

# Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health

Case prepared by Mr. George Dvaladze, LL.M., student at the Geneva Academy of International Humanitarian Law and Human Rights, under the supervision of Professor Marco Sassòli and Ms. Yvette Issar, research assistant, both at the University of Geneva.

**N.B. As per the disclaimer, neither the ICRC nor the authors can be identified with the opinions expressed in the Cases and Documents.** Some cases even come to solutions that clearly violate IHL. They are nevertheless worthy of discussion, if only to raise a challenge to display more humanity in armed conflicts. **Similarly, in some of the texts used in the case studies, the facts may not always be proven;** nevertheless, they have been selected because they highlight interesting IHL issues and are thus published for didactic purposes.

**[Source:** Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/68/297, 9 August 2013, available at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N13/422/97/PDF/N1342297.pdf>, footnotes omitted]

## I. Introduction

[...]

2. Contemporary conflicts take a variety of forms, including internal disturbances, protests, riots and civil strife and unrest, in addition to armed conflicts as addressed under international humanitarian law. They also include occupied territories and territories with constant military presence where populations may be affected by conflict for many years despite the lack of active hostilities. The report defines State obligations in relation to the right to health in all such conflict situations. Situations which do not meet the criteria for armed conflict or occupation are governed exclusively by human rights law, including the right to health. Armed conflict however is governed by international humanitarian law as well as human rights law.

[...]

5. The concurrent application of both sets of laws in armed conflict enhances the rights of affected populations. Additionally, human rights law ensures protection of affected populations where the application of international humanitarian law is disputed. Concurrent application is also helpful in situations directly concerning the right to health, such as the effects of general insecurity on health and its underlying determinants that may not be adequately captured under international humanitarian law. Human rights law also contains more specific obligations regarding availability, accessibility, acceptability and quality of health services than international humanitarian law does.

6. Both international humanitarian law and human rights law share the aim of protecting all persons and are grounded in the principles of respect for the life, wellbeing and human dignity of the person. They provide complementary and mutually reinforcing protection. The application of human rights law to conflict would ensure greater protection of civilian population and additional accountability mechanisms for States and remedies for affected population.

## **II. Conceptual framework**

7. The right to health in international law is, *inter alia*, contained in article 12 of the International Covenant on Economic, Social and Cultural Rights. The right to health framework is set forth in general comment No. 14 of the Committee on Economic, Social and Cultural Rights, which interprets the right to health and mandates States to respect, protect and fulfil the right to health of everyone, including persons affected by and/or involved in conflicts.

8. The right to health framework comprises a range of socioeconomic aspects, termed as underlying determinants such as nutritious food, potable water, housing, a functioning health system and situations of violence and conflict. Conflict has negative repercussions on other underlying determinants, as it can result in a breakdown in systems and infrastructures, including health systems. Conflicts can also result in worsening public health conditions due to physical injuries, poor mental health, an increase in malnutrition, particularly among children, and outbreaks of communicable diseases.

### **A. Right to health framework in times of conflict, including armed conflict**

9. States are obliged to utilize the maximum available resources towards the realization of economic social and cultural rights, including the right to health. An aspect of this obligation is that the right to health is progressively realizable. However, due to the destruction or diversion of resources to military or police needs, conflicts often reduce the availability of resources which may, at times, be detrimental to the right to health. Even where resources are available, States may not be able to make use of them due to the insecurity and poor infrastructure in many conflict environments.

10. Nonetheless, progressive realization is a specific and continuous State obligation. It does not dilute certain immediate obligations of States, including taking concrete steps towards the full realization of the right

to health to all, without discrimination and regardless of the status of persons as combatants or civilians.

[...]

#### **B. State obligations**

13. As at other times, States have the obligation to respect, protect and fulfil the right to health in conflict. This includes situations where States occupy or otherwise exercise effective control over foreign territory, where the full spectrum of obligations under the right to health applies. States also have other human rights obligations, including but not limited to the right to life and the obligation to refrain from torture and other forms of cruel, inhuman or degrading treatment or punishment.

[...]

### **III. Availability, accessibility, acceptability and quality of health facilities, goods and services**

[...]

#### **A. Non-discrimination and medical impartiality**

18. The right to health framework obliges States, including public health-care workers, to ensure access to health facilities, goods and services, without discrimination. Refusal to treat persons wounded in conflict or providing preferential treatment to people of the same allegiance constitutes a direct violation of the right to health.

19. Moreover, acceptability requires health facilities, goods and services to be in line with medical ethics. This includes provision of impartial care and services by health professionals to people affected by conflict. Medical impartiality in treating wounded people is also mandated by international humanitarian law. Therefore, health professionals have obligations vis-à-vis provision of health services to people affected and/or involved in conflict.

20. The right to health framework requires that prisoners and detainees be allowed equal access to health facilities, goods and services. International humanitarian law also requires prisoners and detainees to be treated humanely with access to medical care. Yet in many conflict situations, prisoners and detainees are restricted from accessing health facilities, goods and services. This contravenes the non-discriminatory protections afforded to them under the right to health.

[...]

#### **C. Physical barriers**

23. Availability and accessibility of functioning hospitals and clinics are essential to the enjoyment of the right to health. States are under the obligation to ensure that health facilities are not harmed as a consequence of conflict. However, a number of physical barriers are deployed in times of conflict which severely affect access to health facilities and services. Obstacles such as forcible detours, arbitrary stops at checkpoints, imposition of travel permits and interrogation of patients result in worsening medical conditions of patients. Other measures such as blockades, long or indeterminate curfews and roadblocks also restrict movement of people and transport, thereby negatively effecting access to and delivery of essential health-care services in conflict-affected areas. States have also prevented civilian groups from accessing medical goods, especially life-saving medicines and supplies by obstructing, restricting, limiting or diverting medical supplies.

[...]

#### **D. Attacks on health facilities and health-care workers**

26. Destruction of health infrastructure by States, or failure to protect against such destruction by third parties, impairs the availability and accessibility of quality health facilities, goods and services. Intentional targeting of health facilities also constitutes a violation of the principle of distinction under international humanitarian law, which obliges parties to the conflict to refrain from attacking medical personnel, units, material and transports unless they are used to commit hostile acts outside their medical and humanitarian functions. Acts that do not involve specific targeting of health facilities may also violate the right to health where the acts increase the risk of damage to the facility or decrease patient access to it, such as by locating military outposts or weapons in the vicinity of a clinic.

[...]

28. Attacks on health workers including assaults, intimidation, threats, kidnapping, and killings, as well as arrests and prosecutions, are increasingly used as a strategy in conflict situations. Conflict-affected areas have recorded disruption in supply chains, looting of health facilities, demanding of confidential information about patients, intentional and recurrent shelling and bombardment of clinics and hospitals, and shooting at ambulances carrying patients to target civilians and health-care workers as a military strategy.

[...]

[...]

#### **E. Military use and militarization of health facilities**

30. Militarization refers to the taking over or use of health facilities and services by armed forces or law

enforcement agencies for achieving military objectives. Such military use poses a serious risk to the life and health of patients and healthcare workers and erodes the role and perception of hospitals as a safe space to access health care. The impartiality of medical facilities is often compromised by the constant presence of security forces in hospitals and intimidation of patients and health-care workers in hospitals and clinics.

[...]

31. In occupied territories and in areas where health care is funded or provided by the military, health-care workers have been targeted due to their perceived association with military forces. Health professionals may also be targeted for providing services to anti-Government groups due to perceived support for such groups.

[...]

## **IV. Vulnerable groups**

[...]

### **C. Women**

43. Conflict may aggravate women's vulnerability to ill-health, discrimination and gender-based violence. Women often experience higher incidence of poor health outcomes in conflict owing to their physical and reproductive needs during pregnancy and childbirth. Most maternal deaths in conflict occur during delivery or in the immediate post-partum period due to lack of availability of quality reproductive and maternal care, such as family planning, emergency obstetric services, and pre- and post-natal care. Women in conflict situations are more likely to turn to unsafe abortion services when facing an unplanned pregnancy.

[...]

45. Mass displacement, breakdown of community and family networks, and institutional collapse may create a vacuum in which women and young girls are vulnerable to sexual violence. They face a heightened risk of sexual exploitation and trafficking, as well as increased domestic violence and abuse from family members. Health facilities that lack qualified health professionals, patient referral mechanisms and psychological counselling may be unable to identify and respond to these forms of conflict-related sexual violence. This is especially true when health services are restricted to sexual violence perpetrated by armed groups. The stigma associated with sexual violence and HIV and the absence of adequate protection mechanisms may also contribute to negative physical and mental health outcomes. Stigma, abandonment by families and communities, and retribution from perpetrators create an atmosphere that perpetuates gender-based violence and leads to the exclusion and disempowerment of survivors. The failure to provide services that promote the safety and respect the confidentiality of survivors undermines their full participation in society, particularly in post-conflict reconstruction efforts.

## **D. Children**

[...]

48. Conflict may also result in children adopting new roles and responsibilities, which may increase their vulnerability to sexual violence and exploitation. Health facilities in conflict often lack child-appropriate services for survivors of sexual violence, particularly for boys. Exposure to sexual violence increases the risk of further violations for girls. For example, marriage to the perpetrator is often seen as a means of 'protecting a girl's honour'. However, forcing survivors of sexual violence to marry their attackers re-victimizes them and results in the legitimization of the actions of the perpetrator and social acceptance of sexual violence [...].

[...]

## **V. Obligations of entities other than the primary State**

51. The primary responsibility for realizing the right to health in conflict lies with States who are involved in the conflict. However, other States and non-State actors, including armed groups, international organizations and humanitarian non-governmental organizations, also bear obligations towards the realization of the right to health of affected populations.

### **A. International obligations**

[...]

### **B. Non-State armed groups**

55. The majority of contemporary conflicts are non-international armed conflicts involving one or more non-State armed groups. These non-State armed groups may significantly affect the enjoyment of the right to health in conflict. One study has found that non-State armed groups are as likely as State forces to attack or interfere with health facilities, and nearly twice as likely to enter hospitals for illegitimate purposes.

56. There is growing acceptance that non-State armed groups reaching a certain level of organization and control should respect international humanitarian law and human rights law. Common article 3 of the Geneva Conventions of 1949 and Additional Protocol II thereto both address parties to the conflict, which are understood by international courts to include organized non-State armed groups. Similarly, fact-finding commissions have concluded that armed groups that are stable, organized, and have effective control over territory have legal personality regarding a defined range of international humanitarian law and human rights obligations [...] (see A/HRC/19/69, paras. 106-107, and A/HRC/17/44). These include obligations to refrain from attacking or interfering with humanitarian facilities, vehicles, and personnel, and to refrain from harming civilian populations, including through sexual violence or destroying food or water systems.

57. Non-State armed groups are also bound by the expectation of the international community that they will respect norms contained in the Universal Declaration of Human Rights, especially where they exercise control over territory (A/HRC/2/7, para. 19, and E/CN.4/2006/53/Add.5, paras 25-26). Additionally, the right to health framework recognizes the responsibility of all sectors of society towards realizing the right to health, which includes the responsibility of non-State actors such as armed groups and other arms bearers in conflict. Finally, armed groups have been held accountable for obligations voluntarily assumed through agreements, unilateral statements and monitoring systems under the Security Council (resolution 1998 (2011)), which have included both obligations to respect human rights and to protect or fulfil them where armed groups exercise the control and authority to do so. Armed groups must therefore, at the minimum, respect human rights, including the right to health, and may assume further obligations to protect or fulfil human rights. The obligation of States to protect people against third-party violations continues regardless of whether armed groups are present on its territory, and the presence of third-party armed groups should not be used by States as an excuse to abdicate from their right to health responsibilities in conflict areas.

58. Nonetheless, there is currently a gap in the delineation of the human rights responsibilities of non-State armed groups and in mechanisms for holding them accountable, other than criminal prosecutions. In this respect, the obligation of the State to facilitate the discharge of right to health responsibilities by all sections of society becomes particularly important. States, civil society and international organizations have successfully facilitated agreements on human rights and humanitarian issues with non-State armed groups, including agreements to provide 'days of tranquillity' for health workers to safely provide vaccinations. States should adopt, support and expand these initiatives to protect and fulfil the right to health in conflict and minimize the impact of conflict on vulnerable groups.

[...]

## **VI. Accountability and remedies**

61. Accountability is an essential aspect of the right to health framework. It requires independent monitoring, prompt investigations, transparent governance, including collecting and disseminating accurate and complete information to the public, and access to remedies for victims of violations. These requirements are also addressed under international humanitarian law, which obliges States to prevent, investigate and punish violations of international humanitarian law. Clear policies and codes of conduct should be in place within the military, police force, and medical institutions to protect the right to health in conflict.

[...]

### **B. Remedies**

65. Prompt, effective and adequate remedies for violations are a key component of accountability. Under the right to health framework, any person or group whose right to health has been violated should have access to

effective judicial or other appropriate remedies at both national and international levels, including adequate reparations, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. States should provide effective, prompt and accessible means of claiming remedies within judicial and administrative systems. They should also ensure that peacebuilding processes such as amnesties, statutes of limitation or exemptions from civil or criminal action for military or police forces do not obstruct access to remedies, and provide means for claiming remedies against both State and non-State actors.

[...]

## **Discussion**

### **I. General Issues**

1. Does IHL impose obligations on parties to the conflict regarding the healthcare? Does IHL provide individual rights? What does IHL say about the right to health? (CIHL, Rules 25-30 and 109-110; GC I-IV, Art. 3; P II, Arts 7 and 8; GC I, Arts 12(2), 15(1), 19, 21-22, 24-25 and 33-35; GC II, Arts 12(2), 18(1) and 22; GC III, Arts 30 and 31; GC IV, Arts 16, 55-57 and 59-62; P I, Arts 8, 9, 10, 12-15 and 21)
2. (Paras 2, 5-10 and 13) Does International Human Rights Law (IHRL) provide for a right to health? Does right to health apply also to the situations of armed conflict?

### **II. Non-Discrimination**

1. (Paras 18-20) Does IHL prohibit discrimination in the provision of healthcare? Can prioritizing the treatment of persons based on medical need be considered discriminatory? Can priorities in medical treatment be based on the status of person and his/her prior actions or belonging to the adversary? Do rules of IHL on medical care apply to combatants? Civilians? (CIHL, Rule 88 and 109-110; GC I-IV, Art. 3; P II, Arts 7 and 8; GC I, Arts 12 and 15; GC II, Art. 12 and 18; GC IV, Art. 16(1); P I, Art. 10)

### **III. Access to Medical Care**

1. (Para 23) Does IHL oblige parties to the conflict to not impede access to medical care for the civilian population? What does IHL say about requisition of civilian hospitals? (CIHL, Rules 109-110; GC I-IV, Art. 3; P II, Arts 7 and 8; GC IV, Arts 55-57; P I, Arts 68-70)
2. (Paras 23 and 55) Do members of an armed group and persons considered to be linked to an armed group who are wounded or sick have a right to access medical care? (CIHL, Rules 88 and 109-110; GC I-IV, Art. 3; P II, Arts 7 and 8; GC I, Arts 12 and 15; GC II, Arts 12 and 18; GC III, Arts 30 and 31; P I, Arts 9 and 10)
3. (Paras 23 and 55) Does IHL prohibit military forces from being present in hospitals if this discourages members of an armed group and persons linked to the armed group from seeking access to medical care there for fear of arrest? Would such arrests violate IHL if they are made before medical care is provided? After medical care is provided? (CIHL, Rule 110; GC I-IV, Common Art. 3; P II, Arts 7 and 8; GC I, Arts 12, 13 and 15; GC II, Arts 12, 13 and 18; GC III, Arts 4, 5, 30 and 31; P I, Arts 9 and 10)

### **IV. Protection of Hospitals**

1. (Paras 26 and 28) Does IHL prohibit the destruction of the hospitals? Is a hospital a legitimate target

under IHL? When might it become a legitimate target? If a party to the conflict uses it to treat wounded fighters? (CIHL, Rules 7-10 and 28; P II, Art. 11; GC I, Arts 19-22; GC IV, Arts 18-19; P I, Arts 12-13, 48 and 52)

2. (Paras 30-31) Does IHL prohibit military use of health facilities? Do health facilities automatically lose protection from direct attack if they are used for military purposes? (CIHL, Rules 7-10 and 28; P II, Art. 11; GC I, Arts 19-22; GC IV, Arts 18-19; P I, Arts 12-13, 48 and 52)
3. Is it a war crime to attack a hospital during a non-international armed conflict? (CIHL, Rules 28 and 156; Case, The International Criminal Court, ICC statute, Art. 8(2)(b)(ix) and Arts 8(2)(e)(ii) and (iv))

## **V. Protection of Medical Personnel**

1. (Para 26) Does IHL provide special protection for medical personnel? Can medical personnel become a target of direct attack? If they commit acts harmful to the enemy? If they are directly participating in hostilities? Do the phrases 'acts harmful to the enemy' and 'direct participation in hostilities' covering the same kinds of conduct? Do medical personnel regain protection from direct attack if they cease such conduct? (CIHL, Rule 25; GC I, Arts 21 and 24–26; GC II, Art. 36; GC IV, Art. 20; P I, Art. 10 and 15)

## **VI. Protection of Women and Children**

1. (Paras 43, 45 and 48) Does IHL provide special protection for women and children? How is such protection relevant for health care? (GC IV, Arts 16–18, 21–24, 38, 50, 76, 89, 91 and 127; P I, Arts 70 and 76; CIHL, Rules 134 and 135)

## **VII. Accountability and Remedies**

1. (Paras 55-58) Are non-state actors bound by rules of IHL? IHRL? Are these obligations identical to those of States? On what do you base your response? (CIHL, Rule 139; GC I-IV, Arts 1 and 3; P II, Art. 1)
2. (Paras 61 and 65) What does IHL say about accountability for violations of rules of IHL? Do parties to the conflict have an obligation to investigate violations of rules of IHL concerning healthcare and punish the perpetrators? Does the obligation to investigate and punish the perpetrators extend to non-state actors which are parties to non-international armed conflict? (CIHL, Rules 149 and 150; GC I, Art. 50; GC II, Art. 51; GC III, Art. 130; GC IV, Art. 147; P I, Art. 91)