**Written Submission to the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health**

**Thematic report on "Racism and the Right to Health"**

The Global Initiative for Economic, Social and Cultural Rights (GI-ESCR) welcomes the opportunity to contribute to the next thematic report on "Racism and the Right to Health" of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, which will be presented to the General Assembly in October 2022.

As the COVID-19 pandemic once again showed, it is urgent to strengthen public healthcare services to realise the right to health of all, including marginalised populations that are at substantial risk of suffering from discrimination, including indigenous people, minorities and those living in marginalised areas. Our responses to the questionnaire present findings from our work in light of states' obligations to protect the right to health and eliminate all forms of discrimination, including on racial grounds.

**Contact Details**

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| Type of Stakeholder (please select one) | International Civil Society Organisation with ECOSOC Consultative Status |
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| Can we attribute responses to this questionnaire to your Institution publicly*?<br><br>*On OHCHR website, under the section of SR health | Yes<br><br>Comments (if any): |

**Key Questions**

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 Global Initiative for Economic, Social, and Cultural is conducting research on the experiences and perspectives of indigenous peoples and minorities regarding access to public services, including health services. By reviewing the existing literature on the barriers faced by indigenous peoples to enjoy the right to health, it is possible to confirm that language is a major component of discrimination for a variety of countries across continents, such as Australia,[1] Argentina,[2] Congo, Namibia,[3] Panama,[4] and Sri Lanka.[5]

The UN Special Rapporteur on the Rights of Indigenous Peoples as well as the Special Rapporteur on Minority Issues have emphasised that States must ensure that indigenous peoples are able to use their own language to communicate with and understand medical staff,[6] including by providing health specialists operating in indigenous areas with training on interculturality and indigenous languages.[7]

Similarly, the Special Rapporteur on the Rights of Indigenous Peoples has emphasized that measures should be developed to generate trained indigenous health-care workers, to incorporate traditional medicine in the delivery of health services, and to increase participation of indigenous communities in designing health services that are responsive to their needs.[8]

The Global Initiative's ongoing research has also showed that inadequate cultural adaptation in the delivery of health services can create a barrier to the enjoyment of the right to health for these peoples

[1] Human Rights Council, 'Report of the Special Rapporteur on the rights of indigenous peoples, James Anaya Addendum: the Situation of Indigenous People in Panama' (3 July 2014) A/HRC/15/37/ADD.4, para 94.
[2] Human Rights Council, 'Report of the Special Rapporteur on the rights of indigenous peoples, James Anaya – Addendum: the Situation of Indigenous People in Argentina', (4 July 2012) A/HRC/21/47/Add.2, para 110.
[3] Human Rights Council, 'Report of the Special Rapporteur on the Rights of Indigenous Peoples, James Anaya – Addendum: the Situation of Indigenous People in Namibia' (25 June 2013) A/HRC/24/41/Add.1, para 95.
[4] Human Rights Council, 'Report of the Special Rapporteur on the rights of indigenous peoples, James Anaya Addendum: the Situation of Indigenous People in Panama' (3 July 2014) A/HRC/27/52/Add.1, paras 74, 75.
[5] Human Rights Council, 'Report of the Special Rapporteur on minority issues on her mission to Sri Lanka - Note by the Secretariat' (20 February 2017) A/HRC/34/53/ADD.3, para 59.
[6] See, for instance: Human Rights Council, Report of the Special Rapporteur on the rights of indigenous peoples, James Anaya – Addendum: the Situation of Indigenous People in Argentina', (4 July 2012) A/HRC/21/47/Add.2; Human Rights Council, Report of the Special Rapporteur on the Rights of Indigenous Peoples, James Anaya – Addendum: the Situation of Indigenous People in Namibia' (25 June 2013) A/HRC/24/41/Add.1; Human Rights Council, Report of the Special Rapporteur on the rights of indigenous peoples, James Anaya – Addendum: the Situation of Indigenous People in Congo' (11 July 2011) A/HRC/18/35/Add.5; Human Rights Council, 'Report of the Special Rapporteur on minority issues on her mission to Sri Lanka - Note by the Secretariat' (20 February 2017) A/HRC/34/53/Add.3.
[7] Human Rights Council, 'Report by the Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people, James Anaya - Addendum - Situation of indigenous peoples in Australia' (01 June 2010) A/HRC/27/52/Add.1.
[8] See UN documents A/HRC/18/35/Add.5; E/CN.4/2004/80/Add.3; E/CN.4/2005/88/Add.2; A/HRC/42/37/ADD.1; A/HRC/33/42/Add.2; A/HRC/18/35/Add.5

in countries across different continents, such as Botswana,[9] Chile,[10] Congo,[11] Colombia,[12] Ecuador,[13] and Honduras.[14]

2. **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.**

Strong public healthcare services are fundamental in realising the right to health for all, especially for marginalised groups. Recently, the Global Initiative for Economic, Social and Cultural Rights has analysed inequalities in accessing healthcare services in Nigeria[15] and Kenya[16], with a focus on individuals living in urban informal settlements, who are at higher risks of discrimination, including on racial grounds. In both cases, the reports show that public governance, financing and provision of healthcare services are central to guarantee the right to health without discrimination. By contrast, the reports show that the involvement of commercial actors in healthcare can undermine the enjoyment of the right to health for marginalised populations living in disadvantaged urban areas.

In Kenya, a WHO survey shows that 80% of respondents belonging to the poorest quintile declare to seek healthcare services in the public sector, against only 19% in the private.[17] However, in Nairobi's informal settlements, where we conducted our research, public services are not enough and do not have enough medical equipment and staff. For instance, as of 2020, in the settlement of Mathare, there was only one county government health facility according to UN Habitat Data.[18] Meanwhile, in

[9] Human Rights Council, 'Report of the Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people, James Anaya - Addendum - The situation of indigenous peoples in Botswana' (02 June 2010) A/HRC/15/37/Add.2, para 81.
[10] Human Rights Council, 'Human rights and indigenous issues: report of the Special Rapporteur on the Situation of Human Rights and Fundamental Freedoms of Indigenous People, Rodolfo Stavenhagen, submitted in accordance with Commission resolution 2003/56: addendum', (17 November 2003) E/CN.4/2004/80/Add.3, para 78.
[11] Human Rights Council, 'Report of the Special Rapporteur on the rights of indigenous peoples, James Anaya – Addendum: the Situation of Indigenous People in Congo' (11 July 2011) A/HRC/18/35/Add.5, para 74.
[12] Human Rights Council, 'Human rights and indigenous issues: report of the Special Rapporteur on the Situation of Human Rights and Fundamental Freedoms of Indigenous Peoples, Rodolfo Stavenhagen: addendum: corrigendum' (2 February 2005) E/CN.4/2005/88/Add.2, para 110.
[13] Human Rights Council, 'Visit to Ecuador, Report of the Special Rapporteur on the Rights of Indigenous People', (4 July 2019) A/HRC/42/37/ADD.1, para 103.
[14] Human Rights Council, 'Report of the Special Rapporteur on the rights of indigenous peoples on her visit to Honduras' (21 July 2017) A/HRC/33/42/Add.2, para 102.
[15] Global Initiative for Economic, Social and Cultural Rights and Justice & Empowerment Initiative (2022) 'The failure of commercialised healthcare in Nigeria during the COVID-19 pandemic. Discrimination and inequality in the enjoyment of the right to health. DOI: 10.53110/ZYQT7031.
[16] Global Initiative for Economic, Social and Cultural Rights, 'Patients or Customers? The impact of Commercialised Healthcare on the Right to Health in Kenya during the COVID-19 pandemic (2021) DOI: 10.53110/RPCN4627; Global Initiative for Economic, Social and Cultural Rights and Justice & Empowerment Initiative (2022) 'The failure of commercialised healthcare in Nigeria during the COVID-19 pandemic. Discrimination and inequality in the enjoyment of the right to health. DOI: 10.53110/ZYQT7031.
[17] WHO Global Health Observatory data, https://www.who.int/data/gho. Data are available here: https://www.who.int/data/gho/data/themes/topics/indicator-groups/sources-of-care-in-mixed-health-systems.
[18] Global Initiative for Economic, Social and Cultural Rights, 'Patients or Customers? The impact of Commercialised Healthcare on the Right to Health in Kenya during the COVID-19 pandemic (2021) DOI: 10.53110/RPCN4627, page 21.

less than 10 years, between 2013 - 2021, the share of for-profit health establishments in Kenya grew from 33% to 43%.[19]

Marginalised individuals, when unable to obtain medical care in public establishments, are left with a diverse network of private providers, including faith-based, non-profit and for-profit ones. From the 47 interviews and three focus groups we conducted in three urban informal settlements of Nairobi, it emerged that several for-profit providers are unsafe, and offer substandard medical care, including widespread episodes of misdiagnosis, lack of referral to the appropriate level of care and unnecessary treatment. Our report also found that, across the three settlements where the study was conducted, individuals experience information and financial barriers in accessing medical services and healthcare insurance, with these barriers being exacerbated amidst the COVID-19 pandemic. This might potentially result in discrimination in accessing healthcare services based on relative wealth and income, education level, employment status or access to information. These barriers can also interact, causing the risk of intersectional discrimination.[20]

Likewise, in Nigeria, public healthcare services are fundamental for the poorest. The formally registered private sector, which provides an estimated 60% of all medical services, is concentrated in the relatively wealthier Southern regions in cities such as Lagos, serving the well-off. By contrast, these services are less present in the poorer Northern regions. Furthermore, as illustrated by our interviews in Lagos and Port Harcourt, most private healthcare actors in informal settlements appear to be at the lowest end of the quality spectrum, employing unqualified and untrained staff in informal, often unregistered, facilities. The latter are the services most likely used by those living in poverty in low- and middle-income countries.[21]

A cross-cutting theme in Nigeria and Kenya has been the barriers to access healthcare insurance. Marginalised populations in informal settlements face information and financial barriers in accessing healthcare insurance. Informal workers struggle to pay the monthly premiums to be enrolled in the programme, while several respondents were not aware nor informed of the procedure to enrol in the social healthcare insurance scheme.[22]

Based on these findings, we recommend governments to invest on public healthcare services to achieve universal healthcare for all and protect marginalised groups from discrimination. States must ensure the provision of universal quality public services that fulfil human rights.

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.**

To ensure that everyone can access quality healthcare, it is fundamental to collect public resources fairly and progressively and redistribute them to funding public healthcare services, so that everyone can access quality services irrespective of their ability to pay. In particular, the Principles for Human

[19] Ministry of Health, 'Kenya Service Availability Readiness Assessment Mapping (SARAM) Report', page 12.
[20] Global Initiative for Economic, Social and Cultural Rights (2021), see note 18, at page 27.
[21] Anna Marriott, 'Blind Optimism: Challenging the Myths about Private Health Care in Poor Countries' Oxfam (1 February 2009).
[22] Global Initiative for Economic, Social and Cultural Rights, see note 18, at page 29; Global Initiative for Economic, Social and Cultural Rights and Justice & Empowerment Initiative (2022) 'The failure of commercialised healthcare in Nigeria during the COVID-19 pandemic. Discrimination and inequality in the enjoyment of the right to health. DOI: 10.53110/ZYQT7031.

Rights in Fiscal Policy affirm that 'States must use fiscal policy to eradicate structural discrimination and promote substantive equality, integrating in a cross-cutting manner the perspectives of populations who suffer from discrimination in the design and implementation of such policies, and adopting affirmative action when necessary'.[23]

In this context GI-ESCR, together with other organisations, has developed *The Future is Public: Global Manifesto for Public Services* to serve as a tool to mobilise a civil society movement to demand public services, providing a concrete alternative to the dominant neoliberal narrative that has failed to ensure a dignified life for all. The manifesto positions public services as the foundation of a fair and just society and of the social pact that implements the core values of solidarity, equality, and human dignity. It advances a series of ten principles for universal quality public services in the 21st century, and outlines how funding universal quality public services is possible. Among the principles that underpin quality public services, there is the requirement that these be adaptable, responsive, and transformative to those they serve, which includes racial and linguistic minorities and indigenous peoples.[24] It also requires public services, such as healthcare, to be committed to equality and to recognise and actively challenge power imbalances, structural and systemic discrimination, and systems of oppression.

Universal quality health services that fulfil human rights can only be realised through predictable, accountable, and sustainable funding mechanisms. The Global Manifesto reinforces that health services cannot be left to the market. Unlike a commodity, their value is determined by the role they play in fulfilling human dignity, rather than their market position. It is thus fundamental for these populations to ensure that public healthcare services exist for everyone, regardless of status or ability to pay.

**For more information, please consult the following publications:**

- *The Future is Public: Global Manifesto for Public Services* (2021), available at: https://futureispublic.org/globalmanifesto/manifesto-en/
- Global Initiative for Economic, Social and Cultural Rights and Justice & Empowerment Initiative (2022) 'The failure of commercialised healthcare in Nigeria during the COVID-19 pandemic. Discrimination and inequality in the enjoyment of the right to health. DOI: 10.53110/ZYQT7031. Available at:
- Global Initiative for Economic, Social and Cultural Rights, 'Patients or Customers? The impact of Commercialised Healthcare on the Right to Health in Kenya during the COVID-19 pandemic (2021) DOI: 10.53110/RPCN4627.
- *Principles for Human Rights in Fiscal Policy* (2022), available at: https://www.cesr.org/sites/default/files/2021/Principles_for_Human_Rights_in_Fiscal_Policy-ENG-VF-1.pdf

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[23] Principles of Human Rights in Fiscal Policy (2022), available at: https://www.cesr.org/sites/default/files/2021/Principles_for_Human_Rights_in_Fiscal_Policy-ENG-VF-1.pdf
[24] *The Future is Public: Global Manifesto for Public Services* (2021), available at: https://futureispublic.org/globalmanifesto/manifesto-en/.