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Health and Humanitarian Assistance: Towards an Integrated Norm under International Law

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Abstract
This contribution assesses how a set of health-related norms under international law and ethics apply to situations where humanitarian assistance is provided. It asserts that the right to health, as an international human rights norm, is reinforced by similar standards under international humanitarian law, medical ethics and the International Health Regulations (WHO). Based on this integrated norm, there is a legal obligation to ensure access to a set of essential health-related services during emergencies, and to offer health-related protection. With respect to the duty to deliver such services we suggest that there is a shared responsibility of a number of actors. For the State where the emergency is taking place there is a primary legal responsibility to deliver essential health services. Nonetheless, if the services are (partly) provided by third parties there is a legal duty on the part of this State to respect and to guarantee the safe delivery of the services, and a duty to consent to the delivery of such aid. These duties could potentially also fall upon non-state actors, for example armed opposition groups, if they exercise certain governmental functions and *de facto* authority over a population. Arguably the international community and donor States have correlated duties to provide a certain amount of assistance and cooperation. Lastly, humanitarian aid organizations and their staff are bound by their professional ethical standards, including the principle of medical neutrality, which requires that medical aid is to be provided to everyone, irrespective of nationality and civil status.

Keywords
humanitarian assistance; international humanitarian law; human rights law; economic; social; cultural rights; right to health; access to healthcare; medical personnel; medical neutrality; International Health Regulations; human rights responsibilities of non-state actors; minimum core obligations

* For a shorter version of this paper see the author's post at http://www.hhropenforum.org/2013/03/to-the-rescue-the-right-to-health-supports-and-protects-the-provision-of-humanitarian-assistance/, accessed May 2013. The author wishes to thank Stefanie Jansen for her valuable comments.

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1. Introduction

The environment in which humanitarian assistance is provided has changed dramatically over the past decades. While most conflicts taking place in the world today are of a non-international character, there has also been a significant increase in the number of people in need of assistance in the aftermath of other emergencies besides conflicts and man-made and natural disasters.[1] A major issue in such settings has become the security of humanitarian staff, and the restrictions imposed on humanitarian assistance.[2]

The primary body of law regulating humanitarian assistance is international humanitarian law (IHL or 'Geneva Law'). Human rights law (HRL) forms an important additional framework, in particular during non-international armed conflicts, emergencies and disasters. When it comes to providing humanitarian assistance during such circumstances, economic, social and cultural rights (or so-called 'second generation rights') are of particular importance. As these rights grant individuals rights to basic socio-economic services (food, clothing, water, housing, and healthcare) they are strongly linked to the provision of humanitarian assistance.

This contribution focuses on the applicability of economic, social and cultural rights in settings where humanitarian assistance is provided. This analysis is conducted with particular reference to the internationally recognized human 'right to health', and in relation to this, to the delivery of health-related services and the creation of healthy conditions in situations where humanitarian assistance is provided. This contribution analyses how the right to health, in conjunction with other international standards, is applicable during armed conflicts and other emergencies, so as to create a solid foundation for the adequate provision of humanitarian assistance. It will be asserted that minimum rights to essential health services can be derived from the right to health, a position which is supported by IHL. There is furthermore an interlinked obligation to create healthy conditions, an obligation which is reinforced by other economic, social and cultural rights, including the right to an adequate standard of living, and the rights to food, clothing and housing. In addition, the notion of 'medical neutrality' which is also codified under IHL strengthens and defines the position of those providing care. A framework will be presented outlining obligations for all responsible authorities involved in the conflict,

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[1] Rebecca Barber, 'Facilitating Humanitarian Assistance in International Humanitarian and Human Rights Law' (2009) 91 International Review of the Red Cross [874] 371, 372.

[2] Barber (n 1) 373-381, referring to the conflicts in Darfur and Somalia.

emergency or disaster. This framework will be based on economic, social and cultural rights, with particular emphasis on the right to health. The ultimate aim is to protect and to strengthen the delivery mechanism of health-related services, as well as the position of humanitarian aid workers, as well as civilians receiving the aid.

A preliminary issue that needs to be raised is that the applicability of the right to health and of economic, social and cultural rights more generally during emergencies and armed conflicts is not self-evident. As the relevant treaties do not contain clear derogation clauses, the implications of economic, social and cultural rights are that emergency situations are surrounded with obscurity. To bring this back to the right to health, the question arises: to what extent does the right to health apply during emergencies? What happens to the notion of 'progressive realisation' during such situations? And is there perhaps a part or a so-called 'core' of the right to health that remains intact?

Another preliminary question that needs to be addressed is which actors are responsible for realizing the right to health in emergencies and conflicts. States on whose territory the disaster is taking place will carry the primary responsibility for securing access to the aid. Based on the right to health, these States need to ensure that health-related services are delivered safely and that healthy conditions are created for those receiving the aid. Arguably, however, the disaster involves the responsibility of a range of actors beyond the States, on whose territory the humanitarian disaster is taking place. Firstly, the international community and individual foreign donor States potentially have human rights responsibilities when it comes to receiving the aid. But in addition, there is a range of non-state actors involved in the disaster, varying from armed opposition groups, to civil society organisations who provide aid. Furthermore, implicated in the disaster are the humanitarian aid organizations and their employees, as the ones who are directly involved in providing the aid. In relation to all these actors, the question arises whether HRL has legally binding status beyond the national State, and whether it can bind all the parties in the conflict or emergency, including foreign donor States, armed opposition groups, civil society organisations, and humanitarian aid workers.

2. Applicable Legal and Ethical Framework

In this section, attention will be paid to the international framework relevant to the provision of humanitarian assistance. As will be clarified further below, this framework consists of a set of rules and principles that can be

derived from the intertwined fields of international humanitarian law (IHL), human rights law (HRL) and medical ethics. Of further importance are the International Health Regulations from the World Health Organization (WHO). While the 'right to health' is presented as the key provision in this area, it is argued that other norms and principles reinforce this right.

2.1. International Humanitarian Law

Firstly, IHL was developed to offer a minimum level of 'humanity' during armed conflict.[3] Likewise, HRL is intended to protect the 'human dignity' of individuals, in principle during both peacetime and armed conflicts. While there is considerable normative overlap between bodies of law, there are also substantial differences. Most importantly, while IHL binds all belligerent parties, including non-state armed groups, IHL primarily binds States, and not necessarily other actors in society, e.g. armed opposition groups.

IHL consists of the four Geneva Conventions and Additional Protocols I and II. For the applicability of this body of law a distinction must be made between international armed conflicts (IACs) and non-international armed conflicts (NIACs). The four Geneva Conventions (which have the status of customary international law) and Additional Protocol I apply predominantly during IACs. During IACS, the provision of humanitarian assistance is specifically regulated by Geneva Convention IV and Additional Protocol I.[4] Without discussing these provisions in detail, it can be concluded that during IACs, IHL provides a strong basis for the protection of humanitarian actors.[5] Furthermore, during NIACs, 'common Article 3' in the Geneva Conventions and Additional Protocol II apply.[6] In such situations, the relevant provisions are common Article 3 of the Geneva Conventions and Article 18 of Additional Protocol II.[7] According to Barber, based on Geneva law and subsequent customary norms there is an

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[3] For a worthwhile overview see ATHA (Advanced Training Programme on Humanitarian Action) available at <www.atha.se> accessed 3 April 2013.

[4] Geneva Convention IV Articles 11, 13, 23, and 30, and even more explicitly see Additional Protocol I, Article 70 (1). For a more elaborate discussion see Barber (n 1) 383.

[5] See also Barber (n 1) 384.

[6] See Geneva Convention IV relative to the Protection of Civilian Persons in Time of War, Geneva, 12 August 1949 and Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I); both applicable in international armed conflicts (IACs).

[7] See also Barber (n 1) 382.

obligation to consent to and to facilitate humanitarian assistance, both in IACs and in NIACs.[8]

Furthermore, IHL also regulates the safe delivery of medical services. It contains many norms regulating and protecting the position of medical staff and the safe and undisturbed delivery of medical services during armed conflicts.[9] The Geneva instruments also contain additional rules stipulating, *inter alia*, that transports of the wounded and sick have to be respected and protected; and that medical aircraft shall not be attacked.[10]Along similar lines, the Statute of the International Criminal Court considers it a war crime to intentionally direct attacks against medical units.[11] It is also worth mentioning that many domestic military manuals contain rules regulating the inviolability of medical personnel.[12] All in all, the protection of medical personnel during armed conflicts and other situations of emergency is firmly embedded in international and domestic law. As will be explained below, this notion, also addressed as the principle of 'medical neutrality' is also firmly established as a principle of medical ethics.

2.2. Human Rights Law

The obligation to provide and to consent to humanitarian assistance is reinforced by HRL, which provides for a similar set of rules. As the 'right to health' is identified as the core standard in our analysis, we will pay some attention to the nature of HRL more generally, and the right to health more specifically. Firstly, a distinction is made between several 'generations' or

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[8] Barber (n 1) 391. For a more restricted interpretation of the duty to consent see Sefanie Jansen -Wilhelm, 'A Duty to Accept Humanitarian Assistance under the ICESCR' in A. Zwitter, H.J. Heintze, Ch. Lamont & J. Herman (eds), *International Law and Politics of Humanitarian Action* (Cambridge University Press, forthcoming 2013).

[9] Geneva Convention I, Articles 24-26.Geneva Convention II, Article 36. Geneva Convention IV, Article 20. Additional Protocol I, Article 15. Additional Protocol II, Articles 9-11. See also Rule 25 of ICRC's customary rules, see *Customary International Law*, an updated version of the Study on customary international humanitarian law conducted by the International Committee of the Red Cross (ICRC) and originally published by Cambridge University Press, available at <http://www.icrc.org/customary-ihl/eng/docs, accessed 10 May 2013.

[10] *Inter alia*: Geneva Convention I, Articles 14-23; Geneva Convention II: Article 7 and 12-40; Geneva Convention III: Article 33; Geneva Convention IV: Article 13-26; Additional Protocol I: Articles 8-30.

[11] International Criminal Court (ICC), Rome Statute of the International Criminal Court, UN Doc. A/CONF.183/9 of 17 July 1998, Article 8(2) (b) (xxiv).

[12] In relation to Rule 25, aee also ICRC Commentary (n 9).

'categories' of rights: civil and political rights (first generation); economic, social and cultural rights (second generation), and collective or solidarity rights (third generation). Examples of civil and political rights are the rights to life and the prohibition of torture, and freedom rights such as freedom of expression and freedom of religion. Examples of economic, social and cultural rights are the rights to food, housing, and education, and examples of collective rights are rights to self-determination, peace and development.

There has been a gradual move towards the recognition of the equal importance and legal status of all these rights. At the World Conference on Human Rights in 1993, the 'Vienna Declaration and Programme of Action' was adopted, which stresses that all rights are 'interdependent, interrelated and of equal importance'.[13] Moreover, several of the more recent human rights treaties contain civil and political rights as well as economic, social and cultural rights.[14] But while all rights are now equal 'on paper', in practice the debate continues. And while an extensive body of case law has come to existence in relation to civil and political rights, courts are still very reluctant to adjudicate cases on the basis of economic, social and cultural rights. This refers to the question of the so-called 'justiciability' of economic, social and cultural rights and the question of whether these rights are enforceable before judicial and quasi-judicial bodies.[15]

Although there is still a lot to be gained in this field, the normative debate about economic, social and cultural rights has progressed steadily over the past decennia. Particular progress has been made with respect to the identification of the State obligations resulting from economic, social and cultural rights. This debate started in the 1980s, when Henry Shue identified three undertakings on the part of States resulting from all rights: duties to avoid depriving, duties to protect from deprivation, and duties to aid the deprived.[16] Along the same lines, the then Special Rapporteur on the Right

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[13] World Conference on Human Rights: Vienna Declaration and Programme of Action, UN doc. A/CONF.157/23, Part I, para 5.

[14] For example: Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), concluded 18 December 1979, entered into force 3 September 1981, 1249 UNTS 13 and the Convention on the Rights of the Child, concluded 20 November 1989, entered into force 2 September 1990. 28I.L.M. 1456 (1989). Regional human rights treaties, however, show the old divide: for example, the European Convention on Human Rights (ECHR, 1950, ETS No. 5) and the European Social Charter (ESC, 1961, ETS No. 35) of the Council of Europe.

[15] Fons Coomans (ed.), *Justiciability of Economic, Social and Cultural Rights* (Intersentia, 2006).

[16] Henry Shue, *Basic Rights, Subsistence, Affluence and U.S. Foreign Policy*, (Princeton University Press, 1980).

to Food, Asbjørn Eide, explained that economic, social and cultural rights imply three types of obligations on the part of States: 'negative' obligations to respect (refraining from infringing on the right), as well as 'positive obligations to protect (protecting individuals against the acts of third parties), and to fulfil (realising the right).[17] While this so-called tri-partite typology of State obligations is not set in stone and has also been criticised for not being sufficiently refined,[18] it remains a helpful tool for exploring and identifying the obligations resulting from economic, social and cultural rights, especially in fields where their applicability is still uncertain, e.g. in armed conflicts.[19] In the conclusions of this contribution, this typology will be applied to the right to health, so as to illustrate how the right to health translates into concrete (State) obligations in settings where humanitarian assistance is provided.

It would go beyond the scope of this paper to explain the normative content of all economic, social and cultural rights, and how they can apply with respect to humanitarian settings. It has therefore been decided to focus specifically on the right to health, as a key right in humanitarian settings.

'Health' is a crucial condition for leading a dignified life and as such a key element of the concept of 'human dignity': the core notion underlying HRL. As a result references to the protection of health are plentiful under HRL law and also under national constitutional law.[20] While HRL recognises a 'right to health', many national constitutions contain a similar right or a reference to the duty of governments to enhance and promote the health of their population. We also find numerous references to health in other

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[17] Asbjørn Eide in his position as the UN Special Rapporteur on the Right to Food, UN Doc. E/CN.4/Sub.2/1987, paras 66-69.

[18] Ida Elizabeth Koch, *Human Rights as Indivisible Rights*, (Martinus Nijhoff Publishers, 2009) 17-21.

[19] Brigit Toebes, 'The use of depleted uranium as a potential violation of human rights', in Avril McDonald, Jann Kleffner and Brigit Toebes (eds) *International Law and the Use of Depleted Uranium Weapons* (T.M.C. Asser Press, 2008) 187-216.

[20] In addition to Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the right to health is recognized by provisions in a number of other international human rights instruments, including Article 25 of the Universal Declaration on Human Rights (UDHR); Article 5(e) of the International Convention of All Forms of Racial Discrimination (CERD); Articles 11.1 and 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) and Article 24 of the Convention on the Rights of the child (CRC). At the regional level we come across the right to health in Article 11 of the (revised) European Social Charter (ESC), in Article 16 of the African Charter of Human and Peoples' Rights and in Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights. Furthermore, over 100 national constitutional provisions include a right to health.

international treaties, for example in the conventions of the ILO. Altogether, a right to health can be derived fromHRL, international law more generally, and national (constitutional) law.

Over the course of the past twenty years, attempts have been made to clarify the meaning and implications of this human right.[21] An important milestone was the adoption of a 'General Comment' on the right to health under Article 12 ICESCR (2000): the most important international provision that stipulates a right to health.[22] Although strictly speaking not legally binding, this document is the most authoritative document on the right to health. This document explains that the right to health is not a right to be healthy, but rather a broad human right extending not only to access to health care services but also to the underlying determinants of health, including as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information.[23] As such the right to health has two dimensions: a right to health care services and a right to a broad set of underlying conditions for health.

A further important component of the General Comment concerns the identification of a set of principles that apply with respect to all health-related services: availability, accessibility, acceptability and quality of health facilities (the so-called 'AAAQ').[24] Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility.[25] The other UN General Comments on the substantive rights in the ICESCR contain similar principles,[26] and also in a domestic health law context references are made to such principles.[27] Furthermore, General Comment 14 defines a set of State obligations to 'respect, protect and fulfil' human rights and also describes potential violations of States in relation to a right to health.[28]

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[21] See, *inter alia*, Brigit Toebes, *The Right to Health as a Human Right in International Law* (Intersentia-Hart, 1999) and more recently Maite San Giorgi, *The Human Right to Equal Access to Health Care* (Intersentia, 2012).

[22] Committee on Economic, Social and Cultural Rights, *The right to the highest attainable standard of health*, UN General Comment No. 14 (2000), UN Doc. E/C12/200/4, 11 August 2000.

[23] General Comment 14 (n 22), paragraphs 8 and 11.

[24] General Comment 14 (n 22), para. 12.

[25] General Comment 14 (n 22), para. 12.

[26] See in particular the UN General Comments on the rights to water, education, food and housing, CESCR (1997-2002). Available at <http://www2.ohchr.org/english/bodies/cescr/comments.htm> accessed 29 May 2013.

[27] Brigit Toebes and Maite San Giorgi, (n 21).

[28] General; Comment 14, paragraphs 33-37.

This identification of State obligations is an important framework for defining specific State obligations in relation to the provision of humanitarian aid (see below). As pointed out by the former Special Rapporteur on the Right to Health, Paul Hunt, the 'AAAQ' is especially relevant to *policy* analysis, while the identification of obligations further on in this paper (obligations to 'respect, protect and fulfil') is more suited to *legal* analysis.[29]

2.3. International Health Regulations

Of further importance for the clarification of the specific health-related obligations are the (revised or 'New') International Health Regulations (IHR), which were adopted by the WHO in 2005.[30] These binding regulations were adopted in response to an 'exponential increase in international travel and trade, and emergence and reemergence of international disease threats and other health risks'.[31] Their aim is to 'prevent, protect against, control and provide a public health response to public health risks, and which avoid unnecessary interference with international traffic and trade' (Article 2). Without discussing the Regulations in detail, it is worth observing that there are many cross-connections between this document and other frameworks presented in this section. To start with, Article 3(1) of the Regulations states that their implementation 'shall be with full respect for the dignity, human rights and fundamental freedoms of persons', thereby underscoring the importance of human rights protection during public health emergencies.

The question arises how relevant these regulations are in the context of situations where humanitarian assistance is provided? The scope of the New Regulations is broader than the old Regulations, which focused exclusively on a limited set of diseases. The New Regulations focus generally on 'public health risks', which are defined as a 'likelihood of an event that may affect adversely the health of human populations, with an emphasis on one which may spread internationally or may present a serious or direct

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[29] Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health, Paul Hunt, Mission to the World Trade Organization, UN Doc. E/CN.4/2004/49/Add.1,1 March 2004, para. 39.

[30] World Health Organization, Fifty-Eight World Health Assembly, Revision of the International Health Regulations, W.H.A. Doc. 58.3 (May 23, 2005). Entry into force: 15 June 2007. Available at <http://www.who.int/ihr/9789241596664/en/index.html> accessed 29 May 2013.

[31] World Health Organization, <http://www.who.int/ihr/9789241596664/en/index.html> accessed 29 May 2013.

danger' (Article 1). However, while this definition suggests that the IHR focus on public health risks generally, the aggregate of the provisions in the new IHR still very much focus on preventing the spread of a (wide range of) diseases. So it seems that the Regulations are of particular relevance if during humanitarian emergencies, there is a risk of the spread of (any) disease. Examples include combating the spread of diseases caused by bodies lying in the water (as in Myanmar), or through disposal of human waste, (as was the cause of the cholera outbreak in Haiti). On a smaller scale, health concerns may arise, for example, due to a lack of certain food types, for example the availability of rice and flour.[32]

Furthermore the question arises who is responsible for the protection against public health risks, based on the IHR? It is interesting to note that the Regulations stipulate that it should be a joint effort, consisting of the State as the primary duty holder and other actors offering support. Based on the Regulations, States are under an obligation to maintain core surveillance and response capacities (Articles 5(1) and 13(1)), while WHO shall assist States in this task (Articles 5(3) and 13(3)). When requested by WHO, other States Parties should provide, to the extent possible, support to WHO-coordinated response activities (Article 13(5)). As we will argue below, the 'integrated norm' to offer health protection in humanitarian settings is based on a similar multi-stakeholder approach, with the State, where the emergency is taking place, as the primary duty holder.

2.4. Principles of medical ethics

A last interlinked framework concerns the principles of medical ethics, as a system of moral principles that applies to the practice of medicine.[33] An important principle for the purposes of this paper is the principle of 'medical neutrality', which is also embedded in IHL.[34] According to the British

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[32] For concrete examples and indicators see The Sphere Project, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, 2011 ed.

[33] Important principles are, for example, the principles of autonomy, informed consent and confidentiality. For an authoritative code, see the International Code of Medical Ethics, adopted by the World Medical Association in 1949 and last amended in 2006, available at <http://www.wma.net/en/30publications/10policies/c8/index.html> accessed 29 May 2013.

[34] *Inter alia* Articles 14-23 Geneva Convention I; Article 7 and 12-40 Geneva Convention II; Article 33 Geneva Convention III; Article 13-26 Geneva Convention IV; Articles 8-30 Additional Protocol I (mostly focusing on the protection of medical personnel rather than on setting professional standards for medical personnel). For a definition see Physicians for Human Rights (US), available at <http://physiciansforhumanrights.org/issues/persecution-of-health-workers/medical-neutrality/> accessed 29 May 2013.

Medical Association (BMA), medical neutrality embraces two issues: while healthcare providers themselves should practice medicine impartially without regard to factors such as the nationality, class, sex, religion or political beliefs of the patient, healthcare providers providing care impartially must not be attacked or be persecuted for doing so.[35] This shows that medical neutrality has two dimensions: on the one hand, the doctor's duty to perform his work impartially and on the other hand, the State's duty to ensure that this impartiality is not being infringed upon.

The principle of medical neutrality is important in settings where humanitarian assistance is provided. Medical aid workers should provide medical aid impartially, without taking into account the background of the patient. On the one hand, providers of medical aid must be able to provide medical services in an undisturbed fashion, without being attacked or persecuted. This principle is very much intertwined with the right to health. General Comment 14 on the Right to Health states that all health-related services must be 'acceptable': meaning being respectful of medical ethics and being culturally appropriate. They should also be provided based on the principle of non-discrimination.[36] It can be argued that when assistance meets these conditions, there is less ground to refuse it.

3. Questions of Applicability

Below, a link will be explained, between economic, social and cultural rights and the provision of humanitarian assistance during armed conflicts and other emergencies, with particular emphasis on the right to health. When it comes to the applicability of these rights during such situations, a few complications arise. Firstly, the question arises whether economic, social and cultural rights apply during armed conflicts and other emergencies, or whether they can be derogated from. Furthermore, as conflicts and emergencies may involve several non-state actors, varying from armed opposition groups to civil society organisation, the question arises whether the right to health can also bind these non-state actors.

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[35] British Medical Association, *The Medical Profession and Human Rights, Handbook for a changing agenda* (Zed Books, 2001) 241.

[36] General Comment 14, paragraph 12.

3.1. (Non-) Derogability of Economic, Social and Cultural Rights: In Search of Core Obligations

Unlike the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) does not single out a set of non-derogable rights, i.e. rights which cannot be derogated from during armed conflicts and other situations of emergency.[37] Rather, the ICESCR contains two limitation clauses, neither of which specifically mentions war or any other type of emergency. While Article 2(1) ICESCR sets out a clause based on limitations of available resources, Article 4 ICESCR contains a general clause, which allows for limitations if 'determined by law, compatible with the nature of rights, and solely for the purpose of protecting the general welfare in a democratic society'. As mentioned, notions of emergency and armed conflict do not appear in these clauses, and as such it is unclear if and to what extent these limitation clauses apply during emergencies.

Article 2(1) ICESCR is a key provision of the Covenant and of particular importance for understanding its scope and impact. It stipulates that States should take steps 'to the maximum of their available resources', so as to 'realize progressively' the rights in the Covenant.[38] The implications of these statements have been set out further by the treaty-monitoring body of the ICESCR and the Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment 3.[39] The Committee states that despite the notion of 'progressive realization', this provision also imposes 'various obligations which are of immediate effect'.[40] One of these obligations of immediate effect is the duty 'to take steps'; and such steps should be 'deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant.'[41] Despite this clarification, this

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[37] ICCPR and ICESCR both adopted within the framework of the UN on 16 December 1966 (entry into force 1976). Derogation clause in the ICCPR: article 4-2 ICCPR.

[38] For an elaborate discussion of this provision see also Stefanie Jansen-Wilhelm, 'A Duty to Accept Humanitarian Assistance under the ICESCR' in A. Zwitter, H.J. Heintze, Ch. Lamont & J. Herman (eds), *International Law and Politics of Humanitarian Action* (Cambridge University Press, forthcoming 2013).

[39] Committee on Economic, Social and Cultural Rights (1990) The nature of States Parties Obligations, 14 January 1990, General Comment 3. UN Doc. E/1991/23, Article 2, para 1. http://www.unhchr.ch/tbs/doc.nsf/0/94bdbaf59b43a424c12563ed0052b664?Open document> accessed 29May 2013.

[40] General Comment 3, para 1.

[41] General Comment 3, para 2. For an elaborate analysis see also Stefanie Jansen-Wilhelm (n 37).

provision remains surrounded with a lot of ambiguity, and it is difficult to identify what it could mean with respect to settings where humanitarian assistance is provided.[42] Similar confusion exists with respect to the notion of 'progressive realization' in Article 2(1) ICESCR. Nonetheless, in General Comment 3, the Committee makes an interesting statement, namely that a denial of essential core services to individuals would deprive the Covenant of its *raison d'être*:

> (…) the Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, *prima facie*, failing to discharge its obligations under the Covenant.[43]

This suggests that despite the possibility of 'progressive realization', there is a minimum level of protection inherent in economic, social and cultural rights that should remain intact under all circumstances, including during humanitarian emergencies.[44] The subsequent General Comments on the substantive rights of the Covenant spell out specific core obligations for each specific right.[45]

Given the focus on health in this paper, it is worth looking at the definition of core obligations in General Comment 14 on the Right to Health. General Comment 14 asserts that 'primary healthcare', as given shape in the Alma-Ata Declaration (1978),[46] should be read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development.[47] Read in

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[42] See also Jansen-Wilhelm (n 8).

[43] General Comment 3, paragraph 10.

[44] CESCR, General Comments 3 and 14, paras 10 and 43-44 respectively. The 'Limburg Principles' claim in paragraph 4 that limitations on rights should not affect the 'subsistence or survival' of the individual or integrity of the person (paragraph 47). See also Toebes (n 19) 209-210.

[45] General Comment 14, paras 43 and 44 and more generally General Comment 3, para 10.

[46] World Health Organization, *Primary Health Care, Report of the International Conference on Primary Health Care*, Alma-Ata, USSR, 6-12 September 1978, *'Health for All' Series No. 1*, Geneva/New York: WHO, 1978.

[47] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex, chaps. VII and VIII.

conjunction with each other, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(e) To ensure equitable distribution of all health facilities, goods and services;
(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.[48]

Subsequently, the Committee confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
(b) To provide immunization against the major infectious diseases occurring in the community;
(c) To take measures to prevent, treat and control epidemic and endemic diseases;
(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
(e) To provide appropriate training for health personnel, including education on health and human rights.[49]

This list provides a very comprehensive set of duties for States parties and other actors in light of the right to health. It also illustrates that a minimum right to health is not only about providing access to health care

[48] General Comment 14, para 43.
[49] General Comment 14, para 44.

services, but also about securing a number of underlying determinants of health (e.g. access to clean water and shelter).[50]

Altogether, based on these notions, we may conclude that during all types of armed conflicts and other emergencies, State parties have a duty to secure access to, *inter alia*, minimum health services and basic healthy conditions, at the very least on a State's own territory and extending to where it exercises its jurisdiction. This leads to the important conclusion that during armed conflicts and emergencies of all natures the affected individuals have a minimum right to a limited set of health-related services, based on the internationally guaranteed 'right to health', supported by IHL.[51] In section 4, we will identify more precisely what this means for the provision of humanitarian assistance. However, we first need to identify which actors carry responsibility for realizing the right to such minimum health-related services.

3.2. Responsible Actors under Economic, Social and Cultural Rights

As mentioned, the question arises of who are bound by the human rights? Is it the State parties on whose territory the emergency situation is taking place; but potentially also the international community and foreign donor States, as well as armed opposition groups involved in the conflict, or even civil society organisations and humanitarian aid workers? As will be discussed further below, arguably the international community has a shared responsibility to provide international assistance. Furthermore, whether non-state actors are bound by HRL is a matter that has been the subject of intense debate. The Universal Declaration of Human Rights (UDHR), by referring to the human rights responsibilities of 'all actors in society', provides a basis for underlining the human rights responsibilities of non-state actors. An important starting point is nonetheless that HRL primarily binds ratifying States who have to realize the rights of everyone residing on their territory. As such, any form of third-party applicability should never undermine the primary responsibility of States as the entities that have ratified the human rights treaties.

Firstly, we must briefly assess the question whether foreign donor states have legal duties to provide or to facilitate humanitarian assistance. Based on Article 2(1) ICESCR, there is an obligation on the part of States Parties to realize the rights 'through international assistance and co-operation'. This

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[50] See also General Comment 14, para 11.

[51] See also Toebes (n 19) 209-214.

wording suggests that Member States may have certain duties with respect to the provision of humanitarian assistance in other States where emergencies are taking place.[52] This would imply that States have to realize the rights of the Covenant, to some extent, extraterritorially or internationally, or outside their national borders. While the Covenant does not contain a provision on the territorial effect of its provisions, it has been suggested on several occasions that the Covenant has a certain extraterritorial (or international) scope.[53] The Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights seek to define the duty to provide international assistance. According to guideline 33, States that are in a capacity to do so, must provide international assistance to contribute to the fulfilment of economic, social and cultural rights.[54] This document provides an important starting point for the further definition of such international duties to assist. Furthermore, with respect to the right to health more specifically, General Comment 14, with respect to the definition of core obligations (for its definition see above), asserts that:

> For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide "international assistance and cooperation, especially economic and technical" which enable developing countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

While the binding effect and precise implications of these statements are still very much open for debate, these assertions provide important starting points for the further definition of the State's 'duty to assist'.

Furthermore, we must look into the human rights responsibilities of several non-state actors. Firstly when it comes to armed conflicts, armed opposition groups may become an important and powerful force. Their activities can have a devastating impact on the lives and health of persons engaged in and affected by the conflict. Once they occupy a part of a

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[52] See also for example Article 11(2) ICESCR, which mentions an international obligation with respect to the right to food.

[53] Fons Coomans, 'Application of the International Covenant on Economic, Social and Cultural Rights in the Framework of International Organisations' in A. van Bogdandy and R. Wolfrum (eds.), *Max Planck Yearbook of United Nations Law*, Volume 11, 2007, 359-390, at p. 362. See also Lawrence O. Gostin, 'The Duty of States to Assist Other States in Need: Ethics, Human Rights, and International law', (2007) 35 Journal of Law, Medicine & Ethics, 526, 526-533.

[54] Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights, adopted 28 September 2011, available at <http://oppenheimer.mcgill.ca/IMG/pdf/Maastricht_20ETO_20Principles_20-_20FINAL.pdf> accessed 29 May 2013.

territory, and exercise some form of self-government, there are reasons to assert that they have acquired a certain responsibility for the realization of economic, social and cultural rights. According to Bellal *et al.* an important factor for them to be bound by HRL will be, whether they exercise an element of governmental functions and whether they have *de facto* authority over a population.[55]

Lastly, the question arises whether civil society organizations and individual humanitarian aid workers also carry duties underHRL. As employees of independent aid organizations they cannot be characterized as State agents, and as such they do not carry direct responsibilities underHRL.[56] For sure, it could be argued that they have a *moral* responsibility to respect human rights, and doctors among them are morally bound by the relevant principles of medical ethics.

4. Conclusions: Towards a Multi-stakeholder Approach for Providing Health Services during Emergencies

Based on the above, the question arises: what are the exact implications of our 'integrated norm' in situations where humanitarian assistance is provided? Firstly, we may conclude that States have legal duties to 'respect, to protect and fulfil' with respect to the delivery of essential health-related services in humanitarian emergencies. This may translate into the following obligations:

State duties to respect:

- accepting essential health-related services provided by foreign donor organizations, the international community, and assisting States (duty to consent);
- respecting equal access to available health-related services to all population groups (non-discrimination and medical neutrality);

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[55] A. Bellal, G. Giacca and C-M Stuart, 'International law and armed non-state actors in Afghanistan', (2001) 93 International Review of the Red Cross [881] 1-3, 23.

[56] In another publication I have argued that military medical personnel, as State agents, carry direct responsibilities under human rights law. See Brigit Toebes, 'Doctors in arms: exploring the legal and ethical position of military medical personnel in armed conflicts', forthcoming in Marielle Matthee, Marcel Brus and Brigit Toebes, *Essays in the honour of the late Avril McDonald*, (TMC Asser Press, forthcoming in 2013).

- not obstructing humanitarian aid organizations and their workers in the exercise of their tasks, either wilfully or through negligence (medical neutrality).

State duties to protect:

- offering protection to civilians so as to secure their health (eg. against attacks by armed opposition groups);
- offering protection to humanitarian aid workers, so as to ensure that they can carry out their tasks safely and adequately (medical neutrality).

State duties to fulfil:

- adopting and implementing a plan of action, addressing the health emergency;
- based on the definition of the 'minimum core' and in compliance with the criteria of the 'AAAQ', providing the following essential health-related services:
  - minimum essential food;
  - basic shelter, housing and sanitation;
  - adequate supply of safe and potable water;
  - essential drugs;
  - reproductive, maternal (pre-natal as well as post-natal) and child health care;
  - immunization against the major infectious diseases occurring in the community;
  - measures to prevent, treat and control epidemic and endemic diseases;
  - education and access to information concerning the main health problems in the community;
  - appropriate training for health personnel, including education on health and human rights.[57]

Such obligations may potentially also fall upon armed opposition groups, once they exercise a certain amount of governmental functions and *de facto* authority over a population.

In connection with these wider State obligations, international governmental donor organisations and foreign donor States potentially have more limited duties to provide economic, technical and other assistance so as to enable developing countries to ensure the above-mentioned core

[57] General Comment 14, para 44.

obligations. While the precise content and scope of these international obligations are still rather unclear, there is a firm basis in international law for asserting that the international community has a shared responsibility for realising the core obligations under the right to health.

Furthermore, we may assume that non-governmental humanitarian aid organizations and their employees have a shared moral responsibility to ensure the safe delivery of essential health services. They also have to respect the ethical codes to which they have committed themselves throughout their training and operation. The principle of 'medical neutrality' implies that medical aid is to be provided to everyone, irrespective of nationality and civil status.