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)
Name of State Name of Survey Respondent	Brazil Nucleo da Defensoria Pública do Estado de São Paulo
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Can we attribute responses to this questionnaire to your Institution publicly*? *On OHCHR website, under the section of SR health	Yes - X 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?

Racism and how it affects access to health is a great issue in Brazil, especially for black people. Despite being half of Brazil's population, according to IBGE (Brazilian Institute of Geography and Statistics) black people have lower incomes and higher rates of poverty than white people, which compromises access to health care, medicines, and information. According to National Health Research ("Pesquisa Nacional de Saúde") in 2013, by Brazil's Ministry of Health, black and biracial people have accessed health care fewer times than the white population; in the same way, just a minority of this group could afford private health care. Yet, some minorities within this group also face other forms of discrimination and prejudice alongside racism.

For instance, black women are more vulnerable because of sexism and racism, which reflects in mistreatment and violence, especially obstetric violence – which is a broad concept that comprehends any violence against women before and after labor. Examples of such kind of violence experienced and reported by black women are shorter medical consultations, lack of information on pregnancy risks, and racist remarks. Studies have appointed that black women who are poor, very young, who are denied the right of a companion, sex workers, alcohol/drug addicts, or homeless are more prone to negligence and omission during gestation, labor, postpartum, and abortion procedures. That was unfortunately the case of "*Alyne" v. Brazil*, a landmark decision about maternal mortality. Alyne da Silva Pimentel Teixeira was a young, poor pregnant black woman that died in 2002 because of racism and negligence of Brazil's healthcare system. In 2003, a domestic claim was submitted to the judiciary, but after four years without a decision, the Center for Reproductive Rights and "Advocacia Cidadã pelos Direitos Humanos" submitted an international claim before the CEDAW Committee. In 2011, the Committee held Brazil accounted for violations of article 2(c) (access to justice); article 2(e) (the state's obligation to regulate activities of private health providers), in conjunction with article 1 (discrimination against women), read together with General Recommendations 24 (on

women and health) and 28 (related to article 2 of the Convention); and article 12 (access to health).

Incarcerated women, who are majority black women, suffer additionally with precarious conditions in prisons, like lack of health assistance and period poverty. According to a report by National Penitentiary Department ("Departamento Penitenciário Nacional"), 24,9% of 37.828 female inmates are incarcerated in units that cannot provide an adequate health structure, which is, by itself, a violation to Brazil's legislation. Most female prisons don't offer pads or tampons to inmates, as hygiene kits are the same for both genders, so they must improvise - with bread, newspapers, traps, toilet paper - or rely on family to provide them when visiting. However, contrary to men, who are often visited by relatives and companions who bring provisions, women in prison are usually forgotten by their families. They also are victims of obstetric violence, such as the abrupt separation of babies after labor or being denied breastfeeding.

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.

As established in the first question, the most affected people are black women since they are subject to double vulnerability because of institutional racism and sexism. Poverty is also concentrated in this group.

As stated before, pregnant black women have fewer prenatal follow-ups and don't receive enough information about pregnancy risks compared to white women. Also, they receive less analgesia during medical procedures, because they are falsely considered "stronger" – a racist stereotype about black people - and are more mistreated and disrespected in public and private institutions.

During the COVID-19 pandemic, black mothers had a higher mortality rate than white mothers. According to a report from "Fundação Oswaldo Cruz" (FIOCRUZ), a health research organization in Brazil, 56,2% of 1.204 deaths registered between 2020 and 2021 were of black mothers. In the same way, black women had a lower vaccination rate compared to white women.

Black women that are not heterosexual or cisgender also face difficulties because of LGBT-phobia, since most health services have a strict heteronormative view of women's health, focusing only on contraception, pregnancy care, and prevention of sexually transmitted infections (STIs) and exams to prevent womb and breast cancer. Because of

that, black women who are lesbian, bisexual, or trans suffer not only from discrimination but also from invisibility regarding their health. A report named Homophobic Violence in Brazil ("Violência Homofóbica no Brasil"), in 2013, suggests that black people are the biggest victims of violence based on sexual orientation and gender identity.

Lastly, most of the women that endure period poverty are black women, a reality harder for girls in school age. Since these girls are too poor to buy tampons and pads, most do not attend school during their period. Alas, most brazilian public schools do not have an adequate infrastructure – like restrooms, separated restrooms, sinks – for these girls, much less soap or toilet paper. According to a report about Period Dignity by UNICEF, it is estimated that 1.24 million brazilian girls, which accounts for 11.6% of the total number of female students, do not have access to toilet paper in their school restrooms; among these girls, 66.1% are black. In the same way, black girls have three times the chance of not having a bathroom at their homes/property than white girls. Yet, the probability of a black girl living in a house with four or more privative bathrooms is 78% lower than a white girl in the same conditions.

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.

In Brazil, we have the Unified Health System (SUS) which has as one of its main functions the health care of every individual completely free of charge, supported by the Brazilian State. The prohibition of any type of discrimination in health care is expressed in the country's own Constitution when it provides in article 196 that "Health is a right of all and a duty of the State, guaranteed through social and economic policies aimed at reducing the risk of death, disease and other diseases and universal and equal access to actions and services for their promotion, protection, and recovery." (Federal Constitution of 1988).

However, the reality of health in Brazil differs from what its laws propose and, although the right to health is foreseen as a universal and integral right in the country, the Unified Health System, which in theory would enable access to health mainly for the poorest people, does not do so effectively and fully. According to the Brazilian Institute of Geography and Statistics (IBGE) and data from the National Health Survey that

interviewed thousands of people in all states and regions of Brazil in 2019, 71.5% of Brazilians — which corresponds to more than 150 million people — do not have any supplementary health service, such as medical-hospital or dental plans. This only reinforced the role of the public health system in serving the population and fighting diseases.

The indicator did not show great oscillation in relation to the previous edition of 2013 when 72.1% of Brazilians claimed to have access only to the SUS. Basic units (public health system) were the Brazilian's favorite destination to seek health services, being the preference of 46.8% of respondents. Soon after, came the private physicians' offices and private clinics, with 22.9%.

In addition, it is worth highlighting the social inequalities that this research demonstrated: 16.1% of people without education or with incomplete Elementary Education have access to supplementary health, against 67.6% of those with complete Higher Education. As for income, only 2.2% of people earning less than 1/4 of the minimum wage have a health plan, a proportion that rises to 86.8% among those earning more than five minimum wages per month.

Also, according to the IBGE, there is a direct relation between color or race and the level of education and health plan coverage, meaning that white people or people with higher education have the highest proportions of plan coverage.

It is necessary to point out that some social sectors find it even more difficult to access health care due to a historically constructed structure of marginalization. Among the social sectors most affected in terms of access to health, black women stand out, who feel the impact of two negative aspects present within the scope of discrimination, racism, and sexism, as mentioned in the previous questions.

Available in: https://summitsaude.estadao.com.br/desafios-no-brasil/acesso-a-saude-150-milhoes-de-brasileiros-dependem-do-sus/#:~:text=76%2C2%25%20da%20popula%C3%A7%C3%A3o%20procurou%20um%20m%C3%A9dico&text=De%20acordo%20com%20a%20Pesquisa,todas%20as%20interna%C3%A7%C3%B5es%20no%20Pa%C3%ADs.

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.

One of the legacies of colonialism was the slavery of the black population for a long time (approximately 300 years). Brazil is the country that practiced slavery the longest and was the last to abolish it, only in 1888. In addition, it is the country that practiced slavery on a larger scale.

As a result, we have the largest black population outside of Africa. With the abolition of slavery, black people began to have, from a legal point of view, their humanity finally recognized, and they achieved the status of citizens with rights and duties. However, the legal achievement was not enough to break the structural barriers that continued to disadvantage the black population in accessing public goods, rights, and services. As a result of the period of slavery in the country, the "quilombos" were created by the slaves and their descendants to serve as a refuge for them. Nowadays, "quilombos" are communities spread across the country. The residents of the "quilombos" performed traditional health practices to supply the demands of the population living there. Traditional health practices are recognized worldwide due to their important role in health promotion, as well as in the prevention and treatment of diseases. Such practices result from the accumulation of popular wisdom and traditional communities, quilombos and "terreiros communities", in the form of theories, beliefs, and experiences, whose benefits are often inexplicable according to the logic of the hegemonic scientific model.

Furthermore, it is recognized that, in certain situations, the use of natural products can be safer and more effective compared to the adoption of drugs processed by the pharmaceutical industry. Traditional communities such as quilombos and "terreiro communities" are spaces typically characterized by bonds of solidarity and mutual care for the populations that live in them. In these territories, the therapeutic use of natural products (including herbal medicines), and the maintenance of vegetable gardens and spaces dedicated to healing practices jointly contribute to health care from an integral perspective.

Among the traditional health practices, it is worth mentioning the figure of traditional midwives, among which the "quilombolas", who provide childbirth care and enjoy recognition by the community, and the Brazilian Ministry of Health, which advocates

respect for ethnic and cultural specificities. cultural. Traditional midwives work, based on traditional knowledge and practices, favoring humanized childbirth, promoting the parturient autonomy and female solidarity ties at the moment of birth. As an established policy, there is, within the scope of the Unified Health System, the National Policy on Integrative and Complementary Practices and the National Policy on Medicinal Plants and Phytotherapeutics, which represent necessary instruments in the valorization of traditional knowledge.

Available in: https://www.defensoria.sp.def.br/documents/20122/83e20a0e-27a1-3cc1-d273-0051fcc98e1d.

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.

A good example that can be cited is the creation of the National Policy for the Integral Health of the Black Population (PNSIPN), through Ordinance GM/MS number 992/2009. This public policy is the result of the recognition of historical state neglect for the treatment and access to health of the black population. The Brazilian State for a long time disregarded the daily obstacles that negatively affect the health indicators of this population - precocity of deaths, high rates of maternal and infant mortality, higher prevalence of chronic and infectious diseases, and high levels of violence, therefore the National Policy of Integral Health of the Black Population seeks to overcome this situation through mechanisms to promote the integral health of the black population and to confront institutional racism in the Unified Health System (SUS).

In addition to indicating the diseases that most affect the black population in Brazil, the National Policy for the Integral Health of the Black Population has among its specific objectives the inclusion of the theme Combating Gender and Sexual Orientation Discrimination, with emphasis on the intersections with the health of the black population, in the processes of training and permanent education of health workers and the exercise of social control.

With this, there was recognition that racism and sexism are social indicators of health and that the guarantee of integral health care for black women, for example, involves considering the heterogeneous character of this group, based on diverse factors such as sexual orientation and gender identity. Confronting health inequities and institutional

racism involves a universal health policy that meets the integrality of demands, considers the diversity of the population served, and that has health professionals committed to offering a public service, free of charge, integral, and with quality.

Available in: https://www.defensoria.sp.def.br/documents/20122/e0c47767-172b-d828-2373-b72c9a262372

https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_saude_populacao_negra_3d.pdf

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.

As mentioned earlier, Brazil has a National Policy for the Integral Health of the Black Population (PNSIPN), which aims to guide health professionals and the population to combat racism in the health institutions, public and private. According to the Brazilian Ministry of Health, its work has been focused on building new possibilities and access, proof of this is the actions that qualify the professionals who are part of the SUS in the fight against racism and in the integral promotion of health.

Also, according to the Ministry of Health, the "Saber para Cuidar" initiative, which addresses sickle cell disease at schools, within the scope of the "Saúde na Escola" program, was presented to 1,109 health professionals. Another 1,300 people participated in an extension project that proposes activities to combat institutional racism. In addition, in 2018, it produced the Management Manual for the Implementation of the National

Policy for the Integral Health of the Black Population, which guides managers on the diseases prevalent in this population.

One of the goals of the Manual is to promote reflection on the subject and guide health professionals so that, in their work routine, they can identify the ethnic-racial inequalities that impact the health of the black population, in addition to monitoring and evaluating the results of actions to prevent and combat these inequities.

The document also provides general information about the black population, their culture, and traditional health practices. The publication is part of a series of strategic actions that the ministry has been developing since the launch of the National Policy for the Integral Health of the Black Population (PNSIPN) in 2009. The Policy aims to promote health care for the black population and is guided by the principles and guidelines of integrality, equity, and universality, fighting racism and discrimination in the institutions and services of the Unified Health System (SUS).

The PNSIPN defines the principles, framework, objectives, guidelines, strategies, and management responsibilities, aimed at improving the health conditions of this segment of the population. It includes care, attention, health promotion, and disease prevention actions, as well as participatory management, popular participation and social control, knowledge production, training, and continuing education for health workers, aimed at promoting equity in the health of the black population.

Available in : https://aps.saude.gov.br/noticia/11636

https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_saude_populacao_negra_3d.pdf

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."

A good example that enables accountability, both in the private and public sectors, for the practice of racism is the country's own criminal legislation. Racial insult is considered a crime against honor and consists of the offense to the dignity or decorum of someone,

using elements referring to race or color. The penalty provided for the crime of racial slur varies between one to three years in prison and a fine. The crime is prosecuted through public criminal action conditioned to representation, that is, who promotes the action is the State's attorney, provided that the offended person, after registering the Occurrence Bulletin, formally confirms, before the Police Chief, the interest in ascertaining the facts within a period of six months after becoming aware of the identity of the author of the crime.

In this case the offense is directed at a single offended person. The crimes of racism are provided for in Law No. 7,716/89. This crime is committed by anyone who practices, induces, or incites discrimination or prejudice based on race, color, ethnicity, religion, or national origin. It also characterizes a crime of racism to refuse, deny or prevent a student from enrolling in or entering a public or private educational establishment of any degree; prevent access or refuse accommodation in a hotel, pension, inn, or any similar establishment prevent access or refuse service in restaurants, bars, or similar places open to the public, based on race, ethnicity, religion, or national origin, among other conducts. The penalties can vary from one to five years. Such crimes are prosecuted through unconditional public criminal action, that is, it is the Public Prosecutor's Office that initiates the criminal action, regardless of the victim's representation.

The Federal Constitution of Brazil establishes that crimes of racism are non-bailable and imprescriptible. Both racism and racial slurs can be identified in the observation of everyday conduct that is often masked as "jokes" or supposedly well-intentioned speeches and actions. The most typically observed racist behaviors are those of inferiority, humiliation, offensive comments about appearance, intellectual capacity or moral values, verbal abuse, refusal of care and physical aggression. Racial insult and racism can be reported by the victim, who must go to the nearest Police Station to register the occurrence.

Cases of racism can also be reported at the National Ombudsman for Racial Equality, an integral part of the Special Secretariat for Policies for the Promotion of Racial Equality of the Ministry of Justice and Citizenship – SEPPIR/MJC. It is up to the Ombudsman to exercise its institutional role of receiving, recording, and monitoring cases of denunciation of racism. Dial Human Rights - Dial 100 is the Ombudsman's main communication channel. Complaints can be made anonymously and/or confidentially. The telephone service is free and operates 24 hours a day, 7 days a week. All complaints are analyzed and forwarded to appropriate institutions and/or responsible organs. In addition, the victim or someone interested can seek guidance from the Public Defender's

Office, the State's attorney, the Coordination of Policies for the Black and Indigenous Population (State Department of Justice and Defense of Citizenship), and the State Council for the Development and Participation of the Black Community.

Another important tool, in the health scope specifically, is Dial Health 136, option 7, which is the call center channel for public manifestations of the services provided by the SUS. Dial 136 analyzes and forwards the demands received and acts, spontaneously, in active contact with users of public health services so that the information collected can improve public health policies, that is, it is a resource that can facilitate access to public health services. health services and receive complaints about cases of racism suffered in consultations.

Available in: https://www.defensoria.sp.def.br/documents/20122/83e20a0e-27a1-3cc1-d273-0051fcc98e1d

https://aps.saude.gov.br/noticia/11636

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.

Between 2015 and 2019, Brazil had a growth of 25,5% in public health expenditure, according to a document by the Health Ministry and other entities. Nonetheless, private health care had a significantly higher growth of 39,6% in the same period.

In 2019, the average of Organization for Economic Co-operation and Development (OECD) countries had public healthcare systems accounting for 6,1%, of their Gross Domestic Product GDP), whilst private healthcare accounted for 2.1% of GDP. In Brazil, in the same year, the opposite situation occurred: private regimes represented 5.4% of GDP and public regimes, 3.9%.

According to the authors, there is still a model in Brazil focused on curative care, with lower volumes of funding for long-term care and rehabilitation, which they evaluated will be challenged in the next years because of Brazil's aging population and post-Covid-19 long term care. In 2015-2019, curative care represented half of the health expenditures (49.8%), followed by 20.5% of expenditures on medicines and medical items and 11.3% on complementary exams. Altogether, they accounted for 81.5% of total expenditures,

with a smaller share of prevention, health promotion and surveillance, long-term care, and rehabilitation and management.

In 2019, the examination of the participation of each funding scheme in health spending also showed that curative care was mostly financed by public schemes (52.5%), followed by voluntary prepayment schemes (36.9%). In that same year, expenditures on prevention, promotion, and health surveillance are, for the most part, financed by government funding schemes – notably by "Sistema Único de Saúde" (SUS), Brazil's publicly funded health care system, responsible for 89.6% of these. On the other hand, expenditures on medicines and medical items were mostly financed by people's own money (87.7%).

Available in: https://portal.fiocruz.br/noticia/gasto-capita-com-saude-aumentou-293-de-2015-2019

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 legal institution of human slavery, mostly of african groups and their descents, was prevalent in Brazil for almost 300 years, making it the country that practiced slavery for the longest time – for comparison, black slavery in the USA was practiced between 1776 until 1865. Brazil was the country to abolish it, only in 1888. Furthermore, it was the nation that practiced it on a larger scale (about five million Africans were captured and trafficked to be enslaved on monoculture plantations). As a result, Brazil has the largest black population outside the African continent and the second largest in the world, second only to Nigeria.

With the abolition of slavery, black people began to have, from a legal point of view, their humanity finally recognized and achieved the status of citizens with rights and duties. However, the legal conquest was not enough to break the structural barriers that continued to negatively impact the black population in terms of access public goods, rights and services. This is due to the systematic omission of the Brazilian State regarding the promotion of policies, programs, and anti-discrimination legislation focused on overcoming the various scales of violations of rights to which the black population is subject.

Systemic racism in public and private health care prevents black people to access these services, aggravating inequality between them and other ethnic groups, as mentioned in the previous questions of these document.

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

The CEDAW Committee's decision on the case “Alyne” v. Brazil had a critical impact on issues regarding quality maternal health to all women, free of discrimination, and accountability for the state’s obligation to ensure quality health care services. The decision recommended that Brazil adopted the following measures:
(a) Ensure women’s right to safe motherhood and affordable access for all women to adequate emergency obstetric care, in line with general recommendation No. 24 (1999) on women and health; (b) Provide adequate professional training for health workers, especially on women’s reproductive health rights, including quality medical treatment during pregnancy and delivery, as well as timely emergency obstetric care; (c) Ensure access to effective remedies in cases where women’s reproductive health rights have been violated and provide training for the judiciary and for law enforcement personnel; (d) Ensure that private health care facilities comply with relevant national and international standards on reproductive health care; (e) Ensure that adequate sanctions are imposed on health professionals who violate women’s reproductive health rights; and (f) Reduce preventable maternal deaths through the implementation of the National Pact for the Reduction of Maternal Mortality at state and municipal levels, including by establishing maternal mortality committees where they still do not exist, in line with the recommendations in its concluding observations for Brazil, adopted on 15 August 2007 (CEDAW/C/BRA/CO/6).

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

[2] 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."[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 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.

[3] Ibid para 87.