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THE UK'S EXTRATERRITORIAL OBLIGATIONS AND THE RIGHT TO HEALTH IN A TIME OF POLYCRISIS

FAILURE TO MEET CERD REQUIREMENTS ON ACCESS TO HEALTH IN THE CONTEXT OF INTELLECTUAL PROPERTY AND TRADE, THE GLOBAL DEBT CRISIS, AND THE PALESTINIAN GENOCIDE

Alternative report to the 113th session of the UN CERD

Alternative report to the 113th session of the UN Committee on the Elimination of Racial Discrimination (CERD) for the review of the United Kingdom of Great Britain and Northern Ireland

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Submission by:

Feminists for a People's Vaccine Campaign (FPV)
and
Campaign Against Racism (CAR)

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Summary

1. Executive Summary

The world is currently in an era of polycrisis, which has exacerbated existing challenges to the international human rights system and threatened many people's right to the highest sustainable standard of physical and mental health. This report is presented on behalf of the Feminists for a People's Vaccine Campaign (FPV)[1] and the Campaign Against Racism (CAR) for the UN Committee on the Elimination of Racial Discrimination **(CERD Committee)** in advance of its consideration of the 18th and 19th periodic reports of the United Kingdom of Great Britain and Northern Ireland **(UK)**. It focuses on the right to health in the context of the ongoing 'post'-pandemic access to medicines crisis, a growing global debt crisis, and the crisis of impunity in relation to the Palestinian genocide. It asks the CERD Committee to use its powers under the International Convention on the Elimination of All Forms of Racial Discrimination **(ICERD)** to strongly recommend that the UK remove intellectual property **(IP)** barriers to the equitable access to medicines, treatments and diagnostics, protect human rights in its debt restructuring and negotiations actions, and fulfil its international human rights obligations with respect to the ongoing Palestinian genocide.

2. List of recommendations

Regarding access to medicines, treatments and diagnostics, and the removal of intellectual property barriers to racial equality and non-discrimination, we respectfully request the CERD Committee to recommend that the UK:

1. Ensure that it or the corporations governed by UK law does not invoke or apply intellectual property rights in a manner that is inconsistent with the right to health, including access to medicines, vaccines and other health products, or the right of States to exercise the flexibilities of the TRIPS agreement (as recommended by the UN Office of the High Commissioner for Human Rights **(OHCHR)** in a recent study[2] on key challenges in access to health).

2. Refrain from requiring "TRIPS-Plus"[3] proposals that undermine pharmaceutical manufacturing capacity and timely access to affordable vaccines and medicines in any current and future negotiations with developing countries.

3. Support Colombia's proposal submitted to the WTO Council for Trade-Related Aspects of Intellectual Property Rights on 15 April 2024.[4]

4. Ensure equity in the process of negotiations and the final substance of the Pandemic Agreement. The terms of the Agreement must provide for stronger commitments on technology transfer and the removal of intellectual property barriers, concrete obligations on the sharing of essential medical products, a legally binding fair, transparent, accountable and effective Pathogens Access and Benefit Sharing System (PABS), expanding manufacturing capacity in the Global South and strict conditions that any product resulting from publicly funded research and development must be a global public good to be equitably shared.

5. Commit to adequately supporting low- and middle-income **(LMICs)** countries in meeting their obligations under the Pandemic Agreement through the principle of common but differentiated responsibilities.[5]

Regarding the global debt crisis, particularly the UK's role in the debt crises across Africa, we respectfully request the CERD Committee to recommend that the UK:

1. Through democratic and participatory processes internationally, domestically, and in affected countries, co-develop:

   a. fair restructuring mechanisms like debt freezes (for short-term solutions) and unconditional cancellations (for long-term), including debts held by private lenders;

   b. a holistic approach to compensation of harms subjected to people from historical injustices of slavery and colonialism to ongoing harms rooted in the legacies of European colonialism that continue to kill black and other people of colour globally, and are perpetuated through existing debt instruments.

2. Ensure policies that protect human rights, including public health, during debt negotiations, ultimately facilitating prioritisation of health of the communities in African countries.

As per the CERD Committee's Statement 5 (2023)[6] and Decision 2 (2023)[7] on Israel and Palestine under its Early Warning and Urgent Action system, we respectfully request the Committee to recommend that the UK:

1. Fulfil the CERD Committee's recommendation to "provide all necessary financial and humanitarian aid to Palestinians" by,

   a. supporting the Palestinian people's right of return and right to self-determination;

b. creating a Gaza family reunification scheme, similar to the process and legal framework created for Ukraine family reunification;

b. creating a pathway for children affected by the genocide to receive life-saving medical care in the UK, as it did in the case of Malala Yousafzai – and again in 2022, when, after the Russian invasion of Ukraine, Britain welcomed 21 Ukrainian children with cancer to continue their treatment.

2. Fulfil the CERD Committee's recommendation to "cooperate to bring an end to the violations that are taking place and to prevent … genocide"[8] by,

a. calling for an immediate and permanent ceasefire;

b. recognising Palestinian statehood, as a means to bolster the potential for peace through a democratic and diplomatic processes; and

c. ending all transfers of weapons and ammunition to Israel, including indirect transfers through intermediary countries that could ultimately be used by Israeli forces, in accordance with the recent call by a group of UN experts.[9]

3. Health in the time of polycrisis: the role of CERD in enabling an equitable, non-discriminatory global health system

a. The global context: a continuation of colonial systems and racial discrimination

The universal right to public health is enshrined in Article 5(e)(iv) of ICERD and confirmed within the larger body of international human rights law. Every State has ratified at least one international human rights treaty recognising the right to health.[10] Situations that exacerbate vulnerability - poverty, irregular migratory status, health status, racism - can nullify or impair our equal enjoyment and exercise of the right to health, which includes other determinants such as water, electricity, a healthy emotional environment, healthy planet, healthy environment and information and services such as on sexual and reproductive health. The growing multitude of complex global challenges - starting with COVID-19 and now compounded by a heightening of military assaults and the debt crises faced by LMICs - has worsened those underlying determinants.[11] In this polycrisis context, the right to the highest sustainable standard of physical and mental health remains a "distant goal".[12]

This erosion of access to health - embedded in the structure of racial and patriarchal neo-capitalism - is self-perpetuating. The proliferation of profit-making by multinational corporations during the COVID-19 pandemic - often facilitated by public funds - and IP constraints, supported by countries like the UK, have further tipped the scales in favour of high-income countries to whom huge debts have already been accumulated. This leads to the erosion of already unstable health infrastructure and national health budgets in LMICs. Conflicts and military assaults such as those in Palestine, Syria, Sudan, the Democratic Republic of the Congo, Yemen and Ukraine - heighten both current and future health crises and economic crises and are by their nature incompatible with the full attainment of the right to health.

This reality did not begin with COVID-19 or even in recent years. Today's inequalities have historical, colonial roots that endure because of the frameworks and rules that govern global political economy; that is, the international and national laws and institutions that entrench power relations and drive these inequalities, poverty and injustice, shaping and condoning corporate driven decision-making in a way that prioritises profits over humanity.

b. The manifestation of racial discrimination in health: trade and access to medicines; the global debt crisis; and the Palestinian genocide

i. The 'post'-pandemic crisis of access to medicines and intellectual property barriers to intersectional racial equality

Long-standing health inequities upheld by racialised systems rooted in slavery and colonialism are part of the structural causes of intersectional inequities in health systems and policies, leading to increased economic and social vulnerabilities.[13] Alongside other structural causes, racial discrimination and inequities affect health-related intermediary factors, including the "non-recognition of the health needs of key groups" stigmatised by race, caste, ethnicity, and migration status.[14] Colonialism itself is a determinant of health, resulting from the colonial structures that continue to shape racist inequalities in health access, resources and health outcomes. [15]

Indeed, racial discrimination in access to medicines is not a phenomenon restricted to COVID-19 medicines, treatments, and diagnostics, although the pandemic exacerbated these inequalities.[16] Rather, it is a longstanding concern equally prevalent in relation to medicines such as access to HIV/AIDS antivirals[17] and racial disparities in access to medical advancements and technologies[18] (e.g. in the treatment of Alzheimer's[19] and sickle cell disease, even in high-income countries such as the US)[20], with the racial discrimination of COVID-19 responses repeated shortly after in responses to the Mpox outbreak in 2022.[21]

Between States, there is gross imbalance in the priorities of global health initiatives, exacerbated by limited national health budgets (which are in turn impacted by the global debt crisis discussed in other sections below). LMICs have been forced to accept stringent patent protections in bilateral and multilateral agreements to avoid trade sanctions[22], to the benefit of pharmaceutical corporations largely domiciled in high-income countries, such as the UK. All with deteriorating impacts on the right to health and, as stated by the CERD Committee in the context of COVID-19, attributable to the "consequences of the historic racial injustices of slavery and colonialism that remain largely unaccounted for today."[23]

This continued opposition to waiving IP barriers even temporarily, to the benefit of high profit making of pharmaceutical corporations domiciled in countries such as the UK, raises serious concerns about the UK's compliance with its extraterritorial obligations under ICERD, such as the duties of international cooperation and assistance, which include the obligation to refrain from infringing on the ability of other States to fulfil their own human rights obligations.

ii. The global debt crisis and the draining of resources from public health systems

In 2022, Debt Justice classified 54 countries as being in debt crisis[24], whereby debt repayments undermine a country's economy and/or its government's ability to protect its citizens' basic economic and social rights. This 'debt' has its roots in historical injustices and global economic structures that leave many countries with few options but to borrow on terms that undermine their ability to fulfil international human rights obligations. Neo-colonialism and imperialism persist, with rich countries continuing to rely on the exploitative extraction of raw materials, goods and services from the Global South to prop up their exponentially growing prosperity. The drain of Global South commodities by the Global North - including the UK - is estimated to be worth $2.2 trillion annually.[25] Meanwhile, LMICs are paying up to 15.5% of their government revenues to external creditors - an increase from <8% before the pandemic.[26] This trend undermines States' human rights obligations and their ability to comply with international health standards, such as WHO policy guidance which directs Member States to reduce reliance on private healthcare financing, including out-of-pocket spending and voluntary health insurance. [27]

In LMICs, the COVID-19 pandemic brought with it the 'perfect storm' of increasing debt repayments, declining tax revenues and rising expenditure demands,[28] with stretched budgets reallocated towards COVID-19 and lockdowns, in countries whose health systems were already hindered by corruption.[29] For example, in Zambia, debt repayments increased from 20% in 2018 to 38% in 2021,[30] while its health sector budget declined from 9.5% in 2018 to 8% in 2022.[31]

Debt restructuring and "fiscal consolidation" programmes offered to LMICs by International Financial Institutions (such as the International Monetary Fund (IMF) and the World Bank), high-income countries (primarily the predominantly European countries including the UK that make up the 'Paris Club')[32] and private lenders impose harsh austerity measures on public budgets.[33] Countries are only eligible to seek loans from the Paris Club if they have an existing agreement under an IMF debt programme.[34] Such programmes have been shown to harm health in three ways: (1) restraining the public financing of health systems through loan conditionalities (leading to privatisation, user fees and copayments for public health services);[35] (2) increasing the cost of health commodities and medicines when stabilisation measures such as currency devaluation are introduced; and (3) affecting the social determinants of health through the cutting of public funding for education, transport and social welfare as part of debt-related health austerity measures.[36] This was seen in practice with the rapid spread of Ebola in West Africa in 2014, caused in part by weak health systems.[37] In the years leading up to the crisis, the main hosts of the epidemic - Guinea, Liberia and Sierra Leone - had implemented IMF structural adjustment programmes.[38] Systematic under-investment in public healthcare systems leads to poor health outcomes for the most vulnerable.

The unjust dynamics of the modern global financial system perpetuate the same disadvantages committed in the slave trade and colonialism, undermining the advancement of racial equality between and within States. In November 2020, creditor countries such as the UK collaborated with the IMF and commercial lenders to set up the 'Common Framework' for debt restructuring, which has since been credited with severe debt distress in countries such as Chad, Zambia, Ghana, Sri Lanka and Pakistan,[39] echoing the decades of lost development seen in the 1980s and 1990s off the back of punitive stabilisation and austerity programmes.[40] Minimal participation of private creditors in debt relief initiatives and instead taking it as an opportunity for reckless lending to African countries with high interest rates has undermined debt relief initiatives. This highlights significant weaknesses in the initiatives that are intended to support low income countries to overcome the debt crises.

As discussed in Section 4(b), the UK holds a particularly powerful position in its ability and obligation to solve the debt crisis, both in terms of its national laws - e.g., "[o]ver 90% of lower-income external debt payments to private creditors are governed under English law"[42] - as well as its decision-making power within the IMF and World Bank as a member of the G7 and its historical obligations for the horrors and ongoing legacies of the slave trade and colonialism.[43] The UK's unwillingness to use its powers over private creditors and on the global stage to repair these injustices undermines efforts to liberate African economies and economies throughout the Global South.

iii. The ongoing genocide in Palestine and the destruction of health infrastructure

Over nearly 10 months of an "unrelenting assault"[44] in Gaza, Israel has deliberately targeted health workers, hospitals, ambulances, medical convoys and water, sanitation and hygiene facilities **(WASH facilities)n**[45] in a total obliteration of an already fragile health system that, alongside the weaponisation of famine[46], has led multiple international law and human rights experts to conclude, at minimum, that there are "reasonable grounds" genocide is being committed in Gaza, as well as direct findings of war crimes.[47] Dr Tlaleng Mofokeng, the UN Special Rapporteur on the Right to Health, has condemned Israel's failure - both as an occupying power and as a member of the UN - to meet its obligations under international human rights and humanitarian law by "knowingly and intentionally imposing famine, prolonged malnutrition and dehydration" and exacerbating the risks of water and airborne diseases, lack of medical and surgical supplies and lack of sexual and reproductive health and mental services.[48] The "intergenerational physical and mental health, health impacts of racism, structural discrimination, violence and imperialism" will leave Palestinian people with deep and long-term trauma.[49] Israel's violent dismantling of the health infrastructure in Gaza - including damage to Gaza's only specialised cancer hospital and using it as an army base - has been met with a overwhelming silence which amounts to a "racist dehumanisation of the Palestinian people",[50] particularly when contrasted to the 2023 and 2024 response by the international community to similar events in Ukraine. [51]

The international community - including parties to ICERD - carries obligations under international humanitarian and human rights law to prevent genocide,[52] and has been called on by the CERD Committee to "develop and implement an immediate and complete ceasefire" and "provide all necessary financial and humanitarian aid to Palestinians in the occupied Gaza Strip".[53] In a recent report of the Independent International Commission of Inquiry on the Occupied Palestinian Territory, all UN Member States were also called on to ensure compliance "with all treaty body obligations".[54] Indeed, it is to these treaties - and the international human rights system they embody - that many turn to address root and structural causes of violations, with legal experts calling the "Question of Palestine" a "litmus test" for the system as a whole in its ability to address historical wrongs, calling for the application of an anti-colonial framework for assessing harms and ensuring accountability.[55] The UK's review by the CERD Committee is an opportunity to meet this test and hold the UK accountable to its international obligations in relation to the Palestinian genocide, discussed in more detail under Section 4(c) below.

4. The UK's extraterritorial obligations under the ICERD in relation to health

The right to public health and medical care is enshrined in Article 5(e)(iv) of ICERD.[56] States parties are required to take actions to eliminate racial discrimination and to ensure equality in measures aimed at realising this right to health. These obligations apply not only to a State Party's domestic actions, but also extraterritorially. The International Court of Justice (ICJ) has found that "there is no restriction of a general nature in ICERD relating to its territorial application" and that Article 5 does not contain a specific territorial limitation, observing that ICERD "generally appear[s] to apply, like other provisions of instruments of that nature, to the actions of a state party when it acts beyond its territory." [57]

a. Trade and Access to Medicines: the UK's support for intellectual property barriers violates ICERD

Everyone has the right to enjoy the benefits of scientific progress and its applications (Article 15(1)(b) ICESCR). However, States have for decades used TRIPS - a WTO agreement on the protection of IP rights - and the right to protect moral and material interests from scientific productions (Article 27(2) UDHR) to justify strict and unfair limitations on access to medicines that disproportionately impact people of colour in LMICs. This conflict was addressed in a 2000 OHCHR resolution on IP rights and human rights[58] and has now been reiterated in its most recent report published in July 2024.[59] The OHCHR reminds us that,

> *[a]ccess to medicines, vaccines and other health products is deeply unequal in many countries owing to structural barriers, social determinants of health and other factors affecting various populations that are marginalised. These inequalities are further aggravated in contexts of fragility, conflict and violence…This impact is most dramatic in low- and middle-income countries…Children, women and girls, older persons, migrants, persons in geographically remote areas and persons with disabilities are among those who are disproportionately affected by limitations on access to medicines. Frequently, intersectional and multiple discrimination has a compounded differential impact." One of the recommendations which the OHCHR then makes is that States are "to ensure that intellectual property rights are not invoked and applied in a manner that is inconsistent with the right to health, including access to medicines, vaccines and other health products, or the right of States to exercise the flexibilities of the TRIPS agreement".*[60]

As demonstrated in the CERD Committee's statements during the COVID-19 pandemic,[61] inequitable and discriminatory access to treatments and medicines is an important area of

concern under ICERD. The CERD Committee has made several recommendations to States parties on racial discrimination in the context of access to vaccines and medicines.[62] E. Tendayi Achiume, the then-UN Special Rapporteur on contemporary forms of racism, in a letter to the WTO's 12th ministerial conference, highlighted the obligations of WTO Members - including the UK - to tackle racial discrimination in international IP law.[63] A similar recommendation from the CERD Committee would complement its calls in the first draft of its *General recommendation No. 37* on *Racial discrimination in the enjoyment of the right to health* **(Draft GR No. 37)**[64] for States to "take all necessary national and multilateral measures, including temporary waivers of IP protections on healthcare technologies, to mitigate the disparate impact of global challenges, such as pandemics, climate change and disasters, and their socioeconomic consequences on groups and minorities protected under the Convention".[65]

Despite international law precedents and the UK's agreement, as a WTO member state, that TRIPS "does not and should not prevent member governments from acting to protect public health,"[66] the UK has consistently acted to undermine the right to health, particularly in LMICs. The CERD Committee has issued several communiques[67] on the matter, calling for the said developed countries to ensure international cooperation by supporting the TRIPS waiver proposal including the triggering of its early warning and urgent action procedure. At the same time, the UK imposed export restrictions on health products that could have been relevant to COVID-19 treatment[68], and hoarded vaccines,[69] causing implementation challenges to the COVAX Facility.[70]

The UK, together with the European Union, led by Germany, and Switzerland, continuously adopted intransigent positions on the TRIPS waiver proposal filed by India and South Africa[71] in 2020 at the WTO during the COVID-19 pandemic: blocking much-needed scaling up and diversification of global manufacturing of health products and technologies for the prevention, treatment and containment of COVID-19. In so doing, the UK took positions which protected the monopolies and massive profits of large pharmaceutical companies domiciled within its boards, resulting in enormous loss of lives globally[72] and prompting a letter by southern civil society organisations to then Prime Minister, Boris Johnson, to act in solidarity with more than 100 countries that supported the proposal.[73]

The statistics of inequity in the roll-out of COVID-19 vaccines are now well-known. Among other things, research by Gozzi et al showed that in twenty LMICs which were considered, more than 50% of deaths that occurred could have been averted had these countries been able to afford the same per capita daily vaccination rate reported in the selected high-income countries.[74]

The TRIPS waiver discussion ended in a stalemate with the WTO failing to deliver a comprehensive multilateral solution on diagnostics and treatments for the COVID-19 pandemic at its 13th Ministerial Conference.[75]

Most recently, in March 2024, after 30 years of TRIPS implementation, Colombia tabled a proposal.[76] The proposal is filed under Article 71 of TRIPS, requesting, among other things, a review of TRIPS implementation. Implementation has been controversial and after 30 years, requires a Member-driven policy discussion, supported by metrics and data on best practices, identifying obstacles and potential implementation improvements, among other elements. The Colombia proposal provides this crucial opportunity[77] and the UK must now support it. The UK also continues to thwart efforts at ensuring that equity is restored into multilateral efforts and processes in health emergency preparedness and response whether in negotiations to be made to the International Health Regulations 2005 (IHR 2005) or for the Pandemic Agreement.[78] In the former, disregarding the WGIHR's[79] mandate arising from the WHO Executive Board Decision 150(3) to tackle equity gaps in IHR 2005[80] by pushing to water down proposed equity-related text; in the latter, opposing the adoption of the principle of common but differentiated responsibility, a core tenet of sustainable development in the implementation of pandemic prevention, preparedness and response in the first week of negotiations at the ongoing 9th meeting of the Intergovernmental Negotiating Body (INB).[81] At this session, "developed countries called "international solidarity" a contested concept, taking the discussions to a stage where the WHO legal counsel had to refer to dictionaries and WHO resolutions to explain the meaning of the principle of international solidarity, according to a developing country delegate."[82] Although negotiations on amendments to the IHR have concluded, negotiations for the Pandemic Agreement continue.

In its trade negotiations, such as the UK-India free trade agreement **(FTA)**, the UK has pursued "TRIPS-Plus" provisions - i.e., "tougher or more restrictive conditions [in] patent laws than are required by the TRIPS Agreement."[83] Not only are the negotiations being carried out in a non-transparent manner, the UK's proposed provisions would water down transparency and patent opposition mechanisms in India's IP regime while extending the patent term beyond 20 years, and allow for the granting of market exclusivities over clinical data.[84] India is renowned for its dynamic IP system, which is seen as achieving a good balance between promoting innovation while ensuring robust protection. India is a global provider of affordable generics used by the NHS itself.[85] Based on our information, the TRIPS Plus proposals were withdrawn due to global pressure; however, the UK's proposed provisions would have allowed for greater abuse of the Indian patent system, likely resulting in 'evergreening' of patents, thereby impacting global supply of affordable generic pharmaceuticals. It is therefore vital that the UK refrain from including these provisions in all future trade agreements.

The UN Special Rapporteur on the right to health has emphasised that "Developing countries and [least developed countries (**LDCs**)] should not introduce TRIPS-Plus standards in their national laws. Developed countries should not encourage developing countries and LDCs to enter into TRIPS-Plus FTAs and should be mindful of actions which may infringe upon the right to health."[86] Moreover, the UK's own historical experience shows that a "strong" IP

regime, in the sense of providing strong protection of private IP rights, was not an essential condition for its economic development. The UK itself established a strong IP regime only in the mid-19th century. It is very important to note that in relation to pharmaceutical patents especially, few of the developed countries today allowed patents on chemical and pharmaceutical substances (as opposed to the processes) until later in the 20th century.[87] The UK's efforts to impose more stringent IP protections in the national laws of India, therefore, be interpreted, at best, as a double standard, and at worst a deliberate attempt to protect the wealth of the UK and its pharmaceutical industry at the expense of the right to health and right to development of other countries.

b. The Global Debt Crisis and the Right to Health: the UK's ICERD obligations require fair debt restructuring and cancellation

UN Member States are bound by the UN Charter, Article 1(3), to "achieve international co-operation in solving international problems of an economic [character …] without distinction as to race". States have a duty to solve the foreign debt crisis, if nothing else than to uphold their ICERD obligations to realise the right to public health and medical care that is currently being eroded with cumulative effects, particularly for vulnerable and marginalised groups.[88] Debt servicing is leading States to redirect vital funds and failing to meet the universal human rights standards of availability, accessibility, acceptability, and quality in health services.[89] Debt and loan conditionalities and austerity measures are leaving countries unable to use the "maximum of their available resources"[90] to achieve the full realisation of the right to health. The American Public Health Association reported in 2022 that no country that spends more on public debt service than on healthcare meets the minimum health expenditure required to provide universal health coverage and achieve Sustainable Development Goal 3.[91] A review of IMF loans approved from 2020 to 2023 found that most project a decrease in public spending, with 80% including at least one measure that risks harming rights.[92]

State obligations under ICERD - and the international law regime more broadly - must therefore be considered in all aspects of loan and debt repayment negotiations, with countries like the UK, at minimum, ensuring that lending conditions do not interfere with other States' ability to direct sufficient resources toward the fulfilment of human rights, including the right to health.

This is particularly true given the well-known exacerbation of economic challenges by COVID-19, which led to significant debt distress and increased borrowing to finance public services in the Global South, particularly in African countries.[93] As a result, these countries are spending a higher proportion of their Gross National Income on debt servicing,[94] impacting their ability to fund essential areas like health.[95] Reports indicate that as of August 2022, African countries owed £2,758 million to the UK, comprising 56% of all foreign debt owed to

the UK. Among these, Zimbabwe's standing debt was £342.34 million, Uganda's was £380.37 million, and Zambia's was £252.44 million. African nations spent over 50 times more on external debt than they received in UK aid, highlighting a severe imbalance.[96]

The World Bank's September 2023 report indicates that many African countries are at high risk of debt distress, with nine already in distress.[97] This crisis is partly due to private lenders' high interest rates post-2008 financial crisis, with Western private creditors holding the highest external interest payments.[98] Despite efforts, UK debt relief initiatives with private creditors have been largely unfruitful, yet these debts are governed by English law, presenting a unique opportunity for legislative action to compel debt cancellation.[99] Failure to address this could repeat the 1980s and 1990s crises, where private creditors were unchecked, leading to economic shocks and further IMF and World Bank loans. [100]

The UK must support fair restructuring mechanisms like debt freezes (for short-term solutions) and unconditional cancellations (for long-term), and ensuring policies that protect public health during debt negotiations, ultimately facilitating prioritisation of health of the communities in African countries.[101] Indeed, a recent study has shown that "45% of Brits agree with the UK wiping the debts of lower income countries".[102] Besides debt cancellation, the UK must recognise the continuing legacy of its role in the debt crisis and support a holistic approach on compensation of harms subjected on people, from historical injustices of slavery and colonialism to ongoing harms rooted in the legacies of European colonialism that continue to kill Black and other people of colour globally.

These recommendations are consistent with the duty to cooperate through, at minimum, non-interference with African countries' ability to mobilise their maximum available resources around the fulfilment of the right to health. They also ensure that the UK is complying with its own extraterritorial obligations to respect the right to health in its dealings with other countries. The primacy of human rights over economic agreements applies not only to those accepting loans and formulating policies within their own countries, but also to those extending the loans and with the power to shape loan conditions, the laws governing loan agreements, and political decisions on the kinds of financial instruments that are offered - be they loans (concessional or otherwise), grants, or other reparative arrangements. In all this, ICERD must be guiding the UK's actions, with concrete measures to eliminate racial discrimination within and outside its borders.

c. The Palestinian Genocide: The UK's inaction to safeguard the rights of Palestinian people violates its ICERD obligations

Since December 2023, the CERD Committee has "warned of hate speech and dehumanising discourse targeted at Palestinians, raising severe concerns regarding Israel's and other

State parties' obligation to prevent crimes against humanity and genocide."[103] It has also "raised the alarm on the deteriorating human rights situation in the occupied West Bank and East Jerusalem… including the increase in unlawful use of lethal force by the Israeli forces, violence by settlers, arbitrary arrests and detention of Palestinians." The Committee highlighted the obligations of States to "provide all necessary financial and humanitarian aid to Palestinians", fully respect the international obligation (including under ICERD) to "cooperate to bring an end to violations that are taking place and to prevent…genocide", and ensure that all those responsible for international crimes are promptly brought to justice. In its Draft GR No. 37, the CERD Committee emphasises that international cooperation in health is a "key element in respecting freedom from racial discrimination"[104] and affirms that "Donor States should not promote, condone, or perpetuate policies and practices which establish, reinforce, and do not aim at removing barriers of groups exposed to racial discrimination in the enjoyment of the right to health".[105]

Despite urgent calls from the CERD Committee, other UN human rights mandate holders, and global solidarity movements, many State Parties - including the UK - continue to fail to take the action necessary to meet their international obligations. There is no right to health in the context of genocide. Perversely, health activists across the globe have called Israel's targeting of Gaza's health infrastructure "using healthcare…as weapons of war", adding "once health system is destroyed, injuries cannot be treated, primary care cannot be delivered, and famine cannot be managed - in other words, life cannot be sustained."[106]

Through its country reporting processes and constructive dialogues, the CERD Committee - and the treaty body system as a whole - is in a unique position to ensure all States are taking the necessary measures to prevent genocide and secure the right of return for all Palestinians.

In particular, since the beginning of Israel's military assault on Gaza on 7 October 2023, the UK government has consistently demonstrated inaction around the protection of the human rights of the Palestinian people, ignoring its obligations under international humanitarian and human rights law. Two months into the genocide, more than 10,000 Palestinian people were confirmed killed, including 4,000 children, and evidence showed the deliberate destruction of health infrastructure in Gaza. By the end of December 2023, at least 312 health workers had been killed, only 13 of the initial 33 hospitals were still functional, while 53 health care centres, 104 ambulances and 20 WASH facilities were destroyed.[107] Amidst news of this carnage, the Scottish National Party put forward a motion for a ceasefire which was rejected by parliament, with the UK instead supporting limited "humanitarian pauses".[108] These pauses were described as "part of measures to facilitate the flow of life saving humanitarian aid and ensure civilians are safe."[109] These measures did not have the intended impact and the death toll in Gaza continued (and continues) to rise at horrifying rates, with evidence of deliberate attacks on Gaza's healthcare system and workers.[110] The destruction of the health system

has severely impacted maternal care, with a survey conducted in April 2024 by UN Women finding that 76% of pregnant women had anaemia and that 99% faced challenges accessing necessary nutritional products and supplements. Furthermore, 55% of breastfeeding mothers reported health conditions impeding their ability to breastfeed and 99% faced challenges securing enough breastmilk.[111] Newborns are dying because of a lack of prenatal and postnatal services,[112] terror and anxiety are causing a rise in premature births,[113] women are giving birth in shelters or in the streets amid rubble[114] or undergoing C-sections without anaesthesia.[115]

On 21 February 2024 (after more than 4 months of active genocide), the UK parliament voted for an immediate ceasefire in Gaza and the rapid and unimpeded humanitarian relief to be allowed into the Gaza Strip.[116] However, according to War Child UK, the motion passed excluded statements on collective punishment of the Palestinian people - a war crime that was widely recognised as occurring early on in Israel's military assault.[117] Many members of the government walked out as the motion was being passed, undermining the legitimacy of the motion.

Moreover, while these debates were ongoing in the UK, growing calls were being made for the government to stop weapons exports to Israel.[118] Oxfam found that "over 100 new licences allowing UK companies to sell arms to Israel were issued by the UK government between October 2023 and May 2024", concluding that "by continuing to sell arms the UK is complicit in the killing of civilians in Gaza."[119] This conclusion was recently supported by a group of UN experts who called on States to stop all transfers of arms to Israel, listing in particular UK weapons manufacturer BAE Systems.[120]

The UK's slow action - or, put differently, complicity - in regard to the genocide demonstrates that, despite a recognition of the need for urgent humanitarian aid, the UK has not heeded the calls of the international community, including the CERD Committee, to cooperate to bring an end to all violations taking place and prevent genocide.

These actions include measures that can be taken within the UK, such as supporting the medical evacuation of children from Gaza and creating a Palestinian family visa scheme similar to the visa scheme that was developed for Ukrainian families, including providing a waiver of the current requirement on biometrics for application given the context of genocide.

It is clear that the infrastructure exists for the UK to support children to evacuate and to respond to their urgent medical needs, whether these stem from the current genocide or from medical situations that were exacerbated as a result of the decimation of healthcare facilities by the occupying force.

A clear model exists to bring a limited number of children facing urgent medical needs, whether direct casualties of the conflict or suffering from other serious conditions such as cancer, to the UK on a temporary basis for short-term treatment. Once they are stabilised and on the path to recovery they will return to continue their rehabilitation in the region. The UK brought 21 children from Ukraine to England for cancer treatment in March 2022, within only three weeks of Russia's invasion. This recommendation is also supported by UNICEF, which has called for "urgent medical cases in Gaza to be able to safely access critical health services or be allowed to leave, and for injured or sick children evacuated to be accompanied by family members."[121]

Regarding the visa scheme, proposals are already being put forward, with MP Alison Thewliss recently noting in Parliament that:[122]

> Gazans are stuck in a cruel and irrational Catch-22 situation: they cannot cross the border to Egypt because they do not have visas, as they cannot get their biometrics registered, but they cannot get their biometrics registered because they cannot get to a visa application centre in Egypt. The Government has the power to waive the requirement for biometrics to be registered.

Lastly, we continue to ask that the UK government follow the recent actions of Spain, Norway and Ireland in formally recognising Palestine as a state. To date, the UK has shown a firm reluctance to engage on the issue.[123] We are, now more than ever, reminded of the relevance of the statement that was made after the UK House of Commons vote on Palestinian recognition (unfortunately not binding on the government):

> The power of symbolism cannot and should not be underestimated, but there is also overwhelming evidence that international recognition of Palestine would serve the causes of peace, justice and international law.[124]

At its 67th session the CERD Committee developed a set of key indicators to assess the existence of factors leading to conflict and genocide.[125] All of these indicators are present in Israel's actions against Palestine historically and currently. The UK must heed the CERD Committee's recommendations in its recent decisions and statements on Israel and Palestine[126] and take all necessary due diligence and other direct measures to comply with its obligations to prevent genocide, under ICERD and international law more broadly.

5. Conclusion

In today's complex, multilateral world, the international human right system must stand ready to hold individual States accountable for the human rights impacts - within and outside their territory - of their conduct within a web of global systems. The CERD Committee has repeatedly risen to this challenge, guiding State Parties on their obligations under ICERD with respect to trade, intellectual property, access to medicines, external debt, and with respect to obligations to prevent genocide. The UK's review during the 113th Session provides a further opportunity to address the ongoing legacies of its colonial past and demonstrate how ICERD obligations to end racial discrimination and advance racial equality can be put into action at the global level and in the context of some of today's most urgent crises.

We therefore respectfully request that the CERD Committee include the list of recommendations noted above in its constructive dialogue with the UK and Concluding Observations.

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