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Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, submitted in accordance with Human Rights Council resolutions 6/29 and 15/22.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Summary

In the present report, the Special Rapporteur considers the right to health obligations of States and non-State actors towards persons affected by and/or involved in conflict situations. The report's scope extends beyond armed conflicts and includes internal disturbances, protests, riots, civil strife and unrest, occupied territories and territories with a constant military presence. The effect of conflict on the right to health of affected populations may endure long after the cessation of active hostilities. Throughout the continuum of conflict, it is therefore essential that States ensure the full realization of the right to health of populations affected by and/or involved in conflict.

In this context, the Special Rapporteur addresses the availability, accessibility and acceptability of health facilities, goods and service during and after conflict. He outlines State obligations, international obligations of entities other than the primary State and responsibilities of non-State armed groups. The report also focuses on vulnerable groups, which may experience greater challenges in the enjoyment of their right to health as a result of conflict, and addresses the need for accountability and remedies for violations of the right to health. The Special Rapporteur concludes his report by emphasizing the importance of effective participation of affected communities and putting forward a set of recommendations on concrete and continuous steps towards the full realization of the right to health of persons affected by conflict situations.

I. Introduction

1. Conflicts pose immense challenges to the realization of the right to health. Some 1.5 billion people currently live in conflict-affected areas or fragile States, which face levels of child mortality and malnutrition twice as high as countries that are not affected by conflict, have poverty levels that are 21 per cent higher, and are furthest away from achieving the Millennium Development Goals.[1] Conflict affects health not only through direct violence, but also through the breakdown of social structures and health systems, and lack of availability of underlying determinants of health. This leads to a high incidence of preventable and treatable conditions including malaria, diarrhoea, pneumonia and malnutrition.[2] These health effects often persist well after the end of active hostilities, and negatively impact health indicators for years thereafter.[3] Addressing the right to health in conflict and post-conflict situations is therefore imperative to realizing the right to health for all.

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

3. Armed conflict is divided into international armed conflict — where there is "resort to armed force between States",[4] and non-international armed conflict — where there is "protracted violence" involving at least one non-State organized armed group.[5] In both situations, international humanitarian law prescribes rules of conduct for States and non-State organized armed groups that are parties to the conflict. These govern circumstances such as the conduct of hostilities, treatment of prisoners, guarantees of fundamental rights such as access to justice and treatment of civilians and civilian property.

4. Human rights law continues to apply in situations governed by international humanitarian law. This has been affirmed by the International Court of Justice,[6]

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[1] World Bank, *World Development Report 2011: Conflict, Security and Development* (Washington D.C., 2011), pp. 2, 5.

[2] International Rescue Committee (IRC), *Mortality in the Democratic Republic of Congo: an ongoing crisis* (New York, 2007), p. ii. Available from www.rescue.org/sites/default/files/migrated/resources/2007/2006-7_congomortalitysurvey.pdf.

[3] Ibid., World Bank, *World Development Report 2011*, p. 2.

[4] International Tribunal for the Former Yugoslavia, *Prosecutor v. Tadic*, case No. IT-94-1-A, ICTY, Decision on the Defence Motion for Interlocutory Appeal on Jurisdiction, 2 October 1995, para. 70.

[5] International Committee of the Red Cross (ICRC), "How is the term 'armed conflict' defined in international humanitarian law?", Opinion Paper (Geneva, 2008). Available from www.icrc.org/eng/assets/files/other/opinion-paper-armed-conflict.pdf.

[6] *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory, Advisory Opinion, I.C.J. Reports 2004*, p. 136, para. 112; *Case Concerning the Armed Activities on the Territory of the Congo (Democratic Republic of the Congo v. Uganda) I.C.J. Reports 2005*, para. 216.

human rights treaty bodies,[7] regional bodies such as the European Court of Human Rights[8] and domestic courts.[9] The General Assembly, in its resolution 57/233, and the Security Council, in its resolution 1181 (1998), have also condemned violations of human rights in armed conflict.

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

6. Both international humanitarian law and human rights law share the aim of protecting all persons and are grounded in the principles of respect for the life, well-being and human dignity of the person.[10] They provide complementary and mutually reinforcing protection.[11] The application of human rights law to conflict would ensure greater protection of civilian population and additional accountability mechanisms for States and remedies for affected population.

II. Conceptual framework

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

8. The right to health framework comprises a range of socioeconomic aspects, termed as underlying determinants such as nutritious food, potable water, housing, a functioning health system and situations of violence and conflict. Conflict has negative repercussions on other underlying determinants, as it can result in a breakdown in systems and infrastructures, including health systems. Conflicts can also result in worsening public health conditions due to physical injuries, poor mental health, an increase in malnutrition, particularly among children, and outbreaks of communicable diseases.[12]

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[7] See *Sergio Euben López Burgos v. Uruguay*, communication No. R.12/52, A/36/40, annex XIX; para. 176; concluding observations of the Committee on Economic, Social and Cultural Rights: Israel (E/C.12/1/Add.69), para. 19.

[8] European Court of Human Rights, *Loizidou v. Turkey*, application No. 15318/89, judgement, 28 December 1996, para. 44.

[9] *Public Committee against Torture in Israel et al. v. Government of Israel and others*, High Court of Justice, case No. 769/02, 14 December 2006, para. 18.

[10] Office of the High Commissioner of Human Rights (OHCHR), *International Legal Protection of Human Rights in Armed Conflict* (New York and Geneva, 2011), p. 7.

[11] Ibid., p. 1.

[12] World Health Organization (WHO), "Briefing note on the potential impact of conflict in Iraq: March 2003" (Geneva, 2003), p. 1.

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

9. States are obliged to utilize the maximum available resources towards the realization of economic social and cultural rights, including the right to health. An aspect of this obligation is that the right to health is progressively realizable. However, due to the destruction or diversion of resources to military or police needs, conflicts often reduce the availability of resources which may, at times, be detrimental to the right to health.[13] Even where resources are available, States may not be able to make use of them due to the insecurity and poor infrastructure in many conflict environments.

10. Nonetheless, progressive realization is a specific and continuous State obligation. It does not dilute certain immediate obligations of States, including taking concrete steps towards the full realization of the right to health to all, without discrimination and regardless of the status of persons as combatants or civilians.

11. Furthermore, the right to health framework imposes upon States certain core obligations. Core obligations are minimum essential levels of the right to health, non-compliance with which cannot be justified even in times of resource constraints as they are non-derogable. These include, inter alia, the obligation of States to ensure equitable distribution and access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; the obligation to provide essential medicines; and the obligation to formulate a national health plan or policy in a transparent and participatory way, taking into consideration the special needs of vulnerable populations. Therefore, even if conflicts result in resource constraints, States are required to ensure the availability, accessibility and acceptability of good quality health facilities, goods and services, especially to groups rendered vulnerable by conflict.

12. A crucial facet of the right to health framework is the effective participation of affected people and communities, especially vulnerable groups. Effective participation should be ensured in all phases of formulating, implementing and monitoring decisions which affect the realization and enjoyment of the right to health in times of conflict. However, policies thus formulated should not be limited to the views of the majority and should take into account the views and needs of the minority within the participating group. Involvement in decision-making processes empowers affected communities and ensures ownership of decisions and resources, which leads to sustainable systems and, potentially, the resolution of conflicts. The participation of affected populations ensures responsive and effective laws and policies by taking into consideration the needs of the people. This is of special significance in protracted conflict situations, in post-conflict situations, in areas with a constant military presence and in areas under occupation. Informed participation can only be ensured when affected populations have the ability to seek and disseminate information affecting their health.

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[13] Solomon R. Benatar, “Global disparities in health and human rights: a critical commentary”, *American Journal of Public Health*, vol. 88, No. 2 (February 1998), p. 296; Barry S. Levy and Victor W. Sidel, “The health consequences of the diversion of resources to war and preparation for war”, *Social Medicine*, vol. 4, No. 3 (September 2009) p. 133.

B. State obligations

13. As at other times, States have the obligation to respect, protect and fulfil the right to health in conflict. This includes situations where States occupy or otherwise exercise effective control over foreign territory, where the full spectrum of obligations under the right to health applies.[14] States also have other human rights obligations, including but not limited to the right to life and the obligation to refrain from torture and other forms of cruel, inhuman or degrading treatment or punishment.

14. The obligation to respect the right to health requires States to not interfere with the enjoyment of the right to health of people by refraining from discrimination. States should neither formulate policies nor act in ways which create barriers to the enjoyment of the right to health, such as obstructing access to health facilities, goods and services generally or to members of disfavoured groups.

15. The obligation to protect the right to health requires States to prevent interference by third parties. States should ensure that third parties such as health professionals do not violate the right to health by providing health care in a discriminatory manner. States in conflict may face unique challenges with respect to the obligation because of the presence of armed groups operating beyond the control of the State. In such cases, States should take concrete steps to provide protection for health-care workers and individuals seeking health-care services. States should also formulate policies on engaging with third parties, such as non-State armed groups, over their responsibility under human rights law or international humanitarian law, such as the obligation of States to make available health facilities, goods and services and the responsibility of non-State armed groups to refrain from preventing delivery of health care.

16. The obligation to fulfil the right to health by facilitating, providing and promoting conditions conducive to its enjoyment may also be difficult in conflict due to resource constraints or security reasons. States should, however, make available essential and minimum levels of health facilities, goods and services. For instance, States may be obliged to fulfil the right to health by making available ambulances during protests or riots. States may also fulfil the right to health by entering into ceasefire agreements with non-State armed groups to ensure delivery of health services such as immunization and vaccination programmes. States could provide information about traditional medicine and support its use by communities who may be unable to access institutional care due to conflict. In the absence of their own capacity, States should request assistance from other States, civil society and humanitarian organizations, especially to fulfil their core obligations. States should not obstruct humanitarian organizations and practitioners of traditional and community-based medicine from providing health-care services.

[14] *Legal Consequences of the Construction of a Wall*, para. 112.

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

17. Availability, accessibility and acceptability of quality health facilities, goods and services are critical in times of conflict. A functioning health system, including health-care workers, is vital to the enjoyment of the right to health of people affected by and/or involved in conflict.

A. Non-discrimination and medical impartiality

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

19. Moreover, acceptability requires health facilities, goods and services to be in line with medical ethics. This includes provision of impartial care and services by health professionals to people affected by conflict.[15] Medical impartiality in treating wounded people is also mandated by international humanitarian law.[16] Therefore, health professionals have obligations vis-à-vis provision of health services to people affected and/or involved in conflict.

20. The right to health framework requires that prisoners and detainees be allowed equal access to health facilities, goods and services. International humanitarian law also requires prisoners and detainees to be treated humanely with access to medical care.[17] Yet in many conflict situations, prisoners and detainees are restricted from accessing health facilities, goods and services. This contravenes the non-discriminatory protections afforded to them under the right to health.[18]

B. Legal barriers

21. States may enact laws that impose a duty on health-care workers to report persons who may have committed a crime. However, some States have enacted laws and policies restricting or criminalizing provision of medical care to people opposing the State, such as political protestors[19] and non-State armed groups. Laws criminalizing support for terrorists or others opposing the State may also be inappropriately applied to the provision of medical care. Consequently, doctors and other health-care workers have been arrested, charged and sentenced for acting

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[15] World Medical Association, *Regulations in Times of Armed Conflict and Other Situations of Violence*, paras. 1-3.

[16] ICRC, "Health care in danger: the responsibilities of health-care personnel working in armed conflicts and other emergencies" (Geneva, 2013), p. 35.

[17] See common article 3, Geneva Conventions of 1949 for the protection of victims of war and Additional Protocol II thereto.

[18] OHCHR and United Nations Assistance Mission in Afghanistan, "Treatment of conflict-related detainees in Afghan custody" (Geneva, October 2011), p. 3.

[19] Physicians for Human Rights (PHR), "Under the gun: ongoing assaults on Bahrain's health system" (Cambridge, Massachusetts and Washington, D.C., 2012), p. 5.

within their professional duty of ensuring medical impartiality.[20] Such laws may deter health-care workers from providing services in conflict situations due to fear of prosecution, thus creating a chilling effect on health-care providers.

22. The fear of being reported to law enforcement agencies also prevents access to health facilities and services by patients. This is especially true of people wounded as a result of direct involvement in conflict. However, criminalization also has a chilling effect on people who are not involved in conflict, who may avoid seeking health services because they fear being suspected of involvement in the conflict.

C. Physical barriers

23. Availability and accessibility of functioning hospitals and clinics are essential to the enjoyment of the right to health. States are under the obligation to ensure that health facilities are not harmed as a consequence of conflict. However, a number of physical barriers are deployed in times of conflict which severely affect access to health facilities and services. Obstacles such as forcible detours, arbitrary stops at checkpoints,[21] imposition of travel permits[22] and interrogation of patients result in worsening medical conditions of patients. Other measures such as blockades (S/2012/376, para. 11), long or indeterminate curfews and roadblocks also restrict movement of people and transport, thereby negatively effecting access to and delivery of essential health-care services in conflict-affected areas.[23] States have also prevented civilian groups from accessing medical goods, especially life-saving medicines and supplies by obstructing, restricting, limiting or diverting medical supplies.[24]

24. Where restricting the right to health may be necessary, States should adopt the least restrictive alternative. States should ensure that the objective of such barriers is legitimate, and that the restrictions are proportionate to achieving the objective. For instance, States should ensure that movement restrictions for people in conflict areas are legitimate and essential, and provide exceptions for access to health facilities, goods and services which can be exercised with minimal delays. States should also take steps to enable passage of individuals in need of health services in insecure areas.

25. Persons who require continuous care have particular health needs which, if unaddressed, can increase unnecessary deaths during conflict. For example, treatment interruption and lack of availability of treatment may render people living with HIV, tuberculosis and cancer, more vulnerable to ill-health. The lack of availability of medication and psychosocial services can likewise prove especially

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[20] Ibid., p. 4.

[21] M. Rytter and others, “Effects of armed conflict on access to emergency health care in Palestinian West Bank: systematic collection of data in emergency departments”, *British Medical Journal*, vol. 332, No. 7550 (13 May 2006), p. 1123.

[22] WHO, “Right to health: barriers to health access in Palestine Territory, 2011 and 2012”, special report (Geneva, 2013), pp. 11-12.

[23] “Nepal: reproductive health and conflict”, Integrated Regional Information Network (IRIN), Humanitarian news and analysis, 26 April 2006. Available from www.irinnews.org/report/34255/nepal-reproductive-health-and-the-conflict.

[24] Report of the Secretary-General’s Internal Review Panel on United Nations Action on Sri Lanka, November 2012, p. 18.

detrimental to mental health patients, some of whom may require continuous treatment.[25]

D. Attacks on health facilities and health-care workers

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

27. Health-care workers are essential for ensuring availability of health-care services. States therefore have an immediate and continuous obligation to provide health-care workers and humanitarian organizations with adequate protection during periods of conflict.

28. Attacks on health workers including assaults, intimidation, threats, kidnapping, and killings, as well as arrests and prosecutions, are increasingly used as a strategy in conflict situations.[26] Conflict-affected areas have recorded disruption in supply chains, looting of health facilities, demanding of confidential information about patients, intentional and recurrent shelling and bombardment of clinics and hospitals, and shooting at ambulances carrying patients to target civilians and health-care workers as a military strategy.[27] In countries with poor health infrastructure, as may be the case with most conflict-affected regions, destruction of even a single hospital or attacks on already scarce health-care workers can have a devastating impact on the availability and accessibility of health services and therefore on public health.[28] Furthermore, health-care workers may condemn the actions of security forces or may not cooperate in providing information about patients where laws may violate fundamental human rights. Such health-care workers may frequently be harassed, relocated, tortured, arrested and sentenced.[29]

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[25] Bayard Roberts and others, "Post-conflict mental health needs: a cross-sectional survey of trauma, depression and associated factors in Juba, Southern Sudan", *BMC Psychiatry*, vol. 9, No. 7 (2009), pp. 7-8. Available from www.biomedcentral.com/content/pdf/1471-244X-9-7.pdf.

[26] Saúl Franco and others, "The effects of armed conflict on the life and health in Colombia", *Ciência & Saúde Coletiva*, vol. 11, No. 2 (June 2006), p. 357; John M. Quinn and others, "Iraqi physician brain drain in prolonged conflict", *The New Iraqi Journal of Medicine*, vol. 7, No. 1 (April 2011) pp. 91-92; Leonard S. Rubenstein and Melanie D. Bittle, "Responsibility for protection of medical workers and facilities in armed conflict", *Lancet*, vol. 375, No. 9711 (23 January 2010), p. 332.

[27] Human Rights Watch, "Sri Lanka: repeated shelling of hospitals evidence of war crimes", 8 May 2009. Available from www.hrw.org/news/2009/05/08/sri-lanka-repeated-shelling-hospitals-evidence-war-crimes.

[28] ICRC, "Health care in danger: a sixteen-country study" (Geneva, July 2011), p. 3. Available online in English only from www.icrc.org.

[29] PHR, "Under the gun", p. 6; Médecins Sans Frontières (MSF), "Syria two years on: the failure of international aid", special report (New York, 6 March 2013). Available from www.doctorswithoutborders.org/publications/article.cfm?id=6669.

29. Such attacks not only violate the right to health of people affected by conflict, including people involved in the conflict, but may also cripple the health-care system as a whole. Insecurity, stemming from the targeting of health-care workers by either the State forces or non-State groups, may result in health-care professionals fleeing, creating a dearth of trained medical professionals in these regions.[30] This may result in the increase of preventable health problems such as maternal health and child mortality and morbidity, besides the morbidity caused by conflict itself.[31]

E. Military use and militarization of health facilities

30. Militarization refers to the taking over or use of health facilities and services by armed forces or law enforcement agencies for achieving military objectives. Such military use poses a serious risk to the life and health of patients and health-care workers and erodes the role and perception of hospitals as a safe space to access health care. The impartiality of medical facilities is often compromised by the constant presence of security forces in hospitals and intimidation of patients and health-care workers in hospitals and clinics.[32] Hospitals and clinics are sometimes taken over by security forces in order to identify or arrest protestors injured in clashes with pro-Government forces. Those identified with protest-related injuries are often prevented from seeking emergency medical attention, removed from medical care, tortured or arrested (A/HRC/19/69, para. 63). Militarization of health care has also led to undesirable fallouts in respect of access to basic health care in some countries. Widespread fear of persecution leads civilians to avoid seeking treatment at health facilities and resort to treatment in unsafe conditions instead (ibid.). Such persecution violates the right to health of persons by impeding their access to quality health services.

31. In occupied territories and in areas where health care is funded or provided by the military, health-care workers have been targeted due to their perceived association with military forces.[33] Health professionals may also be targeted for providing services to anti-Government groups due to perceived support for such groups.[34] Misuse of health-care delivery programmes, such as vaccination programmes, to further military aims may erode the perception of impartiality of medical personnel and create mistrust of health workers among the civilian population, which may lead to killings of health-care workers and rejection of

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[30] David Stein and Barbara Ayotte, “East Timor: extreme deprivation of health and human rights”, *Lancet*, vol. 354, No. 9195 (11 December 1999), p. 2075.

[31] Paul C. Webster, “Roots of Iraq’s maternal and child health crisis run deep”, *Lancet*, vol. 381, No. 9870 (16 March 2013), p. 892; Bernadette A. M. O’Hare and David P. Southall, “First do no harm: the impact of recent armed conflict on maternal and child health in sub-Saharan Africa”, *Journal of the Royal Society of Medicine*, vol. 100, No. 12 (December 2007), p. 565.

[32] PHR, *Do no harm: a call for Bahrain to end systemic attacks on doctors and patients* (Cambridge, Massachusetts and Washington, D.C., April 2011), pp. 27-29.

[33] MSF, *In the Eyes of Others: How People in Crises Perceive Humanitarian Aid* (New York, 2012), pp. 134-154.

[34] Peter Apps, “Once seen as neutral, aid workers fight perceived bias”, *Reuters*, 31 August 2007. Available from www.reuters.com/article/2007/08/31/us-aid-bias-idUSL3184999120070831.

vaccination programmes to the detriment of public health.[35] Making health facilities, goods and services available through civilian, rather than military, structures may negate such apprehension and increase access to health-care services.

F. Post-conflict availability, accessibility, acceptability and quality of health facilities, goods and services

32. States, in the aftermath of conflict, are likely to face depletion of resources and experience political instability and disintegration of infrastructure, including health systems.[36] Most post-conflict reconstruction takes place after conflict has subsided to a certain degree, but continues or recurs in some parts of the country. Moreover, States that have already been in conflict situations are more likely to face repeated cycles of violence, which further burdens existing health systems and resources. Additionally, such States are marked by a high burden of disease, both mental and physical.[37]

33. Policies for States recovering from conflict need to focus on multiple issues such as reduction of the disease burden; immediate treatment of the injured and their long-term rehabilitation; reconstruction of infrastructures; increase in availability and accessibility of quality health facilities, goods and services; and sustainability of the health system. States should therefore formulate detailed and time-bound plans for the reconstruction of systems, including for delivery of underlying determinants of health, and restoring community and social structures, in a participatory and transparent manner. Participation of affected communities ensures responsive policies and promotes their ownership over such processes.

34. States should address imminent public health concerns, including injuries and disabilities caused during conflict, and less visible effects on health such as mental health. For example, post-traumatic stress disorder and depression are common in States recovering from conflict and should be effectively addressed.[38] Making mental health services available and accessible is essential and also helps empower people and communities affected by conflict and may enable them to bring about change in their social and political environment.[39]

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[35] Dara Mohammadi, "The final push for polio eradication", *Lancet*, vol. 380, No. 9840 (2 August 2012); Liz Borkowski, "Pakistan sees first polio case since vaccination camp disrupted", *Science Blogs*, 9 May 2013. Available from http://scienceblogs.com/thepumphandle/2013/05/09/pakistan-sees-first-polio-case-since-vaccination-campaign-disrupted/.

[36] Ibid.; Graeme MacQueen and Joanna Santa-Barbara, "Peace building through health initiatives", *British Medical Journal*, vol. 321, No. 7256 (29 July 2000), pp. 293-296.

[37] Bayard Roberts, Preeti Patel and Martin McKee, "Noncommunicable diseases and post-conflict countries", *Bulletin of the World Health Organization*, vol. 90, No. 2-2A (2012); Hazam Adam Ghobarah, Paul Huth and Bruce Russett, "The post-war public health effects of civil conflict", *Social Science and Medicine*, vol. 59, No. 4 (August 2004).

[38] F. Charlson and others, "Predicting the impact of the 2011 conflict in Libya on population mental health: PTSD and depression prevalence and mental health service requirements", *PLOS Medicine*, vol. 7, No. 7 (July 2012). Available from www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0040593.

[39] WHO Regional Office for Europe, "User empowerment in mental health" (Copenhagen, 2010), pp. 1-14, 1-2. Available from www.euro.who.int/__data/assets/pdf_file/0020/113834/E93430.pdf.

35. Due to the depletion of resources, exodus of doctors and health-care personnel and attacks on health-care workers,[40] countries and areas in post-conflict situations may be dependent on international donors and initiatives by non-governmental and intergovernmental organizations for the reconstruction of their health systems. Such health initiatives can be used as a tool for peacebuilding.[41] International aid agencies have used such strategies to break through ethnic divides, thereby increasing the availability and accessibility of health facilities, goods and services and reducing discrimination.[42] To ensure acceptability and accessibility of health services, international aid providers should also be cognizant of the culture of countries and communities. For example, in some countries, provision of health services to pregnant women by male doctors may not be culturally acceptable and may thus impede accessibility.[43]

36. Sustainability of donor-aided policies and initiatives is essential for ensuring long-term availability and accessibility of quality health facilities, goods and services in countries recovering from conflict. Ensuring participation and ownership in all phases of decision-making processes by the affected population is essential for the success and sustainability of donor-aided reconstruction of the health system.[44] Such health initiatives could be successful through continuous collaboration and cooperation with the local population, and by sharing technical know-how with them. An understanding of political realities, especially in areas of protracted conflict and transitioning societies is equally important to ensure sustainability of donor-aided initiatives.[45]

IV. Vulnerable groups

37. States should give particular attention to persons rendered vulnerable by conflict, such as women, children, older persons, people with disabilities and displaced communities. This requires States to address marginalization arising from social, political and economic exclusion; discrimination against persons belonging to or perceived to belong to a specific community; vulnerability due to ill-health; and conflict strategies that deliberately render certain communities vulnerable. These factors, individually or in combination, may expose certain groups to multiple vulnerabilities and an increased risk of violation of their right to health. Recognizing the diverse vulnerabilities in different communities and empowering them to participate in all decision-making processes that affect their health enable States to fulfil their obligation under the right to health during conflict and also promotes a sustainable recovery from conflict.

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[40] ICRC, “Health care in danger: making the case” (Geneva, 2012), p. 6.

[41] MacQueen and Santa-Barbara, “Peace building through health initiatives”, p. 293.

[42] WHO Regional Office for Europe/Department for International Development (United Kingdom), “WHO/DFID peace through health programme: a case study prepared by the WHO field team in Bosnia and Herzegovina”, document EUR/ICP/CORD 03 05 01 (Copenhagen, September 1998).

[43] Rita Giacaman, Hanan F. Abdul-Rahim and Laura Wick, “Health sector reform in the Occupied Palestinian Territories: targeting the forest or the trees?” *Health Policy Plan*, vol. 18, No. 1 (March 2003), p. 59.

[44] Nelson Martins and others, “Reconstructing tuberculosis services after major conflict: experiences and lessons learned in East Timor”, *PLOS Medicine*, vol. 3, No. 10 (October 2006), pp. 1765-1775.

[45] Ibid.; Giacaman, Abdul-Rahim and Wick, “Health sector reform in the Occupied Palestinian Territories”, p. 10.

A. Marginalized communities

38. Communities excluded from social, political and economic institutions are often marginalized and inhabit areas marked by weak infrastructure and poor governance, such as urban slums, ghettos and border areas. The impact of conflict may further devastate underlying determinants, such as food and housing, and disproportionately increase the vulnerability of marginalized communities to ill-health. This vulnerability is heightened during conflict when health resources are inappropriately and inequitably distributed prior to and after conflict.

39. Unaffordable health-care services, high taxes and confiscation of essential supplies by parties to the conflict increase the vulnerability of marginalized communities.[46] Accessibility may further be hindered due to lack of linguistic and culturally appropriate health services and information. Failure to recognize the different needs of marginalized communities may deter them from accessing health care, as well as contribute to a profound sense of isolation and disempowerment.

40. The health needs of certain groups are often overlooked in conflict due to limited or suspended services. Older persons are more at risk in conflict due to poor mobility and are less able to travel to health facilities. They may be unable to carry heavy packages of food or containers of water, and often live without family support, which renders them vulnerable to higher levels of malnutrition and disease.[47] Similarly, persons with disabilities, often abandoned by families fleeing conflict, may face greater health and safety risks.[48] Many facilities are unable to provide children with disabilities with the treatment and care suited to their physical developmental needs, hampering their ability to enjoy their right to health.[49]

B. Displaced communities

41. Conflicts often result in displacement of people, within States and across borders. Displaced persons may be deprived of the same rights and underlying determinants as host communities.[50] A large number of displaced persons may be forced to migrate to relief camps that are characterized by dilapidated and overcrowded conditions where basic services are inadequate, contributing to the spread of communicable diseases. Displaced persons may also be forced to migrate to urban slums, which renders them susceptible to vulnerabilities arising not only from a lack of capacity and resources, but also from the unwillingness of the State to address their needs.

42. Moreover, displaced persons are particularly vulnerable when their legal status prevents them from accessing health facilities, goods and services and availing

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[46] Minority Rights Group (MRG), *Uganda: The Marginalization of Minorities* (London, MRG International, 2001), p. 17.

[47] Unni Karunakara and others, "Ending neglect of older people in the response to humanitarian emergencies", *PLOS Medicine*, vol. 9, No. 12 (December 2012), pp. 1-3.

[48] HRW, *As If We Weren't Human: Discrimination and Violence against Women with Disabilities in Northern Uganda* (New York, 2010), p. 29.

[49] Tami Tamashiro, "Impact of conflict on children's health and disability", paper commissioned for the Education for All Global Monitoring Report 2011, *The Hidden Crisis: Armed Conflict and Education* (Paris, United Nations Educational, Scientific and Cultural Organization, 2011).

[50] IRC, "Syria: a regional crisis", 2013, p. 12.

themselves of economic opportunities.[51] Many may be forced to work in poor or unsafe working conditions, further exposing them to poor health.[52] Competing demands for access to health care and the underlying determinants of health may lead to rising tensions at the expense of both host and displaced communities.[53] Displaced communities may consequently face discrimination in accessing health facilities, goods and services and underlying determinants.

C. Women

43. Conflict may aggravate women's vulnerability to ill-health, discrimination and gender-based violence. Women often experience higher incidence of poor health outcomes in conflict owing to their physical and reproductive needs during pregnancy and childbirth.[54] Most maternal deaths in conflict occur during delivery or in the immediate post-partum period due to lack of availability of quality reproductive and maternal care, such as family planning, emergency obstetric services, and pre- and post-natal care.[55] Women in conflict situations are more likely to turn to unsafe abortion services when facing an unplanned pregnancy.[56]

44. Women are also often primary caretakers in conflict situations and may struggle to provide for their families, neglecting their own needs. Unequal access to resources such as land, employment and financial loans may leave many women and their families destitute and vulnerable.[57] Faced with limited choices, women may turn to employment in low-skilled jobs and in the informal sector, which yields lower benefits and exposes them to danger and exploitation.[58] Women who depend on armed groups and aid agencies may also engage in sex work in exchange for money, shelter, food or other basic necessities.[59] This may further expose women to increased risk of HIV and sexually transmitted infections.[60]

45. Mass displacement, breakdown of community and family networks, and institutional collapse may create a vacuum in which women and young girls are

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[51] Office of the United Nations High Commissioner for Refugees (UNHCR), "Syria regional response plan: January to June 2013" (Geneva, 2013), pp. 11, 39. Available from www.unhcr.org/.

[52] Ibid.

[53] IRC, "Syria", p. 13.

[54] ICRC, "Addressing the needs of women affected by armed conflict" (Geneva, 2004), pp. 10, 121, 133.

[55] MSF, "Maternal death: the avoidable crisis" (New York, 2012); N. Howard and others, "Reproductive health for refugees by refugees in Guinea III: maternal health", *Conflict and Health*, vol. 5, No. 5 (12 April 2011), p. 1.

[56] United Nations Population Fund (UNFPA), "The impact of armed conflict on women and girls: a consultative meeting on mainstreaming gender in areas of conflict and reconstruction, Bratislava, 13-15 November 2001" (New York, 2002), p. 44.

[57] Austrian Development Agency, "Focus: women, gender and armed conflict" (Vienna, 2009), pp. 2-3. Available from www.oecd.org.

[58] *Women, Peace and Security* (United Nations publication, Sales No. E.03.IV.9), pp. 115-117.

[59] Kirsti Lattu, "To complain or not to complain still the question: consultations with humanitarian aid beneficiaries on their perceptions of efforts to prevent and respond to sexual exploitation and abuse" (Geneva, Humanitarian Accountability Partnership, 2008), pp. 20-22.

[60] WHO Regional Office for Europe, "Violence against women living in situations of armed conflict" (Copenhagen, 2000), p. 13.

vulnerable to sexual violence.[61] They face a heightened risk of sexual exploitation and trafficking, as well as increased domestic violence and abuse from family members. Health facilities that lack qualified health professionals, patient referral mechanisms and psychological counselling may be unable to identify and respond to these forms of conflict-related sexual violence. This is especially true when health services are restricted to sexual violence perpetrated by armed groups.[62] The stigma associated with sexual violence and HIV and the absence of adequate protection mechanisms may also contribute to negative physical and mental health outcomes. Stigma, abandonment by families and communities, and retribution from perpetrators create an atmosphere that perpetuates gender-based violence and leads to the exclusion and disempowerment of survivors. The failure to provide services that promote the safety and respect the confidentiality of survivors undermines their full participation in society, particularly in post-conflict reconstruction efforts.

D. Children

46. Children are particularly vulnerable in conflict due to poor hygiene and food insecurity.[63] Malnutrition, in particular, undermines children's immunity and resistance to preventable and communicable diseases, such as diarrhoea or malaria.[64] The breakdown of disease surveillance and vaccination systems also contributes to the vulnerability of children to ill-health and hinders their right to health.[65]

47. Conflict may also have a devastating psychological impact on a child's well-being and development. Distressing experiences, abuse and chronic stress may increase the risk of trauma, particularly where children are separated from their families. Mental health needs of children may, however, be left unaddressed due to the unavailability of psychosocial services.[66]

48. Conflict may also result in children adopting new roles and responsibilities, which may increase their vulnerability to sexual violence and exploitation.[67] Health facilities in conflict often lack child-appropriate services for survivors of sexual violence, particularly for boys. Exposure to sexual violence increases the risk of further violations for girls. For example, marriage to the perpetrator is often seen as

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[61] UNFPA, "HIV/AIDS, gender and conflict situations", p. 1. Available from www.unfpa.org/hiv/docs/factsheet_conflict.pdf.

[62] Human Security Research Group, *Human Security Report 2012: Sexual Violence, Education and War: Beyond the Mainstream Narrative* (Vancouver, Human Security Press, 2012), pp. 34-35, 45.

[63] International Bureau for Children's Rights (IBCR), *Children and Armed Conflict: A Guide to International and Humanitarian Law* (Montreal, 2010), p. 160.

[64] Flavia Bustreo and others, "Improving child health in post-conflict countries: can the World Bank contribute?" (Washington, D.C., World Bank, 2005).

[65] Ibid.; IBCR, p. 160.

[66] M. Hasanović and others, "Psychological disturbances of war-traumatized children from different foster and family settings in Bosnia and Herzegovina", *Croatian Medical Journal*, vol. 47, No. 1 (2006), pp. 86-87.

[67] Watch List on Children and Armed Conflict, "Caught in the middle: mounting violations against children in Nepal's armed conflict" (New York, 2005), pp. 30-31.

a means of "protecting a girl's honour".[68] However, forcing survivors of sexual violence to marry their attackers re-victimizes them and results in the legitimization of the actions of the perpetrator and social acceptance of sexual violence (see A/66/657-S/2012/33).

Conflict strategies

49. As noted by the Security Council (resolution 1820 (2008)) and others,[69] certain civilians may be targeted on the basis of their perceived or actual association with ethnic, religious or political groups. Such strategies infringe human dignity and are manifestly incompatible with the right to health. In certain circumstances, they may also qualify as crimes against humanity, genocide or war crimes. For example, the use of gender-based violence as a strategy of conflict has been well documented.[70] Such violence can include incestuous rape and public rape, rape as a deliberate vector of HIV, camps specifically designed for forced impregnation of women, and premeditated rape as a tool of political repression.[71] Women and girls are common targets of sexual violence, although men and young boys may also be targeted with equal severity.[72] As the United Nations High Commissioner for Human Rights has noted (see E/CN.4/2004/13) among others,[73] armed groups may also specifically target sex workers, sexual and ethnic minorities and other communities as a tool for "social cleansing" of "undesirable elements". By treating civilians as objects of conflict, the physical and psychological impact of sexual violence may extend beyond immediate survivors and disempower whole communities.[74] Due to the stigma attached to sexual violence, survivors are often

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[68] Save the Children, "Unspeakable crimes against children" (London, 2013), p. 7; Megan Bastick, Karin Grimm and Rahel Kunz, *Sexual Violence in Armed Conflict: Global Overview and Implications for the Security Sector* (Geneva, Geneva Centre for the Democratic Control of Armed Forces, 2007), p. 14.

[69] Inter-American Commission on Human Rights, "Violence and discrimination against women in the armed conflict in Colombia". OEA/Ser.L/V/II, doc.67, 16 October 2006, para. 47.

[70] The International Criminal Tribunal for the Former Yugoslavia (ICTY) and the International Criminal Tribunal for Rwanda (ICTR) have upheld convictions of sexual violence as an instrument of crimes against humanity (ICTR, *Prosecutor v. Akayesu*, case No. ICTR-96-4-T, judgement of 2 September 1998, para. 596); war crimes (ICTY, *Prosecutor v. Zejnil Delalic, Zdravko Mucic, Hazim Delic and Esad Landzo*, case No. IT-96-21-T, judgement of 15 November 1998, para. 495); and indicia of enslavement (ICTY, *Prosecutor v. Dragoljub Kunerac, Radomir Kovas and Zoran Vukovic*, case Nos. IT-96-23-T and IT-96-23/1-T, para. 543).

[71] Obijiofor Aginam, "Rape and HIV as weapons of war" (Tokyo, UNU Press, 27 June 2012). Available from http://unu.edu/publications/articles/rape-and-hiv-as-weapons-of-war.html; Anuradha Kumar, *Human Rights: Global Perspectives* (New Delhi, Sarup & Sons, 2002), pp. 101-152; Bülent Diken and Carsten Bagge Lausten, "Becoming abject: rape as a weapon of war", *Body & Society*, vol. 11, No. 1 (2005), p. 115.

[72] Sandesh Sivakumaran, "Sexual violence against men in armed conflict", *European Journal of International Law*, vol. 18, No. 2 (2007), pp. 253, 263.

[73] Maria Zea and others, "Armed conflict, homonegativity and forced internal displacement: implications for HIV among Colombian gay, bisexual and transgender individuals", *Culture, Health, and Sexuality*, vol. 15, No. 7 (April 2013), p. 8.

[74] HRW, *The War Within the War: Sexual Violence against Women and Girls in Eastern Congo* (New York, 2002), p. 41.

forced into silence and excluded from their communities.[75] The impact of sexual violence on the mental health of survivors, as well as their family and community may endure for generations.[76] Sexual violence also compromises the participation of targeted communities in public health efforts long after conflict has ended.

50. Parties to conflict may also use health services as a strategy to target specific communities. Parties may deliberately deny humanitarian aid and health services to certain individuals or communities based on their ethnic, religious or political affiliation.[77] Destruction of underlying determinants of health, such as by poisoning wells and burning farmland, is another strategy that may deny affected communities a life of dignity and well-being.[78] Such strategies may undermine the ability of targeted groups to respond to serious health needs.[79] Groups thus targeted may be unable to access nutritious food, hygiene or medical care, which may prevent them from enjoying their right to health. They may also be excluded from participation in democratic decision-making, including decisions on health services, which may perpetuate health inequities in post-conflict settings.

V. Obligations of entities other than the primary State

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

A. International obligations

52. According to the International Covenant on Economic, Social and Cultural Rights, all States have an obligation to take steps, individually and through international cooperation and assistance, towards the full realization of economic, social and cultural rights, including the right to health. To comply with their international obligations, States must respect the right to health of populations in other countries, protect against violations by third parties where they are able to influence those third parties through legal or political means, and facilitate access to essential health services in other countries, depending on the availability of resources. In particular, States have an obligation to provide humanitarian aid in disasters and emergencies, including conflict and post-conflict situations.

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[75] WHO, “Rape: how women, the community and the health sector respond” (Geneva, 2007). Available from www.svri.org/rape.pdf, pp. 12-14; Nadera Shalhoub-Kevorkian, “Towards a cultural definition of rape”, *Women’s Studies International Forum*, vol. 22, No. 2 (March/April 1999), pp. 165-166.

[76] Colleen Kivlahan and others, “Rape as a weapon of war in modern conflicts”, *British Medical Journal*, vol. 340, No. 3270 (June 2010), pp. 468-469.

[77] MSF, “Syria: medicine as a weapon of persecution” (New York, 2012).

[78] PHR, *Darfur: Assault on Survival: A Call for Security, Justice and Restitution* (Washington, D.C., 2006), pp. 37-38.

[79] Ibid.

53. As an aspect of international cooperation and assistance, States should respect, protect and fulfil the right to health of people fleeing from conflict situations. The burden of caring for populations displaced by conflict often falls on States that are least equipped to bear it.[80] In this regard, other States should ensure that they provide appropriate international assistance, including aid, to countries facing an influx of persons displaced by conflict and measures to assist in their resettlement. States should also ensure the availability and accessibility of quality health facilities, goods and services and the underlying determinants of health to such persons, whether or not they are nationals of the State. States should also refrain from policies that violate the right to health such as mandatory detention or deportation.[81]

54. States also frequently impose economic sanctions in conflict to coerce parties to the conflict, or to control the flow of resources to conflict-affected areas.[82] Such sanctions may adversely impact on the right to health of civilian populations, not only by restricting medical supplies, but also by increasing administrative delays for essential goods and services, worsening poverty and reducing the resources available for health, infrastructure and education systems.[83] To ensure the full enjoyment of the right to health of people affected by conflict, medical supplies and equipment, water, food and other essentials important for the health of the population should never be placed under sanctions. Furthermore, all sanctions should be monitored both before and after imposition for their effect on the right to health, and should be transparent and responsive, regardless of their political purpose.[84]

B. Non-State armed groups

55. The majority of contemporary conflicts are non-international armed conflicts involving one or more non-State armed groups.[85] These non-State armed groups may significantly affect the enjoyment of the right to health in conflict. One study has found that non-State armed groups are as likely as State forces to attack or interfere with health facilities, and nearly twice as likely to enter hospitals for illegitimate purposes.[86]

56. There is growing acceptance that non-State armed groups reaching a certain level of organization and control should respect international humanitarian law and human rights law.[87] Common article 3 of the Geneva Conventions of 1949 and Additional Protocol II thereto both address parties to the conflict, which are

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[80] UNHCR, *Global Trends 2012* (Geneva, 2013), p. 2.

[81] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 43 (a) and 54. On the effect of mandatory detention on the right to health, see, e.g., the report of the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health: mission to Australia (A/HRC/14/20/Add.4), paras. 92 and 97.

[82] Committee on Economic, Social and Cultural Rights, general comment No. 8 (1997), para. 2.

[83] Ibid., paras. 3-6.

[84] Ibid., paras. 12-13.

[85] World Bank, *World Development Report 2011*, p. 52.

[86] ICRC, *A Sixteen-Country Study*, pp. 8-10.

[87] See Andrew Clapham, "Non-State actors", in Daniel Moeckli and others (eds.), *International Human Rights Law*, 2nd ed. (Oxford University Press, forthcoming).

understood by international courts to include organized non-State armed groups.[88] Similarly, fact-finding commissions have concluded that armed groups that are stable, organized, and have effective control over territory have legal personality regarding a defined range of international humanitarian law and human rights obligations (see A/HRC/19/69, paras. 106-107, and A/HRC/17/44). These include obligations to refrain from attacking or interfering with humanitarian facilities, vehicles, and personnel, and to refrain from harming civilian populations, including through sexual violence or destroying food or water systems.[89]

57. Non-State armed groups are also bound by the expectation of the international community that they will respect norms contained in the Universal Declaration of Human Rights, especially where they exercise control over territory (A/HRC/2/7, para. 19, and E/CN.4/2006/53/Add.5, paras. 25-26). Additionally, the right to health framework recognizes the responsibility of all sectors of society towards realizing the right to health,[90] which includes the responsibility of non-State actors such as armed groups and other arms bearers in conflict. Finally, armed groups have been held accountable for obligations voluntarily assumed through agreements, unilateral statements and monitoring systems under the Security Council (resolution 1998 (2011)), which have included both obligations to respect human rights and to protect or fulfil them where armed groups exercise the control and authority to do so.[91] Armed groups must therefore, at the minimum, respect human rights, including the right to health, and may assume further obligations to protect or fulfil human rights. The obligation of States to protect people against third-party violations continues regardless of whether armed groups are present on its territory, and the presence of third-party armed groups should not be used by States as an excuse to abdicate from their right to health responsibilities in conflict areas.

58. Nonetheless, there is currently a gap in the delineation of the human rights responsibilities of non-State armed groups and in mechanisms for holding them accountable, other than criminal prosecutions. In this respect, the obligation of the State to facilitate the discharge of right to health responsibilities by all sections of society becomes particularly important. States, civil society and international organizations have successfully facilitated agreements on human rights and humanitarian issues with non-State armed groups, including agreements to provide "days of tranquillity" for health workers to safely provide vaccinations.[92] States should adopt, support and expand these initiatives to protect and fulfil the right to health in conflict and minimize the impact of conflict on vulnerable groups.

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[88] Ibid.; *Prosecutor v. Akayesu*, para. 611; International Court of Justice, *Military and Paramilitary Activities in and around Nicaragua (Nicaragua v. United States of America), Judgments, I.C.J. Reports 1986*, p. 14, para. 119; Inter-American Court of Human Rights, *Abella v. Argentina*, Report No. 55/97, case No. 11.137, 18 November 1997.

[89] "Report of the International Commission of Inquiry on Darfur to the United Nations Secretary-General", 25 January 2005, paras. 165-166.

[90] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 42.

[91] Geneva Call, Deed of commitment under Geneva Call on the protection of children from the effects of armed conflict, para. 7. Available from www.genevacall.org; Agreement on Human Rights between El Salvador and the Frente Farabundo Marti para la Liberación Nacional, 26 July 1990. Available from www.geneva-academy.ch.

[92] Leonard Rubenstein, "Defying expectations: polio vaccinations amid political and armed conflict". Peace Brief (Washington, D.C., United States Institute of Peace, 2010). Available from www.usip.org/.

59. The Special Rapporteur recognizes that parties to conflict may be reluctant to conclude such agreements for fear of legitimizing the other party or due to concerns that they may concede control over territory or governmental functions.[93] However, many of these objections can be overcome by measures such as decoupling human rights agreements from ceasefire or power-sharing negotiations, explicitly stating that such negotiations will not affect political recognition or mediating negotiations through a mutually trusted third party, and should not be seen as insurmountable.[94] States should also ensure that such initiatives are not hampered by overly broad counter-terrorism laws. Many counter-terrorism laws currently criminalize all forms of engagement with organizations listed as terrorist groups, deterring many humanitarian agencies from engaging with armed groups on their human rights responsibilities for fear of being labelled as or connected to armed groups termed "terrorists".[95]

C. Intergovernmental and non-governmental organizations

60. The right to health framework recognizes that international and non-governmental organizations have particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including providing assistance to refugees and internally displaced persons.[96] International and non-governmental organizations may also be involved in conflict as monitors, mediators, peacekeeping forces and territorial administrators. Such organizations should ensure that they take due account of the right to health in their decisions and activities, including by adopting rights-based health policies, paying special attention to the needs of vulnerable groups and ensuring participation of affected communities. They should ensure that robust accountability mechanisms exist, particularly in peacekeeping and peace-enforcement situations. These include effective disciplinary systems, clear operational standards, systems for monitoring and data collection, and accessible independent dispute-resolution systems, especially for international organizations that enjoy immunity from domestic jurisdiction.

VI. Accountability and remedies

61. Accountability is an essential aspect of the right to health framework. It requires independent monitoring, prompt investigations, transparent governance, including collecting and disseminating accurate and complete information to the public, and access to remedies for victims of violations. These requirements are also addressed under international humanitarian law, which obliges States to prevent,

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[93] See Geneva Academy of International Humanitarian Law and Human Rights, *Rules of Engagement: Protecting Civilians through Dialogue with Armed Non-State Actors* (Geneva, 2011), pp. 5-7, Available from www.geneva-academy.ch. See also the report of the Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism (A/HRC/6/17 and Corr.1), paras. 42-50.

[94] Geneva Academy, *Rules of Engagement*, pp. 8-57.

[95] Naz K. Modirzadeh, Dustin A. Lewis and Claude Bruderlein, "Humanitarian engagement under counter-terrorism: a conflict of norms and the emerging policy landscape", *Review of the International Committee of the Red Cross*, vol. 93, No. 883 (September 2011), p. 623.

[96] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 65.

investigate and punish violations of international humanitarian law.[97] Clear policies and codes of conduct should be in place within the military, police force, and medical institutions to protect the right to health in conflict.[98]

A. Monitoring and transparency

62. Violations of the right to health in conflict, including attacks on, and interference with, the delivery of health care, are often not fully captured in current monitoring systems.[99] Monitoring of such violations in conflict and post-conflict situations is often poor or incomplete, due to insecurity and lack of systematic data collection and dissemination by States and international organizations.[100] Monitoring mechanisms may focus excessively on high-profile issues such as attacks on international aid workers rather than more common violations such as threats against local workers or damage to underlying determinants.[101] The practice of retaliating against whistleblowers may also mean that health-care workers and affected populations, who are in the best position to report violations of the right to health, may be reluctant to do so for fear of being unable to provide or access medical care.

63. Security concerns should not be used to justify blanket bans on reporting violations, particularly where a less restrictive means of ensuring security is available, such as allowing anonymous reporting of incidents.[102] States should ensure that accurate information is available to independent monitors and should not retaliate against persons who report violations. States should also prevent and investigate threats and attacks against such persons by both State agents and third parties. States should especially promote community-based monitoring initiatives, which ensure that the views of the local population are taken into account, and provide transparent and reliable information to civil society and affected communities.

64. Lack of transparency and accountability in health programming and governance in conflict also undermines confidence between affected populations and States, impeding attempts to better provide and protect health services in conflict-affected areas and preventing accurate assessments of aid allocation. This can increase the risk of further violations and the difficulty of remedying them. In particular, lack of transparency and accountability discourages aid to conflict areas, depriving devastated health systems of much-needed funding. Conflict-affected countries receive 43 per cent less aid than countries with similar development needs,

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[97] See sources cited in Jean-Marie Henckaerts and Louise Doswald-Beck, *Customary International Humanitarian Law*, vol. I, *Rules* (Cambridge, United Kingdom, ICRC and Cambridge University Press, 2005), rule 158. Available from www.icrc.org.

[98] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 55-56, 59.

[99] Leonard Rubenstein, "Protection of health care in armed and civil conflict: opportunities for breakthroughs" (Washington, D.C., Center for Strategic and International Studies, 2012), pp. 2-4. Available from http://csis.org/files/publication/120125_Rubenstein_ProtectionOfHealth_Web.pdf.

[100] Ibid., p. 2.

[101] ICRC, "Health care in danger: violent incidents affecting health care: January to December 2012" (Geneva, 2013), p. 5.

[102] P. J. Jennings and S. Swiss, "Supporting local efforts to document human rights violations in armed conflict", *Lancet*, vol. 357, No. 9252 (January 2001), p. 302.

with increased risks of misappropriation and monitoring difficulties being two reasons for this disparity.[103]

B. Remedies

65. Prompt, effective and adequate remedies for violations are a key component of accountability. Under the right to health framework, any person or group whose right to health has been violated should have access to effective judicial or other appropriate remedies at both national and international levels, including adequate reparations, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. States should provide effective, prompt and accessible means of claiming remedies within judicial and administrative systems. They should also ensure that peacebuilding processes such as amnesties, statutes of limitation or exemptions from civil or criminal action for military or police forces do not obstruct access to remedies, and provide means for claiming remedies against both State and non-State actors.

66. Remedies should not be limited to punitive actions against perpetrators but should also be directed towards restoring the right to health of affected persons and bridging the divisions in society that may arise from or give rise to continued conflict. As such, the remedies of satisfaction and guarantee of non-repetition, which include measures to cease current violations and prevent future violations as noted by the General Assembly in its resolution 60/147, are particularly important given the ongoing and systemic effects of conflict on the right to health. In the context of the right to health, guarantees of non-repetition include improving protection of health workers in conflict areas; providing clear codes of conduct on the appropriate use of medical facilities in conflict; training of, and awareness-raising among, appropriate actors, including law enforcement, on all aspects of the right to health; undertaking legal reforms including enacting laws that mandate non-interference with the impartial provision of health care; and setting up independent dispute settlement and monitoring systems. The remedy of satisfaction includes judicial and administrative sanctions, acknowledgement of wrongdoing, and effective measures to end continuing violations.

67. Remedial measures should involve removing discriminatory policies and laws, and formulating and implementing comprehensive national health plans to realize the right to health post-conflict. States should also provide platforms to heal the rifts in society caused by conflict. Mechanisms such as truth and reconciliation commissions, international and hybrid criminal tribunals, international and regional human rights mechanisms and fact-finding missions can provide important complements to judicial and administrative remedies at the national level in this regard. At all levels, the participation of affected communities in remedial processes is essential to ensuring a meaningful and sustainable resolution of the conflict.

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[103] Preeti Patel and others, “A review of global mechanisms for tracking official development assistance for health in countries affected by armed conflict”, *Health Policy*, vol. 100, Nos. 2-3 (2011), p. 117.

VII. Conclusion and recommendations

68. **A right to health approach to conflict situations obliges States to take continuous and concrete steps towards the realization of the right to health of persons affected by conflict, including those who are actively involved in conflict. The Special Rapporteur recommends that States enact and implement laws and policies which respect, protect and fulfil the right to health of affected populations, especially vulnerable groups, prior to, during and after conflict.**

69. **The Special Rapporteur emphasizes that the effective participation of affected communities, especially vulnerable groups, is essential to the right to health framework. Affected communities should, at all times, be involved in the formulation, implementation and monitoring of decisions and agreements that affect their right to health, including policies regarding conflict situations and post-conflict situations.**

70. **The Special Rapporteur urges States involved in conflict situations:**

(a) **To make resources available, including through humanitarian assistance, to fulfil their obligations under the right to health. States should fulfil their non-derogable core obligations under the right to health at all times;**

(b) **To ensure the availability, accessibility and acceptability of quality health facilities, goods and services to all people involved in and/or affected by conflict, without discrimination. Particular attention should be given to vulnerable groups;**

(c) **To avoid formulating laws and policies which criminalize provision of health services by health professionals to people involved in conflict, or repeal them where they exist. States should also refrain from interfering with the duty of health professionals to provide services in an impartial manner;**

(d) **To refrain from obstructing, restricting or limiting access to health facilities, goods and services. In cases where such barriers become necessary, restrictions should be proportionate to the objective sought and should follow the least restrictive alternative;**

(e) **To abstain from attacking health facilities, goods, services and workers, especially as a conflict strategy, including in areas controlled by armed groups. States should also take measures to protect health facilities, goods, services and workers from attacks by non-State armed groups;**

(f) **To forgo militarizing health facilities, goods and services;**

(g) **To engage with non-State armed groups, through voluntary agreements, to facilitate access to health facilities, goods and services;**

(h) **To ensure effective monitoring of violations of the right to health during conflict by making information available and accessible to independent monitoring groups, including community-based monitoring groups.**

71. **The Special Rapporteur urges States recovering from conflict:**

(a) **To formulate and implement plans for the reconstruction of infrastructure and delivery of underlying determinants, with particular attention to the needs of vulnerable groups. States should formulate laws to**

ensure the equitable distribution of underlying determinants and for the realization of the right to health of all people, especially vulnerable groups;

(b) **To make sufficient resources available to implement reconstruction policies. Donor-funded initiatives should supplement and support national health policies where required and should be implemented with the participation of affected populations;**

(c) **To ensure the availability and accessibility of essential and primary health facilities, goods and services, including mental health services, to people affected by and involved in conflict, especially vulnerable groups;**

(d) **To establish access to justice mechanisms to address the violations of rights and provide remedies for such violations, including restitution, compensation, guarantees of non-repetition and satisfaction;**

(e) **To provide peacebuilding mechanisms for meaningful and sustainable resolution of conflicts through restorative justice processes such as fair and transparent truth and reconciliation commissions.**

72. **The Special Rapporteur urges States to fulfil their international obligations and, in particular:**

(a) **To ensure transparency in the implementation of aid programmes;**

(b) **To guarantee that economic sanctions imposed on States during conflict do not hinder the realization of the right to health of people affected by conflict;**

(c) **To respect, protect and fulfil the right to health of persons fleeing from conflict situations.**

73. **The Special Rapporteur urges international and non-governmental organizations undertaking humanitarian activities in conflict:**

(a) **To adopt health initiatives in line with the right to health framework, which includes ensuring the participation of affected communities. These initiatives should promote traditional medicines and practices which are in line with the right to health;**

(b) **To establish effective accountability mechanisms for violations of the right to health by their personnel, such as members of peacekeeping forces and humanitarian workers.**

74. **The Special Rapporteur urges non-State armed groups:**

(a) **To respect norms of international human rights and humanitarian law, including those related to the right to health;**

(b) **To comply with agreements that may have been entered into to protect the right to health of affected populations.**