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I. Introduction

General recommendation (GR) No. 37 was adopted by the Committee in August 2024. Unsurprisingly, the pandemic was the catalyst for the initiation of a general recommendation by the Committee on the Elimination of Racial Discrimination (CERD/Committee) on racial discrimination in the enjoyment of the right to health. The process started with a thematic discussion between States parties to the Convention, international organisations and other agencies, health providers' associations and civil society associations, followed by a consultation process in all 5 regional groups of the UN. The Committee received input by all stakeholders on the first draft. A very limited number of States, including a CoE one under former government, supported the view that the draft adopted a broad interpretation which goes beyond the scope of the provision, in particular the scope of reproductive rights as enshrined in their national legislation.

II. Racial discrimination as structural social determinant of health

Although the World Health Organization (WHO) recognised the role of 'ethnicity' in health as early as 2008, it was the pandemic COVID-19 that fully exposed the synergistic effect of structural inequalities. Racial discrimination affects access to resources, opportunities, quality of life, economic, social and development policies. It causes and exacerbates health inequities, contributing to, or increasing the occurrence of preventable disease and deaths. GR No. 37 attempts to explain how laws, policies or practices may have an unjustifiable disparate impact upon racialised communities or fail to ensure their equal enjoyment of the right (article 1(4)). Adopting an informative model and an intersectional framework, GR No. 37 provides examples on how direct and indirect racial discrimination occur by acts and omissions and how racial bias, including algorithmic, may perpetuate structural inequalities. Implicit bias is prevalent in the healthcare sector and can lead to inaccurate pain diagnoses and treatment recommendations, ultimately impacting the quality of care provided. Clinical algorithms reproduce structural inequalities by translating them into health indicators or by failing to assess the synergies among psychosocial, genetic and environmental factors. It recalls that a race-based distinction nullifying the exercise of the right to health whether in law or practice is disproportionate to any legitimate aim and constitutes a violation. This is particularly relevant in frameworks where migratory status, statelessness, or legal regimes failing to address discrimination in accessing necessary legal documents exclude from access to universal health coverage or prioritise deprivation of liberty or deportation without due regard to health.

GR No. 37 emphasises that our monitoring should include all dimensions of structural discrimination, historical, societal and institutional: question and combat the legacies of slavery and colonialism in the education and training of health providers, the failure to address high rates of poverty and social exclusion, the low rate of participation and representation in political and institutional decision-making processes, the limited social recognition and valuation of ethnic and cultural diversity, and the disproportionate presence in prison or involuntary institutionalization increasing the vulnerability of racialised communities.

In GR No. 37, the Committee clarifies the scope of equality, combining formal with substantive equality, including by the adoption of special measures. National legislation in CoE Member

States does not fully incorporate the prohibition of racial discrimination under article 1 (1) ICERD and non-discrimination clauses are weakened by often disproportionate exceptions in other areas of law, such as migration or social security law. In the GR No. 37, the Committee recalls that to achieve substantive equality, States should : i) recognise and remedy the effect of racial bias and stigmatisation (articles 2(1)(d) and 4), ii) redress the disadvantage of protected individuals and groups by ensuring positive and special measures (article 2(2)), iii) ensure the active participation of underrepresented groups (article 2(1)(e)), iv) pursue structural changes (article 2(1)).

GR No. 37 analyses the content of the right to health under the Convention, encompassing freedoms and entitlements in prevention, autonomy and healthcare. This comprehensive approach implies that monitoring bodies at national and international levels should integrate indicators reflecting all three dimensions of the right to health.

Prevention

GR No. 37 establishes the link between disproportionate exposure to vulnerabilities and health-harming conditions and lack of the necessary material and psychosocial conditions to prevent and mitigate harms. In practical terms, this means that in our work, we should closely monitor to what extent racial discrimination in key determinants of health jeopardies health, particularly where racialized communities experience greater disadvantages, such as water and sanitation infrastructure, residential segregation, unsafe food, hazardous working conditions and toxic environments, or disproportionate exposure to the effects of climate change and environmental health hazards, due to their geographical location and socioeconomic status. Knowledge of this link activates both negative and positive obligations to refrain from laws, policies and practices that heighten the risk for racialised communities and to prevent and mitigate the harm by positive measures, including enhancing monitoring capacity in these areas, to protect them from harms inflicted by private actors and activities. Equality bodies at international and domestic levels should integrate in their monitoring intersecting factors, such as gender, migratory status, or disproportionate rates of incarceration, leading to inadequate healthcare, violence, mental health issues, and challenges in reintegration.

Autonomy

GR No. 37 clarifies how disproportionate interferences with the right to bodily autonomy and physical integrity exposes racialised communities to health-harming conditions, such as forced sterilizations or unsafe abortions. Equality bodies should monitor the enjoyment of reproductive autonomy and privacy. Racial bias often results in the overdiagnosis of mental health issues and excessive use of coercive practices with a disproportionate impact on the person, their family and the wider community.

Healthcare

GR No. 37 clarifies the right to equal and unhindered access to culturally appropriate, gender-sensitive and context-responsive quality health facilities, goods, services. Equality bodies at international and national levels should monitor based on quantitative and qualitative indicators the:

i. *Availability*: distribution of trained personnel, essential medicines, vaccines, and preventive goods within geographic reach of racialised communities.
ii. *Accessibility*: to what extent physical accessibility for those in remote areas or vulnerable conditions is fulfilled by positive measures and healthcare services are affordable, not resulting in financial hardship for racialised communities. We should

monitor the accessibility of health information. We should upgrade our monitoring of digital healthcare to prevent discrimination and the digital divide.

iii. *Acceptability*: GR No. 37 reaches out to health providers and other actors to promote acceptable healthcare, culturally sensitive, respectful of the diversity of racialised communities, and adapted to their linguistic and cultural characteristics.

iv. *Quality*: GR No. 37 clarifies that racial discrimination also affects the right to healthcare of good quality. Racialised communities are subject to institutional racial bias, stereotypes in medical training, and normalization of social constructs in health practices, protocols and policies. Women belonging to racialised communities often wait longer before they have access to medicine, including during labour.

III. Expected impact

General recommendations reflect the Committee's practice, in particular constructive dialogues with States parties resulting in recommendations on issues of concern. They describe emerging forms of racial discrimination, and new challenges in the implementation of the Convention, both in law and practice. This approach aims to keep States informed and up to date on their obligations under the Convention and how best to fulfil them. CoE Member States have ratified the Convention and submit reports on measures they adopt to fulfil their obligations. Every EU Member State invokes national legislations and measures applying EU legislation, in particular the Race Equality Directive and migration or refugee law. CERD always considers ECRI's conclusions and other CoE's bodies findings, strengthening the coordination of monitoring at UN and CoE levels. Equality bodies at international, regional and national levels have a common language on racial discrimination and the right to health. However, anti-discrimination and equality obligations related to the right to health, like other economic and social rights, have been explored in less systematic way. GR No. 37 clarifies the obligations to respect, protect and fulfil the right to equality and freedom from racial discrimination in the enjoyment of the right to health and promotes a symmetrical approach on the right to health. Combatting structural inequalities requires comprehensive strategies that address the root causes of health inequities and promote social justice, equality, and inclusion. This includes investing in collecting and disaggregating data, 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 perpetuating racial health disparities. As equality bodies, we have the same objective: identify and combat exclusions and advance equality. While global challenges risk widening the divide, this is not irreversible. Now, more than ever, it is essential to join our forces for a healthier and more inclusive society.