# Fact Sheet:

## Sexual and Reproductive Health and Rights in the Committee on the Elimination of Racial Discrimination's General Recommendation No. 37 on Racial Discrimination in the Enjoyment of the Right to Health

CENTER *for*
REPRODUCTIVE
RIGHTS

# Sexual and Reproductive Health and Rights in the Committee on the Elimination of Racial Discrimination's General Recommendation No. 37 on Racial Discrimination in the Enjoyment of the Right to Health

The Committee on the Elimination of Racial Discrimination (CERD Committee) monitors State compliance with the International Convention on the Elimination of Racial Discrimination (ICERD), which has been ratified by 182 countries.[1] Its General Recommendation No. 37[2] provides guidance to States on fulfilling their obligations under the right to the highest attainable standard of health enshrined in the Convention. While the general recommendation addresses numerous health issues affected by racial discrimination,[3] this fact sheet delves into the implications for sexual and reproductive health and rights (SRHR) and the overarching principles that influence both SRHR and other health concerns.

This general recommendation marks a pivotal moment in acknowledging and addressing the intricate link between racial discrimination and the right to health. General Recommendation No. 37 comes after historic calls for accountability for racially motivated human rights violations[4] and after evidence of the disproportionate impact of the COVID-19 pandemic on racialized and marginalized communities and individuals and on the protection of SRHR and maternal health.[5] As the first general recommendation from the CERD Committee explicitly focused on the right to health, it sets forth groundbreaking standards, many of which are presented below and analyzed within the context of SRHR.[6]

Overall, the general recommendation notes that the obligation to respect the right to health without racial discrimination requires States to refrain from disproportionately restricting or affecting the enjoyment of the right to health by racial and ethnic groups.[7] It also requires States to take positive measures to ensure equality in the enjoyment of the right to health.[8] The Committee crucially notes, for example, that the criminalization of "safe traditional health practices or the exercise of reproductive rights, such as the right to abortion," must be prohibited and that protection against obstetric violence, including segregating practices, should be explicitly included in national legislation.[9]

Under the right to health, States parties have an obligation to ensure equal access to culturally appropriate, gender-sensitive, and context-responsive quality health facilities, goods, and services. This includes "ensuring that primary care at local and referral levels relies on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as 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."[10]

# I. Introduction[11]

In the introductory section of the general recommendation, the CERD Committee remarks that "inequalities and discrimination have the largest impact on patterns of health inequities"[12] and that "disadvantaged groups experience higher levels of exposure to health risks and higher levels of associated mortality, 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, including mental health."[13] It notes that employment, education, housing, and the physical environment have a significant impact on one's health and well-being.[14] The Committee also recognizes that "racism, classism, sexism, ableism, xenophobia, homophobia, and transphobia are all structural determinants of health."[15] It points out that States have an obligation to address the legacies of colonialism, slavery, and apartheid that continue to disadvantage people of African descent and other racial and ethnic groups.[16]

# II. Normative Framework and Select Issues[17]

General Recommendation No. 37 reinforces some critical standards and fills essential gaps in the prohibition of racial discrimination related to the right to health, including sexual and reproductive health. Some of these are presented below.

## Prohibition of All Forms of Racial Discrimination[18]

"The prohibition of racial discrimination in international law imposes strict scrutiny in assessing the proportionality of the effect of any distinction, exclusion, or restriction in the enjoyment of the right to health."[19] Under the ICERD, health is understood as "the highest attainable standard of physical and mental health,"[20] increasingly viewed through an "ecocentric lens."[21] This perspective is closely tied to the United Nations Declaration on the Rights of Indigenous Peoples, the right to self-determination, and the individual and collective dimensions of Indigenous Peoples' understanding of health, which integrates spirituality, traditional medicine, biodiversity, and interconnectedness.[22]

## Intersectional Discrimination[23]

Intersectionality is a concept and theoretical framework included in the prohibition of racial discrimination that "provides recognition of the complex ways in which social identities overlap and create compounding experiences of discrimination and concurrent forms of oppression"[24] on the grounds of race, color, descent or national or ethnic origin, age, religion and belief, health status, disability, migratory status, socioeconomic status, sex, sexual orientation, gender identity, and gender expression or sex characteristics.[25]

General Recommendation No. 37 recognizes that discrimination is rarely experienced in isolation.[26] This intersectional approach to discrimination articulated by the Committee recognizes the compounded and unique experiences of disadvantaged persons that cannot be understood by considering each ground of discrimination separately. For example, barriers in reproductive health care have a cumulative effect on Indigenous women and girls not only because of their race but also because of their gender.[27] These forms of discrimination intersect and reinforce each other, creating a distinct experience of disadvantage that is greater than the sum of its parts. Similarly, an Indigenous woman with a disability may face discrimination based on her indigeneity, gender, and disability, resulting in a unique set of challenges that require an intersectional approach to address.

The general recommendation emphasizes that the prohibition of racial discrimination must encompass intersectional discrimination, and, as a result, States have an obligation to:

- **Recognize and address the specific ways in which different forms of discrimination intersect and create unique experiences of disadvantage.** This requires collecting disaggregated data that captures the experiences of different groups and using an intersectional lens to analyze this data.[28]
- **Develop and implement policies and programs that address the root causes of intersectional discrimination.** This may involve addressing systemic inequalities in education, employment, health care, and other areas that contribute to the marginalization of certain groups.[29]
- **Empower marginalized communities to participate in decision-making processes that affect their lives.** This includes ensuring that the voices of those experiencing intersectional discrimination are heard and that their needs are taken into account in the development and implementation of policies and programs.[30]

*Delving into the implications for SRHR, by acknowledging and addressing intersectional discrimination, the general recommendation provides a nuanced and comprehensive understanding of how racial discrimination operates in practice. This is essential for developing effective strategies to eliminate discrimination and promote equality for all.*

## Racial Bias, Including Algorithmic[31]

General Recommendation No. 37 recognizes that the stereotyping of patients belonging to racial and ethnic groups perpetuates sexism, power hierarchies, and mistrust in their ability to make their own decisions and can lead to inaccurate pain diagnoses and treatment recommendations that impact the quality of care.[32] It calls attention to the increasing use of algorithms in health care and the potential for these algorithms to reproduce structural inequalities that perpetuate racial bias.[33]

To address algorithmic bias, the general recommendation urges States to ensure that diverse and representative data sets are used in algorithm development, to promote transparency and explainability in algorithmic decision-making, to establish oversight and accountability mechanisms, and to involve affected communities in the development and implementation of algorithms used in health care.[34] By taking these steps, States can help ensure that technology is used to promote health equity rather than exacerbate existing inequalities.

*Algorithmic bias occurs when algorithms used for risk assessment, clinical decision support, or resource allocation produce outcomes that disproportionately harm racial and ethnic minorities. This can happen if the algorithms are trained on the basis of biased data or incorporate biased assumptions. Delving into the links with SRHR, an algorithm used, for example, to predict the risk of maternal mortality might be biased against Black women if it is trained on data that reflects existing racial disparities in maternal health outcomes.*

## Scope of Equality[35]

The general recommendation expressly states that "[e]quality underpinned by the ICERD combines formal equality with substantive equality in the enjoyment of the right to health."[36] Substantive equality necessitates actively addressing ongoing structural disparities and existing inequalities, taking into account the specific needs of different groups or individuals affected by racial discrimination.[37] Under the ICERD, States should recognize and remedy the effect of racial bias and stigmatization (articles 2(1)(d) and 4);[38] redress the disadvantage of protected individuals and groups by ensuring positive and special measures (article 2(2)); ensure the active participation of underrepresented groups (article 2(1)(e));[39] and pursue structural changes (article 2(1)).[40]

*Delving into the context of SRHR, these obligations set forth by the general recommendation mean that States must acknowledge and address how historical and ongoing systemic discrimination creates unique barriers to the realization of SRHR for certain groups. This could include, for example, targeted programs to improve access to contraception and maternal health care for marginalized communities, age-appropriate SRHR education, and measures to address the specific SRHR needs of Indigenous women, women with disabilities, and LGBTQ+ individuals. By actively working to eliminate these structural barriers and tailor interventions to the needs of*

*diverse groups, States can help ensure that everyone has the opportunity to achieve the highest attainable standard of sexual and reproductive health.*

## The Right to Bodily Autonomy and Physical Integrity[41]

General Recommendation No. 37 expressly recognizes that individuals and groups protected under the ICERD have the right to bodily autonomy and physical integrity.[42] "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 or forced interventions."[43] In doing so, the Committee underscores the principles of dignity, autonomy, and self-determination.[44]

*Delving into SRHR, this is of paramount importance, as it upholds the right of individuals, particularly women, girls, and gender-diverse persons, to make informed decisions about their bodies, their sexuality, and their reproductive lives free from coercion and discrimination.*

## Sexual and Reproductive Health[45]

The general recommendation expressly addresses sexual and reproductive health issues, recognizing that "the right to equality requires addressing causes of maternal mortality,[46] reproductive and maternal morbidities, and related disabilities disproportionately affecting persons within the purview of the ICERD, strengthening health systems to collect high-quality data to respond to the needs and priorities of women, girls and gender-diverse persons, as well as ensuring accountability in case of violations to improve quality of care and equity."[47] It also remarks that States must not prohibit or impede access to traditional medicine and practice or adopt discriminatory laws and practices in sexual and reproductive health. This translates into a State obligation to prohibit forced sterilization, to decriminalize and remove other barriers to accessing to abortion, and to ensure access to contraceptives and other health goods.[48]

It specifically recommends that States:

- tackle the root causes of maternal mortality and morbidity, which disproportionately affect women of color and Indigenous women due to systemic inequities in health care access and quality of care.[49]
- strengthen health information systems to collect disaggregated data that accurately reflects the specific health needs and priorities of women, girls, and gender-diverse persons, ensuring that SRHR programs and policies are evidence based and responsive to the needs of diverse populations.[50]
- ensure robust accountability mechanisms for any violations of SRHR, including

medical malpractice, denial of care, and forced sterilization, to enhance the quality of care and promote equity in access to sexual and reproductive health services.[51]

## Criminalization and Unsafe Abortions[52]

General Recommendation No. 37 importantly recognizes that "the criminalization of abortion in all circumstances constitutes an indirect form of intersecting racial and gender-based discrimination"[53] and that States have an obligation to implement World Health Organization (WHO) guidance on abortion, including its decriminalization.[54] In doing so, the Committee highlights that "[s]afe, 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 ICERD."[55] It acknowledges that banning access to abortion has a profound disparate impact on persons facing intersecting forms of discrimination[56] and exacerbates the underreporting of important health indicators that reveal racial inequalities.[57] The Committee also refers to the failure to recognize the impact of racially motivated sexual violence in a context of lack of access to information and programs on modern contraception and safe abortion care and the criminalization of abortion as "a chain of compounded discriminatory exposure to health-harming conditions."[58]

*It is important to highlight that the Committee condemns the criminalization of abortion as a form of intersectional discrimination on the grounds of race and gender. This is particularly significant because restrictive abortion laws disproportionately harm marginalized communities who already face barriers to health care access. The general recommendation urges States to align their legal frameworks with WHO's guidance on abortion, which calls for the full decriminalization of abortion and for ensuring access to safe abortion services.*

### WHO's Abortion Care Guideline

WHO's 2022 Abortion Care Guideline is the definitive guidance to States and other stakeholders on the provision of abortion care. It notes that all norms, standards, and clinical practice related to abortion should promote and protect informed and voluntary decision-making, autonomy in decision-making, non-discrimination (including intersectional discrimination), equality, and individuals' health and human rights.[59]

The recommendations contained in the Abortion Care Guideline are based on an evaluation of public health evidence and human rights standards. In the context of law and policy, the guideline recommends that States ensure the following:

- the full decriminalization of abortion and the absence of laws and other regulations that restrict abortion.[60] (Importantly, WHO's guidance provides the first-ever definition of "decriminalization" in the context of abortion by a UN agency or human rights mechanism, providing that "[d]ecriminalization means removing abortion from all penal/criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors." The guidance notes that "decriminalization would ensure that anyone who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care" and that "decriminalization of abortion does not make women, girls or other pregnant persons vulnerable to forced or coerced abortion. Forced or coerced abortion would constitute serious assault as these are non-consensual interventions."[61])
- that abortion be available on the request of the woman, girl, or other pregnant person.[62]
- the absence of gestational age limits,[63] mandatory waiting periods for abortion,[64] and third-party authorization requirements.[65]
- the option of self-management of medical abortion in whole or in part at gestational ages of less than 12 weeks.[66]
- that regulations on who can provide and manage abortion are consistent with WHO guidance.[67]

## Accessibility[68]

General Recommendation No. 37 notes that health care services must be accessible, encompassing physical, economic, informational, and digital accessibility. It recognizes that equality in accessibility can be strengthened by digital forms of health care, such as telemedicine,[69] and the ability to obtain, process, understand, and apply basic health information and services needed to make appropriate health decisions.[70] These obligations must protect against harassment and violence against persons attempting to access services,[71] including those related to sexual and reproductive health, especially abortion services.[72]

*The general recommendation stresses the importance of accessible health care services. Delving further into the context of sexual and reproductive health services, this means that contraception, abortion, maternal care, and the prevention and treatment of*

*sexually transmitted infections, among other services, should be available, affordable, and accessible to all without discrimination. It also emphasizes the need to protect individuals seeking these services from harassment and violence, a problem in the context of sexual and reproductive health services, which can be a significant deterrent to seeking health care, especially for marginalized communities.*

## Acceptability[73]

The general recommendation notes that "[e]quality in acceptability of health entails actively combatting stereotypes and legacies of theories of racial superiority, slavery and colonialism,[74] and bias against traditional knowledge, healers and practices."[75] It continues by stating that "[a] lack of recognition, or the arbitrary prohibition, of traditional healers, medicines, and pharmacopoeia specific to certain ethnic groups make them vulnerable to diseases."[76]

*Delving into SRHR, it highlights the need to combat harmful stereotypes and biases that permeate health care settings, including those related to traditional knowledge and practices. This includes recognizing and respecting diverse cultural perspectives on SRHR, including Indigenous birthing practices, and ensuring that health care providers are culturally acceptable and competent in providing care to individuals from various backgrounds.*

## Climate Change and Environmental Health Hazards[77]

The general recommendation recognizes that racial and ethnic groups have the "right not to be disproportionately subjected and to be protected against climate-induced health hazards, owing to their geographical location or socioeconomic situation, cultural norms and intrinsic psychological factors."[78] They also have the right "not to be subjected to and to be protected against degradation and adverse effects arising from exploitation of natural resources,"[79] including by private actors; the right to equal protection against harming practices; and the right to mitigation and reparation of harms.[80] The general recommendation also refers to the obligation to not conduct activities causing disproportionate environmental damage and to not impose "restrictions on the permanent rights of Indigenous Peoples, endangering their self-determination, traditional livelihoods, and cultural rights, per the standards of the [UN Declaration on the Rights of Indigenous Peoples]."[81]

*Delving into the disproportionate impact of climate change and environmental health hazards on racial and ethnic groups is particularly relevant to SRHR, as climate change can exacerbate existing inequalities and create new challenges to accessing sexual and reproductive health services and information. For example, it can disrupt health services, limiting access to contraception and abortion and increasing the risk of gender-based violence, including sexual violence. Additionally, environmental toxins and pollution can have a direct impact on reproductive health, leading to infertility, pregnancy complications, and adverse birth outcomes.*

*States therefore have an obligation to provide access to essential sexual and reproductive health services in climate-affected communities and to address the specific SRHR needs of those displaced by environmental disasters. By taking a proactive and intersectional approach, States can help protect the SRHR of all individuals and communities in the face of climate change.*

### Humanitarian Crises, Armed Conflicts, and Unilateral Coercive Measures[82]

General Recommendation No. 37 remarks that the ICERD, like all human rights treaties, continues to apply in humanitarian settings, including during conflict and war, and provides for "the right not to be subject to violence and trauma, ... depression, and anxiety and the right to equal enjoyment of the right to health, humanitarian assistance, protection, and opportunities for recovery and rebuilding."[83]

*Delving into the link between humanitarian contexts and SRHR, the general recommendation emphasizes that the right to health, which includes sexual and reproductive health, must be upheld even in challenging contexts such as humanitarian crises, armed conflicts, and situations where unilateral coercive measures are in place. These situations often disproportionately impact marginalized and racialized communities, exacerbating existing inequalities and creating new barriers to accessing essential sexual and reproductive health services. For instance, displacement, disruptions in health care systems, and increased risk of sexual violence can severely compromise the SRHR of women, girls, and LGBTQ+ individuals.*

*States thus have an obligation to ensure that humanitarian responses are inclusive and to address the specific SRHR needs of affected populations. This includes providing access to emergency contraception, abortion, maternal health services, and services for survivors of sexual violence. It also requires ensuring the meaningful participation of affected communities in the design and implementation of humanitarian programs, paying particular attention to the needs of the most vulnerable.*

## III. Participation and Accountability

### Participation, Consultation, and Empowerment[84]

The general recommendation refers to article 2(1)(e) of the ICERD to remind States of their obligation to involve associations, communities, and their representatives, including women, in designing and implementing health programs and projects for racial and ethnic groups.[85]

*Delving into the SRHR context, this observation reinforces the link between a lack of inclusive participation in political decision-making processes and inadequate health care for women, especially women facing intersecting forms of discrimination.*[86]

### Accountability[87]

The general recommendation calls on States to establish robust accountability mechanisms, both within health care settings and externally, with disciplinary measures for misconduct. Regular audits by independent experts should be conducted to identify shortcomings in internal procedures, with transparent reporting to foster trust. Independent nonjudicial bodies should be created to investigate racial discrimination, determine responsibility, and provide redress. These remedies should be designed in collaboration with affected racial and ethnic groups, including Indigenous Peoples, ensuring their involvement in eliminating barriers to accountability. A victim-centered, community-driven approach with an intersectional lens is crucial, as is providing full reparation for harm caused by racial discrimination, including individual and structural measures, as well as positive actions such as education and community empowerment.[88]

*Delving into SRHR, the general recommendation addresses obligations to ensure accountability across all stages of the policy cycle and not only in reaction to alleged violations.*[89] *It underscores the importance of centering the effective participation of rights holders and building or strengthening existing accountability mechanisms to realize human rights.*[90] *Due to the time-sensitive nature of reproductive health care, these mechanisms should be implemented in an effective, immediately accessible, and rapid manner when access to reproductive health services is denied.*[91]

## IV. Conclusion

In sum, General Recommendation No. 37 delineates obligations for States to uphold the right to equality and freedom from racial discrimination in the enjoyment of the right to health. In the context of SRHR, these obligations include the following:

- **Legal reforms:** Refraining from enacting or enforcing laws that prohibit or impede access to abortion services; decriminalizing abortion; and reforming laws to make abortion available and accessible.
- **Service provision:** Ensuring access to a comprehensive range of contraceptive methods and other essential SRHR-related health goods and services, including maternal care, the testing and treatment of sexually transmitted infections, and comprehensive sexuality education.

- **Eliminating harmful practices:** Prohibiting forced sterilization and obstetric violence, which are forms of gender-based violence that disproportionately affect marginalized women.
- **Combating stigma and discrimination:** Eliminating racial stereotypes and misinformation in health care settings that perpetuate stigma and discrimination against certain communities and hinder their access to sexual and reproductive health services.
- **Community participation:** Meaningfully involving affected communities, including women, Indigenous Peoples, and people of African descent, in the design, implementation, and monitoring of SRHR programs and policies to ensure that they are culturally appropriate and responsive to the needs of diverse populations.
- **Accountability:** Establishing effective and independent accountability mechanisms to address violations of SRHR, including mechanisms for reporting complaints, investigating allegations of abuse, and providing redress to victims.

General Recommendation No. 37 provides a robust framework for addressing the complex interplay between racial discrimination and the right to health, including SRHR. It serves as a clarifying call for States to dismantle discriminatory laws and practices, guarantee access to quality and comprehensive sexual and reproductive health services, and promote bodily autonomy and self-determination for all. By fulfilling these obligations, States can contribute to achieving health equity and social justice for marginalized communities.

The CERD Committee General Recommendation No. 37 can be found at https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-recommendation-no-37-2024-racial

## Endnotes

1 UN Office of the High Commissioner for Human Rights (OHCHR), Status of Ratification Interactive Dashboard (n.d.), *available at* https://indicators.ohchr.org/.

2 Committee on the Elimination of Racial Discrimination, General Recommendation No. 37: Racial discrimination in the enjoyment of the right to health, U.N. Doc. CERD/C/GC/37 (August 2024) [hereinafter CERD Committee, Gen. Rec. No. 37].

3 "In this Convention, the term 'racial discrimination' shall mean any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life." International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), *adopted* December 21, 1965, General Assembly Resolution 2106 (XX), *entered into force* January 4, 1969, art. 1.

4 *See* UN Media Center, "Human Rights Council holds an urgent debate on current racially inspired human rights violations, systemic racism, police brutality and violence against peaceful protests," June 17, 2020, *available at* https://www.ohchr.org/en/statements/2020/06/human-rights-council-holds-urgent-debate-current-racially-inspired-human-rights; OHCHR, Expert Mechanism to Advance Racial Justice and Equality in Law Enforcement (n.d.), *available at* https://www.ohchr.org/en/hrc-subsidiaries/expert-mechanism-racial-justice-law-enforcement; UN General Assembly, Human Rights Council Resolution for the "Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers through transformative change for racial justice and equality," U.N. Doc. A/HRC/RES/47/21 (July 13, 2021); UN General Assembly, Human Rights Council Resolution on the "Mandate of the International Independent Expert Mechanism to Advance Racial Justice and Equality in Law Enforcement," U.N. Doc. A/HRC/RES/56/13 (July 16, 2024).

5 *See* UN, COVID-19 and Human Rights Treaty Bodies (n.d.), *available at* https://www.ohchr.org/en/treaty-bodies/covid-19-and-human-rights-treaty-bodies; World Health Organization (WHO), Essential health services face continued disruption during COVID-19 pandemic, February 7, 2022, *available at* https://www.who.int/news/item/07-02-2022-essential-health-services-face-continued-disruption-during-covid-19-pandemic.

6 The Center for Reproductive Rights' application of the standards to SRHR is provided in italics.

7 CERD Committee, Gen. Rec. No. 37, *supra* note 2, paras. 49-50.

8 *Id*. para. 52.

9 *Id*. para. 51 (citing Committee on Economic, Social and Cultural Rights (CESCR Committee), General Comment No. 14 on the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), U.N. Doc. E/C.12/2000/4 (August 11, 2000)).

10 *Id*. para. 52(n) (citing WHO, Declaration of Alma-Ata, International Conference on Primary Health Care (September 6-12, 1978), *available at* https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata.

11 *Id*. paras. 1-4.

12 *Id*. para. 2 (citing Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (Geneva, WHO, 2008), p. 8, and World Health Assembly resolution WHA74.16 (May 31, 2021)).

13 *Id*. para. 3 (citing UN General Assembly, Report of the High Commissioner for Human Rights to the Human Rights Council, "Compendium of good practices on access to medicines, vaccines and other health products in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," U.N. Doc. A/HRC/53/50 (April 17, 2023), para. 8).

14 *Id*. para. 2.

15 *Id*. para. 12 (citing WHO, Operational framework for monitoring social determinants of health equity (January 18, 2024), *available at* https://www.who.int/publications/i/item/9789240088320

16 *Id*. para. 3 (citing CERD Committee, General Recommendation No. 34 on racial discrimination against people of African descent, U.N. Doc. CERD/C/GC/34 (October 3, 2011)).

17 *Id*. paras. 5-45.

18 *Id*. paras. 7-15.

19 *Id*. para. 7 (citing UN General Assembly, Report of the International Law Commission on the Seventy-third session (April 18 – June 3 and July 4 – August 5, 2022), U.N. Doc. A/77/10, Conclusion 23, *Yearbook of the ILC, 2022*, vol. II, Part Two; CERD Committee, General Recommendation No. 30 on discrimination against non-citizens (2005), para. 4).

20 *Id*. para. 6 (citing International Covenant on Economic, Social and Cultural Rights (ICESCR), *adopted* December 16, 1966, General Assembly Resolution 2200A (XXI), *entered into force* January 3, 1976, art. 12(1)).

21 *Id*. para. 6.

22 *Id*. para. 6 (citing UN Economic and Social Council (ECOSOC), Permanent Forum on Indigenous Issues, "Indigenous determinants of health in the 2030 Agenda for Sustainable Development," U.N. Doc. E/C.19/2023/5 (January 31, 2023); UN ECOSOC, Permanent Forum on Indigenous Issues, "Report on the twelfth session," U.N. Doc. E/2013/43-E/C.19/2013/25 (May 20-31, 2013), para. 4; and UN General Assembly, Human Rights Council, Study by the Expert Mechanism on the Rights of Indigenous Peoples on the right to health and indigenous peoples with a focus on children and youth, U.N. Doc. A/HRC/33/57 (August 10, 2016)).

23 *Id*. para. 12.

24 *Id*. para. 12 (quoting UN Network on Racial Discrimination and Protection of Minorities, Guidance Note on Intersectionality, Racial Discrimination & Protection of Minorities (2022), p. 11, *available at* https://www.ohchr.org/sites/default/files/documents/issues/minorities/30th-anniversary/2022-09-22/GuidanceNoteonIntersectionality.pdf

25 *Id*. para. 12 (citing UN Network on Racial Discrimination and Protection of Minorities, Guidance Note on Intersectionality, Racial Discrimination & Protection of Minorities (2022), p. 11).

26 "Discriminatory acts may be experienced individually, such as lack of access to quality obstetric care, or within a group, such as geographic and residential segregation without access to health care providers." *Id*. para. 9 (citing UN General Assembly, Report of the Committee on the Elimination of Racial Discrimination, 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, U.N. Doc. A/76/18, para. 18).

27 *Id*. para. 12 (citing Committee on the Elimination of Discrimination against Women (CEDAW Committee), General Recommendation No. 39 on the rights of Indigenous women and girls, U.N. Doc. CEDAW/C/GC/39 (October 26, 2022), para. 51).

28 *Id*. paras. 44, 45, 51(w), 54(o), 59, 60.

29 *Id*. paras. 2, 11, 21, 46, 59.

30 *Id*. paras. 10, 17, 18, 35, 42, 46.

31 *Id*. paras. 13-15.

32 *Id*. para. 14.

33 *Id*. para. 15.

34 *Id*. paras. 15, 57.

35 *Id*. paras. 16-17.

36 *Id*. para. 16 (citing CERD Committee, General Recommendation No. 32 on the meaning and scope of special measures in the International Convention on the Elimination of All Forms Racial Discrimination, U.N. Doc. CERD/C/GC/32 (September 24, 2009), para. 6).

37 *Id*. para. 16 (citing CERD Committee, General Recommendation No. 27 on older women and protection of their human rights (December 16, 2010), U.N. Doc. CEDAW/C/GC/27, para. 33; CERD Committee, General Recommendation No. 34 on racial discrimination against people of African descent, U.N. Doc. CERD/C/GC/34 (October 3, 2011), para. 55; CERD Committee, General Recommendation No. 32 on the meaning and scope of special measures in the International Convention on the Elimination of All Forms Racial Discrimination, U.N. Doc. CERD/C/GC/32 (September 24, 2009), paras. 11, 14).

38 *Id*. para. 16 (citing CERD Committee, Concluding observations on the combined twenty-second

to twenty-fourth periodic reports of the Kingdom of the Netherlands, U.N. Doc. CERD/C/NLD/CO/22-24 (November 16, 2021), paras. 27-28; CERD Committee, Concluding observations on the thirteenth to seventeenth reports of Rwanda, U.N. Doc. CERD/C/RWA/CO/13-17 (April 19, 2011), para. 16).

39 *Id*. para. 16 (citing CERD Committee, Concluding observations on the combined tenth to twelfth reports of the United States of America, U.N. Doc. CERD/USA/CO/10-12 (September 21, 2022), para. 9; CERD Committee, General Recommendation No. 34 on racial discrimination against people of African descent, U.N. Doc. CERD/C/GC/34 (October 3, 2011), para. 56).

40 *Id*. para. 16 (citing CERD Committee, Concluding observations on the combined twenty-fourth to twenty-sixth periodic reports of Argentina, U.N. Doc. CERD/C/ARG/CO/24-26 (May 24, 2023), para. 21; CERD Committee, Concluding observations on the combined tenth to twelfth reports of the United States of America, U.N. Doc. CERD/USA/CO/10-12 (September 21, 2022), para. 36).

41 *Id*. paras. 30-34.

42 *Id*. para. 18.

43 *Id*. para. 30 (citing CESCR Committee, General Comment No. 14 on the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), U.N. Doc. E/C.12/2000/4 (August 11, 2000), para. 8; CESCR Committee, General Comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), U.N. Doc. E/C.12/GC/22 (May 2, 2016), para. 5; UN General Assembly, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. Doc. A/HRC/35/21 (March 28, 2017), paras. 30-34).

44 *Id*. para 30.

45 *Id*. para. 44.

46 *Id*. para. 44 (citing WHO, Strategies toward ending preventable maternal mortality (EPMM) (February 25, 2015), *available at* https://www.who.int/publications/i/item/9789241508483 and WHO, Ending preventable maternal mortality: a renewed focus for improving maternal and newborn health and well-being (November 16, 2021), *available at* https://www.who.int/publications/i/item/9789240040519.

47 *Id*. para. 44 (citing WHO, Maternal mortality (April 26, 2024), *available at* https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.

48 *Id*. paras. 8, 32, 33, 34, 36, 37, 51.

49 *Id*. para. 44.

50 "Disaggregated data allows authorities to monitor the social determinants of health, and identify the impact of racial discrimination intersecting with gender and other inequalities." *Id*. paras. 59-60.

51 *Id*. paras. 44, 67.

52 *Id*. paras. 33-34.

53 *Id*. para. 34 (citing CERD Committee, Concluding observations on the combined tenth to twelfth reports of the United States of America, U.N. Doc. CERD/USA/CO/10-12 (September 21, 2022), para. 35; CERD Committee, U.N. Doc. CERD/C/BRA/CO/18-20 (December 19, 2022), para. 16(b); CERD Committee, Concluding observations on the combined eighteenth and nineteenth periodic reports of El Salvador, U.N. Doc. CERD/C/SLV/CO/18-19 (September 13, 2019), para. 27).

54 *Id*. para. 33 (citing WHO, Abortion care guideline: Web Annex A. Key international human rights standards on abortion (2022), *available at* https://iris.who.int/bitstream/handle/10665/349317/9789240039506-eng.pdf; *see also* CERD Committee, Gen. Rec. No. 37, *supra* note 2, para. 57(e)).

55 *Id*. para. 33.

56 "Indigenous women, gender-diverse persons and women of racial and ethnic minorities are often at a higher risk of unwanted pregnancy, often lacking the means to overcome socioeconomic and other barriers to access modern contraceptive methods and safe abortion." *Id*. para. 33.

57 *Id*. para. 34 (citing UN General Assembly, Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. Doc. A/66/254 (August 3, 2011), para. 19).

58 *Id*. para. 34.

59 WHO, Abortion Care Guideline (March 8, 2022), *available at* https://www.who.int/publications/i/item/9789240039483, p. 31.

60 *Id*. pp. 24-25.

61 *Id*.

62 *Id*. pp. 26-29.

63 *Id*. pp. 24-25.

64 *Id*. pp. 41-42.

65 *Id*. pp. 42-44.

66 *Id*. p. 98.

67 *Id*. p. 59.

68 CERD Committee, Gen. Rec. No. 37, *supra* note 2, paras. 37-40.

69 *Id*. para. 37 (citing WHO, Recommendations on digital interventions for health system strengthening (June 6, 2019), *available at* https://www.who.int/publications/i/item/9789241550505; and UN General Assembly, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Digital innovation, technologies and the right to health, U.N. Doc. A/HRC/53/65 (April 21, 2023), paras. 31-36).

70 *Id*. paras. 37, 40.

71 *Id*. para. 37 (citing CERD Committee, Concluding observations on the combined eighteenth to twenty-fifth periodic reports of Hungary, U.N. Doc. CERD/C/HUN/CO/18-25 (June 6, 2019), para. 20).

72 *Id*. para. 34 (citing CERD Committee, Concluding observations on the combined eighteenth and nineteenth periodic reports of El Salvador, U.N. Doc. CERD/C/SLV/CO/18-19 (September 13, 2019), paras. 26-27).

73 *Id*. para. 41.

74 *Id*. para. 41 (citing UN General Assembly, Report by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Racism and the right to health, U.N. Doc. A/77/197 (July 20, 2022), paras. 47-60).

75 *Id*. para. 41 (citing WHO Executive Board, Report by the Director-General on the WHO traditional medicine strategy: 2014–2023 (December 14, 2022), *available at* https://apps.who.int/gb/ebwha/pdf_files/EB152/B152_37-en.pdf).

76 *Id*. para. 41 (citing UN General Assembly, Declaration on the Rights of Indigenous Peoples, U.N. Doc. A/RES/61/295 (October 2, 2007), art. 21, 24, 29, and 31).

77 *Id*. paras. 22-23.

78 *Id*. para. 23 (citing UN General Assembly, Report of the Office of the UN High Commissioner for Human Rights: Analytical study on the relationship between climate change and the human right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. Doc. A/HRC/32/23 (May 6, 2016)).

79 *Id*. para. 22.

80 *Id*. para. 19.

81 *Id*. para. 51(f) and (i) (citing CERD Committee, Concluding observations on the combined seventeenth to nineteenth periodic reports of Zambia, U.N. Doc. CERD/C/ZMB/CO/17-19 (June 3, 2019), paras. 25-26; CERD Committee, Concluding observations on the combined twenty-third and twenty-fourth periodic reports of Mongolia, U.N. Doc. CERD/C/MNG/CO/23-24 (September 17, 2019), para. 23).

82 *Id*. paras. 28-29.

83 *Id*. para. 28.

84 *Id*. para. 58.

85 *Id*. para. 57 (citing CERD Committee, General Recommendation No. 27 on older women and protection of their human rights (December 16, 2010), U.N. Doc. CEDAW/C/GC/27, para. 34; WHO, Social participation for universal health coverage, health and well-being, U.N. Doc. A77/A/CONF./3 (May 28, 2024)).

86 WHO, Sexual health, human rights, and the law (2015), *available at* https://iris.who.int/bitstream/handle/10665/175556/9789241564984_eng.pdf, p. 6. Based on evidence from cases of marginalized populations being refused access to sexual and reproductive health services, WHO recognizes the association between the participation of affected populations and health outcomes and recommends guaranteeing the participation of marginalized and affected populations in all stages of decision-making and implementation of policies and programs.

87 CERD Committee, Gen. Rec. No. 37, *supra* note 2, paras. 66-67.

88 *Id*. para. 67.

89 *See* UN General Assembly, Follow-up on the application of the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity, U.N. Doc. A/HRC/39/26 (June 29, 2018), paras. 38, 62(j).

90 *Id*. para. 45.

91 CEDAW Committee, *L.C. v. Peru*, Views adopted by the Committee under article 7, paragraph 3, of the Optional Protocol to the Convention, concerning Communication No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (October 17, 2011), para. 8.17.