverage is generally low and limited to certain regions and urban centers.[20] There are also considerable differences between the regions in terms of harm reduction

14 INPUD (2021), 'Drug Decriminalisation: Progress or Political Red Herring?' [pdf].
15 Transform Drug Policy Foundation (2013), 'The War on Drugs: Wasting Billions and Undermining Economies' [pdf].
16 Harm Reduction International (2018), 'The lost decade: Neglect for harm reduction funding and the health crisis among people who use drugs' [pdf].
17 Harm Reduction International (2021), 'Failure to Fund: The Continued Crisis For Harm Reduction Funding In Low- And Middle-Income Countries' [pdf].
18 Tanguay, P. for Harm Reduction International (2019) 'Law Enforcement Expenditure in Thailand: Consultant findings from Law Enforcement expenditure Study conducted within the Global Fund Harm Reduction Advocacy in Asia project' [unpublished].
19 Drug Enforcement Administration, 'Staff and Budgeting' [web page, accessed October 2021].
20 Harm Reduction International (2020), 'Global State of Harm Reduction 2020' [pdf].

implementation. While NSPs are available in most countries in Eurasia, North America and Western Europe, they are severely lacking in the majority of countries in other regions. An unfavorable drug policy environment hinders harm reduction service implementation in many countries across Asia, Latin America, the Caribbean, the Middle East and Africa.[21] For people in prison the situation is even starker: only 11 countries around the world have NSPs in prison.[22]

The solution can be simple: redirect resources from the billions spent on drug control to fund harm reduction and other health and social services for the people impacted by drug policy.

In Austin, Texas, US, the city council redirected USD 150 million in funds from law enforcement to purchase housing for people experiencing homelessness, and to expand healthcare, access to food and prevent violence. In Denver, Colorado, US, the city has been running a program to send medics and clinicians instead of the police out on emergency calls related to mental health, homelessness and addiction. As a result, people in crisis in Denver received help without having to talk to police on 748 occasions. No one was arrested, and people received healthcare and opportunities to heal instead.[23] These are some example models that show how we can change the system.

In addition to a redirection of resources, reforming drug policy requires a relocation of influence. In the context of the aims of decolonizing drug policy, it is unsustainable that the UN agency tasked with dealing with crime, the UN Office on Drugs and Crime (UNODC), also holds the portfolio on drug use, which is an issue of health and bodily autonomy. With a broader mission of making the world safer from drugs, crime, corruption and terrorism, and an active commitment to supporting governments in the practical implementation of the colonial international drug policy commitments[24], there is little space for questioning the hegemonic powers behind international drug policy or creating political support to explore a decolonized path forward. A clear demonstration of this tension is found in the UNODC strategy, which seeks to improve HIV prevention, treatment and care for people who use drugs but fails to use the term 'harm reduction'. Focusing on prevention, treatment and care allows UNODC to endorse services rather than engaging with the more holistic approach to drug use inherent in the term harm reduction.[xv] As described by Harm Reduction International:

Harm reduction is rooted in a commitment to addressing discrimination and ensuring that nobody is excluded from the health and social services they may need because of their drug use, their race, their gender, their gender identity, their sexual orientation, their choice of work, or their economic status. People should be able to access services without having to overcome unnecessary barriers, including burdensome, discriminatory regulations.[25]

21 Ibid.
22 Ibid.
23 Schmelzer, A. / The Denver Post (7 September, 2020), 'Call Police for a Woman Who is Changing Clothes in an Alley? A New Program in Denver Sends Mental Health Professionals Instead' [web article, accessed October 2021].
24 UNODC (2021), 'Strategy 2021-2025' [pdf].
25 Harm Reduction International, 'What is harm reduction?' [web page, accessed October 2021].

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.

In Saskatchewan (Canada), major efforts have been made to address hepatitis C among Indigenous and rural communities by implementing nurse-led treatment; for example collaboration with Indigenous leadership both on and off reserve to actively screen and treat Indigenous people living with hepatitis C.

Indigenous Services Canada provides OAT to Indigenous populations, but civil society actors report that these programmes often specifically target abstinence rather than harm reduction.[46]

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?

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.[26]

"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

[26] A/HRC/47/28, paras 87-88.

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."[27]

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.

[27] Ibid para 87.

ENDNOTES

[i] McLeod M, Gurney J, Harris R, Cormack D, King P. COVID-19: we must not forget about Indigenous health and equity. Australian and New Zealand Journal of Public Health [Internet] [cited 2020 Jul 15];n/a. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/1753-6405.13015

[ii] Burns J. Florida Picks Harm Reduction Over Politics With New Needle Exchange Law [Internet]. Forbes 2019 [cited 2020 May 13]. Available from: https://www.forbes.com/sites/janetwburns/2019/06/28/florida-picks-harm- reduction-over-politics-with-new-needle-exchange-law/

[iii] Florida Health. Infectious Disease Elimination Act (IDEA) | Florida Department of Health [Internet]. 2019 [cited 2020 May 13]. Available from: http://www. floridahealth.gov/programs-and-services/idea/index.html

[iv] Global State of Harm Reduction 2020. Harm Reduction International. London, UK, 2020

[v] Ministry of Health (New Zealand). 'High Alert' website launched to help reduce drug harm [Internet]. Ministry of Health NZ2020 [cited 2020 Jul 29]. Available from: https://www.health.govt.nz/news-media/media-releases/ high-alert-website-launched-help-reduce-drug-harm

[vi] Global State of Harm Reduction 2020. Harm Reduction International. London, UK, 2020

[vii] Global State of Harm Reduction 2020. Harm Reduction International. London, UK, 2020

[viii] Graham R, Masters-Awatere B. Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research. Australian and New Zealand Journal of Public Health 2020;44(3):193–200.

[ix] Markwick A, Ansari Z, Sullivan M, Parsons L, McNeil J. Inequalities in the social determinants of health of Aboriginal and Torres Strait Islander People: a cross-sectional population-based study in the Australian state of Victoria. International Journal for Equity in Health 2014;13(1):91.

[x] Pearson O, Schwartzkopff K, Dawson A, Hagger C, Karagi A, Davy C, et al. Aboriginal Community Controlled Health Organisations address health equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia. [Internet]. BMC Public Health - In Review; 2020 [cited 2020 Aug 18]. Available from: https://www. researchsquare.com/article/rs-25090/v1

[xi] Zambas SI, Wright J. Impact of colonialism on Māori and Aboriginal healthcare access: a discussion paper. Contemp Nurse 2016;52(4):398–409

[xii] Global State of Harm Reduction 2020. Harm Reduction International. London, UK, 2020

[xiii] Global State of Harm Reduction 2020. Harm Reduction International. London, UK, 2020

[xiv] Global State of Harm Reduction 2020. Harm Reduction International. London, UK, 2020

[xv] Daniels, C., Aluso, A., Burke-Shyne, N. et al. Decolonizing drug policy. Harm Reduct J 18, 120 (2021). https://doi.org/10.1186/s12954-021-00564-7