

States' obligations to mitigate the direct and indirect health consequences of non-international armed conflicts: complementarity of IHL and the right to health

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Abstract

Armed conflicts have numerous adverse health consequences for the affected populations, many of which occur in the long-term. This article analyses in detail how international humanitarian law (IHL) and the right to health complement each other in obliging states to mitigate the direct and indirect health consequences of non-international armed conflicts. With its historical origin and purpose of protecting wounded and sick combatants of standing governmental armies, IHL focuses on the protection of the wounded and sick suffering from the direct health consequences

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of armed conflicts, such as injuries resulting from ongoing hostilities. The right to health is more expansive: it obliges states to prioritise the provision of primary health care through creating and maintaining an accessible basic health system. This focus enables it to highlight and address the indirect health consequences of armed conflicts, such as the spreading of epidemic and endemic diseases and rising child and maternal mortality and morbidity.

Keywords: right to health, wounded and sick, medical personnel, medical transports, medical units, non-international armed conflict, primary health care, prevention and treatment of disease, health systems.



Armed conflicts continue to cause civilian and military deaths and have grave consequences for human health, interfering greatly with people's ability to enjoy their rights to life and health. Among the direct and indirect effects of armed conflicts on public health that are the focus of this article are injuries resulting from hostilities, long-term physical disabilities and mental health problems, increasing rates of epidemic and endemic diseases, insufficient health care for mothers and children, substantial reductions of public health budgets, the departure of trained medical professionals, and the interruption of medical and food supplies. These effects are associated with a complete or partial breakdown of health systems and the destruction of essential infrastructure in armed conflicts.

In particular, the indirect and long-term adverse impact of armed conflicts on public health have often been underestimated and overlooked.¹ This is despite the fact that frequently rising death rates in armed conflicts are predominantly due to the conflict's indirect impacts on public health: the great majority of victims of war worldwide die from diseases (mainly acute respiratory infections, diarrhoeal diseases, maternal and neonatal morbidity, tuberculosis, and malaria) and malnutrition.²

This contribution asks whether, and if so, how, the law applicable to non-international armed conflicts takes account of the direct and indirect health effects of armed conflicts and contributes to their mitigation. This is intrinsically linked to the question of the parallel application of international humanitarian law (IHL) and international human rights law (IHRL), in particular IHL and the right to health. The analysis focuses on the complementarity of IHL rules relating to the protection of the wounded and sick and medical personnel, units, and transports, and relevant aspects of the right to health as set out in Article 12 of the

1 Bethany Lacina und Nils Petter Gleditsch, 'Monitoring trends in global combat: a new dataset of battle deaths', in *European Journal of Population*, Vol. 21, 2005, pp. 158 ff.

2 See e.g. *ibid.*, p. 159; Geneva Declaration, *Global Burden of Armed Violence*, Report, September 2008, available at: www.genevadeclaration.org/fileadmin/docs/Global-Burden-of-Armed-Violence-full-report.pdf (last visited 15 June 2013); Hazem Adam Ghobarah, Paul Huth, and Bruce Russett, 'Civil wars kill and maim people – long after the shooting stops', in *American Political Science Review*, Vol. 97, No. 2, 2003; and the findings of the reports of the International Rescue Committee on Mortality in the Democratic Republic of the Congo between 1998 and 2007, available at: www.rescue.org/special-reports/congo-forgotten-crisis (last visited 15 June 2013).

International Covenant on Economic, Social and Cultural Rights (ICESCR).³ It will be shown that, overall, IHL and the right to health complement each other well in setting out the obligations of states to mitigate the mentioned direct and indirect health consequences of armed conflicts. To this end, first the applicability of economic, social, and cultural (ESC) rights to situations of non-international armed conflict is briefly outlined, as well as their relationship to IHL. Second, the protection of the wounded and sick and the possible scope of health services to be provided in non-international armed conflicts under IHL and the right to health are explored in some detail. Third, the special protection that is given to medical personnel, facilities, and transports is examined. In the concluding remarks, the main findings on the complementarity between IHL and the right to health are summarised.

In articles of limited scope, choices have to be made between either focusing on certain aspects in detail or giving a general overview of the subject. This article has opted for the former. This is also the main reason why concessions concerning the scope of the analysis had to be made: first, the article focuses on the law applicable to non-international armed conflicts, leaving the law of international armed conflicts aside. This choice was made because the vast majority of armed conflicts are of a non-international character today,⁴ and because it is this type of conflict in which IHL and IHRL have to interact most for the effective protections of affected individuals.⁵ Second, this contribution mainly concentrates on *states'* obligations in non-international armed conflicts. The obligations of non-state armed groups and possibly international humanitarian organisations are only touched upon, since no sufficiently thorough research could be conducted into the actual practice of diverse non-state armed groups in regard to socio-economic issues (IHL and ESC rights), or into the opinion of states and international organisations on these matters and the approach adopted in national and international jurisprudence. Such research would be needed to draw persuasive conclusions on the scope of the IHL obligations of diverse non-state armed groups, and possibly their obligations by virtue of the right to health and other socio-economic rights.⁶ Third, the question of whether accepting the parallel application of IHL and the

- 3 Other questions, for example whether obligations flowing from the right to health have to be factored into the process of making military targeting decisions, cannot be discussed here. The question of the circumstances under which parties to a conflict are obliged under IHL and the right to health to accept humanitarian and impartial assistance are also beyond the scope of this study. For an analysis of these and other questions concerning the parallel application of IHL and the right to health, see Amrei Müller, *The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law: An Analysis of Health-Related Issues in Non-International Armed Conflicts*, Martinus Nijhoff, Leiden, 2013.
- 4 Lotta Themner and Peter Wallenstein, 'Armed conflict – 1946–2011', in *Journal for Peace Research*, Vol. 49, No. 4, 2012.
- 5 This does not imply that the present author is of the view that IHRL does not apply to international armed conflicts. On the contrary, many of the findings of this article are as relevant for international armed conflicts as they are for non-international armed conflicts.
- 6 For a recent study on this matter, see Sandesh Sivakumaran, *The Law of Non-International Armed Conflict*, Oxford University Press, Oxford, 2012, covering non-state armed groups' obligations under IHL, including in relation to the protection of the wounded and sick (pp. 273–277), medical personnel (pp. 277–280), and medical units and transports (pp. 373–375). Also see below for some further initial observations on the scope of non-state armed groups' obligations under IHL and possibly IHRL.

right to health to armed conflict situations results in a right to human rights-based humanitarian assistance of the affected populations cannot be explored in all its details.

The applicability of ESC rights to armed conflict situations and their relationship to IHL

The parallel applicability of IHL and IHRL, including ESC rights, in times of armed conflict is widely accepted today.⁷ Most prominently, this was pronounced by the International Court of Justice (ICJ) in its Advisory Opinion on the *Legal Consequences of the Construction of a Wall in Occupied Palestinian Territory*, where the ICJ referred directly to the applicability of the ICESCR and other international human rights treaties containing socio-economic rights to armed conflict situations.⁸ In its 2012 fourth periodic report to the United Nations (UN) Human Rights Committee (HRC), even the United States signalled a departure from its previous position on the non-applicability of IHRL to armed conflict situations.⁹ Together with Israel, the United States had on occasion denied the applicability of IHRL to conflict situations, in particular its extraterritorial applicability.¹⁰

Questions can be asked about the scope of states' obligations under the ICESCR in times of armed conflict. In this context, it has to be noted that the ICESCR does not contain a derogation clause. A tendency can be observed that states, the UN Committee on Economic, Social and Cultural Rights (CESCR), and other international bodies nonetheless accept derogations from labour rights¹¹ in times of armed conflicts and other emergencies that 'threaten the life of the nation'.¹² If accepted, such derogations shall arguably conform to the derogation principles set out in Article 4 of the International Covenant on Civil and Political Rights (ICCPR).¹³ The non-derogability of all other ESC rights, in particular

7 For a recent overview of the practice of states and UN Charter bodies, including the International Court of Justice, see Louise Doswald-Beck, *Human Rights in Times of Conflict and Terrorism*, Oxford University Press, Oxford, 2011, chapter I; see also S. Sivakumaran, above note 6, p. 83.

8 ICJ, *Legal Consequences of the Construction of a Wall in Occupied Palestinian Territory*, Advisory Opinion, 9 July 2004, *ICJ Reports 2004*, paras. 106 and 112.

9 United States of America, Fourth Periodic Report to the United Nations Human Rights Committee, UN Doc. CCPR/C/USA/4, 22 May 2012, paras. 506–509.

10 HRC, Concluding Observations – Israel, UN Doc. CCPR/C/ISR/CO/3, 3 September 2010, para. 5; CESCR, Concluding Observations – Israel, UN Doc. E/C.12/ISR/CO/3, 16 December 2011, para. 8; and HRC, Concluding Observations – United States of America, UN Doc. CCPR/C/USA/CO/3/Rev.1, 18 December 2006, para. 10.

11 As set out, for example, in ICESCR, Arts. 6, 7, and 8(1).

12 See an analysis in Amrei Müller, 'Limitations to and derogations from economic, social and cultural rights', in *Human Rights Law Review*, Vol. 9, 2009, pp. 594–597, examining *inter alia* the practice of the UN Committee on Economic, Social and Cultural Rights and the opinions of states in the reports to the same Committee, and of the International Labour Organization, on this question.

13 *Ibid.*, pp. 595–597. ICCPR, Art. 4, allows for derogations of some rights set out in the ICCPR in times of 'public emergency which threatens the life of the nation and the existence of which is officially proclaimed'. Derogations are only permitted 'to the extent strictly required by the exigencies of the situation'; they shall not be 'inconsistent with' states' 'other obligations under international law' and shall 'not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin'.

of so-called survival rights (the rights to food and health), is substantiated primarily by the fact that it seems inherently unnecessary to derogate from these rights to protect or restore public order.¹⁴

The non-derogability of most ESC rights in times of armed conflict does not, however, require states to do the impossible and to guarantee these rights in all their sometimes very detailed aspects to the same extent as in peacetime. The notion of progressive realisation in Article 2(1) of the ICESCR and the Covenant's general limitation clause (Article 4 of the ICESCR) offer sufficient flexibilities for states to adapt their implementation strategies for ESC rights in difficult situations of armed conflict. The requirements of Article 4 of the ICESCR¹⁵ have to be followed in such possible adaptation processes, and have been understood in the literature¹⁶ as follows: first, states must show that limitations are necessary for the 'purpose of promoting general welfare' – or at least that their implementation preserves 'general welfare' to the greatest extent possible. Based, *inter alia*, on the *travaux préparatoires* of the ICESCR, general welfare primarily refers to the economic and social well-being of individuals and the community, and excludes notions of 'public morals', 'public order', and 'national security'. Second, states must ensure that limitations are determined by national law that conforms to all their international human rights obligations and is sufficiently clear and publicly accessible. Third, the requirement that limitations must be acceptable in a democratic society calls upon states to legitimise any limitations of ESC rights through a participatory and transparent decision-making process. Fourth and most importantly, limitations should 'be compatible with the nature of these [ESC] rights'. This can reasonably be interpreted to exclude limitations which infringe upon minimum core obligations/rights as defined by the CESCR in its respective General Comments and as concretised through national legislation.¹⁷ National particularities, including the availability of resources, can be taken into account in domestic law. And lastly, limitations must respect the principle of proportionality. This requires states to show that the scope and severity of a limitation is proportionate to the aim it seeks to pursue (that is, the promotion of general welfare).¹⁸

The parallel application of IHL and IHRL is often described as being regulated by the *lex specialis* maxim. There is, however, no agreement on the actual

14 See *ibid.*, p. 599; Allan Rosas and Monika Sandvik-Nylund, 'Armed conflicts', in Asbjørn Eide, Catarina Krause, and Allan Rosas (eds), *Economic, Social and Cultural Rights: A Textbook*, Martinus Nijhoff, Dordrecht, 2001, p. 414; and Philip Alston and Gerard Quinn, 'The nature and scope of States Parties' obligations under the International Covenant on Economic, Social and Cultural Rights', in *Human Rights Quarterly*, Vol. 9, 1987, p. 217. These sources also contain more detailed discussions of the possibility of derogating from ESC rights in times of armed conflict.

15 ICESCR, Art. 4, reads: 'The States Parties to the present Covenant recognise that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.'

16 See P. Alston and G. Quinn, above note 14; and A. Müller, above note 12.

17 *Ibid.*, pp. 579–583; A. Rosas and M. Sandvik-Nylund, above note 14, p. 412.

18 For more details on all of these aspects of limitations to ESC rights, see P. Alston and G. Quinn, above note 14; and A. Müller, above note 12.

meaning of this maxim.¹⁹ Nonetheless, as an operational tool, *lex specialis* can be useful to guide the simultaneous application of IHL and IHRL. This is most clearly set out in the International Law Commission's (ILC) study on *Fragmentation of International Law*,²⁰ which sums up the two main functions of the maxim. In its first function, *lex specialis* is applicable to conflicts of norms, where it promotes the setting aside of the more general rule to an extent that it is inconsistent with the more special rule. The second function of the *lex specialis* maxim comes into play when the two norms are consistent with each other, but when one rule is more detailed or tailored to the particular situation at hand. In this case, any tension between the rules is solved through interpretation, and the more specific rule is an application of the general rule. In practice, it will often be difficult to determine whether one rule is more special than another, whether there is indeed a direct conflict between the two, and thus whether the special rule sets aside the general rule or applies in addition to the general rule.²¹ The ILC study also highlights that even in cases where the more special law sets aside the more general rule, the general rule remains in the background and 'provide[s] interpretative direction'²² to the special rule. Moreover, the exact function of the *lex specialis* maxim depends on the character of the two rules at hand, the specific situation to which those rules shall be applied, and any additional rule of treaty interpretation that might be taken into account in the parallel application of two norms.²³ From this, it is clear that the application of the *lex specialis* maxim to the relationship between IHL and IHRL is not a schematic exercise; it does not mean that IHL must always be given absolute preference in armed conflict situations, and that IHRL can simply be ignored.

For the context of this article, the *lex specialis* maxim seems to be limited to the second function mentioned above. With regard to the issues to be examined in this article – states' obligations under IHL and the right to health to mitigate the direct and indirect health consequences of armed conflicts – no direct conflicts arise between IHL and the right to health. As will be shown, they seem to complement each other well. Thus, the *lex specialis* maxim will rather promote a harmonious parallel application of both bodies of law, furthering the situation-dependent interpretation of relevant IHL rules in the light of the right to health and vice versa in situations of non-international armed conflict.²⁴

19 See, among others, Anja Lindroos, 'Addressing norm conflicts in a fragmented legal system: the doctrine of *lex specialis*', in *Nordic Journal of Human Rights*, Vol. 74, 2005; Marko Milanovic, 'A norm-conflict perspective on the relationship between international humanitarian law and human rights law', in *Journal of Conflict and Security Law*, Vol. 14, No. 3, pp. 473–476; and Nancie Prud'homme, 'Lex specialis: oversimplifying a more complex and multifaceted relationship?', in *Israel Law Review*, Vol. 40, No. 2, 2007.

20 *Fragmentation of International Law: Difficulties Arising from the Diversification and Expansion of International Law*, Report of the ILC's Study Group on Fragmentation, A/CN.4/L.682, 13 April 2006 (hereinafter ILC Report), paras. 56–58.

21 *Ibid.*, paras. 91–92. See also S. Sivakumaran, above note 6, pp. 89–92; and A. Müller, above note 3, pp. 24–25.

22 See ILC Report, paras. 102–103; and A. Müller, above note 3, pp. 28–29 for more details.

23 ILC Report, paras. 36, 106–107, 112, and 119–120; A. Müller, above note 3, pp. 25–33.

24 See also *ibid.*, pp. 192–194.

Another issue to be touched on before entering into the substantive discussion of states' obligations to mitigate the direct and indirect health consequences of non-international armed conflicts is the scope of non-state armed groups' obligations under IHL and, in particular, the ICESCR. It is not questioned that non-state armed groups have obligations under IHL (as long as they meet the organisational requirements provided for by IHL), but it remains unclear whether non-state armed groups are bound by IHRL, and if so, to what extent.²⁵ The possibility shall not be excluded that well-organised non-state armed groups can have (limited) obligations flowing from IHRL, in particular when they control territory or even establish a functioning administration.²⁶ It seems problematic, however, to demand that all types of non-state armed groups are obliged to implement, for example, the sometimes far-reaching obligations that states have under the right to health. It is questionable whether non-state armed groups regularly have the capacity to devise and implement a comprehensive public health policy and to build an accessible public health system, as states are required to do under their obligations flowing from the right to health. Rather, the current author assumes that non-state armed groups are primarily bound by IHL rules, complemented and reinforced by the ICESCR, that allow the smooth delivery of humanitarian assistance to individuals under their control. In other words, arguably non-state armed groups will primarily have obligations towards national and international humanitarian organisations that may take on the implementation of many obligations under IHL and the right to health that will be discussed below, when they themselves lack the capacity for implementation.²⁷ However, as mentioned above, the obligations of non-state armed groups are not the main focus of this article. Their obligations will possibly take the form of a 'sliding scale'²⁸ of obligations, providing for non-state armed groups' increasing obligations according to their degree of organisation, the intensity of violence in which they are involved, and the extent to which they control territory.

With these general observations on the scope of states' obligations flowing from the ICESCR in times of armed conflict as well as their relationship to IHL in mind, we will now move to discuss the protection of the wounded and sick and the possible scope of health services to be provided to individuals

25 In the affirmative, see e.g. Andrew Clapham, 'Human rights obligations of non-state actors in conflict situations', in *International Review of the Red Cross*, Vol. 88, No. 863, September 2006, pp. 491–523; for a rejection, see Liesbeth Zegveld, *Accountability of Armed Opposition Groups in International Law*, Cambridge University Press, Cambridge, 2002, pp. 38–54.

26 Several resolutions of the UN Security Council suggest that non-state armed groups are bound by IHRL. See e.g. the Report of the UN Secretary-General's Panel of Experts on the Accountability in Sri Lanka, 31 March 2011, para. 188, available at: www.un.org/News/dh/infocus/Sri_Lanka/POE_Report_Full.pdf (last visited 16 June 2013); the discussion by A. Clapham, above note 25, pp. 500–508; and S. Sivakumaran, above note 6, pp. 96–98.

27 For more details, see A. Müller, above note 3, pp. 4–5 and chapter VIII; see also S. Sivakumaran, above note 6, pp. 329–333, confirming that non-state armed groups are bound and consider themselves bound by IHL rules relating to the delivery of humanitarian assistance.

28 As contemplated by Marco Sassòli, 'Taking armed groups seriously: ways to improve their compliance with international humanitarian law', in *International Humanitarian Legal Studies*, Vol. 1, 2010, p. 20.

affected by non-international armed conflicts under IHL and the right to health. First, the article explores who is covered by the protection offered by the right to health and by relevant IHL rules. Second, the question of the possible scope of health services, facilities, and goods that states are obliged to provide under these rules are discussed, addressing the direct and indirect health consequences of armed conflicts.

The protection of the wounded and sick and the possible scope of health services to be provided in non-international armed conflicts

Personal scope of application

Reflecting the realities of the 1859 Battle of Solferino, IHL applicable to international armed conflicts has historically focused on the protection of wounded and sick combatants.²⁹ Although the Fourth Geneva Convention (GC IV) already provided some protection to wounded and sick civilians in international armed conflicts, it is only with the adoption of the First Additional Protocol to the Geneva Conventions (AP I) in 1977 that wounded and sick civilians benefited from the full protection traditionally guaranteed to wounded and sick combatants.³⁰ Due to the absence of a combatant status in the law of non-international armed conflicts, protection offered to the ‘wounded and sick’ in Common Article 3 of the First to Fourth Geneva Conventions (GC I–IV) and the Second Additional Protocol to the Geneva Conventions (AP II) of 1977 applies to all persons ‘whether or not they have taken part in the armed conflict’.³¹ Thus, treaty rules on the wounded and sick were more inclusive in non-international than in international armed conflicts already in 1949, when Common Article 3 of GC I–IV was adopted.³²

29 At Solferino, wounded soldiers roused Henry Dunant’s compassion, and it was for their protection that the first Geneva Convention was adopted in 1864: the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field. The civilian population in and around Solferino had not been directly affected by the battle.

30 As most clearly expressed in Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, 8 June 1977, 1125 UNTS 3 (entered into force 7 December 1978) (hereinafter AP I), Art. 8, which refers to ‘the “wounded” and “sick”, whether military or civilian’.

31 AP II, Art. 7(1); GC I–IV, Common Art. 3(1) includes protection of those placed *hors de combat* by sickness or wounds; GC I–IV, Art. 3(2) provides for the collection and care for the wounded and sick; see also ICRC, *Customary International Humanitarian Law, Vol. I: Rules*, Jean-Marie Henckaerts and Louise Doswald-Beck (eds.), ICRC and Cambridge University Press, Cambridge, 2005 (hereinafter ICRC Study), Rule 109, pp. 396–399.

32 GC IV introduced some provisions aimed at the amelioration of the condition of wounded and sick civilians in international armed conflicts (in particular Arts. 14–22), but these provisions lagged behind the detailed regulation in GC I and GC II on the protection of wounded, sick, and shipwrecked members of armed forces.

As is clear from Article 8(a) of AP I, the definition of 'wounded and sick' in IHL covers everyone who (a) requires medical care and (b) does not engage in any act of hostility:³³

'Wounded' and 'sick' mean persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility. These terms also cover maternity cases, new-born babies and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility.³⁴

Though originally applicable to international armed conflicts only, this definition is usually resorted to for situations of non-international armed conflict as well.³⁵ It can also be assumed that it underlies rules 109–111 of the ICRC Study on Customary IHL (hereinafter ICRC Study), which do not give a customary definition of the 'wounded and sick'.³⁶ The definition is not restricted to those conflict-affected individuals who are wounded and sick for reasons related to the armed conflict, but covers all persons in need of medical treatment: the ICRC Commentary on Article 8(a) of AP I observes that 'this criterion – being in need of medical care – is the *only valid one* for determining whether a person is "wounded" or "sick" in the sense of the Protocol (insofar as the second condition [to refrain from any act of hostility] is fulfilled)'.³⁷ Article 8(a) of AP I even allows the inclusion not only of individuals who do not require *immediate* medical care in the sense of emergency medical treatment, but also of those who need other curative or rehabilitative

33 Yves Sandoz, Christophe Swinarski, and Bruno Zimmermann (eds), *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*, ICRC, Geneva, 1987, para. 4638 (hereinafter ICRC Commentary to AP I/AP II); Jann Kleffner, 'Protection of the wounded, sick and shipwrecked', in Dieter Fleck (ed.), *The Handbook of International Humanitarian Law*, Oxford University Press, Oxford, 2nd edition, 2008, pp. 328–329.

34 AP I, Art. 8(a).

35 ICRC Commentary to AP II, above note 33, para. 4637; Michael Bothe, Karl Josef Partsch, and Waldemar Solf, *New Rules for Victims of Armed Conflict*, Martinus Nijhoff, The Hague, 1982, p. 656.

36 ICRC Study, Vol. I, Rules 109–111, pp. 396–405. It is not clear why the ICRC Study does not comment on the customary status of this definition. The present author assumes that this is because the 'practice' cited in Vol. II of the Study (mainly military manuals) does usually refer to the 'wounded and sick' without restating the definition of AP I, Art. 8(a) (see ICRC Study, Vol. II, chapter 34, pp. 2590–2654).

37 ICRC Commentary to AP I, Art. 8(a), para. 304 (emphasis added). This is reiterated for situations of non-international armed conflicts in the ICRC Commentary to AP II, Art. 7(1), para. 4639, holding that '[a]ny person, military or civilian, fulfilling these two conditions is included amongst the wounded or sick'. See also Jean Pictet, *Commentary to the Geneva Conventions of 12 August 1949*, Geneva, ICRC, 1952–1959 (hereinafter ICRC Commentary to GC I–IV) on GC IV, Art.16, p. 134. AP I, Art. 9(1) should not be understood as limiting the definition of the 'wounded and sick' to those who are in this condition for reasons directly related to the armed conflict. The ICRC Commentary to AP I, Art. 9(1) sets out the complex drafting history of this Article, and concludes in para. 417 that '[t]he expression "all those who are affected by a situation referred to in Article 1" is . . . insufficiently precise to determine exactly the field of application "*ratione personae*" of Part II [of AP I]. Only an examination, article by article, of the whole of this Part, makes it possible to provide a more precise list of the persons to whom it applies in various circumstances.' In any event, even if it was meant to limit the definition of the 'wounded and sick' to those who are in this condition because they are directly affected by the hostilities, it is not clear whether AP I, Art. 9(1) applies to non-international armed conflicts – the types of conflict that are of interest to us here – as a matter of custom. The ICRC Study does not contain a provision in this regard.

treatment, for example because of chronic sickness or disability. The adjective ‘immediate’ does not qualify ‘medical assistance’ in the first sentence, and moreover, the definition refers to ‘physical and mental disorder or disability’. As the ICRC Commentary to Article 8(a) of AP I explains, the second sentence of this Article aims to cover those persons who are ‘neither wounded nor sick in the usual sense of these words’ but ‘whose condition may at any moment necessitate immediate medical care’,³⁸ and thus it includes the adjective ‘immediate’.

The right to the highest attainable standard of physical and mental health is held by ‘everyone’³⁹ under the jurisdiction of states that have ratified the ICESCR, including in times of armed conflict. Article 12(2)(d) of the ICESCR specifies that the right to health poses an obligation on the state to create the ‘conditions that assure to *all* medical service and medical attention in the event of sickness’⁴⁰ – the element of the right to health that is particularly relevant here. The health system and goods, services, and programmes that states should ensure under their minimum core and non-core obligations must be available, accessible, acceptable, and of good quality.⁴¹

The right to access various elements of the health system made available through the implementation of the right to health is clearly not limited to those in need of emergency medical treatment because they have been injured in ongoing hostilities, but includes those in need of preventive, curative, and rehabilitative care. Yet it must be recalled that the scope of health care provided under the right to health in a particular situation can rarely meet the health needs of everyone because this scope depends on the availability of resources and the related definition of the national minimum core right to health.⁴² The question of the likely material scope of the obligations flowing from Article 12 of the ICESCR, in particular the scope of the emerging international minimum core right to health in situations of non-international armed conflict, will be discussed next, together with relevant states’ obligations under IHL.

Obligations to mitigate the direct health consequences of armed conflicts

IHL obligations and those flowing from the right to health aiming to alleviate the direct health consequences of armed conflicts can be divided into obligations to search for and collect those in need of medical care, and obligations describing the

38 ICRC Commentary to AP I, Art. 8(a), paras. 305–306. See also ICRC Commentary to AP II, Art. 7, para. 6439.

39 ICESCR, Art. 12(1); and Universal Declaration of Human Rights, Art. 25(1). In its ‘jurisprudence’ the CESCR made clear that this includes an obligation to give nationals and non-nationals access to the health system on an equal footing; see e.g. CESCR, Concluding Observations – Sweden, UN Doc. E/C.12/SWE/CO/5, 1 December 2008, para.10; Cyprus, UN Doc. E/C.12/CYP/CO/5, 12 June 2009, para.18; UK, UN Doc. E/C.12/GBR/CO/5, 2 June 2009, para. 27; and France, UN Doc. E/C.12/CO/FRA/CO/3, 9 June 2008, paras. 26 and 46.

40 Emphasis added.

41 CESCR, General Comment 14 – The Right to the Highest Attainable Standard of Health (ICESCR, Art. 12), E/C.12/2000/4, 11 August 2000, para. 12.

42 See the observations above.

scope of medical attention and care that is to be provided to those suffering the direct health consequences of armed conflict.

Obligations to search for and collect the wounded and sick

Article 7(1) of AP II contains the general obligations toward the wounded and sick in IHL: it requires that the wounded and sick shall be 'respected and protected'.⁴³ This entails that they are not made the subject of any attack, that they are not mistreated, and that their belongings are not taken away.⁴⁴ It also implies an obligation on the parties to the conflict to take more proactive measures to safeguard the protection of the wounded and sick against harmful acts by third parties, and their removal from the scene of combat as soon as possible.⁴⁵ Both obligations are confirmed in Article 8 of AP II, which specifies that the wounded and sick shall be protected against pillage⁴⁶ as well as searched for and collected. These obligations extend to non-state armed groups.⁴⁷

The obligation to ensure physical and economic access to minimum health-care facilities and services for everyone under the right to health includes an obligation not to unduly interfere with existing access, and thus reinforces the IHL obligations. As highlighted by the CESCR, this obligation entails that states refrain from 'limiting the access to health services as a punitive measure, for instance during armed conflicts'.⁴⁸ The UN HRC considers that a similar obligation flows from the right to life under the ICCPR.⁴⁹

As specified in Article 8 of AP II, states' IHL obligations to search for and collect the wounded and sick imply that 'whenever circumstances permit, and in particular after an engagement, all possible measures shall be taken, without delay, to search for and collect the wounded, sick and shipwrecked [in order] to ensure

43 This obligation forms part of customary IHL, as is clear from Rules 109–111 of the ICRC Study, Vol. I, pp. 396–405. These rules – and Rules 25–26 and 28–30 relating to the protection of medical personnel, medical units, and medical transports – are backed by extensive state practice collected in Vol. II of the ICRC Study, and their customary status is therefore undisputed in most aspects; see also Susan Breau, 'Protected persons and objects', in E. Wilmschurst and S. Breau (eds), *Perspectives on the ICRC Study on Customary International Humanitarian Law*, Cambridge University Press, Cambridge, 2007, pp. 175–179.

44 ICRC Commentary to AP II, above note 33, para. 4635; ICRC Study, Vol. I, Rule 111, pp. 403–405; J. Kleffner, above note 33, p. 330; Leslie Green, *The Contemporary Law of Armed Conflict*, Manchester University Press, Manchester, 3rd edition, 2008, pp. 358–359.

45 ICRC Commentary to AP II, above note 33, para. 4635; ICRC Study, Vol. I, Rule 109, pp. 396–399; J. Kleffner, above note 33, p. 330; and L. Green, above note 44, pp. 358–359.

46 See also ICRC Study, Vol. I, Rules 52 and 111, pp. 182 and 403.

47 S. Sivakumaran, above note 6, pp. 273–277. See also below note 66 and above note 27.

48 CESCR, General Comment 14, above note 41, para. 34, where the CESCR directly observes that such interference would also amount to a violation of IHL. This is also reiterated in its Concluding Observations – Sri Lanka, UN Doc. E/C.12/LKA/CO/2-4, 9 December 2010, para. 28. See also the examples from national case law given in International Commission of Jurists, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights – Comparative Experience of Justiciability*, Human Rights and Rule of Law Series No. 2, 2008, p. 43, available at: www.icj.org/dwn/database/ESCR.pdf (last visited 26 July 2012). States' direct threats to or interference with the health of individuals or health care given to them can also amount to inhuman or degrading treatment or a violation of the right to life. See the remarks below on ICCPR, Art. 6, and jurisprudence of the ECtHR, below note 108.

49 See below note 54.

their adequate care'.⁵⁰ The phrase 'whenever circumstances permit' implies that the duty to search for and collect the wounded and sick extends beyond the duty to do so on the battlefield, in particular because in contemporary armed conflicts it is 'difficult to determine where exactly the battlefield is in place and time'.⁵¹ Moreover, it makes clear that there is a duty to search for the wounded and sick not only after each engagement, but also in other situations – for instance, when civilians have been injured by mines or unexploded ordnance outside an area of active combat.

Similarly to IHL, obligations flowing from the right to health require states to undertake more proactive measures to safeguard the health of those suffering direct health consequences of hostilities. As part of their obligation to ensure equal access to existing health facilities, goods, and services, in an armed conflict situation states should arguably pay priority attention to those particularly vulnerable persons who have been wounded in ongoing hostilities.⁵² States are moreover obliged under the right to health to directly ensure access to health facilities when individuals are unable, for reasons beyond their control, to realise that element of the right to health themselves.⁵³ There is no reason why the measures that are to be taken to ensure these individuals' access to medical treatment required by their condition should differ from the mentioned obligations under IHL: obligations to search for and collect the wounded and sick, with all the implications described above.

This would also be strengthened by states' obligations under the right to life, a right closely connected to the right to health. The HRC has long observed that ICCPR Article 6(1) should not be interpreted narrowly and requires states to adopt 'positive' measures to safeguard lives, including ensuring access to medical assistance.⁵⁴ In addition, the UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials stipulate that law enforcement officials shall,

50 AP II, Art. 8, corresponds to GC I, Art. 15(1) and GC II, Art. 18(1), and introduced the explicit duty to search for the wounded and sick into IHL of non-international armed conflicts for the first time; see M. Bothe, K. J. Partsch, and W. Solf, above note 35, p. 659; ICRC Study, Vol. I, Rule 109, pp. 396–399; ICRC Commentary to AP II, above note 33, para. 4635; J. Kleffner, above note 33, p. 330; and L. Green, above note 44, pp. 358–359.

51 ICRC Commentary to AP II, above note 33, para. 4653; with this, AP II, Art. 8 goes further than GC II, Art. 18, which only requires taking such action 'after each engagement'; see also M. Bothe, K. J. Partsch, and W. Solf, above note 35, p. 659.

52 CESCR, General Comment 14, above note 41, para. 43(a); Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, para. 42.

53 CESCR, General Comment 14, above note 41, para. 37.

54 HRC, General Comment No. 6 – The Right to Life, 30 April 1982, para. 5; and HRC, Concluding Observations – Israel, UN Doc. CCPR/ISR/CO/3, 3 September 2010, para. 8; UN Doc. CCPR/CO/78/ISR, 21 August 2003, para. 19; HRC, Concluding Observations – United States of America, UN Doc. CCPR/C/USA/3/Rev.1, 18 December 2006, para. 26. This is also reiterated by the HRC's Concluding Observations that do not directly concern armed conflict situations, see e.g. HRC, Concluding Observations – Mali, UN Doc. CCPR/CO/77/MLI, 16 April 2003, para. 14; HRC, Concluding Observations – Uganda, UN Doc. CCPR/CO/80/UGA, 4 May 2004, para. 14; HRC, Concluding Observations – Kenya, UN Doc. CCPR/CO/83/KEN, 29 April 2005, paras. 14, 15, and 19; HRC, Concluding Observations – Mauritius, UN Doc. CCPR/CO/83/MUS, 27 April 2005, para. 9. See also Manfred Nowak, *UN Covenant on Civil and Political Rights – CCPR Commentary*, Kehl am Rhein, N. P. Engel, 2nd edition, 2005, pp. 123–124. And see the Inter-American Court of Human Rights' jurisprudence on 'the right to a dignified life', encompassing many aspects of the right to health, as discussed by Steven Keener and Javier Vasquez, 'A life worth living: enforcement of the right to health through the right to life in the Inter-American Court of Human Rights', in *Columbia Human Rights Law Review*, Vol. 40, 2009, pp. 595–624.

‘whenever the lawful use of force and firearms is unavoidable’, ensure ‘that assistance and medical aid are rendered to any injured or affected persons at the earliest possible moment’.⁵⁵

The jurisprudence of the European Court of Human Rights (ECtHR) shows that obligations under the right to life (Article 2) of the European Convention on Human Rights (ECHR) can equally reinforce and specify obligations under the right to health. The ECtHR has long found that Article 2(1) of the ECHR obliges states not only ‘to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within [their] jurisdiction’.⁵⁶ More concretely, in *Cyprus v. Turkey*, the ECtHR held that ECHR Article 2 may be violated ‘where it is shown that the authorities of a Contracting State put an individual’s life at risk through the denial of health care which they have undertaken to make available to the population generally’.⁵⁷ In this case, the restrictions placed on the freedom of movement of Greek Cypriot and Maronite populations by the Turkish Republic of Northern Cyprus (TRNC) in northern Cyprus resulted in some delay in their access to health care, and hampered medical visits.⁵⁸ That this is equally valid for situations of non-international armed conflict is clear from another judgement, *Albekov and Others v. Russia*. In this judgement, the ECtHR found that Russia had violated its ‘positive’ obligations to take appropriate steps to safeguard the lives of victims who had died from landmine explosions in Chechnya.⁵⁹ The finding was based on the Russian authorities’ ‘failure to endeavour to locate and deactivate the mines, to mark and seal off the mined area so as to prevent anybody from freely entering it, and to provide the villagers with comprehensive warnings concerning the mines laid in the vicinity of their village’.⁶⁰

The ECtHR did not mention, as a further violation of Russia’s ‘positive’ obligations to safeguard lives, the repeated refusal⁶¹ of the Russian military unit stationed close to the applicants’ village to search for one villager who had been wounded by a landmine, but such a finding is conceivable. This would be the case in

55 Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Adopted by the 8th UN Congress on the Prevention of Crime and the Treatment of Offenders, Havana, Cuba, 27 August to 7 September 1990, available at: www.unrol.org/files/BASICP~3.PDF (last visited 18 June 2013). The Principles are *inter alia* designed to give effect to the right to life in domestic law.

56 ‘Positive’ obligations to safeguard the right to life are a well-established part of the ECtHR’s jurisprudence, see e.g. ECtHR, *Cyprus v. Turkey*, Appl. No. 25781/94, Judgement (Grand Chamber), 10 May 2001, para. 219; ECtHR, *L.C.B. v. UK*, Appl. No. 23413/94, Judgement, 9 June 1998, para. 36; *Osman v. UK*, Appl. No. 23452/94, Judgement (Grand Chamber), 28 October 1998, para. 115; discussed in more detail in Harris *et al.* (eds.), *Harris, O’Boyle and Warbrick, Law of the European Convention on Human Rights*, Oxford University Press, Oxford, 2nd edition, 2009, pp. 42–46.

57 ECtHR, *Cyprus v. Turkey*, Appl. No. 25781/94, Judgement (Grand Chamber), 10 May 2001, para. 219.

58 The ECtHR did not, however, find a violation of the right to life since it ‘was unable to establish on the evidence that the “TRNC” authorities deliberately withheld medical treatment from the population concerned or adopted a practice of delaying the processing of requests of patients to receive medical treatment in the south’ (*ibid.*, paras. 219–221). Instead, it took the TRNC’s interference with access to medical facilities into account as one factor in its finding that the overall living conditions of enclaved Greek Cypriots in northern Cyprus amounted to a violation of Art. 8 (right to private and family life) (paras. 299–301).

59 ECtHR, *Albekov and Others v. Russia*, Appl. No. 68216/01, Judgement, 6 April 2009, para. 90.

60 *Ibid.*, para. 90.

61 *Ibid.*, paras. 18, 19, and 21.

particular when aforementioned IHL obligations to search for and collect the wounded and sick as well as obligations under the right to health were taken into consideration.⁶² In this specific case it was even known to the military that a wounded villager was in need of medical assistance, since residents of the village had explicitly approached the military unit with the request to search and collect the wounded villager. The villagers were afraid of triggering more landmine explosions when searching for him on their own without the help of sappers. Since the IHL duty to search and collect the wounded and sick usually rests with the governmental armed forces operating military and civilian medical services – including independent national Red Cross and Red Crescent Societies – the residents’ appeal to the military unit stationed in the region should have been responded to.

Rule 109 of the ICRC Study includes an obligation to take all possible measures to evacuate the wounded and sick when circumstances permit,⁶³ an obligation closely related to the obligation to search for and collect the wounded and sick. It can be argued that this obligation also includes a duty to create the conditions in which searches and evacuations can be carried out successfully. The more detailed provisions applicable to international armed conflicts in GC I can, by analogy, give more specific indications as to what an obligation to evacuate the wounded and sick could entail: for example, GC I Article 15(2) suggests that parties to the conflict arrange ‘an armistice or a suspension of fire’ or make ‘local arrangements’ to ‘permit the removal, exchange and transport of the wounded’. Reinforced by states’ obligations under the right to health to undertake actions to restore the health of the population,⁶⁴ these measures should be applied to non-international armed conflicts as well.⁶⁵ This would also allow national and international humanitarian organisations to take care of the wounded and sick in territories where parties to the conflict are unable to provide necessary medical care themselves, including in territories under the control of armed groups. In fact, both state and non-state parties to conflicts have frequently agreed that humanitarian organisations could assist in the search, collection, and evacuation of the wounded and sick in non-international armed conflicts.⁶⁶ This obligation is strengthened by Article 2(1) of the ICESCR, which calls on states to request and accept international assistance for the implementation of in particular minimum core ESC rights when they are unable to secure these rights themselves.⁶⁷

The analysis now turns to the scope of the medical attention and care that states must provide to those wounded or psychologically traumatised by ongoing hostilities under IHL and the right to health.

62 The CESCR also points to this direction in its Concluding Observations – Colombia, UN Doc. E/C.12/COL/CO/5, 7 June 2010, para. 16; Angola, UN Doc. E/C.12/AGO/CO/3, 1 December 2008, para. 33; and Bosnia and Herzegovina, UN Doc. E/C.12/BIH/CO/1, 24 January 2006, para. 48.

63 ICRC Study, Vol. I, Rule 109, p. 396.

64 CESCR, General Comment 14, above note 41, paras. 16 and 37.

65 As suggested in the commentary to ICRC Study, Vol. I, Rule 109, pp. 398–399.

66 See *ibid.*, p. 398, and the wealth of examples given by S. Sivakumaran, above note 6, pp. 276–277.

67 For more details, see A. Müller, above note 3, pp. 243–245.

The scope of medical attention and care to be provided to those suffering from direct health consequences of armed conflicts

Article 7(2) of AP II requires that the wounded and sick are 'treated humanely' in all circumstances and that they 'receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition'.⁶⁸ Article 8 of AP II confirms this, emphasising the obligation 'to ensure their adequate care'.

The phrase 'in all circumstances' leaves no doubt that military necessity cannot be invoked to justify non-compliance with this obligation.⁶⁹ However, as pointed out in the ICRC Commentary on AP II, the provision 'to the fullest extent practicable and with the least possible delay' is informed by realism, since sometimes it might be impossible to provide the care that is immediately necessary due to the prevailing circumstances. Nonetheless, the provision clearly requires that the parties to the conflict act in good faith and that they make their best efforts to provide the required medical care to the wounded and sick as quickly as possible.⁷⁰

Explaining the obligation to provide wounded and sick persons with adequate care, the ICRC Commentary to Article 8 of AP II further holds that

'adequate care' is first aid given on the spot, which may be of the utmost importance to avoid wounded, sick or shipwrecked succumbing during evacuation, which must take place as quickly as possible. Obviously such care includes ensuring the transport of the wounded to a place where they can be adequately cared for.⁷¹

Beyond the provision of first aid and emergency medical treatment, the details and types of medical care that have to be given to the wounded and sick are rarely specified in commentaries on relevant provisions of IHL.⁷² One reason for this is presumably IHL's focus on protecting mainly the traditional function of medical services attached to governmental armed forces, which is primarily concerned with caring for those who have been wounded in battles and focuses on first aid, surgeries, and amputations.

However, the inclusive definition of the 'wounded and sick' given above shows that 'adequate care' today goes beyond first aid and emergency medical treatment for those suffering from the direct health consequences of armed conflicts: it may, for example, include short- and long-term medical, mental, and rehabilitative care for those with conflict-related physical and psychological health

68 See also ICRC Study, Vol. I, Rule 110, pp. 400–403.

69 J. Kleffner, above note 33, p. 331.

70 ICRC Commentary to AP II, above note 33, para. 4645; interpretation of ICRC Study, Vol. I, Rule 110, p. 402; and J. Kleffner, above note 33, pp. 330–331, referring to the analogous provision in AP I, Art. 10(2).

71 ICRC Commentary to AP II, above note 33, para. 4655.

72 Most sources do not comment on what constitutes 'medical care and attention required' (AP II, Art. 7(2)) or 'adequate care' (AP II, Art. 8), e.g. J. Kleffner, above note 33, p. 330. The ICRC Study's comment on Rule 110 does not clarify the extent of this obligation either.

problems, including for victims of sexual violence.⁷³ Non-state armed groups' obligations in this area are most likely concentrated on obligations to give consent to the work of national and international humanitarian organisations implementing these and other obligations discussed below, in particular when the non-state armed group in question is relatively weak.⁷⁴

The question of whether obligations to provide long-term rehabilitative care lie outside the regulatory realm of IHL is intrinsically linked to the question of the temporal scope of application of IHL of non-international armed conflicts. Conventional rules of IHL fail to determine the point in time at which IHL of non-international armed conflicts ceases to operate, but the ICRC Commentary and the jurisprudence of the International Criminal Tribunal for the Former Yugoslavia (ICTY) give some further guidance on the temporal scope of application of IHL of non-international armed conflicts. The ICRC Commentary suggests that IHL is no longer applicable 'after the end of hostilities',⁷⁵ leaving the question open as to whether this refers to the point in time when a ceasefire agreement has been reached or to the time at which general hostilities have come to a close, typically through a peace agreement.⁷⁶ The latter interpretation is supported by the ICTY, which held that the application of IHL of non-international armed conflicts 'extends beyond the cessation of hostilities until . . . a peaceful settlement is achieved'.⁷⁷ Such an interpretation is further backed by the fact that IHL of both international and non-international armed conflicts contains provisions that are explicitly meant to have effect beyond the cessation of hostilities.⁷⁸ While the present author agrees with Sivakumaran that the temporal application of IHL should ultimately be determined by the existence or non-existence of certain facts (an armed conflict), which have to be judged on a case-by-case basis,⁷⁹ some more recent IHL treaties suggest that longer-term obligations could flow from IHL that are of relevance even after the end of hostilities and even when the fact-condition 'armed conflict' is no longer met. This is particularly so in regard to treaties that draw from IHL as well as from IHRL,⁸⁰ and whose temporal scope of application is not limited to armed

73 See also the section below, further analysing the question of the extent to which IHL obligations also include the provision of health care aiming to mitigate the indirect public health impact of armed conflicts.

74 See S. Sivakumaran, above note 6, pp. 275 and 333–334 for accounts of non-state armed groups' practice in this regard. The assumption is also supported by the ICRC Commentary to AP II, above note 33, para. 4878. On states' and non-state armed groups' obligations to give consent to the delivery of humanitarian assistance by humanitarian organisations, see also A. Müller, above note 3, chapter VIII.

75 ICRC Commentary to AP II, para. 4492.

76 See the observations by S. Sivakumaran, above note 6, p. 252.

77 ICTY, *Prosecutor v. Dusko Tadić*, Decision on the Defence Motion for Interlocutory Appeal on Jurisdiction, IT-94-1-AR72, 2 October 1995, para. 70; and *Prosecutor v. Ramush Haradinaj, Idriz Balaj and Lahi Brahimaj*, Judgement (Trial Chamber), IT-04-84-T, 3 April 2008, para. 100.

78 AP II, Art. 2(2); GC I and GC III, Art. 5; GC IV, Art. 6; and ICTY, *Tadić*, Decision on Interlocutory Appeal on Jurisdiction, para. 67.

79 S. Sivakumaran, above note 6, pp. 253–254; cp. also ICTY, *Prosecutor v. Ante Gotovina, Ivan Čermak, Miladen Markač*, Judgement (Trial Chamber), IT-06-90-T, 15 April 2011, para. 1694.

80 E.g. the 1997 Ottawa Convention, 2056 UNTS 211, entered into force on 1 March 1999; the 2003 Protocol V to Conventional Weapons Convention, 2399 UNTS 100, entered into force on 12 November 2006; and the 2008 Convention on Cluster Munitions (CCM).

conflict situations.⁸¹ For example, in his foreword to the Convention on Cluster Munitions (CCM), the ICRC's former president Jakob Kellenberger observes that the CCM 'established a broader norm that those who engage in armed conflict can no longer walk away from the long-term consequences of the weapons they use, leaving local communities to carry the burden'.⁸² Article 5(1) of the CCM obliges each state party to 'adequately provide age- and gender-sensitive assistance, including medical care, rehabilitation and psychological support' to cluster munition victims, as well as to 'provide for their social and economic inclusion'. From CCM Article 5(2)(e) it is furthermore clear that this obligation is not limited to victims of cluster munitions, but includes all 'who have suffered injuries or disabilities from other causes'. The recognition of the parallel application of ESC rights to armed conflicts is made explicit in the CCM.⁸³

To explore this further, the discussion will now move to analyse the extent to which states' obligations flowing from the right to health address the mentioned direct impacts of armed conflicts on public health. This is linked to the difficult question about the more exact scope of the health facilities, goods, and services that states are most likely obliged to grant equal access to under an emerging internationally defined minimum core right to health, possibly encompassing the provision of emergency as well as longer-term rehabilitative care to those who have been injured in hostilities. To recall, the implementation of the right to health in non-international armed conflicts will in most cases inevitably be limited to the implementation of a nationally defined minimum core right to health that mirrors the internationally defined minimum core as closely as possible, in accordance with ICESCR Articles 2(1) and 4.⁸⁴

The first question to be asked for the conflict context is whether emergency medical treatment is part of the international minimum core content of the right to health, strengthening the mentioned IHL obligations. The CESCR's General Comments 3 and 14 seem rather to regard 'essential primary health care'⁸⁵ as the minimum core of the right to health. Trauma care and surgery that require specialised training and sophisticated technology and resources are not usually part of 'primary health care'.⁸⁶ General Comment 14 refers to the Alma-Ata

81 See e.g. CCM, Arts. 1 and 4; Ottawa Convention, Arts. 1 and 5; Protocol V to Conventional Weapons Convention, Art. 1(3).

82 Entered into force on 1 August 2010, reprinted by the ICRC, with a foreword by Jakob Kellenberger, p. 7, available at: www.icrc.org/eng/assets/files/other/icrc_002_0961.pdf (last visited 26 July 2012).

83 E.g. in the preamble, paras. 6 and 22 and Art. 5(1) of the CCM; it should be recalled, however, that these obligations are subject to 'progressive realisation' in accordance with available resources; see also below text accompanying notes 116–118.

84 As outlined in the section 'The applicability of ESC rights . . .', above.

85 CESCR, General Comment 3 – The Nature of States Parties' Obligations, contained in document E/1991/23, 14 December 1990, para. 10; and General Comment 14, above note 41, para. 43; see also CESCR, Concluding Observations – Bolivia, UN Doc. E/C.12/BOL/CO/2, 8 August 2008, para. 34.

86 WHO, *World Health Report 2008 – Primary Health Care (Now More Than Ever)*, p. 55, including figure 3.5, available at: www.who.int/whr/2008/en/index.html (last visited 26 July 2012); see also the definition of 'primary health care' in John M. Last (ed.), *A Dictionary of Public Health*, Oxford University Press, Oxford, 2007, accessed via *Oxford Reference Online* at: www.oxfordreference.com/views/ENTRY.html?subview=Main&entry=t235.e3639 (last visited 26 July 2012).

Declaration⁸⁷ as a ‘compelling guidance on the core obligations arising from Art. 12⁸⁸ of the ICESCR – that is, on what constitutes ‘essential primary health care’:

at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.⁸⁹

The Humanitarian Charter and Minimum Standards in Humanitarian Response of the Sphere Project, which claim to be built on the minimum core right to health,⁹⁰ also suggest that health interventions by humanitarian organisations should emphasise community-based public health and primary care. This is based on the aforementioned fact that the indirect impacts of armed conflicts on public health often constitute a far greater health threat to the people affected than violent injury, especially in poorer countries.⁹¹ This is further discussed in the section ‘Obligations to mitigate the indirect health consequences . . .’, below.

The focus of the international minimum core right to health on primary health-care does not exclude emergency medical treatment and specialised surgical services from being considered immediately accessible services under a nationally defined minimum core, in particular in high-income countries. For example, the existence of an effective referral system has been named as a decisive component of a health system that conforms with the right to health, even if this health system prioritises primary care.⁹² This presumes the existence of primary (community-based), secondary (district-based), and tertiary (specialised) facilities and services, providing a continuum of prevention and care.⁹³ It also reflects an understanding

87 The Declaration of Alma-Ata was adopted by the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978, available at: www.searo.who.int/LinkFiles/Health_Systems_declaration_almaata.pdf (last visited 26 July 2012).

88 CESCR, General Comment 14, above note 41, para. 43.

89 Declaration of Alma-Ata, above note 87, para. IV(3); the CESCR’s understanding of states’ minimum core obligations set out in paras. 43 and 44 of General Comment 14 follow this definition; see also Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, para. 51; and WHO, *World Health Report 2008*, above note 86, pp. 55–56.

90 Sphere Project, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, 2011, available at: www.sphereproject.org/handbook/ (last visited 26 July 2012), p. 291, holds that: ‘The Minimum Standards . . . are not a full expression of the right to health. However, the Sphere standards reflect the core content of the right to health and contribute to the progressive realisation of this right globally.’

91 *Ibid.*, pp. 292, 311, and 331–333. See also the table on p. 293, indicating the public health impact of selected disasters; and the sources cited in above notes 1 and 2.

92 See, e.g. Gunilla Backman *et al.*, ‘Health systems and the right to health: an assessment of 194 countries’, in *The Lancet*, 10 December 2008, p. 6; and Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, paras. 22(e), 55, and 66. See also WHO, *World Health Report 2008*, above note 86, pp. 55–56.

93 See Backman *et al.*, above note 92; and WHO, *World Health Report 2000 – Health Systems: Improving Performance*, available at: www.who.int/whr/2000/en/ (last visited 26 July 2012). In addition, even if not

of primary care as a hub from which patients are guided through a health system.⁹⁴ As noted by the World Health Organization (WHO), even in resource-constrained settings it is 'not acceptable that . . . primary care would be reduced to a stand-alone health post or isolated community-health worker',⁹⁵ although the notion of 'progressive realisation' recognises that a comprehensive health system cannot be constructed immediately.⁹⁶ Moreover, there are indications from constitutions, state practice, and cases at the national level that states may regard the provision of emergency medical care, including specialised surgeries, as forming part of the minimum core right to health, whether defined nationally or internationally.

The South African⁹⁷ Constitution contains a right to emergency medical treatment.⁹⁸ In other countries, access to emergency medical treatment has been recognised in case law: the Supreme Court of India found that there was a constitutional duty of government-run hospitals to provide timely emergency treatment to those who are seriously ill, derived from the right to life.⁹⁹ Similar cases are known from Colombia,¹⁰⁰ Argentina,¹⁰¹ and Venezuela.¹⁰² Many countries that restrict access to health care for non-citizens seem to at least allow for their access to emergency medical treatment,¹⁰³ a requirement that is reiterated in Article 28 of the Convention on Migrant Workers.¹⁰⁴

The right to emergency medical treatment could also flow from the right to life and the prohibition of torture or cruel, inhuman, or degrading treatment. The UN HRC has held that states are under an obligation to provide such treatment to persons in detention,¹⁰⁵ and it has voiced its concern about inadequate health

mentioned as part of the international minimum core of the right to health, General Comment 14, above note 41, holds that the right to treatment in ICESCR, Art.12(2)(c), para. 16, includes 'the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations'.

94 WHO, *World Health Report 2008*, above note 86, pp. 55–56.

95 *Ibid.*, p. xvii, box 2, warns that 'what has been considered primary care in well-resourced contexts has been dangerously oversimplified in resource-constrained settings'.

96 Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, para. 46.

97 Chapter II, Section 27(3) of the South African Constitution reads: 'No one may be refused emergency medical treatment.'

98 See also the Moldovan Constitution, analysed in ECtHR, *Pentiacova and 48 Others v. Moldova*, Appl. No. 14462/03, Decision, 4 January 2005.

99 Supreme Court of India, *Paschim Banga Khet Majoor Samity v. State of West Bengal*, Judgement, 6 May 1996, AIR SC 2426/ (1996) 4 SCC 37, para. 6.

100 Magdalena Sepulveda, 'Colombia – the Constitutional Court's role in addressing social justice', in M. Langford (ed.), *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law*, Cambridge University Press, Cambridge, 2008, p. 125.

101 Christian Courtis, 'Argentina – some promising signs', in M. Langford (ed.), above note 100, pp. 174–176.

102 Enrique Gonzalez, 'Venezuela – a distinct path towards social justice', in M. Langford (ed.), above note 100, p. 203.

103 See the discussion by Birgit Toebes, *The Right to Health as a Human Right in International Law*, Intersentia, Antwerp, 1999, pp. 318–319; and European Committee of Social Rights (ECSR), Complaint 15/2003, *European Roma Rights Centre (ERRC) v. Greece*, Decision on the Merits, 8 December 2004, paras. 33–38.

104 2220 UNTS 3, entered into force on 1 July 2003.

105 To name but a few examples, see e.g. HRC, *Lantsov v. Russian Federation*, Communication No. 763/1997, UN Doc. CCPR/C/74/D/763/1997, 15 April 2002, para. 9.2; HRC, *Fabrikant v. Canada*, Communication No. 970/2001, UN Doc. CCPR/C/79/D/970/2001, 11 November 2003, para. 9.3, where Canada had

facilities in different countries in its concluding observations.¹⁰⁶ An obligation to provide emergency medical treatment to individuals against which force or firearms have been used lawfully by law enforcement officials is also reinforced by the UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials.¹⁰⁷ Several cases decided by the ECtHR also suggest that the right to emergency medical treatment could be contained in the right to life and the prohibition of torture or inhuman and degrading treatment.¹⁰⁸ The ECtHR is, however, not consistent in this regard.¹⁰⁹ The South African *Soobramoney* case moreover shows that it is not always easy to agree on what constitutes ‘emergency medical treatment’. In this case, the South African Constitutional Court held that Mr. Soobramoney, in need of dialysis treatment because of renal failure, was not an ‘emergency’ in the sense of an accident or sudden illness, but that his condition was rather an ‘ongoing state of affairs’ and was thus not entitled to this treatment.¹¹⁰ The package of services that constitute ‘emergency medical treatment’ has to be determined at the national level, with the help of human rights principles such as participation, non-discrimination, and concentration on marginalised and disadvantaged groups, and the resources available to a particular country.¹¹¹

Thus, at least in high-income countries, it can be expected that the provision of specialised emergency medical treatment will form part of a nationally defined minimum core right to health that can be accessed by everyone. Every effort must be made to continue the provision of such treatment in times of armed conflict in order to address direct health consequences, if necessary with assistance from humanitarian organisations.¹¹² This would also be in line with the requirement of ICESCR Article 4 to limit the right to health only for the reason of ‘promoting general welfare’. Cutting down on specialised medical care when there are numerous victims suffering from serious injuries in a non-international armed conflict would not be conducive to the ‘promotion of general welfare’. If high- and middle-income countries are affected by armed conflicts, the main cause of excess mortality and

provided appropriate surgery to a prisoner and the communication was therefore held inadmissible; and HRC, Concluding Observations – Portugal, UN Doc. CCPR/CO/78/PRT, 17 September 2003, para. 11. See also Sarah Joseph, Jenny Schultz, and Melissa Castan, *The International Covenant on Civil and Political Rights*, Oxford University Press, Oxford, 2nd edition, 2004, p. 197.

106 See above note 54; and S. Joseph, J. Schultz, and M. Castan, above note 105, pp. 184–187.

107 See above note 55.

108 ECtHR, *Cyprus v. Turkey*, App. No. 25781/94, Judgement (Grand Chamber), 10 May 2001, para. 219; *Calvelli and Ciglio v. Italy*, Appl. No. 32967/96, Judgement, 17 January 2002, para. 49; *D v. UK*, Appl. No. 30240/96, Judgement, 2 May 1997, paras. 51–54; and *Bensaid v. UK*, Appl. No. 44599/98, Judgement, 6 February 2001, para. 40.

109 ECtHR, *Nitecki v. Poland*, Appl. No. 65653/01, Decision, 21 March 2002, para. 1; *Pentiacova and 48 Others v. Moldova*, Appl. No. 14462/03, Decision, 4 January 2005; see also the analysis by Harris *et al.*, above note 56, p. 47. On the approach of the Inter-American Court of Human Rights, see S. Keener and J. Vasquez, above note 54, p. 617.

110 Constitutional Court of South Africa, *Soobramoney v. Minister of Health (Kwazulu-Natal)*, Judgement, 27 November 1997, 1998 (1) SA 765 (CC), paras. 20–21. See also the discussion of the South African constitutional provisions in Marius Pieterse, ‘Enforcing the right not to be refused emergency medical treatment: towards appropriate relief’, in *Stellenbosch Law Review*, Vol. 18, 2007, pp. 75–90.

111 As suggested in the section ‘The applicability of ESC rights . . .’, above.

112 Cp. ICESCR, Art. 2(1), referring to international assistance and cooperation in the implementation of ESC rights; see also above notes 27 and 67.

morbidity is often violence, at least when the conflict is limited to a short period of time.¹¹³ This would justify prioritising the provision of emergency medical services in these situations.¹¹⁴

Even in resource-poorer countries where definitive trauma and surgical care may not (yet) be available even in peacetime, there are simple procedures that can increase the survival chances of severely injured individuals, as pointed out in the Sphere Charter. These include 'clearing the airway, controlling haemorrhage and administering intravenous fluids' as well as 'cleaning and dressing wounds, and administering antibiotics and tetanus prophylaxis'.¹¹⁵ These measures can stabilise patients until adequate assistance arrives from national or international humanitarian actors.

The provision of long-term medical care, rehabilitation, and psychological support for those who have been injured in armed conflicts seems not to be part of the emerging internationally defined minimum core right to health. These obligations appear rather to be part of non-core obligations, the implementation of which is more dependent on resources and therefore subject to progressive realisation to a greater extent than minimum core obligations.¹¹⁶ This is clear from General Comment 14, which does not list such care under the heading of 'minimum core obligations', as well as from Article 5(2)(c) of the CCM. The latter seems to recognise that the mentioned obligation established in CCM Article 5(1) to 'provide age- and gender-sensitive assistance, including medical care, rehabilitation and psychological support' to cluster munition victims cannot be realised immediately; states must therefore 'develop a national plan and budget, including time-frames to carry out these activities',¹¹⁷ reflecting the notion of progressive realisation. Moreover, as noted in the CESCR's Concluding Observations on Bosnia and Herzegovina, under the right to health and other rights of the ICESCR, social assistance provided to victims of war should be distributed equally among different groups of victims.¹¹⁸ In this particular case, considerably lower social assistance was given to civilian victims of the 1990s armed conflicts than to military victims.

113 Data collected from Kosovo, a relatively well developed country, between February 1998 and June 1999 showed that the increase in the mortality rate in this case was mainly due to an increase in deaths resulting from direct violence: see Paul Spiegel and Peter Salama, 'War and mortality in Kosovo, 1998-99: an epidemiological testimony', in *The Lancet*, 24 June 2004; Richard Garfield, 'The epidemiology of war', in B. Levy and V. Sidel (eds), *War and Public Health*, Oxford University Press, New York, 2nd edition, 2008, pp. 29-32; and for a similar finding in regard to Lebanon's cancer care system, see Khahir Ahmad, 'Conflict puts pressure on cancer-care resources in Lebanon', in *The Lancet*, September 2006.

114 The Sphere Charter, above note 90, p. 309, also suggests that humanitarian organisations address the major causes of morbidity and mortality prevalent in a particular conflict situation.

115 *Ibid.*, p. 332.

116 For more details on the relationship between states' core and non-core obligations under the ICESCR, see David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights*, Oxford University Press, Oxford, 2007, pp. 208-215; and A. Müller, above note 3, pp. 96-99.

117 CCM, Art. 5(2)(c).

118 CESCR, Concluding Observations - Bosnia and Herzegovina, UN Doc. E/C.12/BIH/CO/1, 14 January 2006, paras. 18, 19, and 39.

Obligations to mitigate the indirect health consequences of armed conflicts

Among the indirect health effects of armed conflicts are the spreading of infectious diseases (epidemic and endemic), rising numbers of maternal and neonatal deaths, increasing prevalence of mental illness, and complications from chronic diseases. As already observed, civilian deaths and suffering resulting from these indirect health effects tend to be far greater than those from violent injuries, and some of them may occur only in the long term.¹¹⁹ However, the exact scope of this indirect impact on public health depends very much on the circumstances, including the state of the health system of the country in which the armed conflict takes place. The question arises as to whether and to what extent IHL and the right to health place obligations on states to mitigate these indirect health consequences.

States' obligations under IHL to alleviate the indirect health consequences of armed conflicts

Due to its historical origins, IHL focuses primarily on the protection of military medicine and the mitigation of the direct health effects of armed conflicts. However, there are several indications that obligations to alleviate armed conflicts' indirect impacts on public health are also part of IHL.

First, the broad definition of 'wounded and sick' referred to in the above section is not restricted to those who suffer from injuries sustained in ongoing hostilities, but also includes maternity cases, newborn babies, and other persons who may be in need of medical assistance or care. Moreover, Article 7(2) of AP II contains the obligation to ensure that medical care is provided to the wounded and sick as '*required by their condition*', no matter whether this 'condition' is due to violence or other illness, as well as the requirement that the wounded and sick are treated humanely.¹²⁰ The 'requirement of humane treatment is an overarching concept',¹²¹ demanding in general terms that a human being is provided with the things that are necessary for his or her 'normal maintenance as distinct from that of an animal' and treated 'as a fellow human being and not as a beast or a thing'.¹²² It is clear that the concrete prohibitions listed in common Article 3 of GC I–IV and Part II of AP II are manifestations of the obligation to treat persons *hors de combat* humanely, but also that the principle as such and therefore the obligations under IHL are broader.¹²³ It can thus be argued that as an obligation flowing from the requirement of humane treatment, parties to the conflict should do everything that

119 See above notes 1 and 2.

120 See Art. 3(1) common to all four Geneva Conventions; AP II, Part II; and ICRC Study, Vol. I, Rule 87, pp. 306–308.

121 ICRC Study, Vol. I, pp. 307–308.

122 ICRC Commentary to GC I–IV, above note 37, Common Art. 3, p. 53; Jean Pictet, *The Fundamental Principles of the Red Cross: Commentary*, 1979, 'I – Principle of Humanity', available at: www.icrc.org/eng/resources/documents/misc/fundamental-principles-commentary-010179.htm (last visited 26 July 2013).

123 See ICRC Study, comment to Rule 87, p. 308; ICRC Commentary to GC I–IV, Common Art. 3, pp. 53–54; and S. Sivakumaran, above note 3, p. 258, citing relevant ICTY jurisprudence and academic literature.

'is feasible'¹²⁴ in order to address the indirect health effects of armed conflicts in a similar way as violent injuries.

Second, this is further confirmed by the wide understanding of 'medical activities' protected by Article 10 of AP II. The ICRC Commentary on this Article holds that the term 'medical activities' should be interpreted broadly – that is, in addition to medical care and treatment of the wounded and sick, it includes acting to 'vaccinate people, make diagnoses, give advice *etc.*'.¹²⁵ These activities are vital for mitigating indirect health consequences of non-international armed conflicts.

Third, IHL protects all medical units and transports, no matter whether they care for the war-wounded or other patients. Although more complex than the protection of medical units and transports, the IHL protection of medical personnel is also not restricted to the protection of military doctors and nurses. It includes all 'persons assigned, by a Party to the conflict, exclusively to . . . medical purposes',¹²⁶ for example 'the prevention of disease'.¹²⁷

All these IHL obligations to address indirect health consequences are clearly reinforced and specified by the simultaneous application of the minimum core right to health, as will be shown in the following section.

Minimum core obligations under the right to health addressing indirect health consequences of non-international armed conflicts

As suggested, under the international minimum core obligations flowing from the right to health, states are to concentrate on building a basic health system that ensures the provision of 'essential primary health care'.¹²⁸ This includes a prioritisation of 'immunisation against major infectious diseases occurring in the community', of taking 'measures to prevent, treat and control epidemic and endemic diseases', and of ensuring 'reproductive, maternal (pre-natal as well as post-natal) and child healthcare'.¹²⁹ Moreover, the internationally defined minimum core right to health emphasises the great importance of protecting the underlying determinants of health: 'access to a minimum essential food which is nutritionally adequate and safe' as well as 'access to basic shelter . . . and sanitation, and an adequate supply of safe and potable water'.¹³⁰

This focus seems particularly helpful for averting some of the most dreadful indirect health consequences of armed conflicts. This shall be illustrated with the example of infectious diseases, which account for a great majority of preventable

124 ICRC Commentary to GC I-IV, Common Art. 3, p. 53.

125 ICRC Commentary to AP II, above note 33, para. 4687.

126 AP I, Art. 8(c). This is also of relevance for non-international armed conflicts; see the section on 'The IHL definition of "medical personnel" . . .', below.

127 AP I, Art. 8(e). See also below note 197, on the importance of the protection of medical personnel for the mitigation of not only direct but also indirect health consequences of armed conflicts.

128 CESCR, General Comment 14, above note 41, para. 43; and General Comment 3, above note 85, para. 10.

129 CESCR, General Comment 14, above note 41, paras. 44(a)–(c); see also the above section 'The scope of medical attention and care . . .'.¹²⁹

130 *Ibid.*, paras. 43(b) and (c).

indirect deaths.¹³¹ As public health experts observe, armed conflicts create conditions that are conducive to their transmission, progression, and lethality.¹³²

Among the most deadly infectious diseases in times of armed conflict are, according to the Sphere Charter, measles, diarrhoea, acute respiratory infections, and malaria.¹³³ Checchi *et al.* add tuberculosis.¹³⁴ Epidemiologists explain that different diseases have different routes of transmission: by air droplet (breathing, sneezing, and coughing), faecal-orally, sexually, vector-borne (through insect bites), through blood, from mother to child, or through unclean wounds.¹³⁵ Various risk factors can increase the likelihood of an outbreak and of transmission. Among the risk factors that are recognised to cause the majority of excess morbidity and mortality from infectious diseases in armed conflict situations are ‘overcrowding; inadequate shelter; insufficient nutrient intake; insufficient vaccination coverage; poor water, sanitation and hygiene conditions; high exposure to and/or proliferation of disease vectors; [and] lack of and/or delay in treatment’.¹³⁶

Different risk factors are linked to an increased risk of an outbreak of certain infectious diseases, depending on their route of transmission, and to faster transmission. To name but a few examples, overcrowded settings favour the spread of diseases that are transmitted by air droplet (particularly acute respiratory infections, measles, meningitis, tuberculosis, and flu) and by the faecal-oral route (diarrhoeal diseases including *Shigella* and cholera).¹³⁷ Vector-borne diseases such as malaria do not particularly depend on overcrowding,¹³⁸ but inadequate shelter can increase exposure to disease vectors. Insufficient nutrition intake increases the risk of outbreak of almost all infectious diseases¹³⁹ due to its immediate effect on the human immune system.¹⁴⁰ Inadequate water, sanitation, and hygiene conditions primarily increase the infection rate of faecal-oral diseases.¹⁴¹

131 As recognised e.g. by the CESC in its Concluding Observations – Democratic Republic of the Congo, UN Doc. E/C.12/COD/CO/4, 20 November 2009, para. 34. See also above notes 1 and 2.

132 Checchi *et al.*, *Public Health in Crisis-Affected Populations: A Practical Guide for Decision Makers*, Network Paper 61, Humanitarian Practice Network, December 2007, p. 2; Sphere Charter, above note 90, p. 311; Oscar Thoms and James Ron, ‘Public health, conflict and human rights: towards a collaborative research agenda’, in *Conflict and Health*, Vol. 1, 2007, p. 16.

133 Sphere Charter, above note 90, p. 311; WHO, *Manual on Communicable Disease Control in Emergencies*, 2005, p. 1, available at: www.who.int/hac/techguidance/pht/communicable_diseases/field_manual/en/ (last visited 26 July 2012).

134 Checchi *et al.*, above note 132, pp. 26–27.

135 *Ibid.*, p. 4; and WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, chapter 5.

136 Checchi *et al.*, above note 132, p. 20; WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, p. 110; and WHO, *World Health Report 2008*, above note 86, pp. 20–21.

137 Checchi *et al.*, above note 132, pp. 20–21; WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 47–48.

138 Checchi *et al.*, above note 132, pp. 20–21; WHO, *World Health Report 2008*, above note 86, pp. 21–22.

139 See e.g. Helen Young and Susanne Jaspars, *The Meaning and Measurement of Acute Malnutrition in Emergencies: A Primer for Decision-Makers*, HPN Network Paper 56, HPN, London, 2006, pp. 23–33; WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 1, 65, and 68; and Checchi *et al.*, above note 132, p. 23.

140 Described in detail by Checchi *et al.*, above note 132, p. 29.

141 *Ibid.*, p. 25; WHO, *World Health Report 2008*, above note 86, pp. 21–22; WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 27 and 33.

Control measures for infectious diseases must consider both transmission routes and risk factors. The provision of adequate shelter, access to sufficient and safe food and water, and adequate sanitation facilities are recognised as measures that will always be conducive to the affected population's health status, since they reduce risk factors regardless of the specificities of the situation.¹⁴² This is in harmony with the internationally defined minimum core obligations flowing from the right to health that call on states to prioritise the implementation of the 'underlying determinants of health'.¹⁴³

The further priority measures that epidemiologists recommend to prevent the spread of infectious diseases in emergencies depend on the local context:¹⁴⁴ the climate of a region, the health status of the population prior to the armed conflict, whether the population has been displaced and is living in camps, the extent to which affected populations can be accessed by health workers, the relative importance of prevention and treatment, the available financial and human resources, and so on.¹⁴⁵ This flexibility conforms to the international minimum core obligations formulated in broad terms in General Comment 14. It does not specify against which infectious diseases the state has to provide immunisation, it just requires that immunisation covers 'the major infectious diseases occurring in the community'.¹⁴⁶ Likewise, it does not specify the exact measures that are to be taken to 'prevent, control and treat epidemic and endemic diseases'.¹⁴⁷

Nonetheless, human rights principles as well as public health principles seem to reasonably guide the choice of priority health interventions. States should define what health services they provide for individuals under their jurisdiction as part of a nationally defined minimum core right to health, in accordance with available resources, and guided by the internationally defined minimum core which is inevitably formulated in broad terms. Such definition should be the outcome of a consultative process which includes health professionals, should take equal account of the health-care needs of all members of society (particularly marginalised

142 See e.g. recommendation in Sphere Charter, above note 90, p. 312; Checchi *et al.*, above note 132, p. 39; and WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 1, 33, and 40.

143 CESCR, General Comment 14, above note 41, paras. 11 and 43–44; Report of the UN Special Rapporteur on the Right to Health, UN Doc. E/CN.4/2003/58, 13 February 2003, para. 23; Manisuli Ssenyonjo, *Economic, Social and Cultural Rights in International Law*, Hart Publishing, Oxford and Portland, Oregon, 2009, pp. 327–330.

144 See the Sphere Charter, above note 90, pp. 61, 294, and 309; Checchi *et al.*, above note 132, p. 39; and mentioned time and again in WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, e.g. pp. 18–19.

145 For more details see Checchi *et al.*, above note 132, pp. 35–39; and WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133.

146 CESCR, General Comment 14, above note 41, para. 44(b); Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, para. 52.

147 CESCR, General Comment 14, above note 41, para. 44(c). It should be noted that in higher-income countries rising mortality rates due to indirect health consequences are caused by complications with the treatment of chronic diseases. Responding to this as a matter of priority in times of armed conflict is not excluded under the minimum core right to health. On this see e.g. Sphere Charter, above note 90, p. 336; and Andrew Miller and Bonnie Arquilla, 'Chronic disease and natural hazards: impact of disasters on diabetic, renal and cardiac patients', in *Prehospital and Disaster Medicine*, Vol. 23, 2008, p. 187 (analysing the context of natural disasters).

groups), and should address the most common health issues prevailing in a community.¹⁴⁸

These priorities will not necessarily change in times of armed conflict, and, if existent, a nationally defined minimum core will remain relevant for guiding priority health interventions in non-international armed conflicts.¹⁴⁹ Diseases that are common in a community may become even more prevalent in non-international armed conflicts. Yet adaptations will sometimes have to be made, if only to accommodate the fact that national health-care providers are supported by international actors in order to cope with the strains put on the health system by the armed conflict, in accordance with states' obligations to seek international assistance under ICESCR Article 2(1).¹⁵⁰ This obligation gains importance when states are unable to implement minimum core obligations by utilising their maximum available resources.¹⁵¹ In some cases, priorities need to be shifted if the armed conflict brings about diseases that were previously absent from a community¹⁵² or if the health system has to treat a large number of people wounded and traumatised in hostilities.

Human rights and public health principles can equally guide those adaptation processes: the Sphere Charter stipulates that the principle of participation shall be followed in the form of consulting affected populations on priority health interventions as far as possible.¹⁵³ Likewise, ensuring non-discriminatory/equal access to health services, and their acceptability and quality, remains relevant.¹⁵⁴ Guaranteeing equal access to health care may also require

148 CESCR, General Comment 14, above note 41, paras. 11, 17, and 54.

149 See Sphere Charter, above note 90, p. 298, suggesting that interventions to address the health impact of armed conflicts shall e.g. make use of national standards and guidelines, including treatment protocols and essential drug lists, as far as these are up to date and reflect evidence-based practice.

150 This obligation has been confirmed by the CESCR in many of its concluding observations, e.g. Concluding Observations – Afghanistan, UN Doc. E/C.12/AFG/CO/2-4, 7 June 2010, paras. 26, 35, and 45; Democratic People's Republic of Korea, UN Doc. E/C.12/1/Add.95, 12 December 2003, paras. 27 and 42; Democratic Republic of the Congo, UN Doc. E/C.12/COD/CO/4, 20 November 2009, para. 16; and Sri Lanka, UN Doc. E/C.12/LKA/CO/2-4, 9 December 2010, paras. 28–29.

151 Resources 'available' to the state under ICESCR, Art. 2(1) regularly include those resources that are made available by international organisations and through bilateral development assistance. For more details see A. Müller, above note 3, pp. 99–102.

152 E.g. when internally displaced persons/refugees bring a disease to their host community; see WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 18–19, 47, 104, 110; and Stefan Elbe, 'HIV/AIDS and the changing landscape of war in Africa', in *International Security*, Vol. 27, 2002, pp. 171–175.

153 Sphere Charter, above note 90, pp. 55–57 and 255; WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, pp. 30, 46, and 88; Report of Four UN Special Rapporteurs on Their Mission to Lebanon and Israel, UN Doc. A/HRC/2/7, 2 October 2006, paras. 103(e) and 104(e); CESCR, Concluding Observations – India, UN Doc. E/C.12/IND/CO/5, 8 August 2008, para. 72. This is also recognised in other literature relating to the provision of humanitarian assistance: see e.g. Paul Harvey and Jeremy Lind, *Dependency and Humanitarian Relief: A Critical Analysis*, Humanitarian Policy Group Report 19, London, Overseas Development Institute, 2005, pp. 40–41; Marion Harroff-Tavel, 'Do wars ever end? The work of the International Committee of the Red Cross when the guns fall silent', in *International Review of the Red Cross*, Vol. 58, No. 851, September 2003, pp. 482–483.

154 Sphere Charter, above note 90, pp. 55–57, 296; see also CESCR, Concluding Observations – Sri Lanka, UN Doc. E/C.12/1/Add.24, 16 June 1998, para. 22; and Democratic People's Republic of Korea, UN Doc. E/C.12/1/Add.95, 12 December 2003, para. 42; and HRC, Concluding Observations – USA, UN Doc.

particular attention to disadvantaged groups, which in conflict situations can include children, pregnant women, and elderly or disabled people, but also members of a specific ethnic or religious group, people with a particular political affiliation, internally displaced persons, and people living in areas with damaged infrastructure.¹⁵⁵ The strict application of the equality/non-discrimination principle becomes exceedingly important in the implementation of the right to health in highly politicised armed conflict situations.¹⁵⁶

These principles will interact with public health principles such as the maxim to ensure the greatest health benefits to the greatest number of people through priority health interventions in non-international armed conflicts.¹⁵⁷ For instance, epidemiologists have methods to determine high-risk infectious diseases and assess which will be a priority.¹⁵⁸ However, difficult decisions that involve inevitably utilitarian considerations in view of limited available resources and capacities will always remain to be made in armed conflicts.

To conclude, the minimum core right to health as well as other human rights and public health principles promise to help states (and humanitarian actors) to set priorities in their efforts to mitigate one of the most prevalent indirect health consequences of non-international armed conflicts: the spread of epidemic and endemic diseases. Similar analyses could be conducted with regard to other elements of the internationally defined minimum core right to health, such as the obligation to 'ensure reproductive, maternal and child healthcare'¹⁵⁹ and 'to provide education and access to information concerning main health problems in the community, including methods of preventing and controlling them'.¹⁶⁰ The right to health thereby broadens and complements the scope of protection as well as giving further specification to the aforementioned IHL rules that indicate states' obligations to address the indirect impact that armed conflicts can have on public health. Moreover, the right to health thereby complements the obligations under IHL that continue to operate beyond the cessation of active hostilities and arguably beyond the existence of the fact-condition of 'armed conflict'.¹⁶¹

CCPR/C/USA/CO/3/Rev.1, 18 December 2006, para. 26 (referring to the assistance provided to people affected by Hurricane Katrina).

155 Sphere Charter, above note 90, pp. 63–64 and 294–295; M. Harroff-Tavel, above note 153, p. 471; Report of Four UN Special Rapporteurs on Their Mission to Lebanon and Israel, UN Doc. A/HRC/2/7, 2 October 2006, paras. 63, 89, and 104(d); and CESCR, Concluding Observations – Algeria, UN Doc. E/C.12/DZA/CO/4, 7 June 2010, paras. 19–20; Afghanistan, UN Doc. E/C.12/AFG/CO/2-4, 7 June 2010, paras. 40 and 42; and Sudan, UN Doc. E/C.12/1/Add.48, 1 September 2000, para. 37.

156 This is also recognised in the Report of the UN Special Rapporteur on the Right to Health, UN Doc. A/HRC/7/11, 31 January 2008, para. 63.

157 Sphere Charter, above note 90, pp. 309–310.

158 See Checchi *et al.*, above note 132, pp. 35–36, describing a systematic epidemiological assessment of disease risk designed to guide interventions in emergency settings; see also WHO, *Manual on Communicable Disease Control in Emergencies*, above note 133, chapter 5.

159 CESCR, General Comment 14, above note 41, para. 44(a); and Sphere Charter, above note 90, pp. 320–330.

160 *Ibid.*, para. 44(d). In armed conflict situations, health-related information provided should for example relate the risks posed by land mines, cluster munitions, and unexploded ordnance.

161 See the discussion above, in the text accompanying notes 75–81.

Medical personnel, medical facilities, and medical transports

Mitigating the direct and indirect health consequences of non-international armed conflicts discussed so far is impossible without the presence of skilled medical personnel and functioning medical units (facilities) and transports. In the following, it is shown that IHL gives detailed definitions of ‘medical personnel’, ‘medical units’, and ‘medical transports’ and offers them special protection from the effects of hostilities, *inter alia* by giving them the right to display the distinctive emblem (Red Cross/Crescent/Crystal) to render their protected status visible. These detailed definitions can be regarded as a very valuable specification of the components of a health system that states have to create and maintain for individuals to enjoy their minimum core and non-core rights to health. However, the IHL definitions also have some limits that can be complemented by the simultaneously applicable right to health. For example, obligations under the right to health would strengthen some of the more proactive state obligations to facilitate the work of medical personnel, units, and transports under IHL, and would offer some protection to medical personnel, units, and transports that have not been recognised and authorised by a competent authority.

IHL of non-international armed conflicts protects medical personnel,¹⁶² medical units,¹⁶³ and medical transports¹⁶⁴ in a similar way as the wounded and sick themselves (they must be respected and protected), and also gives them the right to make their protected status visible.¹⁶⁵ Violations of these rules in non-international armed conflicts are criminalised under Articles 8(2)(e)(ii) and (iv) of the ICC Statute.

The IHL definitions of ‘medical units’ and ‘medical transports’ – specifying obligations under the right to health

Because there is no IHL definition of medical units and medical transports in AP II, the comprehensive definitions set out in GC I, GC IV, and AP I are resorted to, as suggested in the ICRC Commentary on Article 11 of AP II¹⁶⁶ and affirmed by the ICRC Study.¹⁶⁷ Thus, based on GC I Article 19, GC IV Article 18, AP I Article 8(e), and Rule 28 of the ICRC Study, ‘medical units’ include all medical establishments and other units, be they permanent or temporary, military or civilian, fixed or mobile. Moreover, under Article 8(e) of AP I these medical establishments and other

162 AP II, Art. 9(1); ICRC Study, Vol. I, Rule 25, p. 79.

163 AP II, Art. 11(1); ICRC Study, Vol. I, Rule 28, p. 91.

164 AP II, Art. 11(1); ICRC Study, Vol. I, Rule 29, p. 98. S. Breau, above note 43, p. 176, analysing the ICRC Study, does not doubt the customary status of these rules, but holds that the ICRC Study could have cited much more evidence for state practice and *opinio iuris* dating from the earliest military manuals and Geneva Conventions, to further support their customary status.

165 AP II, Art. 12.

166 ICRC Commentary to AP II, above note 33, paras. 4711–4712.

167 ICRC Study, Vol. I, p. 95 (medical units) and p. 100 (medical transports); see also J. Kleffner, above note 33, p. 340.

units must be 'organised for medical purposes';¹⁶⁸ and Rule 28 of the ICRC Study requires that they are 'exclusively assigned to medical purposes'. While the reasons behind this change in wording in Rule 28 are not entirely straightforward,¹⁶⁹ it is clear that for medical establishments and other units to count as 'medical units' under customary and conventional IHL, they must first and foremost be assigned for a medical purpose (interpreted very flexibly¹⁷⁰), and such assignment must be made to the exclusion of any other assignment.¹⁷¹ In particular, medical units should not be used for activities that lie outside their humanitarian functions.¹⁷² Examples of 'medical units' that are assigned for medical purposes include hospitals, laboratories, transfusion and rehabilitation centres, equipment depots, preventive medicine centres and institutes, medical and pharmaceutical stores, and first aid posts.¹⁷³

Based on Articles 8(f)–(g) of AP I and Rule 29 of the ICRC Study,¹⁷⁴ 'medical transport' means any means of transportation on land, water, or air assigned exclusively to transporting the wounded, sick, and shipwrecked, medical personnel, and medical equipment and supplies, be they military or civilian, permanent or temporary. Medical transports should be under the control of a competent authority.¹⁷⁵ Ambulances or other medical land vehicles (such as trucks or trains), hospital ships, and medical helicopters are examples of such 'medical transports'.

These are all important elements of a well-developed health system for the realisation of the minimum core and non-core components of the right to health. In particular, they can be seen as a specification of what states are obliged to provide under ICESCR Article 12(2)(d), which calls on states to take steps to create

168 AP I, Art. 8(e); GC I, Art. 19, refers to 'medical units of the Medical Service'; and GC IV, Art. 18, refers to 'civilian hospitals organised to give care'.

169 It can be assumed that leaving out the direct reference to 'organised for medical purposes' reflects the possibility that even unauthorised medical units could be protected under Rule of the 28 ICRC Study, or at least that it is not to be regarded as a requirement under customary IHL that medical units must be authorised and recognised in order to benefit from protection. This is supported by the commentary to Rule 28, holding that 'a lot of [state] practice does not expressly require medical units to be recognised and authorised by one of the parties'. This may, in particular, be the case in non-international armed conflicts, where medical units could be set up in form of makeshift hospitals or other 'improvised' medical establishments, including in territories under the control of non-state armed groups, and including by international and local humanitarian organisations that may not have direct links with one of the parties to the conflict. In contrast to AP I, Arts. 8(e) and 12(2)(b), Rule 28 applies to international and non-international armed conflicts. See also the discussion below, on the IHL obligation to recognise medical personnel, units and transports.

170 ICRC Commentary to AP I, Art. 8(e), above note 33, para. 379.

171 *Ibid.*, para. 371, refers to the requirements that medical units must be both "'organised for medical purposes" and exclusively assigned to these purposes'. Similarly, the commentary to ICRC Study, Vol. I, Rule 28, p. 95, refers to the criterion 'organised for medical purposes', in addition to the criterion 'exclusively assigned to medical purposes' that is directly included in Rule 28.

172 AP II, Art. 11(2); ICRC Study, Rule 28; and AP I, Art. 13(1).

173 The customary status of this definition is endorsed by ICRC Study, Vol. I, Rule 28, p. 91; and is confirmed also by S. Breau, above note 43, pp. 177–178. The ICRC Commentary to AP I, Art. 8(e), above note 33, para. 378, adds that establishments where dental care is administered are also considered as 'medical units'.

174 See in particular the commentary to ICRC Study, Rule 29, p. 100.

175 On this requirement see also the section 'The IHL obligation to recognise medical personnel ...', below.

‘conditions which would assure to all medical service and medical attention in the event of sickness’. Direct destruction or dismantling of such facilities not in conformity with the requirements of ICESCR Article 4 in armed conflicts would violate the right to health as well as IHL requiring respect for and protection of medical units and transports ‘at all times’¹⁷⁶ – that is, prohibiting their direct attack.

By giving special attention to the protection of medical transports, IHL highlights the importance of this particular medical service for the protection of the right to health during non-international armed conflicts, when potentially more injured or sick individuals have to be transported to hospitals for emergency care than is normal, under more challenging conditions. The ICRC Commentary on Article 11 of AP II specifies that medical transports cannot be attacked even when they are not being used to transport any wounded or sick,¹⁷⁷ nor can their work or movement be interfered with arbitrarily in any other manner. While not always respected by them, it is clear that this rule also binds non-state armed groups.¹⁷⁸ The IHL provisions on medical transports are a good example of how IHL imposes obligations that aim to mitigate the direct health consequences in the specific situation of armed conflict, specifying also the content of the right to ensure access to health-care facilities, goods, and services in this particular situation. As mentioned, an effective, integrated referral system is an important part of a health system functioning in accordance with the right to health,¹⁷⁹ which arguably includes sufficient medical transport. Yet a detailed protection of medical transports as given in IHL might be less relevant for ensuring the health of conflict-affected individuals in poorer countries, where effective medical transport are frequently absent even in peacetime, *inter alia* because of insufficient roads. In these situations the protection of the activities of international and local humanitarian organisations not linked to any party to the conflict¹⁸⁰ may be more important for safeguarding the health of conflict-affected communities.

The IHL definition of ‘medical personnel’ – specification of the different health professionals needed to ensure comprehensive health care

The definition of ‘medical personnel’ in IHL applicable to non-international armed conflicts is rather complex. While AP II does not contain a definition of medical personnel, the definition given in Articles 8(c) and (e) of AP I is regularly relied on.¹⁸¹ Accordingly, medical personnel covers ‘those persons assigned, by a Party to the conflict, exclusively to . . . medical purposes’¹⁸² – that is, to ‘the search for,

176 AP II, Art. 11(1).

177 ICRC Commentary to AP II, Art. 11, above note 33, para. 4716.

178 S. Sivakumaran, above note 6, p. 375.

179 See above note 92; and Report of the UN Special Rapporteur on the Right to Health on His Mission to India, UN Doc. A/HRC/14/20/Add.2, 15 April 2010, para. 54.

180 On this requirement see the section ‘The IHL obligation to recognise medical personnel . . .’, below.

181 ICRC Commentary to AP II, above note 33, para. 4661; similarly, see M. Bothe, K. J. Partsch, and W. Solf, above note 35, p. 656; commentary on ICRC Study, Vol. I, Rule 25, p. 82; and J. Kleffner, above note 33, p. 345.

182 AP I, Art. 8(c).

collection, transportation, diagnosis or treatment – including first-aid treatment – of the wounded, sick and shipwrecked, or for the prevention of disease',¹⁸³ and 'to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary.'¹⁸⁴ The ICRC Study suggests that the definition of 'medical personnel' has been further specified through developments in customary law applicable to non-international armed conflicts. It holds that the definition of 'medical personnel' that was originally suggested in the drafting process of AP II, but which was removed during the simplification process shortly before the Protocol was adopted, could be relied on.¹⁸⁵ According to this definition, in non-international armed conflicts the term 'medical personnel' includes:

- (i) medical personnel of a party to the conflict, whether military or civilian;
- (ii) medical personnel of Red Cross or Red Crescent organisations recognised and authorised by parties to the conflict;
- (iii) medical personnel of other aid societies recognised and authorised by a party to the conflict and located within the territory the conflict is taking place.¹⁸⁶

The definition differs in two ways from the more specific definition of medical personnel given in Articles 8(c) and (e) of AP I,¹⁸⁷ and reflects states' ongoing fear of undue foreign intervention in non-international armed conflicts. First, the phrase 'Red Cross and Red Crescent organisations'¹⁸⁸ was introduced 'to cover not only assistance available on the government side, but also groups or sections of the Red Cross on the other side which already existed, and even improvised organisations which might be set up during the conflict'.¹⁸⁹ Second, the phrase 'aid societies . . . located within the territory the conflict is taking place' discloses the intention of states to avoid situations in which obscure private groups from outside the country establish themselves by claiming the status of a relief society, and are then recognised by the insurgents.¹⁹⁰ Thus, in non-international armed conflicts it is only

183 AP I, Art. 8(e).

184 AP I, Art. 8(c).

185 Commentary on ICRC Study, Vol. I, Rule 25, p. 83; while this seems to be a reasonable suggestion, none of the 'practice' collected in Vol. II, pp. 453–480 of the ICRC Study suggest that states regard this definition as customary.

186 ICRC Commentary to AP II, above note 33, para. 4667, based on the wording of the official records from the drafting conference of AP I/II; see also commentary on ICRC Study, Vol. I, Rule 25, p. 83.

187 These two differences are noted in ICRC Commentary to AP II, above note 33. To compare, in AP I the term 'medical personnel' includes: '(i) medical personnel of a Party to the conflict, whether military or civilian, including those described in the First and Second Conventions, and those assigned to civil defence organisations; (ii) medical personnel of national Red Cross or Red Crescent Societies and other national voluntary aid societies duly recognised and authorised by a Party to the conflict' (AP I, Art. 8(c)), and '(iii) medical personnel of medical units or medical transports made available to a party to the conflict for humanitarian purposes by: (a) a neutral State which is not Party to that conflict; (b) by a recognised and authorised aid society of such a State; (c) by an impartial international humanitarian organisation' (AP I, Art. 9(2)).

188 Emphasis added.

189 ICRC Commentary to AP II, above note 33, para. 4666; the phrase 'Red Cross and Red Crescent Organisations' is also used in AP II, Art. 18(1).

190 ICRC Commentary to AP II, above note 33, para. 4667.

the personnel of those (recognised and authorised) aid societies (other than Red Cross or Red Crescent organisations) that are located *within* the territory of the state where the conflict takes place that enjoy protection as ‘medical personnel’ under AP II.¹⁹¹

Similar to medical units and transports, the CESCR’s General Comment 14 recognises the existence of ‘trained medical and professional personnel’¹⁹² as essential for the realisation of the right to health¹⁹³ – and the definitions given in IHL can be regarded as a helpful specification of the range of health professionals needed to ensure comprehensive health care of the population. Unlike the more general protection that is afforded to all persons under the jurisdiction of a state under the right to health, including to medical personnel,¹⁹⁴ the specific protection that IHL gives to the specific category of persons of ‘medical personnel’ highlights the utmost importance of the work of these personnel in the exceptional context of an ongoing armed conflict, where the number of persons in need of medical care is particularly high. The IHL prohibition of direct attacks on these personnel is well established in conventional and customary IHL, addressing both state and non-state parties to armed conflicts.¹⁹⁵ The observance of these rules is important not only for ensuring the care of those whose health is directly affected by the hostilities, but also for minimising interruption of the work of medical personnel engaged in, for example, the treatment, control, and prevention of diseases, in order to reduce the indirect health consequences of armed conflicts discussed above.¹⁹⁶ The recent killing of several doctors who were conducting an anti-polio vaccination campaign in Nigeria serves as a tragic illustration of this point.¹⁹⁷ States’ obligations under the right to health not to arbitrarily interfere with the work of health professionals¹⁹⁸ will reinforce these IHL obligations. For example, reports of the UN Special Rapporteur on the Right to Health express concern that ‘in some countries, on account of their professional activities, health workers have been victims of discrimination, arbitrary detention, arbitrary killings and torture, and have their freedom of opinion, speech and movement curtailed’.¹⁹⁹ The right to health will also

191 Further, see the section ‘The IHL obligation to recognise medical personnel . . .’, below.

192 CESCR, General Comment 14, above note 41, paras. 12(a) and (d), 36, and 44(e).

193 The importance of health professionals in the realisation of the right to health is also recognised in various reports of the UN Special Rapporteur on the Right to Health, e.g. UN Doc. E/CN.4/2003/58, 13 February 2003, para. 95; UN Doc. A/60/347, 12 September 2005, from para. 8; UN Doc. A/HRC/4/28, 17 January 2007, para. 41; and UN Doc. A/HRC/7/11, 31 January 2008, paras. 68(b) and 75–86.

194 See the section ‘Personal scope of application’, above.

195 AP II, Art. 9(1); ICRC Commentary on AP II, Art. 9(1), paras. 4673–4674; ICRC Study, Rule 25, including the commentary thereto, pp. 81–84; ICC Statute, Article 8(2)(e)(ii); see also S. Sivakumaran, above note 6, p. 278.

196 See in particular the section ‘Minimum core obligations . . .’, above.

197 ‘Three DPRK doctors killed in northern Nigeria: police’, in *Xinhua*, 10 February 2013, available at: http://news.xinhuanet.com/english/africa/2013-02/10/c_132163579.htm (last visited 27 June 2013); see also reports from e.g. Afghanistan: Reuters, ‘Thousands lack health services since attack on Afghan Red Crescent’, 28 May 2013, available at: www.trust.org/item/20130528165900-ulpb3 (last visited 27 June 2013).

198 CESCR, General Comment 14, above note 41, paras. 28 and 50.

199 Report of the UN Special Rapporteur on the Right to Health, UN Doc. E/CN.4/2003/58, 13 February 2003, para. 97.

extend its protection to medical personnel that may not directly fall under the customary IHL definition of 'medical personnel' applicable to non-international armed conflicts – for example, to those (medical) personnel that belong to humanitarian organisations not located *within* the territory of the state where the conflict takes place.²⁰⁰ Before this is discussed below in the section 'The IHL obligation to recognise medical personnel, units, and transports', we will now examine further aspects of the protections offered to medical personnel, units, and transports under IHL and the right to health, in particular states' obligations to promote and facilitate their work.

Obligations to promote and facilitate the work of medical personnel, units and transports

States are obliged to actively promote and facilitate the work of medical personnel, units, and transports. Under IHL, these obligations flow from the general obligations to respect and protect medical personnel, units, and transports, which have achieved customary status²⁰¹ and are to be interpreted in a similar manner as the obligation to respect and protect the wounded and sick themselves.²⁰² These obligations are strengthened and complemented by the parallel application of the right to health, in particular in those areas where some uncertainty exists as to the exact scope of the more proactive obligations under IHL applicable to non-international armed conflicts, as well as to their customary status in these types of conflicts.

For example, Article 9(1) of AP II requires that medical personnel be granted 'all available help for the performance of their duties'. Article 15(2) of AP I further specifies, in the context of international armed conflicts, that civilian medical personnel shall be granted all available help in particular in areas where civilian medical services have been disrupted due to hostilities; and Article 15(4) of AP I explicitly gives 'civilian medical personnel access to any place where their services are essential' albeit 'subject to such supervisory and safety measures as the relevant Party to the conflict may deem necessary'.²⁰³ The question can be asked about the extent to which these more far-reaching obligations to grant all available help to medical personnel are applicable to non-international armed conflicts, and whether they have attained customary status, given that rules 25, 28, and 29 of the ICRC Study limit themselves to restating the general obligation to 'respect and protect' medical personnel, units, and transports. The commentary to Rule 25 reiterates the treaty obligation under Article 9(1) of AP II, suggesting that it may have attained customary status.²⁰⁴ Some of the military manuals relied on in the ICRC Study also indicate that states recognise more far-reaching, proactive IHL obligations towards medical personnel, units, and transports in international and non-international

200 See the section 'The IHL obligation to recognise medical personnel . . .', below.

201 See above notes 162–164.

202 See the section 'Obligations to search for and collect the wounded and sick', above.

203 AP I, Art. 5(4); and J. Kleffner, above note 33, p. 347.

204 ICRC Study, commentary to Rule 25, p. 84.

armed conflicts. For instance, Argentina's military manual stipulates that 'medical personnel shall be respected, protected and *assisted* in the performance of their duties';²⁰⁵ Spain's military manual states that medical personnel shall be 'defend[ed], assist[ed] and support[ed] when needed';²⁰⁶ and the German military manual formulates a 'positive' duty towards medical transports, holding that 'their unhampered employment shall be ensured at all times'.²⁰⁷ There are indications that non-state armed groups have also accepted some more proactive obligations toward medical personnel, units, and transports.²⁰⁸ However, the ICRC Commentary's observation on Article 11 of AP II, proposing that the obligation to respect and protect medical units and transports includes a proactive obligation 'to actively take measures to ensure that medical units and transports are able to perform their functions and to give them assistance where necessary',²⁰⁹ are not affirmed in the commentaries to rules 28 and 29 of the ICRC Study.²¹⁰

Any proactive obligations under conventional IHL applicable to non-international armed conflicts are reinforced by, and any possible gaps in customary IHL in this area are closed by, the parallel application of the right to health, in particular as far as the state party to the conflict is concerned. State parties to the ICESCR clearly have an obligation to take proactive measures to facilitate the work of medical personnel, transports, and units, in particular in their endeavours to guarantee the implementation of the minimum core right to health, including in territories under the control of non-state armed groups.²¹¹ It starts with the obligation to 'provide appropriate training to health personnel', which the CESCR considers part of the international minimum core right to health.²¹² Guaranteeing physical accessibility to at least the essential health services contained in the minimum core right to health and relevant IHL rules discussed above in the section 'Obligations to mitigate the indirect health consequences of armed conflicts' would for example imply an obligation to support medical personnel and transports in their efforts to reach populations in areas where infrastructure is damaged, who would otherwise be denied their right to treatment.²¹³ The CESCR's Concluding Observations on Israel point in this direction. Referring to Israel's closures of the Occupied Palestinian Territories, the CESCR recalled Israel's obligation to 'give full effect to its obligations under the Covenant and, as a matter of priority, to undertake

205 ICRC Study, Vol. II, chapter 7, p. 457 (emphasis added); likewise, see the Canadian military manual, in *ibid.*, p. 459; the Netherlands military manual, in *ibid.*, p. 462; and the New Zealand military manual, in *ibid.*, p. 463.

206 *Ibid.*, p. 464.

207 *Ibid.*, p. 551.

208 S. Sivakumaran, above note 6, pp. 227–278, 375.

209 ICRC Commentary to AP II, above note 33, para. 4714.

210 ICRC Study, Vol. I, p. 96 (units) and 101–102 (transports).

211 States are arguably obliged to allow independent humanitarian organisations to negotiate access to conflict-affected civilian populations in territories under the control of a non-state armed group. For more details see the sources cited in above notes 27, 67, and 74.

212 CESCR, General Comment 14, above note 41, paras. 44(e) and 36; see also the reports of the UN Special Rapporteur cited in above note 193.

213 This is observed e.g. by Victor Correa-Lugo, 'Protecting the health sector in Colombia: a step to make the conflict less cruel', in *International Review of the Red Cross*, Vol. 83, No. 844, December 2001, p. 1122.

to ensure safe passage at checkpoints for Palestinian medical staff²¹⁴ – an obligation that includes a proactive dimension. Similarly, in its Concluding Observations on Russia, the CESCR for instance called on the government 'to allocate sufficient funds to reinstate basic services, including the health and education infrastructure' in Chechnya despite the 'difficulties posed by on-going military operations'.²¹⁵ Reinstating basic health services would surely include an obligation to actively facilitate the work of medical personnel, transports, and units in conflict-affected areas.

The IHL obligation to recognise medical personnel, units, and transports – a restricting requirement in situations where many medical tasks are fulfilled by international actors

The right to health has the potential to partially compensate for another limit of IHL of non-international armed conflicts. In IHL, the special protected status, including the right to display the distinctive emblem is reserved for those civilian medical personnel, transports, or units (in addition to military medical personnel, units, and transports) that have been 'recognised' (that is, they must have been regularly trained, constituted, and registered in accordance with national legislation) and 'authorised' (that is, the party to the conflict must agree that the personnel are employed as medical personnel) by one of the parties to the conflict.²¹⁶ This includes medical personnel, units, and transports of Red Cross and Red Crescent organisations.²¹⁷ The recognition and authorisation requirement, together with the restricted definition of 'medical personnel' given above, focuses IHL's protection on recognised and authorised *national* medical personnel, units, and transports that were present in a particular territory before a non-international armed conflict started.²¹⁸ As is clear from the drafting records of AP II, this was mainly due to the fear of states that broader definitions of in particular 'medical personnel' could be exploited by foreign forces to intervene in non-international armed conflicts.²¹⁹

214 CESCR, Concluding Observations – Israel, UN Doc. E/C.12/1/Add.27, 4 December 1998, para. 39.

215 CESCR, Concluding Observations – Russia, UN Doc. E/C.12/1/Add.94, 12 December 2003, paras. 10 and 39; similarly, Colombia, UN Doc. E/C.12/COL/CO/5, 7 June 2010, para. 7.

216 While AP II, Art. 11 does not – in contrast to AP I, Arts. 12(2) and 9(2) – explicitly include the requirement of authorisation and recognition by a party to the conflict, from AP II, Art. 12, it is clear that only recognised and authorised medical units and transports can display the distinctive emblem. AP II, Art. 12, holds that the distinctive emblem can only be displayed 'under the direction of the competent authority concerned'. Moreover, the ICRC Study's commentary, Vol. I, p. 95 (on Rule 28) and p. 100 (on Rule 29), holds that authorisation and recognition remain a precondition for displaying the distinctive emblem. See also S. Sivakumaran, above note 6, p. 278.

217 ICRC Commentary to AP II, above note 33, paras. 4739–4740; ICRC Commentary to AP I, para. 334; and J. Kleffner, above note 33, p. 346.

218 For a more detailed analysis of the limited protection of international humanitarian organisations (non-ICRC, non-UN, and non-national Red Cross/Red Crescent Societies) under IHL of international and non-international armed conflict, see also Kate Mackintosh, 'Beyond the Red Cross: the protection of independent humanitarian organisations and their staff in international humanitarian law', in *International Review of the Red Cross*, Vol. 89, No. 865, March 2007, pp. 113–123.

219 However, it shall be noted that the recognition requirement also aims to prevent exploitation of the distinctive emblem, as is noted in the ICRC Commentary, above note 33, to AP II, Art. 9, para. 4660; see also the commentary on the ICRC Study, Vol. I, Rule 25, p. 82; and J. Kleffner, above note 33, p. 345.

While undoubtedly important, in many low-income countries such (restricted) protection might be less appropriate for guaranteeing minimal health care for conflict-affected populations.²²⁰ A functioning health system built of these nationally recognised and authorised medical personnel, units, and transports may not (yet) exist. In these settings, the protection of (international) medical personnel and medical units of international humanitarian organisations, as well as the promotion and facilitation of these organisations' activities, becomes more important for providing the minimum health services described above in the section 'The protection of the wounded and sick . . . '.

While the simultaneous applicability of the right to health will not give foreign medical personnel, units, or transports of international humanitarian organisations the right to display the distinctive emblem, the obligation not to attack them and the more proactive obligations to facilitate their work that were discussed above will extend to them. It can also be argued that this includes an obligation on states affected by non-international armed conflicts to speed up the process of recognising foreign medical qualifications to ensure that the civilian population can get access to basic health care under their minimum core right to health.²²¹ This should not exclude the possibility of states setting up mechanisms to monitor foreign medical interventions in order to prevent conflict-affected populations from being exposed to the danger of unskilled or inappropriate treatment.²²² Moreover, medical personnel deployed by international humanitarian organisations are protected under Article 10 of AP II, as humanitarian relief personnel²²³ and by their status as civilians.²²⁴

Concluding remarks

This contribution analysed some elements of states' obligations under IHL and the right to health that aim to mitigate the direct and indirect health consequences of non-international armed conflicts. In sum, relevant IHL rules and obligations flowing from the right to health complement each other well in this endeavour.

In general terms, due to its historical origin and purpose of protecting wounded and sick soldiers of standing governmental armies, IHL focuses on the protection of the wounded and sick, and those civilians and persons *hors de combat*

220 This is not to say that it is of *no* relevance, since IHL protects all kind of health facilities, including primary care points at the community level which might exist in poor countries.

221 See also the discussion in David Fisher, 'Domestic regulation of international humanitarian relief in disasters and armed conflict: a comparative analysis', in *International Review of the Red Cross*, Vol. 89, No. 866, June 2007, pp. 363–364; and IFRC, *Guidelines for the Domestic Facilitation and Regulation of International Disaster Relief and Initial Recovery Assistance*, 30 November 2007, available at: www.ifrc.org/PageFiles/41203/introduction-guidelines-en.pdf (last visited 26 July 2012), which suggest that states adopt procedures which allow for temporary recognition of foreign medical personnel (Section 16, para. 1(c)).

222 For example see D. Fisher, above note 221, p. 363.

223 See ICRC Study, Rule 31, pp. 105–109. However, international humanitarian relief personnel have to be authorised as well before they can profit from the special protection given to them under IHL.

224 See also S. Sivakumaran, above note 6, p. 279.

suffering from the *direct* health consequences of armed conflicts. For example, the IHL obligations to 'respect and protect' as well as 'search for and collect' the 'wounded and sick' give welcome details on how to implement the right to access minimum health facilities, goods, and services in an armed conflict context. IHL obliges states to immediately provide emergency medical treatment to the wounded and sick.

The right to health, on the other hand, is more expansive, and takes better account of the fact that the relationship between health and armed conflict is not confined to medical attention to the war-wounded. The internationally defined minimum core right to health encourages states parties to the ICESCR to prioritise the provision of primary health care by creating and maintaining an accessible basic health system. This focus enables it to highlight and address the *indirect* health consequences of non-international armed conflicts, such as the spreading of epidemic and endemic diseases and rising child and maternal mortality and morbidity. These may occur in the long term, and are – particularly in low-income countries – the main causes of death during and after armed conflicts. Moreover, the minimum core right to health gives flexibility to states to adopt the measures required to address the specific indirect health problems in a particular situation, which can vary substantially. In particular, the human rights principles of non-discrimination and the concentration on disadvantaged and marginalised groups can guide this process. Consultation with public health professionals is equally essential for pinpointing the exact measures that are to be taken to implement minimum core obligations under the right to health in non-international armed conflicts.

Complementarity between IHL and the right to health can also be observed in the protection offered to medical personnel, facilities/units, and transports. The detailed definitions of these entities given in IHL can be regarded as a welcome specification of the components of a well-developed health system that states have to create under minimum core and non-core obligations flowing from the right to health. On the other hand, obligations under the right to health can compensate for some uncertainties in the scope of the more proactive obligations to facilitate and promote the work of medical personnel, units, and transports in the customary rules 25, 28, and 29 of the ICRC Study, and offer some protection to (international) medical personnel, units, and transports that may not be covered by the IHL definitions of these terms.