



RACISM AND THE RIGHT TO HEALTH

AMNESTY INTERNATIONAL SUBMISSION TO THE SPECIAL RAPPOREUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH

Amnesty International is a movement of 10 million people which mobilizes the humanity in everyone and campaigns for change so we can all enjoy our human rights. Our vision is of a world where those in power keep their promises, respect international law and are held to account. We are independent of any government, political ideology, economic interest or religion and are funded mainly by our membership and individual donations. We believe that acting in solidarity and compassion with people everywhere can change our societies for the better.

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1. INTRODUCTION

Amnesty International welcomes the opportunity to contribute to the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on the theme of “Racism and the right to health”. The submission is structured around some of the themes covered in the questions laid out by the Special Rapporteur in the call for submissions. Due to the limited space available in this submission ‘racism’ is used to cover discriminations based on race, ethnicity, religion, work, and descent, intersecting with discriminations based on socio-economic status, gender, sexual orientation and identity.

2. MANIFESTATIONS OF RACISM IN ACCESS TO SOCIAL DETERMINANTS OF HEALTH [QUESTIONS 1 AND 2]

The right to health includes a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying social determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.¹ The Committee on Economic, Social and Cultural Rights (CESCR) also lists social factors essential to good health such as education, economic development and gender equity.² Any discrimination in access to the underlying determinants of health, as well as to means and entitlements for their procurement is prohibited.³ Access to these determinants often reflect structural inequality and discrimination which drive/perpetuate racial health disparities.⁴ Amnesty International’s research across countries has documented how groups subject to racism often face barriers due to discrimination and structural inequalities in accessing the underlying determinants of health, which contributes to their experience of poorer health outcomes and long-term health inequalities. Inequalities in the access to the social determinants themselves are often linked to racial and other discrimination, as detailed in the examples below. In several of the countries mentioned in this submission, key information on access to healthcare, and health status, was not being collected or disaggregated by race, making it harder for governments to understand what challenges exist and how to formulate policies to address them.

Racialised communities are also disproportionately targeted with unjust criminalisation, i.e. criminal sanctions or punitive laws, policies or regulations that have the effect of punishing people because of discrimination on the basis of, for example, their identities, work, health or other socio-economic status.⁵ Unjust criminalization is a driver of poor health outcomes and is linked to violations of the right to health, among other rights. It creates and perpetuates marginalization, stigma and discrimination and can create barriers to health information, goods and services. For example, unjust criminalization can compromise individuals’ access to care by allowing, and in some cases encouraging, discrimination against them in the provision of services by healthcare workers.⁶

In **Namibia**,⁷ Amnesty International documented the health status and access to healthcare of San peoples. The Special Rapporteur on the rights of Indigenous peoples has stated that the San “are

¹ CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12), UN Doc. E/C.12/2000/4, para. 4

² CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12), UN Doc. E/C.12/2000/4, para. 16.

³ CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12), UN Doc. E/C.12/2000/4, para. 18

⁴ See for example Amnesty International, Unequal and Lethal: Five key actions to recover from the human rights crisis unleashed by the pandemic in Latin America and the Caribbean, AMR 01/5483/2022, <https://www.amnesty.org/es/documents/amr01/5483/2022/es/>

⁵ Amnesty International, There is no help for our community: The impact of states’ Covid-19 responses on groups affected by unjust criminalization, POL 30/5477/2022, <https://www.amnesty.org/en/documents/pol30/5477/2022/en/>

⁶ Amnesty International, Body Politics: a primer on criminalization of sexuality and reproduction, POL40/7763/2018, [amnesty.org/en/documents/pol40/7763/2018/en](https://www.amnesty.org/en/documents/pol40/7763/2018/en)

⁷ Amnesty International, “We Don’t Feel Well Treated” , Tuberculosis and the Indigenous San peoples of Namibia, AFR 42/4784/2021, <https://www.amnesty.org/en/documents/afr42/4784/2021/en/>

understood to be the most vulnerable of the Indigenous peoples in Namibia”.⁸ San peoples are the only ethnic group in Namibia whose health status has declined since independence in 1990.⁹ San people display some of the worst health indicators, including higher rates of malnutrition as well as childhood and maternal mortality, and a higher burden of disease.¹⁰ As such the life expectancy of Indigenous San peoples is considerably lower than the national average.¹¹ Covid-19 has increased the risk of poor health outcomes in this community. Owing to the remoteness of the settlements they live in, San communities already experience poor access to healthcare, clean water, sanitation, and other essentials, such as soap and disinfectants.

In **South Africa**, access to health services continues to be impacted by spatial injustice that reflect racial segregation and colonial and apartheid repression combined with government failures to address stark inequalities in the public health system's infrastructure and resources.¹² Amnesty International's research in relation to access to antenatal care and safe abortion services, has documented that those in the poorest and most marginalized communities, including women, girls and people living with HIV, and sex workers, continue to experience physical, and economic barriers to accessing their right to health. Access to safe abortion is especially challenging in areas of poverty and in rural communities due to large distances to health facilities, the high costs of transport to reach them and ongoing failures to provide accessible information on which public health facilities provide abortion services.¹³

In **Sweden**, European Union (EU) citizens from Eastern Europe, most of whom identify as Roma, are currently living in desperate and dangerous situations in Swedish cities and towns. Many Roma people have left structural discrimination and “anti-Gypsyism” in their home countries, mainly Romania and Bulgaria, and have travelled to Sweden to try to make a living for themselves and their families. Those without housing and a regular income are categorized as “vulnerable EU citizens” in Sweden. Inadequate legal and policy frameworks mean that many in this group fall through the cracks in Sweden, with serious consequences for their health and lives. Roma people interviewed by Amnesty International said the conditions they were living in, often sitting or standing outdoors for many hours at a time, frequently in the cold, and without access to toilet facilities and clean water, had serious health consequences. Some also had chronic pre-existing conditions, such as diabetes, heart or kidney problems or ulcers, before coming to Sweden. These had been exacerbated by their living conditions, making the difficult life in Sweden even harder. At the same time, many faced obstacles in accessing the necessary health care and treatment from the medical system in Sweden. These obstacles included challenges accessing subsidized health care due to vague laws and high costs of health care.¹⁴

Amnesty International also published a report in 2010 on African-American women in the **USA** being at especially high risk of maternal deaths; they were nearly four times more likely to die of pregnancy-related complications than white women at the time. It also documented the barriers women, in particular women of colour, women living in poverty and immigrant women, faced in accessing health care when pregnant.¹⁵ The disproportionate rates of maternal death have not changed since our last reporting.¹⁶

⁸ UN Human Rights Council (2013). Report of the Special Rapporteur on the rights of indigenous peoples, Addendum: The situation of indigenous peoples in Namibia, 25 June 2013, A/HRC/24/41, <https://www.refworld.org/docid/522db4014.html>

⁹ African Commission on Human and Peoples' Rights & International Work Group for Indigenous Affairs. (2008) Report of The African Commission's Working Group on Indigenous Populations/Communities: Mission to The Republic of Namibia, p 89, https://www.iwgia.org/images/publications/ACHPR_Namibia_UK.pdf

¹⁰ African Commission on Human and Peoples' Rights & International Work Group for Indigenous Affairs. (2008) Report of The African Commission's Working Group on Indigenous Populations/Communities: Mission to The Republic of Namibia, p 89, https://www.iwgia.org/images/publications/ACHPR_Namibia_UK.pdf

¹¹ Suzman, J & Legal Assistance Centre (Namibia). (2001) An Assessment of the Status of the San in Namibia. Windhoek, Legal Assistance Centre, <http://www.lac.org.na/projects/lead/Pdf/sannami.pdf>

¹² Amnesty International, South Africa: Barriers to safe and legal abortion in South Africa, AFR 53/5423/2017, <https://www.amnesty.org/en/documents/afr53/5423/2017/en/>

¹³ Amnesty International, South Africa Submission to the UN Committee on Economic, Social and Cultural 64th Session, 24 September - 12 October 2018. AFR 53/8980/2018

¹⁴ Amnesty International, Sweden: A cold welcome: Human rights of Roma and other ‘vulnerable EU citizens’ at risk, EUR 42/9403/2018, <https://www.amnesty.org/en/documents/eur42/9403/2018/en/>

¹⁵ Amnesty International, USA: Deadly delivery: The maternal health care crisis in the USA, AMR 51/007/2010, <https://www.amnesty.org/en/documents/amr51/007/2010/en/>

¹⁶ <https://www.cdc.gov/healthequity/features/maternal-mortality/index.html>

3. BARRIERS TO HEALTH CARE FACED BY PEOPLE SUBJECT TO RACISM [QUESTION 3]

Amnesty International's research has highlighted the barriers that people subject to racism face in accessing timely and quality health care. Often, these barriers are the result of not only a person or group's race, but also a combination of other factors, such as their gender, sexuality, income, citizenship, employment-status, and presence of a health condition or disability.

In **Libya**, Amnesty International documented how pre-existing discrimination against ethnic minority groups such as the Tabu and Tuareg create additional barriers to their access to healthcare. Some members of the Tabu and Tuareg communities face additional barriers in accessing healthcare as they do not possess identity documents or family identity booklets to prove Libyan citizenship, necessary to access the free public health system. The lack of documentation has also had serious economic consequences, and many cannot afford to privately pay for medical expenses. Amnesty International further noted that members of both communities were also potentially more at risk of contracting Covid-19, in case of an outbreak, as they live in impoverished and densely populated neighborhoods such as Taouiri in Sabha, where social distancing is effectively impossible.¹⁷

In **Namibia**, the San people face significant barriers to access healthcare. The remote location of many San communities has impacted their access to healthcare. Although most rural Namibians face similar distance-related barriers to accessing healthcare facilities, the San's multiple socio-economic challenges including the lack of education, financial means and poor access to public transport exacerbated their inability to access healthcare facilities, which in some cases were 80kms away. Amnesty International found that the government had failed to prioritize the provision of mobile health outreach and extension services in the most remote areas. Primary healthcare facilities in Namibia are under-resourced in terms of physical infrastructure, personnel and material resources such as medications and equipment. The burden of TB and MDR-TB in predominantly San communities is high, and healthcare facilities had severe shortages in human, financial and material resources and lacked the capacity to respond to the health needs of San communities. The language barrier between San patients and their healthcare providers, majority of whom are neither San nor fluent in any San languages was another major obstacle standing in the way of the San peoples' realization of the right to health. Furthermore, while the Namibian government acknowledged Indigenous San people's health disparities and vulnerability to TB and MDR-TB, there is a pervasive lack of national health and epidemiological data on Indigenous San peoples. The lack of data on San peoples not only limits the understanding of the health status of Indigenous San peoples but also excludes them from national priority setting and policymaking.

In **Spain**, the federal government introduced austerity measures in the aftermath of the economic crisis that began in 2008. The exclusion of adult irregular migrants from freely receiving many aspects of healthcare was one of the most controversial aspects of the RDL 16/2012, introduced by the austerity measures. From 2012, it is estimated that almost 750,000 migrants were excluded from free public health coverage. Several regional governments in Spain disagreed with this decision, and restored access to health care for irregular migrants, within their jurisdiction. However, Amnesty International documented how some healthcare centres continued to charge for emergency services or deny access to healthcare for people who should have been covered as per the decision of regional governments. The discrepancy in rules at the national and regional level on access also acted as a deterrent: many people did not seek healthcare they were entitled to, thinking they would be turned away.¹⁸

Amnesty International's recent report on the failure to protect Indigenous women from sexual violence in the **USA** found that American Indian and Alaska Native women who survive sexual violence often do not receive adequate and timely sexual assault forensic examinations (including a rape kit), which are vital for a successful prosecution. This failure is caused in part by the federal government's severe

¹⁷ Amnesty International, Libya: Historic discrimination threatens right to health of minorities in the south amid COVID-19, April 20, 2020, <https://www.amnesty.org/en/latest/news/2020/04/libya-historic-discrimination-threatens-right-to-health-of-minorities-in-the-south-amid-covid19/>

¹⁸ Amnesty International, Spain: Wrong prescription: The impact of austerity measures on the right to health in Spain, EUR 41/8136/2018, <https://www.amnesty.org/en/documents/eur41/8136/2018/en/>

underfunding of the Indian Health Service (IHS), IHS understaffing, a lack of clarity within the IHS on the availability of rape kits or trained professionals who can administer the exam, and policies resulting in major geographical gaps in post-rape care. Additionally, IHS policy on sexual assault response protocols have not been fully implemented and are not adequately monitored. The IHS is not adequately keeping track of each facility's spending, decision-making or self-assessment and it does not have data on tribal facilities, suggesting that even if there was a severe shortage of rape kits, the IHS itself might not be aware of this. These barriers result in many survivors being overwhelmed by the emotional and logistical difficulties involved in accessing post-rape care, often giving up when faced with needing to go to a second hospital or clinic after being unable to access the closest IHS facility. Survivors who must seek treatment at non-Native health facilities also face non-culturally sensitive care and, at times, discriminatory treatment.¹⁹

4. IMPACTS OF PUBLIC HEALTH MEASURES, INCLUDING THE USE OF COERCIVE APPROACHES AROUND PUBLIC HEALTH

In the context of the Covid-19 pandemic, several countries introduced measures to protect public health, including 'lock-downs', quarantines, compulsory testing, and use of law enforcement agencies to enforce these public health rules. Amnesty International's research has indicated how in many instances these measures stigmatized racialized groups, or disproportionately impacted them.

In 12 European countries, Amnesty International reported human rights concerns in the application of measures to counter the Covid-19 pandemic including institutional racism and discrimination in law enforcement.²⁰ The use of coercive measures to protect public health in Europe has had a disproportionate impact on racialized groups already subject to discriminatory identity checks and unlawful use of force prior to the pandemic. Coercive approaches contradict evidence-based public health best practice, and often target disadvantaged communities which are marginalized, impoverished or at risk of discrimination, resulting in increased stigma and fear, and thwarting trust in authorities. The 12 countries covered in the report are Belgium, Bulgaria, Cyprus, France, Greece, Hungary, Italy, Serbia, Slovakia, Romania, Spain and the UK.

In **Slovakia**, Amnesty International raised serious concern that conducting targeted testing in Roma settlements – in the context of the Covid-19 pandemic - without providing Roma the necessary means to protect themselves would only add to stigmatization and prejudice they already face. Amnesty International also noted that inadequacies around the social determinants of health in Roma communities made it harder for them to follow public health recommendations. For example, a long-standing problem is the lack of access to water and sanitation in informal settlements where a majority of the Roma live.²¹ According to the 2013 Atlas of Romani Communities in Slovakia, approximately 23% of Roma settlements lack access to any public water supply. There has not been any significant progress in ensuring access to water and sanitation since then and segregated Roma settlements are particularly affected.

Amnesty International had similar concerns about the treatment of Roma communities in **Bulgaria** during the Covid-19 pandemic. Reports indicated that the government had imposed measures, including mandatory quarantines, targeting Roma settlements. The government did not apply these measures to other groups or the general population. Such selective application, in the absence of evidence that less restrictive alternatives were considered, raised questions over compliance of these measures with the obligation to prohibit discrimination under the European Convention on Human Rights and the European Union's Race Equality Directive. There was also concern that mandatory quarantines had

¹⁹ Amnesty International, USA: The never-ending maze: Continued failure to protect Indigenous women from sexual violence in the USA, AMR 51/5484/2022, <https://www.amnesty.org/en/documents/amr51/5484/2022/en/>

²⁰ Amnesty International, Europe: Policing the pandemic: Human rights violations in the enforcement of COVID-19 measures in Europe, EUR 01/2511/2020, <https://www.amnesty.org/en/documents/eur01/2511/2020/en/>

²¹ Amnesty International, Slovakia: Roma must not be further stigmatised during COVID-19, EUR 72/2110/2020, <https://www.amnesty.org/en/documents/eur72/2110/2020/en/>

disproportionately affected Roma living in poverty. Restrictions on their freedom of movement severely affected their ability to engage in work, including informal work, on which many families depend, exposing them to increased poverty and further social exclusion. With limited savings and lack of adequate support, many struggled to sustain themselves through the quarantine period without an income.²²

5. IMPACTS OF HOW HEALTH IS FINANCED [QUESTION 6 AND QUESTION 9]

Amnesty International has conducted research in a number of countries on the impacts of austerity measures on the right to health; however, Amnesty International's research did not always focus on the impact of these measures on specific groups who are subject to systemic racism. In most of these countries, austerity measures tended to impact people from marginalised groups more, and in distinct ways.²³ In many instances international financial institutions, multilateral agencies and donors played a role in how these measures were developed and implemented. In **Spain**, Amnesty International's report showed how recommendations by the Excessive Debt Procedure and European Semester increased pressure on the Spanish government to put in place the austerity measures that it did. EU institutions should have played a greater role in identifying and mitigating the human rights impact of these policies. Instead, they either steered the Spanish government towards policies that were incompatible with Spain's obligations to fulfil the right to health or did not do enough to mitigate potential human rights impact.²⁴ In **Greece**, Amnesty International's report demonstrated how the three economic programs the government concluded with creditors included conditionalities, some of which encouraged, or influenced, the austerity measures imposed by the government of Greece that resulted in violations of the right to health in Greece.²⁵ In **Chad**, Amnesty International documented the impact of austerity measures, some of which had been implemented in the aftermath of conditions introduced by lenders, without adequate consideration for human rights obligations.²⁶

6. CONCLUSIONS AND KEY RECOMMENDATIONS

Amnesty International has several recommendations to address the barriers that people face in accessing the highest attainable standard of health free from discrimination based on race and intersectional forms of discrimination. These are contained in the reports listed in this submission. Some key overarching calls include:

- States should put in place processes to understand the range of barriers that racialised groups face in accessing healthcare and the underlying determinants of health and take urgent steps to remove them. This includes putting in place positive measures to address these concerns and ensuring that such measures are adequately resourced and funded as matter of priority.
- States must ensure that efforts to address racial discrimination in healthcare, health inequalities, and barriers to health based on race, also consider and address multiple and

²² Amnesty International, Quarantines of Roma Settlements in Bulgaria and Slovakia Require Urgent Attention, 18 May 2020, <https://www.amnesty.eu/news/quarantines-of-roma-settlements-in-bulgaria-and-slovakia-require-urgent-attention/>

²³ For example, Amnesty International's report in Spain showed how austerity measures had a particular and disproportionate impact on people with lower incomes, and especially on people with chronic health conditions, people with disabilities, older persons, and people accessing mental health care. Amnesty International, Spain: Wrong prescription: The impact of austerity measures on the right to health in Spain, EUR 41/8136/2018, <https://www.amnesty.org/en/documents/eur41/8136/2018/en/>

²⁴ Amnesty International, Spain: Wrong prescription: The impact of austerity measures on the right to health in Spain, EUR 41/8136/2018, <https://www.amnesty.org/en/documents/eur41/8136/2018/en/>

²⁵ Amnesty International, Greece: Resuscitation required – The Greek health system after a decade of austerity, EUR 25/2176/2020, <https://www.amnesty.org/en/documents/eur25/2176/2020/en/>

²⁶ Amnesty International, Chad: Strangled budgets, silenced dissent: The human cost of austerity measures in Chad, AFR 20/8203/2018, <https://www.amnesty.org/en/documents/afr20/8203/2018/en/>

intersecting forms of discrimination. They must ensure that people who are subject to discrimination based on multiple and intersecting identities - and are often at risk of specific, compounded impacts - are covered by any measures implemented.

- States should collect health-related data, including on health outcomes, access to health services, access to social determinants of health, and the financial impact of health expenditure, and ensure that this is disaggregated on the grounds of race, and other prohibited grounds of discrimination, including gender, gender identity, sexual orientation, disability-status, ethnicity, and nationality, among others.
- States should ensure that all measures to protect public health, including in the context of the Covid-19 pandemic, are designed and implemented in a strictly proportionate and non-discriminatory manner, and accompanied with safeguards to mitigate any disproportionate effects that such measures may have on marginalized groups and individuals.
- States must ensure that any policies and measures are developed with the meaningful participation of all people affected by them.
- States should enable and support people to adhere to public health measures. Penalties for failing to comply with public health restrictions must be a last resort, and marginalized communities and individuals should not be penalized or otherwise sanctioned solely for not having the necessary resources and conditions to comply with public health restrictions.
- States should ensure that legal systems and health systems have effective accountability mechanisms in place to address direct and indirect discrimination based on race and intersectional discrimination, and linked human rights violations, including clear legal prohibitions against these forms of discrimination.
- States should ensure that any austerity measures introduced during economic crises are not discriminatory, mitigate the inequalities that can emerge in times of crisis, and ensure that the rights of disadvantaged and marginalized individuals and groups – including racialised groups - are not disproportionately affected.



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This submission to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on racism and the right to health covers the following themes, based on a list of questions provided by the Special Rapporteur: manifestations of racism in access to social determinants of health, barriers to health care faced by people subject to racism, impacts of public health measures (including the use of coercive approaches around public health), and the impacts of how health is financed. It is based on Amnesty International's research on these issues across countries. It also provides some conclusions and key recommendations.