August 3rd, 2023

**Comments on the first draft of *General Recommendation N° 37 on racial discrimination in the enjoyment of the right to health***

Physicians for Human Rights Israel (PHRI) stands at the forefront of the struggle for human rights—the right to health in particular—in Israel and the occupied Palestinian territory. Founded in 1988 by a group of Palestinians and Israeli physicians, PHRI works to promote a just society where the right to health is granted equally to all people under Israel’s responsibility.

PHRI would like to extend its appreciation and gratitude to the Committee on the Elimination of Racial Discrimination, for its initiation of the process of drafting **General Recommendation N° 37 on racial discrimination in the enjoyment of the right to health** under Article 5 (e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (“ICERD”). Following the committees' call for contributions, we hereby submit PHRI's comments on that first draft.

**Section I, Introduction:**

**Paragraph 3**: With respect to the various contexts that ought to be taken into consideraton in order to "…recognise and combat patterns of hierarchies, classifications, unequal representation etc.": We ask the committee to consider adding an explicit mention of such *Political contexts*as life in areas of conflict, under oppressive regimes of occupation and apartheid. Leading Palestinian, Israeli and international organizations have spoken to the existence of a regime of apartheid in the occupied Palestinian territory and beyond, with PHRI previously delineating the impact of this apartheid regime on the right to health to the Committee.

**Section II,**  **The Convention and the right to health;**

**A. The meaning and content of the right to health under Article 5(e)(iv)**

**Paragraph 8**: with respect to the set of interconnected *areas* in the context of health, we ask the committee to explicitly address **the setting of prisons and detention facilities** as an important setting, area, public and social service which is of high relevance and impact for the assessment of racial discrimination in the context of health.

**B. Racial discrimination in the enjoyment of the right to health under Article 5 (e)(iv);**

**2. Racial discrimination in the right to public health, including healthcare facilities, services and goods;**

**Paragraph 11:**Here, the committee addresses the issue of intergenerational trauma and the ongoing health effects of slavery and colonialism. To this we propose to add such traumatic events as torture,[[1]](#footnote-1) trafficking in persons, and political persecution, including administrative detention and/or mass incarceration. Moreover, we request the committee to include, under "colonialism" a specific mention of the type of colonialism often referred to as "Settler colonialism", as it is contrasted with "Exploitation colonialism", which impacts social determinants of health and leads to consistent health inequities.[[2]](#footnote-2)

**Paragraph 12, *a* (iii):** Noting deliberate instances of de-development of the health system, as is evidenced in the occupied Palestinian territory, we request the Committee to include a specific mention of the impact of *de-development of health-services*, including when this is politically motivated, i.e., under regimes of occupation, apartheid and blockade. Leading Palestinian and Israeli human rights organizations have detailed the impact of Israeli policies on the de-development of the Palestinian healthcare system, including in the West Bank and Gaza, resulting in dramatic disparities between Palestinian and Israeli health indices. During the COVID-19 crisis, this resulted in extensive delays in the ability of the Palestinian Authority to supply vaccinations to the Palestinian populations, compared to the early and comprehensive access of Israeli citizens to these vaccines.[[3]](#footnote-3)

Furthermore, in discussing situations where individuals and groups protected under the convention are spatially concentrated, we believe further clarifications may be in order, as per the grounds and circumstances for such spatial concentrations, i.e., detention, occupation, refugee camps, etc.

**Paragraph 12, *b* (i):** Under the list of causes, acts and omissions that lead to the outcome of non-stable and affordable access to healthcare, we propose to add the existence of policies that are geared towards limiting access to helathcare of individuals and groups protected under the convention, to cover i.e., limitations on the freedom of movement in the context of access to healthcare, as well to cover limitations on treatment as coersive measures against marginalized groups, such as mirgant workers and asylum seekers.[[4]](#footnote-4) PHRI has long documented deliberate restrictions on freedom of movement placed on Palestinians seeking medical treatment by the Israeli authorities. When treatment isn’t available in a specific locality, e.g., Gaza, Palestinians must apply and secure a medical exit permit from the Israeli authorities to access Palestinian hospitals in East Jerusalem and the West Bank. According to the WHO, from 2019 to 2021, Israeli authorities did not approve on average 35% of patient permit applications from the Gaza strip.[[5]](#footnote-5) Various UN Committees have criticized this violation of the right to health, including the Committee on Economic, Social and Cultural Rights, which noted that it is “concerned about the lengthy and complicated exit-permit system, which has impeded the ability of residents of the Gaza Strip to access medically recommended treatment that is not available in Gaza in the West Bank, including East Jerusalem, in Israel and abroad. Furthermore, it is concerned that in recent years there has been a significant increase in the number of requests for permits that have been refused or delayed, with devastating consequences, including the death of patients waiting for permits and the carrying out of critical medical procedures on children without their parents at their side (art. 10 and 12).”[[6]](#footnote-6)

**Paragraph 15*:***With respect to the impact of climate change on the health of racial and ethnic minorities: We believe this should be measured also in the light of politically motivated policies. Thus, to the list at the end of paragraph 15 ("geographical location, socio-economic situation, cultural norms and intrinsic psychological factors") we propose to add "political factors and policies".

**C. Racial discrimination in the right to control one’s health and body**

**Paragraph 19:** In citing the grounds and causes for deprivation of liberty ("over policing, racial profiling, and overrepresentation in the penitentiary system") we ask the committee to acknowledge also politically motivated administrative detention as an important cause for deprivation of liberty for racial minorities, linked also to their overrepresentation in the penitentiary system. Moreover, we ask the committee to include and address the connection between insufficient health services (including mental health and welfare services) in communities with a high proportion of racial minorities, and the ways these correlate with their overrepresentation in the penitentiary system. Furthermore, we ask the committee to note thateven within deprivation of liberty settings, there is a pipeline of additional coercive measures used against racial minorities - e.g., the practice of solitary confinement within incarceration settings, that gravely impacts their overall physical and mental health. This has been noted by the [International Guiding Statement on Alternatives to Solitary Confinement,](https://www.phr.org.il/wp-content/uploads/2023/05/5298_SolitaryStetement_paper_Eng.pdf) an international consensus document that recommends that all prison systems collect individualized records on placement in solitary confinement, that includes noting whether an individual placed in solitary confinement belongs to a racial minority. Placement in solitary confinement beyond 15 days, or the use of solitary confinement against individuals with mental disabilities, may amount to torture and must be addressed within the current discussion.

**Section III. Obligations under ICERD**

**A. General and cross-cutting obligations;**

**Paragraph 25**: With respect to the concluding sentence "Article 5(e)(iv) must be read in conjunction with Articles 2, 4, 6 and 7 of the Convention": We request that the committee includes **Article 3** of the Convention, so as to make an explicit acknowledgment of the connection of crimes of apartheid and the right to enjoy the highest attainable standard of physical and mental health.

**B. Monitoring racial inequalities in health**

**Paragraphs 33-36**: Given the need to fully expose all forms racial discrimination, further emphasis ought to be made on the obligation of State-agencies and the relevant health (and other) authorities, to consistently collect and periodically **publish and/or** **render publicly available and accessible** all information on monitoring mechanisms, data collected and statistical information pertaining to racism and racial discrimination in access to health and the provision of medical treatment. This includes information and data collected in the healthcare system, in specific medical facilities and geographical regions, in public and social services, and in the incarceration settings, including the use of coercive measures against racial minorities.

**Section IV. Recommendations;**

1. **Legislative and policy related measures**

**Paragraph 38**: Here again, as was noted in paragraph 25 above, we request an explicit mention of Article 3 of the Convention, thereby making an explicit reference to the obligation to prevent, prohibit and eradicate all practices of racial segregation and apartheid in their connections to the adoption of comprehensive legislation against racial discrimination in the right to health in civil, administrative and criminal law.

**B. Data and statistics**

**Paragraph 45:** Monitoring of racial discrimination in health should also be made periodically and publicly available, i.e., for researchers as well as for human rights organizations and advocates.

Furthermore, under "…areas where coercive measures may disproportionately apply and affect groups within the purview of the Convention" please add all forms of detention settings (not solely prisons).

Last, but not least, we urge the committee to address the situation of **medical personnel** vis-à-vis dual loyalty considerations, which increase under oppressive regimes of occupation and/or apartheid. This is especially relevant to medical personnel working in detention settings. Given how such settings are funnels for increased number of minorities, we urge the committee to include mention for the need of health personnel working in detention settings to be independent and to include mechanisms to ensure non-discrimination with respect to the right to health and medical treatment. This must include the structural independence of medical personnel, including the need to ensure that custodial authorities are not responsible for health systems and medical personnel within incarceration settings, as recommended by the Committee against Torture.[[7]](#footnote-7)

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1. See for example, *Not Passive Victims: Towards the Rehabilitation of the Sinai Torture Survivors in Israel.* Physicians for Human Rights Israel, August 2016 <https://www.phr.org.il/wp-content/uploads/2016/11/2550_Sinai_Print_Eng-25.10.16-%D7%A1%D7%95%D7%A4%D7%99.pdf> [↑](#footnote-ref-1)
2. See, for example, Wispelwey, B. et al. (2023) ‘*Because its power remains naturalized: Introducing the settler colonial determinants of health’*, Frontiers in Public Health, 11. doi:10.3389/fpubh.2023.1137428. [↑](#footnote-ref-2)
3. See, for example, *Responsibility Shirked: Israel and the Right to Health in the Occupied West Bank during COVID-19*, Physicians for Human Rights Israel, August 2021, available at https://www.phr.org.il/wp-content/uploads/2021/08/4601\_ResponsibilityReport\_Eng\_digital-FINAL-VER.pd [↑](#footnote-ref-3)
4. See, for instance, *Excluded from Care: Status-Less Cancer Patients in Israel*. Physicians for Human Rights Israel August 2021 <https://www.phr.org.il/wp-content/uploads/2021/08/Excluded_From_Care.pdf>

   *Painful Exclusion*. Physicians for Human Rights Israel, November 2017 <http://cdn2.phr.org.il/wp-content/uploads/2017/11/painful-exclusion-report-english-phri-2017.pdf> [↑](#footnote-ref-4)
5. See *Right to Health. Barriers to health and attacks on health care in the Palestinian occupied territory, 2019-2021*. WHO Report 2022 <https://applications.emro.who.int/docs/9789292740887-eng.pdf?ua=1> [↑](#footnote-ref-5)
6. UN Committee on Economic, Social and Cultural Rights (CESCR), UN Committee on Economic, Social and Cultural Rights: Concluding Observations, Israel, 12 November 2019,

   E/C.12/ISR/CO/4, available at <https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW0fekJcyLVE4h%2FkYmh4jSatSY66nsJOxboaAu4bfCDK5HY6MTTcGy79Oycfl9hr1wv3zD%2FCRdXz86uGTURl%2BJvrNJQLfgjL9vVSE7OE5dJet> [↑](#footnote-ref-6)
7. UN Committee Against Torture (CAT), Concluding observations on the fifth periodic report of Israel, 3 June 2016, CAT/C/ISR/CO/5, available at: https://www.refworld.org/docid/57a99c6a4.html [accessed 2 August 2023] [↑](#footnote-ref-7)