

The International Convention on the Elimination of All Forms of Racial Discrimination as a Quasi-Global Tool

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This article belongs to the debate » [The World Health System After the Pandemic: Towards Equity and Decolonization?](#)

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Advancing Equality in the Enjoyment of the Right to Health

A few months after the outbreak of the pandemic, the Committee on the Elimination of Racial Discrimination [urged](#) States parties to the [International Convention on the Elimination of All Forms of Racial Discrimination \(ICERD\)](#) to protect against and mitigate the disproportionate impact on Indigenous Peoples, migrants, refugees, asylum-seekers, Roma, non-citizens, people of African descent, and other groups facing discrimination based on descent. Anti-discrimination laws and policies play a crucial role in addressing and mitigating the impact of such crises on different groups. The Committee on the Elimination of Racial Discrimination is currently working on a [General Recommendation](#) on racial discrimination in the enjoyment of the right to health. The Committee builds on the evidence-based understanding that racial discrimination is a structural determinant of health negatively influencing people's health throughout their life. Racial discrimination shapes individuals' exposures to disease, as well as their vulnerabilities and health outcomes. During times of crises, such as natural disasters, pandemics, or economic downturns, existing social, economic, and health inequalities are exacerbated. The purpose of the general recommendation currently developed is to identify the obligations of States to address the inequalities along racial or ethnic lines when it comes to the enjoyment of the right to health.

The content of the right to health under the ICERD

Recognizing racism as a structural determinant of health emphasizes the need for comprehensive and systemic interventions to ensure freedom from racial discrimination and advance equality in the enjoyment of the right to health. Against this background, an inclusive understanding of the right to health encompassing three dimensions is necessary:

autonomy, prevention, and health care. The International Convention on the Elimination of All Forms of Racial Discrimination can be a useful tool in advancing equality in the enjoyment of the right to health. According to [Article 5, para e \(iv\)](#),

“States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: (...)

[T]he right to public health, medical care, social security and social services;”

The Committee distances itself clearly from the restrictive position that the prohibition of racial discrimination applies only to the provision of health-related goods and services as such. The draft general recommendation rather builds on a more sophisticated concept of public health, with a view, on the one hand, to identify and prevent diseases among groups protected under the Convention, and on the other hand, to promote, and protect their health by improving the underlying social, economic and cultural determinants of their health. The draft promotes an intersectional approach in public health, acknowledging that factors such as sex, gender, gender identity, age, disability, migratory status, class, social status, income, or place of residence and location and others operate inseparably with race, colour, descent, or national or ethnic origin. Treating these cases solely as race-based discrimination essentializes victims and only partly satisfies human rights obligations while failing to unmask and tackle racial discrimination in a comprehensive manner.

Racial discrimination affects the availability, the accessibility, the adaptability and the quality of health. *Availability* is impacted by racial discrimination as health systems fail to recognize causes of mortality and morbidity affecting disproportionately groups protected by the Convention. Furthermore, groups subject to racial discrimination are oftentimes spatially concentrated in areas with high exposure to environmental health hazards or highly impacted by climate change. Such exposure to health hazards calls for appropriate mitigation measures. Environmental policies and laws, however, often do not respond to these risks through the required epidemiological studies, ongoing health outcome monitoring, and suitable health services.

Accessibility to timely, stable and affordable health care is not ensured for a high number of people of African descent, Indigenous Peoples, Roma, other ethnic groups, migrants, asylum seekers, among them many deprived of their liberty. Among the causes to be addressed are gaps in anti-discrimination laws and policies, rigid interconnectedness between employment and social security, lack of information on sexual and reproductive health, services, and medicine, including family planning, unequal distribution of resources, privatisation and commercialisation of the health sector without due regard to accessibility in practice. The

digital divide and the persistence of harassment, violence and criminalization of services related to sexual and reproductive health, especially abortions, continue to undermine the accessibility of health.

Civil society organisations and communities often report to the Committee on the limited availability of *culturally sensitive and gender-responsive* health care. The history of medicine has played a pivotal role in theories of racial superiority. This influence has extended to the creation of health systems, contributing to the stereotyping and bias against traditional medicine, as well as culturally sensitive personnel and practices, including midwifery care and culturally adapted interpreters. Arbitrarily prohibiting traditional healers, medicines, and pharmacopoeia specific to certain ethnic groups renders members of these communities vulnerable to diseases that have culturally grounded responses.

Racial discrimination not only impacts health through social determinants but also influences the *quality* of scientific and medical practices. Accessing skilled medical personnel, scientifically approved drugs, and hospital equipment is often impaired by unequal resource distribution. However, quality of health is also undermined due to persistent institutional bias and exclusion from medical research and treatment studies. Recognizing this, health providers' associations and medical schools are increasingly adopting a self-critical stance, acknowledging the broad effects of using "race" rather than addressing racism or racial discrimination when explaining differences in disease prevalence and standards of care. The use of Artificial Intelligence (AI) in health is increasingly raising concerns, as studies reveal that clinical algorithms, employed in hospitals, replicate structural inequalities by translating them into health indicators. Bias is further perpetuated by studies that do not challenge embedded racial ideologies and fail to assess the interplay between psychosocial, genetic, and environmental factors in explaining differences in health outcomes.

Racial bias severely affects the autonomy dimension of the right to health by exposing vulnerable persons to coercion, either through imposed treatments in institutional settings or criminalisation of health services, such as abortion. Structural inequalities compromise the right to informed consent. Limited access to culturally adapted information, distrust in public institutions, often intensified by health policies involving law enforcement, or misinformation disproportionately affect individuals and groups subjected to racial discrimination. Under its reporting procedure, the Committee has often discussed forced sterilizations and unsafe abortions. There is a vicious circle in failing to address the impact of racially motivated sexual violence, hindering access to information and programs on involuntary pregnancies, stigmatizing and criminalizing midwives belonging to racial and ethnic groups, and punishing abortion access.

General obligations under ICERD

Racial discrimination is considered one of the most severe forms of discrimination in international law. States have limited leeway in making distinctions based on grounds prohibited under Article 1 (1) ICERD. The Convention requires that States take actions to eliminate racial discrimination and to ensure equality in measures aimed at realizing the right to health (Article 5 e(iv)). Public health systems and policies must reflect the obligation of States to adopt special measures to secure that disadvantaged groups can enjoy the right to health on an equal footing (Articles 1 (4) and 2 (2)); see also General Recommendation No. 32 on the meaning and scope of special measures in the ICERD).

States parties must be in a position to measure the impact of racial discrimination in the enjoyment of the right to health, identify quantitative and qualitative trends and adopt specific and concrete measures within a broader policy. Monitoring of racial discrimination in health at the national level goes hand in hand with Articles 2(2) and 9 (reporting procedure). The reporting obligations under the Convention require that States keep their policies under review, develop indicators for their assessment and evaluate their human rights impact accordingly with a view to observe progress in eliminating racial discrimination and advancing equality.

This obligation was reaffirmed in the Durban Declaration and Programme of Action urging States to establish, on the basis of statistics, national programmes, including affirmative or positive measures, to promote the access of individuals and groups of individuals who are or may be victims of racial discrimination to basic health care, and to promote strong efforts to eliminate disparities, inter alia in infant and maternal mortality rates, childhood immunizations, HIV/AIDS, heart diseases, cancer and contagious diseases (paras. 100-101).

Articles 5 and 2 ICERD require States to pursue a policy of eliminating discrimination comprehensively, specifying that a wide range of measures is necessary to eradicate racial discrimination in all its forms and without delay. The obligations under the Convention encompass the duty to respect, to protect and to fulfil the right to health: States have undertaken the obligation to refrain from discriminatory practices in the enjoyment of the right to health. Moreover, States must protect the right to health by adopting preventative, protective, mitigating, and restorative measures and ensuring equality and non-discrimination in health by private actors. Finally, States must fulfil the right to health under ICERD by providing for an inclusive and anti-racist public health system, targeted trainings, public education, monitoring tools, representation, and participation of affected communities at all levels. Under Articles 5(e)(iv) and 4 of the Convention, States are required to refrain from and protect against stigmatization, incitement to racial hatred, and acts of discrimination based on health status against individuals and groups within the Convention's scope. Article 7 complements these obligations with regard to measures in the fields of teaching and education, with a view to combating prejudices and stereotypes.

Cross-cutting obligations under ICERD: participation, consultation, empowerment

Article 2(1)(e) provides for 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.” This obligation echoes the statement in the Preamble that “... the existence of racial barriers is repugnant to the ideals of any human society”. Integrationist multiracial organizations and movements supporting the principles of the Convention encompass grassroots and community organisations and civil society organisations, including health-related organisations. Anti-discrimination laws and public health often operate in silos. Participation and consultation of groups and communities within the purview of the Convention in health decision-making integrates their knowledge, improves the quality of decision-making processes and facilitates the implementation of policies. Legitimacy and transparency of decision-making processes and their outcomes are increased, and trust is built between health institutions and communities. If communities within the purview of the Convention are involved in the decision-making, at community, local, regional, or national level, they exercise their right to be heard and their right to information.

Conclusion

States parties to the ICERD must improve their public health systems by measurably advancing racial equality in law and in practice. As the world moves forward in understanding the structural dimension of racial discrimination in all areas of life, the General Recommendation No. 37 on racial discrimination in the enjoyment of the right to health can serve as a quasi-global instrument towards a more equitable and inclusive landscape for the realization of the right to health for all.

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