QUESTIONNAIRE

"Racism and the right to health"

I have the honour to address you in my capacity as Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, pursuant to Human Rights Council resolution 42/16.

I would like to invite you to respond to the questionnaire below. Submissions received will inform my next thematic report on "Racism and the right to health", which will be presented to the General Assembly in October 2022.

The questionnaire on the report is available at OHCHR website in English (original language) as well as in French, and Spanish: (https://www.ohchr.org/en/special-procedures/sr-health).

All submissions received will be published in the a forementioned website, unless it is indicated that the submission should be kept confidential.

There is a word limit of 750 words per question. Please submit the completed questionnaire to ohchr-srhealth@un.org. The deadline for submissions is: **2 June 2022.**

Tlaleng Mofokeng
Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Contact Details

Please provide your contact details in case we need to contact you in connection with this survey. Note that this is optional.

Type of Stakeholder (please select one)	X Member State ☐ Observer State ☐ Other (please specify)
Name of State Name of Survey Respondent	Suriname Jupta Itoewaki
Email	juptaitoewaki@mulokot.com
Can we attribute responses to this questionnaire to your Institution publicly*? *On OHCHR website, under the section of SR health	Yes Comments (if any):

Background

Within the framework of Human Rights Council resolution 42/16, the Special Rapporteur on the highest attainable standard of physical and mental health has identified racism and the right to health as one of her priorities during her tenure (See A/HRC/47/28 paras 87-94). In compliance with her mandate and in line with this priority she has decided to devote her next thematic report to the General Assembly in October 2022 to the theme of "Racism and the right to health."

Objectives of the report

The Special Rapporteur underlines that racism is a key social determinant of health and a driver of health inequities. With this report, she would like to shed light on the impact of racism and discrimination on the grounds of race, colour, descent, caste, national or ethnic origin or migrant or refugee status, on the enjoyment of the right to health. She will focus on its impact particularly on Black people, persons of African descent, Arabs and Muslims, Asians and persons of Asian descent, migrants and persons belonging to indigenous peoples and minorities and the intersection of factors such as poverty, or discrimination based on age, sex, gender identity, expression, sexual orientation, disability, migration status, health status eg HIV, Albinism etc. and the rural and urban divide.

She intends to consider the historic perspective of the impact of past and contemporary forms of racism on the right to health and on the ability of individuals and communities to realize their right to access health care, services and goods including the realization of sexual and reproductive health rights and on the ability of States to fulfill their obligations under the right to health. The focus of the report will be on the impact of racism on human dignity, life, non-discrimination, equality, the right to control one's health, including the right to be free from non-consensual medical treatment and experimentation as well their entitlement to a system of health protections. In so doing, and by adopting the anti-coloniality[1] and anti-racism frameworks, the report will expose the impact of the living legacy of past and ongoing forms of racism, apartheid, slavery coloniality and oppressive structures in the global health including the economic architecture and funding, national health systems on racialized people.

Importantly, the Special Rapporteur will adopt an intersectional approach and take into account the multiple forms of discrimination affecting persons experiencing racism and related discrimination in the context of health care. She will analyze the links between inequalities in accessing adequate health care and social disparities, sex, age, gender, poverty, class, nationality, exclusion, disability and the rural and urban divide and related systems of oppression.

The Special Rapporteur would also like to identify good practices that affirm the right to a system of health protection (i.e. health care and the underlying social determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health.

[1] Coloniality is a concept coined by Walter Mignolo around 1995,4 refers to the living legacies of European colonialism in social orders and knowledge systems, which created racial hierarchies that enable the social discrimination that has outlived formal colonialism. See A/HRC/47/28 para 9.

She seeks examples of how to combat racism and discrimination on the grounds of race, colour, descent, national or ethnic origin – in accessing health care health facilities, goods and services and the underlying determinants of health.

Key Questions

You can choose to answer all or some of the questions below. (750 words limit per question).

1. What are the main ongoing manifestations of racism, and related forms of discrimination enabled by racism that may be prevalent in your country in the area of the right to health broadly including in underlying determinants of health, health outcomes and access to health care?

The current health system in the interior (in the south of Suriname) is based on a system of health assistants, mid-level health workers recruited from local communities, or not, who are trained by the Medical Mission over four years. Once employed in the field, they are supervised by physicians and nurses.
Currently about 10 physicians have the coordination for over a population of 60.000 through these assistants. The Medical Mission (MZ) is comprised of a group of religious NGOs, funded by the government, who provide first-level care for residents of the rural interior living in traditional settings along the main rivers, many only reachable by river or small aircraft. If patients needed to be referred to the city, cost for transportation, stay etc. are also high. Even locally at the post of MZ frequently there is a lack of basic medicines and instrument to guarantee optimal primary care.
The health determinant "Food and water safety" is also an area of concern, because there is still no access to safe drinking water in most the villages of South Suriname. Also there is still ongoing unsafe gold mining practices with mercury in regions where those people live.

2. Who are the most affected people and why? Please describe existing disparities in the provision of and access to health services that affect people of different racial and ethnic origin, descent as well as other groups, such as migrants. The lack of data, analysis or health indicators in this regard may also be reflected.

The people most affected are people living (the Indigenous and Tribal people) in the interior of Suriname. As stated above that there is inequality with regard to health care. Fewer doctors are available for this region an no option for specialistic treatment. Also the environment is still being polluted with ongoing goldmining activities with much concern for the health of local people.
Furthermore not many data is available about the health status of the local villages. It is known though by the local people that there are for example existing problems with suicide, alcoholism and overall mental health. Also the underlying causes for these phenomenon taking place, are not well understood, because not many research is being done.

3. Under the right to health, States have a special obligation to refrain from denying or limiting equal access for all persons, comprising minorities, asylum seekers and migrants including undocumented migrants, to preventive, curative and palliative health services; abstain from enforcing discriminatory practices as a State policy as well as to ensure equal access to health care and health-related services provided by third parties. Please explain how the above point is

implemented in your country, what works well and not so well and illustrate with disaggregated data if possible.

One example is in recent years, the malaria program has been successful in reducing transmission, the number of severe cases and associated deaths. Specifically, the reduction in transmission has been successful through targeted strategies. But if look we at sexual and reproductive health for example. In 2006, the national contraceptive prevalence rate was only 45.6% (2901 women) with considerable disparities between urban (47.6%) (2065 women) and rural interior (14.6%). Limited access to contraceptive and the effect of culture and traditions, such as the high value placed on fertility and motherhood, and the overall lower education levels of the people in the interior results in low contraceptive prevalence rate among women in the interior. It is not known if these numbers have been improved in the recent years.

4. What has been the impact of colonialism and the imposition of allopathic medicine on the availability of indigenous and traditional health knowledge systems, medicine and practices, and on the right to health more broadly in your country?]. Are health services available in your country that give due consideration and acknowledgment of, or respectfully incorporate indigenous/traditional health knowledge systems and practices, preventative care, healing practices and medicines? Please share examples of good practices.

There are no official health services that incorporate indigenous/traditional knowledge. The health assistants are trained with western based knowledge and is the use of traditional knowledge discouraged. The traditional methods are only practiced outside those official health institutes. Also the church has his ways to discourage local people to use traditional medicine.

5. Please share examples of good legal and policy frameworks that address past or ongoing racism and racial and related forms of discrimination, specifically in relation to access to underlying determinants as well as quality health care, goods, services and facilities, including sexual and reproductive health.

One example is in recent years, the malaria program has been successful in reducing transmission, the number of severe cases and associated deaths. Specifically, the reduction in transmission has been successful through targeted strategies. These strategies included the distribution of impregnated bed nets, mobile teams to test and treat gold miners, active case detection, house spraying, media campaigns and the reimpregnation of bed nets.

Another good example is the maternal health nationally. Most pregnant women receive some type of prenatal care nationally; 99.4% were reported as visiting a prenatal clinic at least once. In 2006, skilled health personnel attended 89.8% of deliveries (doctors, midwives and auxiliary midwives). Assistance by traditional birth attendants was 1.2% and community health workers assistance was 3.3%. The majority of deliveries (90%) took place in hospitals and 10% in primary health care facilities.

6. Please share examples of public health financing, non-governmental sector funding practices, inter-agency finance solutions, medical insurance products that show manifestations of ongoing or past racism and related discrimination, at the local and global levels that impact racialized people, as well as other factors such as poverty, or discrimination based on age, sex, gender identity, expression,

sexual orientation, disability, migration status, health status eg HIV, Albinism etc. and the rural and urban divide."

The local government for example is passively tolerating the environmental pollution that is going on in the regions where indigenous and tribal people stay. No concrete actions are undertaken to stop this, while they well informed about the practices going on in the illegal gold mining business.

7. Please share good practices and examples of public health interventions resulting in adequate access (inside and outside the health sector), support knowledge production or implementation of programs that successfully address inequalities in particular the impact of racism and related racial discrimination, as well as other factors such as poverty, or discrimination based on sex, gender identity, expression, sexual orientation, disability and migration status.

Few measures haven been taken by the government to gain more knowledge about these factors.

8. Please share good examples and practices that enable accountability in public and private sector that enable access to justice and redress to victims of racism and discrimination on the grounds such as colour, descent, national or ethnic origin or migrant or refugee status in the provision of health care and as it intersects with factors such as poverty, or discrimination based on age, sex, gender identity, expression, sexual orientation, disability, migration status, health status eg HIV, Albinism etc. and the rural and urban divide."

9. Please share information about the sources of health financing for your country, the quantity and quality of said financing, as well as any aid or funding conditionalities, global economic policies, and austerity or other measures requested or encouraged by international financial institutions, multilateral agencies or donors, that negatively affect health systems and people's access to health in your country.

70% of the population has a health insurance from the SZF (Stichting Staats Ziekenfonds). In the Indigenous villages in the South of Suriname frequently the people have no health insurance though and treated free of cost locally by MZ. The problem starts when they have to receive specialistic treatment and the costs not covered by a health insurance.

10. What are the historical and ongoing legacies and impacts of colonialism and slavery on the right to health in your country? And how has the lack of reparations for slavery, colonialism, apartheid and racial discrimination impacted the right to health in your country?

The unequal social development of the urban areas compared to the interior has his roots back in colonialism for example unequal health services, education to, employment, etc.

11. Please also share good practices and examples of reparations for racial discrimination related to the right to health violations and abuses.

There are no known examples of reparation.

Key definitions

In her first report to the Human Right Council, the Special Rapporteur echoed Prof. Charles Ngwena's reflections on racism, and noted they would extend to ethnicity as well.[2]

"In 2018, Charles Nwgena noted:

[…] Race remains an associational criterion that people often claim as part of their identity or that may be ascribed to them by others or the political community of which they are part. Race has political implications where the body politic is racialized, overtly or covertly, in the sense that racial differentiation is tethered to hierarchized essences that carry social, political and economic meanings that may be positive or negative for the racialized subject, depending on which side of the "colour line" the person falls or is deemed to fall."[3]

The International Convention on the Elimination of All Forms of Racial Discrimination defines "racial discrimination" as: "any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life." (Article 1)

The Declaration and Programme of Action adopted at the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance held in 2001 in Durban, (South Africa) by the United Nations - known as the Durban Conference urged States, individually and through international cooperation, to enhance measures to fulfil the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, with a view to eliminating disparities in health status, (…), which might result from racism, racial discrimination, xenophobia and related intolerance. (Durban Programme of Action, para. 109)

In 2009, Durban Review Conference accepted the interpretation given by the Committee on the Elimination of Racial Discrimination to the definition of the concept of racial discrimination as contained in the Convention, so as to address multiple or aggravated forms of racial discrimination, as reflected in its outcome document.

[2] A/HRC/47/28, paras 87-88.
[3] Ibid para 87.