Submission to the Committee on the Elimination of Racial Discrimination to inform the elaboration of General Recommendation nº 37 on racial discrimination and the right to health
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The **Sexual Rights Initiative** is a coalition of national and regional organisations based in Argentina, Canada, Egypt, India, Poland and South Africa, that work together to advance human rights related to sexuality at the United Nations. For more information, please visit www.sexualrightsinitiative.org

The **National Council of Women Leaders (NCWL)** is a coalition of grassroots women leaders from marginalised communities across India working towards empowering and addressing issues of women and girls in their communities.

Dalit Human Rights Defenders Network (DHRDNet) is a coalition of Dalit human rights defenders across India. The main objective of DHRDNet is to create an efficient network of leading Dalit Human Rights Defenders to combat the rights abuses and to ensure that anti-discrimination mechanisms are properly and thoroughly implemented.

The **International Dalit Solidarity Network (IDSN)** was founded in March 2000 to advocate for Dalit human rights and to raise awareness of Dalit issues nationally and internationally. IDSN is a network of international human rights groups, development agencies, national Dalit solidarity networks from Europe and national platforms in caste-affected countries.

AWID is a global, feminist, membership, movement-support organization working to achieve gender justice and women's human rights worldwide.

Her Rights Initiative (HRI) is a social impact organisation formed in 2009 to advocate for sexual and reproductive rights of women, particularly women living with HIV in South Africa. HRI is made up a group of feminists and women rights advocates claiming their human, sexual and reproductive rights in the context of HIV.

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Introduction

1. We are pleased to make this submission to the Committee on the Elimination of Racial Discrimination to inform the elaboration of its General Recommendation n°37 on racial discrimination and the right to health under Article 5 (e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (CERD).

2. The main argument of this submission is that a tripartite approach is necessary in order for states to meet their obligations under CERD Article 5 (e)(iv) concerning access to health and healthcare of all people. First, states must ensure that healthcare is publicly funded through progressive taxation; second, states must adopt a systems approach to fulfil the right to health; and, third, states must take an intersectional approach in all aspects of healthcare provision. The absence of any of these will compromise people's rights to health, bodily autonomy and non-discriminatory services, especially among the marginalised. Racialised and gendered people everywhere will be excluded and oppressed unless they are actively included through such an approach. This approach is in alignment with human rights treaties and their respective committees' General Comments and Concluding Observations on the right to health.

3. Privately funded healthcare has failed to provide for the needs of the marginalised in every instance and in every national context. Between low or absent accountability and the overriding profit motive that dominates corporate ideology, privately funded healthcare as well as private-public partnerships sacrifice the interests of those who lack the social or economic clout to demand the attention of service providers and privilege those whose health needs or wants yield the greatest profit.[1] Only the presence of a universally accessible publicly funded healthcare system will ensure that health and healthcare do not become commodities (instead of public goods) that only 'paying customers' can afford.[2]

4. In accordance with human rights principles of universality, interdependence, indivisibility and inalienability, a systems approach to health is vital. This approach ensures that health is treated as one piece of a larger mosaic instead of as a stand-alone right fractured away from other entitlements that determine people's ability to live decent lives. Thus, good quality and publicly funded education, equitable access to adequate and nutritious food and clean water, supportive and sustainable physical and natural environments (including adequate sanitation), social security, community participation and decision making that enhance self-worth and belonging for all people are all essential elements of a system in which people can thrive and come closest to realising their capabilities.[3] A systems approach is a precondition for ensuring that individual sectors will deliver quality goods and services to all.

5. This submission further argues that only an intersectional approach can generate a holistic understanding of both the nature and the effects of oppression and exclusion on different groups and individuals. This concept is explored in detail below.

Scope *(questions 5 to 12)*

6. Article 12 of ICESCR defines the right to health as the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. CESCR Committee General Comments 22 (the right to sexual and reproductive health), 20 (non-discrimination in economic, social and cultural rights), 14 (the right to the highest attainable standard of health) as well as CEDAW Article 14 and its General Recommendation 24 (women and health), CRC Article 24 and General Comment 15 (the right of the child to the highest attainable standard of health), and CRPD Article 25 have all elaborated specifically on the right to health, including articulation of state obligations in this regard. Several treaty monitoring bodies have also elaborated on the right to non-discrimination including in the context of health through their General Comments and Recommendations.

7. Recognising the considerable advancements in human rights standards through the adoption of these General Comments and Recommendations, three major protection gaps stand out as requiring attention

from the CERD committee through the proposed draft General Comment on racial discrimination and the right to health.

8. The first gap lies with the acceptance and normalisation of for-profit healthcare services by various Committees as a legitimate means for states to fulfil their human rights obligations without meaningful consideration of how this interacts with and undermines states' obligations to guarantee non-discrimination based on any status. In this regard, the Human Rights Council mandated reports and technical guidance on a human rights based approach to preventable maternal mortality and morbidity could be instructive to the Committee in its deliberations, as it is grounded in the principle that "claims for sexual and reproductive health goods, services and information should be understood by health system users, providers and policymakers as fundamental rights, not as commodities to be allocated by the market or matters of charity."[4] The Special Rapporteur on the Right to Health has also highlighted that "[i]n many cases, privatization has led to increased out-of-pocket payments for health goods and services, disproportionate investment in secondary and tertiary care sectors at the expense of primary health care, and increased disparity in the availability of health facilities, goods and services among rural, remote and urban areas."[5] The Independent Expert on foreign debt has similarly exposed the gendered and racialised impacts of privatisation and austerity.[6] Through CERD Article 5 (e)(iv), which specifies the right to **public health**, medical care, social security and social services, the Committee is uniquely positioned to articulate the impact of privatisation of health services on communities and individuals subject to racial discrimination and also to provide clear guidance on state obligations to make use of maximum available resources to progressively realise the right to health. Privatisation of health services, often forced upon countries in the Global South through structural adjustment, 'international assistance' or other 'good governance' measures, inevitably benefits the elite few, both within the country and transnationally, and follows the colonial playbook in resource extraction, exploitation and forced underdevelopment.

9. The second protection gap points to existing human rights standards assuming a baseline predicated on western, neoliberal and hegemonic racial and class experiences that give rise to standards often not met by 'other' individuals and communities, thereby cyclically replicating systemic and structural racism. It is imperative that the Committee examine health from an expansive and holistic perspective, going beyond western medicine's focus on individual disease and the capitalist conceptualisation and commodification of health as a product. The Expert Mechanism on the Rights of Indigenous Peoples has highlighted that Indigenous peoples' concept of health "is generally broader and more holistic than that of mainstream society, with health frequently viewed as both an individual and a collective right, strongly determined by community, land and the natural environment," which implicates a range of other rights denied to most Indigenous peoples: self-determination and -governance, development, culture, land, language and the natural environment.[7] Because of European colonisation, "relationships with and duties of care for water, land, and living beings were uprooted, replaced with a worldview animated by domination, exploitation, and profit."[8]

10. The disregard for Indigenous peoples' concept of health and health knowledge in non-Indigenous health systems, combined with ongoing threats of colonial expansion[9] and other legacies of colonialism, such as forced assimilation, political and economic marginalisation, racial discrimination and prejudice, and poverty, all contribute to Indigenous peoples' poorer health across the world.[10] Even the WHO definition of health fails to acknowledge that Indigenous conceptions of health all over the world understand individual health to be inextricably linked and, in fact, co-constitutive with collective and community health.[11] Such a conception of health is more compatible with a systems approach and a human rights based approach to health. Further, in the context of racial discrimination and the right to health, there is an inevitable nexus in this regard as individuals are directly or indirectly subjected to discrimination because of their perceived belonging to a collective racial group. Racial discrimination is therefore perpetrated against, and the corresponding harm is experienced by, both the individual and the collective, such as in the case of forced sterilisation of Indigenous women.

11. We therefore encourage the Committee to centre their analysis of human rights standards on the right to health such as availability, accessibility, acceptability and good quality from the perspective of those who do not belong to hegemonic racial or economic classes, are denied the economic, social and cultural rights necessary to achieve good health throughout their life cycle and who do not subscribe to neoliberal and capitalist approaches to health which have never served their interests and have, in fact, caused great collective harm over generations. Additionally, consideration of equality measures in relation to the right to health and racial discrimination must be consistent with this approach to emphasise substantive equality measures and state obligations thereto. As Saidiya Hartman notes, "the stipulation of abstract equality produces white entitlement and black subjection in its promulgation of formal equality. [...] Abstract universality presumes particular forms of embodiment and excludes or marginalizes others."[12]

12. Finally, we have identified a third gap in the absence of a truly intersectional approach to racial discrimination and the right to health. This approach encompasses *inter alia* gender and class and is necessary to identify and address the root causes of human rights failures. Existing health and human rights standards have drawn attention to particular groups that are disproportionately subjected to discrimination in various contexts. However, these standards simultaneously segregate and homogenise groups and ignore the different social locations that people occupy within them and across multiple groups; characterise people belonging to these groups as somehow inherently vulnerable without due consideration of the systemic and structural factors that create conditions of vulnerability; and do not acknowledge that barriers obstructing the fulfilment of human rights persist when members of marginalised groups seek accountability and effective remedies, which thereby render the promise of human rights perpetually elusory.

13. In her foundational work on intersectionality, Kimberlé Crenshaw explored the tensions between identity politics and an approach that would recognise and address the multiple social locations and differences within groups:

> "The problem with identity politics is not that it fails to transcend difference, as some critics charge, but rather the opposite – that it frequently conflates or ignores intragroup differences. In the context of violence against women, this elision of difference in identity politics is problematic, fundamentally because the violence that many women experience is often shaped by other dimensions of their identities, such as race and class."[13]

14. Intersectionality offers us of a critique of patriarchy, capitalism, white supremacy and other forms of domination grounded in the everyday experiences of marginalised people, and it complicates any sense of gender, sex, class, race, caste or disability as singular and discrete identities. It rejects any hierarchy of one categorical determination over others and brings us to the conclusion that no form of oppression or subordination ever stands alone.[14]

15. This is true of all oppressions, and certainly of race and class: in the words of Stuart Hall, "race is the modality in which class is lived."[15] It is worth highlighting class in the context of this submission because it remains an under-addressed frame of analysis in the human rights sector,[16] and also requires addressing the racist roles and impacts of capitalism and neoliberalism. Adding the lens of "class" is critical. In Latin America and the Caribbean, as in other places, class and ethnicity are closely linked: "Only by [...] appreciating how the gender and racial/ethnic dimensions fuse [with social class, sexuality and other axes of differentiation] will it be possible to take the full measure of the situation of Indigenous people and Afro-descendants."[17]

16. We encourage the Committee to use an intersectional approach to racial discrimination that truly engages with the operation of interlocking systems of oppression and elaborates on states' obligations to address them. Until states eradicate white supremacy, patriarchy, racism, caste discrimination and all other forms of oppression and discrimination, they will be failing their obligations to ensure the right to the highest attainable standard of health and all its determinants.

17. We therefore urge the Committee to engage with the full range of the determinants of health and to incorporate a wide range of sources, scholarship and jurisprudence in its work on this General Comment, especially those authored by people subjected to intersectional discrimination and who are working to build effective accountability measures that lead to transformative remedies.

Determinants of Health *(questions 9 to 12)*

Racism

18. We urge the Committee to reflect on the impact on the human rights system that is demonstrably reluctant to engage with entrenched structures of racism and colonialism, as a decolonial approach requires, and which instead focuses on perceived "extreme" manifestations of racism and on individual prejudice. As the Special Rapporteur on racism has stated, "[a]lthough influential actors within the global human rights system have raised the alarm against visceral expressions or acts of racism and xenophobia, these actors fail seriously to engage with the historically entrenched structures of racial oppression, exploitation and exclusion that violate the human rights of many but are largely invisible even in the global human rights discourse."[18] States that may champion human rights in certain spheres can also act with impunity and can themselves be among the most egregious violators of human rights, as demonstrated by Israel coercing Ethiopian Jewish women into accepting contraceptive measures in Israeli-run transit camps in Ethiopia as they sought to immigrate to Israel.[19]

19. In this context, the upcoming General Recommendation represents a crucial opportunity to address and engage with racism, colonialism, patriarchy, capitalism and ableism as health determinants, and also as interlocking systems of oppression, predicated upon colonial and white supremacy, that go far beyond interpersonal interactions and are fundamentally incompatible with the right to health. As pointed out by the Special Rapporteur on the right to health in her latest report, the violence inherent in the everyday operation of these oppressions and structures have a severe accumulated impact on people's integrity, agency, and ultimately, their rights to health and to bodily autonomy.[20] Exposing racism not merely as a health determinant, but as oppression and structural violence, is helpful to surface "the deep structural roots of health inequities [...], explicitly identif[y] social, economic, and political systems as the causes of poor health"[21] and explicitly name health inequities as an act of violence and "a reflection of power relations."[22]

20. Racism is often absent from health research and policy,[23] and insufficiently addressed within a human rights discourse that "[has] long understood the social determinants of health to include a healthy environment, food security, water and sanitation [but has] been slow to acknowledge, much less repair, the racial hierarchies that structure access to these public goods."[24]

21. One of the manifestations of racism in health care is testimonial injustice, which takes place when racialised patients' account of their symptoms or their pain is dismissed because they are not perceived as credible narrators,[25] and which is compounded by other factors including gender,[26] class,[27] disability,[28] body size,[29] age,[30] or health status.[31] As Rageshri Dhairyawan states, "[w]omen have had their pain ascribed to "hysteria", resulting in the undertreatment of their symptoms, [and] racial bias in pain assessment and treatment has also been well documented in western medicine."[32] This can result in silencing, with patients preferring to "self-censor their symptoms and concerns so as to remain a 'good patient'" and to avoid facing disbelief,[33] in refusal of care, delayed diagnosis, ineffective treatment and inadequate pain relief.[34] The dehumanisation and dismissal of racialised patients can have deadly consequences, as shown by the deaths of Black and Indigenous women due to racist and sexist medical neglect and abuse in many countries including France,[35] Canada,[36] the USA,[37] and South Africa.[38]

22. Racism in pain assessment, management and treatment is one of the legacies of a history of white supremacist conspiracy theories and pseudoscience seeking to justify slavery, colonisation and the exploitation of racialised people's bodies and territories on the basis of ludicrous claims that racialised people, and Black people particularly, did not feel pain.[39] These racist claims also formed the basis of violent

medical experimentation: "[the] bodies [of enslaved women] considered property, were treated as medical laboratories, sites of violence, exploration and theft, without which modern medicine would have been impossible."[40] Infamous examples include the theft of Henrietta Lacks' cervical tumour cells, which became the HeLa line,[41] or Marion Sims' violent experimentations on Black women leading to the modern speculum.[42] This denial of Black women's pain remains a critical and widespread problem in medicine today.[43]

Colonialism

23. The dismissal of racism's role in determining health is related to frequent denial in multilateral and human rights spaces of the historical and ongoing impacts of colonisation on human rights, including the right to health.[44] In addition to racism, it is important for the Committee to address the effects of colonialism and neo-colonialism as determinants of health.[45] Omitting these would obscure the colonial structures that continue shaping racist inequalities in resources, health access and outcomes within and among countries and people depending on whether they benefited from or were subjected to colonialism, and leave unexplained the reasons for health inequalities between Indigenous and settler populations worldwide.[46] It would mean silencing the colonial reasons for the health impacts of generational trauma, dispossession and violence, and for the current economic, geopolitical and global health structures reflecting colonial power dynamics. Lastly, it would contribute to isolating racism from the colonial and capitalist enterprise that invented race to justify slavery, colonial conquest, exploitation and countless atrocities for profit. The CERD Committee is uniquely positioned for this analysis, given the Convention's historical link to anti-colonial struggles, its unequivocal rejection of all forms of colonialism in its preamble, and the Committee's analysis and recommendations on the harms and human rights impacts of colonialism,[47] including with regard to the right to health.[48]

Gender

24. As recognised by the Committee in its General Recommendation 25 on gender-related dimensions of racial discrimination, gender and race must be examined in tandem, as gender profoundly shapes and compounds the experience of racial discrimination, and vice-versa. This must be done in a way that engages with the relationship between the multiple oppressions that are in operation, and their compounded harm, rather than in an essentialist and additive approach to oppression that prioritises one aspect of identities and lives over others.[49] As Angela P. Harris puts it, "in an essentialist world, black women's experience will always be forcibly fragmented before being subjected to analysis, as those who are 'only interested in race' and those who are 'only interested in gender' take their slices of our lives."[50]

25. The relationship between health, race, class and gender is rooted in colonial, patriarchal and capitalist control over women's sexuality, reproduction and bodies and produces distinct experiences of oppression that are often fatal. As noted by the Special Rapporteur on Health "....certain people are encouraged or coerced to reproduce, while others are systematically discouraged. States' encouragement of high fertility rates among "desired" populations emerges through pro-natalist policies, to ensure national strength, economic growth and protection from outside aggression, as well as to preserve a "national identity". The capacity to control one's reproductive choices is unequally distributed across race, sexual orientation, gender identity, sex characteristics, gender, class and socioeconomic status."[51] For example, the stark disparities of maternal mortality and morbidity rates within and among countries are not because of medical mysteries for which there is no clinical diagnosis but instead because of cascading human rights failures that begin long before pregnancy. In this regard, the data speaks for itself on whose health, lives and human rights are valued: Ninety-four per cent of all maternal deaths occur in low and middle income countries.[52] Rates of maternal mortality among Black women is three times higher than among white women in the United States[53] and Black people are 1.8 more times more likely to live in poverty than white people. In South Africa, maternal death rates vary considerably depending on the GDP of the region.[54] In Brazil, maternal deaths are four times higher among Black and Indigenous women[55] and are highest in regions with poorer living conditions.[56] In the UK, Black women are four times more likely and Asian women twice as likely to die in childbirth than white women.[57] At the same time, the Working Group on Discrimination against Women has

rightly emphasised that “[p]olicies regarding women’s health services are often limited to questions of “maternal health”....such a restrictive focus fails to recognise the full spectrum of women’s rights to sexual and reproductive health at all stages of their life cycle and contributes to the instrumentalisation of women’s bodies, viewing them mainly as a means of reproduction."[58]

26. From harmful stereotypes, to essentializing all women down to their reproductive capacities, to forced sterilisation as well as forced pregnancy, to subjection to chromosomal testing in elite sporting events, racialised women are specifically targeted by the state for interventions or purposeful inaction that have profound impacts on their health and human rights. We therefore urge the Committee to explicitly include a rigorous gender analysis throughout the whole General Comment and to specifically address gender as a determinant of health.

Neoliberalism (questions 32-33, 38-40)

27. Capitalist and neoliberal approaches to health and human rights are harmful to the right to health,[59] and invariably racist in effect. In its analysis on racism and the right to health, we urge the Committee to include class as an under-addressed but crucial health determinant[60] often intersecting with race, gender, ethnicity and caste, and to expose the harms of prevailing neoliberal approaches to health and economics, including austerity, reduction of public spending, aid conditionality, structural adjustments and other measures mandated or encouraged by international financial institutions and donors.

28. The obligation for states having inflicted and benefited from colonialism and slavery to provide reparations is well-established under international law.[61] The Special Rapporteur on Racism clearly asserted that “reparations for slavery and colonialism include not only justice and accountability for historic wrongs, but also the eradication of persisting structures of racial inequality, subordination and discrimination that were built under slavery and colonialism to deprive non-whites of their fundamental human rights.”[62] In addition, and despite claims to the contrary by states owing reparations,[63] “[development aid] initiatives cannot do the necessary work of repairing structures of racial inequality and discrimination rooted in historic injustice [and] fail to fulfil specific international human rights obligations relating to the contemporary manifestations of historic racial discrimination and injustice.”[64]

29. And indeed, the Independent Expert on foreign debt’s reminder that “human rights require resources”[65] goes to the heart of the issue of absence of reparations for colonialism, and the resulting turn to loans and attached conditionalities. When we look at states’ obligation to guarantee the right to health “to the maximum of their available resources,”[66] we must also look at the racist reasons for which some states have ample resources while others see theirs hamstrung by a history of colonial dispossession and exploitation, followed by neo-colonial capitalist domination. As Jonathan Cohen puts it, “[c]alls for rights-based approaches to health and development ring hollow coming from colonial masters disguised as ‘development partners.’”[67] The health determinants and right to health of racialised people across the Global South, and in settler colonies in the North, continue to be directly shaped by the structures and effects of colonisation and slavery, including the resulting debt and attached conditionalities.

30. Neoliberal approaches to health spending have disproportionate impacts along race, gender and class lines and are themselves a form of structural and economic violence inflicted upon racialised communities in the Global South and North, and privatisation in the healthcare sector inevitably has a disproportionate and negative impact on marginalised groups, for example, on women seeking reproductive health services,[68] and lower-income groups who are often turned away or accrue significant debts to access basic health care.[69] This has been especially destructive in countries across the Global South, where the concept of structural violence has been used to describe the effects of neoliberalism, austerity and structural adjustment programmes, combined and compounded with the enduring impacts of colonial dispossession and domination.[70] Debt itself, along with “the ‘indebtedness’ of countries of the South is both a consequence and a tool for domination.”[71]

31. This privatisation is fuelled and exacerbated by persistent deficits, unavailability of public funds in absolute terms and low prioritisation of health by governments in their public expenditure.[72] None of these factors work alone; they feed into each other resulting in making health systems inaccessible for the people who most need them.[73] In addition to health, the World Bank and International Monetary Fund have also notoriously imposed or pushed for water privatisation with serious health consequences, especially in "African countries and the smallest, poorest and most debt-ridden countries."[74] The Special Rapporteur on the human rights to safe drinking water and sanitation has warned against such neoliberal approaches to water, including its commodification, financialisation and privatisation, and recommended that water and sanitation infrastructure be publicly funded.[75]

32. Sri Lanka's current economic crisis is a clear example of the devastating consequences of international financial institutions' neocolonial and neoliberal loan conditionalities: following 16 IMF loans, and with debt repayments reaching new heights, Sri Lankans are bearing the brunt of shortages in medicines, food and essential products.[76]

33. Intellectual property regimes are another legacy of colonialism allied with neoliberal capitalism, that enable the colonial theft of Indigenous peoples' traditional knowledge and genetic resources,[77] threatening food sovereignty and Indigenous cultural heritage in the process.[78] One concrete example is the TRIPS Agreement, for its advancement of northern countries' interests and corporations through western-style intellectual property rights, at the expense of access to medicines in Southern countries.[79] This was recently exposed by northern countries' obstruction of WTO negotiations resulting in the failure to adopt a meaningful TRIPS waiver for access to COVID-19 vaccines and medical tools,[80] following a long history of blocking access to HIV treatment[81] and HPV vaccines,[82] among others. As the Special Rapporteur on racism has commented, "[r]esistance [to a TRIPS waiver] from high-income countries suggests that health inequities are not merely a result of weak international cooperation but a deliberate strategy to cement nationalist and capitalist interests at the expense of justice and equality"[83] and "[t]he monopolised authority of "developed" nations to select and dictate the terms of "who is worth saving" cannot be decoupled from its colonial origins,"[84] as also recognised by the Committee.[85] The same power dynamics can also be seen at the Human Rights Council in negotiations on resolutions on access to medicines and vaccines, including during the latest 50th session.[86] This is perpetuated by the idea that intellectual property regimes are a 'technical matter' which should not be accountable to human rights norms and principles.

Health funding and financing

34. At the global level, health funding comes mostly from high-income countries in the north; businesses and corporations; and private foundations/people. It is generally channelled to Global South countries through UN agencies, bilateral organisations based in donor countries (such as USAID or Grand Challenges Canada), global health partnerships (Global Fund or Gavi, for instance) and INGOs.[87] Donors' priorities regularly dictate the attention and funding given to specific issues, often without prior consultation with beneficiaries or regard for the context. There is a dire lack of accountability mechanisms to ensure that global health priorities and funding follow recipients' needs.[88] In other words, the current global health and health funding landscape replicates colonial and racist power dynamics.[89]

35. The Special Rapporteur on the right to health's 2012 report on health financing made the case for financing health through progressive taxation, as a key measure to reduce financial barriers to healthcare such as out-of-pocket payments, and warned against international tax competition and its promotion by international financial institutions through free-trade agreements.[90]

36. Aid, international funding and technical cooperation practices modelled like aid, are often harmful to existing health systems and undermine human rights, particularly sexual and reproductive health and rights (SRHR).

Generally, “funders fail to focus their activities on the health needs of recipient states and direct assistance towards health systems development, inadequately incorporate the inputs of affected communities in their activities, and attach conditionalities to the receipt of funding for health.”[91] International health financing is not designed to make existing domestic health systems sustainable. On the contrary, it has the impact of making health financing reliant only on international financing. Consequently, changes in donor priorities require overhauling the health infrastructure in the recipient country. One of the most prominent examples illustrating this phenomenon is the reinstatement of the Mexico City Policy, also known as the Global Gag Rule, by the United States of America.[92] Constantly responding to changing donor priorities results in an absence of sustained, well-developed, context-specific, available, accessible, acceptable and quality services or commodities. Traditional systems in Global South states are upended to “modernise” without adapting to the context, based on colonial ideas positioning racialised people’s ‘traditions’ as a barrier to ‘progress.’[93] Some examples include the kinds of contraception available and pushed onto women in the Global South like Depo-Provera,[94] and the dismantling of traditional birth attendant systems,[95] among others.

37. In the Palestinian context, humanitarian and development aid has also been criticised for its negative long-term impacts, including on health systems: “Humanitarian interventions, while important in a war-affected setting, do not come without costs as they have been shown to hamper long-term development considering that their visions and outcomes are treated as projects with short timelines and narrow goals, rather than systemic programmes impacting the livelihoods of people.”[96] In addition, projectised aid “act[s] as a distraction from systemic oppression. Second, the delivery of healthcare in the form of projects allows international actors to provide aid without questioning the status quo of Israeli occupation and involvement of Europe and the USA in the quagmire; that is, it allows aid provision without laying bare and questioning historical injustices to address the root causes of the Palestine Question and develop long-term, sustainable development of the health sector.”[97]

38. Differential funding for health research efforts between diseases affecting high-income countries in the North, and research needs in the Global South, is one of the ways in which the coloniality of global health manifests.[98] Large funds are allocated to health conditions and illnesses prevalent in the Global North (such as Alzheimer's and Parkinson's diseases, heart disease, cancer) while health conditions and illnesses prevalent in the Global South are neglected (such as the effects of early and prolonged malnutrition, including during pregnancy, tropical diseases, mosquito and other vector borne diseases, diarrhoea, parasitic diseases, or the effects of agrotoxics fumigation and presence in contaminated drinking water).[99]

Climate change

39. Climate change, environmental racism and the resulting denial of the right to a safe, clean, healthy and sustainable environment are a health emergency most acutely felt by countries and communities subjected to racial and economic discrimination and exploitation.[100] In addition to damaging impact on health, climate change also directly impedes physical access to healthcare facilities. Human rights bodies have addressed the severe impacts on the right to health of climate change and its exacerbation of structural inequalities,[101] thus illustrating the inaccuracy of narratives of personal responsibility in the face of structural problems. We encourage the Committee to elaborate on states’ obligations to address climate injustice and environmental racism as a core part of their obligations under the Convention and the right to health, and to challenge the failure by international climate frameworks to meaningfully address colonialism, racial capitalism and extractivism[102] and the responsibility of wealthy states.

Case studies *(questions 14-17, 27-28)*

Indigenous communities in Canada

40. Indigenous communities in Canada uniformly face greater health risks and challenges than non-Indigenous people and have, in common with all other Indigenous communities, histories of colonial violence and imposition that lead to disenfranchisement from self-governance[103]; loss of land, water, and languages, of

traditional knowledges and healing practices[104] (including cohabiting with other animal and plant species and natural systems in sustained and sustainable ways that ensured individual and collective health), and of cultural cohesion and identity; and decimation of supportive food systems and livelihoods.[105] It is this genocide and colonial attempts at the destruction of a collective way of life that are at the root of individual health problems as well as the public health crises facing Indigenous communities, including food insecurity[106]; additionally, they also serve as barriers to accessing healthcare.[107] Investigations into the British Columbia healthcare system revealed a series of systemic challenges for Indigenous patients; 84% of the respondents reported experiences of racism and discrimination that discouraged them from seeking necessary healthcare.[108]

41. As with other precariously positioned marginalised communities, Indigenous communities predictably also face greater setbacks than non-Indigenous communities when faced with extreme or emergency events, for example, in the fight against already disproportionately high HIV rates among the Saskatchewan First Nations during the Covid-19 pandemic[109] and in the life-threatening impact of climate change on Indigenous communities and individuals, which results in greater food insecurity and, obviously, in further ill health.[110]

42. Indigenous women face particular and additional challenges in securing good health as well as access to healthcare.[111] There is a thread of continuity from the gendered effects of colonialism,[112] such as the severing of women's caretaking relationship with water or the exclusion of women from decision making processes,[113] to the institutional treatment of Indigenous women in healthcare facilities that routinely include coercive practices and the *de facto* denial of bodily autonomy. One manifestation of this historical and ongoing destruction of Indigenous lives and ways of living is the epidemic[114] of forced and coerced sterilisation of women in and from Indigenous communities in Canada.[115] The overall disempowerment of Indigenous communities results in individual Indigenous women often not being aware of their right to bodily autonomy and informed consent to medical procedures, leave alone having the social and economic power to claim it.[116] As the research indicates, coerced sterilisation of Indigenous women is a part of, and the consequence of, larger systemic failures[117]; thus, addressing these (and other) rights violations would require a systemic rather than piecemeal approach.[118] The United Nations Committee Against Torture and other cruel, inhuman or degrading treatment termed unwanted sterilisation "torture" and called on Canada in 2018 to take measures to address the gaps in its criminal code, to prevent the practice, to hold those responsibile accountable, to investigate the practice and to compensate the victims.[119] The Canadian Senate has held two studies into the practice and their report is forthcoming in summer 2022.

43. Forced sterilisation is not only a continuation of colonial genocidal logics but also intimately connected to other systematic violations, including of other health related rights, for example, through the chemical poisoning of extant Indigenous lands, toxic waste incineration, mining, nuclear weapons testing, and military waste.[120] The effects of such poisoning lead to devastating health impacts for all Indigenous people, such as high levels of diabetes and significantly lower life expectancy.[121] As this analysis suggests, access to health and healthcare is part of a larger web of relations and it is impossible to isolate one or a few threads out without warping the fabric.

Caste-based oppression in India

44. Caste-based discrimination and oppression continue to prevent millions of people in South Asia (and elsewhere) from realising their rights to health and healthcare. In addition to historical exclusion and de facto denial of access to various institutions and services due to economic barriers, Dalit and Adivasi (Indigenous peoples of India) communities are further dispossessed of their rights through the attitudes and treatment they receive in healthcare institutions.[122] Dalit women face specific barriers in accessing sexual and reproductive healthcare, with more than 46% receiving no antenatal care (this number is significantly higher for certain sub-castes).[123] This is hardly surprising considering that a core element of the social exclusion and marginalisation faced by Dalits rests upon their historical classification as 'impure' and 'untouchable'.[124] On average, a Dalit woman lives 15 years less than women from dominant castes.[125]

45. The historical and contemporary stigma and de facto exclusion from institutions of education combined with circumscribed choices of occupation relegate members of Dalit communities to some of the worst paid (or even unpaid), dangerous and demeaning jobs, such as in sanitation, including manual scavenging (outlawed since 1993)[126] and disposing of dead bodies. During the pandemic the plight of these workers became, predictably, even worse.[127]

46. There is higher malnutrition and stunting among Dalits and Adivasis and the steady privatisation of healthcare in India has only exacerbated matters. The combination of low healthcare spending by the government and relentless privatisation of the health and education sectors has resulted in further excluding historically marginalised communities, even before caste-based discrimination is factored in.[128] Nearly two-thirds of India's health infrastructure is in private hands, and only 15% of Dalits and less than 5% of Adivasi populations access private health facilities, not least because costs in private healthcare centres are over 500% higher than in public facilities.[129]

47. One-third of Dalits and about half of the Indigenous / tribal population in India is multidimensionally poor; this also translates into lower education levels and concomitant disadvantages, with particular consequences for girls and women.[130] All these factors combine to constitute the historical and contemporary experiences of Dalit individuals and communities, and treating Dalit empowerment as a question of individual resilience and growth is symptomatic of the original problem of caste-based oppression.

48. The situation of Dalits in other countries in South Asia is hardly better: about half of Nepal's Dalits live below the poverty line; in Pakistan, they are often forced into bonded labour and 90% of Dalit women and girls are illiterate; about 40% of the 6.5 million Dalits in Bangladesh face caste-based violence but rarely report it to the police; Dalits make up more than 80% of tea plantation workers in Sri Lanka, an industry that makes widespread use of bonded labour.[131] Caste-based discrimination is also widely present in diasporic communities in the UK, the USA and in other countries that contain people of South Asian descent, including recent migrants.

Women living with HIV in South Africa

49. We can draw a continuous line from 17th-century colonial incursions into present-day South Africa – through the invention of whiteness[132] and of race as an organising category[133] that was used to justify the genocide and subjugation of the majority of the people on the planet – to the legacy of racist policies in Apartheid South Africa, including reproductive policies,[134] and forced and coerced sterilisation of Black women living with HIV in South Africa today.[135]

50. The particular strategies deployed by settler colonialists created a taxonomy in which Black women were placed at the bottom of a race and gender hierarchy[136] whose main goal was to extract value from the land and from Black labour for the benefit of a white minority. The continuation of (economic) Apartheid by other means after 1994[137] has meant that at least half the country's black population continues to live in poverty on the periphery of a capitalist economy in the service of an elite class. To add insult to injury, public resources are used to subsidise private healthcare, for example, through the provision of tax funded medical aid to government employees that they use in private clinics.

51. Given this background, it is no surprise that Black women living with HIV are primarily considered to be 'vectors' of transmission, not as people with agency and a right to bodily autonomy. Healthcare provision is, predictably, racialised and gendered – just as access to quality education, decent livelihood, basic amenities such as water, legal recourse, and other public goods are, and the normalisation of shaming and humiliating treatment in healthcare facilities is part of a system that reinforces the *de facto* political disempowerment of Black women. In effect, forced and coerced sterilisation of Black women must be understood less as a *denial* of existing rights and – in the absence of enforcement and accountability – more as the abnegation of the very *entitlement* to rights.[138]

52. The influence of donors, pharmaceutical corporations and international organisations (often held hostage by philanthrocapitalists) has continued this trend of extreme marginalisation; UNAIDS, UNFPA, and WHO policies that mandate the integration of SRH services into HIV service systems are in effect focussed on population control and target young Black women living with HIV. For instance, 37% of women in a 2014 study reported that they had been forced into taking Depo Provera in the previous twelve months, and in some instances, agreeing to take Depo Provera was the condition for receiving HIV treatment.[139] The right to give informed consent is clearly violated when poor Black women are offered only one, often harmful, option at public healthcare centres (for example, if they can only receive Stavudine, a drug that causes lipodystrophy, which not only announces their HIV+ve status but causes further gendered stigma or when their access to medication or treatment is predicated upon them agreeing to undergo a harmful procedure.

53. That the lives and rights of marginalised women everywhere are considered disposable is borne out by the continuation of similarly misogynist, racist, and casteist policies and practices in other parts of the world; the most emblematic case in Latin America is from Peru, where in the mid- and late-1990s, it is estimated that 200,000 women were sterilised; many of them, especially poor Indigenous women, were tricked or forced into the medical procedure.[140] They are still fighting for reparations. State sanctioned sterilisation camps in India also make a mockery of informed consent by targeting poor and uneducated women under the aegis of the Family Planning Programme desperate to meet population targets and goals; the sterilisation procedures themselves and the conditions in the camps are such that women suffer life-long complications or die as a direct result of the operations.[141]

54. There is no doubt that the relationship between race and health is a deep and deeply problematic one. However, as we have tried to show, only an intersectional approach that accounts for all the other factors that compound people's vulnerabilities to exploitation, exclusion, and oppression can be adequate to the task of properly understanding this relationship.

Recommendations

55. We encourage the Committee to treat racial, caste and gender discrimination as fundamentally incompatible with states' obligations under the right to health, and to:

    1. Engage with all the elements outlined under Article 5 (e)(iv), including the right to **public** health:
        a. Call on states to fund health publicly through progressive taxation,[142] free from control from other governments, multilateral agreements and transnational corporations;[143]
        b. Treat privatisation of health care and health determinants as incompatible with human rights and racial equality[144]

    2. Adopt a systems approach to the right to health, which encompasses all the rights and entitlements necessary to the fulfilment of the right to health, including its determinants;

    3. Adopt an expansive and intersectional approach to the right to health and its determinants:
        a. Explicitly include gender, class, and other forms of oppression and discrimination in its analysis of racial discrimination;
        b. Engage with holistic and expansive conceptions of health by Indigenous and racially marginalised people;
        c. Ensure meaningful access, participation and leadership of racialised people, groups and organisations in the Committee's work and analysis;
        d. Address colonialism and neo-colonialism as a determinant of health, with the corresponding state obligations to address it, including through full reparations.

[1] "COVID-19 pandemic shows how India's thrust to privatise healthcare puts the burden on the poor." T Sundararaman, Daksha Parmar and S Krithi. 11 January 2021. https://scroll.in/article/983344/covid-19-pandemic-shows-how-indias-thrust-to-privatise-healthcare-puts-the-burden-on-the-poor

[2] The 'solution' of providing low-cost healthcare to economically depressed classes within a country without dismantling privatised healthcare – through government insurance, for instance – has also been shown to fail in both rich countries such as the United States and in a country with high rates of poverty, such as India. *Ibid.*

[3] Martha Nussbaum, 2011, *Creating Capabilities: The Human Development Approach*, Cambridge, Mass.: HUP.

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[6] Report of the Independent Expert on the effects of foreign debt and other related international financial obligations of States on the full enjoyment of all human rights, particularly economic, social and cultural rights: Impact of economic reforms and austerity measures on women's human rights, http://www.undocs.org/A/73/179, 2018, paras. 7, 10, 12, 39, 46-49, 78, 89.

[7] Study by the Expert Mechanism on the Rights of Indigenous Peoples: Right to health and Indigenous peoples with a focus on children and youth, A/HRC/33/57, https://undocs.org/A/HRC/33/57, 2016, para. 4.

[8] Marya, Rupa, and Raj Patel. *Inflamed: deep medicine and the anatomy of injustice*. New York: Farrar, Straus and Giroux, 2021. Page 14.

[9] According to Marya and Patel, "[t]here are over seventy countries with Indigenous people whose lives are under threat by colonial expansion today." *Ibid.,* page 13.

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[11] Bautista-Valarezo, E. et al., "Towards an indigenous definition of health: An explorative study to understand the indigenous Ecuadorian people's health and illness concepts," available at https://www.researchgate.net/publication/342363497_Towards_an_indigenous_definition_of_health_an_explorative_study_to_understand_the_indigenous_Ecuadorian_people's_health_and_illness_concepts. However, countries can misuse notions of collective welfare to deny rights, for example, through expanding unchecked surveillance mechanisms, such as in the proposed new law in India: https://www.bbc.com/news/world-asia-india-61015970.

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