Racial Discrimination and the Right to Health

Summary of the submission to the Committee on the Elimination of Racial Discrimination (CERD) to inform the elaboration of General Recommendation no 37 on racial discrimination and the right to health

Submitted by: Sexual Rights Initiative (SRI), National Council of Women Leaders (NCWL), Dalit Human Rights Defenders Network (DHRDNet), International Dalit Solidarity Network (IDSN), The Association for Women's Rights in Development (AWID), Her Rights Initiative (HRI), and Alisa Lombard

To read our full submission to CERD click the following link: https://www.sexualrightsinitiative.org/resources/submission-committee-elimination-racial-discrimination-racial-discrimination-and-right

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Introduction

This is a summary of a submission made by the Sexual Rights Initiative, the National Council of Women Leaders, the Dalit Human Rights Defenders Network, the International Dalit Solidarity Network, The Association for Women's Rights in Development (AWID), Her Rights Initiative and Alisa Lombard to the Committee on the Elimination of Racial Discrimination (CERD). The main argument of the 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. The 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.

Gaps

Recognising the considerable advancements in human rights standards and the adoption of General Comments and Recommendations from many Treaty Bodies, such as Article 12 of the International Covenant on Economic, Social and Cultural Rights and its Committee's 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); Article 14 of the Convention on the Elimination of All Forms of Discrimination Against Women and its Committee's General Recommendation 24 (women and health), among others, 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:

a. **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;**
b. **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;**
c. **A third gap is 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.**

Rethinking the Approach to the Right to Health

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 for 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.

Publicly funded healthcare

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

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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.

customers' can afford[2].

A Systems and Intersectional Approach

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. Together with this, an intersectional approach only can generate a holistic understanding of both the nature and the effects of

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Determinants of Health

The upcoming General Recommendation represents a crucial opportunity to address and engage with racism, colonialism, patriarchy, capitalism, gender 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.

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[4]. In addition to racism, it is important for the Committee to address the effects of colonialism and neo-colonialism as determinants of health. 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. 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 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[5]. Gender and race must be examined in tandem, as gender profoundly shapes and compounds the experience of racial discrimination and vice-versa.

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

4. For more analysis on the workings of race and gender in the UN human rights system, please see the recording of SRI and IMADR's webinar "Race Matters" (2020): https://youtu.be/r0ovIgwlAFw

5. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,Tlaleng Mofokeng: Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic. A/76/172, 2021, https://www.undocs.org/A/76/172, para. 4.

Case studies

Indigenous communities in Canada

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[6]; loss of land, water, and languages, of traditional knowledge and healing practices (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. 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; additionally, they also serve as barriers to accessing healthcare. 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[7].

Indigenous women face particular and additional challenges in securing good health as well as access to healthcare. One manifestation of this historical and ongoing destruction of Indigenous lives and ways of living is the epidemic of forced and coerced sterilisation of women in and from Indigenous communities in Canada. 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.

Caste-based oppression in India

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[8]. Dalit women face specific barriers in accessing sexual and reproductive healthcare, with more than 46% receiving no antenatal care (this

8. Subramaniam, S. (2018). “Inequities in Health in India and Dalit and Adivasi Populations.” In: Ravindran, T., Gaitonde, R. (eds) Health Inequities in India. Springer, Singapore. https://doi.org/10.1007/978-981-10-5089-3_5; for specific health challenges faced by Adivasi communities, see “From the Margins to the Centre: A study on the health inequities among the tribal communities in selected districts of Chhattisgarh, Jharkhand and Odisha” by Sama – Resource Group for Women and Health: https://nhrc.nic.in/sites/default/files/SAMA%20Final%20Report.pdf

number is significantly higher for certain sub-castes)[9]. 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'[10]. On average, a Dalit woman lives 15 years less than women from dominant castes.

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. 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.

Women living with HIV in South Africa

We can draw a continuous line from 17th-century colonial incursions into present-day South Africa – through the invention of whiteness and of race as an organising category[11] 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[12], and forced and coerced sterilisation of Black women living with HIV in South Africa today[13]. The continuation of (economic) Apartheid by other means after 1994 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.

Given this background, it is no surprise that Black women living with HIV are primarily considered to be 'vectors' of transmission, not 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[14].

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9. Raghavendra R.H. (2020). "Literacy and Health Status of Scheduled Castes in India." Contemporary Voice of Dalit 12(1) 97–110, 2020.

10. India prohibited untouchability in 1950 but it continues in practice; in fact, the flexibility of the caste system is such that guidelines for social distancing were used by upper castes in India to strengthen their caste-based prejudices, while marginalised communities, including Dalits, living in slums and other crowded spaces were often unable to maintain social distance or quarantine. See Sandip Mondal and Ranjan Karmakar, "Caste in the Time of COVID-19 Pandemic." Contemporary Voice of Dalit. https://doi.org/10.1177/2455328X211036338. See also "Impact and Resilience in COVID-19 Pandemic: A Study of Dalits in India" at http://www.theinclusivityproject.org/assets/publications/doc/India_Report_98g6k.pdf.

Recommendations

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

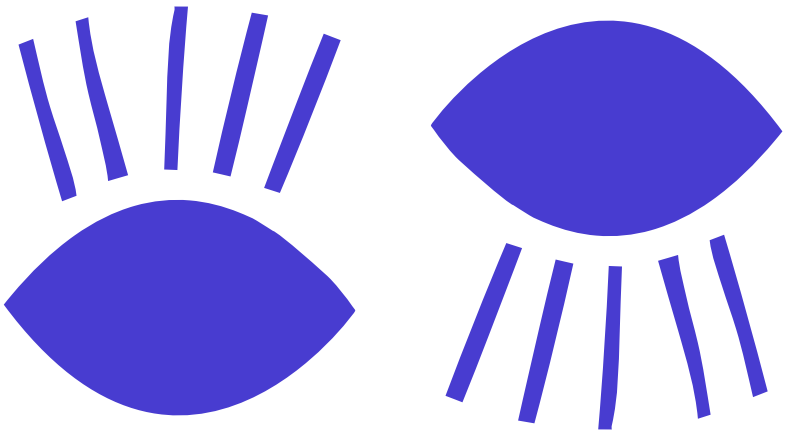
1. **Engage with all the elements outlined under Article 5 (e)(iv), including the right to public health:**
   a) **Call on states to fund health publicly through progressive taxation, free from control from other governments, multilateral agreements and transnational corporations;**
   b) **Treat privatisation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

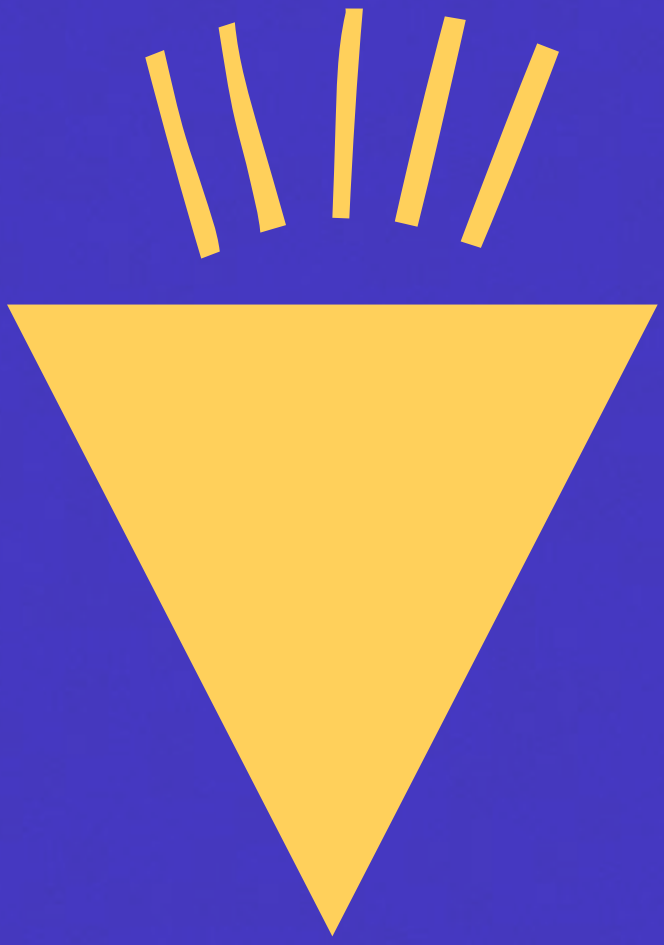
11. Nancy Stepan, 1982, The Idea of Race in Science: Great Britain 1800-1960, Macmillan.

12. Carol Kaufman, 2000, "Reproductive Control in Apartheid South Africa," Population Studies Vol. 54, No. 1, 105-114.

13. Commission for Gender Equality (South Africa) investigative report on the forced sterilisation of women living with HIV/AIDS in South Africa: Complaint Ref No: 414/03/2015/KZN, http://srjc.org.za/wp-content/uploads/2020/03/Forced-Sterilisation-Report.pdf; see also the January 2022. submission by Her Rights Initiative, the Women's Legal Centre and SRI to the Special Rapporteur on the right to health.

14. Hannah Arendt claimed that rights must be preceded by the right to have rights; in South Africa, access to rights is a privilege reserved for the socioeconomically advantaged.





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