

A human rights approach to health care in conflict

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Abstract

Attacks on and interference with health care services, providers, facilities, transports, and patients in situations of armed conflict, civil disturbance, and state repression pose enormous challenges to health care delivery in circumstances where it is most needed. In times of armed conflict, international humanitarian law (IHL) provides robust protection to health care services, but it also contains gaps. Moreover, IHL does not cover situations where an armed conflict does not exist. This paper focuses on the importance of a human rights approach to addressing these challenges, relying on the highest attainable standard of health as well as to civil and political rights. In particular we take the Committee on Economic, Social and Cultural Rights General Comment No. 14 (on Article 12 of the International Covenant on Economic, Social and Cultural Rights) as a normative framework from which states' obligations to respect, protect and fulfil the right to health across all conflict settings can be further developed.

Keywords: human rights, right to health, conflict, violence, health worker, hospital, ethics.

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During armed conflicts and internal disturbances such as political protests, civil rioting or state repression, health care facilities are often subjected to violent attacks, obstructed access, interference with operations, and looting. Health care workers may be arrested or intimidated for offering care impartially to those in greatest need.

Many who provide care in conflict-affected regions of the world, where the risk of attack is becoming a daily occurrence, have begun to see violence as an occupational hazard. A national health worker in the Democratic Republic of the Congo (DRC) explained their situation as follows: ‘What can we do? There are no means to protect us – nothing can be done to stop this, so we just complain to each other and help each other as much as we can’.¹

International humanitarian law (IHL) has provided a framework for assuring protection and respect for medical personnel, medical facilities, and ambulances, as well as the wounded and sick, in international and non-international armed conflicts. Over the 150 years since the original 1864 Geneva Convention, these protections have become more extensive and detailed, for example, by prohibiting interference with practices required by medical ethics. Nevertheless, the legal framework for protection under IHL does not comprehensively address the problem of attacks or interference with health services. In some circumstances of political volatility or violence, attacks on health care providers, facilities, transports, and patients take place, but IHL does not apply at all, because no armed conflict exists. For example, during political protests in the Kingdom of Bahrain in 2011, state forces responded by obstructing the capital’s main hospital, and arresting, torturing, and prosecuting doctors and nurses for allegedly using their medical roles to commit hostile acts against the state.² In Syria, before the threshold of a non-international armed conflict was reached,³ attacks on patients, the medical community, and medical institutions by state forces created a climate of fear in which patients would not attend hospitals, leading instead to an underground network of makeshift clinics that could not replace the sophisticated medical services needed.⁴ In volatile regions in Nigeria, vaccination workers have been attacked and killed, severely disrupting vaccination programmes.⁵

Even in armed conflict, IHL does not fully address needs for availability of and access to health services for civilian populations. In Iraq, for example, the killing and kidnapping of doctors committed during the period of armed conflict⁶ clearly violated IHL – to the extent that these acts were committed as part

1 Merlin, *A Grave New World*, 2010, p. 6, available at: www.who.int/workforcealliance/news/agravenewworld_report.pdf (last visited 22 August 2012).

2 Physicians for Human Rights, *Do No Harm: A Call for Bahrain to End Systematic Attacks on Doctors and Patients*, April 2011, available at: https://s3.amazonaws.com/PHR_Reports/bahrain-do-no-harm-2011.pdf (last visited 19 August 2012), and Human Rights Watch, *Targets of Retribution Attacks against Medics, Injured Protestors, and Health Facilities*, July 2011, available at: www.hrw.org/sites/default/files/reports/bahrain0711webcover.pdf (last visited 27 August 2012).

3 See *inter alia* International Committee of the Red Cross (ICRC), ‘Syria: ICRC and Syrian Arab Red Crescent maintain aid effort amid increased fighting’, Operational Update, 17 July 2012, available at: www.icrc.org/eng/resources/documents/update/2012/syria-update-2012-07-17.htm; see also Geneva Academy, ‘Syria’, in *Rulac Project*, available at: www.geneva-academy.ch/RULAC/applicable_international_law.php?id_state=211 (last visited 27 August 2012).

4 Physicians for Human Rights, *Syria: Attacks on Doctors, Patients, and Hospitals*, December 2011, p. 8, available at: https://s3.amazonaws.com/PHR_Reports/syria-attacks-on-drs-patients-hospitals-final-2011.pdf (last visited 12 June 2012).

5 Donald G. McNeil Jr., ‘Gunmen kill Nigerian polio vaccine workers in echo of Pakistan attacks’, in *New York Times*, 8 February 2013, available at: http://www.nytimes.com/2013/02/09/world/africa/nigeria-polio-vaccine-workers-are-killed-by-gunmen.html?_r=0 (last visited 27 May 2013).

of the armed conflict. However, these acts also contributed to the emigration of health professionals in the period 2004–2007, meaning access to health care services and maintenance of an adequate workforce also deteriorated. The state’s responsibility to assure protection of health workers and provide for adequate health professional coverage to meet the health needs of the population may not have been fully covered by IHL.

In Sri Lanka, during the final stages of the war, allegations that the Sri Lankan army undertook large-scale and widespread shelling of civilian areas, resulting in large numbers of civilian deaths, as well as the systematic shelling of hospitals on the front lines, were found ‘credible’ by the United Nations (UN) Secretary-General’s Panel of Experts on Accountability in Sri Lanka. If proven, these allegations would constitute serious violations of IHL.⁷ But how does international law address the state’s failure to provide adequate care to the Tamil population prior to the ceasefires? An assessment of health infrastructure carried out following the 2002 ceasefire revealed that of a total of 400 health institutions, 55 had been destroyed and 49 were not functioning. The remaining facilities experienced severe shortages of essential drugs and a breakdown in health information and monitoring systems.⁸ Further, while the number of physicians per 100,000 members of the population dramatically increased in the country as a whole in the years of the conflict, in the Northern Province it substantially declined, severely compromising needed access to health services.⁹ Except in cases of occupation,¹⁰ IHL is silent on obligations to assure continuity of health services.

The provision of health services is also frequently compromised during armed conflicts indirectly through curfews, reduced geographical access due to roadblocks and checkpoint closures, and reduced social access based on patients’ fear of seeking care in areas of insecurity. Moreover, marginalised and vulnerable populations, even if not overtly denied health care, often experience lower access to care, and their health suffers additionally from social exclusion. Not all of these acts and omissions are covered by IHL.

Public health programmes, including infectious disease control and eradication strategies and vaccination campaigns, are often disrupted in conflict settings.

6 Gilbert M. Burnham, Riyadh Lafta, and Shannon Doocy, ‘Doctors leaving 12 tertiary hospitals in Iraq, 2004–2007’, in *Social Science & Medicine*, Vol. 69, 2009, pp. 172–177.

7 UN Secretary-General, Report of the Secretary-General’s Panel of Experts on Accountability in Sri Lanka, 31 March 2011, pp. ii–iii, available at: www.un.org/News/dh/infocus/Sri_Lanka/POE_Report_Full.pdf (last visited 24 August 2012).

8 Mayan Vije and Dr Suppiah Ratneswaren, *Enduring War and Health Inequity in Sri Lanka*, Tamil Information Centre, 2009, p. 22, available at: www.tamilinfo.org/healthreport.pdf (last visited 24 June 2012).

9 Mari Nagai, Sandirasegaram Abraham, Miyoko Okamoto, Etsuko Kita, and Atsuko Aoyama, ‘Reconstruction of health service systems in the post-conflict Northern Province in Sri Lanka’, in *Health Policy*, Vol. 84, 2007, pp. 84–93.

10 See Art. 56 of Convention (IV) relative to the Protection of Civilian Persons in Time of War, Geneva, 12 August 1949 (hereafter ‘GC IV’). Art. 56 GC IV provides that ‘the Occupying Power has the duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health and hygiene in the occupied territory, with particular reference to the adoption and application of the prophylactic and preventative measures necessary to combat the spread of contagious diseases and epidemics’.

In Nepal, low uptake in tuberculosis treatment and diagnostic services among conflict-affected populations was associated with the closure of health services and curfews in areas of fighting that limited patient access and led to an increase in the prevalence of tuberculosis.¹¹ Such disease control programmes may not be the subject of direct attacks or threats, nor within the scope of an occupying power's duty to maintain public health within an occupied territory,¹² and so may escape the coverage of IHL.

Human rights law (HRL) applies in all of these contexts. Its applicability to interference with health care in situations of armed conflict or other situations of violence, however, has not been sufficiently explored. For instance, what is the extent of protection afforded to health care workers, facilities and ambulances in situations of civil violence or state repression in the absence of an armed conflict? In armed conflicts, do states have responsibilities to ensure access and availability of health services beyond those required by IHL? If health care services are to be truly respected in situations of violence, these questions require answers, but they have generated little discussion – likely because the other major source of protection, HRL, is not nearly as explicit on these questions as IHL. When properly understood, however, HRL not only requires broad respect and protection for health by states in situations of civil violence, but can offer additional protections in armed conflict beyond those provided by IHL. This article explores how HRL can address violence, both real and threatened, against health care workers, services, and beneficiaries, as well as other forms of deprivation of access to health care services in situations of armed conflict or internal disturbances falling short of armed conflict.

Application of IHL and HRL

Overview of IHL and HRL

Both IHL and HRL derive from international treaties, and from customary international law (CIL). IHL treaties represent agreements between states on the conduct of war and on the protection of individuals that apply to the parties to an armed conflict. Key principles include distinguishing between civilian and military targets, proportionality in the use of force, and precautions in attack. HRL, on the other hand, establishes the obligations and rights as between a state and the individuals over which it has jurisdiction. Despite differences in their evolution and purpose, both have the aim of protecting and preserving the life, well-being, and human dignity of the person.¹³

In times of international armed conflict, the First, Second, and Fourth Geneva Conventions of 1949 and the Protocol Additional to the Geneva

11 S. K. Tiwari, *et al.*, 'Prevalence of TB and service utilization in conflict affected areas of Nepal', in *Journal of Nepal Health Research Council*, Vol. 3, No. 1, 2005, pp. 45–57.

12 GC IV, Art. 56.

13 United Nations Human Rights Office of the High Commissioner for Human Rights, *International Legal Protection of Human Rights in Armed Conflict*, New York and Geneva, 2011, p. 7.

Conventions of 12 August 1949, and Relating to the Protection of Victims of Armed Conflicts (Additional Protocol I), provide a framework for the respect and protection of sick, wounded, and shipwrecked military and civilian medical personnel, units, and transports. Article 3 common to the four Geneva Conventions (Common Article 3) and the Protocol Additional to the Geneva Conventions of 12 August 1949 relating to the Protection of Victims of Non-International Armed Conflicts (Additional Protocol II) offer less detailed protections in non-international armed conflict. As there was apparent uncertainty in the scope of protection offered in the two types of armed conflicts, the International Committee of the Red Cross (ICRC) study on customary international law (hereafter ‘the ICRC Customary Law Study’) has provided much-needed clarification. The study indicates that rules of CIL regarding respect for and protection of health apply in both international and non-international armed conflicts.¹⁴

As will be discussed more fully below, among other provisions, parties to a conflict must respect and protect medical personnel, units, and transports, meaning that these must not be attacked or interfered with and shall have access to any place where their services are essential. Parties may not make distinctions in care based on considerations other than medical ones. Nor may they punish a person for engaging in medical care activities consistent with medical ethics or compel a person to engage in acts prohibited by medical ethics.¹⁵

Unlike IHL, which has rules designed specifically to address the respect and protection of health care in armed conflict, HRL instruments are formulated in more general terms. Civil and political rights are the foundation of protection against violence, discrimination, and denial of rights of citizenship and due process committed or tolerated by the state. The rights to life, to liberty, to security of person, and not to be subjected to torture or cruel, inhuman, or degrading treatment or punishment are of special relevance to attacks on health services and are enshrined in major international and regional human rights treaties, as well as in a number of subject-specific treaties.¹⁶ These treaties also contain and affirm the rights to equality and non-discrimination. A growing body of CIL supports this treaty law – indeed, many of the rights set out in the Universal Declaration of Human Rights (UDHR) are now widely regarded as such.

14 Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law, Vol. I: Rules*, ICRC/Cambridge University Press, Cambridge, 2005 (hereafter ‘ICRC Customary Law Study’), p. 197.

15 See Art. 12 of Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, Geneva, 12 August 1949 (hereafter ‘GC I’); Art. 12 of Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea, Geneva, 12 August 1949 (hereafter ‘GC II’); Arts. 18, 20, and 21 of GC IV; Arts. 12(1), 15, and 21 of Protocol Additional to the Geneva Conventions of 12 August 1949 and relating to the Protection of Victims of International Armed Conflicts, 8 June 1977 (hereafter ‘AP I’); Arts. 8, 10, and 11(1) of Protocol Additional to the Geneva Conventions of 12 August 1949 and relating to the Protection of Victims of Non-International Armed Conflicts, 8 June 1977 (hereafter ‘AP II’); CIL, Rules 25, 28, and 29.

16 See International Covenant Civil and Political Rights (ICCPR); African Charter on Human and People’s Rights (ACHPR); Convention on the Rights of the Child (CRC); and Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

The right to the highest attainable standard of health as articulated in Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) is the principal framework from which to understand states' obligations regarding the availability of, access to, and quality of health services. Other sources of interpretation, especially General Comment No. 14 of the Committee on Economic, Social, and Cultural Rights (CESCR), illuminates the scope and application of this right, and can play a critical role in assuring respect and protection of health services, health personnel, and patients, both in armed conflict and in other circumstances where civil violence or state repression is taking place.

The relationship between IHL and HRL

Complementarity

Attention to human rights law is especially germane as the debate over whether human rights law applies in situations of armed conflict is now settled, and application of human rights law alongside IHL well accepted.¹⁷ The complementary application of both legal bodies is no better evidenced than by the inclusion of HRL in the ICRC Customary Law Study, which identified HRL's role as being to 'support, strengthen and clarify analogous principles of international humanitarian law'.¹⁸ As pointed out by Cordula Droege, the relationship between the two bodies of law is often 'described as a relationship between the general and specialized, in which humanitarian law is *lex specialis*'.¹⁹ This does not prevent a complementarity approach, but will on occasion provide a 'conflict solving method'²⁰ for situations where norms cannot be reconciled.

Rights holders and duty bearers in IHL and HRL

Lack of respect for health care, in the form of attacks and interferences, whether in times of armed conflict or other situations of violence, can be attributed to both state entities and armed non-state actors.²¹ The focus of IHL is the protection of civilians and others not taking part in combat – such as prisoners of war or the sick and wounded – as well as civilian objects, which include hospitals and other health facilities. Under IHL, parties to an armed conflict are the primary, although not exclusive, duty bearers. Obligations extend to all those participating in hostilities and to those individuals to whom one party to the conflict has delegated

17 See, *inter alia*, International Court of Justice (ICJ), *Legal Consequences of the construction of a Wall in the Occupied Palestinian Territory*, Advisory Opinion, ICJ Reports 2004, 9 July 2004, para. 106.

18 ICRC Customary Law Study, Vol. 1, p. xxxvii.

19 Cordula Droege, 'The interplay between international humanitarian law and international human rights law in situations of armed conflict', in *Israel Law Review*, Vol. 40, No. 2, December 2007, p. 340.

20 Noëlle Quénivet, 'The history of the relationship between international humanitarian law and human rights', in Roberta Arnold and Noëlle Quénivet (eds), *International Humanitarian Law and Human Rights Law: Towards a New Merger in International Law*, Martinus Nijhoff, Dordrecht, 2008, p. 7.

21 ICRC, *A Sixteen-Country Study: Health Care in Danger*, July 2011, available at: www.icrc.org/eng/assets/files/reports/4073-002-16-country-study.pdf (last visited 28 April 2013).

responsibility, for example in relation to the treatment of protected persons. Non-state parties to a non-international armed conflict are bound by Common Article 3, the provisions of Additional Protocol II, and CIL.²² The ICRC Customary Law Study reflects a large body of CIL rules applicable in non-international armed conflicts. Although some controversy remains as to whether state custom creates binding obligations for non-state actors, it is recognised that a number of rules relating to the conduct of hostilities, such as proportionality and distinction, apply to armed non-state actors regardless of whether or not they have agreed to abide by the Geneva Conventions or their Additional Protocols.²³

Under HRL, human rights belong to individuals. The responsibility to meet human rights obligations rests primarily with the state – including justice authorities, the police, and its health ministry as far as the right to health is concerned. However, with the increasing threat posed by non-state actors, such as attacks on vaccine workers by militias in Pakistan and Nigeria,²⁴ greater attention has been given to these actors' HRL obligations in conflict. Rather than viewing the extension of human rights to armed groups as lending dangerous legitimacy or quasi-governmental status, there is broadening agreement that armed groups can be bound by at least standards or principles of HRL, if not specific legal rules. This shift is evidenced in the evolving practice of the UN Security Council and the reports of some Special Rapporteurs, who increasingly identify circumstances where non-state armed groups are bound to abide by both IHL and HRL obligations.²⁵ Human rights monitors are also including conduct by armed opposition groups in their reports.²⁶ Another pertinent example of the application of human rights principles to non-state actors is the UN Security Council mechanism to monitor and report on the 'six grave violations' committed by states and non-state parties to an armed

22 In *Nicaragua v. United States of America*, Judgement of 27 June 1986, ICJ Reports 1986, para. 219, the ICJ confirmed that Common Article 3 applied directly to the non-state armed group fighting the government. With respect to AP II it should be noted that the threshold for its application is higher than for Common Article 3; for further details see Yves Sandoz, Christopher Swinarski, and Bruno Zimmermann (eds), *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*, ICRC, Geneva/Martinus, Martinus Nijhoff, Dordrecht, 1987.

23 Annysa Bellal, Gilles Giacca, and Stuart Casey-Maslen, 'International law and armed non-state actors in Afghanistan', in *International Review of the Red Cross*, Vol. 93, No. 881, March 2011, p. 62.

24 See, *inter alia*, 'Pakistan suspends polio-vaccination program after deadly attack', in *Radio Free Europe*, 28 May 2013, available at: www.rferl.org/content/polio-pakistan-killing-vaccination/24999412.html; and 'Nigerian polio vaccination centers attacked', in *Radio Free Europe*, 8 February 2013, available at: www.rferl.org/content/nigerian-polio-vaccination-centers-attacked/24896626.html (last visited June 2013).

25 The Report of the UN Special Rapporteur on extrajudicial, summary or arbitrary executions indicated in the context of his mission to Sri Lanka that, 'As a non-State actor, the Liberation Tigers of Tamil does not have legal obligations under [the ICCPR], but it remains subject to the demands of the international community, first expressed in the UDHR, that every organ of society respect and promote human rights'. The Special Rapporteur further indicated that: 'It is increasingly understood, however, that the human rights expectations of the international community operate to protect people, while not thereby affecting the legitimacy of the actors to whom they are addressed. The UN Security Council has long called upon various groups that the Member States do not recognize as having the capacity to formally assume international obligations to respect human rights'. UN Doc. E/CN.4/2006/53/Add. 5, 27 March 2006, paras. 25 and 27.

26 Human Rights Watch has reported on the human rights abuses of armed opposition groups; see Human Rights Watch, *No Exit: Human Rights Abuses inside the MKO Camps*, May 2005, available at: www.unhcr.org/refworld/docid/45d085002.html (last visited 3 June 2011).

conflict against children, including ‘attacks on schools and hospitals’.²⁷ All six violations are grounded in IHL and HRL. For armed non-state actors a violation carries the same consequences as it would for a state, namely listing in the Annex of the Report of the Secretary-General on children and armed conflict, which can in turn lead to sanctions being imposed against such groups.²⁸

In highlighting the links between human rights norms and health care in conflict situations, the focus of this paper will be on the obligations of states. However, the increasing recognition of armed groups as violators of human rights represents an important shift in discourse, and expands the scope of human rights protection to include health care, especially when considering other features of a rights-based approach such as monitoring and accountability.

Concurrent application: the example of the use of force

One area where the rule of *lex specialis* plays a role is that of the use of force and its consequences. One key element of IHL is that combatants cannot be punished for using lethal force against enemy combatants as long as they are in compliance with proportionality and precaution requirements. Moreover, incidental loss of civilian life caused by an armed attack is permissible so long as the principles of distinction and proportionality are respected, the latter requiring that the expected loss of civilian life not be excessive in relation to the concrete and direct military advantage anticipated.²⁹ The attacker must also comply with the requirements of taking precautions to minimise harm to civilians.³⁰ The incidental killing or injury of medical personnel or their patients is subject to these proportionality and precaution requirements. The same rules apply in relation to civilian objects, which include medical facilities.³¹

HRL rules regarding the use of force for law enforcement purposes or in the framework of an armed conflict are, in contrast, rooted in the protection of individuals from abuse by the state. The state may not subject any individual under its jurisdiction, including the wounded and sick or health care personnel, to arbitrary deprivation of life.³² In using force for law enforcement purposes, states have an obligation to use the smallest amount of force necessary and with tight restrictions

27 The other grave violations are: killing or maiming of children; recruitment or use of children as soldiers; sexual violence against children; denial of humanitarian access for children, and abduction of children. See, *inter alia*, Office of the Special Representative of the Secretary-General for Children and Armed Conflict, ‘The six grave violations’, available at: <http://childrenandarmedconflict.un.org/effects-of-conflict/the-most-grave-violations/> (last visited 22 July 2013).

28 See UN Security Council Resolution 1612, 26 July 2005, and UN Security Council Resolution 1998, 12 July 2011.

29 See AP I, Arts. 51(5)(b) and 57(2)(a)(iii); and CIL, Rule 14.

30 See AP I, Art. 57.

31 See AP I, Arts. 48 and 51(4), (5); and CIL, Rules 7, 11–15.

32 See the right to life as enshrined in Art. 6(1) of the ICCPR; Art. 4 of the American Convention on Human Rights (ACHR); Art. 4 of the ACHPR; and Art. 2 of the European Convention on Human Rights (ECHR). Note that the ECHR does not use the term ‘arbitrary’ but specifies a general right to life and gives an exhaustive list of circumstances under which a deprivation of the right to life may be lawful.

on the use of lethal force.³³ This prohibition is non-derogable and therefore applicable at all times.³⁴ There are some circumstances, however, where unwelcomed entry into a health facility for law enforcement purposes is permissible under HRL as a reasonable exercise of state authority, if certain safeguards are in place.

Monitoring and accountability

Accountability and enforcement mechanisms are more advanced under HRL than IHL in terms of formal compliance reviews, rights to individual remedy, reparation, and the obligation to investigate.³⁵ Achieving compliance with IHL obligations mainly focuses on incorporation in national law and military policies, training, and negotiation, though of course serious violations can be prosecuted as war crimes. As noted above, the UN Security Council has also created monitoring, reporting, and accountability mechanisms regarding the six grave violations against children in armed conflict, which should over time result in greater compliance with international law.

Under HRL, accountability is provided through institutions established within the UN and regional bodies, who engage with states and civil society, receive reports on adherence from States Parties and others, conduct field investigations, issue findings and recommendations, and condemn violations. These accountability mechanisms are explored more fully below.

Protection of health under IHL

In both international and non-international armed conflicts, the Geneva Conventions and Additional Protocols, as well as CIL, provide that medical personnel, facilities, and transports, and the wounded and sick, may not be the subject of attack or harm, and the provision of health care may not be unnecessarily interfered with.³⁶

Medical personnel

Medical personnel pursuing their exclusively humanitarian task, whether military or civilian, must be respected and protected from attack and harm unless they commit, outside of their humanitarian work, acts harmful to the enemy.³⁷ The phrase

33 For more details, see, *inter alia*, Louise Doswald-Beck, *Human Rights in Times of Conflict and Terrorism*, Oxford University Press, Oxford, 2012, pp. 163–177.

34 See Art. 4(2) of the ICCPR; Art. 27(2) of the ACHR; and Art. 15(2) of the ECHR. It should be noted that Art. 15(2) of the ECHR provides for the exception of ‘lawful acts of war’ in situations amounting to armed conflict.

35 C. Droege, above note 19, p. 340.

36 See GC I, Arts. 19, 18, 24–26; GC II, Art. 36; GC IV, Arts. 18 and 20; AP I, Arts. 12 and 15; 1949 GC Common Article 3; AP II, Art. 9(1); and CIL, Rules 25, 28, and 29.

37 See GC I, Art. 21; AP I, Art. 13; and AP II, Art. 11. Acts not considered ‘harmful to the enemy’ include carrying light individual weapons for self-defence or defence of the wounded and sick; the presence of, or

‘medical personnel’ has a relatively narrow meaning in the Geneva Conventions and Additional Protocols, referring to individuals, whether temporary or permanent, exclusively assigned to medical duties by a party to a conflict as well as health workers affiliated with the Red Cross and Red Crescent societies or certain other humanitarian organisations.³⁸

Other persons performing medical duties, however, broadly enjoy protection against attack and interference. The two Additional Protocols expand protection to all health professionals who act in accordance with their professional ethical obligations, such as the duty to provide impartial care to all, regardless of whether they meet the definition of ‘medical personnel’.³⁹ They cannot be punished for acting in accordance with the rules of medical ethics, compelled to refrain from acts required by medical ethics, or required to act against the mandates of medical ethics. This is a key protection, as in many places around the world, including Chechnya, Kosovo, Burma, and Syria, health workers have been threatened, arrested, prosecuted, or killed for having adhered to their ethical obligation to provide care impartially, regardless of the affiliation or political belief of the patient. The only limitation concerns medical confidentiality, where disclosure of information concerning the wounded and sick under a health worker’s care is subject to national law.⁴⁰ Finally, insofar as they are civilians, it is a rule of CIL that medical personnel are protected from attack, unless and for such time as they take a direct part in hostilities.⁴¹

The wounded and sick

Under the Geneva Conventions and Additional Protocols, parties to a conflict have an obligation to respect the wounded and sick by providing them with medical care and attention as far as practicable and with the least possible delay. The requirement is not absolute and instead requires parties to take all possible measures subject to resources and feasibility in the midst of hostilities.⁴² Further, non-discrimination is a fundamental principle of IHL. The Geneva Conventions and Additional Protocols stipulate that, among others, the wounded and sick must be treated humanely and cared for by a party to the conflict without any adverse distinction, with decisions being made on medical grounds alone.⁴³ By definition the wounded and sick refrain from any act of hostility,⁴⁴ but like civilians they may also lose their protection against attack when and for such time as they take a direct part in hostilities.

escort by, military personnel; and the possession of small arms and ammunition taken from the wounded and sick and not yet handed over to the proper authority. See ICRC Customary Law Study, commentaries of Rules 25 and 29.

38 See AP I, Art. 8(c).

39 See AP I, Art. 16; and AP II, Art. 10.

40 See AP I, Art. 16; and AP II, Art. 10.

41 See AP I, Art. 51(3); AP II, Art. 13(3); and CIL, Rule 6.

42 See AP I, Art. 10, commentary.

43 See GC I, Art. 12; GC II, Art. 12; AP I, Art. 10(2); AP II, Art. 7(2); GC Common Article 3.

44 See AP I, Art. 8(a).

The First and Fourth Geneva Conventions provide for the protection of the civilian population from the consequences of war. This includes the establishment of hospital safety zones and the protection of civilian hospitals and their staff, again without any adverse distinction based, in particular, on race, nationality, or religion.⁴⁵ These provisions have become part of CIL.⁴⁶

Medical units and transports

Under IHL, medical units such as hospitals, clinics, and pharmacies, whether military or civilian, fixed or mobile, permanent or temporary, must be respected and protected in all circumstances.⁴⁷ In the same way, medical transports assigned exclusively to the conveyance of the wounded and sick or of medical personnel, equipment, or supplies must be respected and protected.⁴⁸ The meaning of the term 'respect and protect' according to military manuals requires that medical units must not be attacked, fired upon, or harmed in any way.⁴⁹ Nor should they be used to shield military objectives from attack.⁵⁰ State practice generally indicates that medical transports enjoy the same protection as mobile medical units.⁵¹ They both lose their protection if they are being used, outside of their humanitarian function, to commit acts harmful to the enemy, such as by using a hospital for a military purpose or transporting weapons in ambulances.⁵² A deliberate attack on a hospital or other place where there are sick and wounded people, provided the location is not a military objective, is a war crime under the Statute of the International Criminal Court,⁵³ as is an attack on an ambulance displaying the distinctive emblem of the Geneva Conventions.⁵⁴

As noted above, in cases where medical facilities and transports are misused for military purposes, such as hospitals used as military outposts or ambulances used to transport weapons, they lose their protection, but a party must issue a warning before attack and take steps to minimise harm to civilians in the facility.⁵⁵

Protection of health under HRL

Civil and political rights

Medical personnel and the wounded and sick are protected from violence by Article 6 of the International Covenant on Civil and Political Rights (ICCPR), under

45 See GC I, Art. 23; GC IV, Art. 14; CIL, Rule 35.

46 See CIL, Rule 35.

47 See GC I, Art. 19; GC IV, Art. 18; AP I, Art. 12; AP II, Art. 11(1), CIL, Rule 28.

48 See GC I, Art. 35; GC IV, Art. 21; AP I, Art. 21; AP II, Art. 11(1); CIL, Rule 29.

49 See ICRC Customary Law Study, Vol. I, commentary of Rule 28.

50 Art. 12 (4) AP I.

51 See ICRC Customary Law Study, Vol. I, commentary of Rule 29.

52 See CIL, Rules 28 and 29.

53 See Rome Statute of the International Criminal Court, Arts. 8(2)(b)(ix) and 8(2)(e)(iv).

54 See Rome Statute of the International Criminal Court, Arts. 8(2)(b)(xxiv) and 8(2)(b)(e)(ii).

55 See GC I, Art. 21; GC IV, Art. 19; AP I, Art. 13(1); AP II, Art. 11(2).

which states have a non-derogable obligation not to subject any individuals under their jurisdiction or control to arbitrary deprivation of life. A prohibition of torture and cruel, inhuman, or degrading treatment or punishment is found in Article 7 of the ICCPR and specific treaties that address the problems of torture and disappearances.⁵⁶ These treaties outlaw the killings, beatings and other forms of torture, and abductions of health workers and patients such as those documented in recent human rights reports.⁵⁷ In certain circumstances, the denial of medical treatment might also constitute cruel, inhuman, and degrading treatment, or even torture.⁵⁸ Arrests of medical personnel for providing impartial care can also constitute a violation of the protection against arbitrary arrest and detention.⁵⁹

Economic, social, and cultural rights

Equally powerful and often overlooked protections of health care in conflict and other situations of violence stem from the right to the highest attainable standard of health (referred to here as the 'right to health'). A number of human rights instruments address the protection and promotion of health as a human right. The UDHR provided the first affirmation that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care'.⁶⁰ All key international and regional human rights treaties adopted since contain provisions designed to protect and promote the right to health. The most widely cited is the ICESCR of 1966, Article 12, which states:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Other UN human rights treaties enshrining the right to health include the Convention on the Elimination of All forms of Discrimination against Women and the Convention on the Rights of the Child. Examples of regional human rights treaties include the European Convention on Human Rights, the African Charter on

56 See ICCPR, Art. 7; and CAT.

57 Physicians for Human Rights, above note 2.

58 Report of the Special Rapporteur on torture and other cruel, inhumane or degrading treatment or punishment, Juan E. Mendez, 1 February 2013, A/HRC/22/53.

59 See UDHR, Art. 9; and ICCPR, Art. 9.

60 See UDHR, Art. 25.

Human and People's Rights, and the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social, and Cultural Rights (the Protocol of San Salvador). The shift from expansive aspirational language to a right with firm content and standards to address access, availability, quality, and cultural appropriateness of health services and the underlying determinants of health accelerated in 2000 when the (Committee on Economic, Social and Cultural Rights) CESCR issued General Comment No. 14, an interpretation of Article 12 with important normative force. It clarifies states' obligations and remains the most comprehensive articulation of the right to health in HRL.

The CESCR recognised the widening scope of notions of health, and proposed an approach that 'takes into account such socially-related concerns as violence and armed conflict'.⁶¹ Achieving respect, protection, and fulfilment of the right to health in armed conflict and other situations of violence is a colossal challenge, but as the International Court of Justice has expressly affirmed, economic, social, and cultural rights obligations remain in force in armed conflict alongside IHL.⁶²

Three layers of obligations

The right to health, like all human rights, imposes three layers of obligations on states: the responsibility to respect – to refrain from directly interfering with a right; to protect – to prevent third-party interference with the enjoyment of a right; and to fulfil – to take steps to ensure the fullest possible realisation of a right. Put simply, these duties 'define what governments can do to us, cannot do to us and should do for us'.⁶³ They provide a powerful framework for assessing to what extent human rights are reflected in states' norms, institutions, legal frameworks, and political and policy environments. States must respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons and abstaining from enforcing discriminatory practices as a state policy.⁶⁴ The example above of Bahrain's state security forces denying impartial care to protestors is a clear illustration of a state's failure to respect the right to health.

Under the duty to protect, states are under an obligation to prevent third parties from interfering with the right to health, which includes such practices as perpetrating violence against health care providers and patients, within their capacity to do so. Further, states should ensure that health workers have the appropriate standards of education and skill and ethical codes of conduct to meet the challenges of their work in these difficult environments.⁶⁵

61 CESCR, General Comment No. 14 on the right to the highest attainable standard of health, 11 August 2000, UN Doc. E/C.12/2000/4 (hereafter CESCR, General Comment No. 14), para. 10.

62 See, *inter alia*, ICJ, *Legal Consequences of Construction of the Wall in Occupied Palestine Territory*, Summary of Advisory Opinion, 9 July 2004, paras. 102–113.

63 Sofia Gruskin and Daniel Tarantola, 'Health and Human Rights', in Sofia Gruskin (ed.), *Perspectives on Health and Human Rights*, Routledge, London, 2005, p. 8.

64 CESCR, General Comment No. 14, para. 34.

65 *Ibid.*, para. 35.

Finally, the obligation to fulfil requires State Parties to take appropriate legislative, administrative, budgetary, judicial, and other measures towards full realisation of the right to health.⁶⁶ Disinvestment, assault, and persecution in times of conflict have often led to the migration of skilled health care personnel. Fulfilment of the right to health requires investment and protection in the health workforce within the scope of progressive realisation and non-retrogression requirements. The obligation to fulfil provides for broader states' obligations than exist under IHL, where parties to the conflict generally have obligations to ensure medical services such as are available, including humanitarian aid, to the wounded and sick, without distinction except on medical grounds. Only an occupying power has the duty to fulfil the obligations of ensuring public health standards and the provision of medical supplies.⁶⁷

In conflict settings, disease control programmes are often stalled through the interruption of a patient's ability to seek care, breakdown of drug supply chains, or the diversion of economic resources by the state to military ends. These obstacles do not, however, relieve states of their 'right to health' obligations. For example, the three countries where polio remains endemic – Afghanistan, Nigeria, and Pakistan – are experiencing war or severe political conflict, disrupting vaccination programmes and leading to new outbreaks.⁶⁸ The right to health requires states to avoid interfering directly with polio immunisation programmes (respect), and to take steps to prevent interference with the right by third parties (protect). Finally, ensuring full realisation of the right to health requires policies to ensure that polio immunisation programmes can continue in times of unrest or violence. After the US-led invasion of Afghanistan in 2001, the Afghanistan Ministry of Public Health took active steps to cooperate, through the intermediary of the ICRC, with the Taliban in order to help facilitate the movement of vaccinators and increase access to children living in Taliban strongholds. The ministry administered the campaign with the support of the World Health Organization and UNICEF, enabling coverage to reach some of the most volatile areas of Afghanistan.⁶⁹

Elements of the right to health

The right to health has been interpreted as consisting of key entitlements and state responsibilities, including the interrelated and essential elements of availability, accessibility, acceptability, and quality of health care services, facilities, and goods.⁷⁰ Availability requires that a state provide functioning public health and health care

66 *Ibid.*, para. 36.

67 See GC IV, Arts. 55–57.

68 Leonard Rubenstein, 'Defying expectations: Polio vaccination programs amid political and armed conflict', United States Institute of Peace, *PeaceBrief*, Vol. 64, 3 November 2010, p. 2, available at: www.usip.org/sites/default/files/PB%2064%20%20Polio%20Vaccination%20Programs%20Amid%20Political%20and%20Armed%20Conflict.pdf (last visited 27 August 2012).

69 *Ibid.*, p. 3.

70 CESCR, General Comment No. 14, para.12.

facilities, goods, and services, to include adequate hospitals and clinics, trained health care professionals, and essential medicines.⁷¹ The destruction or closure of health facilities as a result of attacks, violence, or insecurity, the loss of trained medical personnel who migrate from these dangerous situations as explained above, and the destruction or stealing of drugs or disruption of supply chains all undermine availability.

Accessibility requires that health facilities, goods, and services be accessible to all without discrimination within the jurisdiction of the State Party. Discrimination in access to health care on the grounds of, among others, race, colour, sex, language, religion, political or other opinion, national or social origin, or civil, political, social, or other status, which has the intention of nullifying or impairing the quality, enjoyment, or exercise of the right to health is prohibited.⁷²

Non-discrimination is also a basic tenet of both the right to health and civil and political rights. In the context of health, the obligation expands on the requirement of accessibility and obliges the state to assure that government or private health care providers do not discriminate on the basis of ethnic, religious, racial, national, or other prohibited grounds.⁷³ Further, the right to health, like other economic, social, and cultural rights, seeks to address and remedy the marginalisation and disenfranchisement of women and ethnic, religious, and national groups, as well as others, both in the exclusion from equal access to quality health services and in the material and social determinants of health.

In conflict situations, discriminatory practices are frequently employed. During Libya's uprising in 2011, for example, cars were stopped to prevent patients belonging to opposing ethnic groups reaching hospitals.⁷⁴ Discrimination may also be less obvious, but with potentially far-reaching public health consequences. In Burma, ethnic minorities along the eastern border have been struggling for independence against the Burmese government for over three decades in one of the longest and most forgotten civil conflicts. In these conflict regions the state appears to have abdicated responsibility for providing health care services, while at the same time interfering with indigenous groups seeking to provide those services. This basic lack of access to health services has increased the risk of multi-drug-resistant diseases such as tuberculosis and malaria.⁷⁵ Such consequences are the result of a denial of health care that is rooted in a policy of systematic discrimination aimed at undermining and suppressing the ethnic uprising.⁷⁶

71 *Ibid.*, para. 12(a).

72 *Ibid.*, para. 12(b).

73 *Ibid.*, para. 18.

74 Paul-Henri Arni, 'Health care in danger: Today's Solferinos', interview, 20 July 2012, available at: www.icrc.org/eng/resources/documents/interview/2012/health-care-in-danger-todays-solferinos-2012-07-20.htm (last visited 3 August 2012).

75 Back Pack Health Worker Team, *Ten Years Report 1998–2009: Life, Liberty and the Pursuit of Health*, 2009, p. 9, available at: http://www.burmalibrary.org/docs11/BPHWT10yearReport_1998-2009.pdf-red.pdf (last visited 12 August 2012).

76 Physicians for Human Rights, *Life Under the Junta: Evidence of Crimes Against Humanity in Burma's Chin State*, January 2011, p. 40, available at: http://s3.amazonaws.com/PHR_Reports/life-under-the-junta-burma-chin-state.pdf (last visited 28 April 2013).

IHL does not generally cover these dimensions of health services, as it focuses on impartiality in responding to individuals in immediate need of care rather than on the structure and availability of services. For example, while IHL would forbid turning away a woman in labour based on her ethnic or political affiliation, it does not address entrenched practices that limit the availability, accessibility, and quality of facilities and services to members of her group and may make it dangerous for her to seek care. HRL can assist in powerfully addressing these infringements.

Physical accessibility includes the requirement that health facilities, goods, and services be within safe physical reach for all sections of the population.⁷⁷ Conflict often leads to general insecurity and oppression, making it unsafe for patients to seek care or for health care workers to access areas or engage in home visits where care is needed, or for goods such as essential medicines to be delivered.⁷⁸ Using again the example of eastern Burma, the Burmese army has targeted patients and health workers affiliated (or thought to be affiliated) with opposition groups, confiscating medical supplies, preventing patients from travelling to clinics to seek care, and denying health workers free passage to deliver care.⁷⁹ While there are limits to the state's ability to preserve access in circumstances where armed groups undermine it, such as in the case of vaccination programmes in volatile areas of Pakistan, the state must nevertheless take practical steps to provide the security needed to permit campaigns where feasible. Further, where the state itself limits physical access to health care to certain groups either as a political strategy or simply as an abdication of responsibilities because of the challenges of doing so, it is in violation of its human rights obligations.

Acceptability requires that the state's health facilities, goods, and services be operated in accordance with the standards of medical ethics and cultural traditions.⁸⁰ That includes refraining from interfering with health care providers' ethical duty to provide impartial care, reflected in international medical ethics standards, as well as respecting the duty of confidentiality, which under the right to health is both an ethical obligation of health providers and a right of the patient, both to be assured by the state.⁸¹ In Bahrain, state security forces interfered with medical decision-making, restricting access to patients in need of treatment where wounds were protest-related, and interfering with doctors' autonomy to decide if and where ambulances should be sent to assist the wounded.⁸² Security forces in Bahrain also reviewed confidential medical records, compromising doctors' ethical duties towards patient confidentiality.

77 CESCR, General Comment No. 14, para. 12(b).

78 ICRC, *Violent Incidents Affecting Health Care: Health Care in Danger, January–December 2012*, available at: www.icrc.org/eng/assets/files/reports/4050-002_violent-incidents-report_en_final.pdf (last visited 22 May 2013).

79 Back Pack Health Worker Team, above note 75.

80 CESCR, General Comment No. 14, para. 12(c).

81 *Ibid.*, paras. 12(b) and 12(c).

82 Human Rights Watch, above note 2, p. 31.

Finally, the entitlement to quality under the right to health requires that health facilities, goods, and services must also be scientifically appropriate and of good quality, to include skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.⁸³ Particularly in regions of sustained conflict, the destruction of health facilities, collapse of health infrastructure, and depletion in the health workforce means that quality is often undermined during and for decades after the conflict itself. South Sudan, for instance has just begun the transition from emergency response to post-conflict health systems development.⁸⁴ However, the intimate relationship a country's poverty has to the presence of a conflict does not absolve a state from guaranteeing the right to health, including providing health services of an appropriate quality, subject to the availability of resources even where these are constrained, as discussed in the next section.

Progressive realisation and core obligations

The principle of progressive realisation contained in Article 2(1) of the ICESCR requires that States Parties are to undertake steps, to the maximum of their available resources, with a view to progressive realisation of the rights contained in the Covenant, including the right to health. The concept of progressive realisation underscores that there are circumstances where full realisation of the right cannot be achieved. As noted, this limitation is particularly relevant to countries in protracted conflicts or emerging from the aftermath of conflict. Conflict alone, however, is not a blanket excuse for not meeting obligations, as the burden remains on the state to justify limitations on services and to show that it has made every effort to use all available resources at its disposal in order to meet its obligations. Further, progressive realisation involves international assistance and cooperation, providing a human rights basis for action at the global level to assure health services in places where they are under severe strain.

There are, moreover, some obligations with immediate effect regardless of resources, requiring concrete and targeted steps towards realisation of economic, social, and cultural rights.⁸⁵ Applied to the right to health, states have a core obligation to ensure the satisfaction of a minimum essential level of services without delay and on a non-discriminatory basis,⁸⁶ which should be realised forthwith. These are known as core obligations.⁸⁷ Although, to some extent, these non-derogable core obligations are still resource-dependent and challenged by conflict, a state cannot ignore them because of the existence of conflict.

83 CESCR, General Comment No. 14, para. 12(d).

84 Andrew Green, 'Healthcare in South Sudan at a crossroads', in *The Lancet*, Vol. 379, No. 9826, April 2012, p. 1578.

85 CESCR, General Comment No. 3 on the nature of States Parties' obligations, 14 December 1990, fifth session, para. 2.

86 CESCR, General Comment No. 14, paras. 43 and 44.

87 *Ibid.*, para. 10.

General Comment No. 14 identifies a number of core obligations arising from the right to health, which are of special importance to addressing health care in conflict. These include access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalised groups; provision of essential drugs; equitable distribution of all health facilities, goods, and services; adoption and implementation of a national public health strategy; reproductive, maternal (pre-natal as well as post-natal), and child health care; immunisation against the major infectious diseases occurring in the community; and treatment and control of epidemic and endemic diseases.⁸⁸

The ICESCR has no derogation clause, and the CESCR does not, on the whole,⁸⁹ allow derogations from economic, social, and cultural rights, especially from the minimum core obligations under these rights. The CESCR makes clear that there is a strong presumption that retrogressive measures taken in relation to these core obligations are not permissible, with the burden being on the state to prove that any such measures taken deliberately were justified by reference to the totality of the Covenant.⁹⁰ In times of conflict there will be limits to a state's ability to fulfil all of these core obligations where it is under attack from other states or armed groups. However, it is sometimes the case that states retain the capacity to meet at least some obligations, yet abdicate their responsibilities to their own health system as a means of repressing all or particular groups of their citizens. In those circumstances these core obligations are an important framework for assessing adherence to human rights responsibilities.

Requirements for human rights

Participation

Aside from its substantive requirements, the right to health, like other human rights, has process requirements, especially participation and accountability. Informed participation of local communities as well as health care providers who are often at the front line of providing care in conflict is an important but neglected requirement. The right to health includes a specific entitlement of individuals and groups to participate in health policy-making processes that affect them.⁹¹ Scholars who have promoted community participation as part of a rights-based approach in conflict have noted the challenges that fragmentation within the community, displacement, and erosion to services pose to effective participation.⁹² Nevertheless, meaningful participation by communities and health providers at the local, national, and

88 *Ibid.*, para. 43.

89 States and the CESCR have allowed derogation from the ICESCR's labour rights. For an interesting discussion of derogations from economic, social, and cultural rights, see Amrei Muller, 'Limitations to and derogations from economic, social and cultural rights', in *Human Rights Law Review*, Vol. 9, No. 4, 2009, pp. 557–601.

90 CESCR, General Comment No. 14, para. 32.

91 CESCR, General Comment No. 14, para. 54.

92 Emily Waller *et al.*, 'Rights-based approaches in conflict-affected settings', in Elvira Beracochea *et al.* (eds), *Rights-Based Approaches to Public Health*, Springer Publishing, New York, 2011, p. 236.

international levels can help promote the reduction in incidence of attacks and interference with health care services. Greater participation of national health workers and communities can influence decisions by ministries of health and justice, as well as militaries, to strengthen protection and security in health care services and improve field practices in dangerous health care settings.

Participation is also germane to health worker security. In many contexts, whether involving conflict or other situations of violence, there are few effective or genuinely enforced policies directed towards the security of national health workers. A human rights approach can encourage the active involvement of the local health workforce in helping to establish plans and programmes for protection, identifying and sharing strategies on how to increase security, and holding duty bearers to account. This sort of effective participation is not easily generated. It should involve the participation of national and international medical associations, as well as non-governmental organisations – many of which are heavily involved in the delivery of essential health care in times of conflict, and employ a large number of national health care staff. Engagement of these actors is essential to making progress on an issue that often attracts outcry from the international community but little concerted action or formulation of policies to address the problem. Participation can also ensure that law enforcement agencies do not penalise or harass health care workers for offering impartial care to patients deemed to be hostile to the state, both in circumstances of armed conflict and in civil disturbances. Participation in these decisions also empowers health workers with a better understanding of their rights.

Monitoring and accountability

A second and important process feature of a human rights approach is monitoring of and accountability for duty bearers. Monitoring is a pre-condition of accountability, yet there has been a surprising lack of attention from global institutions regarding the need to systematically report on attacks and interference with health care in conflict situations.⁹³ A human rights approach provides a framework for assessing and developing innovative methodologies for reporting that can incorporate the right to health as a central component. Accountability comes in a variety of forms – from international treaty bodies' own reporting processes and compliance procedures⁹⁴ to national and international judicial or quasi-judicial mechanisms such as ombudsmen. A human rights approach to health care in conflict provides a spotlight for identifying what accountability mechanisms exist and how they might be better utilised in respect to attacks on and interferences with health care.

Within the UN system, treaty bodies play a crucial role in monitoring and accountability, such as the Human Rights Committee, the Committee Against Torture, the CESCR, and the Committee on the Rights of the Child.

93 Leonard S. Rubenstein and Melanie D. Brittle, 'Responsibility for protection of medical workers and facilities in armed conflict', in *The Lancet*, Vol. 375, 2010, p. 336.

94 See ICESCR, Arts. 16–23.

Thematic mechanisms include the United Nations Special Representative of the Secretary-General on Children in Armed Conflict, which, as noted above, monitors and promotes accountability for six categories of violations, including attacks on schools and hospitals, and has its legal foundations in both the laws of armed conflict and human rights law.⁹⁵ UN Security Council Resolution 1998, adopted in 2011,⁹⁶ provides for the listing of parties who engage in persistent attacks on schools and hospitals, reaffirming the need to enhance monitoring and reporting of such incidents and giving concrete impetus towards actions to protect such facilities. Monitoring activities of the Office of the High Commissioner for Human Rights include violations of IHL and HRL, but its activities could be expanded based on a more thorough reflection of the applicability of HRL. The creation of a formal UN tool of accountability that addresses health care facilities and personnel in all conflict settings, not just armed conflict, and not just in relation to children, would be an important step forward in accountability.

The systematic monitoring of attacks on and interference with health care as a health systems and protection issue also needs to be addressed. Collecting information on the scale and nature of the problem would provide an evidence base from which to evaluate the impact of attacks and interference on elements like health infrastructure, health workforce and drug supply chains. In conflict-affected environments, such monitoring presents a challenge. The World Health Assembly passed a resolution in 2012 calling on the Director-General to take leadership at the global level in order to collect data on attacks on health facilities, health workers, health transports, and patients in complex emergencies.⁹⁷ Such monitoring should take place within a human rights as well as an IHL framework. This requires that information on attacks and interference be collected and assessed against human rights and humanitarian norms, including the right to health.

A decade ago, the medical and nursing community urged the Human Rights Commission to create a Special Rapporteur on attacks on health workers. The commission (now the Human Rights Council) chose a more general mandate to monitor and report on the right to health. Among other roles, the Special Rapporteur on the right to health presents annual reports to the Human Rights Council and to the General Assembly – these reports often have a particular theme. The Special Rapporteur can use this opportunity to look at attacks on health care as a particular theme, or a new rapporteur could be established on the issue.

Human rights accountability extends to the national level – judicial mechanisms could elevate the priority of prosecutions of crimes perpetrated against health care providers and their beneficiaries. Indeed, human rights accountability

95 United Nations Office of the Special Representative of the Secretary-General for Children and Armed Conflict, *Working Paper No 1: The Six Grave Violations Against Children During Armed Conflict – The Legal Foundation*, October 2009, available at: <http://www.crin.org/docs/SixGraveViolationspaper.pdf> (last visited 22 August 2012).

96 See above note 28.

97 World Health Organization Executive Board, 'WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies', 21 January 2012, available at: http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_R14-en.pdf (last visited 13 August 2012).

mechanisms can and should provide a welcome addition to the more limited number of mechanisms available to enforce compliance with IHL.

Conclusion

Assuring the health care of people in situations of armed conflict or other situations of violence is complex, and requires multiple strategies founded on protection, respect, and affirmative steps to respond to insecurity. In circumstances of conflict, health care providers and their beneficiaries have increasingly become highly vulnerable as they are either targeted directly as a means of state action or as part of the activities of armed groups, or suffer indirectly on account of the failure of states to live up to their obligations under the right to health. IHL remains a critically important set of rules through which to address obligations with respect to health in armed conflict, with HRL acting as a powerful complement to it; and in circumstances where no armed conflict exists, but where health workers, facilities, patients, and ambulances are subject to threats, attacks, and other forms of interference and denial, HRL fills an important gap.

One of the greatest contributions of human rights is its role in ensuring that the interests and needs of the powerless and vulnerable are addressed. The essential elements of a human rights approach to health care in conflict include principles of non-discrimination and equality, coupled with entitlements to availability, accessibility, acceptability, and quality in health care. The obligations to respect, protect and fulfil can be promoted through participation and enforced through accountability, providing a powerful means of addressing the plight of health care workers and patients in conflict situations. Indeed, this is a strong framework through which to engage with many of the recommendations emerging from the 31st International Conference of the Red Cross and Red Crescent, which included support for the dissemination and promotion of obligations under both IHL and HRL.⁹⁸ Human rights bodies have also begun to play a role in strengthening respect and accountability for IHL as well as HRL violations in armed conflict. With careful oversight, human rights mechanisms can be employed to strengthen humanitarian law principles of respect and protection of medical personnel and patients as individual victims in armed conflict.

The time has come to properly grasp human rights' role in redressing the powerlessness experienced by those seeking care and those trying to provide it, across all conflict settings.

98 ICRC, *Healthcare in Danger: Respecting and Protecting Healthcare in Armed Conflict and Other Situations of Violence, Resolution*, adopted at the 31st International Conference of the Red Cross and Red Crescent, 28 November – 1 December 2011, Geneva, Switzerland, available at: http://www.rcrcconference.org/docs_upl/en/R5_HCID_EN.pdf (last visited 30 August 2012).