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International Convention on the Elimination of All Forms of Racial Discrimination

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Committee on the Elimination of Racial Discrimination

General recommendation No. 37 (2024) on equality and freedom from racial discrimination in the enjoyment of the right to health*

I. Introduction

1. The realization of the right to equality and non-discrimination is an absolute prerequisite for the effective enjoyment of the right to the highest attainable standard of physical and mental health. Those rights are enshrined in numerous international human rights instruments,[1] and the health of all peoples has been recognized as "fundamental to the attainment of peace and security".[2] The commitment to ensuring healthy lives for all at all ages and to reducing inequalities within and among countries was renewed in the 2030 Agenda for Sustainable Development, namely in Sustainable Development Goals 3 and 10. Equality is embedded in the One Health approach, which is aimed at sustainably balancing and optimizing the health of people, animals and ecosystems[3] for global health security.

2. Employment, education, exposure to the physical environment, occupational hazards, housing, chemicals, air and water quality, sanitation and hygiene, climate change and economic, social and development policies have a significant impact on one's health and well-being, as they influence access to resources, opportunities and quality of life. Structural determinants have the largest impact on patterns of health inequities.[4] Racism, classism, sexism, ableism, xenophobia, homophobia and transphobia are among the structural determinants of health.[5]

3. Disadvantaged groups experience higher levels of exposure to health risks and higher levels of associated mortality,[6] while the denial of access to essential medicines, vaccines and other health products creates or perpetuates discrimination and exacerbates existing inequalities in the realization of the right to health,[7] including mental health. The legacies of

* Adopted by the Committee at its 113th session (5–23 August 2024).

1 See, e.g., International Covenant on Economic, Social and Cultural Rights, arts. 2 (2), 3 and 12; Convention on the Elimination of All Forms of Discrimination against Women, art. 12; Convention on the Rights of the Child, arts. 2 (2) and 24; Convention on the Rights of Persons with Disabilities, art. 25; and International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, arts. 43 and 45.

2 Constitution of the World Health Organization (WHO).

3 WHO, One Health High-Level Expert Panel, "The One Health definition and principles developed by OHHLEP" (2023).

4 WHO, *Operational Framework for Monitoring Social Determinants of Health Equity* (2024), p. 2. See also Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (WHO, 2008), p. 8; and World Health Assembly resolution WHA74.16.

5 WHO, *Operational Framework*.

6 WHO, *World Health Statistics 2023: Monitoring Health for the SDGs, Sustainable Development Goals* (2023).

7 A/HRC/53/50, para. 8.

colonialism, slavery and apartheid persist,[8] and States parties have shown reluctance to effectively acknowledge in their policies and actions the negative effects that continue to disadvantage people of African descent[9] and members of other racial and ethnic groups.

4. Evidence shows that reducing inequalities and eliminating racial discrimination in the enjoyment of the right to health have a positive effect on health outcomes.[10] This contributes to building healthier societies in which everyone's right to health is respected, protected and fulfilled. With the present general recommendation, the Committee addresses urgent calls for action, and aims to promote better coordination within and among States parties to clarify the measures under the International Convention on the Elimination of All Forms of Racial Discrimination necessary for eliminating racial discrimination and guaranteeing equal enjoyment of the right to health.[11]

II. Normative framework

A. Right to equality and freedom from racial discrimination in the enjoyment of the right to health

5. Articles 1 (1) and 5 (e) (iv) of the Convention provide for the right of everyone to be free from all forms of racial discrimination and for the right to equality in the enjoyment of the right to public health, medical care, social security and social services. All persons,[12] including those belonging to ethnic or minority groups, such as Roma, Travellers, members of Indigenous Peoples, members of castes, people of African descent, people of Asian descent, migrants, asylum-seekers, refugees, stateless persons and persons subjected to skin colour-based discrimination, including persons with albinism,[13] have the right to health irrespective of age, religion and belief, health status, disability, migratory status, class, socioeconomic status, sex, sexual orientation, gender identity, gender expression, sex characteristics or substance use.[14]

6. Under the Convention, health is understood in the light of article 12 (1) of the International Covenant on Economic, Social and Cultural Rights, namely as the highest attainable standard of physical and mental health, and is increasingly viewed through an ecocentric lens. This perspective resonates with elements of Indigenous Peoples' definitions of health, which include individual and collective dimensions and integrate spirituality, traditional medicine, biodiversity and interconnectedness,[15] and which are closely tied to the right to self-determination and supported by the principles of the United Nations Declaration on the Rights of Indigenous Peoples. The right to health extends not only to timely and appropriate healthcare but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.[16] This holistic approach is aligned with the text of article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination. Public health is focused on the prevention and control of disease and injury,

[8] A/HRC/54/4.
[9] General recommendation No. 34 (2011).
[10] WHO, *Operational Framework*, p. 29.
[11] The Committee held a thematic discussion on racial discrimination and the right to health during its 107th session, and four online regional consultations between July 2023 and March 2024. Observations were submitted by States parties, international organizations and agencies, national human rights institutions, civil society organizations, associations of health professionals, and academics.
[12] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 1.
[13] CERD/C/SEN/CO/19-23, paras. 22 and 23; and CERD/C/ZAF/CO/4-8, paras. 20 and 21.
[14] General recommendation No. 32 (2009), para. 7; and A/77/197, paras. 3 and 6.
[15] E/C.19/2023/5 and A/HRC/33/57. See also E/2013/43-E/C.19/2013/25, para. 4.
[16] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 11.

the improvement of underlying determinants of health, and the quality of interaction among authorities, health-related professionals and the population. Medical care integrates the right to timely and appropriate health goods and services and includes palliative, curative and rehabilitative health. Social security and social services, inextricably linked to societal efforts to improve the determinants of health, [17] are strategic rights in eliminating racial discrimination in health.[18]

1. Prohibition of all forms of racial discrimination

Direct, indirect and structural racial discrimination

7. The Convention prohibits direct and indirect discrimination.[19] This includes action, either acts or omissions, taken pursuant to laws, policies or practices that disproportionately disadvantage racial or ethnic groups, that have an unjustifiable disparate impact upon racial or ethnic groups[20] or that fail to secure adequate advancement for disadvantaged racial or ethnic groups to ensure equal enjoyment of their rights (art. 1 (4)). The status of the prohibition of racial discrimination in international law[21] necessitates the imposition of the strict scrutiny standard in assessing the proportionality[22] of the effect of any distinction, exclusion or restriction in the enjoyment of the right to health. A distinction based on the grounds of race, colour, descent or national or ethnic origin that nullifies, whether in law or practice, the exercise of the right to health is disproportionate to any legitimate aim and constitutes a violation of the Convention.

8. Discriminatory criteria, such as those based on race-based disease stereotyping, even where not explicitly stated in law, are still used as a basis for decision-making. Discriminatory practices, such as those based on the misrepresentation of traditional health practices, disadvantage individuals or groups protected under the Convention.

9. Discriminatory acts may be experienced individually, for example as lack of access to quality obstetric care,[23] or within a group, for example as geographic and residential segregation without access to healthcare providers.[24] Discriminatory omissions may be experienced individually, for example as the failure to offer a treatment owing to racial bias regarding the health status of the person, or may be group related, such as a failure to take measures against racism, including against stigmatization, labelling and scapegoating, which often results in discriminatory acts and even violence against groups and minorities.[25]

10. Racial discrimination also occurs at the structural level, particularly in relation to a lack of adequate policies addressing long-standing health inequities and high rates of poverty and social exclusion,[26] and is reflected in the low rate of participation by, and representation of, persons protected by the Convention in political and institutional decision-making processes; the limited social recognition and valuation of ethnic and cultural diversity; the disproportionate presence of persons protected by the Convention in prison populations;[27] and involuntary institutionalization in psychiatric hospitals, which disproportionately affects persons protected by the Convention.

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[17] Committee on Economic, Social and Cultural Rights, general comment No. 19 (2007), paras. 2, 29 and 30.

[18] General recommendations No. 27 (2000), para. 33, and No. 34 (2011), para. 55.

[19] General recommendation No. 32 (2009), para. 7; and *L.R. et al. v. Slovakia* (CERD/C/66/D/31/2003 and CERD/C/66/D/31/2003/Corr.1), para. 10.4.

[20] General recommendation No. 14 (1993), para. 2.

[21] A/77/10, p. 87.

[22] General recommendation No. 30 (2004), para. 4.

[23] Committee on the Elimination of Discrimination against Women, Da Silva *Pimentel* v. Brazil (CEDAW/C/49/D/17/2008), para. 7.7.

[24] General recommendation No. 27 (2000), para. 31.

[25] Statement 3 (2020) on the coronavirus disease (COVID-19) pandemic and its implications under the International Convention on the Elimination of All Forms of Racial Discrimination (A/76/18, para. 18).

[26] CERD/C/MEX/CO/16-17, para. 18; CERD/C/RWA/CO/13-17, para. 16; CERD/C/SLV/CO/18-19, para. 14; and CERD/C/HUN/CO/18-25, para. 20.

[27] General recommendation No. 34 (2011), paras. 5 and 6.

11. Structural inequalities were deepened during the coronavirus disease (COVID-19) pandemic, which exacerbated vulnerabilities linked to enduring practices of discrimination and exclusion.[28] The pandemic's disproportionate impact on individuals and groups protected by the Convention resulted from a combination of factors.[29] Higher poverty rates and limited access to social determinants of health hindered compliance with public health measures, such as handwashing and physical distancing. A higher prevalence of underlying health conditions increased their vulnerability to severe illness. Overpolicing and disproportionate incarceration heightened the risk of infection in detention and increased stress and anxiety levels, further contributing to the likelihood of serious illness.

Intersectional discrimination and inequalities

12. The prohibition of racial discrimination includes intersectionality as "a concept and a theoretical framework that facilitate comprehension of the ways in which social identities overlap and create compounding experiences of discrimination and concurrent forms of oppression"[30] on the grounds of race, colour, descent or national or ethnic origin and other grounds, such as age, religion and belief, health status, disability, migratory status, socioeconomic status, sex, sexual orientation, gender identity, gender expression or sex characteristics. For example, barriers in reproductive healthcare have a cumulative effect on Indigenous women and girls,[31] women and girls of African descent, women and girls belonging to ethnic minorities or castes, and gender-diverse persons; particularly affected among those groups are adolescents and those who are socioeconomically disadvantaged or live in rural areas.[32] Evidence shows that persons living in poverty or vulnerable conditions are more likely than persons from higher socioeconomic groups to be arrested and prosecuted for drug-related offences, and that arrest rates among Indigenous young persons and young persons of African descent are especially high.[33]

Racial bias, including in algorithms

13. Racially prejudiced attitudes, beliefs and stereotypes are pervasive and influence perceptions, decisions, behaviours and interactions in both conscious and unconscious ways. Historically linked with inequalities in power,[34] racial biases are reinforced by societal and cultural norms and by personal experiences. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has affirmed that acknowledging implicit bias and taking actions to break down institutional barriers are the first steps to eliminating pervasive racial disparities in healthcare and improving the outcomes for patients.[35]

14. Health studies have revealed that biases result in the stereotyping of patients belonging to racial and ethnic groups, perpetuating sexism and other power hierarchies and engendering mistrust regarding the symptoms they report or their ability to make informed decisions. Implicit bias is prevalent in the healthcare sector and can lead to inaccurate pain diagnoses and treatment recommendations, ultimately affecting the quality of care provided.[36]

[28] Statement 3 (2020) on the coronavirus disease (COVID-19) pandemic.

[29] Statement 2 (2022) on the lack of equitable and non-discriminatory access to COVID-19 vaccines (A/77/18, para. 20).

[30] United Nations network on racial discrimination and protection of minorities, *Guidance Note on Intersectionality, Racial Discrimination and Protection of Minorities* (2023), p. 11.

[31] Committee on the Elimination of Discrimination against Women, general recommendation No. 39 (2022), para. 51.

[32] Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999), para. 7.

[33] WHO, *Global Status Report on Alcohol and Health and Treatment of Substance Use Disorders* (2024), p. 12.

[34] United Nations Educational, Scientific and Cultural Organization, Declaration on Race and Racial Prejudice, art. 2.

[35] A/77/197, para. 49.

[36] WHO, *Strengthening Primary Health Care to Tackle Racial Discrimination, Promote Intercultural Services And Reduce Health Inequities: Research Brief* (2022), p. 10.

15. Despite the positive effect that new technologies may have on the quality of healthcare and the enjoyment of the right to health, racial discrimination may permeate artificial intelligence through electronic health records fed to machine-learning algorithms,[37] which are being used increasingly in health systems. Clinical algorithms reproduce structural inequalities in outcomes in hospitals by translating them into health indicators or by failing to assess the combined effects of psychosocial, genetic and environmental factors. The lack of transparency prevents health providers from adjusting the algorithms in practice.

2. Scope of equality

16. The principle of equality underpinned by the Convention combines formal equality before the law with equal protection of the law, with substantive equality in the enjoyment of the right to health as the aim.[38] To achieve formal equality, national legislation must prohibit racial discrimination in the enjoyment of the right to health. The law should be applied equally to everyone, without any racial discrimination, and everyone should have an equal right to a remedy against racial discrimination. Achieving substantive or de facto equality requires active efforts to address ongoing structural disparities and existing inequalities. The aim of such efforts is to achieve adequate advancement for disadvantaged groups, ensuring their full and equal enjoyment of the right to health, taking into account the specific needs of different groups or individuals affected by racial discrimination.[39]

17. In accordance with the Convention, States parties should: recognize and remedy the effect of racial bias and stigmatization (arts. 2 (1) (d) and 4);[40] redress the disadvantage of protected individuals and groups by ensuring positive and special measures (art. 2 (2)); ensure the active participation of underrepresented groups (art. 2 (1) (e));[41] and pursue structural changes (art. 2 (1)).[42]

3. Prevention, autonomy and healthcare under the Convention

18. Racial discrimination is both a separate health risk and a structural social determinant of health. It produces and exacerbates health inequities, leading to, or increasing the incidence of, cases of preventable disease and death. The right to equality and freedom from racial discrimination in the enjoyment of the right to health comprises: the right to the prevention of health-harming conditions, disease and injury, including during emergencies; the right to bodily autonomy and physical integrity, including the right to informed consent; the right to equal and unhindered access to information and culturally appropriate, gender-sensitive and context-responsive health facilities, goods and services, and the right to privacy and confidentiality in that context; the right to be protected against practices by private actors that cause ill-health; the right to participation in health-related decision-making at the community, national and international levels; and the right to an effective remedy and reparation for any damage suffered as a result of racial discrimination.

B. Prevention of and protection against vulnerabilities and inequalities in key determinants of health

19. Freedom from racial discrimination and structural inequalities in key determinants of health includes freedom from disproportionate exposure to vulnerability and health-harming conditions, the right to equal protection of necessary material and psychosocial conditions, the right to be equally protected against practices by private actors that cause harm and the right to the mitigation and reparation of harm. Children and adolescents, older persons, persons with disabilities, women and gender-diverse persons have the right to

[37] A/HRC/53/65, para. 82.
[38] General recommendation No. 32 (2009), para. 6.
[39] General recommendations No. 27 (2000), para. 33, No. 32 (2009), paras. 11 and 14, and No. 34 (2011), para. 55.
[40] CERD/C/NLD/CO/22-24, paras. 27 and 28; and CERD/C/RWA/CO/13-17, para. 16.
[41] CERD/C/USA/CO/10-12, para. 9; and general recommendation No. 34 (2011), para. 56.
[42] CERD/C/ARG/CO/24-26, para. 21; and CERD/C/USA/CO/10-12, para. 36.

context-sensitive preventive and protective measures aimed at combating structural and intersectional discrimination.

1. Safe drinking water, adequate sanitation, safe food and housing

20. In line with paragraph 6 above, article 5 (e) (iv) is understood to encompass the right to a sufficient quantity of acceptable and safe drinking water and adequate sanitation,[43] safe food[44] and housing. This includes the right not to be subjected to inadequate maintenance of water and sanitation infrastructure, contributing to health risks such as waterborne diseases and environmental contamination. Racial and ethnic groups have the right to be protected from residential segregation, discrimination in private rental markets, overcrowded residences and forced evictions. They are entitled to measures that address issues such as food deserts, limited economic resources, discriminatory practices in the food industry and other barriers to accessing healthy food. Vulnerability and poverty affect their diet and health, contributing to higher rates of diet-related diseases and nutritional deficiencies.

2. Safe and healthy working environment

21. Workers who belong to racial or ethnic minorities, and/or who are migrants, asylum-seekers, refugees or stateless, have the right to a safe and healthy working environment,[45] and the right to equality with regard to decent working conditions, fair employment and opportunities for health and well-being. This includes the right not to be subjected to a higher risk of workplace injury or occupational illness, or of exposure to toxins and pollutants or other physical and psychosocial hazards, linked to factors such as job segregation, discrimination in hiring and promotion, and unequal enforcement of regulations on health and safety in the workplace.

3. Climate change and environmental health hazards

22. Racial and ethnic groups have the right to a clean and healthy environment and the right to be protected against climate-induced hazards.[46] They have the right not to be subjected to, and the right to be protected against, environmental degradation and the adverse effects arising from the exploitation of natural resources, nuclear testing, toxic-waste storage, mining, logging and other sources of environmental harm,[47] and the right to be protected against violence by State authorities and private security personnel.[48] They have the right to participate and be heard in meaningful consultations focused on health-harming effects. Indigenous Peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources, which includes the right to free, prior and informed consent.[49]

23. Racial and ethnic groups, some of whom are particularly vulnerable to the health effects of climate change owing to their geographical location, socioeconomic situation, cultural norms and intrinsic psychological factors, have the right not to be disproportionately subjected to, and to be protected against, climate-induced health hazards.[50] This extends to the prevention of and protection from negative outcomes related to heatwaves, air pollution and the increasing frequency and intensity of extreme weather events and natural disasters,

[43] See also A/62/214.

[44] A/78/185, para. 26.

[45] See International Labour Conference, document ILC.110/Resolution I.

[46] Inter-American Court of Human Rights, *Inhabitants of La Oroya v. Peru*, Judgment, 27 November 2023.

[47] CERD/C/USA/CO/10-12, paras. 45 and 46; CERD/C/USA/CO/7-9, para. 10; CERD/C/USA/CO/6, para. 29; CERD/C/64/CO/9, para. 15; CERD/C/GUY/CO/14, para. 19; CERD/C/NGA/CO/18, para. 19; and CERD/C/62/Dec/3.

[48] CERD/C/NGA/CO/18, para. 19.

[49] United Nations Declaration on the Rights of Indigenous Peoples, art. 29; Inter-American Court of Human Rights, *Indigenous Communities of the Lhaka Honhat (Our Land) Association v. Argentina*, Judgment, 6 February 2020; and African Commission on Human and Peoples' Rights, *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v. Nigeria*, communication No. 155/96, 27 October 2001.

[50] A/HRC/32/23.

and to the impact such hazards have on social networks and cultural traditions. In that regard, Indigenous Peoples have the right to mitigation, through non-harmful measures to protect cultural and linguistic diversity, knowledge systems, food security, health and livelihoods.[51]

4. Gender

24. Women, girls and gender-diverse persons belonging to racial and ethnic groups are exposed to disproportionate health risks,[52] harmful behaviours and practices, and inequalities in health systems and healthcare. They are often at increased risk of violence, including femicide,[53] as well as forced marriage or deception (cross-border marriage migration), trafficking, abuse and exploitation, owing to their subordinate social position and their higher levels of vulnerability. Men belonging to some racial and ethnic groups are also disproportionately exposed to health risks because of gun violence[54] or stereotypes concerning their capacity to endure extreme working conditions.

25. Disproportionately high levels of sexually transmitted infectious diseases have been fuelled by patterns of sexual coercion, forced marriage and economic dependency. In the area of HIV, inequality and violence against women and girls, denial of sexual and reproductive health rights, misuse of criminal law, punitive approaches[55] and mandatory testing are among the main barriers to effective responses. Women and girls have the right not to be subjected to harmful practices such as female genital mutilation or *ukuthwala*, which have severe health consequences.[56] Women from the communities concerned, including migrant communities, must be directly involved in the design and implementation of policies aimed at protecting women and girls from harmful traditional practices, and all forms of racial discrimination in this context should be prevented.[57]

5. Migratory status

26. Article 5 (e) (iv) of the Convention applies regardless of a person's migratory status. Migrants, refugees, asylum-seekers and stateless persons have the right not to be subjected to health risks that are linked to poor living conditions, the confiscation of their passports or other relevant documents, health-harming work situations and exclusion from social security schemes. Non-citizens have the right to integration into local health systems, including health insurance systems, and equal eligibility for social security without discrimination.[58] They have the right not to be subjected to health-harming conditions, such as live-in requirements and physical or mental abuse.[59] Providing access to preventive and primary care for all migrants, including undocumented persons, beyond emergency care reduces health costs and ensures that migrants are protected against racial discrimination.

6. Deprivation of liberty

27. Members of racial and ethnic groups have the right not to be subjected to disproportionate incarceration,[60] which exposes them to inadequate healthcare, violence, mental health challenges and barriers to reintegration into society, thus perpetuating existing health disparities. Migrants, asylum-seekers and stateless persons have the right not to be exposed to health-harming conditions while held in immigration or other detention centres.

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[51] Human Rights Committee, *Billy et al. v. Australia* (CCPR/C/135/D/3624/2019).

[52] Orielle Solar and Alec Irwin, "A conceptual framework for action on the social determinants of health", Social Determinants of Health Discussion Paper, No. 2 (WHO, 2010), pp. 33 and 34.

[53] CERD/C/BRA/CO/18-20, para. 16.

[54] CERD/C/USA/CO/10-12, para. 16.

[55] Joint United Nations Programme on HIV/AIDS (UNAIDS), *The Path that Ends AIDS: UNAIDS Global AIDS Update 2023* (2023), pp. 58 and 144.

[56] CERD/C/ZAF/CO/9-11, para. 33; CERD/C/ZMB/CO/17-19, para. 23; CERD/C/KGZ/CO/8-10, para. 15; and 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, para. 19.

[57] End FGM European Network, "Position paper: FGM, antiracism & intersectionality" (2022), p. 17.

[58] CERD/C/KOR/CO/17-19, para. 32.

[59] CERD/C/CHN/CO/14-17, paras. 30 and 31.

[60] CERD/C/USA/CO/10-12, para. 28.

Women and children have the right not to be subjected to increased risks of exploitation, abuse and gender-based violence in such settings. Individuals with disabilities face additional barriers to accessing healthcare and support services in detention settings. Eliminating the racial discrimination inherent in disproportionate incarceration requires the provision of alternatives to detention and the provision of humane conditions where detention is strictly necessary, including with regard to access to healthcare, legal assistance and support for vulnerable individuals, such as children, pregnant women and survivors of torture or trauma.

7. Humanitarian crises, armed conflicts and unilateral coercive measures

28. Where racism and racial discrimination are among the root causes of international and non-international armed conflict, individuals protected under the Convention may be exposed disproportionately to killings, maiming and other violence, including torture and sexual violence, forced displacement and discrimination in the enjoyment of the right to health and its key determinants. Lethal autonomous weapons[61] heighten the risk of systematizing racial bias and dehumanizing their targets. The Convention continues to apply in such armed conflict. All persons have the right not to be subjected to violence and trauma, which may contribute to, inter alia, post-traumatic stress disorder, depression and anxiety, and also have the right to equal enjoyment of the right to health and to equal access to humanitarian assistance, protection and opportunities for recovery and rebuilding.

29. Racial and ethnic groups have the right to be protected from the disproportionate effects of, and overcompliance with, unilateral coercive measures. Effective systems for humanitarian exemptions from sanctions[62] must be implemented to secure the passage of healthcare equipment and medication, food, humanitarian aid and other assistance for critical infrastructure and services, such as water, sanitation and electricity.

8. Right to bodily autonomy and physical integrity

30. Individuals and groups protected under the Convention have the right to bodily autonomy and physical integrity. This encompasses the right to consent to medical treatment, the right to access reproductive healthcare services, including medicines and health products, and the right to be free from violence, coercion or forced interventions.[63] The right entails full respect of the principles of dignity, autonomy and self-determination. Mandatory HIV/AIDS testing limited to non-citizens, or based on race, colour, descent or national or ethnic origin, for employment, entry, stay or residence purposes is ineffective for public health purposes and discriminatory.[64]

Involuntary placement, seclusion and treatment

31. Racial bias may lead to overdiagnosis of mental health issues and disproportionate use of coercive practices in the area of mental health, including involuntary admission and treatment, as well as seclusion and restraint. The rights to equality and to freedom from racial discrimination encompass the prevention of and protection against the involuntary admission and treatment, and seclusion and restraint, of persons protected by the Convention, both in the context of mental health services and in the general community.[65]

Forced sterilization

32. Indigenous women, women of African descent, Roma women and women belonging to other ethnic groups and castes have been targeted in policies related to population control,

[61] General Assembly resolution 78/241.

[62] A/HRC/54/23.

[63] Committee on Economic, Social and Cultural Rights, general comments No. 14 (2000), para. 8, and No. 22 (2016), para. 5; and A/HRC/35/21, paras. 30–34.

[64] UNAIDS and United Nations Development Programme (UNDP), "Still not welcome: HIV-related travel restrictions" (2019). See also CERD/C/MDA/CO/8-9, para. 13. See further *L.G. v. Republic of Korea* (CERD/C/86/D/51/2012); the State party has since abolished mandatory HIV/AIDS testing and the petitioner has received compensation.

[65] CERD/C/GBR/CO/21-23, para. 31.

including those resulting in coercive sterilizations,[66] and policies to control HIV and other infections. Within those groups, women with intellectual and/or psychosocial disabilities have been denied their legal capacity and, as a consequence, their right to give consent. Forced sterilization is a violation under the Convention; it violates the rights to reproductive autonomy, to access to information, to integrity of the person, to privacy and to be free from racial and gender-based violence and discrimination.[67]

Criminalization of, and unsafe, abortion

33. Legal and effective access to safe abortion is part of the right to control one's health and body and the right to life of persons protected under the Convention.[68] Indigenous women, gender-diverse persons and women of racial and ethnic minorities are often at a higher risk of unwanted pregnancy, and often lack the means to overcome socioeconomic and other barriers to gain access to modern contraceptive methods and safe abortion. Banning access to abortion has a profound disparate impact and is contrary to the principle of non-retrogression, with respect to the standards on providing access to safe, legal and effective abortion detailed in the World Health Organization (WHO) *Abortion Care Guideline*.[69]

34. The criminalization of abortion in all circumstances constitutes an indirect form of intersecting racial and gender-based discrimination as it has a greater impact on Indigenous women and women of African descent, particularly those with low income,[70] exposing them to life-threatening situations and constituting a violation of the principle of non-retrogression. Criminalization of abortion further exacerbates the underreporting of important health indicators and undermines the monitoring of racial inequalities.[71] Failing to recognize the impact of racially motivated sexual violence, hindering access to information and programmes on modern contraception and safe abortion care, and criminalizing and punishing access to abortion constitute a chain of compounded discriminatory exposure to health-harming conditions, and each such act or omission constitutes a violation of article 5 (e) (iv).

C. Right to a system of health protection, including entitlements to public health and to healthcare facilities, goods and services

35. The right set out in article 5 (e) (iv) encompasses the right to an inclusive health system, the right to equal and unhindered access to culturally appropriate, gender-sensitive, context-responsive and quality health facilities, goods and services, the right to privacy and confidentiality and the right to participation. The principle of freedom from racial discrimination and entitlements to substantive equality apply in all four of the essential elements of the right to health,[72] described below.

[66] Office of the United Nations High Commissioner for Human Rights (OHCHR) and others, "Eliminating forced, coercive and otherwise involuntary sterilization: an interagency statement" (WHO, 2014). See also Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 30.

[67] Inter-American Court of Human Rights, *I.V. v. Bolivia*, Judgment, 30 November 2016; European Court of Human Rights, *A.P., Garçon and Nicot v. France*, Applications No. 79885/12, No. 52471/13 and No. 52596/13, Judgment, 6 April 2017; African Commission on Human and Peoples' Rights, general comment No. 4 (2017), para. 58; Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 30; Committee on the Rights of Persons with Disabilities, general comment No. 3 (2016), para. 32; and A/HRC/31/57, para. 45.

[68] WHO, *Abortion Care Guideline* (2022).

[69] "Web annex A: key international human rights standards on abortion", available at https://iris.who.int/bitstream/handle/10665/349317/9789240039506-eng.pdf.

[70] CERD/C/SLV/CO/18-19, para. 27. See also CERD/C/USA/CO/10-12, para. 35; and CERD/C/BRA/CO/18-20, para. 16 (b).

[71] A/66/254, para. 19.

[72] Committee on Economic, Social and Cultural Rights, general comments No. 14 (2000), para. 12, and No. 22 (2016), paras. 12–21.

1. Availability

36. Racial and ethnic groups have the right to substantive equality with regard to an adequate quantity of functioning healthcare facilities and goods, services and programmes, and to the availability of traditional healing practices and medicines, within reasonable geographical reach.[73] To that end, pre-existing inequalities, high levels of vulnerability and long-standing disparities in health outcomes must be taken into account to ensure substantive equality in the distribution of trained medical and professional personnel and essential medicines, vaccines, tests and other preventative goods and services,[74] and to address causes of mortality and morbidity that disproportionately affect groups within the purview of the Convention,[75] including neglected tropical diseases. Microaggressions, racist hate crimes and hate speech, and the resulting stress, have been linked to a range of negative health outcomes, including depression, anxiety and physical health problems, such as hypertension and cardiovascular disease.[76] Racial and ethnic groups have the right to services that provide support for persons with psychosocial conditions and persons with non-communicable diseases.

2. Accessibility, including physical, economic (affordability), information and digital accessibility

37. Individuals and groups protected by the Convention have the right to equal and unhindered accessibility, including physical, economic (affordability), information and digital accessibility, to healthcare facilities, goods, services and programmes, including to traditional medicines and practices.[77] Equality in accessibility includes protection against the harassment of and violence against persons attempting to access services,[78] including services related to sexual and reproductive health, especially abortion services.[79] The right includes universal and non-discriminatory access to healthcare facilities, goods and services for all; intersectional discrimination must be taken into account in efforts to mitigate and redress disadvantage, exclusion and marginalization. Equality in accessibility can be strengthened by digital forms of healthcare, such as telemedicine, provided that guarantees of equality and non-discrimination ensure the prohibition of racial discrimination and equal protection of sensitive personal data, and that such forms of healthcare do not reinforce the digital divide as a result of the use of digital tools and online spaces.[80]

38. Physical accessibility should be ensured for all persons belonging to racial and ethnic groups, including persons living in rural and remote areas, persons with disabilities, refugees, internally displaced persons, stateless persons and persons in detention. Substantive equality includes entitlements to positive measures, such as those that ensure the availability and affordability of communication with and transportation to such services.

39. Equal access to affordable essential health services requires that health services are accessible to all and that they do not result in financial hardship;[81] they should be free of charge at the point of care. States parties should remove financial barriers to accessing healthcare by advancing towards universal health coverage, and by ensuring that health insurance systems, public and private, do not discriminate against anyone, including individuals within the purview of the Convention.[82]

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[73] Committee on Economic, Social and Cultural Rights, general comments No. 14 (2000) and No. 22 (2016). See also CERD/C/SLV/CO/18-19, paras. 34 and 35.

[74] CERD/C/HUN/CO/18-25, para. 20; CERD/C/BRA/CO/18-20, para. 15; and CERD/C/THA/CO/4-8, para. 37.

[75] CERD/C/CZE/CO/12-13, para. 15 (c); and CERD/C/RUS/CO/25-26, para. 30 (g).

[76] A/77/197.

[77] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000).

[78] CERD/C/HUN/CO/18-25, para. 21.

[79] CERD/C/SLV/CO/18-19, paras. 26 and 27.

[80] *WHO Guideline: Recommendations on Digital Interventions for Health System Strengthening* (2019); and A/HRC/53/65, paras. 31–36.

[81] WHO, "Universal health coverage (UHC)", 5 October 2023, available at https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

[82] CERD/C/KOR/CO/17-19, para. 32; and CERD/C/CHN/CO/14-17, paras. 29 and 31.

40. Information accessibility includes the right of persons belonging to racial and ethnic groups to the health-related education and evidence-based information they require to actively participate in their own healthcare and to advocate for their health needs.[83] This includes the right to health literacy. It encompasses the right to: access reliable and relevant health information; understand the health information; evaluate the credibility, accuracy and relevance of health information in order to make informed decisions; use health information to make decisions about healthcare, preventive measures and lifestyle choices that promote well-being; communicate effectively with healthcare providers; and understand how healthcare systems operate, including insurance coverage and administrative processes.

3. Acceptability

41. All health providers, goods, services and information must be respectful of the cultures of racial and ethnic groups and Indigenous Peoples and sensitive to gender, age, disability, gender and sexual diversity and life-cycle requirements. Healthcare services that are culturally sensitive, culturally acceptable and respectful must be available within reasonable geographical reach.[84] They should: be adapted to the linguistic characteristics of the beneficiaries; be designed jointly or in close cooperation with the communities concerned; and include members of the communities concerned in the health workforce.[85] Ensuring equality in the acceptability of healthcare entails actively combating stereotypes and legacies of theories of racial superiority, slavery and colonialism[86] and bias against traditional knowledge, healers and practices.[87] A lack of recognition, or the arbitrary prohibition, of traditional healers, medicines and pharmacopoeia specific to certain ethnic groups makes members of those groups vulnerable to diseases.

4. Quality

42. Racial and ethnic groups have the right to healthcare facilities, goods, services and information that are of good quality, evidence-based, scientifically and medically appropriate and up to date. This requires access to trained and skilled healthcare personnel, and scientifically approved drugs (unexpired) and equipment. Institutional racial bias continues to impede and restrict access to quality and adequate healthcare goods and services owing to unequal participation in clinical decision-making and the normalization of social constructs in health practices, protocols and policies. Disease stereotyping and bias in medical training approaches and materials are perpetuated by conflating race and ancestry, by using terms with racial connotations and by referring to differences in the prevalence of disease.

43. Under the historical legacy of slavery, women and men of African descent have been considered to be physically stronger and to be able to endure more pain.[88] The Working Group of Experts on People of African Descent has received reports indicating a lack of knowledge among health providers on how symptoms manifest in and on black bodies.[89] Women of African descent, Indigenous women and Roma women often wait longer before they have access to medicine,[90] including during labour. Groups within the purview of the Convention tend to be excluded from medical research and studies on treatments and medicine. Physicians report that, owing to bias, structural barriers and an unwillingness to demonstrate flexibility and responsiveness with regard to integrating participation by

[83] CERD/C/SLV/CO/18-19, paras. 34 and 35.

[84] CERD/C/MNG/CO/23-24, para. 24 (e). See also CERD/C/GTM/CO/16-17, para. 14 (c); and New Zealand, Ministry of Health, “Māori health”, available at https://www.health.govt.nz/maori-health.

[85] CERD/C/ECU/CO/20-22, para. 21; CERD/C/MEX/CO/16-17, para. 19; CERD/C/COL/CO/14, para. 22; and CERD/C/GTM/CO/16-17, paras. 33 and 34.

[86] A/77/197, paras. 47–60.

[87] WHO, Global strategies and plans of action that are scheduled to expire within one year: WHO traditional medicine strategy, 2014–2023, document EB152/37. See also United Nations Declaration on the Rights of Indigenous Peoples, arts. 21, 24, 29 and 31.

[88] CERD/C/CHL/CO/22-23, para. 12.

[89] Submission of the Working Group for the Committee’s day of general discussion on racial discrimination and the right to health, p. 2, available at https://www.ohchr.org/en/events/days-general-discussion-dgd/2022/thematic-discussion-racial-discrimination-and-right-health.

[90] CERD/C/CHL/CO/22-23, paras. 12 and 13.

members of ethnic and racial groups, the situations of those groups are not taken into consideration when medication and other goods and services are tested.

D. Sexual and reproductive health

44. Freedom from racial discrimination, and the right to equality, in sexual and reproductive health includes equal access to and equal quality of sexual, reproductive and newborn healthcare services. It requires the provision of universal and comprehensive healthcare coverage, in order to prevent discriminatory practices related to costs of labour and childbirth care and to decrease the risk of obstetric emergencies and complications during childbirth.[91] Ensuring the right to equality requires the addressing of causes of maternal mortality, reproductive and maternal morbidities and related disabilities that disproportionately affect persons within the purview of the Convention; the strengthening of health systems to collect high-quality data in order to respond to the needs and priorities of women, girls and gender-diverse persons; and accountability in the event of violations in order to improve quality of care and equity. Women and gender-diverse persons protected by the Convention have the right to equality in: the availability of prenatal and postnatal care, skilled birth attendants and emergency obstetric services; the accessibility, in law and in practice, of maternal health services; the acceptability of maternal health services, which must respect their dignity and be sensitive to their needs and perspectives; and the adequacy of the quality of facilities, goods, services and information related to sexual and reproductive health, including the standard that services must be evidence-based and scientifically and medically appropriate, up to date and of good quality.

E. Right to privacy

45. The right to privacy guarantees that racial and ethnic groups and Indigenous Peoples have the right to equality and freedom from racial discrimination with respect to the protection and use of their health-related data.[92] Every person protected by the Convention has the right to the protection of their personal data, including the right to transparency in data processing; the right to object to the processing of health-related data; the right to access to, and to the portability, rectification and erasure of, health-related data; and the right to effective remedies against violations. Health practitioners and beneficiaries protected by the Convention should be able to enjoy the right to privacy without any racial discrimination or any other intersecting grounds recognized in the present general recommendation.

III. Obligations and recommendations

46. Articles 5 (e) (iv), 6 and 7 entail obligations to ensure: (a) the prevention of health-harming conditions, including climate change and environmental hazards; (b) access to safe drinking water, adequate sanitation, safe food, housing and safe and healthy working conditions; (c) adequate quantity and quality of preventive, curative and rehabilitative healthcare services, and essential medicines, including traditional medicines and healing practices, within reasonable geographical reach; (d) access to information and technology and measures bridging the digital divide; (e) the elimination of racial disparities in health outcomes and resources and protection against health hazards that result from actions of third parties; (f) the collection and disaggregation of up-to-date statistics and the monitoring of health inequities; (g) the promotion of public awareness and education on combating racial discrimination in the enjoyment of the right to health; (h) direct participation of racial and ethnic groups in decision-making; (i) the adoption and implementation of a national public health strategy and plan of action; and (j) accountability and reparation for any damage suffered as a result of racial discrimination. States must prevent discrimination, protect individuals against harm and promote equality and dignity for all members of society. Combating structural inequalities requires comprehensive strategies that address the root

[91] CERD/C/CZE/CO/12-13, para. 23.
[92] A/74/277, annex, chaps. II and III.

causes of health inequities and promote social justice, equality and inclusion. This includes investing in community-led initiatives and resources, promoting diversity and cultural competence in healthcare and other sectors, and identifying and addressing broader structural inequalities and systemic barriers that perpetuate racial health disparities.

A. General principles on obligations under the Convention

47. Article 2, read in conjunction with article 5 (e) (iv), entails obligations to respect, protect and fulfil the right to equality and freedom from racial discrimination in the enjoyment of the right to health. States parties are required to pursue a policy of eliminating discrimination; a wide range of concrete measures, including special measures, must be taken "without delay". Obligations undertaken under article 5 (e) (iv) are of immediate effect.[93] Retrogressive measures are not permissible.[94] States must strictly scrutinize the necessity and proportionality of measures affecting racial and ethnic groups and Indigenous Peoples. Given the evidence-based knowledge on the impact of racism on health, intersectional anti-racist measures should be prioritized over other competing interests. Obligations under the Convention apply not only to the territory of every State party, but also to all other territories over which the State party exercises control, including in armed conflicts.[95]

B. Obligation to respect

48. The obligation to respect the right to health without racial discrimination requires States to refrain from any act or omission, including with regard to any law, policy or practice, that directly or indirectly restricts or disproportionately affects the enjoyment of the right to health by racial and ethnic groups. It also requires States to take general and special positive measures to ensure equality in the enjoyment of the right to health.

1. Refrain from any discriminatory act, and repeal any policy or law, that results in bodily harm, preventable morbidity and mortality[96]

49. Authorities, including law enforcement officials and health authorities, must refrain from acts of racial bias, stigmatization, discrimination, bias-motivated violence and incitement to racial hatred.

50. States parties should repeal:

(a) Any law and policy that disproportionately limits access, including for non-citizens, to preventive, curative and palliative health services;

(b) Laws that require health providers to report undocumented migrants to police.[97]

51. States parties should refrain from:

(a) Prohibiting or impeding access to traditional medicine and practices;

(b) Conducting discriminatory experimental research, and applying coercive treatments and discriminatory restrictions, in the control of communicable and non-communicable diseases and in the area of mental health;

(c) Placing in detention persons with pre-existing health vulnerabilities;

(d) Adopting disproportionate migration laws and enforcement practices that are health-harming;

[93] See also Committee on Economic, Social and Cultural Rights, general comments No. 14 (2000), para. 30, and No. 3 (1990), para. 1.
[94] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 32.
[95] CERD/C/RUS/CO/25-26, para. 4. See also CERD/C/MDA/CO/8-9, para. 3.
[96] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 48–50.
[97] CERD/C/DEU/CO/23-26, para. 38 (b); and CERD/C/CZE/CO/12-13, para. 24.

(e) Adopting discriminatory laws and practices in sexual and reproductive health; instead, they should prohibit forced sterilization; decriminalize access to abortion; and ensure access to contraceptives and other health goods;

(f) Conducting activities that cause disproportionate environmental damage;

(g) Promoting residential segregation and placing racial and ethnic groups in remote areas without access to healthcare and other providers;[98]

(h) Expropriating lands from, and displacing, Indigenous Peoples without their prior, free and informed consent; and installing waste disposal sites or other environmental hazards on Indigenous Peoples' territories;[99]

(i) Imposing restrictions on the permanent rights of Indigenous Peoples and endangering their self-determination, traditional livelihoods and cultural rights, in accordance with the standards of the United Nations Declaration on the Rights of Indigenous Peoples;[100]

(j) Engaging in the overpolicing of communities, racial profiling, increased surveillance and other forms of policing activity that have a negative impact on the mental health and well-being of individuals and their families;

(k) Subjecting individuals protected under the Convention to involuntary admission to psychiatric institutions, involuntary treatment and seclusion or restraint;

(l) Using solitary confinement and chemical agents, except under strictly defined conditions that are assessed regularly for racial bias;

(m) Criminalizing safe traditional health practices and the exercise of reproductive rights, such as the right to abortion;

(n) Engaging in obstetric violence, including segregation practices in maternity hospitals; States parties should include an explicit prohibition of such practices in their legislation;

(o) Denying access to health services, including through excessive requirements of health insurance policies or through the criminalization of undocumented entry and stay of migrants;

(p) Adopting policies and legislation that tie housing grants and financial aid to conditions that disproportionately affect members of low-income families, especially women from ethnic minorities; [101]

(q) Implementing mandatory income-management schemes; additionally, States parties should remove discriminatory conditions in access to benefits;[102]

(r) Engaging in armed conflicts, the use of weapons and arms trades that result in bodily harm to communities within the purview of the Convention;

(s) Signing bilateral or multilateral agreements that reinforce the vulnerabilities of groups within the Convention's purview and that result in negative health outcomes;

(t) Using racially biased data, and biased algorithms, in forming health and social policies;

(u) Using racial stereotypes and misinformation as a basis for decisions regarding health protection or treatment;

(v) Exposing racial and ethnic groups to health risks within data governance systems.

[98] General recommendation No. 27 (2000), para. 31.
[99] CERD/C/CHL/CO/22-23, para. 28; and CERD/C/USA/CO/7-9, para. 24.
[100] CERD/C/ZMB/CO/17-19, paras. 25 and 26; and CERD/C/MNG/CO/23-24, para. 23.
[101] CERD/C/SGP/CO/1, paras. 17 and 18.
[102] CERD/C/AUS/CO/18-20, para. 24.

2. Equal access to culturally appropriate, gender-sensitive and context-responsive quality health facilities, goods, services, social determinants of health, the right to privacy and confidentiality and the right to participation

52. States must take action to advance and guarantee equality in the enjoyment of the right to health by:

(a) Adopting comprehensive legislation explicitly providing for positive measures ensuring equality and intercultural health,[103] including measures protecting the right to privacy and confidentiality;

(b) Equitably distributing trained medical and professional personnel, essential medicine and preventative goods and services, including through mobile health clinics;[104]

(c) Addressing, through evidence-based policies, causes of mortality and morbidity, including commercial determinants of health, that disproportionately affect racial and ethnic groups;

(d) Providing access to universal health coverage and ensuring an inclusive approach to promote the health of those most in need, including migrants and asylum-seekers and LGBTQI+ persons within those groups;[105]

(e) Ensuring that a sufficient number of health professionals provide services to Indigenous Peoples, and setting up benchmarks for monitoring progress in key areas of Indigenous disadvantage;[106]

(f) Ensuring that healthcare providers: inform every patient protected under the Convention about the nature of procedures, treatment options, and reasonable alternatives, including potential risks and benefits; consider individuals' needs and ensure that they understand the information provided; and ensure that the consent given is free and voluntary;

(g) Including professionals specifically focused on intercultural care, in addition to expanding the intercultural competencies of existing staff;

(h) Providing for communication with health providers and for transportation required to access health facilities, goods and treatments;

(i) Ensuring in all contexts, including in places of deprivation of liberty, appropriate health screening, care and medical, laboratory and pharmacy records;

(j) Ensuring access to interpreters where necessary[107] and to social and health services in appropriate languages;[108]

(k) Providing equal access to health-related education and evidence-based information and removing language and cultural barriers;[109]

(l) Conducting targeted awareness-raising campaigns with information about available health services and the requirements for universal health coverage;[110]

(m) Jointly designing, with racial and ethnic groups and Indigenous Peoples, culturally acceptable and gender-sensitive preventive, curative and palliative health services;

(n) Ensuring that primary care at the local and referral levels relies on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, and traditional practitioners as needed, suitably trained socially and technically to work as a health team and respond to the expressed health needs of the community;[111]

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103 CERD/C/SLV/CO/18-19, paras. 34 and 35.
104 CERD/C/MNG/CO/23-24, para. 24 (e).
105 CERD/C/DEU/CO/23-26, para. 38 (a).
106 CERD/C/AUS/CO/14, para. 19.
107 CERD/C/SGP/CO/1, para. 18.
108 CERD/C/FIN/CO/20-22, para. 14.
109 CERD/C/MEX/CO/16-17, para. 18; and CERD/C/LAO/CO/16-18, para. 19.
110 CERD/C/LTU/CO/9-10, para. 18 (d).
111 Declaration of Alma-Ata.

(o) Ensuring high-quality preventative, curative and palliative health services that are free from racial bias; effective and affordable medicines, including traditional medicines; vaccines; and diagnostics and other technologies.[112]

3. Special measures

53. States must adopt and implement special measures, such as health workforce quotas and additional resources and services for racial and ethnic groups, to eliminate persistent disparities and disadvantages, in accordance with general recommendation No. 32 (2009).[113] Such measures should be designed and implemented with an intersectional approach to identify those who are most disadvantaged and who experience concurrent forms of discrimination. States are responsible for designing a framework for the consistent application of special measures in all parts of the State.[114] States must refrain from shifting away from special measures that are targeted specifically towards vulnerable groups, in order to avoid exacerbating the inequalities that already exist.[115] Reparations for slavery and colonial harm could be a tool to finance special measures and eliminate health disparities while promoting a healthier and more cohesive society.

C. Obligation to protect

54. The obligation to protect the right to equality and freedom from racial discrimination in the right to health requires States to take and implement all measures necessary to ensure that natural and legal persons, or groups of persons, do not nullify or impair, directly or indirectly, the recognition, enjoyment or exercise of the right to health of any person on grounds of race, colour, descent or national or ethnic origin. The impact of racial discrimination on health activates the obligation of States parties to: prevent risks related to racial discrimination and take protective operational measures; monitor and ensure compliance with the legal and operational framework; and provide effective remedies in cases of violation. In particular, States must:

(a) Ensure equal access to culturally appropriate and gender-sensitive preventive, curative and palliative health products and services provided by third parties;

(b) Ensure that vaccines, medicines and other health products are available and affordable to everyone, and address the underlying social and economic factors that contribute to health inequities and racial discrimination;[116]

(c) Ensure that increased involvement of private actors in healthcare financing or in the provision or supply of health services, goods and treatment does not affect the availability, accessibility, acceptability and quality of healthcare facilities and supplies, including medicines and other health products, for racial and ethnic groups, including undocumented pregnant women and gender-diverse persons within those groups;

(d) Ensure that privatization does not decrease the level of the right to health previously enjoyed by groups subject to racial discrimination;

(e) Ensure that preventative policies are designed with the best scientific evidence, free from racial bias and conflicts of interest;

(f) Ensure a human rights impact assessment before the involvement of private actors in healthcare; any private actor involved in healthcare must positively contribute to, and not impede, the fulfilment of the right to health;

(g) Ensure that environmental degradation by private actors does not disproportionately harm the enjoyment of the right to health among members of racial and ethnic groups by adopting environmental norms and policies, monitoring environmental risks

[112] Declaration of Astana.
[113] Para. 34.
[114] CERD/C/USA/CO/10-12, para. 9.
[115] CERD/C/GBR/CO/21-23, para. 13.
[116] A/HRC/53/50. See also A/HRC/49/35 and A/HRC/52/56.

on health, enforcing quality standards and ensuring sustainability in the management of natural resources;

(h) Ensure that harmful practices do not affect access by members of racial and ethnic groups to prenatal and postnatal care and to abortion;

(i) Prevent coercive practices by private actors, such as female genital mutilation, forced marriage and experimental health research;

(j) Ensure that private actors do not restrict access to health-related information and participation;

(k) Ensure that any restriction imposed by private actors on the right to privacy of racial and ethnic groups complies with the human rights principle of doing no harm;

(l) Ensure the investigation of, and punish accordingly, any racially motivated conduct having the purpose or effect of harming the physical or mental integrity of persons protected under the Convention;

(m) Ensure that private business enterprises, private health providers and other relevant organizations comply with the rights to equality and to non-discrimination;[117]

(n) Ensure that private actors: identify and assess actual or potential adverse impacts on the right to health based on race, colour, descent or national or ethnic origin with which they may be involved either through their own activities or as a result of their business relationships; integrate the findings from their assessments across relevant internal functions and processes, and take appropriate action; track the effectiveness of their response; and account for how they address their human rights impacts;[118]

(o) Ensure that companies pay particular attention to the data-related factors that may have a discriminatory purpose or effect and that companies submit to independent third-party audits of their artificial intelligence systems;[119]

(p) Ensure that where the risk of discrimination or other human rights violations has been assessed to be too high or impossible to mitigate, including because of the nature of the planned or foreseeable use by a State, private actors refrain from deploying artificial intelligence systems until they can ensure that the discriminatory outcome is mitigated effectively. Exposure and vulnerability to health risks owing to racial discrimination should be incorporated into ex ante and ex post assessments with the cooperation of a multidisciplinary team and an understanding of how racism and racial discrimination may be experienced;

(q) Ensure that private actors, subject to their involvement, respond to and are accountable for harm caused in relation to the right to health. If the private actors caused the harm, they should cease the actions causing the harm and remedy the harm. If they contributed to harm caused by another party, they should cease the action contributing to the harm, seek to use or build leverage with the other party to prevent or mitigate the risk of future harm, and contribute to the remedy of the harm, including through compensation. If the private actors are only linked to harm they did not cause or contribute to, they should try to use or build their leverage to prevent or mitigate the risk of future harm by the other party but are not expected to contribute to the remedy;

(r) Document cases of racial discrimination associated with health providers, including private actors, as well as related prevention measures, sanctions and remedies, and include information thereon in their reports to the Committee.

[117] Guiding Principles on Business and Human Rights, guiding principles 1–3. See also guiding principles 11 and 24.

[118] Guiding principles 17–21.

[119] See Toronto Declaration: Protecting the right to equality and non-discrimination in machine learning systems.

D. Obligation to fulfil

55. The obligation to fulfil requires States, individually and through international assistance and cooperation, to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other positive measures for the full realization of the right to equality and freedom from racial discrimination in the enjoyment of the right to health. The immediate effect of obligations under the Convention and the International Covenant on Economic, Social and Cultural Rights (art. 2 (1) and (2)) requires States to design, adopt, implement and regularly assess deliberate, concrete and targeted measures, considering intersectionality, without delay.

1. Representation

56. States must encourage multidimensional representation of groups protected under the Convention within their own remit as health providers and experts and at the receiving end of healthcare. Specific indicators of representation must align with other international obligations on human rights, equality and non-discrimination, while reflecting the context and scope of the situation. States should promote, in their supply-chain policies and transactions with private entities, the representation of groups within the purview of the Convention as a measurable indicator of the quality of health.

57. States should reduce barriers to the promotion, and ensure the training, of medical professionals from ethnic and racial groups experiencing discrimination to ensure representativeness across the hierarchy of seniority.

2. Participation, consultation and empowerment

58. Article 2 (1) (e) sets out the obligation of States parties to encourage, where appropriate, integrationist multiracial organizations and movements and other means of eliminating barriers between races, and to discourage anything which tends to strengthen racial division. Integrationist multiracial organizations and movements should be understood as grass-roots, community civil society organizations that support the principles of the Convention. States should allocate resources to co-design intercultural health strategies with racial and ethnic groups and Indigenous Peoples at the community, regional or national levels.[120] States should involve associations and communities and their representatives, including women, in designing and implementing health programmes and projects concerning racial and ethnic groups.[121]

3. Monitoring racial inequalities

59. Monitoring racial discrimination with an intersectional approach at the national level[122] is an essential element of the implementation of the provisions in articles 2 (2) and 9 of the Convention. One of the fundamental obligations under the Convention is to provide all persons with the right to self-identify as belonging to a group[123] and to be included in statistics and social surveys. Disaggregated data allows authorities to monitor the social determinants of health, and identify the impact of racial discrimination intersecting with gender and other inequalities. Such data should be collected voluntarily, anonymously, on the basis of self-identification and in accordance with human rights standards and principles, such as data protection regulations and privacy guarantees, including the human rights principle of doing no harm and guarantees regarding informed consent. Persons protected under the Convention should have access to information regarding the collection of their data, the use of such data and the outcomes of such use.

60. In cooperation with WHO and regional organizations and agencies, States should disaggregate data and make anonymized statistics available to racial and ethnic groups and the general public. States should adopt and implement a national health action plan and

[120] CERD/C/ECU/CO/19, para. 20; and CERD/C/GTM/CO/12-13, para. 13.
[121] General recommendation No. 27 (2000), para. 34; and WHO, resolution WHA77.2.
[122] Durban Programme of Action, paras. 92 and 110.
[123] CERD/C/ZMB/CO/17-19, paras. 25 and 26.

related policies to analyse and address racism and intersecting discrimination, including the root causes.[124] States parties should:

(a) Develop health information systems that collect disaggregated data;

(b) Ensure that data collection efforts also support comprehensive public health monitoring;[125]

(c) Disaggregate data on a regular basis to ensure accountability;

(d) Ensure support for the ministry of health and other ministries, including by seeking support from United Nations entities, in developing an intersectional lens in reporting processes under the Convention and other international human rights treaties.

4. Adopting and implementing national health action plans

61. States should adopt national health strategies and action plans, in consultation with relevant groups, in order to identify gaps, set out clear objectives, provide for special measures in accordance with article 2 (2) and ensure the coordination of all relevant authorities and effective budgeting. They should adopt and effectively implement well-resourced policies, including special measures, to improve the socioeconomic situation of racial and ethnic groups and Indigenous Peoples, including specific programmes for women, children, older persons and persons with disabilities, and to address deep-rooted discrimination.[126] Specific health-related prevention programmes should target persons, including undocumented migrants, who are not covered by the public health insurance scheme.[127] Applying a gender perspective in all policies and strategies for combating racial discrimination is fundamental to putting an end to the multiple and intersectional discrimination faced by Indigenous women, migrant women and women of African descent.[128]

62. States are strongly encouraged to coordinate support services effectively by promoting models of cooperation among authorities, communities and civil society organizations, equality bodies, national human rights institutions and private health providers. States should explore, as a mitigating special measure and in consultation with communities concerned, the possibility of providing healthcare support through mobile health clinics[129] and providing specific health-related prevention programmes, comprehensive emergency healthcare and any care related to childbirth and children under the age of 5 free of charge for all.

63. States should regulate the use of artificial intelligence in all health-related sectors and ensure compliance with the prohibition of racial discrimination. Such systems should be deployed only with a clear objective to advance the enjoyment of the right to health for all without racial or any other discrimination. Before procuring or deploying such systems, States should adopt appropriate legislative, administrative and other measures to determine the purpose of their use, regulate the parameters of that use as accurately as possible, and provide guarantees that prevent and protect against racial discrimination. States should adopt a human rights-based approach to artificial intelligence that incorporates the elimination of racial discrimination at all stages and in all minimum standards.[130] States should assess the potential human rights impact prior to deploying artificial intelligence in the area of health and should consider beginning with a pilot period under the supervision of an independent

[124] A/HRC/4/28, paras. 90–92.
[125] WHO, *World Report on the Health of Refugees and Migrants* (2022), p. 211.
[126] CERD/C/AUS/CO/18-20, para. 24; CERD/C/CHN/CO/14-17, paras. 28 and 29; CERD/C/ISR/CO/17-19, paras. 28–31; CERD/C/HUN/CO/18-25, para. 20; and CERD/C/LTU/CO/9-10, para. 18.
[127] CERD/C/CZE/CO/12-13, para. 24; and general recommendation No. 30 (2004).
[128] CERD/C/GTM/CO/16-17, paras. 14 (c), 33 and 34. See also CERD/C/ISR/CO/17-19, paras. 32 and 33.
[129] CERD/C/MNG/CO/23-24, para. 24 (e).
[130] High-Level Expert Group on Artificial Intelligence, “The assessment list for trustworthy artificial intelligence (ALTAI) for self-assessment” (2020).

multidisciplinary oversight body that includes individuals who reflect the diverse composition of the population.

5. Education, training and public awareness

64. In line with article 7 of the Convention, States parties should promote public awareness of and education on the prohibition of racial discrimination and the right to equality in the enjoyment of the right to health. This includes educating health providers, policymakers and the general public about the importance of addressing racial disparities in health and ensuring equal access to healthcare services for all.

65. States should:

(a) Develop and offer anti-racism, anti-discrimination and cultural competency training for the members of the health workforce, at a minimum those in primary healthcare, including in humanitarian settlements, at the local, regional and national levels;

(b) Ensure that persons experiencing intersecting forms of discrimination participate in developing and delivering the above-mentioned training, where possible. Hospitals, primary healthcare centres and social services should ensure that training is complemented by institutional interventions to limit decision-making discretion and increase oversight in areas vulnerable to stereotyping and biases;

(c) Include human rights education as a mandatory course in the curricula of medical schools and ensure the provision of in-service training on intercultural health, discrimination-related health inequities and racism and exclusion, and on the role of health services in exacerbating and alleviating those inequities;

(d) Encourage medical schools to review their curricula and identify bias and stereotyping in medical training approaches and materials;

(e) Encourage medical schools to increase diversity and the representativeness of Indigenous Peoples, people of African descent, Roma and members of other ethnic groups, as applicable in the national context;

(f) Encourage associations of health professionals to consider integrating human rights and anti-discrimination training into their membership policies, and support them in such efforts;

(g) Conduct targeted awareness-raising campaigns to disseminate information about available health services and compulsory health insurance coverage requirements[131] and prevent the spread of false or misleading information in digital and physical environments.

E. Accountability

66. In accordance with article 6, States must assure to everyone within their jurisdiction effective protection and remedies against any acts of racial discrimination which violate his or her right to health, as well as the right to seek adequate reparation or satisfaction for any damage suffered as a result of such discrimination.

67. States should:

(a) Establish effective and independent accountability mechanisms, both internal – in healthcare establishments – and external, and envisage disciplinary measures for misconduct;

(b) Carry out periodic audits, with the help of independent experts, to identify gaps in internal policies and practices. Transparency regarding the outcomes of these procedures is strongly recommended, as it may strengthen accountability and the trust of individuals and communities;

[131] CERD/C/LTU/CO/9-10, para. 18 (d).

(c) Establish independent non-judicial accountability and grievance mechanisms with the competence to establish facts, and identify those responsible for acts or omissions constituting racial discrimination;

(d) Establish non-judicial remedies co-designed with racial and ethnic groups and Indigenous Peoples;

(e) Ensure the involvement of integrationist multiracial organizations and movements and include other means of eliminating barriers in accountability and redress mechanisms;

(f) Adopt a victim-centred and community-driven approach and an intersectional lens;

(g) Ensure, concerning any violation of the Convention that has resulted in harm, full reparation for the injury caused;[132]

(h) Adopt structural measures along with individual reparation;

(i) As part of reparation, take positive measures, such as education and training, guarantees regarding participation, and empowerment of the community affected, to ensure compliance with the obligation breached.

F. International cooperation and development

68. International cooperation in health is a key element in advancing equality and prohibiting racial discrimination. States should ensure consistency with their obligations under the Convention in the context of all organizations, including international and regional financial and development institutions. States should ensure effective and non-discriminatory access to preventive, curative and rehabilitative health facilities, goods, services and technologies. To this end, States must promote human rights-based development.[133] States should not promote, condone or perpetuate policies and practices that establish or reinforce, and are not aimed at removing, barriers faced by groups exposed to racial discrimination in the enjoyment of the right to health.

69. To combat global health inequities among and within States, States parties should be guided by the principle of international solidarity through international cooperation, including by supporting proposals such as the proposal for a comprehensive temporary waiver on the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights, and taking all additional national and multilateral measures that would mitigate the disparate impact of these challenges and their socioeconomic consequences on groups and minorities protected under the Convention.[134]

70. States are strongly encouraged to include, in multilateral and bilateral agreements and other negotiations that have an impact on global health non-discrimination, clauses that are aligned with article 1 (1) of the Convention and that ensure equality in the enjoyment of the right to health for all ethnic and racial groups, including castes.

IV. Dissemination of the general recommendation

71. States should disseminate the present general recommendation to all relevant authorities, and to racial and ethnic groups and Indigenous Peoples in their languages and other communication forms.

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[132] *Pérez Guartambel v. Ecuador* (CERD/C/106/D/61/2017), para. 6.

[133] See A/HRC/54/50.

[134] Statement 2 (2022) on the lack of equitable and non-discriminatory access to COVID-19 vaccines (A/77/18, para. 20).