O'NEILL INSTITUTE FOR NATIONAL & GLOBAL HEALTH LAW

GEORGETOWN LAW

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Submission to the Committee on the Elimination of Racial Discrimination

Comments to the First Draft General Recommendation No. 37 (2023) on Racial discrimination in the enjoyment of the right to health

1 Introduction

Oscar A. Cabrera and Silvia Serrano Guzmán, co-directors of the Health and Human Rights Initiative of the O'Neill Institute for National and Global Health Law at Georgetown University Law Center, respectfully submit the following comments to the *First Draft General Recommendation No. 37 (2023) on Racial discrimination in the enjoyment of the right to health* (the "Draft General Recommendation") for consideration by the United Nations Committee on the Elimination of Racial Discrimination (CERD).

The O'Neill Institute is a not-for-profit institution located at Georgetown University Law Center in Washington, D.C. Its mission is to conduct rigorous research to identify solutions to pressing national and international health concerns.

The Health and Human Rights Initiative, one of the areas of work within the O'Neill Institute, works to improve health through academic research that focuses on the intersection of health and national and international human rights law. A key facet of our work involves engagement in domestic and international standard-setting processes to advance health, justice, and equity in all of its dimensions through the strategic use of human rights legal frameworks.

Given this background, and acknowledging the considerable significance of CERD's General Recommendations in interpreting international human rights law, we find it relevant to highlight specific topics that, we hope, will contribute to the Committee's efforts to draw attention to the different ways in which racial discrimination can undermine the enjoyment of the right to health and other related entitlements.

Our submission is structured as follows. First, we briefly showcase the positive aspects or strengths of the Draft General Recommendation, explaining how these elements can help clarify State obligations under the right to health. We then delve into some specific topics that, although are mentioned in the draft, would benefit from more extensive discussion, analysis or clarification. Lastly, we identify additional common concerns that are missing from the Draft General Recommendation and suggest their inclusion in the final version of this document.

2 Salient Positive Aspects of the Draft General Recommendation

2.1 Comprehensive understanding of the different dimensions of the right to health

Under international human rights law, the right to health has been understood as a complex right that includes different freedoms and entitlements.[1] Based on both the text of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which recognizes a right to health, and the work of the United Nations Committee on Economic, Social and Cultural Rights (CESCR), these different

[1] Committee on Economic, Social and Cultural Rights, "General Comment No. 14 (2000) on the Right to the Highest Attainable Standard of Health," August 11, 2000, para. 8, https://digitallibrary.un.org/record/425041.

freedoms and entitlements may be interpreted as falling into three distinct yet interrelated dimensions of this right: autonomy, prevention and health care.[2] The autonomy dimension includes those components that are linked to the right of individuals to control one's health and body, including sexual and reproductive freedom and the rights to informed consent, access to information, medical confidentiality and freedom from interference, to name a few. The prevention aspect relates to States' individual and joint obligations to prevent and control diseases and, in general, to create the conditions that allow people to lead a healthy life. Lastly, the health care dimension focuses on access to health goods and services and integrates palliative, curative and rehabilitative health.[3]

Racial discrimination has been shown to have a significant impact on all three dimensions. The Draft General Recommendation effectively illustrates this when analyzing the meaning and content of the right to health under Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). For instance, the freedom dimension is reflected in the discussion of the obligation to eliminate racial discrimination in information accessibility and the right to control one's health and body; while the prevention and health care components permeate the analysis of racial discrimination in the right to public health, including healthcare facilities, services and goods.[4]

We believe that the comprehensive understating of the right to health presented in the Draft General Recommendation can serve as a valuable tool for States in fulfilling their obligations under ICERD for different reasons. First, by identifying all components of this right, the Committee distinguishes itself from the theories that view the right to health solely in terms of the provision of health goods and services. Thinking about health in three dimensions sheds light on other components of this right where racial discrimination is pervasive, and enables States to recognize racism as a key social determinant through which to analyze all aspects of this right (e.g., How racial inequalities may impact the way in which informed consent is thought of, the type of measures needed to prevent a disease, and/or the type of health goods and services needed for that group).

2.2 Comprehensive understanding of the equality and non-discrimination framework

The Draft General Recommendation similarly embraces a comprehensive understanding of equality and non-discrimination, both as rights and guiding principles for the enjoyment of the right to health under ICERD. It acknowledges both formal and material equality and recognizes the negative and positive dimensions of this right. Furthermore, it (i) addresses the various forms in which racial discrimination hinders health; (ii) clarifies how racial discrimination in health can be direct and indirect; and (iii) provides insight into how it operates on micro and macro levels.[5]

In this regard, the draft also effectively grasps the concept of racism as a form of structural discrimination, putting emphasis on the fact that this form of discrimination is not isolated or episodic, but rather deeply rooted in society and health systems as a result of colonialism, slavery and other historical power imbalances.[6]

It is also valuable that the draft refers to intersectionality as a guiding principle for determining State obligations. This approach helps explain how racial discrimination can be compounded by

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[2] Ibid., paras. 8, 44; For a further development of the three interrelated dimensions of the right to health, see Claudia Sarmiento Ramírez, Fernanda Umbach Montero, and Pascual Cortés Carrasco, eds., *¿Cómo Debe Incorporar Una Nueva Constitución El Derecho a La Salud? Oportunidades y Desafíos Del Proceso Constituyente*, 2020, 77.

[3] *¿Cómo Debe Incorporar Una Nueva Constitución El Derecho a La Salud? Oportunidades y Desafíos Del Proceso Constituyente*, 77–79.

[4] Committee on the Elimination of Racial Discrimination, "First Draft General Recommendation No. 37 (2023) on Racial Discrimination in the Enjoyment of the Right to Health," General Recommendation, May 5, 2023, paras. 7, 11–12, 17–22, https://www.ohchr.org/en/documents/general-comments-and-recommendations/first-draft-general-recommendation-no-37-2023-racial.

[5] Ibid., paras. 7, 9.

[6] Ibid., paras. 4, 5.

discrimination associated with other factors such as gender, age, disability, migratory status, class, social status and income. The Draft General Recommendation also emphasizes how the use of racial stereotypes, preconceived ideas or prejudices are a form of discrimination that is affecting different components of the right to health.

We believe that this robust understanding of equality and non-discrimination provides fertile ground for disseminating legal standards and formulating actionable recommendations under Article 5 (e) (iv) of ICERD. It can also encourage States to undertake a thorough and broad review of their legal and policy frameworks to not only identify potential discriminatory impacts on the persons and groups within the purview of ICERD but also assess the broader risks to the enjoyment of health and other related entitlements.

2.3 Inclusion of current global challenges

We similarly commend CERD for exploring the linkages between racial discrimination and current global threats to health and human rights, including climate change, public health emergencies like COVID-19, natural disasters and emerging technologies.[7] This not only highlights the complexity of these issues but also underscores how the persons and groups protected by ICERD are or will be disproportionately affected by them. In turn, this last point can guide States towards more effective policies to respond to these pressing challenges, including tailored regulation and efficient resource allocation.

2.4 Comprehensive understanding of the role of data to avoid discrimination in health

Finally, another positive aspect of the Draft General Recommendation is the in-depth examination of the role of data in identifying and addressing racial discrimination in health.[8] We believe this aligns with CERD's repeated emphasis on this issue in its concluding observations on periodic reports submitted by States. Certainly, the Committee had repeatedly highlighted that the lack of statistical data disaggregated by affected groups makes it difficult to assess the enjoyment of the right to health by communities that are traditionally affected by racial discrimination.[9]

3 Potential Areas for Further Elaboration in the General Recommendation

3.1 Universal Health Coverage as a means to address racial discrimination in health care facilities, goods and services

In the Draft General Recommendation, the Committee cites World Health Assembly resolutions and Political Declarations on Universal Health Coverage (UHC).[10] We believe that it would be valuable for the final version of this General Recommendation to provide a more detailed explanation of how UHC can play a pivotal role in addressing racial discrimination in the enjoyment of the right to health.

In essence, UHC embodies some of the ultimate goals of health systems: system-wide effective coverage combined with universal financial protection.[11] UHC is meant to ensure that everyone will have access to the full range of quality health services they need, when and where they need them, on a non-discriminatory basis and without financial hardship.[12]

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[7] Ibid., paras. 5, 10.

[8] Ibid., paras. 32–35.

[9] See, for example, Committee on the Elimination of Racial Discrimination, "Concluding Observations on the Eleventh and Twelfth Periodic Reports of Suriname," March 13, 2009, para. 15, https://digitallibrary.un.org/record/650538?ln=en.

[10] Committee on the Elimination of Racial Discrimination, "Draft General Recommendation No. 37," para. 8.

[11] Joseph Kutzin, "Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy," *Bulletin of the World Health Organization* 91, no. 8 (August 1, 2013): 602–11, https://doi.org/10.2471/BLT.12.113985.

[12] World Health Organization, "Universal Health Coverage (UHC)," accessed September 7, 2023,

UHC can be a means to break down systemic racism within health systems and address many of the concerns identified by CERD in the draft. By extending coverage of health goods and services to anyone who needs it regardless of race, color, descent, national or ethnic origin, UHC can help solve the disproportionately unequal coverage of persons belonging to groups within the purview of ICERD[13]. It can also improve the overall availability, accessibility, acceptability and quality of health care for these groups. Certainly, in countries like the United Kingdom, some existing evidence has suggested that the provision of universal coverage can substantially reduce –and almost eliminate– inequities in primary care access and quality.[14] Extension of coverage has also been associated with improved mortality outcomes, poverty reduction, and protection from debilitating financial debt.[15]

3.2 The immediate nature of ensuring non-discrimination in the enjoyment of the right to health

Under international human rights law, ensuring non-discrimination in the enjoyment of rights is part of the immediate obligations of States. The CESCR has repeatedly established that:

> While the [International Covenant on Economic, Social and Cultural Rights] provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes various obligations which are of immediate effect. Of these, two are of particular importance in understanding the precise nature of States parties obligations. One of these (…) is the "undertaking to guarantee" that relevant rights "will be exercised without discrimination ..."[16]

In the context of the right to health, this committee has also indicated that "States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2)".[17] Regional human rights bodies, like the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights have similarly indicated that States have an immediate obligation to ensure that economic, social and cultural rights shall be exercised in conditions of equality and without discrimination.[18]

While the Draft General Recommendation appropriately recognizes the prohibition of racial discrimination as a peremptory (or *jus cogens*) norm of international law, the document does not comment explicitly on the fact that eliminating racial discrimination in the enjoyment of the right to health is an obligation of immediate effect.

In this sense, we consider that CERD could leverage CESCR's developments on non-discrimination as an immediate obligation to emphasize that the measures to be adopted under Article 5 (e) (iv) of ICERD are of immediate effect and should not necessarily be contingent upon resource availability.

3.3 The preventive dimension of the right to health and the commercial determinants of health framework

As mentioned, the Draft General Recommendation refers to different State obligations that fall under the preventive component of the right to health. The draft explicitly highlights preventive health as one of the

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https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

[13] Committee on the Elimination of Racial Discrimination, "Draft General Recommendation No. 37," para. 12.b.

[14] Miqdad Asaria et al., "How a Universal Health System Reduces Inequalities: Lessons from England," *J Epidemiol Community Health* 70, no. 7 (July 1, 2016): 637–43, https://doi.org/10.1136/jech-2015-206742.

[15] The Commonwealth Fund, "How Health Care Coverage Expansions Can Address Racial Equity," February 2, 2022, https://doi.org/10.26099/DV2W-6P52.

[16] Committee on Economic, Social and Cultural Rights, "General Comment No. 3 (1990) The Nature of States Parties' Obligations," December 14, 1990, para. 1, https://digitallibrary.un.org/record/425041.

[17] Committee on Economic, Social and Cultural Rights, "General Comment No. 14," August 11, 2000, para. 30.

[18] See, for example, Inter-American Commission on Human Rights, "Compendium. Equality and Non-Discrimination. Inter-American Standards.," February 12, 2019, para. 46, https://www.oas.org/en/iachr/reports/pdfs/Compendium-EqualityNonDiscrimination.pdf; Case of Vera Rojas et al. v. Chile (Inter-American Court of Human Rights October 1, 2021).

essential elements of the right to public health[19] and underscores the importance of providing access to preventive care.[20] However, we believe this analysis could benefit from further development regarding:

i. the role of evidence in policies with proven potential to prevent diseases that disproportionately affect individuals and groups protected under ICERD; and

ii. the notion of commercial determinants of health as a lens through which to interpret the Sate obligations to eliminate racial discrimination in the enjoyment of the right to health.

CERD could refer to the work of other United Nations treaty bodies and special procedures who have addressed this topic within the context of the right to health, considering its interrelationship with the right to enjoy the benefits of scientific progress and its applications.

For instance, Dainius Pūras, the former Special Rapporteur on the right to health, has covered the role of evidence while studying State obligations with respect to the prevention of non-communicable diseases[21] –which the draft identifies as disproportionately affecting individuals under the purview of ICERD.[22] In that context, the Special Rapporteur considered that States were under a duty to formulate preventive policies in accordance with the best scientific evidence, free from conflicts of interest, available at the time.[23] By the same token, Pūras has warned against the biased use of evidence in the design of public health policies, particularly in the realm of mental health.[24] Both lines of analysis could enrich the current text of the recommendation, particularly considering the references to the role of data in combatting racial discrimination in this space.

On the subject of the commercial determinants of health ("CDoH"), we hold the view that CERD's analysis can benefit from making express reference to this theoretical framework. According to the World Health Organization (WHO), CDoH "are a key social determinant, and refer to the conditions, actions and omissions by commercial actors that affect health".[25] This framework complements the social determinants approach used by CERD in the draft, and specifically refers to the different ways in which commercial activities may contribute to direct or indirect racial discrimination in health.

The CDoH framework can also help reinforce some of the concerns expressed by CERD in the draft, like "evidence-based racial tobacco and alcohol disparities".[26] As part of the duty to "recognize the causes of mortality and morbidity affecting disproportionately groups within the purview of the Convention",[27] it is necessary for States to address the role that the tobacco and alcohol industry, among other private actors, are playing in this health outcomes.

For example, in the case of tobacco, there is ample evidence on how certain industry practices have

[19] Committee on the Elimination of Racial Discrimination, "Draft General Recommendation No. 37," para. 12.
[20] Ibid., para. 16.
[21] Office of the High Commissioner for Human Rights, "Statement by the UN Special Rapporteur on the Right to Health on the Adoption of Front-of-Package Warning Labelling to Tackle NCDs," accessed September 7, 2023, https://www.ohchr.org/en/statements/2020/07/statement-un-special-rapporteur-right-health-adoption-front-package-warning.
[22] Committee on the Elimination of Racial Discrimination, "Draft General Recommendation No. 37," para. 11.
[23] Office of the High Commissioner for Human Rights, "Statement by the UN Special Rapporteur on the Right to Health on the Adoption of Front-of-Package Warning Labelling to Tackle NCDs."
[24] Office of the High Commissioner for Human Rights, "Statement by Mr Dainius Pūras, Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health at the 35th Session of the Human Rights Council," accessed September 7, 2023, https://www.ohchr.org/en/statements/2017/09/statement-mr-dainius-puras-special-rapporteur-right-everyone-enjoyment-highest.
[25] World Health Organization, "Commercial Determinants of Health," accessed September 7, 2023, https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health.
[26] Committee on the Elimination of Racial Discrimination, "Draft General Recommendation No. 37," para. 12.a.i.
[27] Ibid.

historically contributed to poor health outcomes for groups protected by ICERD.[28] In the United States alone, the tobacco industry has specifically directed its advertising and promotion of tobacco products towards Hispanic and American Indian/Alaska Native communities by issuing cigarette brands with names like *Rio*, *Dorado*, and *American Spirit*.[29] In the case of African American communities, the industry employed diverse strategies to aggressively market its menthol cigarettes, including (i) campaigns that use urban culture and language to promote these products, (ii) tobacco-sponsored hip-hop bar nights with samples of specialty menthol cigarettes, and (iii) targeted direct-mail promotions.[30] Asian Americans have also been the subject of aggressive marketing by this industry through (i) sponsorship of Chinese and Vietnamese New Year festivals and other activities related to Asian/Pacific American Heritage Month; (ii) heavy billboard and in-store advertisements in predominantly urban Asian American communities; and (iii) financial and in-kind contributions to community organizations and Asian American business associations.[31]

The same can be said with respect to the food and beverage industry, which has made use of the expertise, personnel, and resources from the tobacco industry[32] to expand their market shares through targeted advertising. In Latin America, for example, companies like Nestle have begun implementing marketing strategies targeting low income communities in Brazil;[33] while other actors like Coca-Cola are targeting indigenous communities in Mexico.[34]

It should be noted that the persons and groups protected by ICERD are also fertile ground for industry activities that can deepen racial inequities in health. Literature has explained that certain groups, like the Hispanic population in the United States, can become an attractive consumer market for a variety of industries because it is (i) measurable (of quantifiable size and purchasing power); (ii) substantial (large and profitable); (iii) accessible (geographically concentrated); and (iv) actionable (which means that effective marketing strategies can be designed to attract and serve this group).[35]

3.4 Emphasizing the underlying causes behind the disproportionate impact of COVID-19

The Draft General Recommendation explains that the COVID-19 pandemic further deepened structural inequalities affecting the groups protected by ICERD, leading to intersecting forms of discrimination and higher levels of morbidity and mortality.[36]

While CERD hints to some of the reasons behind this disproportionate impact, including slavery and

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[28] See, for example, D. J. Moore, J. D. Williams, and W. J. Qualls, "Target Marketing of Tobacco and Alcohol-Related Products to Ethnic Minority Groups in the United States," *Ethnicity & Disease* 6, no. 1–2 (1996): 83–98; Centers for Disease Control and Prevention, "Tobacco Use Among U.S. Racial/Ethnic Minority Groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General," 1998; Lisbeth Iglesias-Rios and Mark Parascandola, "A Historical Review of R. J. Reynolds' Strategies for Marketing Tobacco to Hispanics in the United States," *American Journal of Public Health* 103, no. 5 (May 2013): e15–27, https://doi.org/10.2105/AJPH.2013.301256.

[29] Centers for Disease Control and Prevention, "Tobacco Industry Marketing," August 22, 2022, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/marketing/index.htm.

[30] Ibid.

[31] Ibid.

[32] Kim H. Nguyen et al., "Transferring Racial/Ethnic Marketing Strategies From Tobacco to Food Corporations: Philip Morris and Kraft General Foods," *American Journal of Public Health* 110, no. 3 (March 2020): 329–36, https://doi.org/10.2105/AJPH.2019.305482.

[33] Andrew Jacobs and Matt Richtel, "How Big Business Got Brazil Hooked on Junk Food," *The New York Times*, September 16, 2017, sec. Health, https://www.nytimes.com/interactive/2017/09/16/health/brazil-obesity-nestle.html.

[34] Jo Tuckman, "Coca-Cola Country in Southern Mexico – Photo Essay," *The Guardian*, November 15, 2019, sec. World news, https://www.theguardian.com/world/2019/nov/15/coca-cola-country-in-southern-mexico-photo-essay.

[35] Iglesias-Rios and Parascandola, "A Historical Review of R. J. Reynolds' Strategies for Marketing Tobacco to Hispanics in the United States."

[36] Committee on the Elimination of Racial Discrimination, "Draft General Recommendation No. 37," para. 5.

colonialism, we believe that the final recommendation could benefit from a more detailed explanation of the overlapping causes that can drive health inequities in these type of health emergencies.

Indeed, health disparities related to COVID-19 likely resulted from the intersection of multiple factors relating to marginalization, discrimination, and unequal access to health for individuals and groups protected by ICERD.[37] Some of the factors that could have compounded each other in ways that increased the risks of COVID-19 and other diseases for these groups include:

i. higher poverty rates,[38] resulting in limited access to some of the key social determinants of health such as housing, adequate and nutritious food, and safe water and sanitation services. This, in turn, severely affected their ability to comply with some of the public health measures adopted by States in response to the COVID-19 pandemic, including frequent hand washing, physical distancing and isolation.

ii. historical disparities in access to health goods and services, including the lack of infrastructure and access to health services[39] and the undermining of their ancestral knowledge and traditional medicine practices due to the deterioration and loss of their natural habitat.[40]

iii. disproportionate prevalence of underlying health conditions that exacerbated the risks of severe illness or death from COVID-19. Racial disparities in access to health care, including early diagnosis and preventive care, have been associated with higher prevalence of HIV, HIV-associated infections such as tuberculosis, diabetes, systemic arterial hypertension, stroke and certain types of cancers; and[41]

iv. racially discriminatory policing and incarceration, exposing these groups to (i) higher risks of infection in detention, and (ii) increased stress and anxiety, which can also increase the risk of serious illness from COVID-19.[42]

Some of these factors have already been examined by CERD in its concluding observations on periodic reports submitted by States.

It would also be valuable for the final version of this recommendation to explicitly reference disparities in COVID-19 vaccination rates. While disparities have fluctuated over the course of the pandemic, there were large gaps in vaccination for certain groups protected by ICERD in the initial phase of the vaccine rollout.[43] As noted by CERD, ethnic and ethno-religious groups, indigenous peoples, migrants, asylum seekers and refugees initially had

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[37] Office of the High Commissioner for Human Rights, "Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities Needs to Be Urgently Addressed – Bachelet," accessed September 8, 2023, https://www.ohchr.org/en/press-releases/2020/06/disproportionate-impact-covid-19-racial-and-ethnic-minorities-needs-be.

[38] See, for example, Committee on the Elimination of Racial Discrimination, "Concluding Observations on the Fourth and Fifth Periodic Reports of Slovakia," December 10, 2004, para. 11.

[39] See, for example, Committee on the Elimination of Racial Discrimination, "Concluding Observations on the Combined Fourth to Sixth Periodic Reports of Paraguay," October 4, 2016, para. 35.

[40] Comisión Económica para América Latina y el Caribe, *Decenio Internacional para los Afrodescendientes: breve examen en el marco de la pandemia de COVID-19 en América Latina y el Caribe* (CEPAL, 2023), https://www.cepal.org/es/publicaciones/48660-decenio-internacional-afrodescendientes-breve-examen-marco-la-pandemia-covid-19.

[41] Comisión Económica para América Latina y el Caribe, *Afrodescendientes y la matriz de la desigualdad social en América Latina: retos para la inclusión* (CEPAL, 2020), https://www.cepal.org/es/publicaciones/46191-afrodescendientes-la-matriz-la-desigualdad-social-america-latina-retos-la.

[42] "US: Covid-19 Disparities Reflect Structural Racism, Abuses," *Human Rights Watch* (blog), June 10, 2020, https://www.hrw.org/news/2020/06/10/us-covid-19-disparities-reflect-structural-racism-abuses.

[43] KFF, "COVID-19 Cases and Deaths, Vaccinations, and Treatments by Race/Ethnicity as of Fall 2022," *KFF* (blog), accessed September 8, 2023, https://www.kff.org/racial-equity-and-health-policy/issue-brief/covid-19-cases-and-deaths-vaccinations-and-treatments-by-race-ethnicity-as-of-fall-2022/.

limited access to vaccines.[44] In the United States alone, by late 2022, there was still a vaccination gap persists for people of African descent.[45] Racial disparities did not only operate within countries, but also globally. Certainly, the United Nations Special Rapporteur on contemporary forms of racism noted that, as of June 2022, 72.09% of people in high income countries had been vaccinated with at least one dose of the COVID-19 vaccine, whereas only 17.94% of people in low-income countries have been vaccinated.[46] The Rapporteur noted that because the ones affected by this unequal distribution "are racially marginalized peoples, unequal access to COVID-19 vaccines and treatments within and between nations is undeniably an issue of racial injustice".[47] These concerns may be arise during current or future emerging disease outbreaks, like Mpox,[48] underscoring the importance of including an explicit reference in the recommendation.

3.5 Identifying explicit and implicit racial biases that affect the enjoyment of the right to health

Explicit and implicit racial biases within health systems can serve as both institutional and individual barriers that hinder the enjoyment of the right to health for different persons and groups protected by ICERD. Biases are also a good case of intersectional discrimination in the context of healthcare, among many others: different vulnerable groups may encounter distinct sets of biases in healthcare. As a result, biases can overlap, compounding health disparities for specific individuals or groups. For instance, an indigenous woman with a disability seeking access to health may simultaneously face the biases that are traditionally associated with indigenous peoples, women, and persons with disabilities.

For this reason, we consider that the issue of biases and their linkages with racial discrimination in health warrant further development. The Draft General Recommendation appropriately names some of them (e.g. Bias against traditional medicine[49]). Yet, the text could be amended to name and expand other forms of bias that have been examined by the literature and other United Nations mechanisms, including:

i. The claim that racial-ethnic minority patients, in particular people of African descent, have thicker skin and do not feel pain.[50]

ii. The fact that racial-ethnic minority patients presenting with vague conditions often associated with drug-seeking behavior, may be more likely to be judged as "a drug-seeker" relative to other patients presenting with similar pain-related complain.[51]

iii. The common use of terms such as "difficult," "challenging," and "resistant" to describe patients belonging to groups protected by ICERD, under the belief that they are less likely to make responsible informed decisions or follow professional advice.[52]

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[44] Committee on the Elimination of Racial Discrimination, "Concluding Observations on the Combined Fourth to Eighth Reports of Thailand," February 10, 2022, para. 38.

[45] KFF, "COVID-19 Cases and Deaths, Vaccinations, and Treatments by Race/Ethnicity as of Fall 2022."

[46] Office of the High Commissioner for Human Rights, "UN Expert Urges States to End 'Vaccine Apartheid,'" June 14, 2022, https://www.ohchr.org/en/press-releases/2022/06/un-expert-urges-states-end-vaccine-apartheid.

[47] Ibid.

[48] Krishna Kiran Kota, "Racial and Ethnic Disparities in Mpox Cases and Vaccination Among Adult Males — United States, May–December 2022," *MMWR. Morbidity and Mortality Weekly Report* 72 (2023), https://doi.org/10.15585/mmwr.mm7215a4.

[49] Committee on the Elimination of Racial Discrimination, "Draft General Recommendation No. 37," para. 12.

[50] Tlaleng Mofokeng, "Report by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. Racism and the Right to Health," para. 49, accessed September 8, 2023, https://www.ohchr.org/en/documents/thematic-reports/a77197-report-special-rapporteur-right-everyone-enjoyment-highest.

[51] Astha Singhal, Yu-Yu Tien, and Renee Y. Hsia, "Racial-Ethnic Disparities in Opioid Prescriptions at Emergency Department Visits for Conditions Commonly Associated with Prescription Drug Abuse," ed. Soraya Seedat, *PLOS ONE* 11, no. 8 (August 8, 2016): e0159224, https://doi.org/10.1371/journal.pone.0159224.

[52] Michael Sun et al., "Negative Patient Descriptors: Documenting Racial Bias In The Electronic Health Record,"

It would also be important to emphasize that implicit biases can be more widespread among people that participate in the health sector than one might expect, precisely because they operate unconsciously. For instance, a 2013 study conducted on 210 primary care providers in the United States revealed implicit biases against Latinos and African Americans in approximately two thirds of those providers.[53]

Finally, we also consider it would be important for CERD to draw a more direct link between racial biases and the interrelated and essential elements of the right to health. In particular, it would be useful to reinforce that biases affect at least the *quality* and *acceptability* of health facilities, goods and services specifically because they have a significant impact on the attitudes, diagnoses, and treatment decisions of health professionals. Certainly, “a variety of studies, conducted in various countries, using different methods, and testing different patient characteristics, found evidence of implicit biases among healthcare professionals and a negative correlation between level of implicit bias and indicators of quality of care”.[54]

3.6 Racial discrimination in sexual and reproductive health

When discussing abortion, the Draft General Recommendation adequately explains that, because persons within the purview of ICERD are at a higher risk of unwanted pregnancies, restrictive abortion policies are likely to disproportionately affect them and potentially exacerbate adverse birth outcomes. We consider that it would be important to reinforce this analysis by explaining how the criminalization of abortion may increase pre-existing racial disparities in incarceration rates, a higher likelihood of poverty years after birth, and lower access to healthcare for these groups.[55] It should also be noted that, by generating a chilling effect on the open exchange of information and data collection, criminalization further exacerbates the underreporting of important health indicators which can impede monitoring racial inequities in health.[56]

Finally, it would be pertinent to include a reference to the principle of non-retrogression in laws providing access to safe, legal and effective abortion as a way to prevent reintroducing restrictions that disproportionately impact groups protected by ICERD and, therefore, are indirectly discriminatory. It would be relevant for CERD to express concern regarding attempts to overturn abortion laws, considering that the Committee has already expressed similar concerns in other contexts. For instance, in its concluding observations on the combined tenth to twelfth reports of the United States, CERD expressed deep concern for “the Supreme Court’s ruling in Dobbs v. Jackson Women’s Health Organization, of 24 June 2022, which overturned nearly 50 years of protection of women’s access to safe and legal abortion in the State party” due to the disparate impact on the sexual and reproductive health and rights of racial and ethnic minorities. In that context, CERD recommended taking all measures necessary to address these impacts.[57]

3.7 The disproportionate impacts of climate change

Although the Draft General Recommendation mentions some of the negative health outcomes that are linked to climate change, the Committee might consider including more concrete examples of the disproportionate impacts of climate change on protected groups.

Health Affairs 41, no. 2 (February 2022): 203–11, https://doi.org/10.1377/hlthaff.2021.01423.

[53] Irene V. Blair et al., “Assessment of Biases Against Latinos and African Americans Among Primary Care Providers and Community Members,” *American Journal of Public Health* 103, no. 1 (January 2013): 92–98, https://doi.org/10.2105/AJPH.2012.300812.

[54] Chloë FitzGerald and Samia Hurst, “Implicit Bias in Healthcare Professionals: A Systematic Review,” *BMC Medical Ethics* 18 (March 1, 2017): 19, https://doi.org/10.1186/s12910-017-0179-8.

[55] “Abortion Bans Prove yet Again There Is No Race-Neutral Policy,” Economic Policy Institute, accessed September 8, 2023, https://www.epi.org/blog/abortion-bans-prove-yet-again-there-is-no-race-neutral-policy/.

[56] Anand Grover, “Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,” August 3, 2011, https://digitallibrary.un.org/record/710175.

[57] Committee on the Elimination of Racial Discrimination, “Concluding Observations on the Combined Tenth to Twelfth Reports of the United States of America,” September 21, 2022, paras. 35–36, https://www.ohchr.org/en/documents/concluding-observations/cerdcusaco10-12-concluding-observations-combined-tenth-twelfth.

In particular, it would be important to expand on the disparate impact on indigenous groups, who are among the first to face the direct consequences of climate change due to their dependence upon, and close relationship with, the environment and its resources.[58] On this topic, for example, the Intergovernmental Panel on Climate Change (IPCC) has documented that "as 80% of the world's remaining biodiversity is on Indigenous homelands, these losses have cascading impacts on cultural and linguistic diversity and Indigenous knowledge systems, food security, health, and livelihoods, often with irreparable damage and consequences".[59] IPCC has similarly explained that people living in poverty, racial minorities and those ageing are more vulnerable to climate-induced water hazards and that their adaptive capacity is limited.[60]

We believe that including some of these examples would help identify and make visible the specific racial or ethnic groups are most affected by climate change and guide States in the design of tailored mitigation and adaptation measures.

4 Topics that are absent or slightly addressed

4.1 Harmful practices as a form of discrimination

The Draft General Recommendation does not refer to harmful practices and how they might affect the enjoyment of the right to health. We believe that, in alignment with previous statements made by CERD and by other United Nations treaty mechanisms, this topic should be included in the final version of the document to ensure consistency in the interpretation and implementation of ICERD and other human rights treaties.

In fact, in its most recent concluding observations to the periodic reports submitted by States, CERD has expressed concern at the continuation of harmful customary practices against women and girls protected by ICERD, such as the payment of dowry, which was considered by the Committee as tantamount to child and/or forced marriage.[61] In a different observation, CERD similarly conceptualized harmful practices as a form of intersecting discrimination on the grounds of sex, race, ethnicity and age.[62] Within the United Nations system, the Committee on the Rights of the Child (CRC) and the Committee on the Elimination of Discrimination against Women (CEDAW) have similarly conceptualized harmful practices as a form of discrimination based on sex, gender and age, among other things. In a joint document, these committees explained that harmful practices are precisely grounded on discriminatory grounds and often justified by sociocultural and religious customs and values, in addition to misconceptions relating to some disadvantaged groups of women and children.[63]

Certain harmful practices can severely hinder the enjoyment of the right to health. In particular, female genital mutilation –the most prevalent and well documented of these practices– may have various health consequences, including severe pain, shock, infections and complications during childbirth, long-term gynecological problems such as fistula, psychological effects and death.[64]

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[58] United Nations Department of Economic and Social Affairs, "Climate Change," accessed September 8, 2023, https://www.un.org/development/desa/indigenouspeoples/climate-change.html.

[59] Hans-Otto Pörtner et al., eds., *Climate Change 2022: Impacts, Adaptation and Vulnerability. Contribution of Working Group II to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change.*, 2022, 47.

[60] Ibid., 656.

[61] Committee on the Elimination of Racial Discrimination, "Concluding Observations on the Combined Seventeenth to Nineteenth Periodic Reports of Zambia," June 3, 2019, paras. 23–24, https://digitallibrary.un.org/record/3862659?ln=en.

[62] Committee on the Elimination of Racial Discrimination, "Concluding Observations on the Combined Eighth to Tenth Periodic Reports of Kyrgyzstan," May 30, 2018, para. 15, https://digitallibrary.un.org/record/1628166?ln=en.

[63] Committee on the Elimination of Discrimination Against Women and Committee on the Rights of the Child, "Joint General Recommendation No. 31 of the Committee on the Elimination of Discrimination against Women / General Comment No. 18 of the Committee on the Rights of the Child (2019) on Harmful Practices," May 8, 2019, para. 7, https://digitallibrary.un.org/record/425041.

[64] Ibid., para. 19.

Considering that harmful practices are endemic in a wide variety of communities in most countries and often disproportionately affect the enjoyment of the right to health for certain racial or minority groups, we believe that the final General Recommendation should include this topic. Furthermore, since harmful practices have already been addressed by CERD and other UN bodies, this would not only align with previous United Nations work but also strengthen the importance of identifying and eradicating customary practices that disproportionately affect the health of individuals and groups under the purview of ICERD.

4.2 Other racial disparities in mental health care

The Draft General Recommendation extensively covers the effect of racism and racial discrimination on physical and mental health at the micro and macro levels. Yet, we believe it falls short in addressing some dimensions of institutional racism in health care. In particular, there is no reference to how structural racism may be leading to increased involuntary institutionalization of persons protected by ICERD in psychiatric hospitals. CERD had previously addressed this issue in its concluding observations to the United Kingdom, where it noted that another indicator of racial discrimination could be the overrepresentation of persons of Afro-Caribbean descent being treated in psychiatric institutions and the disproportionate use of restraint, seclusion and medication.[65] In this sense, the final version of this recommendation could benefit from a more detailed overview of this problem.

5 Conclusion

Our submission has sought to provide some insights and recommendations for the enhancement of the *Draft General Recommendation No. 37 (2023) on racial discrimination in the enjoyment of the right to health*. Throughout this document, we have highlighted both the strengths and areas for further development within the draft, emphasizing the need for further exploration of crucial issues that are at the intersection of racial discrimination and the right to health. We have similarly referenced previous statements by CERD and other United Nations mechanisms that the Committee could draw from to ensure consistency in the standards included in the final version of this document.

We express our gratitude for the opportunity to comment on this important draft. We hope our suggestions will help strengthen the General Recommendation and ultimately lead to more tailored standards and recommendations to State Parties.

We remain available to answer any questions the Committee might have in regards to this document. In the meantime, please accept our highest appreciation and regard,

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[65] Committee on the Elimination of Racial Discrimination, "Concluding Observations on the Combined Twenty-First to Twenty-Third Periodic Reports of the United Kingdom of Great Britain and Northern Ireland," October 3, 2016, para. 31, https://digitallibrary.un.org/record/1311152?ln=en.

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