31 August 2023

**Submission to the United Nations Committee on the Elimination of Racial Discrimination’s “Call for Contributions on the Draft General Recommendation No. 37 on Racial discrimination in the enjoyment of the right to health”**

Human Rights Watch would like to express our appreciation to the Committee on the Elimination of Racial Discrimination(CERD, or the “Committee”) for the opportunity to provide it with this submission, which responds to its call for contributions on the draft general recommendation No. 37 on racial discrimination in the enjoyment of the right to health.[[1]](#footnote-2)

Human Rights Watch is an independent, international non-governmental organization that investigates and reports on rights violations in over 100 countries worldwide. Human Rights Watch documents and reports on human rights abuses and directs advocacy toward governments, armed groups, and businesses, pressing them to change or enforce their laws, policies, and practices to respect and uphold rights for all.

For years, Human Rights Watch has investigated how systemic racism and intersectional discrimination oppress Black, Indigenous, and people of color (BIPOC) communities worldwide, documenting policies and practices of States and third parties that are inconsistent with international human rights law and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD, or the “Convention”), in particular.

Drawing from some of this research, Human Rights Watch recently provided the Committee with a submission during its 107th Session in August 2022, produced alongside colleagues from Amnesty International, the Global Justice Center, and the Southern Rural Black Women’s Initiative for Economic and Social Justice, which outlined policies of the United States government that disproportionately impact the human rights — and particularly the right to health — of BIPOC women in the country.[[2]](#footnote-3)

Human Rights Watch strongly supports the Committee’s effort to provide clarity and guidance on the obligations under ICERD regarding the right to health. This submission aims to advance this effort by recommending how the Committee can clarify and elaborate on specific language used in its “First draft General recommendation No. 37 (2023) on Racial discrimination in the enjoyment of the right to health” (Draft GR No. 37).[[3]](#footnote-4)

Copied below, we have included sections of Draft GR No. 37, each of which are followed by brief recommendations for clarification and elaboration that are based on our experience documenting human rights abuses and advocating with governments and other parties to respect, protect, and fulfil human rights and the right to health, in particular.

**Recommendations for Clarification and Elaboration**

The potential for the Committee’s general recommendation on racial discrimination and the right to health to provide clarity and guidance on the obligations under ICERD would be significantly strengthened by clarification in future drafts of the following provisions.

**II(B)(2)(a)(iii): “Failure to provide reasonable, proportionate and steadily progressive availability of primary health care, hospitals, clinics and other health-related services, trained medical and professional personnel, and essential medicine. Distribution of public health and health-care facilities, goods and services, as well as programmes, are oftentimes disproportionately lacking in areas where individuals and groups protected under the Convention are spatially concentrated.”[[4]](#footnote-5)**

We recommend that the Committee provide additional language in future drafts that clarifies the meaning of “reasonable, proportionate and steadily progressive,” as used in the context of II(B)(2)(a)(iii) above.

Given that the accepted standard under international human rights law (e.g., article 2.1 of the International Covenant on Economic, Social and Cultural Rights (ICESR) and Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 3) is that States’ have, inter alia, an obligation to realize rights “progressively,” we would appreciate the Committee’s clarification about what the qualifier “steadily” adds to this existing standard.[[5]](#footnote-6) We recommend that the Committee consider whether this qualifier strengthens the meaning of “progressive,” as opposed to weakening it. Similarly, we recommend that the Committee consider whether the call for “reasonable” and “proportionate” availability strengthens or weakens the existing standard.

We also recommend that the Committee provide non-exhaustive examples of healthcare policies that would be unreasonable, disproportionate, and not steadily progressive. It can also clarify what bodies of law or other objective standards the Committee draws upon to determine reasonableness, proportionality, and the steadily progressive nature of policies that impact healthcare availability.

Additionally, we would greatly appreciate further clarification from the Committee with respect to the temporal dimension of the States’ duty to progressively realize the right to health. In particular, given the Committee’s attention to the subjective perspectives of rights holders throughout Draft GR No. 37, we would appreciate any elaboration on whether and how the Committee may consider rights holders’ subjective experience of the time involved in progressive realization (i.e., “waiting for rights”) in considering how States may or may not be meeting their treaty obligations.[[6]](#footnote-7)

**II(B)(2)(b): “Structural racial discrimination nullifies or restricts disproportionately access of groups within the purview of the Convention to public health, healthcare facilities, services, and goods. Under the reporting procedure, the Committee has found that high number[s] of persons belonging to groups within the purview of the Convention do not have access to stable and affordable health care.”**

We recommend that the Committee provide additional language in future drafts that clarifies the meaning of “affordable health care” as used in the context of II(B)(2)(b) above.

In particular, we would appreciate the Committee’s clarification of whether, and if so when, the affordability of health care under ICERD requires that healthcare goods and services be freely available. For example, during the Covid-19 pandemic, vaccines were often distributed at no cost and treated as global public goods, a precedent which recognized that the right to health, particularly for socially and economically marginalized populations, sometimes required the provision of free health care.

As such, we would welcome the Committee’s elaboration on the circumstances under which effective access to health care requires that health goods and services be free to users rather than provided at reduced cost.

**II(B)(2)(b)-(b)(iii): “Under the reporting procedure, the Committee has found that high number[s] of persons belonging to groups within the purview of the Convention do not have access to stable and affordable health care. A number of causes, acts and omissions, lead to this outcome … (iii) Disproportionately unequal coverage due to discrepancies of distribution of resources within the State.”[[7]](#footnote-8)**

We strongly support the Committee’s clarification that “discrepancies of distribution” can be the cause of a States’ failure to ensure healthcare access in a manner consistent with its treaty obligations under ICERD. However, we recommend that the Committee provide additional language in future drafts that clarifies the meanings of both “disproportionately unequal coverage” and “discrepancies of distribution,” as used in the context of II(B)(2)(b)(iii) above.

Regarding “disproportionately unequal coverage,” we would appreciate the Committee’s clarification of whether and how it may ever consider the “unequal coverage” “due to discrepancies of distribution of resources” between individuals and communities protected by the Convention to be proportionate. If, however, the Committee considers "unequal coverage” due to “discrepancies of distribution” unacceptable under ICERD, we recommend that the Committee remove the qualifier “disproportionately.”

Regarding “discrepancies of distribution,” although the Committee includes a footnote to this paragraph citing to CERD’s 2022 concluding observations on Brazil, this document does not use this standard.[[8]](#footnote-9) Instead, it discusses “inadequate funding to implement policies” and the need to “prioritize vaccine distribution to indigenous communities.”[[9]](#footnote-10) As such, we would appreciate additional clarification about what the Committee may or may not consider to constitute a “discrepancy of distribution” that produces racial discrimination in physical, affordable, and information accessibility to health care. For example, the committee could provide additional, non-exhaustive examples of such policies, an explanatory parenthetical to the existing footnote, or additional information about quantitative metrics that can help establish discrepancies inconsistent with the Convention.

**II(B)(2)(b)-(b)(v): “Under the reporting procedure, the Committee has found that high number[s] of persons belonging to groups within the purview of the Convention do not have access to stable and affordable health care. A number of causes, acts and omissions, lead to this outcome … (v) Privatisation and commercialisation without due regard to accessibility in practice by persons subject to racial discrimination, including undocumented pregnant women… ”[[10]](#footnote-11)**

We strongly support the Committee’s attention to “privatisation and commercialization,” as well as its use of these two distinct terms, which reflect nuanced differences in circumstances and policy. To make the scope of the Committee’s attention clearer, we recommend that the Committee provide additional language in future drafts that clarifies the meanings of both “privatisation and commercialization” and “without due regard to accessibility in practice,” as used in the context of II(B)(2)(b)(v) above.

Regarding “privatisation and commercialization,” we would appreciate additional clarification about whether this includes situations where individuals and communities protected by the Convention are already heavily reliant on private sector actors for the delivery of healthcare goods and services, in addition to situations where States may be pursuing policies that increase this reliance on private actors (i.e., efforts to privatize or commercialize health care).

Additionally, we would appreciate additional clarification about what the Committee may or may not consider to constitute a “due regard to accessibility in practice.” In particular, it would be helpful for the Committee to elaborate, potentially through non-exhaustive examples, on the procedural responsibilities (i.e., “due regard”) of states parties with respect to preemptively assessing policies’ de facto (i.e., “in practice”) impacts on healthcare accessibility across its various dimensions.

**III(A)(25): “The status of the prohibition of racial discrimination in international law, as one of the most egregious forms of discrimination, and the link between the right to health and the right to life leave States a very narrow margin of appreciation in differentiations of treatment in fulfilling their obligations to respect the right to health.”**

We recommend that the Committee provide additional language in future drafts that clarifies the meaning of “very narrow margin of appreciation,” as used in the context of III(A)(25) above.

In particular, we would appreciate the Committee’s clarification about any bodies of law or other objective standards that may inform the Committee’s definition and application of the “very narrow margin of appreciation” standard in this context. For example, it would be helpful for the Committee to explain whether and how the margin of appreciation doctrine, as developed in European Court of Human Rights jurisprudence, may inform CERD’s understanding and application of this standard.

**Conclusion**

Human Rights Watch would like to thank the Committee again for the opportunity to provide comments on its “First draft General recommendation No. 37 (2023) on Racial discrimination in the enjoyment of the right to health.” As noted above, we strongly support the Committee’s effort to provide clarity and guidance on the obligations under ICERD regarding the right to health, and are hopeful that the above recommendations for clarification will contribute to this effort.

We would be happy to provide any additional information, and also welcome the opportunity to further discuss our recommendations. Please feel free to contact A. Kayum Ahmed ([ahmedk@hrw.org](mailto:ahmedk@hrw.org)), Matt McConnell ([mcconnm@hrw.org](mailto:mcconnm@hrw.org)), and Almaz Teffera ([teffera@hrw.org](mailto:teffera@hrw.org)) to arrange such a meeting.

Sincerely,

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| **A. Kayum Ahmed**  Special Advisor,  Right to Health  Human Rights Watch | **Matt McConnell**  Researcher,  Economic Justice & Rights  Human Rights Watch | **Almaz Teffera**  Researcher,  Racism in Europe  Human Rights Watch |

1. Office of the High Commissioner for Human Rights, Committee on the Elimination of Racial Discrimination, “Call for contributions: Draft General Recommendation n°37 on Racial discrimination in the enjoyment of the right to health,” <https://www.ohchr.org/en/calls-for-input/2023/call-contributions-draft-general-recommendation-ndeg37-racial-discrimination>. [↑](#footnote-ref-2)
2. See Global Justice Center, “United States of America: Submission to the United Nations Committee on the Elimination of Racial Discrimination, 107th Session, August 8 – 30, 2022,” July 15, 2022, <https://www.hrw.org/news/2022/07/15/us-joint-submission-united-nations-committee-elimination-racial-discrimination> (focusing on the disproportionate racialized human rights impacts of abortion restrictions, the shackling of pregnant prisoners, and racial inequalities in cervical cancer mortality). See also, Human Rights Watch & American Civil Liberties Union, “Joint Submission Regarding the United States’ Record Under the International Convention on the Elimination of All Forms of Racial Discrimination: Racial Discrimination in the United States,” August 8, 2022, <https://www.hrw.org/report/2022/08/08/racial-discrimination-united-states/human-rights-watch/aclu-joint-submission>. [↑](#footnote-ref-3)
3. 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,” May 12, 2023, CERD/C/GC/R.37, <https://www.ohchr.org/en/documents/general-comments-and-recommendations/first-draft-general-recommendation-no-37-2023-racial> (hereinafter “Draft GR No. 37”). [↑](#footnote-ref-4)
4. Ibid., at II(B)(2)(a)(iii) (underline added). [↑](#footnote-ref-5)
5. See International Covenant on Economic, Social and Cultural Rights, December 16, 1966, General Assembly resolution 2200A (XXI), <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights> (hereinafter “ICESCR”); Committee on Economic, Social and Cultural Rights (CESCR), “CESCR General Comment No. 3: The Nature of States Parties’ Obligations,” December 14, 1990, E/1991/23, <https://www.refworld.org/pdfid/4538838e10.pdf> (discussing ICESCR, Art. 2.1). [↑](#footnote-ref-6)
6. For further discussion of this concept, see, for example, K. G. Young, “Waiting for Rights: Progressive Realization

   and Lost Time,” *The Future of Economic and Social Rights*, Cambridge: Cambridge University Press, 2019. [↑](#footnote-ref-7)
7. Draft GR No. 37, at II(B)(2)(b)-(b)(iii) (underline added). [↑](#footnote-ref-8)
8. Committee on the Elimination of Racial Discrimination, “Concluding observations on the combined eighteenth to twentieth periodic reports of Brazil,” December 19, 2022, CERD/C/BRA/CO/18-20, <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2FC%2FBRA%2FCO%2F18-20&Lang=en>. [↑](#footnote-ref-9)
9. Ibid., at para. 15. [↑](#footnote-ref-10)
10. Draft GR No. 37, at II(B)(2)(b)(v) (underline added). [↑](#footnote-ref-11)