QUESTIONNAIRE

"Racism and the right to health"

All submissions received will be published in the aforementioned 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.**

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)	☐ Member State ☐ Observer State ☒ Other (please specify): non-governmental organisation with Special Consultative Status
Name of State Name of Survey Respondent	Medical Aid for Palestinians (MAP)
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Can we attribute responses to this questionnaire to your Institution publicly*? *On OHCHR website, under the section of SR health	Yes No 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.

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?**

Medical Aid for Palestinians (MAP) is dedicated to pursuing a future where all Palestinians can access an effective, sustainable and locally-led system of healthcare and the full realisation of their rights to health and dignity.

[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.

In the West Bank, including East Jerusalem, and Gaza, Israel has maintained effective control over the lives of Palestinians for more than half a century through occupation, annexation, and blockade, wielding that control in ways that privilege its own citizens, while geographically segregating Palestinian communities. Meanwhile, Israel's decades-long denial of Palestinian refugees' right to return to their homelands has kept the communities MAP serves in Lebanon in a state of perpetual humanitarian crisis. These policies deny Palestinians their full rights to health and dignity, and prevent the collective development of essential Palestinian institutions like healthcare.

This deeply inequitable context has caused an increasing plurality of Palestinian, Israeli, and international human rights groups, legal scholars and statespersons to conclude that Israel is imposing a regime of apartheid on Palestinians.

Though the conditions for Palestinians in MAP's areas of operation are distinct, they are connected by policies and practices imposed on them collectively by Israel based on nationality and ethnicity, preventing the enjoyment of the rights to health and dignity, and inhibiting the development of a Palestinian healthcare system of sufficient availability, accessibility, acceptability and quality.

Palestinian refugees

Israel's discriminatory rejection of Palestinian refugees' rights imposes on them a life of perpetual limbo and humanitarian crisis. In Lebanon, many of the approximately 270,000 resident Palestinian refugees languish in unhealthy and unsanitary refugee camps. They face high levels of unemployment, poverty, dependency on international aid, and manifold challenges to their physical and mental health, including the chronically under-resourced semi-permanent system of healthcare available to them. This situation has been deeply exacerbated by Lebanon's economic crisis since 2019.

The Lebanese government's discriminatory laws and practices, including restrictions on Palestinians' right to work, cause social marginalisation and violate fundamental rights including to health, shelter, food, and water. Fundamentally, however, those rights cannot be realised in a context of permanent displacement which cuts them off from their compatriots, unable to contribute to the collective development of sustainable healthcare institutions.

The occupied Palestinian territory (oPt)

In the West Bank, Israel upholds its settlement project through a discriminatory and restrictive planning regime that privileges illegal settlement construction while preventing Palestinians from building homes and essential infrastructure, particularly in the approximately 60% of land under full Israeli military and civil control, designated "Area C". As a result, there are no permanent health centres serving the approximately 300,000 Palestinians in Area C, and the network of 593 movement obstacles including checkpoints, restricted roads and other barriers frustrate access to healthcare services. By contrast, Israel subsidises and invests in the development of settlement healthcare, education and transport infrastructure, ensuring unimpeded access to healthcare for the approximately 400,000 settlers in the West Bank.

Israel's discriminatory practices, including its planning regime and frequent demolition of Palestinian infrastructure, also systematically deny Palestinians in these areas

equitable access to key underlying determinants of health including shelter, water, sanitation and food security, while it guarantees these to the settler population.

In East Jerusalem, in addition to a discriminatory planning regime and demolitions, Israel has systematically neglected Palestinian communities and healthcare institutions, denying them equitable access to essential services and social determinants of health, including education, welfare, transportation, water and sewage infrastructure.

Israel's illegal closure and blockade of Gaza has cut the population off from the West Bank and East Jerusalem through a policy of separation, further fragmenting Palestinian society and institutions. This has severely limited the movement of people and goods in and out of Gaza, resulting in economic collapse and a man-made humanitarian crisis characterised by high rates of poverty, unemployment, and food insecurity. These restrictions have drastically undermined enjoyment of social determinants of health and prevented Gaza's healthcare system from developing in line with the population's needs. Restricted access to professional development opportunities for healthcare staff and shortages of medical equipment are huge challenge in the context of COVID-19 pandemic response.

Pervasive violence from Israeli forces, including systematic use of excessive force against protesters and frequent assaults on healthcare personnel and infrastructure, presents a direct threat to Palestinians' physical and mental health across the oPt. Repeated attacks are fuelled by Israel's consistent failure to conduct genuine investigations into potential serious violations of international law or hold wrongdoers to account, and have accelerated the degradation of the Palestinian healthcare system and its ability to provide adequate care to the population.

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.**

Through occupation, blockade and annexation, Israel maintains effective control over the lives of all people living either side of the Green Line, comprising approximately 6.8 million Palestinians and 6.8 million Jewish Israelis. As Physicians for Human Rights Israel recently explained:

> "As things now stand, Israel controls the entire region between the Jordan River and the Mediterranean Sea and maintains two systems of law: one grants privileges to Israelis while the other deprives Palestinians of their rights and dispossesses them of many resources."

Israel exerts its power in ways that systematically discriminate against Palestinians and fragment Palestinian society and institutions including healthcare, in turn preventing Palestinians across the oPt from enjoying their right to the highest attainable standard of physical and mental health.

Israel's domestic laws which deny Palestinian refugees their inalienable right to return are also discriminatory, entrench fragmentation, and are the root cause of the protracted

humanitarian crisis which has long denied them full enjoyment of health and dignity while in exile.

Inevitably, this has led to divergent health outcomes for Palestinians and Israelis. The data below illustrate the entrenched healthcare inequalities which exist – and are growing – between Israeli citizens (including settlers in the West Bank), and Palestinians in the oPt.

Permits: The geographic separation of Palestinians is a key element of the fragmentation they endure within and between areas of the oPt, and is imposed though policies and practices including the separation wall and other movement barriers; settlements and de facto annexation in the West Bank; de jure annexation of East Jerusalem; the closure of Gaza; controls on travel abroad; and the imposition of a stratified ID system and permit regime. As former UN Special Rapporteur Michael Lynk has highlighted: "This fragmentation … splinters the delivery of Palestinian health services and deforms the social determinants of health throughout the occupied Palestinian territory."

All Palestinians from the West Bank and Gaza without Jerusalem IDs must obtain a permit from Israeli authorities to cross the separation wall and access Palestinian hospitals in the East Jerusalem Hospital Network which provide some services unavailable anywhere else in the oPt, for example radiotherapy and a Level 4 neonatal intensive care unit, through a process the WHO has described as "neither transparent nor timely". In 2021, 10% of West Bank patients' applications for permits were denied, while the rate of denial for their companions was 16%. For patients in Gaza, 37% of permit applications were denied or delayed past the appointment date in 2021, while 60% of companions' permits were denied or delayed.

Israeli citizens living in illegal settlements in the occupied West Bank, however, enjoy access across the Green Line to healthcare services in Jerusalem and Israel, unimpeded by checkpoints or the permit regime.

Hospital beds: There are 87 hospitals and 6,552 hospital beds in the oPt – a rate of 1.28 beds per 1,000 people. In Israel, there are 2.9 beds per 1,000 people.

Universal health coverage: 78% of Palestinians in the oPt, excluding occupied East Jerusalem, are covered by some form of pre-payment healthcare, mainly through Palestinian Government Health Insurance and UNRWA. Many specialist treatments are unavailable at governmental hospitals, and so must be purchased from private providers in East Jerusalem or abroad. In Israel, universal health insurance legislation covers all citizens and documented residents, with 98% of the population covered by some form of insurance. 45.5% of healthcare payments in the oPt are out-of-pocket, compared to just 6.5% for Israelis.

Health workforce: In 2019, there were 1.12 doctors and 1.70 nurses per 1,000 people in the oPt, compared to 3.29 doctors and 5.01 nurses per 1,000 people in Israel. Fragmentation of the healthcare system has contributed to a shortage of certain specialists in some areas of the oPt, such as family practice, oncology, neurology, paediatric surgery and psychiatry.

Vaccinations: While the Palestinian Ministry of Health reports high rates of routine vaccinations, the COVID-19 pandemic has highlighted divergence in non-routine, emergency vaccinations. In Israel, 62% of the population was fully vaccinated against COVID-19 by November 2021, including settlers in the West Bank plus Palestinian residents of occupied East Jerusalem who are covered by Israel's vaccination programme. In the West Bank (excluding East Jerusalem) and Gaza, less than 30% of the population was at that point fully vaccinated.[2]

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.**

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.**

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.**

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,**

[2] **Note:** Vaccination rate (whole population) in those areas of the occupied Palestinian territory not covered by Israel's vaccine allocation policy determined by subtracting the population of Jerusalem J1 district (estimated 304,444 in 2021) from the total oPt population (estimated 5,227,193 in 2021) to provide the population of the oPt excluding annexed East Jerusalem (4,922,749). According to the Palestinian Ministry of Health, 1,363,021 Palestinians have been fully vaccinated as of 09/11/2021, meaning the vaccination rate is 27.69%. Around 110,000 Palestinian workers from the oPt have been vaccinated by Israel. See: WHO COVID-19 Situation Report 77 (2021) https://www.un.org/unispal/document/coronavirus-disease-2019-covid-19-who-situation-report-77/ For population data see: PCBS (2021) Estimated Population in Palestine by Governorate, 1997-2026 https://www.pcbs.gov.ps/statisticsIndicatorsTables.aspx?lang=en&table_id=676; PCBS (2021) Projected Mid -Year Population for Jerusalem Governorate by Locality 2017-2026 https://www.pcbs.gov.ps/statisticsIndicatorsTables.aspx?lang=en&table_id=707.

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

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.**

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.**

Health system financing

The Palestinian healthcare system is made up of networks of government, non-governmental, and private providers, with Government Health Insurance and the UN Relief and Works Agency for Palestine Refugees (UNRWA) accounting for more than 90% of coverage provided.

The PA is in the midst of a severe fiscal crisis, with its economic growth stymied by the matrix of movement and access restrictions imposed across the occupied Palestinian territory, while fifteen years of illegal closure and blockade have de-developed Gaza's economy.

According to the World Health Organisation, the PA's "lack of sovereignty and effective control over natural resources or other potential sources of State revenue hamper the ability of the Palestinian Authority to adequately finance public healthcare."

Israel's policies also inhibit the construction and maintenance of medical infrastructure and the essential services needed to promote health, such as water, sanitation and electricity. Restrictions on free movement between different areas of the oPt (the West Bank, including East Jerusalem, and Gaza) limit the access of health workers to training and professional development. Restrictions on access to medical equipment and materials further prevent the development of services in some areas of the oPt.

These restrictions hamper the ability of Palestinian Ministries and international donors to invest in long-term infrastructure projects. In turn, the Palestinian health sector is forced to make frequent external medical referrals and use outdated treatments while patients suffer delays and obstacles to their treatment pathways. Medical referrals are the Palestinian Ministry of Health's second largest expense, at 34% of the budget, costing £140 million (592,005,962 NIS) for 54,671 patients referred in 2018.

UK donor support for Palestinian health workers:

On 21st October 2021, the UK Government announced that, following its review of Overseas Development Assistance, it will no longer provide financial support to the salaries of health and education public servants in the oPt currently channelled through the European Union's PEGASE Direct Financial Support mechanism. Since 2017, the programme has funded five financial aid disbursements, totalling £98 million, and in 2019, the disbursement of £20m paid more than 37,800 frontline health and education professionals in the West Bank, and enabled 5,058 immunisations against Measles, Mumps and Rubella and 139,445 medical consultations.

A 2020 DFID review found that financial aid for health and education salaries through PEGASE remains one of the most responsive mechanisms to enable the PA to meet its commitments towards Palestinian civil servants, and highlighted that UK assistance *"*continues to be viewed by most stakeholders as a crucial provision of basic services for the OPTs, especially given the current financial and health crises. Although the outputs are on track, the Ministry of Education noted that further support is needed, especially to support the "PA's back to schools plan in light of Covid-19"."

In this context, and at a time of extreme pressure on the Palestinian health system amid the pandemic and ongoing attacks on Palestinian education, cuts to this funding may have severe consequences for essential services. MAP has urged the UK government to immediately restore financial assistance for health and education sector salaries, and provision of technical, economic, and humanitarian assistance to support the sustainable development of the broader Palestinian health system. We also encourage the broader international community to boost their support to the Palestinian health system in this regard.

UNRWA:

More than two-fifths of the Palestinian population in the oPt are registered refugees with UNRWA, which provides primary health services alongside education and social safety net services. UNRWA relies almost entirely on voluntary contributions and is chronically underfunded, seriously hampering its ability to deliver essential health, education and social services and leaving Palestinian refugees even more precarious.

The Agency started 2022 with a debt of $62 million, and requested $1.6 billion from donors to enable it to fulfil its mandate. As of March, donors have only met 20% of this request. While the UK has historically been one of UNRWA's largest donors, that is no

longer the case after a decision to cut its 2021 contributions by more than half from the previous year.

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?**

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

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.[3]

"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."[4]

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

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

multiple or aggravated forms of racial discrimination, as reflected in its outcome document.