DREXEL UNIVERSITY
Ubuntu Center
on Racism, Global Movements
& Population Health Equity
Dornsife School of Public Health

Racism and the Right to Health

Submitted to:
Dr. Tlaleng Mofokeng
Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health

Submitted from:
Ubuntu Center on Racism, Global Movements & Population Health Equity
Dornsife School of Public Health, Drexel University

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) Academic Center
Name of State Name of Survey Respondent	Ubuntu Center on Racism, Global Movements & Population Health Equity ("Ubuntu Center")
Email	ubuntu@drexel.edu
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):

DREXEL UNIVERSITY
Ubuntu Center
on Racism, Global Movements
& Population Health Equity
Dornsife School of Public Health

Ubuntu Center Submission
Racism and the Right to Health

The Ubuntu Center on Racism, Global Movements & Population Health Equity,("Ubuntu Center") Dornsife School of Public Health at Drexel University unites diverse partners to generate and translate evidence, accelerate antiracism solutions, and transform the health of communities locally, nationally, and globally. The Ubuntu Center addresses ways in which structural racism and inequities impact health. The meaning of the center, Ubuntu "I am...because we are" embraces the essence of what we stand for. We collectively work towards a just future, free from systems of oppression, full of new possibilities through bold, collective action, and an equitable world in which all individuals and communities are healthy and thrive.

The Ubuntu Center is rooted in the disproportionate impact of the COVID-19 pandemic; the state-sanctioned violence by law enforcement in 2020, most notably the killings of Breonna Taylor and George Floyd; the resulting global protests; and the renewed sense of urgency around racism as a public health crisis. Partnering with faculty, staff, movement fellows, global constituents, and community members, we work together to connect antiracism and population health scholarship and action locally and nationally to ongoing work happening in other parts of the world. We provide dedicated spaces for rigorous, transdisciplinary research and bold collective action designed to address racism and eliminate racial health inequities.

The Ubuntu Center is pleased to provide this submission in support of the Special Rapporteur on the Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health's ("Special Rapporteur on Health") forthcoming report on racism and the right to health. The Ubuntu Center's contribution focuses on highlighting relevant intersections between racism and health in the two countries in which it operates: Brazil and the United States of America. Specifically, this submission responds to highlighting ongoing manifestations of racism within the context of the right to health, as well as good practices related to public health interventions, accountability mechanisms and reparations in Brazil and the US.

Ongoing Manifestations of Racism and its Impact on the Right to Health (Question #1)

Criminalization is one key manifestation of structural discrimination and racism related to the right to health, impacting health outcomes, health access and underlying determinants of health. Both Brazil and the United States use criminal laws that disproportionately affect people of color, including women.

In Brazil, criminalization of abortion and restrictive abortion laws disproportionately impact Black women and other women of color. Abortion is only permissible in cases to save a woman's life or in cases of rape; it is criminalized in all other situations.[1, 2] The criminalization of abortion forces women, often from rural regions, to seek unsafe abortions. These procedures place women at greater risk of maternal morbidity and mortality, as unsafe abortion is one of the main causes of maternal death (4th or 5th cause in Brazil).[3] In these instances, maternal mortality and morbidity disproportionately impact women who are Black, indigenous and poor.[4] For instance, in 2018, an Afro-Brazilian woman named Ingriane Barbosa Carvalho de Oliveira died from an infection after resorting to unsafe abortion.[5] Even in the scenarios where abortion is legal, like in cases of rape, there are significant barriers to access. In these instances, women and girls experience overly burdensome obstacles in accessing legal abortion services. For example, in 2020, when a

hospital denied abortion services to a 10-year-old[6] girl who became pregnant as a result of rape, she had to both obtain judicial authorization, as well as travel 900 miles, to access an abortion provider. Moreover, even for post-abortion care, evidence has shown that Black and Brown women face more institutional barriers to receiving services.[7]

In the US, the criminalization and incarceration of Black pregnant women is part of a broader manifestation of racism in the criminal legal system. Some laws explicitly criminalize pregnancy based on the belief that women who are marginalized or who use drugs endanger the fetuses. These laws are disproportionately enforced against poor women and women of color, and[8] laws that criminalize substance use during pregnancy amplify the harms of racial inequities in accessing substance use disorder treatment.[9] As is the case in Brazil, U.S. laws restricting access to and criminalizing abortion disproportionately harm Black and poor women and contribute to alarmingly high rates of maternal mortality.[10] The criminalization of abortion and pregnancy feed into a general trend within the criminal justice system: that Black American women are imprisoned at a rate that is 1.7 times higher than White U.S. women.[11] This inequity is even larger for American Indian/Alaska Native women.[11] The vast majority of incarcerated women are survivors of sexual violence, which is itself shaped by structural racism and colonization.[12, 13] Relatedly, the prevalence of lifetime and current mental health disorders is higher among incarcerated women than women without a history of incarceration, and these mental health issues can be exacerbated through incarceration and lack of adequate mental healthcare.[12] Moreover, evidence shows that incarceration reduces life expectancy.[14]

Good practices and examples of public health interventions, activities that enable accountability and reparations (Questions #7, #8, #11)

Public Health Interventions (Q. #7)

One primary way that Brazil is trying to reduce racial health disparities is through its Family Health Strategy, the country's national primary care program and main mechanism for achieving Universal Health Care. The Strategy centers on multidisciplinary healthcare teams, geographically defined catchment populations, and proactive outreach services provided by community health workers. The program was initially, intentionally expanded in communities with greater needs, including for communities that had greater needs among Black Brazilians. Evidence demonstrates that this expansion of the Family Health Strategy has been associated with reductions in infant mortality, cardiovascular deaths, and reductions in health inequalities, including between race/ethnic groups.[15]

In both Brazil and the US, the COVID-19 pandemic caused damage to the sexual and reproductive health of women, exacerbating health outcomes for Black women and other women of color who experience intersectional inequalities (e.g., gender, race, territory, class).[16] However, in this context, there has been some advances, particularly in access to legal abortion. Specifically, the use of telemedicine has helped women access medication abortion in the midst of COVID-19 lockdowns.[17,18,19] Even after the end of COVID-19 lockdowns, telemedicine continues to be used as a resource that facilitates access to services for girls and women.

Accountability (Q. #8)

One of the cornerstones of accountability is the collection of disaggregated data to demonstrate the scope and scale of racism and structural discrimination. In Brazil, Black movements have been pushing the use of data on race/color to produce scientific evidence showing racial inequalities in the access to health services, education, housing, employment, violence, and health outcomes, as well as the various manifestations of racism that place the Black population at a disadvantage in all positive indicators. As a result of the advocacy of the Black movements, Brazil is one of the countries in Latin America with the greatest tradition in collecting information about race/color. In the country, the insertion of the variable race/color occurred for the first time in 1872, and continues through current day (the last census data was collected in 2010).[20]

Another important achievement for race/color data collection in Brazil was the inclusion of this information in the National Health Information Systems, an old demand of the Black Movement since it would allow the identification of the health situation of the Black population, and help to evaluate, plan, and implement health policies to reduce racial injustice and achieve equity. Race/color was first introduced in the Mortality Information Systems (Sistema de Informação de Mortalidade - SIM), the Live Births system (SINASC) and the Disease Notifiable system (SINAN) in 1996, followed by its inclusion in the Hospitalization Information System (SIH) in 2008. Finally, in 2017, the Ministry of Health mandated the collection and disaggregation of data based on race/color in the Unified Health System (SUS).[21] These data collection efforts make it possible to highlight the pervasive effects of racism on the living and health conditions of the Black and indigenous population in the country while allowing the monitoring of health indicators in the national territory.[22-24]

Reparations (Q. #11)

Within the US, the struggle for reparations for African enslavement and subsequent institutionalized anti-Black discrimination has continued since the 1860s and has yet to result in national-level policy. This type of reparatory action and large-scale financial compensation, however, would likely narrow Black-White inequities across a broad range of health outcomes.[25]

Despite lack of action thus far on reparations for African enslavement, there is a precedent for reparations at both the state and federal levels.[26] One example is in reparations policies for victims of forced sterilization under U.S. state-sponsored eugenics programs.[27, 28] The most recent of these initiatives is in the state of California, where working-class Latina and Black women, and also men, were disproportionately sterilized.[29, 30] Between 1909 and 1979 patients in state mental health institutions and prisons were sterilized in the name of promoting public health and social welfare.[30] Beginning in 2022, survivors of forced sterilization in California can apply for compensation through the California Victim Compensation Board. California follows the states of North Carolina and Virginia to offer reparations for survivors of state-sponsored eugenics programs.[31, 32] The field of public health and reproductive health specifically has a deep history of racism—including medical experimentation, forced sterilization, segregated and lethal healthcare—that needs to be further acknowledged and repaired at both local and global levels.[33] Reparations for state-sponsored forced sterilizations are an important acknowledgement of past wrongs and a step towards healing communities.

References

1. *Brazil's Abortion Provisions*. [cited 2022 June 2]; Available from: https://reproductiverights.org/maps/provision/brazils-abortion-provisions/.
2. *The World's Abortion Laws*. Available from: https://reproductiverights.org/maps/worlds-abortion-laws/?country=BRA.
3. Domingues, R., et al., *Unsafe abortion in Brazil: a systematic review of the scientific production, 2008-2018.* Cad Saude Publica, 2020. **36Suppl 1**(Suppl 1): p. e00190418.
4. Motta, C.T. and M.R. Moreira, *Will Brazil comply with the SDG 3.1 of the 2030 Agenda? An analysis of maternal mortality, from 1996 to 2018.* Cien Saude Colet, 2021. **26**(10): p. 4397-4409.
5. Guimarães, P., *A morte evitável de Ingriane*, in *Catarinas*. 2018.
6. Starr, D. *A 10-Year-Old Girl's Ordeal to Have a Legal Abortion in Brazil*. Human Rights Watch, 2020.
7. Freitas Goes, E., et al., *Barriers in Accessing Care for Consequence of Unsafe Abortion by Black Women: Evidence of Institutional Racism in Brazil.* J Racial Ethn Health Disparities, 2021. **8**(6): p. 1385-1394.
8. *Criminalizing Pregnancy*. 2017, Amnesty International: London, UK.
9. Simon, R., J. Giroux, and J. Chor, *Effects of Substance Use Disorder Criminalization on American Indian Pregnant Individuals.* AMA Journal of Ethics, 2020. **22**(10): p. 862-867.
10. Vilda, D., et al., *State Abortion Policies and Maternal Death in the United States, 20152018.* Am J Public Health, 2021. **111**(9): p. 1696-1704.
11. Carson, E.A., *Prisoners in 2020 - Statistical Tables*. 2021, Bureau of Justice Statistics.
12. Karlsson, M.E. and M.J. Zielinski, *Sexual Victimization and Mental Illness Prevalence Rates Among Incarcerated Women: A Literature Review.* Trauma Violence Abuse, 2020. **21**(2): p. 326-349.
13. Crenshaw, K., *Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color.* Stanford Law Review, 1991. **43**(6): p. 1241-1299.
14. Widra, E., *Incarceration shortens life expectancy*, in *Prison Policy Initiative*. 2017.
15. Hone, T., et al., *Association between expansion of primary healthcare and racial inequalities in mortality amenable to primary care in Brazil: A national longitudinal analysis.* PLoS Med, 2017. **14**(5): p. e1002306.
16. Cousins, S., *COVID-19 has "devastating" effect on women and girls.* Lancet, 2020. **396**(10247): p. 301-302.
17. Ramaswamy, A., et al., *Medication Abortion and Telemedicine: Innovations and Barriers during the COVID-19 Emergency*, in *Policy Watch*. 2021, Kaiser Family Foundation.
18. Cohen, M.A., et al., *Special ambulatory gynecologic considerations in the era of coronavirus disease 2019 (COVID-19) and implications for future practice.* Am J Obstet Gynecol, 2020. **223**(3): p. 372-378.
19. *Legal abortion via telehealth: guidelines for health services*. 2021[ebook] Available at: <https://anis.org.br/wp-content/uploads/2021/05/Aborto-legal-via-telessa%C3%BAde-orienta%C3%A7%C3%B5es-para-servi%C3%A7os-de-sa%C3%BAde-1.pdf> [Accessed 2 June 2022].
20. Travassos, C. and D.R. Williams, *The concept and measurement of race and their relationship to public health: a review focused on Brazil and the United States.* Cad Saude Publica, 2004. **20**(3): p. 660-78.
21. Barros, R., *PORTARIA Nº 344, DE 1º DE FEVEREIRO DE 2017*, G.d. Ministro, Editor. 2017.

22. Boccolini, C.S., et al., *Factors associated with perceived discrimination in health services of Brazil: Results of the Brazilian National Health Survey, 2013.* Cien Saude Colet, 2016. **21**(2): p. 371-8.
23. de Oliveira Ramos, D., E.F. Goes, and A.J.F. Ferreira, *Intersection of Race and Gender in Self-Reports of Violent Experiences and Polyvictimization by Young Girls in Brazil.* J Racial Ethn Health Disparities, 2021.
24. Barber, S., et al., *At the intersection of place, race, and health in Brazil: Residential segregation and cardio-metabolic risk factors in the Brazilian Longitudinal Study of Adult Health (ELSA-Brasil).* Soc Sci Med, 2018. **199**: p. 67-76.
25. Bassett, M.T. and S. Galea, *Reparations as a Public Health Priority - A Strategy for Ending Black-White Health Disparities.* N Engl J Med, 2020. **383**(22): p. 2101-2103.
26. *Search the Compensation and Reparations for the Evacuation, Relocation, and Internment Index (Redress Case Files)*. 2017 [cited 2022 June 2]; Available from: https://www.archives.gov/research/japanese-americans/redress.
27. Stern, A.M., et al., *California's Sterilization Survivors: An Estimate and Call for Redress.* Am J Public Health, 2017. **107**(1): p. 50-54.
28. *California Launches Program to Compensate Survivors of State-Sponsored Sterilization*. 2021.
29. Novak, N.L., et al., *Disproportionate Sterilization of Latinos Under California's Eugenic Sterilization Program, 1920-1945.* Am J Public Health, 2018. **108**(5): p. 611-613.
30. Stern, A.M., *Sterilized in the name of public health: race, immigration, and reproductive control in modern California.* Am J Public Health, 2005. **95**(7): p. 1128-38.
31. *Welcome to the Office of Justice for Sterilization Victims*. [cited 2022 June 2]; Available from: https://ncadmin.nc.gov/about-doa/special-programs/welcome-office-justice-sterilization-victims.
32. Robertson, G. *Virginia lawmakers OK payout to forced sterilization survivors*. Reuters, 2015.
33. Swanson, M.L., et al., *Obstetrics and Gynecology and Reparations: The Debt We Owe (and Continue to Accumulate).* Health Equity, 2021. **5**(1): p. 353-355.