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): NGO
Name of State Name of Survey Respondent	Brazil Gisela Foz
Email	giselafoz@live.com; advocacy@milhaspelavidadasmulhere.com.br;
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): Please refer to the NGO as “Milhas pela Vida das Mulheres”

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.

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[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?

In Brazil, institutional racism is a constant in healthcare. Institutional racism is defined by Kalckmann et al. (2007) as the "collective failure of an organization to provide an appropriate and professional service to people because of their color, culture or ethnic origin. It can be seen or detected in processes, attitudes, and behaviors that amount to discrimination through unintentional prejudice, ignorance, neglect, and racist stereotyping that causes disadvantage to people of minority ethnicity." In Brazil, institutional racism in health care preponderantly affects black and indigenous populations. Study shows that the black population has been discriminated against in health services, both as users and as professionals. Black people are more vulnerable to various pathologies due to the historical process of social, economic, political, and cultural exclusion to which it has been subjected. The health services are responsible to ensure adequate care, which would reduce this vulnerability. However, it was verified that the health services, through their professionals, increase the vulnerability of these population groups, imposing barriers to access, reducing the possibility of dialogue, and causing the withdrawal of users[2].

Among the reports of racism and discrimination gathered by the abovementioned study are: (i) restriction to access healthcare services, due to claims that black people are more resistant to pain and illness and a tendency to minimize their complaints; (ii) poor Quality of Prenatal and Childbirth Care, being black mothers the ones receiving poor healthcare, less anesthesia, and having to travel longer distances to seek for childbirth care; and (iii) poor Quality of Sickle Cell Care, being a genetic disease prevalent in Afro-descendants is invisibilized and hard to access proper diagnosis and care. According to the World Health Organization (WHO), in Brazil, there are 2500 children with the pathology annually, of which 20% die before the age of 5 due to complications related to it, and because it is not a subject that health professionals know about, there are difficulties in making the proper diagnosis.

A study performed by the NGO Criola on rights violations during the COVID19 pandemic (2020 and 2021), showed that black women were the ones who suffered the highest rate of unemployment, sexual violence, and abortion mortality, among other indicators. This group corresponded, for example, to 45.21% of the abortion deaths in the period, compared to 17.81% of white women[3]. That was the conclusion based on national and regional data from the Rio de Janeiro state. However, the report points out that very often the information on color and gender is missing.

[2] Kalckmann, S., Santos, C. G. dos, Batista, L. E., & Cruz, V. M. da. (2007). *Racismo institucional: um desafio para a eqüidade no SUS?* Saúde e Sociedade, 16(2), 146–155. https://doi.org/10.1590/S0104-12902007000200014

[3] ONG Criola. (2021). *Mulheres Negras e Justiça Reprodutiva*. https://drive.google.com/file/d/1eHGSM3DmKx1m9NbXEqrFBKRQQnZgeoBx/view

The criminalization of abortion plays a major role in imposing barriers to access to safe abortions. The criminalization of abortion does not discourage women from undergoing an abortion, but rather pushes them towards risky practices, highlighting socioeconomic, cultural, and regional differences when faced with the same illegality of abortion. White women, with better financial conditions, in big cities, have access to safer illegal abortion methods and clinics. For that reason, the criminalization of abortion is an ongoing manifestation of racism itself, even though it has no expressed discrimination. As the Brazilian Supreme Court Minister Nelson Jobim, when judging the ADI No. 1946/DF, stated: "What matters are the consequences of the fact. Whether or not it produces, in concrete, the prohibited discrimination. It doesn't matter what the intention is."[4], as a reference to the Griggs v. Duke Power Co. case judged by the Supreme Court of the United States of America.

The result is an alarming statistic on the effects of racism and criminalization when it comes to abortion. The study points out that black women are 2.5 times more likely to die due to unsafe abortion, and they are also more vulnerable to unsafe procedures. The overall maternal mortality risk doubles when it comes to a Black Woman. Another relation that shows the weight of abortion in maternal mortality is that pregnancies that end in abortion account for 11.1% of maternal mortality for black women, 8.8% of maternal mortality for white women, and 9.5% of maternal mortality for brown women.[5]

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 abovementioned, the criminalization of abortion has a heavier burden on non-white abortion seekers. From an intersectional perspective, those who are struggling financially, living in rural areas, undocumented, homeless, and illiterate are pushed towards unsafe abortion methods. Multiple vulnerabilities are factors that jeopardize access to information and health in Brazil. And the criminalization of abortion plays a major role in imposing barriers to access to safe abortions.

Legal abortion is permitted by the Brazilian Penal Code since 1940 and provided free of charge by the Sistema Único de Saúde (SUS), under three circumstances: (i) rape or incest; (ii) risk of death of the pregnant, and, due to a 2012 Supreme Court decision; (iii) in the case of anencephaly. However, as happens in many countries around the world, the criminalization does not prevent the 500,000 illegal abortions that are estimated to occur every year among women aged 18–39 years (Diniz et al, 2019), which 48% result in medical care needs due to complications. It adds a burden to the health system, as well as extra costs to the public funds. It is also estimated that more than 200 women die because of unsafe abortion every year in Brazil.

The book "Entre a morte e a prisão: quem são as mulheres criminalizadas pela prática do aborto no Rio de Janeiro" (between death and prison: who are the women that are criminalized by abortion practice in Rio de Janeiro) organized and published

[4] Author's translation of the excerpt from the decision "que importa são as consequências do fato. Se produz, ou não, em concreto, a discriminação proibida. Não importa qual seja a intenção"

[5] Francisco, M., Monteiro, G., Adesse, L., & Levin, J. (n.d.) *As mulheres pretas, as analfabetas e as residentes na Região Norte têm um risco maior de morrer por complicações de gravidez que termina em aborto.* *. http://www.nepp-dh.ufrj.br/ole/textos/monteiro_as_mulheres.pdf

by the General Public Defender's Office of the State of Rio de Janeiro illustrated the situation in Rio de Janeiro. One of the reports in the book showed the profile of the criminalized women, by color and income. Most of them were black, poor, with little or no education, and living on the outskirts. This is because the population segment of these women is inserted in a situation of structural inequality in which several factors (social class, gender, race, urban area where they live, low level of education, etc.) converge, subjecting them to a true situation of intersectional discrimination. Consequently, the criminal prohibition of abortion reaches them in a specific way and articulates the multiple levels of subordination in which they are inserted. Abortion is the fourth biggest maternal mortality cause (behind hypertension, hemorrhage, and puerperal infection). Data presented by the Secretariat of Public Policies for Women of the Presidency of the Republic also indicate an increase in the mortality of black women, while there was a reduction in the deaths of white women between 2000 and 2012. While the deaths of white women fell from 39 to 15 per 100,000 births. Among black women, it increased from 34 to 51.

For the group of women seeking an abortion by themselves or with the assistance of a third party, often someone from their inner circle, 60% of the women facing criminal persecution under the criminalization of abortion law are black. When it comes to literacy, only in one of the criminal cases assessed by the study, out of 20, persecuted a woman with higher education. Women who seek abortion clinics have a different profile. Their pregnancies are in an earlier stage, with a greater proportion of white women (53%), a prevalence of women with better education, as well as more women with private lawyers assigned to the process[6]. By analyzing such differences, it is possible to note that the criminalization of the medical procedure in a context of multiple vulnerabilities prevents women to access the health system and the adequate structure they need in case of unsuccessful abortion. By knowing that they are breaching the law, and afraid to face the social stigma of abortion, their decision to terminate the pregnancy often comes is often delayed.

Therefore, the criminalization of abortion impacts disproportionately, targeting target black and poverty-stricken women, easy prey for penal agencies. And this same vulnerable group of women is more subject to serious injury and death as a result of abortion, considering their lesser ability to make a quick decision or to count on medical assistance (even if clandestine) for the procedure. In the emergency care provided to those who cannot endure the physical effects of the abortion procedure outside of legal medical assistance, it is common for women to be subjected to a new cycle of discrimination in the public health system and to be denied adequate care based on preconceived ideas about their sexual and reproductive behavior[7]. They are, therefore, re-victimized by institutional racism and sexism, despite the existence of technical standards of the Federal Health Ministry imposing quality and humanized care to women in abortion situations through sheltering and guidance.[8] Standards that are under constant attack during the current government.

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

[6] Defensoria Pública do Rio de Janeiro, Coordenadoria de Defesa dos Direitos da Mulher (2018). *Entre a morte e a prisão quem são as mulheres criminalizadas pela prática do aborto no Rio de Janeiro*. https://defensoria.rj.def.br/uploads/arquivos/c70b9c7926f145c1ab4cfa7807d4f52b.pdf

[7] VENTURA, Miriam. (2009) *Direitos reprodutivos no Brasil*. 3. ed. rev. e atual. Brasília: UNFPA

[8] MINISTÉRIO DA SAÚDE. (2005) *Atenção humanizada ao abortamento: norma técnica*. Brasília: Ministério da Saúde, 2005. http://bvsms.saude.gov.br/bvs/publicacoes/atencao_humanizada.pdf

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.

The 1988 Constitution[9], that followed the troubled decades of military dictatorship in Brazil set a milestone for health access. It created the biggest public health system currently in place in the world, considering the number of beneficiaries (220 million people), the area coverage (8.5 million km²), and several affiliated clinics (over 50.000). The Sistema Único de Saúde (SUS), is the Brazilian health system created as part of the social movement fight for rights during Brazil's re-democratization period. The new Constitution also defined human dignity as one of the fundamental pillars, holding the Brazilian State responsible for guaranteeing the dignity of its people. Apart from that, throughout the years, the country has also committed to several international documents reinforcing the importance of health, and against racism, obligated to comply with due to the signature of the Vienna Convention on the Law of Treaties in 1969[10].

According to the Brazilian law, all residents, as well as visitors, even undocumented individuals, are allowed to access, free of charge, comprehensive health services. It includes primary care, outpatient specialty, mental health services, and hospital. In some cases, drug prescriptions and rare disease treatments are also available for the population for free. There is no need for application or cost-sharing to use SUS. The health system is guided by three doctrinal principles: (i) universal right to health care for all people, and it is the State's responsibility to ensure this right; (ii) equity, reducing inequalities by treating the unequal unequally, investing more where the need is greatest; and (iii) integrality, assisting people as a whole attending to all their needs. There are also organizational principles, that are guidelines to put SUS into practice. Those are (i) regionalization, as a process of articulation among the services that already exist; (ii) hierarchization, as the division of levels of care to guarantee access to services given the complexity required by the case, within the limits of the resources available. (iii) decentralization, as the power to manage the health system, is distributed among the three levels of government (Union, State, and cities), and (iv) popular participation through councils and conferences with society participation.[11]

The responsibilities are shared by (i) the Ministry of Health at the national level, responsible for national coordination of SUS, including policy development, planning, financing, auditing, and control; (ii) State government duties including regional governance, coordination of strategic programs (such as the provision of high-cost medicines), and delivery of specialized services that have not been decentralized to

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[9] Constitution of the Federative Republic of Brazil, constitutional text of Oct. 5, 1988, with alterations introduced by Constitutional Amendments 1/92–72/2013 and by Revision Constitutional Amendments 1/94–6/94, translated and revised by I. Vajda, P. de Queiroz Carvalho Zimbres, V. Tavares de Souza, 6th rev. ed. (Federal Senate, Undersecretariat of Technical Publications, 1993), p. 351.

[10] The Vienna Convention on the Law of Treaties, internalized in Brazil by Decree No. 7.030/09, provides, in its art. 26, that "every treaty in force binds the parties and must be performed by them in good faith" and in its art. 27, that "a party may not invoke the provisions of its internal law to be performed by them in good faith", and, in its art. 27, that "a party may not invoke the provisions of its internal law to justify its failure to perform a treaty". Other international conventions have similar provisions, as is the case of articles 1 and 2 of the American Convention on Human Rights (ACHR), also known as the Pact of San Jose da Costa Rica, internalized in Brazil by Decree 678/92.

[11] Conselho Estadual de Saúde RJ - *CONHEÇA O SUS E SEUS PRINCÍPIOS FUNDAMENTAIS*. www.conselhodesaude.rj.gov.br. http://www.conselhodesaude.rj.gov.br/noticias/577-conheca-o-sus-e-seus-principios-fundamentais.html#:~:text=Em%20todo%20o%20pa%C3%ADs%2C%20o

municipalities. (iii) The health departments in the 5,570 municipalities largely handle the management of SUS at the local level, including financing, coordinating health programs, and delivery of health services.

During the years that followed the 1988 Constitution enactment, national policies to guarantee human rights and access to health, especially for vulnerable groups were implemented.[12] For instance, the National Human Rights Plan, which the first edition is dated 1996, focused on civil rights, evolved throughout the years to cover social rights, as well as, in 2009, set up a plan with six main approaches to addressing historical and economic inequalities. The main approaches were: (i) democratic interaction between state and civil society; (ii) development and human rights; (iii) universalizing rights in a context of inequality; (iv) public security, access to justice, and combating violence; (v) education and culture in human rights; (vi) right to memory and truth.

When it comes to health policies, there were efforts to implement changes in SUS to reduce inequalities among black, quilombolas (descendants of escaped slaves), LGBTQIA+, the homeless, and people living in rural areas. Colour and race became part of the SUS database, there was an improvement in sickle cell anemia awareness, and the recognition of midwives and healers in healthcare. The Special Secretariat for Indigenous Health was created to ensure indigenous health.

Physicians' distribution is very concentrated in larger and wealthier cities. In 2018, cities with less than 5,000 inhabitants had only one doctor per 3,000 individuals. On the other hand, cities with more than 500,000 inhabitants had one doctor per 230 individuals. In the past, the government has instituted various projects to deal with scarcity. There were national policies to promote medical students education and efforts to guarantee a better supply of primary care doctors.[13] Primary care expansion led to better health outcomes.[14] Mobile clinics for the homeless and floating health units to attend river communities were some of the solutions found to address inequalities. However, after the 2016 coup, and with the election of the right-wing government the investments in health were cut and programs were discontinued.

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.

6. Please share examples of public health financing, non-governmental sector funding practices, inter-agency finance solutions, medical insurance products that

[12] S.A.V. Siqueira, E. Hollanda, and J.I.J. Motta. (2017). *Equity Promotion Policies in Health for Vulnerable Groups: The Role of the Ministry of Health*, Ciência & Saúde Coletiva 22, no. 5.

[13] L. M. P. Santos, A. M. Costa, and S. N. Girardi. (2015). *Programa Mais Médicos: uma ação efetiva para reduzir iniquidades em saúde*, *Ciência & Saúde Coletiva* 20 3547–52.

[14] M. V. Andrade et al. (2013) *Desigualdade socioeconômica no acesso aos serviços de saúde no Brasil: um estudo comparativo entre as regiões brasileiras em 1998 e 2008*," Economia Aplicada 17, no. 4: 623–45.

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.

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.

The SUS is funded[15] by tax revenues from every government level: Union, States, and cities. The law defines this division as: (i) the Union is responsible for investing 15 percent of net current government income in 2017, adjusted for annual inflation; (ii) States governments invest 12 percent of total revenue; and (iii) cities are responsible for 15 percent of total revenue. The overall share of the national level funding has decayed, while funding the cities had assumed a greater financial responsibility. In 2017, the Union share corresponded to around 43% of total public investment, while States were responsible for nearly 26% and the cities 31%. That impacts the cities, that were supposed to invest at least 15% of their own total revenues on health, ended up investing, on average, about 24%.[16]

Even though SUS is available for the whole population, in 2018, 23% of Brazilians mainly the middle- and higher class, pay for private health insurance, to avoid some difficulties to access healthcare. Approximately 70 percent of the private health insurance beneficiaries receive it as an employment benefit. They often have their facilities or offer services through private associated health care facilities. Some insurances also offer the possibility to reimburse their insureds for health care services expenses. Moreover, the private health insurance charges, as well as any payment made for health-related purposes, can be deducted from tax payments. Tax exemptions for private healthcare make up to 0.5% of Brazil's GDP, mostly to subsidize health insurance.[17] Any health-related costs, being insurance, supplies, or services may be

[15] Tikkanen, R., Osborn, R., Mossialos, E., Djordjevic, A., & Wharton, G. A. (2020, June 5). *Brazil | Commonwealth Fund*. Www.commonwealthfund.org. https://www.commonwealthfund.org/international-health-policy-center/countries/brazil

[16] Piola et al., *Consolidação do gasto com ações e serviços públicos de saúde*.

[17] C. O. Ocké-Reis. (2018). *Sustentabilidade do SUS e renúncia de arrecadação fiscal em saúde*, Ciência & Saúde Coletiva 23 2035–42.

deducted from individuals' and legal entities' tax payments. Private health insurance is voluntary and supplementary to SUS, as SUS also plays crucial roles in healthcare, in areas where the private sector does not operate, such as water quality.

The current political and economic crisis has had a big impact on public policies implementation, including in healthcare.[18] In 2016, Brazil adopted fiscal rules that limit the growth of the government's primary expenditure. Many SUS financing programs were unified, allegedly to decrease bureaucracy and improve flexibility in cities' local levels investments. Regardless of the benefits, such an approach brought, strategic areas are underfinanced, including primary care, since most of the financial resources are being spent on hospital care.[19] However, it is important to note that investments in primary care are crucial to ease the burden on the health system and they often mean a better health outcome and good cost-effectiveness. The new presidential mandate that took place in 2019 continued and expanded the fiscal austerity policy, defunding programs in other departments, such as environment, education, and social that may impact health.[20]

Fiscal austerity policies taking place in Brazil and around the world are influenced by several factors, including international pressure[21]. It is estimated that such a policy froze the investment of USD 4.52 billion in health between 2018 and 2020. The policy was also implemented for 20 years, severely underfunding public health in Brazil[22]. Research shows the negative consequences of globalized economic policies, including programs implemented by the World Bank and the International Monetary Fund (IMF) in the early 1980s, and their impacts on health outcomes. Researchers point out how it contributed to the HIV AIDS epidemic by (i) increasing rural poverty[23]; (ii) increasing mass unemployment, meaning a bigger dependence on informal work, which for many women in vulnerable conditions, often meant sex work[24]; and (iii) cuts in investment in health and education policies, that jeopardized the implementation of infrastructure to HIV programmes [25]. Global economic policies designed by big organizations in the Global North very often do not take into consideration local and regional factors, jeopardizing countries' developments, and people's rights.

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?

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[18] A. Massuda et al. (2018). *The Brazilian Health System at Crossroads: Progress, Crisis and Resilience*. BMJ Global Health 3, no.4.

[19] L. Jaccoud and F. S. Vieira, (1990) *Federalismo, integralidade e autonomia no SUS: desvinculação da aplicação de recursos federais e os desafios da coordenação*. Instituto de Pesquisa Econômica Aplicada.

[20] M. C. Castro et al., (2019) *Brazil's Unified Health System: The First 30 years and Prospects for the Future*," Lancet 394, no. 10195: 345–56.

[21] International Monetary Fund. (2016). *2016 ARTICLE IV CONSULTATION—PRESS RELEASE; STAFF REPORT; AND STATEMENT BY THE EXECUTIVE DIRECTOR FOR BRAZIL*. https://www.imf.org/external/pubs/ft/scr/2016/cr16348.pdf

[22] Ravenny, B. (2021). *Teto de gastos públicos e direito fundamental à saúde*. Jusbrasil. https://ravenny151.jusbrasil.com.br/artigos/1141058505/teto-de-gastos-publicos-e-direito-fundamental-a-saude#comments

[23] Denoon, D. J. (1995). *IMF, World Bank programs hinder AIDS prevention*. AIDS Weekly, 8–10. https://pubmed.ncbi.nlm.nih.gov/12289894/

[24] Loewenson, R. (1993). *Structural Adjustment and Health Policy in Africa.* International Journal of Health Services, 23(4), 717–730. https://doi.org/10.2190/wbql-b4jp-k1pp-j7y3

[25] Lurie, P., Hintzent, P., & Lowe, R. A. (1995). Socioeconomic obstacles to HIV prevention and treatment in developing countries. AIDS, 9(6), 539–546. https://doi.org/10.1097/00002030-199506000-00002

"The brutal inheritance of the colonization process in the Americas created at the same time models of racial and gender hierarchy that have been perpetuated in the mediation of violence towards different bodies, especially concerning the onslaughts of the criminal justice system" Flauzina et al. (2015)[26] have brilliantly defined the impacts of colonization in the Americas, as well as in most countries in the Global South. Colonization was a violent process that started in the 1500s in Brazil, promoted mainly by the Portuguese, followed by other European countries. It deeply marked (and threatened) the existence of the native people, who had 70% of their population killed.[27] Even after five centuries of violations, they are still under attack.

With colonization also came slavery. At the very beginning of the process, natives were used as slaves. Three decades later, the first slave ship arrived. Until the abolition of slavery Brazil, the last country in the American continent to do it in 1888, was the country that imported the most African slaves. Between the 16th and mid-19th centuries, some 4 million men, women, and children came, equivalent to more than a third of all slave trade.[28] There is no reason to be proud of the violent and inhuman process that took place centuries ago and still provoke impacts in Brazilian society.

According to the Brazilian Institute of Geography and Statistics (IBGE), currently, 52% of the country's population is black. However, they are the victims in 75% of the cases of death in police actions; black and brown people correspond to 64% of the unemployed, and the chance of a young black person being a victim of homicide in Brazil is 2.5 times greater than that of a young white person. The numbers are appalling and show how racism directly affects the lives of the black population. This chain of inequality also characterizes the prison system in the country. In 2019, blacks represented 66.7% of the prison population, while the non-black population (considered white, yellow, and indigenous, according to the classification adopted by IBGE) represented 33.3%.[29]

The judicial system was designed and implemented by the colonizers. Between 1810 and 1821, 80% of the convicts were enslaved individuals, 19% were former slaves, and only 1% were free who had never been slaves. The Penal Code of 1890, the first enacted after the abolition, included punishments for those who did not practice any profession and, therefore, had no means of subsistence, that is, blacks. After abolition, no right was guaranteed to the then former slaves. Eugenics and whitening policies gain ground and white immigration is encouraged, especially to fill the jobs available at the time.

Even though centuries went by, racism is a very latent matter. It is present in institutions and individuals' actions. Colonization also imposed a very known matter: patriarchy. The religion and the state implemented in Brazil by its colonizers promoted misogynistic customs, coming together for the same purpose: to stifle female sexuality that, when it broke the bonds, threatened the domestic balance, the security of the social group, and the very order of civil and ecclesiastical institutions.[30]

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[26] Flauzina, A., Freitas, F., Vieira, H., & Pires, T. (2015). *Discursos negros : legislação penal, política criminal e racismo*. Brado Negro.

[27] Fern, M., & Garcia. (2020, March 6). *Genocídio no Brasil: mais de 70% da população indígena foi morta*. Observatório Do 3° Setor. https://observatorio3setor.org.br/noticias/genocidio-brasil-mais-de-70-da-populacao-indigena-foi-morta/

[28] IBGE. *Brasil: 500 anos de povoamento | território brasileiro e povoamento | negros*. (n.d.). Brasil500anos.ibge.gov.br. https://brasil500anos.ibge.gov.br/territorio-brasileiro-e-povoamento/negros#:~:text=Presen%C3%A7a%20negra

[29] CCI/ENSP. (2020). *Dia da Consciência Negra: Por que os negros são maioria no sistema prisional?* Fiocruz.br. https://informe.ensp.fiocruz.br/noticias/50418

[30] FARIA, T. (2010) *A mulher e a criminologia: relações e paralelos entre a história da criminologia e a história da mulher no Brasil*, Anais do XIX Encontro Nacional do CONPEDI, Fortaleza.

It is not a coincidence that black women are the group of people more affected by poverty. As the pandemic worsened the social indicators, Before the pandemic, 33% of black women were below the poverty line. In 2021, even with aid, this rate is higher, at 38%. The proportion of black men below the poverty line is slightly below this level. Among the white population, the poverty rate rises from 15% before the pandemic to 19% in 2021. Poverty levels are similar between white men and women. Unemployment is at historically high levels in Brazil, but it affects the black and brown population more than the white population - which reproduces pre-pandemic inequalities. At the end of 2019, the unemployment rate among white people was 8.7%; a year later, it was 11.5%. Among the black population, meanwhile, unemployment was 13.5% in the last months of 2019; by the end of 2020, it was 17.2%.[31]

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

To this end, it is necessary to stimulate discussions on the subject and develop studies that, in addition to giving visibility to the inequities, can contribute to the understanding of how discrimination acts on the health of the black population. Besides being fundamental, considering the territorial dimension and the ethnic-racial diversity of Brazil, it is necessary to promote studies in the country, seeking to identify regional differences. Institutional racism must be measured to be understood as an indicator of the quality of care provided to the population.[32] lack and indigenous people must be part of the policy-making processes, as well as occupy decision-making spaces. The presence of social movements in high-level meetings has added an important discussion to the table. The opportunity to elect representatives that will address institutional racism is a must-do. The issue must be recognized and mapped. The overcoming must include the historically excluded groups. Affirmative measures to guarantee access to higher education. In the first 10 years since the implementation of such measures are responsible for 37,8% of the black medical students. Many of them are dedicated to tackle the institution racism in healthcare.[33]

As mass incarceration is a racism matter, assessing the objectives of criminalization is a crucial task. From the allegedly "war on drugs" to abortion, the Penal Code in force has locked up people based on their skin color and financial resources. In that sense, Milhas pela Vida das Mulheres main activity is to ensure that women in Brazil do not die due to unsafe abortions. We provide all the assistance needed to access the legal abortion services when appropriate and to travel to perform a safe abortion elsewhere. From our experience and research, we can affirm that the decriminalization of abortion is a huge, and much-needed, antiracist step. 56.4% of the requests we received are from white women. Not surprisingly, white women are more often able to pay for their logistics costs.

The indirect discrimination faced by black women in Brazil by the criminalization of abortion. The Brazilian Supreme Court has allowed abortion acknowledging the

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[31] Roubicek, M. (2021). *Desigualdade de gênero e raça: o perfil da pobreza na crise*. Nexo Jornal; Nexo Jornal. https://www.nexojornal.com.br/expresso/2021/04/25/Desigualdade-de-g%C3%AAnero-e-ra%C3%A7a-o-perfil-da-pobreza-na-crise

[32] Kalckmann, S., Santos, C. G. dos, Batista, L. E., & Cruz, V. M. da. (2007). *Racismo institucional: um desafio para a eqüidade no SUS?* Saúde e Sociedade, 16(2), 146–155. https://doi.org/10.1590/S0104-12902007000200014

[33] *Profissionais de saúde negros usam carreira para cuidar da população negra*. (2022, April 14). Nova Manhã. https://novamanha.novabrasilfm.com.br/conhecimento/cultura-e-brasilidade/profissionais-de-saude-negros-usam-carreira-para-cuidar-da-populacao-negra/

burden for people facing vulnerabilities. The Supreme Court Minister Luís Roberto Barroso has decided, in the HC No 124,306-RJ[34]:

> "CRIMINAL PROCEDURAL LAW. HABEAS CORPUS. PREVENTIVE DETENTION. ABSENCE OF THE REQUIREMENTS FOR ITS DECREE. UNCONSTITUTIONALITY OF THE INCIDENCE OF THE CRIMINAL TYPE OF ABORTION IN THE CASE OF VOLUNTARY INTERRUPTION OF PREGNANCY IN THE FIRST TRIMESTER. ORDER GRANTED OF ITS MOTION.
>
> (...)
>
> 5. To all this is added the impact of criminalization on poor women. The treatment as a crime, given by Brazilian criminal law, prevents these women, who do not have access to private doctors and clinics, from resorting to the public health system to undergo the appropriate procedures. As a consequence, the cases of self-mutilation, serious injuries, and deaths multiply."

Even if neuroscience proves that the interruption of pregnancy up to a certain stage does not cause suffering to the fetus; even if medicine demonstrates the unfeasibility of certain pregnancies; even if studies show that the criminalization of abortion brings immeasurable problems of social order and irreparable traumas of personal order; the State still gives in to faith, beliefs, personal opinions, traditions, in short. Abortion criminalization is currently one of the biggest ideological tools of the present federal government, which has just threatened rape victims that go through abortion to be the target of investigation procedures[35]. The Ministry of Health has also enacted a letter affirming that every abortion is a crime, in disagreement with the legislation in force, but showing their intentions to expand rights violations[36]. The patriarchal state, led by men, the vast majority of whom are white, tends to give less importance to the dramas faced by women, especially black women, a massive portion of the low-income population and the most affected by the criminalization of abortion.[37]

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[34] Brazilian Supreme Court. (2014). HC No 124,306-RJ. https://portal.stf.jus.br/processos/detalhe.asp?incidente=4637878

[35] Defensoria Pública do Rio de Janeiro, Coordenadoria de Defesa dos Direitos da Mulher (2018). *Entre a morte e a prisão quem são as mulheres criminalizadas pela prática do aborto no Rio de Janeiro*. https://defensoria.rj.def.br/uploads/arquivos/c70b9c7926f145c1ab4cfa7807d4f52b.pdf

[36] Ministério da Saúde. (2022). *Atenção Técnica para Prevenção, Avaliação e Conduta nos casos de Abortamento.* https://bvsms.saude.gov.br/bvs/publicacoes/atencao_prevencao_avaliacao_conduta_abortamento_1edrev.pdf

[37] Defensoria Pública do Rio de Janeiro, Coordenadoria de Defesa dos Direitos da Mulher (2018). *Entre a morte e a prisão quem são as mulheres criminalizadas pela prática do aborto no Rio de Janeiro*. https://defensoria.rj.def.br/uploads/arquivos/c70b9c7926f145c1ab4cfa7807d4f52b.pdf

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.[38]

"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."[39]

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.

[38] A/HRC/47/28, paras 87-88.
[39] Ibid para 87.