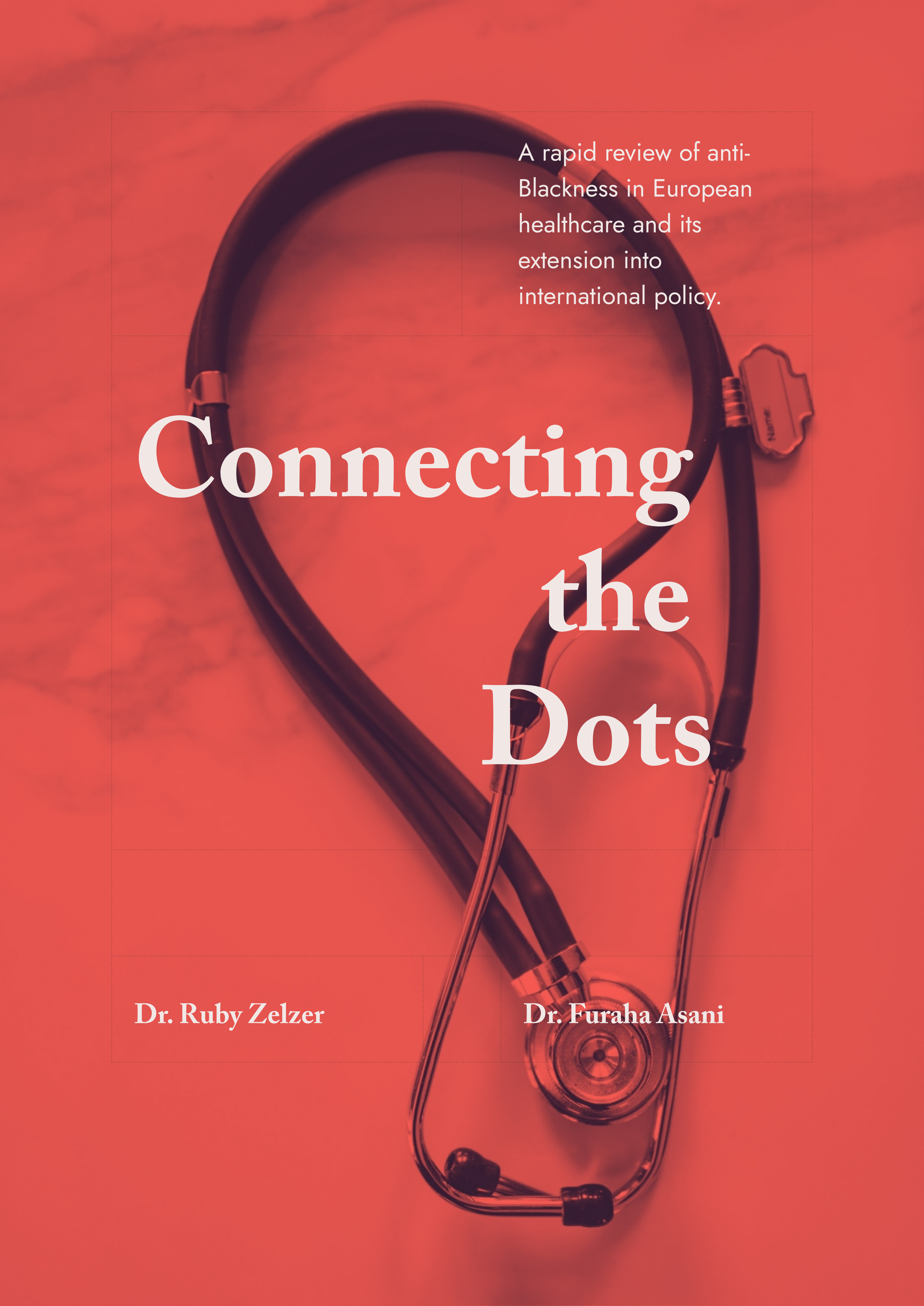

A rapid review of anti-Blackness in European healthcare and its extension into international policy.

Connecting the Dots

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Contents

1. Introduction

Race is a social construct where characteristics such as skin colour are used to create a hierarchy in order for one group to dominate resources or justify inferior treatment of other groups of people[1]. In the UK, there are known differential outcomes based on race in many political, social and economic aspects, including: immigration, housing, employment and education[2–5], that substantiate how Black people are marginalised to a greater extent than other racialised people, and this phenomenon is defined as anti-Blackness. One of the key metrics closely intertwined with anti-Blackness is healthcare inequalities where Black people experience disparities in healthcare access, treatments or treatment outcomes[6].

For healthcare practitioners, researchers, and policy-makers to fully disentangle the overlapping outcomes of these healthcare inequalities and implement solutions, ethical checkpoints need to be established where stock is taken of the current healthcare landscape and how anti-Blackness functions within it. One of these checkpoints is the thorough and rigorous analysis of healthcare data to uncover how exactly anti-Blackness has manifested and its impact in the lives of Black people. Race and/or ethnicity and/or nationality data is available from some UK-based repositories, such as the NHS Race and Health Observatory (NHS-RHO). Additionally, there are certain departments and consortia tasked with the provision of data to show healthcare outcomes in specific contexts (such as MBRRACE-UK, which is a perinatal mortality surveillance consortium publishing a report every couple of years.)

Looking further afield, politically, many countries within Europe have legal frameworks that prevent the collection of race and/or ethnicity data[7]. With the exception of the United Kingdom, most European governments do not collect race and/or ethnicity data. According to the OECD[7], in 2018, just 11 European OECD member countries collected data on race and ethnicity. These are: Bulgaria, Czech Republic, Hungary, Ireland, Latvia, Lithuania, Poland, Slovak Republic, Slovenia, United Kingdom and Romania.

Other countries within Europe which do not collect race and/or ethnicity data, may collect some data on migrant status. There are 18 European countries in the OECD in this category: Austria, Belgium, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and Turkey. While migration data can be used to identify discrimination or disparities in relation to immigration, it also has limitations. For example, country of birth or country of birth parents does not necessarily mean that the person has an immigrant background.

The justification for lack of collection of race and/or ethnicity data in European countries has multiple origins. In Germany, collecting race and/or ethnicity data is prohibited due to concerns about privacy or potential misuse of data[7]. However, there is resistance to the official German government position, and, Black people in Germany have created Afrozensus[8] where they collect data on experiences of discrimination based on race and create resources to empower Black Germans dealing with anti-Black racism. In France, race and/or ethnicity data is not officially collected due to a policy of race-blindness. This is a concept with origins in universalism and secularism, where a belief is held that all citizens are equal and this is not influenced by race and/or ethnicity.[9] Studies of Black France dispute that the race-blindness policy achieves its desired egalitarian effect. Race-blindness is also criticised for avoiding race consciousness where discrimination and racism because of anti-Blackness are acknowledged as a living reality for Black people in France.[9] Nordic states including: Denmark, Finland, Iceland, Norway and Sweden, use similar race-blindness policies as justification for not officially collecting race and/or ethnicity data.[10] In

Sweden, race-blindness has been criticised as rendering race and racism invisible in official policy with a negative outcome for racialised people accessing healthcare.[11]

Failure to collect race and/or ethnicity data makes it harder to officially identify discrimination based on race within key social, economic and political systems such as health, education, housing and employment, amongst other civic necessities. Additionally, if interventions are designed to impact people who are experiencing discrimination, lack of race and/or ethnicity data collection would make it impossible to target resources or measure outcomes for those who are experiencing race-based discrimination.

This rapid review seeks to collate reports of anti-Blackness within Europe which are associated with health disparities. We seek to:

i. identify how race and anti-Blackness is described and substantiated within literature even in the absence of official government data collection.

ii. identify the type of health disparities associated with anti-Blackness within Europe.

iii. make observations on the effect of the health disparities on Black people in Europe.

2. Methodology

We undertook a rapid systematic review guided by the PRISMA method[12], reviewing articles that directly address the topic of health outcomes within Europe for Black people written in English. From peer reviewed databases, we reviewed empirical studies (quantitative, qualitative and mixed method) and non-empirical studies (opinion pieces, theoretical work, commentary, discussions). From non-peer reviewed articles, we reviewed material from journalistic reports in media, blogs and social media, that directly address the topic of health outcomes within Europe for Black people.

For OECD European member countries that collect race and/or ethnicity data, we searched for literature that directly named Black and/or African groups. For OECD countries that do not collect ethnicity data, we took a more lenient approach to ensure that data could be collected and studied. We selected reports where Black individuals or groups could be directly linked although not explicitly named. For example, if the country collects data on migration and a report on data from that country lists the immigrant's country as a Black African country. Another example is where discrimination is named by someone named as a migrant to the country and then further detailed as discrimination based on skin colour.

a. Databases

Databases were searched for the period up to May 2023 and included: Pubmed, Web of Science and individual journal searches including European Journal of Public Health, The Lancet, BMJ Journals, Journal of Racial and Ethnic Health Disparities, Societies, Bioethics, Women's Studies

International Forum, Archives of Public Health, x-mol, Frontiers, International Journal of Public Health, BMC Public Health and PLOS. Personal databases of the authors which listed their own records of research, research from citations and references within journal articles were also included.

b. Search Strategy

The search was carried out using multiple combinations of the keywords and medical subject heading (MeSH) terms. These are listed in Table 1.

anti* antiblack anti-black anti-Black
anti-Blackness
black* Black blackness
rac* race
raci* racism racial
ethni* ethnic ethnicity
EU Europe
UK
health
matern* maternal maternal health
death
mental mental health
physical physical health
mort* mortality
life
exp* expectancy experience
dispar* disparity disparities
discrim* discriminate, discrimination, discriminatory
inequ* inequality inequalities inequities

Table 1: List of search terms used to find relevant literature.

Using very specific search terms such as a Boolean search for **'anti*+black+ raci*+health+eu*'** yielded very few search results in the named databases - usually between 0-10. To ensure a comprehensive overview of current literature and cognizant that race and/or ethnicity data is not officially collected by the majority of European countries, the terms 'racism' or 'discrimination' are likely to be broadly applied and not reference Black people. Nonetheless, we expanded the search to reference racism in general, for example using a Boolean search such as **- 'racism+disparities+health+europe'** and this yielded significantly larger results (typically 50-70 but up to 1831 in one of the databases). While many of these results do not meet the inclusion criteria set out in part c below, there were some relevant search results for this literature review.

c. Inclusion and Exclusion Criteria

i. Inclusion Criteria

Studies selected for this review, compulsorily, had to include all of the following:

- Black or African people or named Black/African group of people.
- Report of healthcare experience and/or outcome to the group above.

Optionally, studies could report racism, discrimination, inequality or disparity relevant to the group above.

ii. Exclusion Criteria

Studies were excluded if any of the following applied:

- Studies where no participants or subjects were Black or African.
- Studies which did not take part in Europe or examine European data or where it was not possible to delineate which part of the study occurred in Europe.
- Studies which did not report healthcare experience and/or outcomes.

d. Data Collection

A selected studies database was created using Zotero bibliographic software and populated with all articles from the rapid systematic review that passed the inclusion/exclusion criteria stage. A PRISMA flow diagram for the selection of studies for the review is presented in Fig 1. The identification stage involved reading the abstract and title of the study to assess if the work met the criteria to pass to the screening stage. At the screening stage, keyword searches of the full texts and skim reading was used to determine if the studies passed the rapid systematic review inclusion/exclusion criteria outlined in part 2c. For the final included group, full text versions were obtained and read in full. In this rapid systematic review this final set of studies that fully met the inclusion/exclusion criteria are referred to as the selected studies. Table 2 shows the characteristics of the 22 selected studies for this rapid systematic review.

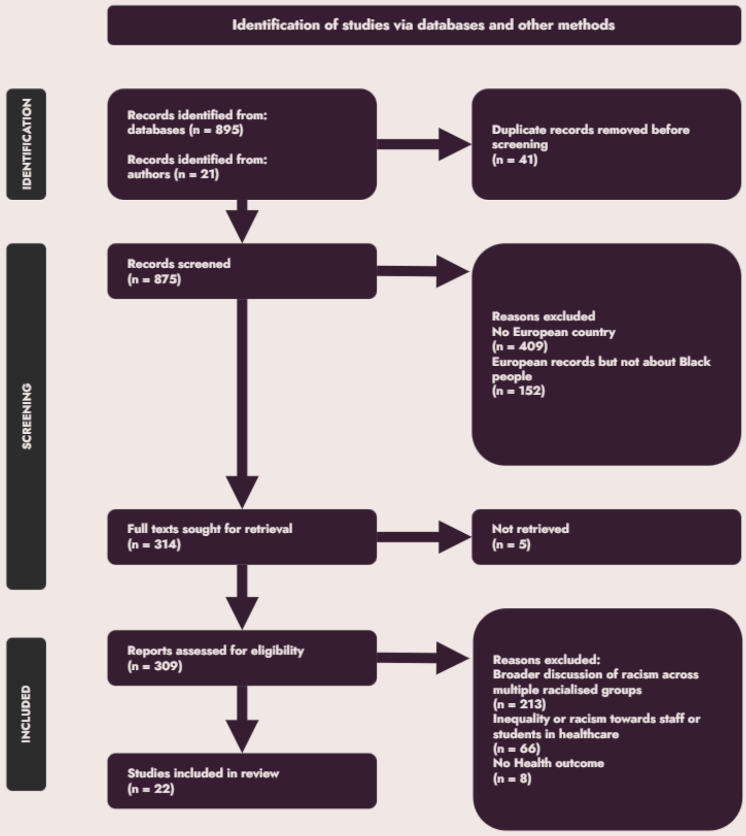


Figure 1: PRISMA diagram for systematic review of literature reporting health disparities/inequalities/inequities for Black people in Europe.

	Author	Year	Region/Country Of Study	Study Type	Ethnicity/Race Descriptor Of Black Cohort
1	Ahlberg[13]	2019	Europe	Review, opinion	Black, minority populations
2	Akbulut[14]	2020	Europe	Statement	Black, ethnic/racial minority
3	Alvarez-del Arco[15]	2013	US and Europe	Meta analysis	Black
4	Araujo[16]	2023	Portugal	Review, opinion	Black
5	Aribot[17]	2022	Europe	Qualitiative	African
6	Barnett[18]	2020	UK	Quantitative, meta	Black Caribbean, Black African
7	Beaman[19]	2020	France	Reflection, review	Black, Black Arab
8	Byrne[20]	2020	UK	Book	Black Caribbean, Black African, ethnic minorities
9	Castellanos M[21]	2023	Germany, Switzerland	Qualitative, survey	Skin colour and origin
10	Devakumar[22]	2022	UK	Review	Black Caribbean, Black African, ethnic minorities
11	Essen[23]	2009	Sweden	Review/ Quantitative	Sub-Saharan African/African

	Author	Year	Region/Country Of Study	Study Type	Ethnicity/Race Descriptor Of Black Cohort
12	Hamed S[24]	2020	Sweden, Germany, and Portugal	Qualitative - interviews	Swedish Sudanese, Swedish Somali, Portuguese Mozambican
13	King[25]	2022	Europe	Thesis	Black
14	Kushnick[26]	1988	UK	Review, opinion	Black
15	Kyobutungi[27]	2023	Europe	Review	African
16	Mazzalai E[28]	2023	Europe	Mixed — meta/quant/qual	Black (UK data), ethnic minority/migrant (Norway, Italy)
17	MBRRACE[29]	2021	UK	Review	Black
18	NHS-RHO[6]	2022	UK	Quantitative meta	Black, Black Caribbean, Black African
19	Okech[30]	2021	Europe	Discussion	Black, African
20	Paccoud[31]	2022	Luxembourg	Mixed methods	Global South migrant
21	Patel[32]	2020	UK	Editorial	Black, BAME
22	Stuhlhofer EW[33]	2022	Austria	Qualitative	Kenyan

Table 2: Characteristics of selected studies for this review

e. Data Analysis and Synthesis

Data analysis involved critical reading of full text versions of the articles from the selected studies database and creating codes that described contents and keywords of each article. The next step was to create themes to collate trends and patterns observed within the articles. The final step was to review, define and name the themes. For this study, RZ performed the first theme selection and this was independently reviewed by FA.

Table 3 and 4 show the final codes and themes.

In this table, X indicates a positive account and - indicates a negative finding.

			Identification Of Black People In Data		Type Of Accounts Featured Within Study		Observations			
	Author	Year	Direct	Indirect-Migration Background	Individual Experiences	Wider Systemic Or Health Policy	Belonging/ Othering	Surveillance Or State Policing	Border Violence At Large	International Policy
1	Ahlberg[13]	2019	X	X	-	X	X	X	X	-
2	Akbulut[14]	2020	X	-	-	X	-	-	X	-
3	Alvarez-del Arco[15]	2013	-	X	-	X	X	-	-	-

			Identification Of Black People In Data		Type Of Accounts Featured Within Study		Observations			
	Author	Year	Direct	Indirect-Migration Background	Individual Experiences	Wider Systemic Or Health Policy	Belonging/ Othering	Surveillance Or State Policing	Border Violence At Large	International Policy
4	Araujo[16]	2023	X	-	X	X	X	X	-	-
5	Aribot[17]	2022	X	-	X	X	X	X	X	-
6	Barnett[18]	2020	X	-	-	X	X	X	-	-
7	Beaman[19]	2020	X	X	X	X	X	X	X	-
8	Byrne[20]	2020	X	-	-	X	X	X	-	-
9	Castellanos M[21]	2023	-	X	X	X	X	-	-	-
10	Devakumar[22]	2022	X	-	X	X	X	X	X	X
11	Essen[23]	2009	-	X	X	X	X	-	X	X
12	Hamed S[24]	2020	-	X	X	X	X	-	-	-
13	King[25]	2022	X	X	-	X	X	X	X	-
14	Kushnick[26]	1988	X	-	-	X	X	-	X	X
15	Kyobutungi[27]	2023	X	-	X	X	X	-	X	X
16	Mazzalai E[28]	2023	X	X	-	X	-	-	-	-
17	MBRRACE[29]	2021	X	-	X	X	X	-	-	-
18	NHS-RHO[6]	2022	X	-	X	X	X	X	X	-
19	Okech[30]	2021	X	-	X	X	X	-	X	X
20	Paccoud[31]	2022	-	X	X	X	X	-	-	-
21	Patel[32]	2020	X	-	-	X	X	X	X	-
22	Stuhlhofer EW[33]	2022	-	X	X	X	X	-	X	-

Table 3: Codes and themes for the 22 selected studies, covering identification of Black people in data, types of accounts of anti-Blackness and observations of the studies.

In this table, X indicates a positive account and - indicates a negative finding.

			Type Of Health Disparity				
	Author	**Year**	**Death**	**Physical Health**	**Mental Health**	**Maternal Health**	**Healthcare Access**
1	Ahlberg[13]	2019	X	X	X	X	-
2	Akbulut[14]	2020	X	-	-	-	X
3	Alvarez-del Arco[15]	2013	-	X	-	-	X
4	Araujo[16]	2023	X	X	-	-	X
5	Aribot[17]	2022	-	-	X	-	X
6	Barnett[18]	2020	-	-	X	-	-
7	Beaman[19]	2020	X	-	-	-	X
8	Byrne[20]	2020	X	X	-	X	X
9	Castellanos M[21]	2023	-	-	X	-	-
10	Devakumar[22]	2022	X	X	X	X	X
11	Essen[23]	2009	X	-	X	X	X
12	Hamed S[24]	2020	X	X	-	X	X
13	King[25]	2022	-	X	X	-	-
14	Kushnick[26]	1988	X	X	X	-	-
15	Kyobutungi[27]	2023	X	X	-	-	X
16	Mazzalai E[28]	2023	X	X	-	-	X
17	MBRRACE[29]	2021	X	X	X	X	X
18	NHS-RHO[6]	2022	X	X	X	X	X
19	Okech[30]	2021	X	X	X	-	X
20	Paccoud[31]	2022	-	-	-	-	X
21	Patel[32]	2020	X	X	-	-	X
22	Stuhlhofer EW[33]	2022	-	X	X	-	-

Table 4: Coding and themes of the rapid review showing the types of health disparities that were identified within the selected studies.

3. Results

a. Black populations in Europe can still be located even where race and/or ethnicity data is not collected

In this review 16 of the 22 studies directly named Black people and of these 16:

- 8 analysed exclusively UK data where collection of race and/or ethnicity data exists,
- a further 3 featured analyses from a Black African perspective,
- 2 were European studies where UK data had been used and references to Black people pertained to that portion of the data,
- Finally, there were 3 papers featuring European work that name Black people, Araujo[16] whose work names Black families in Portugal, Beaman[19] who names Black people in France, and Ahlberg[13] who references Black African migrant nurses.

10 of the 22 studies used migration background which could allude to Black people and were classed in this rapid review as an indirect reference to Black people. Examples of the terminology used by these studies include 'Swedish Sudanese', 'Portuguese Mozambican', 'migrant from a majority ethnic group in Kenya', 'global south migrant' (naming Africa in the context of global south) or 'migrant with an African background'. Further descriptors can be found in Table 2.

One study provided an indirect case but was included as it covered research about children with an immigration background in Germany and

Switzerland who had stated that skin colour abuse was the most common form of hate speech they experience[21].

b. Accounts of anti-Blackness exist as both individual accounts/recollections and wider healthcare systemic issues

For this rapid review, a compulsory part of the inclusion criteria was that studies had to describe health outcomes for Black people. All 22 selected studies reported differential, negative outcomes or experiences of healthcare (see Table 3 and 4). These studies included individual accounts as well as wider systemic racism within healthcare which is detailed in Table 3.

9 of the 22 studies (see Table 3) directly address wider racism in healthcare systems or detail how political systems and health policy in Europe create conditions that enable persistence of systemic racism in healthcare. Further, there were 2 comprehensive reviews from the UK, including the NHS-RHO[6] which detailed health inequalities and racism in healthcare in the UK in 5 areas including: mental health, maternal health, digital access, genetic testing and in the NHS work force. The second review is from MBRRACE-UK[29] which focused on maternal health inequalities in the UK.

13 of the 22 (see Table 3) studies detailed individual accounts of anti-Black racism within the articles, but contextually, all 13 also placed those accounts within the wider scope of healthcare inequalities caused by social, economic and/or political policies that embed discrimination by race. For example, an Austrian Kenyan widow[33] who gave her account that she was ordered by a court to give up her marital home after the death of her husband and was quoted directly linking legal systems to persisting racism in her statement, "When it comes to justice, when you are a foreigner, especially when you are Black, you have no chance here."

Cases of medical racism are also present within individual accounts such as that of a Cameroonian German woman whose doctor refused to examine her arm after she mentioned that she had just come from Africa. The study[24] states, "Although she had no symptoms, the doctor refused to examine her and instead proceeded to google whether there was Ebola in Cameroon and, according to the Cameroonian German woman, looked scared."

c. Effects and Experiences of Anti-Black Health Policy

i. Belonging and othering is very commonly observed when studying anti-Blackness

Within the 22 selected studies in this rapid review, there are a range of effects on people and systems due to anti-Blackness and associated health inequalities. A key theme repeated in 20 of the 22 studies (see Table 3) was belonging/othering. This describes how policies and people create environments of exclusion that affect the feeling of belonging in those environments for Black people. It also describes the nature of othering within society and within healthcare policy or by healthcare professionals, where Black people are treated differently to others who are non-Black. Examples include the MBRRACE-UK report[29] outlining how Black patients may experience a breakdown of trust in their healthcare provider due to dismissal of their concerns. Further, Beaman's work[19] which highlights the French government policy of egalité which enforces the principle that all citizens are equal but also how in real life for Black people, 'Belonging in France, is forever suspect,' because 'white supremacy structures who is French.' Meanwhile, King references autochthones and allochthones in Netherlands where a 'them and us' structure exists and people are framed perpetually according to migrant origin of themselves or their parents.

ii. Surveillance and/or action of state police are features of anti-Black racism

9 out of 22 studies (see Table 3) covered the subject of undue surveillance or the actions of the state via police/policing. Examples include Araujo[16] who discusses surveillance of Black families in Portugal and the government policies within Portugal that perpetuate systemic racism and health inequities. King[25] meanwhile discusses state policing and racism in Europe that can lead to physical harm or death of Black people. The NHS-RHO[6] study details how there is a higher likelihood of police or criminal justice system involvement prior to hospital admission for Black people.

iii. Border violence

14 out of 22 studies (see Table 3) described some aspect of historical or contemporary border violence having an impact on present-day conditions. For example, Devakumar[22] mentions historical "expulsion" of people due to their ethnic identities as well as historical formation of borders; Beaman[19] cites the Algerian war of Independence as well as ongoing discrimination against Black and/or Arab people; and the NHS-RHO[6] details fears faced by refugees and asylum seekers about possible discrimination and abuse whilst trying to access healthcare support- which demonstrates the UK hostile environment in action.

Interestingly, 13 of the 14 studies (see Table 3) that make mention of border violence also noted aspects of othering (see part 3ci), which raises an important question about the interconnection between these two factors.

iv. Anti-Blackness in Europe extends to international policy

4 of the 22 studies (see Table 3) referred to how policies in Europe create external environments of anti-Black racism and health inequities in international policy. The COVID-19 vaccine global distribution discrimination that led to a surplus in Europe while there was a shortage in Africa is highlighted. Visa apartheid was also described, it limits collaboration of health researchers from Africa with those in Europe by European governments refusing African researchers visas or denying African visa holders entry to attend research exchange or training events in Europe. The racist evacuation policy in Ukraine in 2021 which saw Black African people hampered from boarding trains to leave the war zone, while white Ukrainians were offered home and board across several countries in Europe is also mentioned.

Kyobutungi[27] highlighted how European health workers tended to survive Ebola infection due to specialist treatment in Europe but African doctors and health workers did not have the same access to this life-saving treatment and often died if infected during the course of their work.

d. Which areas of health inequalities are most studied in Europe

This review revealed that there are 5 broad areas which have been studied in literature, where anti-Blackness in healthcare in Europe creates health inequities or differential/negative outcomes for Black people. These 5 main areas are outlined in Table 4 and include:

- Death - 15 out of 22 studies
- Physical health - 15 out of 22 studies
- Mental health - 12 out of 22 studies
- Maternal care - 8 out of 22 studies
- Healthcare access - 15 out of 22 studies

It is worth noting that there is great overlap within these areas. For example, all 8 of the studies that discuss maternal care, overlap with either physical health and/or death. None of these inequalities occur in isolation. The NHS-RHO[6] report further noted that there are many areas of healthcare inequality and those that it selected for focus were the ones assessed to be in most urgent need of addressing. It is further notable that 4 of the studies that reference death as a health inequality directly named COVID-19 during the first phase of the 2020 pandemic as the risk factor.

4. Key Themes

a. Race and/or Ethnicity Data Collection – Hidden Figures, Real Racism

At the beginning of this rapid review, it was clear that the absence of data collection on race and/or ethnicity in European countries (UK being the exception) might hamper identification of health inequalities that specifically affect Black people. As evidenced in the results (Part 3a and Table 2 and 3), it was still possible to identify research that pertained to Black people, directly or indirectly identified, which outlined associated health inequalities. Researchers were able to work within the current government restrictions and use migration data to study discriminatory patterns in healthcare that pertained to those specific groups. It is notable that all 22 of the selected studies reported health inequalities faced by the people directly identified as Black or identified as immigrants from Africa.

In many senses, countries in Europe have employed the 'ostrich burying its head in the sand' approach, where a problem is seen but efforts are taken to unsee/not see it, rather than deal with it. Race and/or ethnicity data is not collected for apparently egalitarian reasons where countries such as France frames itself as an idealistic world of equal people or in Germany where discrimination is thought to be prevented by not collecting the race and/or ethnicity data. However, the lack of collection of race and/or ethnicity data creates a situation where racism exists in practice as evidenced by this rapid review, but with no accountability mechanism due to lack of recorded data for government policies to address. It is essentially the classic result of colour-blind policies where there is racism without racists. This is repeatedly highlighted in several of the papers, notably in the work of Keaton[9], Beaman[19], McEachrane[10], King[25] and Araujo[16], and raises the question about the separation of policy makers and general population from the experiences of Black and other minoritised people in Europe. A behavioural analysis of policy makers tasked with public health and addressing inequity, commented that for policy makers, "public health research was also felt to have weak underlying theoretical underpinnings,"[34] and preferred observational evidence and/or narrative accounts[35] to be persuaded. However, as this rapid review shows, high quality research exists and personal narratives are plenty, yet inequity persists.

Further questions arise such as who is funded to do health inequality research, what are their active links to Black and marginalised people and how does that influence the type of data gathering that they do to determine how racism in healthcare can be evidenced and tackled. As Barnett[18] stated, when health inequities are observed in research, "There are often untested explanations for the variation in risk without primary evidence." Additionally, Essen's study[23] did indeed account for risk factors but still ended up with disparities for Black people (identified as Swedish women with a sub-Saharan African migrant background in the study). So, might racism be the actual risk factor?

If there was a true commitment to equality as designed in law, would that not encompass acknowledging the presence of the Black community (by allowing data collection) and then taking steps to be accountable for the inequalities that exist? Pockets of active resistance such as Afrozensus[8], mentioned earlier in the introduction, do exist. This is a German led organisation that collects data on Black Germans and Black Germany.

b. Structural and Systemic Racism is Omnipresent

This work illustrates that while health inequalities have individual impact, they are always linked to larger social, economic and political systems and structures. The individual cases serve as a strong anchor to remind us of the humanity of the people within these systems and structures who experience anti-Black racism. Highlighted in the results section 3b, is the case of the Cameroonian German woman who experienced medical racism in Germany, when she attended a clinic for pain in her arm assessed but instead was suspected of carrying Ebola and refused treatment. As discussed in the introduction, Germany is a country that does not collect race and/or ethnicity data under the guise of preventing discriminatory use of that data. Essentially, not collecting race and/or ethnicity data, does not prevent discrimination, it only provides a mechanism to evade acknowledging its existence.

The wider structural issues of the political policy of hindering race and/or ethnicity data collection and the social issues of ignorance of the Black lived experience that enable racist tropes such as framing of Africa and Africans, in the case above, as 'disease carriers' are the primordial soup from where health inequalities are birthed and sustained. Solutions to tackling anti-Blackness in healthcare that take an individualistic approach to addressing the racism in the system are unlikely to be as effective as steps actively taken to change societal systems and structures and place accountability within political and social institutions that should in the idealistic framing of France, be of service to all people within the country.

c. The most commonly observed/reported health inequalities

In this rapid review, it became apparent that there were 5 key health areas where anti-Blackness has resulted in health inequities. Further, there was generally a great overlap between these health areas demonstrating the interlinking and crosslinking of racism in several areas of healthcare. The 5 key areas are mental health, physical health, death , access to healthcare and maternal care. These are discussed below.

i. An infinity loop of racism - Anti-Black racism as a cause of mental ill-health, and seeking treatment from mental healthcare systems which are structurally and institutionally racist

Of the 22 selected studies, 12 of them either reference effects on mental health as a result of experiencing anti-Black racism e.g., Aribot[17] who discussed psycho-social suffering of Africans in Ukraine who had been denied passage to evacuate during an active war, while white Ukrainians were prioritised, or they reference disparities in the mental healthcare received by Black people who require treatment after experiencing mental-ill health. This second form is illustrated by the comprehensive meta study from the NHS-RHO[6] which showed statistically that Black people in the UK are more likely than white people to be compulsorily admitted to hospital care under the Mental Health Act. Once admitted as an inpatient, Black people within mental health wards are more likely to be given harsher restraints or secluded. From this perspective, it is easy to rationalise why a Black person who has experienced racism and has mental-ill health as a result, would avoid these systems even if they required help as the potential to experience further racism is high. This endless situation of experiencing anti-Black racism and mental-ill health as a result and then compounding the situation by experiencing anti-Black racism from the healthcare provider is what we are referencing as an infinity loop of racism.

The NHS-RHO in its ground-breaking rapid review stated, "...a fundamental cause of the ethnic inequalities we see in healthcare services and health outcomes, which is often not mentioned in research and policy debates, is racism."

ii. COVID-19 - Anti-Blackness when resources are scarce leads to death

Death presents itself as a health inequity in association with other causes such as physical health or maternal health (discussed later). In 2020, at the beginning of the COVID-19 pandemic, statistics from the Office for National Statistics[36] in the UK showed that Black people were disproportionately more likely to die (3.7 times more likely) of COVID-19 compared to white people. At the same time, research showed that 95% of doctors who died from COVID-19 in the UK during the early phase were non-white[37]. These stark figures illustrate how anti-Blackness in Europe led to the death of Black people when resources (such as personal protective equipment) or knowledge (transmission mode of COVID-19, ways to adequately protect yourself as a doctor) were scarce.

iii. A lifecycle of racism - For Black people in Europe, racism presents itself dangerously in health inequalities prior to birth and persists through childhood and adulthood

8 of the 22 studies mention maternal care as a health inequity. It is discussed from a political policy-making angle in Portugal[16] when Black mothers and Black motherhood is treated with disdain and informs policies that lead Black children to enter social care. In Sweden, it is demonstrated as perinatal mortality, where Black mothers (sub-Saharan African women) are more likely to lose their babies just before or shortly after birth compared to Swedish-born (inference to white) women.[23] It is finally discussed as maternal mortality in UK where Black women are 4 times more likely to die during pregnancy compared to white women.[6, 29]

Racism continues into childhood experiences such as German/Swiss children with a migrant background reporting that abuse on skin colour was the most common form of hate speech that they experienced[21]. Further, that some of this hate speech comes from other children of a migrant background.

In adulthood, physical health, death and healthcare access become areas where anti-Black health inequities exist (Table 4).

For those who choose it, the child bearing experience will present a risk once more to them as it did to their parent. The lack of substantial and meaningful change in policy to address anti-Blackness means this cycle is predictably self-perpetuating through the full life time of Black people in Europe.

d. Effects and experiences of anti-Blackness

Taking the anchor back to individual experiences framed within the wider context of systemic racism and anti-Blackness in the healthcare systems in Europe, four key themes emerged: belonging, surveillance or state policing, border violence and the external manifestation of anti-Blackness in international policy.

i. Belonging and Surveillance

Belonging emerged as the most common effect or experience of anti-Black racism and/or the associated health inequities with 20 out of the 22 selected studies commenting in some capacity on it. In many senses, the initial point in part 4a of not allowing race and/or ethnicity data, but allowing collection of migration data has the implied position from European states that Black people will be regarded perpetually as migrants and not as citizens. Beaman[19] and King[25] both described how othering creates a tiered system where one group are more equal than others and Beaman more directly referenced how white supremacism was involved in who was seen as French and who was not.

This is in line with what the literature and anecdotal data shows us about how 'migrant' as a concept is racialised, such that Black people who were born or become nationals of a European country — regardless of performances of neo-assimilation- will always be relegated as 'Other'.

ii. Border Violence

14 out of 22 studies featured border violence but none placed it as the main argument, but rather, formed the context to present an individual's identity (such as 'immigrant') and/or immigration status and highlight a separateness embedded within society and/or healthcare systems. 13 out of these 14 studies described feelings of being 'the other', which further supports our understanding that borders have implications on feelings of (un)belonging and can play a significant role in healthcare; from access to outcome.

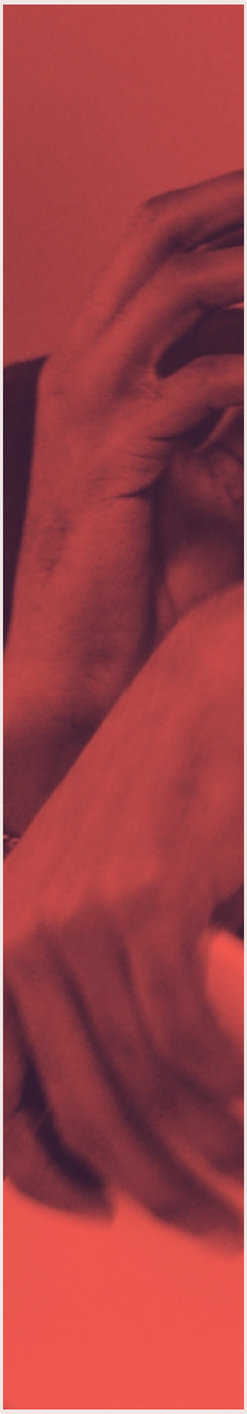
Scholars, activists, and organisers in border and migration justice have long argued that borders themselves are racialised[38-41]. Many European countries allow collection of data on migrant status but disallow race and/or ethnicity data collection purportedly to prevent discrimination. The presence of border violence and its link to (un)belonging for Black people in this rapid review, demonstrates the interplay of anti-Black racism and anti-migrant sentiment in society, and further that this phenomenon can be evidenced even with a lack of race and/or ethnicity data collection. Importantly, all 14 studies contextualise historical and contemporary border violence as an aspect that has led to a present-day health outcome. This suggests that border violence and its pervasive effects play a significant role in public health of Black people- especially of those with migrant status.

iii. Anti-Blackness in European policy manifests itself in international policy

Anti-Blackness in European policy has a long arm that targets Africans within Europe such as in the study by Aribot[17] that detailed racism in the evacuation of Ukraine in 2021. In the UK, the offer of continuation of education was made by some universities but these offers were not extended to African students who had been studying in Ukraine, with the exception of the University of Manchester[42]. Even in times of war, a tiered anti-Black refugee system emerged.

This long arm of anti-Blackness in European policy extends even further into global health and impacts Africans in Africa directly. Two key areas named by Kyobutungi[27] are vaccine and visa apartheid. Vaccine apartheid in itself is a situation that at a base level is unnecessary greed due to necrocapitalism. COVID-19 vaccine production and supply in the early stages of the pandemic led to the hegemonic powers including European countries having a surplus of vaccines due to placing larger orders than required by their populations. They then offered these surplus vaccines to African countries at short notice and very close to the expiry date of the vaccine. Many of these vaccines were discarded due to infrastructure issues that limited the ability to safely store or distribute the vaccines. If supplies had been equitably distributed and thought applied to the infrastructure of the receiving country, there may have been greater numbers of people having effective access to the vaccine. An additional point is how policy makers in UK were presented with a moral case[43] to temporarily waive intellectual property rights (TRIPS waiver) to allow countries in Africa to produce the COVID-19 vaccine but declined to do so, despite the world globally being in a health emergency caused by the pandemic.

Visa apartheid refers to how research on a global stage is hindered by visa refusals for African researchers attending work-based conferences or programmes in Europe. Further pertinent examples exist in literature, including how African researchers studying Ebola were denied entry to the UK to participate at a conference discussing pandemic preparedness in 2019.[44] A year later, the COVID-19 pandemic happened and the skills, knowledge and practical experience of African researchers would certainly have been valuable.



5. Conclusions

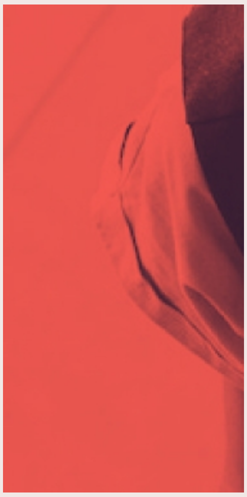
In this review, wider systemic racism in health policy features in all 22 studies and therefore, anti-Blackness cannot be framed into individual experiences only but instead as a far-reaching societal and political problem that has yet to be effectively addressed.

Additionally, there is no singular area of healthcare that can be targeted in isolation. The pervasiveness of anti-Blackness means that there is significant overlap across several areas in healthcare and a system wide approach to tackling racism is necessary.

There is significant impact to Black people specifically in belonging which featured in 20 of the 22 studies. The framing of Black people in Europe as perpetual immigrants, border violence and the extension of anti-Blackness into international policy are all key public health and global health issues.

This rapid review brings up a key existential question. When it comes to health inequalities and anti-Blackness, is it necessary to unwind whether political, social or economic systems are at play or is it more honest to just call it what it is, racism?

6. Future Perspectives



Key areas for future research that have emerged from this review include:

i. Finding methods to record race and/or ethnicity data to evidence existence of health inequalities. Working with organisations such as Afrozensus[8] to understand their process of data collection and navigation of legal framework, in order to share and replicate that knowledge for others in European countries who wish to resist current regulations that embed racism into systems by preventing race and/or ethnicity data collection.

ii. Continued engagement with the Black community to be aware that racism is present within multiple health systems and assure them that their individual experiences whether subtle or overt, are valid and that wider systemic and structural racism is at play. This is in addition to knowledge of self-advocacy, personal safety and rights.

iii. The key as to why racism remains unaddressed in Europe lies with wider society and policy makers placing otherness on Black people and the Black narrative. Research to understand why this is the case and why meaningful commitment to include and accept the humanity of Black people in Europe is important. This has to be framed with a frank message on how not doing so contributes to persistence of racism and inequality in society.

iv. There is a clear case for Africans living and working in Africa to be funded by European institutions to create conferences and research exchange systems that centre their knowledge and skills. European institutions routinely invite Africans to partake in training or conferences but should be aware of the discriminatory anti-Black hostile environment in immigration that limits knowledge and innovation and the onus cannot be on those who are marginalised by that environment to change it.

v. Although not the focus of this current rapid review, it has emerged that Black staff within healthcare experience racism at work, this is discussed in the NHS-RHO[6] rapid review. The double burden of experiencing racism from colleagues and potentially witnessing Black patients also experience racism in hospital, and how that impacts Black healthcare staff is not extensively covered in literature but would provide additional insight into how Black people navigate within systemically racist institutions.

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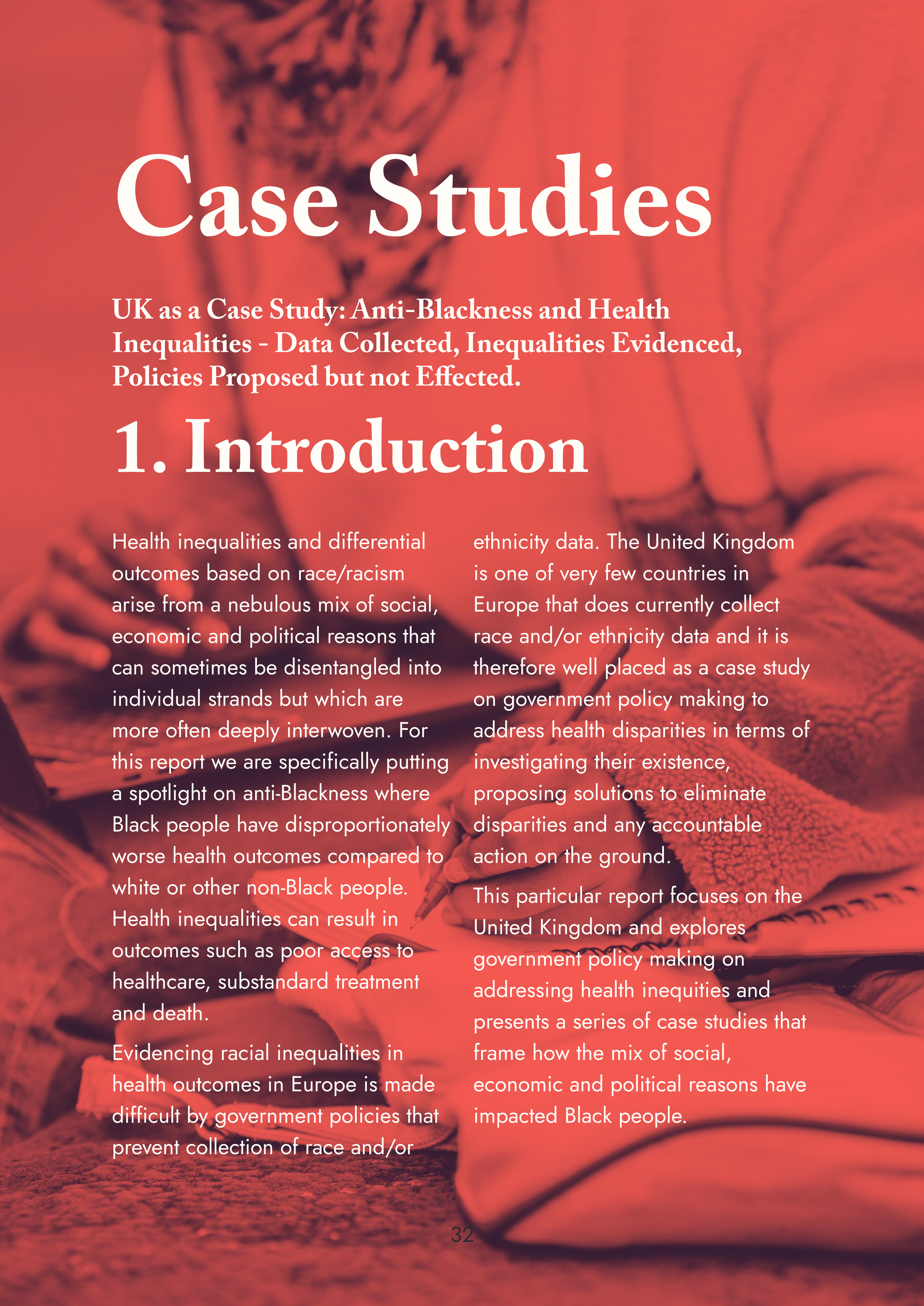


Case Studies

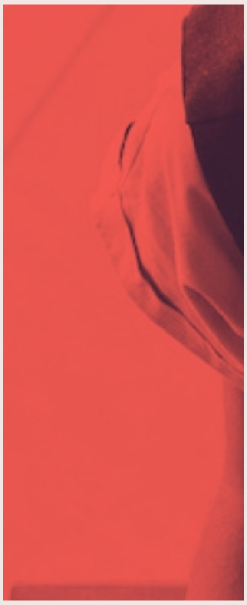
UK as a Case Study: Anti-Blackness and Health Inequalities - Data Collected, Inequalities Evidenced, Policies Proposed but not Effected.

1. Introduction

Health inequalities and differential outcomes based on race/racism arise from a nebulous mix of social, economic and political reasons that can sometimes be disentangled into individual strands but which are more often deeply interwoven. For this report we are specifically putting a spotlight on anti-Blackness where Black people have disproportionately worse health outcomes compared to white or other non-Black people. Health inequalities can result in outcomes such as poor access to healthcare, substandard treatment and death.

Evidencing racial inequalities in health outcomes in Europe is made difficult by government policies that prevent collection of race and/or ethnicity data. The United Kingdom is one of very few countries in Europe that does currently collect race and/or ethnicity data and it is therefore well placed as a case study on government policy making to address health disparities in terms of investigating their existence, proposing solutions to eliminate disparities and any accountable action on the ground.

This particular report focuses on the United Kingdom and explores government policy making on addressing health inequities and presents a series of case studies that frame how the mix of social, economic and political reasons have impacted Black people.



2. Health Inequalities

While health inequalities have existed in the UK for decades, there are two recent independent reports that show contemporary evidence of racism and anti-Blackness in UK healthcare. These are:

i. NHS-RHO[1] – This is the broadest ranging and most current systematic analysis of health inequalities in the UK. It covers 5 main areas including: mental healthcare, maternal and neonatal healthcare, digital access to healthcare, genetic testing and genomic medicine and the NHS workforce.

ii. MBRRACE-UK[2]- a collaborative programme funded to monitor maternal health in the UK and undertaking evidence based surveillance which produce a report that showed Black women in the UK are 4 times more likely to die compared to white women.

The statistics within these reports are stark and highlight serious inequalities in healthcare in the UK for many marginalised groups and how Black people have some of the worst outcomes.

3. Government Policy Making

UK government policy making around the issue of health inequity that specifically mentions Black people, dates back to the Black report of 1980. It was criticised for devoting just 3 pages to the health of Black people and placing them in the context of immigrants rather than UK citizens[3]. Since then, there have been more UK government reports (from 1980 to 2023) and they show that policy making patterns around issues of inequity have generally highlighted anti-Blackness, systemic and institutional racism. The exception is the widely criticised Sewell report of 2021 which the UN stated was attempting to normalise white supremacy in the UK[4]. In 2023, the most recent report by Baroness Casey stated once more that UK policing was plagued by sexism, systemic and institutional racism.

A study[5,6] on UK and international policy makers who worked in inequities in public health showed that they didn't consider current studies to be sufficiently robust evidence but instead are motivated by a personal accounts of users connected to the inequity. Personal accounts and experiences are present in the two leading reports cited previously, as well as extensively in literature, so the disconnection between policy making and health inequalities requires a different explanation.

4. Black Population Experience

i. Windrush Generation/Hostile Environment

In post second world war Britain, Black people from British colonies were invited to work (so welcome to labour to rebuild UK post war between 1948 and 1971) in the Windrush generation. During this period, migration laws were less stringent compared to present time and many Black people from countries in the Caribbean arrived in the UK with a landing card being the only official documentation required to work or live in the UK.

However, it has now emerged that anti-Black racism in the UK to this generation began as early as the 1950s and through the 1970s, where 411 people[7] with mental ill-health were sent back to mainly Caribbean states such as Jamaica, or denied re-entry/having had their passports rescinded in dubious circumstances. This denied them access to their families that were in the UK and further denied them access to treatment in the UK despite having worked and lived in the UK.

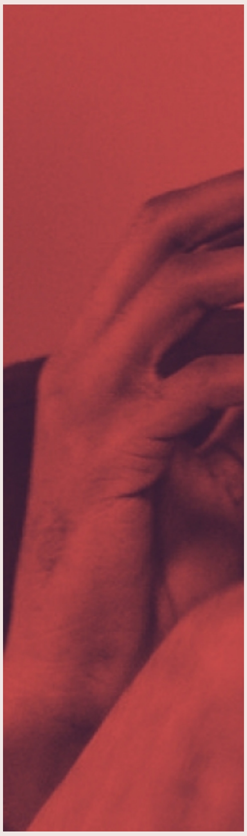
The treatment of the Windrush generation set the foundation for the xeno-racist hostile environment[8] that would have far-reaching implications on their lives, livelihoods, health and families. Patrick Vernon[9] has described some of these effects of the hostile environment on the Windrush generation as, "...loss of liberty, degradation, humiliation, death, attempted suicide, bereavement, anxiety and depression, hypertension and stroke, food deprivation, isolation and loneliness, deportation fatigue and intergenerational trauma." Vernon further described survivors' feelings of being "robbed…of their Black British identities", and argued for tailored mental healthcare for survivors and their descendants.

ii. Hostile Environment in International Policy

The UK hostile environment policy and its anti-Blackness does not apply just to UK residents. It extends further into international policy. During the COVID-19 pandemic in 2020, UK and other European nations participated in vaccine hoarding where surplus vaccines were ordered for their populations and deprived from African countries[10]. Further, UK denied a TRIPS waiver which would have enabled COVID-19 vaccine production in Africa under temporary suspension of intellectual property rights[11].

African health researchers have also faced unfair visa denials to attend workshops and conferences in the UK, even in circumstances where they had full funding from UK institutions[12].

5. UK- Anti-Blackness and Health Inequalities Case Studies



i. Medical Negligence Impacting Physical Health

Evan Nathan Smith, 21

In 2019, Evan died in hospital after negligent care during a sickle cell crisis at North Middlesex Hospital in Edmonton. At one point, while admitted in hospital, he called for an ambulance after being denied oxygen by staff, who did this despite a doctor recommending oxygen for him. There is poor knowledge of specialist care by healthcare staff for sickle cell disease which largely affects people of Black African origin.

Link:
https://hansard.parliament.uk/commons/2021-12-08/debates/5863C203-AECF-424F-996E-AE5AC15AD15F/SickleCellTreatment

Link:
https://www.bmj.com/content/375/bmj.n2782.full

ii. Adultification Resulting in Mental-ill Health

Child Q, 15

In 2020, a 15 year old girl, Child Q was strip searched by police at school. There was no appropriate adult present and the child was on her period. The mental health of Child Q was impacted as a result and she began self harming.

Link:

https://chscp.org.uk/wp-content/uploads/2022/03/Child-Q-PUBLISHED-14-March-22.pdf

iii. Mental-ill Health, State Policing and Physical Health

Olaseni Lewis, 23

Leon Briggs, 39

George Nkencho, 27

Godrick Osei, 35

Kevin Clarke, 35

There are several cases of Black men aged 20-40 who have experienced a mental-ill health crisis, come into contact with police as a result and died while in police custody or during police restraint. The five individuals listed passed away between 2013 and 2022.

Link:

https://irr.org.uk/article/mental-health-police-deaths/

Link:

https://www.judiciary.uk/wp-content/uploads/2017/07/Olaseni-Lewis-2017-0205.pdf

Link:

https://www.independent.co.uk/news/uk/home-news/godrick-osei-devon-cornwall-police-b2247905.html

iv. Environmental Racism – Mould in Social Housing

Awaab Ishak, 2

Awaab passed away after severe mould exposure in his home. His family had been housed in social housing in the UK and the landlord had not been proactive to deal with the mould in the home and placed blame on the family for not airing the home. The term 'othering' was used by the housing ombudsman.

Link:
https://www.judiciary.uk/prevention-of-future-death-reports/awaab-ishak-prevention-of-future-deaths-report/

v. Environmental Racism – Air Pollution

Ella Adoo-Kissi Debrah, 7

Ella passed away after a severe asthma attack. Her death is the first in the UK to cite environmental air pollution as a factor in her death.

Link:
https://ellaroberta.org/about-ella

6. Additional Case Studies on Health Inequalities in the UK

Asani, F (2021) **Drug sharing in desperate times** [My personal experience of not having NHS access and having to accept drug donations from friends via post]

Asani, F et al. (2021) **We Cannot Walk Alone** [Panel with three anonymous UK-based precarious migrants, where they share their experiences including around Covid-19 organising around lack of access to NHS and other support structures]

Asani, F and Kinouani, G. (2021) **Migration, Homelessness, and internalised displacement**. Social and Health Sciences [Guilaine and I talk about anti-Blackness broadly but also make mention of effects on health especially due to border violence.]

Asani, F (2023) **Social isolation and the search for sanctuary**

Johal, N and Hall, J (2023) **Windrush: Hundreds with chronic and mental illness sent back to Caribbean** [Published only a few days ago, mentions case of Joseph Armatrading who was deported with mental illness]

Okafor, K (2019) **A stereotype a day keeps the doctor away - how the healthcare industry is failing Black women** [Graphic description of Kelechi's horrible experience during her miscarriage, and how she was treated]

Ventour-Griffiths, T (2022) **Autistic While Black in the UK: Masking, Codeswitching, and Other (Non)fictions** [Really important first-person anecdote that covers the complexities of expecting a neurodiversity diagnosis in the UK while Black]

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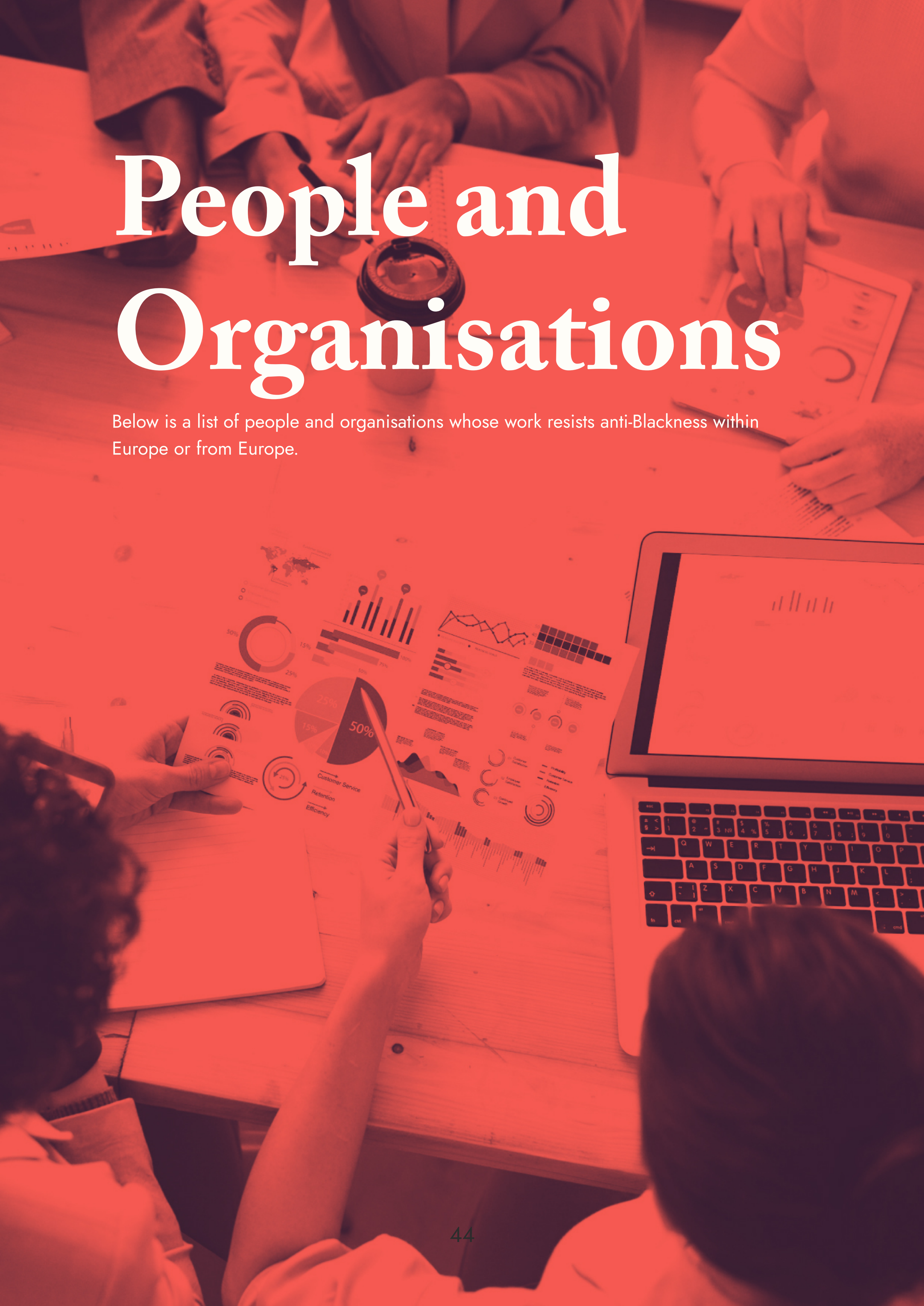
People and Organisations

Below is a list of people and organisations whose work resists anti-Blackness within Europe or from Europe.



1. People

Name: Trica Keaton

Study Area: US based academic but studies Black France.

Link: **https://aaas.dartmouth.edu/people/trica-keaton**

Name: Ojeaku Nwabuzo

Work: Director (Policy, Advocacy, and Network Development) of ENAR, Germany.

Link: **https://www.enar-eu.org**

Name: Beth Maina Ahlberg

Study Area: Sweden, racism in healthcare.

Link: **https://www.katalog.uu.se/profile/?id=XX2345**

Name: Catherine Kyobutungi

Study Area: Chronic disease management and advocate for African led research.

Link: **https://aphrc.org/person/catherine-kyobutungi/**

Name: Michael McEachrane

Study Area: Afro-Nordic area, anti-racism

Link: **https://www.ucl.ac.uk/institute-of-advanced-studies/people/dr-michael-mceachrane**

Names: Rochelle Burgess and Patrick Vernon

Study Area: Focused on mental health justice for Windrush victims.

Link: **The Ties that Bind**.

Name: Candice Braithwaite

Study Area: Author who has done a lot of work in maternal health in the UK.

Link: **https://www.candicebrathwaite.com/**

Name: Reverend Jide Macaulay

Study Area: Destigmatisation of HIV. Activism work for Black UK LGBT+ people.

Link: **https://www.houseofrainbow.org**

2. Organisations

Link: **https://afrozensus.de/**

Synopsis: German organisation independently collecting data on Black Germans

Link: **https://www.baobabfoundation.org.uk/**

Synopsis: Charity funder that supports causes that actively resist anti-Black racism in the UK.

Link: **Black Equity Organisation**

Synopsis: Black civil rights organisation in the UK.

Link: **Decolonising Contraception**

Synopsis: Reproductive justice organisation with activism for Black and racially minoritised people in the UK.

Link: **Black Minds Matter**

Synopsis: Mental health charity focused on Black people in the UK.

Link: **Caribbean & African Health Network**

Synopsis: UK based organisation working to eradicate health inequities for Black and Carribean people.

Link: **Black People Talk CIC**

Synopsis: Black mental health charity for Black university students in the UK.