Submission on the Draft General Recommendation n°37 on Racial discrimination in the enjoyment of the right to health to be adopted by the Committee on the Elimination of Racial Discrimination

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The **Sexual Rights Initiative** is a coalition of national and regional organisations based in Argentina, Canada, Egypt, India and Poland, 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

We welcome the Committee on the Elimination of Racial Discrimination (CERD) for addressing the pressing issue of racial discrimination in the enjoyment of the right to health and welcome the opportunity to provide inputs to its Draft General recommendation n° 37. The suggested changes to the Draft General Recommendation proposed in this document are based on the joint submission[1], and focuses on the impact of systemic racism on global health systems, and consequent impact on people. We welcome the reference to sexual and reproductive freedom, and the specific subsection on forced sterilization and protection of migrants' rights in the Draft General Recommendation. We urge the Committee to strengthen language on colonialism, reparations and on private actors and privatisation as will be discussed in this submission.

Comments

II. The Convention and the right to health

A. The meaning and content of the right to health under Article 5(e)(iv)

Paragraph 8: The Committee should articulate the impact of privatisation of health services on communities and individuals subject to racial discrimination and provide clear guidance on State obligations to use the maximum available resources to 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.

Rationale: Neoliberal approaches to health spending have disproportionate impacts along race, gender, caste, 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[i], for example, on women seeking reproductive health services[2], and lower-income groups who are often turned away or accrue significant debts to access basic health care.[3] 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[ii]. While the draft General Comment addresses the impact on individuals, the global economic architecture which pushes privatisation is a continuation of colonial legacies and perpetuates racial discrimination.

[i] More on this topic is also discussed on the SR on health report A/67/302 available at: https://undocs.org/A/67/302

[ii] This is also further discussed on the SR on health report A/HRC/50/28 available at: https://www.undocs.org/A/HRC/50/28

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.[4] None of these factors work alone; they feed into each other resulting in making health systems inaccessible for the people who most need them.[5] In addition to health, the World Bank and International Monetary Fund have also notoriously imposed or pushed for water privatisation with serious health consequences.[6]

B. Racial discrimination in the enjoyment of the right to health under Article 5 (e)(iv)

1. General principles, including intersectionality

Paragraphs 9-10: We call on the Committee to strengthen the use of an intersectional approach to racial discrimination by engaging with the operation of interlocking systems of oppression and elaborating on States' obligations to address them. Until States put into place rigorous and accountable measures to counter the material manifestations of white supremacy, patriarchy, racism, casteism, xenophobia and all other forms of oppression and discrimination, they will be failing in their obligations to ensure the right to the highest attainable standard of health and all its determinants.

Rationale: Intersectionality offers a critique of patriarchy, capitalism, white supremacy, and other forms of domination grounded in the everyday experiences of marginalised people, and it complicates 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.[7] 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."[8] It is worth highlighting class in the context of this submission, and we encourage the Committee to retain this language because it remains an under-addressed frame of analysis in the human rights sector[9], and also requires addressing the racist roles and impacts of capitalism and neoliberalism.

2. Racial discrimination in the right to public health, including healthcare facilities, services, and goods

Paragraphs 11-13: We welcome the Committee's approach to colonialism and its ongoing effects. However, the language in these paragraphs and throughout the text should be strengthened to reflect the reality of many people still subjected to settler colonialism and occupation. This should also be linked to strong language on the need for reparations. The draft fails to address racial discrimination and related inequalities between and among States at the international level.

Rationale: As highlighted by the Special Rapporteur on racism on her report A/HRC/50/60, "The Bretton Woods institutions essentially universalized the mandate system, at least insofar as they institutionalized a system wherein "developed" countries, the successors of colonial States, sit at the top of the economic hierarchy and intervene on their own terms in the economic, political, and social systems of "underdeveloped" nations and indigenous peoples. In the Durban Declaration, the international community reiterated that persisting colonial legacies of racial and ethnic inequality are manifested in economic and social conditions. The Durban Declaration also recognized that racism, racial discrimination,

xenophobia, and related intolerance remain causes of underdevelopment. A vast body of research has demonstrated that the international economic and financial order and the economic programmes implemented by the Bretton Woods institutions and their backers have perpetuated economic harm, inequality, and the dismantling of social safety nets in the global South and the dependency of formerly colonized peoples." [10]

Specific language suggestions: Paragraph 12 – to include information accessibility necessary for informed consent; 12 (a) (ii) - add housing; 12 (b) (ii) - the word "discrepancy" is inadequate, change to "discriminatory"; 12 (b) (v) - expand on the impact of privatization; 12 (b) (vii) - add rise in disinformation and misinformation. We also believe this is an ideal space to include language on comprehensive sexuality education; Paragraph 13 - add a line that recognizes the need for not only transparency with AI but also States lagging behind in regulating the use AI and data protection measures.

C. Racial discrimination in the right to control one's health and body

Paragraphs 17-22: We welcome the framing on controlling one's health and body, and the inclusion of not only freedom from interference but also the denial of health services within the forms of coercion addressed. We encourage the Committee to make more explicit that the lack of enabling material conditions and health determinants is also a form of coercion and interference with the right to bodily autonomy. We also appreciate having a specific subsection on forced sterilization.

Specific language suggestions: As for language on abortion, we suggest making a link as to why some groups are more at risk of unwanted pregnancy and unsafe abortion - i.e., structural factors noted in other sections. This section focuses on the negative obligations (absence of disease) without considering the positive obligations (well-being) which is linked to the right to also have children and go through pregnancy, delivery, and post-natal period safely. We also suggest the Committee to include language in this set of paragraphs on sexuality and how it interacts with racism.

Rationale: Narrow individualised conceptions of informed consent do not necessarily encapsulate all the scenarios in which coercion is experienced. When health care is inaccessible, or health systems are undermined as a result of colonial and economic exploitation, violence and the neocolonial imposition of structural adjustments, privatisation, deregulation and debt repayments, the experience is one of coercion and denial of the rights to health and bodily autonomy, rooted in historical and ongoing racism. It is therefore important to affirm the right to bodily autonomy and its rejection of racism and all other oppressions as central to the fulfilment of the right to health.[11] The right to bodily autonomy and its rejection of racism and all oppressions is central to the right to health. The concept of bodily autonomy interrogates and encompasses the options and material conditions available to people to exercise autonomy and self-determination over their bodies and lives without coercion, discrimination, or interference from the State, family, society, and other external elements.[12]

III. Obligations under ICERD

A. General and cross-cutting obligations

Paragraphs 24-31: This set of paragraphs states that Article 5(e)(iv) must be read in conjunction with Articles 2, 4, 6 and 7 of the Convention. Cross-cutting obligations, including reparations, should also take into consideration aspects of social protection, condition, and determinants regarding the right to health in a more comprehensive way. Specifically for paragraph 28, representation of groups protected under the Convention is insufficient as this must be accompanied by other robust indicators. We are concerned that this paragraph also legitimizes privatisation of health and provides a pathway for States to be compliant with the Convention while privatising health systems.

Rationale: In accordance with human rights principles of universality, interdependence, indivisibility and inalienability, a systems approach to health is vital. This 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.[13]

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.

IV. Recommendations

D. Private actors

Paragraphs 52-56: The Committee does not recognize the role that private actors and privately funded healthcare have in perpetuating multiple forms of discrimination. It relies on the State's authority and capacity to monitor, prevent, and take measures, but it fails to properly address the accountability of private actors. The Committee's recognition of class, social status, or income as interlinked discrimination grounds in the context of racial discrimination is at odds with formulations implying that it is possible for private enterprises, whose primary purpose is to make profits, to respect the right to equality and non-discrimination in the right to health. We suggest the Committee to reflect on the principle of substantive equality, and extra-territorial obligations as mentioned by CEDAW and CESCR as useful frameworks for transnational accountability.

Rationale: 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 to yield the greatest profit.[14]

In India, for example, the combination of low healthcare spending by the government and relentless privatisation of the health and education sectors has resulted in further exclusion of historically marginalised communities, even before caste-based discrimination is factored in.[15] Nearly two-thirds of India's health infrastructure, which is concentrated in towns and cities, 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.[16]

F. International cooperation

Paragraphs 62-65: The Committee recognizes "international cooperation in health is a key element in respecting freedom from racial discrimination, preventing, protecting against violations and remedying them." But it fails to address the problems intrinsically linked to aid, aid conditionality and reparations. Recommendations towards international cooperation must include the need for accountability towards these actors.

Rationale: Health funding comes mostly from high-income countries in the north, businesses and corporations, and private foundations/people.[17] 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.[18] In other words, the current global health and health funding landscape replicates colonial and racist power dynamics.[19] 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.[20]

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."[21] 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 the 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."[22]

[1] The full submission is available here: https://www.sexualrightsinitiative.org/resources/submission-committee-elimination-racial-discrimination-racial-discrimination-and-right

[2] Marge Berer (2010) "Who has responsibility for health in a privatised health system?", *Reproductive Health Matters*, 18:36, 4-12, DOI: 10.1016/S0968-8080(10)36547-5: https://www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2810%2936547-5. See also 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. 46-49.

[3] SRI submission to the Working Group on Discrimination against Women and Girls on women's and girls' sexual and reproductive health and rights in situations of crisis (2020), para. 21. https://sexualrightsinitiative.com/resources/sri-submission-working-group-discrimination-against-women-and-girls-womens-and-girls

[4] For instance, in Egypt the Constitution-mandated minimum spending of 3% of the GDP on health had been unachieved for several years until 2020, when it was reached not by increasing spending on underfunded aspects, but by broadening the scope of what constitutes "health spending" in the national budget. See https://eipr.org/en/publications/eipr-launches-study-%E2%80%9C-and-after-covid%E2%80%A6-plight-egyptian-physicians%E2%80%9D, page 10.

[5] SRI submission to the Office of the High Commissioner on Human Rights for its report on maternal mortality and morbidity (2020). https://www.sexualrightsinitiative.org/resources/submission-ohchr-maternal-mortality-and-morbidity

[6] Public Citizen: "IMF and World Bank Push Water Privatization." https://www.citizen.org/wp-content/uploads/migration/imf-wb_promote_privatization.pdf; See also Nuria Molina and Peter Chowla: "The World Bank and water privatisation: public money down the drain." Bretton-Woods Project, 2008: https://www.brettonwoodsproject.org/2008/09/art-562458/.

[7] SRI Submission to the Working Group on Discrimination Against Women and Girls, focusing on sexual and reproductive rights in situations of crisis. September 2020. https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/ReproductiveHealthRights/CSOs/srisubmission/submission.docx

[8] Hall, Stuart, Chas Critcher, Tony Jefferson, John N. Clarke, and Brian Roberts (1978). "Policing the Crisis: Mugging, the State, and Law and Order." London: Macmillan. Page 394.

[9] Audrey R. Chapman: "The social determinants of health, health equity, and human rights." *Health and Human Rights: An International Journal* 12/2 (2010): https://www.hhrjournal.org/2013/08/the-social-determinants-of-health-health-equity-and-human-rights/

[10] Report of the Report of the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance: 2030 Agenda for Sustainable Development, the Sustainable Development Goals and the fight against racial discrimination. A/HRC/50/60, 2022, paras.29-30. Available at: https://undocs.org/A/HRC/50/60

[11] SRI Submission to the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health: Inputs for the upcoming report on racism and the right to health. August 2022. Available at: https://www.sexualrightsinitiative.org/resources/sri-submission-special-rapporteur-right-health-racism-and-right-health

[12] For more on SRI and SRI partners' conception of the right to bodily autonomy, see for instance the Highlights from the panel on Bodily Autonomy and Sexual Rights held on 20 September 2016 during the 33rd session of the UN Human Rights Council: https://sexualrightsinitiative.com/ru/node/98; and the SRI Submission to the Office of the High Commissioner for Human Rights on the elimination of discrimination against women and girls in sports (2019), paras 19-20, https://www.sexualrightsinitiative.com/resources/submission-ohchr-eliminationdiscrimination-against-women-and-girls-sports

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

[14] "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

[15] "The myth of development by privatisation." Srishty Anand. Times of India, 15 April 2022. https://timesofindia.indiatimes.com/blogs/developing-contemporary-india/the-myth-of-development-by-privatisation/.
"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
[16] "The private health sector in India from the lens of Dalits and Adivasis." Oxfam India, 28 April 2022. https://www.oxfamindia.org/dalitadivasiprivatehospitals
[17] Olusanya, J.O., Ubogu, O.I., Njokanma, F.O. *et al.* Transforming global health through equity-driven funding. *Nat Med* 27, 1136–1138 (2021). https://doi.org/10.1038/s41591-021-01422-6
[18] *Ibid.*
[19] *Ibid.*
[20] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on health financing in the context of right to health. A/67/302, 2012, https://undocs.org/A/67/302, paras 15-21, 34.
[21] Hammoudeh, Weeam, Hanna Kienzler, Kristen Meagher, and Rita Giacaman. 2020. "Social and political determinants of health in the occupied Palestine territory (oPt) during the COVID-19 pandemic: who is responsible?" *BMJ Global Health.* 5 (9): e003683. https://gh.bmj.com/content/bmjgh/5/9/e003683.full.pdf page 2.
[22] *Ibid.,* page 2