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Chair: Ms. Stavrinaki

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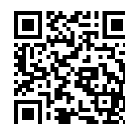

Ms. Stavrinaki (Vice-Chair) took the Chair.

The meeting was called to order at 10.10 a.m.

Organizational and other matters (*continued*)

Thematic discussion on racial discrimination and the right to health

1. **The Chair**, opening the thematic discussion, said that it was the first step in the Committee's work on a general recommendation on article 5 (e) (iv) of the Convention.

2. **Ms. Balbin Chamorro** (Office of the United Nations High Commissioner for Human Rights) said that the coronavirus disease (COVID-19) pandemic, along with other crises, had exacerbated the challenges that the individuals and groups most vulnerable to racism and racial discrimination faced in their attempts to exercise their rights, including their health rights. Systemic racism was still one of the causes of differences in the quality of the care they received.

3. In her 2021 report on the promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers, the High Commissioner had highlighted the obstacles people of African descent faced in their attempts to gain equal access to health care. According to studies cited in the report, intergenerational trauma had negative health consequences on some people of African descent, while repeated racist microaggressions and commonplace experiences of racism caused further stress and trauma. The report also noted that stereotypes and the racial prejudices of health-care providers sometimes had a negative impact on the quality of the care provided.

4. In exercising its mandate, the Committee had systematically addressed the specific barriers that various groups, including indigenous peoples, Roma and other national or ethnic minorities, as well as stateless persons, asylum-seekers, refugees and migrants, could face in enjoying the right to the highest attainable standard of health. Preparing a new general recommendation would give the Committee and other stakeholders an opportunity to deepen their understanding of the structural problems faced by individuals and groups subjected to racism and racial discrimination.

5. The enjoyment and protection of the right to health encompassed the enjoyment of other rights that were determinants of health, such as the rights to drinking water and adequate sanitation, an adequate supply of safe and nutritious food and housing, the right to healthy occupational and environmental conditions and the right to health-related education and information. Structural discrimination and systemic racism, however, had made it hard for some groups to exercise those rights. A holistic approach to combating racial discrimination and its intersections with other forms of discrimination would make it possible to develop health policies that ensured that no one was left behind.

6. The day's discussion would focus on monitoring, accountability and redress. The collection of data broken down by race or ethnic origin was central to accountability efforts, which should cut across all relevant sectors and policy areas. Ensuring accountability also meant ensuring that avenues of redress were readily available where there had been breaches of the right to health or other rights. The discussion would also address intersectionality as it related to racial discrimination in the context of the right to health.

7. **The Chair**, stressing that the discussion was an opportunity for stakeholders to express their views on a topic on which the Committee was planning a general recommendation, said that there would be two panel discussions during the morning meeting, the first moderated by Mr. Diaby and the second by Ms. McDougall.

8. **Mr. Diaby**, introducing the three panellists who would take part in the first panel discussion, said that the discussion would focus on racial discrimination in relation to health as experienced in particular by the persons and groups most vulnerable to racial discrimination.

9. **Mr. Iakovidis** (Greece) said that participating in the drafting of general recommendations enabled States parties and other stakeholders to better understand the Convention. Groups facing racial discrimination encountered barriers in access to health

services, and social determinants of health could have a serious effect on their enjoyment of the right to health.

10. In recent years, Greece had taken steps that could contribute to the elimination of racism as an obstacle to the enjoyment of that right. As part of the National Roma Integration Strategy, community centres had been established to bring services closer to Roma communities; cultural mediators, who helped bridge linguistic and cultural divides, had been hired; and health and other indicators were being used to define objectives for Roma social inclusion, equality and empowerment.

11. The indicators developed within the framework of the Strategy included overall life expectancy at birth, the percentage of Roma children who started primary education at the usual age, the percentage of Roma children over the age of 16 who had a medical record and the percentage who received proper medical care. Those indicators were instrumental to assessing the health conditions of the Roma people and to evaluating the scope and magnitude of the challenges ahead. They also made it possible to measure progress.

12. During the pandemic, the community centres had helped transmit accurate information and had made it possible for students to attend virtual classes. A vaccination campaign for Roma living in remote settlements had also been launched.

13. The world was at a critical juncture. Abortion rights, for example, were under threat, a situation that could have a severe impact on women and girls who already faced other forms of discrimination. When discrimination encroached on the right to health, tackling that discrimination, not least by ensuring that accountability mechanisms were established, was a matter of life and death.

14. **Ms. Ambast** (Amnesty International), noting that Amnesty International had made a detailed written submission to the Committee on aspects of article 5 (e) (iv), said that, in a number of countries, barriers were a primary cause of the comparatively poor health outcomes and unequal access to health care of persons vulnerable to racism. In Libya, for example, members of ethnic minority groups struggled to obtain health care because they did not have the necessary identity documents. In Namibia, members of San communities had to travel long distances and overcome language and other barriers to obtain health care. In the United States, American Indian and Alaska Native women who survived sexual violence found it harder than others to obtain care for many reasons, including the federal Government’s severe underfunding of the Indian Health Service.

15. Inequities resulting from the social determinants of health were a second reason for the poor health outcomes and unequal access to health care of persons vulnerable to racism. Colonial policies, combined with government failures to address inequalities in the public health system, continued to have an impact on access to health care. Unjust criminalization, which affected the members of some communities, also drove poor health outcomes. Laws that criminalized a woman’s conduct during pregnancy, for example, caused pregnant women of some racial communities in particular, to avoid health-care practitioners.

16. Some of the coercive public health measures taken during the pandemic, including lockdowns, had had a disproportionately detrimental impact on the enjoyment of the right to the highest attainable standard of health of individuals and groups vulnerable to racism. In Slovakia, for instance, targeted testing in Roma settlements might have led to increased stigmatization and prejudice, while in Bulgaria quarantines had probably had a disproportionate impact on Roma living in poverty, as restrictions on their freedom of movement had limited their ability to work.

17. Current patterns of international cooperation and assistance were a final cause of comparatively poor health outcomes and unequal access to health care. Many countries in East Africa, for example, had kept strict measures to prevent the spread of the COVID-19 in place much longer than had countries where vaccine supplies were plentiful, thereby adding to the risks to their people’s enjoyment of the rights to health, education and an adequate standard of living.

18. Key among the recommendations included in Amnesty International’s written submission were that States should put in place measures to address intersecting forms of discrimination and make efforts to understand the impact of racism on health. In addition,

they should collect health-related data, disaggregated by race, colour, descent, ethnic or national origin and other relevant categories. Lastly, policies should be developed with the meaningful participation of the people they were likely to affect, and there should be mechanisms to ensure that racial discrimination in health matters did not go unpunished.

19. **Mr. Kort** (World Health Organization (WHO)), speaking via video link, said that WHO had also made a written submission to the Committee on racial discrimination and the right to health. WHO recognized that a person's racial, economic or social status could be a barrier to his or her enjoyment of that right.

20. The health sector alone could not eliminate the racism that often resulted in gross health inequities. The United Nations had thus committed itself to supporting Member States in taking coordinated multisectoral action to eliminate discrimination in health-care settings. An intersectional lens was also critical to understanding how sex, gender identity, disability, poverty and other causes of social stratification could compound the impact of discrimination in such settings.

21. The pandemic, during which indigenous peoples and racial and ethnic minorities had been disproportionately affected, had exposed the effects of systemic racial discrimination. In low-income countries, barely more than a third of health-care workers had received their primary course of vaccinations as of June 2022. WHO was working on the commercial and social determinants of health, including within the framework of comprehensive pandemic-recovery efforts. Those efforts included training the staff members of United Nations country teams in the use of tools that made it possible to address systemic racial discrimination in common country analyses and cooperation frameworks.

22. In some places, indigenous peoples were more likely than others to use tobacco. The WHO Framework Convention on Tobacco Control recognized not only the disproportionate harm done to indigenous peoples' health but also the appropriation of indigenous cultural symbols to promote tobacco use.

23. The fight for sexual and reproductive rights also required combating racism. A strategy on ethnicity and health developed by the Pan American Health Organization was worthy of note in that respect.

24. Common country analyses did not always assess in sufficient detail the situation of traditionally marginalized groups. The world would have to do better if the pledge to leave no one behind, made in 2015 as part of the adoption of the 2030 Agenda for Sustainable Development, was to be honoured.

25. **Ms. Burke-Shyne** (Harm Reduction International), noting that her statement was based on a joint written submission to which her organization had contributed, said that drug control negatively affected access to health services, including highly effective harm reduction services, which were not as widely available as they should be, for black, brown and indigenous people who used drugs. According to the Working Group of Experts on People of African Descent, drug control had been more effective as a means of racial surveillance than as a means of curbing the use and sale of drugs. The racial impact of punitive drug control was a legacy of colonialism. The health risks of the unregulated use of narcotics were ignored where they principally affected people of African descent.

26. Policing priorities were grounded in discrimination and negative racial stereotypes, with black, brown and indigenous people disproportionately targeted in law enforcement narcotics operations; that was associated with health risks, not least as the targets were disproportionately likely not to seek out harm reduction services.

27. In its general recommendation on article 5 (e) (iv) of the Convention, the Committee should emphasize that ethnic minorities were disproportionately affected by punitive drug control policies, that drug control had perpetuated systemic forms of oppression and that the criminalization of people who used drugs resulted in poorer health outcomes for ethnic minorities. The Committee could also point out that those systemic issues could not be addressed until imprisonment was made a last resort and funding for enforcement operations was redirected to harm reduction efforts.

28. **Ms. Lopes** (Ipas – Partners for Reproductive Justice) said that, in Brazil, older persons represented 10 per cent of the population and studies indicated that white people there enjoyed better health in old age than black people owing to sociodemographic factors and discrimination in access to health services.

29. Brazil had reported a sharp increase in maternal mortality during the pandemic, and black women had accounted for 61 per cent of the COVID-19-related deaths and 56 per cent of the COVID infections in women during pregnancy or childbirth. According to the United Nations Population Fund, during the pandemic, large numbers of women had lost access to health services due to movement restrictions and the fear of going to a health facility; persons vulnerable to racism had encountered multiple barriers that impeded access to timely, good quality health care, typically owing to a combination of factors that amounted to structural racism.

30. In the light of those concerns, her organization recommended that States should adopt the concept of intersectionality as a practical instrument that could contribute to the comprehensive understanding and protection of the right to health. Affirmative action should be taken to ensure that health workforces reflected the racial, ethnic, gender and territorial composition of the population. Graduate and postgraduate programmes should cover the health impacts of racism and many other forms of discrimination. Lastly, the Committee's general recommendation should guide other United Nations mechanisms such as the Permanent Forum of People of African Descent.

31. **Ms. Pierre** (Commission des droits de la personne et des droits de la jeunesse) said that inequalities in indigenous persons' access to health care were a legacy of colonialism. In that regard, the Truth and Reconciliation Commission of Canada had called on the Government to recognize that the current situation of indigenous peoples was the result of past policies and to protect their right to health. The health needs of members of indigenous communities were greater than those of the non-indigenous population, and members of First Nations communities were more likely to consider themselves in poor health. Poverty, housing conditions, geographical isolation, and cultural and language barriers all influenced the health status of indigenous persons. Discriminatory obstacles to accessing good quality health services meant that they experienced poorer health outcomes.

32. Racialized minorities and people of African descent also faced disparities in access to health services. As a result, they were less likely to state that they enjoyed good or excellent physical and mental health. People from racialized minorities – including black, Arab, Latino and South Asian communities – were also less likely than white people to have a regular health service provider.

33. Relatively few data were available for the purpose of documenting health inequalities and situations of discrimination in the health system. In 2020, her organization had reminded the Government of the importance of collecting disaggregated data in order to address the discriminatory impacts of the COVID-19 pandemic and to promote equal access to health services. The COVID-19 mortality rate had been higher in densely populated multicultural neighbourhoods, with analysis by Statistics Canada revealing that, in Quebec, the immigrant population had accounted for a disproportionately high number of deaths. Black people and other minorities were overrepresented in front-line jobs, especially in the health system, and thus faced a higher risk of infection.

34. Lastly, she wished to draw the Committee's attention to the case of Joyce Echaquan – an indigenous woman who had died in a Quebec hospital after being subjected to racist abuse by staff members. The case had highlighted the persistence of racist attitudes and conduct in the province's institutions.

35. **Ms. Ratjen** (Franciscans International) said that her organization and its partners had documented discriminatory norms and practices affecting indigenous peoples and migrants. During the pandemic, Governments across the world had failed to implement culturally adequate and targeted measures to protect indigenous peoples. For example, in Guatemala, the lack of information in indigenous languages and the lack of consideration and respect for traditional knowledge had prevented indigenous peoples from effectively accessing health services. In Brazil, the pandemic had aggravated mental health issues among indigenous persons, for whom the suicide rate had reached a new peak in 2021. In July 2020, the

President of Brazil had vetoed several provisions of a bill intended to curb the spread of the virus among indigenous and traditional peoples. Meanwhile, in West Papua, Indonesia, a vaccination programme had been implemented mostly by police and military personnel, without consulting the local population or providing adequate information, with the result that many indigenous West Papuans were reluctant to be vaccinated. In 2018, the Special Rapporteur on the right to health had reported that ethnic Papuans were twice as likely to have HIV/AIDS as the rest of the population and that rates of infection were rising.

36. In Latin America, although many countries provided access to essential health services for everyone without discrimination, migrants and asylum-seekers faced barriers in accessing specialized treatments and medicines and in some cases had been deported after accessing health services. African and Asian migrants faced particular discrimination on the grounds of their colour and origin and were not provided with information in languages other than Spanish. In Mexico, between 40 and 60 per cent of migrant women had experienced sexual or gender-based violence during their journey and they faced challenges in accessing sexual and reproductive health services.

37. Her organization recommended that the general recommendation should address the fact that, in many countries, business activities contributed to violations of the rights to health and to a healthy environment, which particularly affected indigenous peoples.

38. **Ms. Gheorge** (E-Romnja) said that, in Romania, women who lived in marginalized or segregated communities, rural women, women with low levels of education and Roma and LGBT+ women faced challenges in accessing health and reproductive services and were more likely to be subjected to discriminatory and humiliating treatment by health workers. Roma women in particular were discouraged from accessing public health care owing to factors such as the cost of diagnosis and treatment, waiting times, fear of COVID-19 and long distances to public hospitals. Transgender Roma women faced even greater challenges, as racism intersected with transphobia, leading to high levels of distrust in the health system.

39. It was important to increase access to sexual and reproductive health care, including delivery care, for Roma women and girls from remote communities, to reduce maternal mortality and increase life expectancy. States should adopt legislation to combat forced marriages, child abuse, forced sterilization and human trafficking; recognize intersectionality; and promote human rights in their health systems by introducing an ethical code aimed at promoting gender equality and preventing discrimination and racism.

40. **Ms. Carrasco Alurralde** (Plurinational State of Bolivia) said that the pandemic had exposed existing inequalities throughout the world and had had a disproportionate impact on the peoples of the global South. It had also revealed inequities in access to vaccines and discriminatory attitudes towards indigenous and traditional medicine. Her Government considered that the general recommendation should place emphasis on respect for indigenous peoples’ worldviews, cultural practices, customs and traditions and recognize the contribution of traditional medicines to protecting the right to health.

41. The recommendation should also take into consideration the impact of discriminatory policies and actions on the right to health of population groups who were subject to intersecting forms of discrimination. In that regard, it should be recalled that, in late 2019, Bolivia had experienced a serious conflict marked by social polarization, racism and discrimination. The Interdisciplinary Group of Independent Experts for Bolivia, in its report on the acts of violence and human rights violations that had occurred between 1 September and 31 December 2019, described violations of the right to health such as the denial of medical treatment to detainees and arrests in hospitals, causing persons in need of treatment to avoid hospitals for fear of arrest. In some cases, hospitals had refused to provide treatment for discriminatory reasons, such as a person’s political affiliation or participation in protests. Her Government fully trusted that the general recommendation would lead to clear progress in the fight against racism and all forms of discrimination.

42. **Mr. Dehimi** (Algeria) said that all persons had the right to receive the highest quality of health care. The right to health was a fundamental one that was closely related to the rights to water and housing and the right to live in dignity. His Government regretted that peoples throughout the world did not enjoy the right to health on equal terms and took the view that the right to health care should be not an individual right but a collective one.

43. All references in the general recommendation to sexual rights, sexual orientation and gender-affirming surgery should be in compliance with international norms. His Government supported diversity and opposed all forms of discrimination against vulnerable groups; however, undue emphasis on certain elements might be detrimental to international unity.

44. **Ms. Wills** (Group of Human Rights Defenders) said that she represented a group of civil society organizations and human rights defenders from the favelas of Rio de Janeiro who were concerned about the impact of police violence as a social determinant of health. The Special Rapporteur on the right to health, Dr. Tlaleng Mofokeng, had observed that children and adolescents were growing up in communities that not only were ravaged by poverty, food insecurity and crime, but were also subjected to policing methods that attached little value to their lives. It was inevitable that the physical and mental health of the inhabitants of such communities should be compromised.

45. One serious health impact ensued from the killing of family members: families faced huge mental health challenges after the loss of a child to police violence, with some parents becoming so unhappy that they lost the will to live. Another impact was the trauma suffered by children who lived in communities where police were routinely violent: they were often confined indoors, unable to go outside and play with friends; and their sleep was disturbed for days after a police operation. Heavily militarized policing operations in the favelas were reported to be a leading causal factor in the high levels of depression, anxiety, nervousness and post-traumatic stress disorders seen among residents.

46. In the light of those concerns, she requested the Committee to find space in the general recommendation to address the impact of police violence as a social determinant of health and the obligation of States to consider the right to health when planning and conducting police operations.

47. **Ms. Taderera** (Sexual Rights Initiative) said that, to meet their obligations under article 5 of the Convention, States should ensure that health care was publicly funded through progressive taxation; adopt a systems approach to fulfilling the right to health; and take an intersectional approach in all aspects of health-care provision. The acceptance and normalization by various Committees of for-profit health-care services as a legitimate means for States to fulfil their human rights obligations, without meaningful consideration of the racialized and gendered impacts of privatization and austerity, was a serious problem. As article 5 (e) (iv) of the Convention guaranteed the right to public health, medical care, social security and social services, the Committee was uniquely positioned to articulate the impact of privatization of health services on communities and individuals subject to racial discrimination and to provide clear guidance on State obligations to make use of maximum available resources to progressively realize the right to health. Privatization of health services, often forced upon countries in the global South through structural adjustment, international assistance or other "good governance" measures, inevitably benefited the elite few and followed the colonial playbook of resource extraction, exploitation and forced underdevelopment.

48. According to research, less than a quarter of African people had received two doses of any COVID-19 vaccine. That statistic was symptomatic of the struggles of States in the global South to confront the pandemic, owing to a deeply racist intellectual property regime that limited their access to necessary medical resources. Furthermore, the disregard of indigenous concepts of health and health care, combined with ongoing threats of colonial expansion and other legacies of colonialism, had resulted in the disproportionately poor health of indigenous peoples around the world. Yet many indigenous peoples' conception of individual health as being inextricably linked to collective and community health was in fact compatible with a systems and human-rights based approach to health.

49. Her organization recommended that the Committee should encourage States to adopt the systems approach to health, which guaranteed all the rights and entitlements necessary for the fulfilment of the right to health. The approach also ensured that health was not treated as a stand-alone right but was considered alongside the other entitlements that determined people's ability to live decent lives, such as the rights to education, clean water, adequate sanitation, social security and community participation.

50. **Ms. Guerra** (Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos) said that, between 1995 and 2000, a State policy had resulted in the forced sterilization of over 300,000 women and 22,000 men in Peru. The Government had failed to implement the Committee's 2018 recommendations that victims should be ensured access to the Registry of Victims of Forced Sterilization and that all cases should be investigated without delay; over 1,300 victims of forced sterilization continued to demand justice.

51. Sexual violence against women and teenage girls was commonplace in Peru and there was a general lack of access to oral emergency conception, particularly in rural areas. Although obstetric violence had been identified as a specific form of violence against women in national law, rural, indigenous and Quechua-speaking women were still habitually mistreated when receiving maternal health-care services. There was a general feeling among health-care providers that the ancestral customs of indigenous peoples were backwards and ignorant, and there was a lack of culturally appropriate health-care services provided in the language of indigenous or rural women.

52. Her organization encouraged the Committee to use its general recommendation to clarify the importance of an intersectoral approach in public policies as a means to eliminate discrimination from health-care provision.

53. **Ms. Zampas** (Center for Reproductive Rights) said that the latest WHO guideline on abortion care included recommendations calling for the complete decriminalization of abortion and the repeal of laws that only ensured access to abortion on certain grounds. The guideline explained that access to abortion was essential to helping prevent maternal deaths and injuries, but also for the exercise of autonomy and other human rights, and that restrictive laws did not reduce the number of abortions but served only to make abortion less safe. It also illustrated the specific impact of those restrictive laws on black, indigenous and poor women. Her organization recommended that, in its general recommendation, the Committee should call on States to implement all the WHO health-care guidelines and, in particular, the guideline on abortion care.

54. **Ms. Nthenge** (International Disability Alliance) said that many persons with disabilities who were members of racial and ethnic minorities, indigenous peoples and other groups protected under the Convention experienced multiple and intersecting barriers preventing their access to health services on the basis of race and disability. For example, research in the United States had found that women with disabilities from racial minorities were disproportionately affected by health-care inequalities, while a study in the United Kingdom had revealed that persons with psychosocial disabilities from racial minorities were overrepresented among those forcibly institutionalized in care facilities. It was therefore imperative to develop human rights standards that set out the correlation between health, disability and race.

55. In that context, International Disability Alliance recommended that the Committee should call on States to ensure that all persons with disabilities, in particular women, from racial and ethnic minorities and indigenous populations were protected against all forms of discrimination, including intersectional discrimination; to guarantee accessibility in all its dimensions, including full access to health-care services, for all persons with disabilities; to ensure equal recognition before the law for all persons with disabilities, including those from racial and ethnic minorities and indigenous populations; to abolish deprivation of liberty on the basis of disability; and to safeguard the right of persons with disabilities to free, prior and informed consent in the context of medical treatment.

56. **Mr. Iakovidis** (Greece) said that the most important lesson to draw from the discussion was that racial discrimination often intersected with other human rights violations and that the vulnerability experienced by marginalized groups was often of a multidimensional nature. States must take that intersectionality into account when formulating policies aimed at guaranteeing the rights of marginalized persons who were most at risk of experiencing racist discrimination and abuse.

57. **Ms. Ambast** (Amnesty International) said that, if States were to succeed in combating discrimination and guaranteeing the right of everyone to health on an equal basis, it was crucial that they should recognize and address the intersectional nature of the discrimination that many people experienced. It was also important for States to look beyond the simple

matter of access to health care and to consider wider issues such as the social determinants of health, the role of the police and the possible existence of legislation that perpetuated discrimination. Lastly, States had the obligation to ensure that all the measures they took were adequately financed in ways that were fair and did not reinforce existing racial stigmatization and discrimination.

58. **Mr. Kort** (World Health Organization) said that he supported the comments made concerning the intersectional nature of discrimination related to the right to health, the importance of a holistic vision of health and the significance of underlying determinants of health. It must also not be overlooked that the goals that had been set under the 2030 Agenda for Sustainable Development were based on international human rights, including the right to health, and that the failure of the international community to make adequate progress towards achieving them was partly due to the continued prevalence of structural and systemic racial and ethnic discrimination around the world.

The meeting was suspended at noon and resumed at 12.05 p.m.

59. **Ms. McDougall**, introducing the three panellists for the second discussion, said that they would focus on legal obligations regarding the prohibition of racial discrimination and the right to health under international human rights law.

60. **Ms. Duncan Villalobos** (Costa Rica) said that the results of the 2011 census in Costa Rica had shown that Afrodescendent and indigenous persons were at a disadvantage compared with the rest of the population with respect to poverty levels and access to education and health. Furthermore, their high level of unemployment and their overrepresentation in the informal employment sector continued to have a direct and negative impact on their access to public health and social security.

61. National health authorities alone did not have the capacity to guarantee access to health for all people regardless of their social status or other social determinants. To achieve true health equity, States needed to take inter-institutional and multisectoral action on issues such as housing, education, employment, sanitation and waste management and to ensure that private companies complied with their obligations concerning environmental and labour rights. It was important to incorporate measures related to social determinants into health systems, to tailor services to different contexts to meet the needs of all population groups, and to strengthen communities through capacity-building and inclusion in decision-making. For those reasons, the Government of Costa Rica was developing a new inclusive public health policy, based in part on data on specific indigenous and Afrodescendent populations.

62. Issues that were not backed up by concrete statistical data were easily ignored; all Governments must therefore improve their sources and systems of information in order to formulate effective, evidence-based policies aimed at improving the situation of Afrodescendant and indigenous populations, including in respect of their right to health. Censuses were carried out too infrequently; combating racial discrimination required the constant collection of relevant data by all government agencies.

63. The right to health must be considered as a cross-cutting theme in relation to all measures taken to improve access to public services. It should be incorporated into all policies and plans aimed at promoting equity, social justice and equal opportunities. To guarantee the right to health for everyone, without discrimination, States must ensure that everyone enjoyed equal protection under the law and equal opportunities, including in access to social services.

64. **Ms. Kumari** (International Federation of Gynaecology and Obstetrics) said that the work of her organization, which brought together gynaecology and obstetrics associations from over 130 countries, was focused on helping women and girls achieve the highest possible standards of physical, mental, reproductive and sexual health and well-being. It carried out international projects addressing issues such as obstetric fistulas, cervical cancer and post-partum haemorrhage and advocating for safe abortion and better access to contraception, above all in sub-Saharan Africa, Southeast Asia and Latin America.

65. Her organization believed that the aim of every Government, every organization and every society should be to give all women the power to make their own decisions concerning their health. Denying women the right to abortion did not stop abortion; it only resulted in

unsafe abortions that had already caused the deaths of millions of women. Governments had a responsibility to ensure that health care of an acceptable quality was accessible for all people. Unless they took the necessary measures to address discrimination against women, including the manner in which it intersected with discrimination on the grounds of race and caste, they would not be able to fulfil that duty.

66. To guarantee the right to health, it was also essential to take action on the social determinants of health. Women who did not have access to healthy food because of discrimination on the grounds of their race or caste were more likely to suffer from anaemia, which could lead to post-partum haemorrhage and, in turn, maternal mortality. Moreover, when women had access to education, they learned that it was their right to demand equal access to health and nutrition.

67. The right to health meant that every woman, irrespective of colour, race or caste, should have access to high quality care; the Sustainable Development Goals could not be achieved otherwise. Economic factors should also be taken into account as they had a strong impact on access to care. Venezuelan refugees in Colombia, for example, required access to sexual and reproductive health care, including abortion and obstetric care; such care must be available to all women, regardless of immigration status. In terms of abortion care, States needed to decriminalize the provision of abortion services to save lives; they should also honour their pledges on overseas aid.

68. **Ms. Edwards** (Organization for Security and Cooperation in Europe) said that the COVID-19 pandemic had added complexity to the task of addressing intolerance and discrimination, exacerbated intolerant discourse, deepened existing inequalities and exposed vulnerabilities across society. Discrimination could lead to poor health among minority communities, and emergency measures to prevent the spread of the pandemic had often disproportionately affected minorities. Migrant workers in particular had experienced discrimination in access to health care and increased vulnerability due to employment in high-risk workplaces, or had been forced to leave their jobs and return to their home countries.

69. Her organization recommended that States should uphold their commitments and international obligations on tolerance and non-discrimination. The impact of emergency measures on minority or marginalized communities should be assessed, with meaningful participation of those communities' representatives, and mitigating measures adopted as needed to prevent the creation of further disadvantage. Recovery assistance must be non-discriminatory and designed in cooperation with underrepresented groups. Priority for medical assistance must be based on clinical factors, not criteria related to protected characteristics.

70. Discrimination in access to adequate housing for persons from minority communities or with a migrant background contributed to the risk of ill health, as did their overrepresentation among essential workers, including in the health-care sector, which had suffered from a lack of appropriate personal protective equipment during the pandemic. Access to clean water remained an issue for indigenous communities, particularly those living on reservations, and other minority communities. States should promote policies that focused on equality of opportunity by collecting and analysing equality data in the context of the pandemic and other emergencies across the public sector and in cooperation with civil society.

71. **Ms. Rovalo Otero** (Mexico) said that, with a view to guaranteeing the right to health in contexts in which certain groups suffered from particular vulnerabilities, a commitment to all human rights obligations was vital, including the rights to food, housing and education.

72. **Mr. Nuon** (Cambodia) said that the provision of health care in his country was based on the principles of inclusiveness, equity, transparency, quality and professionalism. Particular efforts had been made to ensure equal access to health care for vulnerable groups, including ethnic minorities, migrants and those who lived in remote areas; their needs should be reflected in health policy and its implementation. The elimination of racial discrimination would support the right to health.

73. **Mr. Gunawan** (Open Society Foundations) said that, although prohibitions on drugs were intended to improve population health, they had deep colonial roots and a history of harming communities, and were inconsistent with the right to health and the obligation to eliminate racial discrimination in all its forms. The Committee's general recommendation should therefore direct States parties to move away from the prohibition model towards a human-rights based approach to drugs. Norms and practices that resulted in structural discrimination that disproportionately affected the right to health of marginalized populations placed an obligation on States parties to act. His organization therefore encouraged the Committee to recommend that States parties should decriminalize drug use and possession for personal use in line with the 2018 United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration; release persons detained solely for drug use or possession for personal use and review convictions with a view to expunging criminal records; assess and report on the impact of drug prohibitions on racialized communities by collecting disaggregated data on drug arrests, prosecutions and sentencing; and explore regulatory models for different types of drugs.

74. The general recommendation should guide States parties to engage with indigenous and other groups that used controlled substances in traditional medical, spiritual and cultural practices, in order to assess the impact of the prohibition of those drugs on such communities. Since certain United Nations agencies and programmes had pursued prohibitions on drugs around the world despite growing evidence of the harm caused by such prohibitions, other United Nations agencies should play a leading rule in addressing and reducing that harm and helping States parties to design, implement and monitor alternative models.

75. **Mr. Serrano Alarcón** (Colombia) said that his Government had made particular efforts to ensure access to health care for the most vulnerable groups, including ethnic minorities and indigenous peoples. Initiatives included the establishment of forums for consultation with different ethnic and indigenous groups, the development of an intercultural indigenous public health policy and the introduction of guidelines on the analysis of the health of indigenous groups.

76. **Ms. Ferro** (United Nations Population Fund) said that, in Latin America and the Caribbean, a lack of data on ethnic and racial variables resulted in limited information about access to health for indigenous peoples and persons of African descent. The indicators available, however, showed that those groups had poor health outcomes, including in the areas of maternal morbidity and mortality, infant mortality and unintended pregnancies. The existing literature indicated that health providers viewed discrimination and violence as key barriers to access to health services for women of indigenous and African descent in Latin America.

77. **Ms. Badarinath** (Action Canada for Population and Development) said that, given that only part of the thematic discussion had been held in a hybrid format and that travel could be prohibitively expensive, especially for those in the global South, the Committee should consider hosting regional meetings on the topic to ensure meaningful participation in the discussion by those most affected by racial discrimination.

78. Racism itself was a comorbidity in racialized patients, leading to the dismissal of symptoms or pain, which could be deadly. The relationship between health, race, class and gender was rooted in colonial, patriarchal and capitalist control of women's sexuality, reproductive capacity and bodies, the consequences of which had a profound impact on the health and human rights of racialized women. She urged the Committee to take a holistic approach to health for indigenous and racially marginalized persons, and to include a rigorous gender analysis in the general recommendation.

79. Global funding for action on health replicated racist and colonial power dynamics and donor priorities often dictated the funding available for specific issues without prior consultation of beneficiaries. There was also a lack of accountability mechanisms to ensure that funding matched the needs of recipients. The Committee should encourage States parties to fund health through progressive taxation that was free of control by other governments, multilateral agreements or transnational corporations; and treat the privatization of health care as incompatible with human rights and racial equality.

80. **Ms. Duncan Villalobos** (Costa Rica) said that States needed to gather robust, disaggregated data in order to identify the focus for health-care efforts. Institutions that implemented public policy should support evidence-based decision-making, learn from human rights defenders and strengthen accountability. Inclusive mechanisms were needed to tackle the economic issues that faced vulnerable groups, and the social determinants of health should be taken into account, alongside exclusion and institutional racism.

81. **Ms. Kumari** (International Federation of Gynaecology and Obstetrics) said that the sexual and reproductive rights of women must be upheld and that women must have access to safe abortion.

82. **Ms. Edwards** (Organization for Security and Cooperation in Europe) said that the lessons learned on addressing health emergencies and structural barriers to care for persons of colour and women must be implemented. Efforts to provide access to adequate health care and prepare for the future must include affected communities in the decision-making process.

83. **The Chair** thanked all participants for their contributions to the discussion.

The meeting rose at 1.10 p.m.