THE RIGHT TO HEALTH AND INTERNATIONAL HUMANITARIAN LAW: PARALLEL APPLICATION FOR BUILDING PEACEFUL SOCIETIES AND THE PREVENTION OF ARMED CONFLICT

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INTRODUCTION: PEACE AND HEALTH

Peace and health are mutually reinforcing. They overlap greatly within the wider circle of human well being.[1] The preamble of the World Health Organisation's (WHO) Constitution sets this out very clearly: "[t]he health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States."[2]

For the purpose of this, peace means at the least that two or more entities do no harm to each other and solve their conflicts by non-violent means (negative peace); at the most, it means that two or more entities are in a "harmonious relationship of mutual benefit and cooperation"[3] (positive peace). Entities include, but are not limited to, states, groups, and individuals.

A 2006 review of case studies from countries emerging from conflicts, including Afghanistan, Haiti, Iraq, Kosovo, and Somalia, as well as Germany and Japan after the Second World War, concludes that providing health care has assisted in maintaining peace in these countries.[4] Initiatives like Peace through Health[5] and other studies highlight how qualities connected to the equal provision and promotion

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1 Graeme MacQueen, *Setting the Role of the Health Sector in Context: Multi-track Peacework*, *in* PEACE THROUGH HEALTH – HOW HEALTH PROFESSIONALS CAN WORK FOR A LESS VIOLENT WORLD 21, 24 (Neil Arya & Joanna Santa Barbara, eds., 2008).

2 World Health Organization Constitution, July 22, 1946, 14 U.N.T.S. 185, at 186 [hereinafter WHO], *see also* WHO, *The Ottawa Charter for Health Promotion*, HEALTH PROMOTION (Nov. 21, 1986), *available at* http://www.who.int/healthpromotion/conferences/previous/ottawa/en/ (identifying peace as one prerequisite of health).

3 The paper adopts this definition of peace, suggested by Arya & Santa Barbara in their edited volume. *See* Joanna Santa Barbara & Neil Arya, *Introduction*, *in* PEACE THROUGH HEALTH – HOW HEALTH PROFESSIONALS CAN WORK FOR A LESS VIOLENT WORLD 3, 7 (Neil Arya & Joanna Santa Barbara, eds., 2008); Johan Galtung established the categories negative and positive peace. Galtung refers to negative peace as "the absence of violence, absence of war," and positive peace as "the integration of human society," allegedly incorporating social justice, respect for human rights, and the elimination of *structural violence*, which causes poverty, inequality, and exclusion through inequitable distribution of resources. *See* Johan Galtung, *An Editorial*, 1 J. PEACE RES. 1, 2 (1964); Johan Galtung, *Theories of Peace - A Synthetic Approach to Peace Thinking*, *available at* http://www.transcend.org/files/Galtung_Book_unpub_Theories_of_Peace_-_A_Synthetic_Approach_to_Peace_Thinking_1967.pdf (last visited Oct. 7, 2014).

4 SETH JONES ET. AL, SECURING HEALTH: LESSONS FROM NATION-BUILDING MISSIONS 275 (2006).

5 The Peace through Health initiative is driven by the Department of Peace Studies, McMaster University, Canada. *See generally* McMaster University, *About Peace Through Health*, CENTRE FOR PEACE STUDIES, *available at* http://www.humanities.mcmaster.ca/peace-health/about.html (last visited Oct. 7, 2014).

of health care can contribute to the prevention of armed conflict and other forms of violence, mitigate the public health burden of armed conflicts, and promote post-conflict reconstruction and peace-building.[6] The act of caring for each other, also expressed in the value of altruism that guides health professionals' work and the general quality of health as a 'super-ordinate' value, can bring people together who are divided on other issues.[7] If effective and adequate health services are accessible to everyone, people have one less source of stress in their lives which will give them an essential form of security, and they are strengthened in their sense of belonging to a community or state that has provided for them.[8] Societies where this security and sense of belonging is absent might more easily resort to violence.[9] Other studies mention further factors that add to the contribution that improved health services can make to create more peaceful societies. Among them are the positive effects that health services can have on developing human capital, on generating fiscal reform, on promoting citizens' oversight of health programmes, and on creating monitoring mechanisms.[10]

United Nations (UN) human rights treaty bodies have also pronounced their view that the protection of human rights, among them economic, social and cultural rights (ESC rights), and the right to health, contribute to securing peace. For example, the UN Committee on Economic, Social and Cultural Rights (CESCR or the Committee), in its *Concluding Observations on Israel*, expressed its "firm conviction that the implementation of the International Covenant on Economic, Social

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[6] For a good overview of recent studies, *see* Rohini Jonnalagadda Haar & Leonard Rubenstein, U.S. INST. PEACE, SPECIAL REPORT NO. 301, HEALTH IN POSTCONFLICT AND FRAGILE STATES 4 (2012), *available at* http://www.usip.org/publications/health-in-post-conflict-and-fragile-states; Margaret Kruk, Lynn Freedman, Grace Anglin & Ronald Waldman, *Rebuilding Health Systems to Improve Health and Promote Statebuilding in Postconflict Countries: A Theoretical Framework and Research Agenda*, 70 SOC. SCI. & MED. 89, 90–94 (2010).

[7] MacQueen, *supra* note 1, at 23; Kruk et. al, *supra* note 6, at 91; Susanna Sirkin et. al, *The Roles of Health Professionals in Postconflict Situations, in* WAR AND PUBLIC HEALTH 409 (Barry Levy & Victor Sidel, eds., 2008).

[8] Haar & Rubenstein, *supra* note 6, at 6 (referring to an increased legitimacy of states that are able to provide basic health services without discrimination to the population. This can increase stability and therefore the chances for lasting peace); *See also* Kruk et. al, *supra* note 6, at 92.

[9] Joanna Santa Barbara & Graeme MacQueen, *Peace Through Health: Key Concepts*, 364 THE LANCET 384, 385 (2004); Caecilie Böck Buhmann, *The Role of Health Professionals in Preventing and Mediating Conflict*, MED., CONFLICT & SURVIVAL, Oct.-Dec. 2005, at 299, 306.

[10] Kruk et. al, *supra* note 6, at 94; Nigel Pearson, *The Role of the Health Sector in Wider State-Building*, SAVE THE CHILDREN UK 24 (2010), http://www.savethechildren.org.uk/sites/default/files/docs/The_Role_of_the_Health_Sector_low_res_(2)_1.pdf.

and Cultural Rights [ICESCR[11]] can play a vital role in procuring a lasting peace in Israel and Palestine,"[12] a conviction shared also by the UN Committee on the Rights of the Child.[13]

Conversely, the absence of peace (i.e., war/armed conflict and other forms of violence) has a tragic impact on public health. This can rightly be assumed despite the fact that more recent evaluations call for developing more sophisticated methods of determining the relationship between armed conflict and health in order to establish the more exact public health impact of armed conflicts.[14] There is no question that armed conflicts cause death and disability; destroy families, communities and the environment; divert scarce resources from the promotion and protection of health to military spending; cause the exodus of qualified health personnel; and disrupt or destroy important health infrastructure.[15] States characterised as fragile or conflict-affected tend to have far worse population health indicators than states at comparable levels of development.[16] In other words, armed conflicts can be defined as public health disasters, or the "anathema to public health."[17]

These observations can prompt us to ask the following questions: To what extent does *international law*, in particular international human rights law (IHRL) and international humanitarian law (IHL), applicable in peacetime, in times of armed conflicts, and in post-conflict situations, recognise this relationship between peace and health? And to what extent

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[11] *See generally* International Covenant on Economic, Social and Cultural Rights, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force January 3, 1976) [hereinafter ICESCR].

[12] Comm. on Econ., Soc. & Cultural Rights [CESCR], Concluding Observations: Israel, ¶ 15, U.N. Doc. E/C.12/1/Add.69 (Aug. 31, 2001); *see also* other statements of the CESCR pointing into this direction *infra* notes 194–200.

[13] Comm. on the Rights of the Child [CRC], Concluding Observations: Israel, ¶ 5, U.N. Doc. CRC/C/15/Add.195, (Oct. 9, 2002).

[14] Haar & Rubenstein, *supra* note 6, at 6; Böck Buhmann, *supra* note 9, at 309.

[15] Barry Levy & Victor Sidel, *War and Public Health: An Overview*, *in* WAR AND PUBLIC HEALTH 3 (Barry Levy & Victor Sidel, eds., 2008); Haar & Rubenstein, *supra* note 6, at 2–4. For case studies concerning different conflict-affected countries, *see e.g.,* Int'l Rescue Comm., *Mortality in the Democratic Republic of the Congo 2000-2007*, CONGO CRISIS, http://www.rescue.org/special-reports/congo-forgotten-crisis (last visited Oct. 15, 2014); Debarati Guha-Sapir & Olivia D'Aoust, *Demographic and Health Consequences of Civil Conflict*, WORLD BANK (Oct. 2010), *available at* http://web.worldbank.org/archive/website01306/web/pdf/wdr_background_paper_sapir_d'aoust4dbd.pdf?keepThis=true&TB_iframe=true&height=600&width=800.

[16] Haar & Rubenstein, *supra* note 6, at 2.

[17] Levy & Sidel, *supra* note 15, at 3.

does it oblige states and other actors[18] to respect and promote this mutually beneficial relationship? More concretely: first, what are the obligations, in particular, under the right to health and IHL that have to be implemented in peacetime that could help prevent armed conflicts? Second, what are the obligations under IHL and the right to health that mitigate the health consequences of armed conflicts? And third, what are the obligations under the right to health and IHL, applicable even after active hostilities have ended, that could contribute to building lasting peace through securing good quality health care for all in post-conflict countries?

This article primarily addresses some aspects of the *first* of these questions, without, however, ignoring the second and third questions entirely. It thereby recognizes that in many contemporary armed conflicts, it is impossible to clearly distinguish between a pre-conflict, conflict, and post-conflict phase; and that the implementation of pre-conflict obligations will arguably contribute both to limiting the public health consequences of armed conflicts once a conflict occurs, and to re-establishing peace once an armed conflict is over. The current author's earlier research has engaged with many aspects concerning the second question, (i.e., the legal consequences of the parallel application of IHL and ESC rights, in particular the right to health, *during* armed conflicts).[19] Based inter alia on the findings of this research, the analysis in this article will show that taking the parallel application of IHL and the right to health seriously, even in peacetime, could arguably contribute to building more peaceful societies and to the prevention of armed conflicts (i.e., to securing both aspects of positive[20] and negative[21] peace).[22] Looking at peacetime obligations under both the right to health

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[18] Among the other actors are, for example, non-state armed groups, humanitarian organisations, and third states.

[19] AMREI MÜLLER, THE RELATIONSHIP BETWEEN ECONOMIC, SOCIAL AND CULTURAL RIGHTS AND INTERNATIONAL HUMANITARIAN LAW - AN ANALYSIS OF HEALTH-RELATED ISSUES IN NON-INTERNATIONAL ARMED CONFLICTS 284–88 (2013).

[20] For examples, *see infra* Part IIA.

[21] For examples, *see infra* Part.IIB.

[22] One of the findings of the author's earlier research on the legal consequences of accepting the parallel application of IHL and the right to health in times of armed conflict is that this will bring a longer-term perspective into the applicable law. For example, taking obligations under the right to health into account when making military target decisions will arguably result in an obligation to minimize not only the immediate public health effects of an attack, but also the longer-term effects. Another finding was that the right to health perspective will complement states' positive obligations to mitigate, not only direct health consequences of armed conflict by complying with IHL obligations to provide (emergency) care to the wounded and sick, but to also address the

and IHL will also further contribute that both bodies of law "make better use of . . . [their] points of convergence" to "reinforce the rule of law and hence ensure that no one is deprived of protection" at any time.[23] The necessity for this has been emphasised by the President of the International Committee on the Red Cross (ICRC) in his first ever speech before the UN Human Rights Council (HRC) in February 2013, signalling the new openness and readiness of the ICRC to support the HRC's measures designed to *prevent* serious violations of IHL and IHRL.[24]

The third question mentioned above—about the extent to which the diligent application of IHL and the right to health in post-conflict situations can enhance the chances for a successful transition from conflict to lasting peace—has to be left for future research. Furthermore, the paper concentrates on *states'* obligations under IHL and the right to health on their *own territory* that can contribute to the prevention of conflict.[25] It will thus exclude a thorough discussion of third states' and international organisations' possible obligations to assist (other) states in the implementation of these obligations. Concerning the right to health, the legal instrument relied on in this contribution is primarily article 12 of the ICESCR, its interpretation in the various documents issued by the CESCR,[26] as well as reports by the UN Special Rapporteur on the Right

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indirect health consequences of armed conflicts, including the spreading of epidemic and endemic diseases, rising child and maternal mortality and morbidity, as well as interrupted access to essential drugs, adequate food, and drinking water. If implemented, these obligations can be conducive to a swift re-building of a country after conflict, and thereby to swifter re-establishment of peace. *See* MÜLLER, *supra* note 19, at 281–83.

[23] Statement by Peter Maurer, President of the ICRC, ICRC and Human Rights Council: Complementary Activities, Respect for Differences (Feb. 26, 2013), *available at* http://www.icrc.org/eng/resources/documents/statement/2013/ihl-human-rights-council.htm.

[24] *Id.*

[25] The focus on an analysis of obligations that contribute to the prevention of armed conflicts makes it less necessary to discuss the obligations of non-state armed groups. There is an assumption that no such groups exist in times of peace.

[26] *See* CESCR, General Comment 14: The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, General Comment 14]; CESCR, General Comment 3: The Nature of States Parties' Obligations, U.N. Doc. E/1991/23 (Dec. 14, 1991) [hereinafter CESCR, General Comment 3]; *see also* United Nations Human Rights, *General Comments of the CESCR, available at* http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11 (last visited Oct. 16, 2014) (for General Comments of the CESCR on other Articles of the ICESCR that can also be relevant for understanding the scope of state obligations flowing from Art.12 ICESCR). The CESCR's interpretation of Art.12 ICESCR can in addition be distilled from the Committee's concluding observations on reports of the state parties to the Covenant. *See* U.N., *CESCR Concluding Observations*, OHCHR, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&

to the Highest Attainable Standard of Physical and Mental Health (UN Special Rapporteur on the Right to Health).[27]

The article adopts the following structure. First, to set the scene for the legal analysis, it will engage with the question about the scope of application of the right to health and, in particular, IHL, in times of peace. Second, two areas are explored where obligations under the right to health and relevant health-related obligations flowing from IHL can contribute to prevent international and non-international armed conflicts from occurring, and thereby to secure peace. The first area is an analysis of how IHL peacetime obligations can complement state obligations under the right to health to build an effective, integrated health system that provides quality health services to everyone without discrimination. The second area explored is how, in situations where an armed conflict is imminent, state obligations under the right to health can encourage states to seek a peaceful solution. Lastly, the main findings are summed up and evaluated in the concluding remarks, and suggestions for future research are made.

I. THE SCOPE OF APPLICATION OF THE RIGHT TO HEALTH AND IHL IN TIMES OF PEACE

A. THE SCOPE OF APPLICATION OF THE RIGHT TO HEALTH

Once a state has ratified an international human rights treaty containing the "right to the enjoyment of the highest attainable standard of physical and mental health" (the right to health)[28] and this treaty has entered into force, the respective state is bound by it.[29] The applicability

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DocTypeID=5 (last visited Oct. 15, 2014) (most CESCR Concluding Observations contain a reference to Art. 12).

[27] *Special Rapporteur on the Right to Health Annual reports,* UNHCR, *available at* http://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx (last visited Oct. 15, 2014). In the analysis, particular weight will be placed on the Special Rapporteur's 2008 report on the right to health and health systems. *See* Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Human Rights Council, U.N. Doc. A/HRC/7/11 (Jan. 31, 2008).

[28] ICESCR, *supra* note 11, art. 12(1).

[29] *See* ICESCR, *supra* note 11, art. 27 (setting out that the Covenant enters into force for states three months after they have deposited their instrument of ratification or accession with the UN Secretary-General); *see also, e.g.*, United Nations Convention on the Rights of the Child art. 49, *opened for signature* Nov. 20 1989, 1577 U.N.T. S. 3 (entered into force Sept. 2, 1990); United Nations Convention on the Rights of Persons with Disabilities, *opened for signature* Dec. 13, 2006, 2515 U.N.T.S. 3 (entered into force on May 3, 2008).

of IHRL, including ESC rights, to situations of international and non-international armed conflicts is also widely recognized today.[30] Most prominently, this was pronounced by the International Court of Justice (ICJ) in its *Advisory Opinion on the Legal Consequences of the Construction of a Wall in Occupied Palestinian Territory*, where the ICJ referred directly to the applicability of the ICESCR and other international human rights treaties containing socio-economic rights to armed conflict situations.[31] Thus, the ICESCR, including its article 12, applies in peacetime, in times of armed conflict, and to post-conflict situations.[32] States are obliged to take targeted steps to progressively realize the rights set out in the ICESCR, starting with their minimum core obligations, successively broadening their strategy towards the implementation of non-core obligations.[33]

Additional questions can be asked about the general scope of states' (and possibly non-state armed groups') substantive obligations under the ICESCR and the right to health, in particular, during armed conflicts and in situations where an armed conflict is imminent or has just come to an end. To what extent can states derogate from ESC rights in these situations or limit them in accordance with article 4 of the ICESCR? Concerning the former issue, it has to be noted that the ICESCR does not contain a derogation clause. A tendency can be observed that states, the CESCR, and other international bodies nonetheless accept derogations from labour rights[34] in times of armed conflict and other emergencies that "threaten the life of the nation."[35] The

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[30] For a recent overview of the practice of states and UN Charter bodies, including the ICJ, *see* LOUISE DOSWALD-BECK, HUMAN RIGHTS IN TIMES OF CONFLICT AND TERRORISM 137–81 (2011); *see also* SANDESH SIVAKUMARAN, THE LAW OF NON-INTERNATIONAL ARMED CONFLICT 83 (2012).

[31] Legal Consequences of the Construction of a Wall in Occupied Palestinian Territory, Advisory Opinion, 2004 I.C.J. 131, ¶¶ 106, 122 (July 9).

[32] Unlike the International Covenant on Civil and Political Rights, the ICESCR does not contain a clause limiting its scope of application to "individuals within [a state parties'] . . . territory and subject to its jurisdiction." International Covenant on Civil and Political Rights art. 2(1), *opened for signature* Dec. 19, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) [hereinafter ICCPR].

[33] On the notion of progressive realization, *see* MANISULI SSENYONJO, ECONOMIC, SOCIAL AND CULTURAL RIGHTS IN INTERNATIONAL LAW 58–61 (2009); *see generally* OLIVIER DE SCHUTTER, INTERNATIONAL HUMAN RIGHTS LAW 461–500 (2010).

[34] *E.g.* ICESCR, *supra* note 11, arts. 6-8(1).

[35] *See* Amrei Müller, *Limitations to and Derogations from Economic, Social and Cultural Rights*, 9 HUM. RTS. L. REV., Dec. 2009, at 557, 594–97 (examining inter alia the practice of the CESCR and the opinions of states reflected in the reports to the same Committee, and of the International Labour Organisation, on this question).

non-derogability of all other ESC rights, in particular of so-called survival rights (the rights to food and health), is substantiated primarily by the fact that it seems inherently unnecessary to derogate from these rights to protect or restore public order.[36]

The non-derogability of most ESC rights does not, however, deprive states of all possibilities to react in a flexible manner to situations of instability, tensions, or armed conflict in the implementation of their obligations flowing from the ICESCR and the right to health. The notion of progressive realization in article 2(1) of the ICESCR and the Covenant's general limitation clause (article 4 of the ICESCR) offer sufficient flexibilities for states to adapt their implementation strategies for ESC rights in difficult situations. The requirements of article 4 of the ICESCR have to be followed in such adaptation processes,[37] whatever the underlying reason for them is, ranging from political instability to economic difficulties that can result in shrinking available resources.[38] The requirements to be followed under article 4 of the ICESCR, read in conjunction with article 2(1) of the ICESCR and the so-called principle of non-retrogression, have been understood in the literature as follows: first, states must show that limitations are necessary for the "purpose of promoting general welfare"—or at least that their implementation preserves "general welfare" to the greatest extent possible.[39] Based, inter alia, on the *travaux préparatoires* of the ICESCR, "general welfare" primarily refers to the economic and social well-being of individuals and the community, and excludes notions of "public morals," "public order," and "national security."[40] Second, states must ensure that limitations are determined by national law that conforms to all their international human rights obligations and is sufficiently clear and publicly accessible.[41]

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[36] *See id.* at 599; Allan Rosas & Monika Sandvik-Nylund, *Armed Conflicts*, *in* ECONOMIC, SOCIAL AND CULTURAL RIGHTS: A TEXTBOOK 407, 414 (Asbjørn Eide, Catarina Krause & Allan Rosas, eds., 2001); Philip Alston & Gerard Quinn, *The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights*, 9 HUM. RTS. Q., May 1987, at 156, 217 (containing more detailed discussions of the possibility of derogating from ESC rights in times of armed conflict and other emergencies).

[37] "The States Parties to the present Covenant recognise that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society." ICESCR, *supra* note 11, art. 4.

[38] Müller, *supra* note 35, at 570–75, 585–88.

[39] *Id.*

[40] Alston & Quinn, *supra* note 36, at 201–02; Müller, *supra* note 35, at 570–75.

[41] Müller, *supra* note 35, at 578–79.

Third, the requirement that limitations must be acceptable in a democratic society calls upon states to legitimize any limitations of ESC rights through a participatory and transparent decision-making process.[42] Fourth and most importantly, limitations should "be compatible with the nature of these [ESC] rights."[43] This can reasonably be interpreted to exclude limitations that infringe upon minimum core obligations/rights as defined by the CESCR in its respective general comments, and as concretized through national legislation.[44] National particularities, including the availability of resources, can be taken into account in domestic law.[45] And lastly, limitations must respect the principle of proportionality.[46] This requires states to show that the scope and severity of a limitation is proportionate to the aim it seeks to pursue (that is, the promotion of general welfare).[47] The discussion below will engage further with these criteria.

B. THE SCOPE OF APPLICATION OF IHL

IHL applies first and foremost in times of on-going armed conflicts, which can be of an international[48] or non-international[49]

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[42] *Id.*, at 575–77.

[43] ICESCR, *supra* note 11, art. 4.

[44] Müller, *supra* note 35, at 579–83; Rosas & Sandvik-Nylund, *supra* note 36, at 412.

[45] MÜLLER, *supra* note 19, at 91–96.

[46] Müller, *supra* note 35, at 583–84.

[47] *Id.*; Alston & Quinn, *supra* note 36, at 206.

[48] "[T]he present Convention(s) shall apply to all cases of declared war or of any other armed conflict which may arise between two or more of the High Contracting Parties, even if the state of war is not recognized by one of them." Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field art. 2(1), *opened for signature* Aug. 12, 1949, 75 U.N.T.S 31 (entered into force Oct. 21, 1950) [hereinafter GC I]; Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea art. 2(1), *opened for signature* Aug. 12, 1949, 75 U.N.T.S. 85 (entered into force Oct. 21, 1959) [hereinafter GC II]; Geneva Convention (III) relative to the Treatment of Prisoners of War art. 2(1), *opened for signature* Aug. 12, 1949, 75 U.N.T.S. 135 (entered into force Oct. 21, 1950) [hereinafter GC III]; Geneva Convention (IV) relative to the Protection of Civilian Persons in Time of War art. 2(1), *opened for signature* Aug. 12, 1949, 75 U.N. T.S. 287 (entered into force Oct. 21, 1950) [hereinafter GC IV]. For clearer definition of when an international armed conflict starts, *see* Prosecutor v. Tadić, Case No. IT-94-1-AR72, Appeals Chamber Decision, ¶ 70 (Int'l Crim. Trib. for the Former Yugoslavia Oct. 2, 1995); *see* Dapo Akande, *Classification of Armed Conflicts: Relevant Legal Concepts, in* INTERNATIONAL LAW AND THE CLASSIFICATION OF CONFLICTS 32, 39–49 (Elizabeth Wilmshurst, ed., 2012) (providing a more detailed analysis).

[49] Art. 3 common to all four Geneva Conventions and Additional Protocol II, *see* GC I, *supra* note 48, art. 3; GC II, *supra* note 48, art. 3; GC III, *supra* note 48, art. 3; GC IV, *supra* note 48, art. 3; Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection

character. This article is, however, interested in obligations under IHL that states have to implement in times of peace, and that are likely to contribute to securing peace in a lasting fashion, especially rules related to the building and protection of different elements of a health system.

The general obligation to "respect and ensure respect" for IHL "in all circumstances" can be found in Common Article 1 to all four Geneva Conventions (GCs I-IV),[50] article 1(1) of the First Additional Protocol (API)[51] thereto, and in Rule 139 of the ICRC's study on customary IHL of 2005 (hereinafter ICRC Study).[52] This general obligation applies in peacetime, as well as in times of armed conflict. There is some debate about the actual scope of states' obligation to "respect and ensure respect" of IHL, mainly evolving around the question as to whether the obligation to "ensure respect" includes an obligation *erga omnes* on all states that are not directly involved in an on-going armed conflict to exert their influence, to the degree possible, to stop violations of IHL by parties to a particular conflict.[53]

In the present context, however, the more important question is about the scope of states' peacetime obligations to ensure respect for IHL

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of Victims of Non-International Armed Conflicts art. 1, *opened for signature* June 8, 1977, 1125 U.N.T.S. 609 (entered into force Dec. 7, 1978) [hereinafter AP II]. For the relevant jurisprudence explaining when an non-international armed conflict exists, *see*, Prosecutor v. Tadić, *supra* note 48, at ¶ 70; Prosecutor v. Boškoski, Case No. IT-04-82-T, Judgment, ¶ 175, (Int'l Crim. Trib. for the Former Yugoslavia July 10, 2008); SIVAKUMARAN, *supra* note 30, at 164–80; Akande, *supra* note 48, at 50–56.

[50] GC I, *supra* note 48; GC II, *supra* note 48; GC III, *supra* note 48; GC IV, *supra* note 48.

[51] Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts, *opened for signature* June 8, 1977, 1125 U.N.T.S 308 (entered into force Dec. 7, 1978) [hereinafter AP I].

[52] JEAN-MARIE HENCKAERTS & LOUISE DOSWALD-BECK, CUSTOMARY INTERNATIONAL HUMANITARIAN LAW, VOLUME 1: RULES 495–98 (eds., 2005) [hereinafter ICRC Study].

[53] In the affirmative, *see* Laurence Biosson de Chazournes & Luigi Condorelli, *Common Article 1 of the Geneva Conventions Revisited: Protecting Collective Interests*, 82 INT'L REV. RED CROSS, Mar. 2000, at 67; Toni Pfanner, *Various Mechanisms and Approaches for Implementing International Humanitarian Law and Protecting and Assisting War Victims*, INT'L REV. RED CROSS, Jun. 2009, at 297, 304–306; 2 JEAN PICTET, COMMENTARY TO THE GENEVA CONVENTIONS OF 12 AUGUST 1949, 16, 18, 25–26 (1952) [hereinafter ICRC Commentary to GC I–IV]; IN'T COMM. OF THE RED CROSS, COMMENTARY ON THE ADDITIONAL PROTOCOLS OF 8 JUNE 1977 TO THE GENEVA CONVENTIONS OF 12 AUGUST 1949, 35–36 (Yves Sandoz, Christophe Swinarski & Bruno Zimmermann eds., 1987) [hereinafter ICRC Commentary to AP I/AP II] (discussing AP I, Art. 1(1), §§ 42-43). Others are rejecting such a broad interpretation of the obligation to respect and ensure respect IHL. *E.g.*, Tomasz Zych, *The Scope of the Obligation to Respect and Ensure Respect for International Humanitarian Law*, 27 WINDSOR Y.B. ACCESS JUST. 251 (2009); Frits Kalshoven, *The Undertaking to Respect and Ensure Respect in All Circumstances: From Tiny Seed to Ripening Fruit*, 2 Y.B. INT'L HUM. L. 3, at 60 (1999) (arguing that at the least, there is a moral obligation of states to react to violations of IHL by other states).

by the state authorities and persons under their control. The differences in the wording of Rule 139 ICRC Study and the relevant articles of the Geneva Conventions and API raise some questions regarding this scope, as well as the latter's interpretation in the ICRC's Commentaries. The wording of Rule 139[54] might suggest that states must "respect and ensure respect" for IHL (i.e., ensure compliance with IHL) only by "its armed forces and other persons and groups acting in fact on its instructions, or under its direction or control."[55] This is, of course, a vital element of the obligation, since armed forces, in particular, but also other authorities under a state's control are more directly involved in activities where the observance of IHL can be crucial.[56] The ICRC commentary to article 1(1) of API,[57] and the drafting history[58] of this article and of Common Article 1 of the GCI-IV,[59] however, suggest that they include an obligation of states to also "ensure respect" of IHL by the population at large.[60] The obligation to "respect and ensure respect" of IHL thus requires states to do all that is necessary to ensure that all authorities *and persons* under

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[54] "Each party to the conflict must respect and ensure respect for international humanitarian law by its armed forces or other persons and groups acting in fact on its instructions, or under its direction or control." ICRC Study, *supra* note 52, at 495.

[55] The reasons for this incompleteness of Rule 139 are not entirely clear. It can be assumed that the ICRC's researchers did not find sufficient relevant state practice and *opinio iuris*. The commentary to Rule 139 observes that (only) some domestic legislation and military manuals affirm that states are under an obligation to, at the least, ensure that civilians do not violate IHL. *See* ICRC Study, *supra* note 52, at 496. Moreover, Rule 143 only establishes that "states must *encourage* the teaching of international humanitarian law to the civilian population." ICRC Study, *supra* note 52, at 505 (emphasis added).

[56] Many instruments of IHL therefore include particular provisions that oblige states to teach IHL to their armed forces, as well as obligations on commanders to instruct the armed forces under their command accordingly. *See* GC I, *supra* note 48, art. 47; GC III, *supra* note 48, art. 127; GC IV, *supra* note 48, art. 144; AP I, *supra* note 51, arts. 83, 87(2); AP II, *supra* note 49, art. 19 (obliging commanders to ensure that members of the armed forces under their command are aware of their obligations under IHL). The obligation to disseminate IHL to the civilian population at large is dealt with in the IHL treaties in less strict terms than teaching to the armed forces. *See* GC I, *supra* note 48, art. 47; GC II, *supra* note 48, art. 48; GC III, *supra* note 48, art. 127; GC IV, *supra* note 48, art.144; *see also* Knut Dörmann, *Dissemination and Monitoring Compliance of International Humanitarian Law, in* INTERNATIONAL HUMANITARIAN LAW FACING NEW CHALLENGES – SYMPOSIUM IN HONOUR OF KNUT IPSEN 227, 228–32 (Wolff Heintschel von Heinegg & Volker Epping, eds., 2007).

[57] ICRC Commentary to AP I/AP II, *supra* note 53, AP I, art. 1(1), at 35, § 41.

[58] For a detailed analysis, *see* Kalshoven, *supra* note 53, at 13-16, 21, 28, 59; Adam Roberts, *The Laws of War: Problems of Implementation in Contemporary Conflicts*, 6 DUKE J. COMP. & INT'L L. 11, 29-30 (1995).

[59] It should be noted that the ICRC's Commentaries to common art. 1 GC I-IV fail to take account of this aspect that is clear from the drafting history. *See* ICRC Study, *supra* note 53; *see* Kalshoven, *supra* note 53, at 28–35.

[60] *See also* Zych, *supra* note 53, at 270 (discussing the shortcoming of Rule 139).

their control[61] comply with IHL, in times of international and non-international[62] armed conflicts, but also in times of peace.[63] At the time when the four Geneva Conventions were drafted, the ICRC hoped to increase non-state armed groups' compliance with IHL through states' general implementation obligations that were also to be followed in peacetime. The ICRC's idea was that if the whole population was involved in the implementation efforts of the Geneva Conventions in times of peace, the likelihood would increase that non-state armed groups that could appear in the future would comply with the rules during a non-international armed conflict.[64]

Beyond the general obligation to "respect and ensure respect" for IHL "in all circumstances," IHL contains an entire range of national implementation mechanisms that must be activated in peacetime. Light will be shed briefly on the ones that are relevant for the discussion below.

The general obligation to "respect and ensure respect" for IHL is reiterated in article 80(1) of API, requiring states (and parties to the conflict) "without delay [to] take all necessary measures for the execution of their obligations under the Conventions and this Protocol." As highlighted by the ICRC Commentary on this provision, among the measures that are particularly important is the adoption of domestic laws that ensure the application of all relevant instruments of IHL in the territory of the respective state party.[65] National implementing legislation is necessary in dualist constitutional systems and in regard to IHL-provisions that might be non-self-executing in countries with a monist

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[61] The obligation does not go so far as to require from states to "ensure respect" by the population in territories that are under the control of rebel groups or an occupying force. *See* Zych, *supra* note 53, at 270; *see also* LISBETH ZEGFELD, THE ACCOUNTABILITY OF ARMED OPPOSITION GROUPS IN INTERNATIONAL LAW 208 (2002).

[62] ICRC Study, *supra* note 52, at 495, Rule 139; *see also* Military and Paramilitary Activities in and against Nicaragua (Nicar. v. U.S.), 1986 I.C.J. 14, ¶ 220 (June 27) (holding that the obligation to "ensure respect" also applies to Article 3 common to all four Geneva Conventions and, thus, to non-international armed conflicts).

[63] ICRC Commentary to GC I-IV, *supra* note 53, art. 1 (common to GC I-IV); ICRC Commentary to AP I/AP II, *supra* note 53, AP I, at 35, 37, §§ 41, 47; *see also* Pfanner, *supra* note 53, at 282; Roberts, *supra* note 58, at 14–17, 70; Dörmann, *supra* note 56, at 227, 229. It is furthermore confirmed by Kalshoven's analysis of the drafting history of the relevant Articles in the 1929 Geneva Convention protecting the Wounded and Sick, as well as the later provisions in the Geneva Conventions of 1949 and Additional Protocol I of 1977, *see* Kalshoven, *supra* note 53, at 9, 16.

[64] Kalshoven, *supra* note 53, at 16; this hope is also reiterated in more recent literature, *see, e.g.*, Dörmann, *supra* note 56, at 231–34.

[65] ICRC Commentary to AP I/AP II, *supra* note 53, AP I, at 930, § 3288.

constitutional system to operationalize the rules,[66] and some IHL provisions may be clarified through such implementing legislation.[67] States have to adopt appropriate penal sanctions in domestic law for grave breaches of IHL that fit into domestic criminal law,[68] for example, domestic regulations that determine the competent national authority that is responsible to define who can use the red cross, the red crescent, or the red crystal emblems in peacetime and in times of war,[69] as well as laws relating to the protection of medical personnel,[70] units and facilities,[71] transports,[72] and duties.[73] Moreover, national law needs to stipulate which national authority has to act with regard to different obligations under IHL that prescribe such action. This is particularly important in federal states.[74] Overall, domestic legislation is the first step to ensure that the international obligations under IHL are acted upon both in times of peace and in times of war. In contrast to international human rights treaties,[75] IHL, through article 80 of API, sets out a clear and direct obligation on states to incorporate relevant rules into domestic law "without delay."[76]

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[66] *See* 1 MARCO SASSOLI, ANTOINE BOUVIER & ANNE QUINTIN, HOW DOES LAW PROTECT IN WAR? 360, Part I, ch. 13, at 8 (3rd ed. 2011); such legislation must be communicated to other state parties. *See* GC I, *supra* note 48, art. 48; GC II, *supra* note 48, art. 49; GC III, *supra* note 48, art. 128; GC IV, *supra* note 48, art. 14; AP I, *supra* note 51, art. 84.

[67] ICRC Commentary to AP I/AP II, *supra* note 53, AP I, at 930, § 3289.

[68] GC I, *supra* note 48, art. 49; GC II, *supra* note 48, art. 50; GC III, *supra* note 48, art. 129; GC IV, *supra* note 48, art. 146; AP I, *supra* note 51, art. 85. Obligations to secure the punishment of grave breaches are not the focus of this article, but for more details, *see, e.g.*, Pfanner,*supra* note 53, at 284; INT'L COMM. OF THE RED CROSS, THE DOMESTIC IMPLEMENTATION OF INTERNATIONAL HUMANITARIAN LAW 29–41 (2013) [hereinafter DOMESTIC IMPLEMENTATION MANUAL].

[69] GC I, *supra* note 48, arts. 42, 44, 53; GC II *supra* note 48, arts. 44–45.

[70] GC I, *supra* note 48, arts. 40–41; GC II, *supra* note 48, arts. 37, 42; GCIV, *supra* note 48, art. 20, AP I, *supra* note 51, arts. 15–16, 18, AP II, *supra* note 49, arts. 10,12; *see also* DOMESTIC IMPLEMENTATION MANUAL, *supra* note 68, at 47–50, 60; Maria Teresa Dutli, *National Implementation Measures of International Humanitarian Law: Some Practical Aspects*, *in* 1 YEARBOOK OF INTERNATIONAL HUMANITARIAN LAW 245, 246–47 (1998).

[71] GC I, *supra* note 48, arts. 19, 42; GC II, *supra* note 48, arts. 22, 24–27; AP I, *supra* note 51, arts. 12(2)(b), 12(4), 18; AP II, *supra* note 49, art. 12.

[72] GC I, *supra* note 48, art. 36; GC II, *supra* note 48, arts. 38, 39, 43; GC IV, *supra* note 48, arts. 21–22; AP I, arts. 18, 21–23, *supra* note 51; AP II, *supra* note 49, art. 12.

[73] GC I, *supra* note 48, art. 36; GC II, *supra* note 48, arts. 38–39, 43; GC IV, *supra* note 48, arts. 21–22; AP I, *supra* note 51, arts. 18, 21–23; AP II, *supra* note 49, art. 12.

[74] SASSOLI, ET AL., *supra* note 66, at 361.

[75] These treaties usually include a provision encouraging states to take all measures, including legal measures, to secure the right set out in the respective treaties. *See, e.g.*, ICESCR, *supra* note 11, art. 2(1) (referring to "legislative measures").

[76] ICRC Commentary to AP I/AP II, *supra* note 53, AP I, art. 80(1), at 930, § 3288.

Implementation measures in peacetime are, however, not limited to the adoption of national legislation. As mentioned, states are also obliged to disseminate the Conventions and the Protocols to the armed forces and the civilian population.[77] Often, states can rely on the support of National Red Cross and Red Crescent Societies, as well as the ICRC, in their dissemination activities.[78] The dissemination obligation includes obligations to teach and train armed forces about IHL—an obligation that had been included in early IHL treaties,[79] has been repeated in subsequent treaties,[80] and is also regarded a rule of customary IHL.[81] More important for the current discussion, the Geneva Conventions additionally require states to include the study of IHL in programmes for civilian training, "if possible."[82] Even if this obligation is not as strong as the obligation to instruct the armed forces, it is noted in the ICRC Commentary to the relevant provisions in the Geneva Conventions that "if possible" was not meant to make civilian instruction optional, but was included merely to take account of the fact that in some federal states, the central government would have no authority to determine educational policies.[83] This direct obligation to also instruct civilians is in line with the understanding of the general state obligation set out above to "respect and ensure respect" of IHL, not only by the armed forces and authorities, but also by the population at large. Article 83 of API and Rule 143 of the ICRC Study reiterate these obligations, holding that states "must

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[77] GC I, *supra* note 48, art. 47; GC II, *supra* note 48, art. 48; GC III, *supra* note 48, art. 127; GC IV, *supra* note 48, art. 144; AP I, *supra* note 51, arts. 83, 87(2); AP II, *supra* note 49, art. 19; ICRC Study, *supra* note 52, at 501–05, Rules 142–43.

[78] Concerning the role of the ICRC in this context, *see* Int'l Red Cross, *Statues of the International Red Cross and Red Cresent Movement*, art. 5 (1986), *available at* http://www.icrc.org/eng/assets/files/other/statutes-en-a5.pdf; *see also* ICRC, *Statues of the International Committee of the Red Cross*, art. 4(f)-(g) (2013) *available at* http://www.icrc.org/eng/resources/documents/misc/icrc-statutes-080503.htm. Concerning the role of domestic societies, *see* Int'l Red Cross, *Statues of the International Red Cross and Red Crescent Movement*, art. 3 (1986).

[79] *See* Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field art. 26, (July 6, 1906); Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field art. 27, (July 27, 1929).

[80] *See* GC I *supra* note 48, art. 47; GC II *supra* note 48, art. 48; GC III *supra* note 48, art. 127; GC IV *supra* note 48, art. 144; AP I, *supra* note 51, arts. 83, 87(2); AP II, *supra* note 49, art. 19.

[81] ICRC Study, *supra* note 52, at 501, Rule 142.

[82] GC I, *supra* note 48, art. 47; GC II, *supra* note 48, art. 48; GC III, *supra* note 48, art. 127; GC IV, *supra* note 48, art. 144.

[83] ICRC Commentary to GC I–IV, *supra* note 53, GC I, at 349; *see also* ICRC Study, *supra* note 52, at 506, Rule 143.

encourage" the teaching and study of IHL by the civilian population.[84] Special attention is to be paid in teaching public authorities that are responsible for the application of the relevant IHL provisions, including police forces, civil servants, politicians, judges, lawyers, the medical corps, but also journalists.[85]

In recent years, many states have also set up national committees for the implementation of IHL to assist states with the aforementioned obligations to implement IHL in times of peace and war, even though the creation of such committees is not legally required under IHL. As of August 2013, such national committees existed in 103 countries,[86] and in the words of the ICRC, they "have proved useful in assisting States to fulfil their obligations" under IHL.[87] Often, national committees cooperate with national Red Cross and Red Crescent Societies.[88]

II. OBLIGATIONS UNDER THE RIGHT TO HEALTH AND IHL: CONTRIBUTION TO BUILDING PEACEFUL SOCIETIES AND TO THE PREVENTION OF ARMED CONFLICT

With these general peacetime obligations under the right to health and IHL in mind, this analysis will now turn to a more explicit exploration of some of the substantive and procedural obligations that relate to the establishment and protection of individuals' access to health care, and the implementation of which might contribute to the prevention of armed conflict, and possibly to the building of peaceful societies.

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[84] ICRC Study, *supra* note 52, at 506, Rule 143. The wording of Art. 83(1) AP I refers to an obligation to "undertake . . . to encourage" the study of IHL by the civilian population. AP I, *supra* note 51, art. 83(1).

[85] *See* ICRC Study, *supra* note 52, at 507–08 (commentary to Rule 143); *see also* AP I *supra* note 51, art. 83(2); Dörmann, *supra* note 56, at 232; SASSOLI, ET AL., *supra* note 66, at 356.

[86] For a relevant list of national committees, *see* ICRC, *National Committees and Other National Bodies of International Humanitarian Law* (2013), *available at* http://www.icrc.org/eng/assets/files/2013/national-committes-icrc-16-08-2013-eng-2.pdf.

[87] *See* ICRC, *National Committees* (Jan. 5, 2012), *available at* http://www.icrc.org/eng/war-and-law/ihl-domestic-law/national-committees/overview-national-committees.htm; *see also* ICRC, *National Committees Factsheet* (Jan. 2003), *available at* https://www.icrc.org/eng/assets/files/2012/national-committee-factsheet-icrc-2003-01-eng.pdf.

[88] *Id.*

A. BUILDING AN INTEGRATED HEALTH SYSTEM ACCESSIBLE TO ALL

The parallel implementation of peacetime health-related IHL obligations and obligations flowing from the right to health can arguably contribute to building some elements of an effective, integrated, and responsive health system of good quality that is accessible to everyone. As mentioned in the introduction, the existence of such a health system is conducive to the building of a peaceful society, and thus contributes to the prevention of armed conflicts. This article attempts to show how IHL peacetime implementation obligations and states' obligations under the right to health can complement each other in this endeavor.

One of the fundamental state obligations under the right to health is the obligation to progressively create a health system, providing primary, secondary, and tertiary health care of good quality that is accessible to everyone under their respective state's jurisdiction.[89] In the words of the UN Special Rapporteur on the Right to Health:

> At the heart of the right to the highest attainable standard of health lies an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Without such a health system, the right to the highest attainable standard of health can never be realised.[90]

Thus, states have a legal obligation to ensure that their health systems include a number of features and measures in line with the different components of the right to health; and that more general human rights principles, such as participation, non-discrimination, concentration on particularly vulnerable and disadvantaged groups, and transparency, are followed in the establishing, maintaining, and developing of a health system. Even if not a comprehensive list of all these features and measures, the following elements are interesting for the context of this article, as they can potentially be supplemented by health-related obligations under IHL that states should already take account of in times of peace: a health system must provide a minimum "basket" of health

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[89] This understanding of the right to health is supported by the CESCR's observation that the right to health is not and cannot realistically be a right to be healthy, but should rather be understood as a "right to the enjoyment of variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health." *See* CESCR, General Comment 14, *supra* note 26, ¶ 9.

[90] *UN Special Rapporteur on the Right to Health*, *supra* note 27, ¶ 15.

related facilities, services and goods,[91] qualified health personnel,[92] an effective referral system,[93] non-discriminatory access to its services and facilities,[94] and a comprehensive national plan for maintaining and developing the health system.[95]

In particular, the last feature reflects the general assumption under the right to health that a comprehensive health system cannot be constructed overnight, but that the obligation to progressively realize[96] the full right to the highest attainable standard of physical and mental health requires long-term planning. By contrast, IHL rules relating to the protection of health care in times of armed conflict, presuppose the existence of a well-functioning health system.[97] The rules primarily aim to protect this system from the effects of armed conflicts. The picture of a comprehensive health system that underlies IHL can therefore complement states' obligations under the right to health even in times of peace.

1. Minimum "Basket" of Health-Related Facilities, Services and Goods

Under the right to health, a health system should provide an appropriate mix of community-based primary, district-based secondary, and specialized tertiary facilities and services, providing a continuum of preventive, curative, and rehabilitative health services.[98] This includes obligations of states to make available various health care facilities, such

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[91] As reflected inter alia in minimum core obligations flowing from the right to health. *See* CESCR, General Comment 14, *supra* note 26, ¶¶ 43–44.

[92] CESCR, General Comment 14, *supra* note 26, ¶¶ 12(a), 12(d), 36, 44(e).

[93] A referral system is necessary to allow for a continuum of care within the different components of the health system listed in the CESCR's General Comment 14. CESCR, General Comment 14, *supra* note 26, ¶¶ 14–17.

[94] *See* ICESCR, *supra* note 11, arts. 2(2), (3); *see also* CESCR, General Comment 14, *supra* note 26, ¶¶ 12(b)(i), 18–19, 43(a).

[95] CESCR, General Comment 14, *supra* note 26, ¶ 43(f).

[96] *See supra* Part IA.

[97] This becomes clear from the detailed definitions of IHL, *see* AP I, *supra* note 51, art. 8(c) ("medical personnel"); AP I, *supra* note 51, art. 8(e) ("medical units"); API , *supra* note 51, arts. 8(f), (8)(g) ("medical transportation" and "transports"); AP I, *supra* note 51, art. 16 ("medical activities"). These provisions are analyzed in more detail below.

[98] *See Report of the U.N. Special Rapporteur on the Right to Health, supra* note 27, ¶ 55.

as "hospitals, clinics and other health-related buildings,"[99] and "institutions providing counselling and mental health services."[100]

These obligations concerning health care facilities are arguably complemented by IHL. IHL imposes an obligation on states during armed conflicts to "respect and protect" medical units, which shall "never be the object of attack."[101] "Medical units" have been defined in article 8(e) of API as:

> Establishments and other units, whether military or civilian, organised for medical purposes, namely the search for, collection, transportation, diagnosis or treatment—including first-aid treatment—of the wounded, sick and shipwrecked, or for the prevention of disease. The term includes, for example, hospitals and other similar units, blood transfusion centres, preventive medicine centres and institutes, medical depots and the medical and pharmaceutical stores of such units.

It cannot be assumed that this obligation goes so far as to require states who are parties to API, or are bound by the largely equivalent customary obligation that is set out in Rule 28 of the ICRC Study, to proactively take measures to build up and improve a health system that includes all these facilities during peacetime.[102] But, it can be argued that the details given in IHL as to which medical units are to be respected and protected in times of armed conflict, can also be used to clarify which health *facilities* are considered part of a well-functioning health system. Therefore, they should be part of health systems that states are to build up progressively under their obligations flowing from the right to health. While the text of article 12 of the ICESCR does not define in detail what kind of health facilities states should provide under the right to health, and the CESCR in its General Comment on this Article only refers to

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[99] CESCR, General Comment 14, *supra* note 26, ¶¶ 12(a), 36.

[100] *Id.*, ¶ 36.

[101] GC I, *supra* note 48, art. 19; GC IV, *supra* note 48, art. 18; AP I, *supra* note 51, art. 12; AP II, *supra* note 49, art. 11(1); ICRC Study, *supra* note 52, at 91, Rule 28.

[102] *See, e.g.*, ICRC Commentary to AP I/AP II, *supra* note 57, AP I, art. 10, at 147, § 451 (concerning the level of care to be provided to those who have been wounded in active hostilities. It holds that, "it is obvious that some wounded or sick persons could be saved, or at any rate be better cared for, in the clinics of wealthy countries which have the most advanced resources at their disposal. However, the requirement imposed here relates to the material possibilities existing in the place and at the time that the wounded person is cared for. What is required is that everyone does his utmost. If, because there is no doctor, an orderly is left to care for the wounded on his own, he must do so to the best of its ability. If there is no well-equipped clinic and the wounded must be cared for in an antiquated hospital, an attempt should nevertheless be made to use it to the maximum of its capacity.").

"hospitals, clinics and other health-related buildings," the IHL definition of medical units can give some additional indication of what these other "health-related buildings" could include: for example, blood transfusion centres, preventive medicine centres and institutions, medical depots, and medical and pharmaceutical stores.[103]

Such use of IHL in peacetime would be supported by an interpretation and application of states' obligations under the right to health that is influenced by the so-called principle of systemic integration,[104] as set out in article 31(3)(c) of the Vienna Convention on the Law of Treaties (VCLT).[105] Article 31(3)(c) of the VCLT[106] allows states to take account of "any relevant rules of international law applicable in the relations between the parties" in the interpretation (and application and implementation) of a particular treaty provision.[107] "Any *relevant* rules of international law"[108] include those international treaty and customary rules[109] that "touch . . . on the same subject matter as the treaty provision or provisions being interpreted [or applied] or which in any way affect that interpretation [or application]."[110] IHL provisions on

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[103] As flows from Art. 8(e) AP I, quoted above. AP I, *supra* note 51, art. 12.

[104] Study Group of the Int'l Law Comm'n, Fragmentation of Int'l Law: Difficulties Arising from the Diversification and Expansion of Int'l Law, Sess., 58, ¶ 430, U.N. Doc. A/CN.4/L.682 (April 13, 2006).

[105] Vienna Convention on the Law of Treaties art. 31(3)(c), *opened for signature* May 23, 1969, 115 U.N.T.S. 331 (entered into force Jan. 27, 1980) [hereinafter VCLT].

[106] *Id.*, art. 31(3)(c) ("There shall be taken into account, together with the context: . . . (c) Any relevant rules of international law applicable in the relations between the parties."); recent literature debates the scope of this article. *See,e.g.,* Campbell McLachlan, *The Principle of Systemic Integration and Art.31(3)(c) of the Vienna Convention*, 54 INT'L & COMP. L. Q. 279 (2005); Study Group of the International Law Commission, *supra* note 104, ¶¶ 410-480; Melanie Samson, *High Hopes, Scant Resources: A Word of Scepticism about the Anti-Fragmentation Function of Art.31(3)(c) of the Vienna Convention on the Law of Treaties*, 24 LEIDEN J. INT'L L. 701 (2011); *see infra* notes 107-110.

[107] The phrase "in relation between the parties" is of little significance for the current context because many of the relevant IHL rules have attained customary status and are thus without question applicable "in relation between the parties." For an analysis of the meaning of this phrase, *see* Julian Arato, *Constitutional Transformation in the ECtHR: Strasbourg's Expansive Recourse to External Rules of International Law*, 37 BROOK. J. INT'L L. 349, 377-382 (2012); Ulf Linderfalk, *Who Are 'the Parties'? Article 31, Paragraph 3(c) of the 1969 Vienna Convention on the* Law *of Treaties and the 'Principle of Systemic Interpretation' Revisited,* 55 NETH. INT'L L. REV. 343 (2008).

[108] VCLT, *supra* note 105, art. 31(3)(c) (emphasis added).

[109] There is widely shared agreement that "any rules of international law" includes at the least customary law, treaties, as well as general principles of international law. It is less clear whether soft law instruments are also included. *See* Arato, *supra* note 107, at 375-77.

[110] RICHARD GARDINER, TREATY INTERPRETATION 260 (2009); for a similar interpretation, *see also* Bruno Simma & Theodore Kill, *Harmonising Investment Protection and International Human Rights: First Steps Towards A Methodology*, *in* 678 INTERNATIONAL INVESTMENT LAW FOR THE

the protection of health care cover the same subject matter as the right to health set out in the ICESCR. Moreover, article 31(3)(1) of the VCLT permits states to fill gaps in the treaty provision that is being interpreted or applied/implemented through reference to another relevant treaty or rule of customary law; and/or to derive guidance from treaty provisions parallel to those that are being interpreted and applied/implemented.[111] Arguably, this will often be the case when the right to health is interpreted and applied in light of states' health-related obligations under IHL, for example in regard to the definition of health-related facilities, even in times of peace. IHL obligations should also be taken into account in peacetime when a comprehensive national strategy and plan of action is developed to progressively realise all elements of the right to health when resources are limited.[112]

Such an understanding of the complementary interpretation, application, and implementation of the right to health and IHL protecting medical units based on article 31(3)(c) of the VCLT would, in addition, be supported by the general peacetime obligation to "respect and ensure respect" for IHL at all times that was set out above. It would back an obligation on states to take their obligations under the relevant articles of IHL relating to the protection of medical units into account, when discussing what "hospitals, clinics and other health-related buildings"[113] a state aims to develop and/or to strengthen as part of their obligations to progressively realize the right to health through building an effective health system. It could also be reinforced by states' clear IHL peacetime obligations to identify medical units—an obligation requiring states to regulate in domestic law which medical units can display distinctive emblems (red cross, red crescent, red crystal).[114] These obligations could encourage a discussion about the adequacy of health facilities within a particular country, and how they could be expanded and strengthened, thereby supporting the implementation of states' obligations under the right to health.

21ST CENTURY - ESSAYS IN HONOUR OF CHRISTOPH SCHREUER 695-696 (Christina Binder et al. eds., 2009); Arato, *supra* note 107, at 373-375.

[111] GARDINER, *supra* note 110, at 260.

[112] This obligation is also discussed in Part IIB. It flows from the obligation under articles 2(1) and 12 of the ICESCR to progressively realize the right to the highest attainable standard of health, using the "maximum available resources." *See supra* note 11, arts. 2(1) & 12; *infra* Part IIB.

[113] CESCR, General Comment 14, *supra* note 26, ¶¶ 12(a), 36.

[114] GC I, *supra* note 48, art. 42; GC IV, *supra* note 48, art. 18(2); AP I, *supra* note 51, art. 18(2).

Other IHL peacetime obligations relating to the protection of medical units can contribute to the likelihood that these units are actually protected from attacks in the event of an armed conflict. Their implementation would thereby limit the public health consequences of armed conflicts and thus increase the chances for the re-establishment of (positive) peace after a conflict has ended. For example, under article 12(4) of API state parties, "whenever possible, . . . shall ensure that medical units are so sited that attacks against military objectives do not imperil their safety."[115] The caveat "whenever possible" suggests that sometimes it might be impossible to change the location of an existing medical unit even in peacetime,[116] and, during active combat, it would sometimes be necessary for a mobile medical unit to be moved into the vicinity of combat purposefully, to take care of the wounded and sick.[117] For our context, this obligation would at least imply that it needs to be taken into account in times of peace, when the location for the establishment of any new health facilities are chosen in an effort to realise the right to health through the progressive building of a comprehensive health system.[118] However, it also has to be noted that this IHL rule has not yet achieved customary status, since it is not included in the ICRC Study.

It is suggested that similar synergy effects could be achieved through taking parallel account of obligations under the right to health that describe the minimum essential health *services and goods* that states have to provide as part of an effective health system on the one hand, and IHL obligations that protect certain health services and goods on the other hand. Under the right to health, a health system must, at a minimum, provide the goods and services that are required under the minimum core right to health, as defined by the CESCR. The assumption is that their provision is independent from the resources that are available to a particular state.[119] Under their minimum core obligations, the more

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[115] AP I, *supra* note 51, at art. 12(5); albeit in a slightly different wording, this obligation is also included in Art.19 GC I (concerning military medical units) and in Art.18 GC IV (concerning civilian medical units). *See* GC I, *supra* note 48, art. 19; GC IV, *supra* note 48, art. 18.

[116] ICRC Commentary to GC I–IV, *supra* note 53, GC IV, art. 18(5), at 153.

[117] ICRC Commentary to AP I/AP II, *supra* note 53, AP I, art. 12(5), at 171, § 540.

[118] ICRC Commentary to AP I/AP II, *supra* note 53, AP I, art. 12(5), at 171, § 544 (observing that states should take this obligation into consideration already in times of peace); *see also* ICRC Commentary to AP I/AP II, *supra* note 53, AP I, arts. 56(5), 58(a), (b), at 171 (observing obligations under arts.56(5) and 58(a) and (b) of AP I strengthen the obligations under art.12(5) AP I further).

[119] For a critical analysis of among other this assumption, *see* MÜLLER, *supra* note 19, at 74-96.

exact content of which shall arguably be defined at the domestic level, mirroring as closely as possible the internationally-defined minimum core,[120] states shall concentrate on providing "essential primary health care."[121] This would be the first step in building a sustainable health system that includes primary, secondary, and tertiary health care, providing preventive, curative, and rehabilitative services, including mental health care.[122] Goods and services to be provided as part of "essential primary health care" include:

> At least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.[123]

A look into IHL confirms some of these elements of primary health care. For example, it is clear that IHL presumes the existence of maternal and child health services,[124] as well as services that aim at the "prevention of disease."[125] Moreover, IHL protects all sorts of "medical

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[120] The notion of minimum core obligations and how it could realistically contribute to overcome states' reluctance to accord legal and political importance to their obligations under the ICESCR, was analysed in detail by the current author in MÜLLER, *supra* note 19, at chapters IV and V.

[121] CESCR, General Comment 3, *supra* note 26, at ¶ 10; CESCR, General Comment 14, *supra* note 26, ¶ 43; *see also*, CESCR, *Concluding Observations: Bolivia*, ¶ 34, U.N. Doc. E/C.12/BOL/CO/2, (Aug. 8, 2008).

[122] CESCR, General Comment 14, *supra* note 26, ¶ 17.

[123] Declaration of Alma-Ata, adopted by the International Conference on Primary Health Care, ¶ VII(3), Alma-Ata, USSR, (September 6-12, 1978); the CESCR's understanding of states' minimum core obligations set out in ¶¶ 43 and 44 of CESCR General Comment 14 follow this definition as the Committee holds that the Alma-Ata Declaration provides "compelling guidance on the core obligations arising from Art.12." *See General* Comment 14, *supra* note 26, at ¶ 43; *see also*, *Report of the U.N. Special Rapporteur on the Right to Health*, *supra* note 27, ¶ 51.

[124] In general, this is in line with the definition of the "wounded and sick" as any individual requiring medical care, which includes also new-born babies, maternity cases, invalids and expectant mothers who all must be protected and cared for. AP I, *supra* note 51, arts. 8(a), 77; GC IV, *supra* note 48, arts. 18, 21, 50; *see* ICRC Commentary to AP I/AP II, *supra* note 53, AP I, art. 8(a), at 116-18, §§ 300, 303, 305.

[125] *See, e.g.*, AP I, *supra* note 49, arts. 8(e), (c), at 117 (§ 303); GC IV, *supra* note 48, art. 56 (concerning occupied territories); *see also* ICRC Study, *supra* note 52, at 79 which sets out the customary definition of "medical personnel" applicable to international and non-international armed conflicts. This definition includes medical personnel engaged in activities that aim at "the prevention of disease." This is also in line with the definition of the "wounded and sick" as persons in need of medical care. *See* ICRC Commentary to AP I/AP II, *supra* note 53, AP I, art.8(a), at 117, § 303.

activities," be they related to treatment of those who have been wounded by on-going hostilities or to other activities, such as to "vaccinat[ing] people, mak[ing] diagnoses, giv[ing] advice etc."[126] Other IHL provisions remind us that other health services and goods, which are rather part of secondary and tertiary health care, should be taken account of as well, at the very least in longer-term planning for the building of a comprehensive health system, providing a continuum of care required under the core *and non-core* obligations flowing from the right to health.

The original focus of IHL on the protection of the war-wounded was on military medicine, providing emergency medical treatment and specialised war surgery to those who have been wounded in active combat situations.[127] Today, first and foremost, IHL still requires that the "wounded, sick and shipwrecked," be they military or civilian, be provided with "medical care and attention required by their condition,"[128] implying mainly the provision of first aid given on the spot,[129] as well as surgery and amputation services.[130] Thus, in resource-poor countries, the building of an effective health system might concentrate on the provision of primary health care, as suggested by the minimum core right to health. But, taking into account peacetime obligations under IHL can help us not to lose sight of the fact that, progressively, states have to build an effective health system that also provides secondary and tertiary health services and goods, including more sophisticated trauma care and surgical services. As the WHO has noted in this context, primary care shall always be understood as a hub from which patients are guided through the health system,[131] and not as something to be regarded as satisfactorily and conclusively implementing states' obligations under

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[126] ICRC Commentary to AP I/AP II, *supra* note 53, AP II, art. 10, at 1426, § 4687; *see also* ICRC Commentary to AP I/AP II, *supra* note 53, AP I, art. 16, at 198, § 642.

[127] The first Geneva Conventions limited their protection to wounded and sick military personnel. It was only with the adoption of GC IV in 1949 that the protection offered by IHL to the wounded and sick included wounded and sick *civilians*. With the adoption of AP I in 1977, military and civilian "wounded and sick" obtained equal protection. *See* AP I, *supra* note 51, art. 8 (referring to "the 'wounded' and 'sick,' whether military or civilian.").

[128] AP I, *supra* note 51, art. 10; *see also* GC I, *supra* note 48, arts. 12, 15; GC II, *supra* note 48, arts. 12, 18; GC IV, *supra* note 48, art. 16; AP II, *supra* note 51, AP II, art. 8; ICRC Study, *supra* note 52, at Rule 110.

[129] *See, e.g.*, ICRC Commentary to AP I/AP II, *supra* note 53, AP II, art. 8, § 4655.

[130] *E.g.* the ICRC's commentary to Art.10 AP I, §§ 448, 451, 457, having in mind care for patients suffering from injuries they acquired in active hostilities. *See e.g.*, ICRC Commentary to AP I/AP II, *supra* note 53, AP I, art. 10, at §§ 448, 451 & 457.

[131] *WORLD HEALTH ORGANISATION [WHO], THE WORLD HEALTH REPORT 2008 - PRIMARY HEALTH CARE (NOW MORE THAN EVER)* 55-56, *available at* http://www.who.int/whr/2008/en/.

the right to health when only limited resources are available. After all, minimum core obligations flowing from the right to health should be understood as a "springboard for further action,"[132] from which additional steps to progressively realize all components of the right to health should be taken, including non-core obligations.

In line with this, some countries have enshrined a right to emergency medical treatment in their constitutions,[133] or their supreme or constitutional courts have developed duties of states to provide such care, frequently derived from the right to life.[134] In its *General Comment No 14*, the CESCR has also pronounced that a system of "urgent medical care" in case of accidents should be created as part of states fulfilling their obligations under the right to health.[135] Nonetheless, the notion of progressive realisation recognises that it is impossible for states to immediately construct a comprehensive health system;[136] and frequently, the concentration on the provision of primary health care is a good starting point, as it promises to distinctly increase the health status of a high percentage of the population, in particular, in lower-income countries. The taking into account of obligations concerning the provision of health goods and services under IHL in peacetime will help to ensure that the longer-term goal of the right to health, in particular the realization of non-core obligations flowing from it and requiring a health system that also includes specialised (tertiary) services, are not lost sight of, even in countries with (severe) resource constraints.

2. *Qualified Health Personnel*

Another important component of a health system that states have to build in order to fulfil their obligations under the right to health is the generation of "trained medical and professional personnel."[137] The

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[132] Geraldine van Bueren, *Alleviating Poverty through the Constitutional Court,* 15 S. AFR. J. ON HUM. RTS. 52, 59 (1999); similarly, *see* IDA KOCH, HUMAN RIGHTS AS INDIVISIBLE RIGHTS: THE PROTECTION OF SOCIO-ECONOMIC DEMANDS UNDER THE EUROPEAN CONVENTION ON HUMAN RIGHTS 288 (2009); and SSENYONJO, *supra* note 33, at 67.

[133] *E.g.*, CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, Dec. 18, 1996, Chapter II, Section 27(3) (reading: "No one may be refused emergency medical treatment.").

[134] For an overview of selective domestic courts' approaches, *see* MÜLLER, *supra* note 19, at 99-102, 214-15.

[135] CESCR, General Comment 14, *supra* note 26, ¶ 16.

[136] *Report of the U.N. Special Rapporteur on the Right to Health, supra* note 27, ¶ 46.

[137] CESCR, General Comment 14, *supra* note 26, ¶¶ 12(a) , 12(d), 36; *Report of the U.N. Special Rapporteur on the Right to Health, supra* note 27, ¶¶ 68(b), 75-86; and the *Report of the U.N.*

CESCR's *General Comment No 14* states further that these personnel include doctors and other medical personnel,[138] but does not list additional categories of different health personnel in detail. IHL is clearer in this regard and can thereby again complement obligations under the right to health, even in times of peace, when states plan which health personnel to train for building a strong and well-functioning health system. The commentary to the customary IHL Rule 25 on "medical personnel" that has to be "protected and respected" in times of armed conflict summarizes the rather complex definition deriving from different Articles of the Geneva Conventions[139] and the Additional Protocols[140] as follows:

> The term "medical personnel" refers to personnel assigned, by a party to the conflict, exclusively to the search for, collection, transportation, diagnosis or treatment, including first-aid treatment, of the wounded, sick and shipwrecked, and the prevention of disease, to the administration of medical units or to the operation or administration of medical transports.[141]

This can add to the general obligations under the right to health, indicating some additional types of medical personnel that are necessary to keep a health system running, among them not only military and civilian doctors and nurses but also administrative medical staff, as well as paramedics and ambulance drivers. Once more, when a comprehensive health plan is made for the progressive expansion of a health system, it might be useful to take IHL obligations into account even in peacetime to define which health personnel have to be trained in the nearer and more distant future.

3. An Effective Referral System

Another feature of a health system to be established under the right to health is that it needs to have an effective transportation and referral system, one that allows people both to physically get access to health care, and to be referred to additional services if their condition so

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Special Rapporteur on the Right to Health on His Mission to India, ¶ 20, U.N. Doc. A/HRC/14/20/Add.2 (April 15, 2010).

[138] CESCR, General Comment 14, *supra* note 26, ¶ 36.

[139] GC I, *supra* note 48, arts. 24–26; GC II, *supra* note 48, art. 36; GC IV, *supra* note 48, art. 20.

[140] AP I, *supra* note 51, art. 8(c); AP II, *supra* note 49, art. 9(1).

[141] ICRC Study, *supra* note 52, comment on rule 25, at 81–82.

requires.[142] The UN Special Rapporteur's reports on the health systems of different countries frequently identify inadequate transportation or too high transportation costs as factors that unduly limit patients' access to adequate health care.[143]

IHL contains strong rules for the protection of all types of "medical transports" in times of armed conflict,[144] recognising their importance for saving lives during conflicts. Based on article 8(f)-(g) of API, "medical transports" are clearly defined in IHL as

> any means of transportation, whether military or civilian, permanent or temporary, assigned exclusively to medical transportation under the control of a competent authority of a party to the conflict. This includes means of transportation by land, water or air, such as ambulances, hospital ships and medical aircraft.[145]

In resource-poorer countries, it might not be a priority to invest in expensive medical transports such as medical aircrafts or helicopters when a basic road network is absent.[146] Nonetheless, in this area concerning medical transports and referral systems, taking account of IHL in the implementation of the right to health in times of peace could also contribute to identifying all relevant details of this aspect of an effective health system. Besides, if an armed conflict breaks out, an effective medical transportation system will be key to limiting the number of deaths, particularly, when states also live up to their peacetime IHL obligations and ensure that medical transports are clearly identifiable.[147]

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[142] *Report of the U.N. Special Rapporteur on the Right to Health, supra* note 27, ¶ 55.

[143] *See, e.g.*, the U.N. Special Rapporteur on the Right to Health, *Report of the Special Rapporteur on the Right to Health on His Visit to Tajikistan*, ¶ 27, U.N. Doc. A/HRC/23/41/Add.1 (May 2, 2013); *Report of the Special Rapporteur on the Right to Health on His Visit to India, supra* note 137, ¶¶ 48, 52; *Report of the Special Rapporteur on the Right to Health on His Visit to Ghana*, ¶¶ 37, 39, 61(d), U.N. Doc. A/HRC/20/15/Add.1 (April 10, 2012); *Report of the Special Rapporteur on the Right to Health on His Visit to Guatemala*, ¶ 88(f), U.N. Doc. A/HRC/17/25/Add.2 (March 16, 2011).

[144] GC I, *supra* note 48, art. 35; GC IV, *supra* note 48, art. 25; AP I, *supra* note 51, art. 21; AP II, *supra* note 49, art. 11(2); ICRC Study, *supra* note 52, Rule 29.

[145] *See* ICRC Study, Comment on Rule 29, at 100.

[146] The CESCR has, in several of its Concluding Observations on Least Developed Countries, noted that the absence of a road network and basic infrastructure inhibits the implementation of the right to health in these countries, *see, e.g.*, CESCR, *Concluding Observations: Sudan*, ¶ 16, U.N. Doc. E/C.12/1/Add.48 (Sept. 1, 2000); CESCR, *Concluding Observations: Nepal*, ¶ 10, U.N. Doc. E/C.12/NPL/CO/2 (Jan. 16, 2008); CESCR, *Concluding Observations: Afghanistan*, ¶ 12, U.N. Doc. E/C.12/AFG/CO/2-4 (June 7, 2010).

[147] AP I, *supra* note 51, art. 18(1).

4. Non-Discriminatory Access to a Health System

There is no question that non-discrimination is one of the most important principles of IHRL. It is also relevant for the building and structuring of an effective and integrated health system that states are obliged to create under the right to health.[148] The importance of the principle of non-discrimination is also highlighted by the fact that it is part of the minimum core content of the right to health: even if a resource-poor state has only developed a very basic health system under its minimum core obligations, it has to ensure "access to health facilities, goods and services on a *non-discriminatory* basis."[149] Non-discriminatory access to all facilities, goods, and services of a health system is arguably a very important aspect for such a system to ensure that it unfolds its potential as a social institution that brings people together and reduces the potential for tensions among different segments of a country's population, thus contributing to the prevention of violent conflict.[150] This has also been assumed by the UN Committee on the Elimination of Racial Discrimination, which held in several of its concluding observations that the insufficient implementation of the Convention on the Elimination of All Forms of Racial Discrimination (CERD) "contributes very significantly to the dangerous escalation of tension"[151] in different countries and regions.

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[148] *Report of the U.N. Special Rapporteur on the Right to Health*, *supra* note 27, ¶ 42.

[149] CESCR, General Comment 14, *supra* note 26, ¶ 43(a).

[150] *See, e.g.*, Gudrun Østby, *Polarization, Horizontal Inequalities and Civil Violent Conflict*, 45(2) J. OF PEACE RES. 143 (2008) (showing that social polarization and horizontal social inequality are positively related to conflict outbreak. Such polarization and inequality can arguably be counteracted through constructing a health system that is accessible to all); *see also* Kruk et al., *supra* note 6, at 92; Michael Marmot, *Achieving Health Equity: From Root Causes to Fair Outcomes*, 370 THE LANCET 1153 (2007).

[151] U.N. Committee against Racial Discrimination [hereinafter CERDCttee], *Concluding Observations: Israel*, ¶¶ 4, 10, U.N. Doc. CERD/C/304/Add.45 (Mar. 30, 1998); among many, *see also* CERDCttee, *Concluding Observations: Guatemala*, ¶ 30, U.N. Doc. CERD/C/304/Add.21 (Apr. 23, 1997); CERDCttee, *Concluding Observations: Israel*, ¶¶ 24-29, U.N. Doc. CERD/C/ISR/CO/14-16 (Apr. 3, 2012); CERDCttee, *Concluding Observations: Georgia*, ¶ 14, U.N. Doc. CERD/C/GEO/CO/4-5 (Sept. 2, 2011); CERDCttee, *Concluding Observations: Kyrgyzstan*, ¶¶ 5-8, U.N. Doc. CERD/C/KGZ/CO/5-7 (Apr. 19, 2013); *see also* U.N. Committee on the Rights of the Child [hereinafter CRC], *Concluding Observations: Guatemala*, ¶ 9, U.N. Doc. CRC/C/15/Add.58 (June 7, 1996); CRC, *Consideration of reports submitted by states parties under article 44 of the convention*, ¶¶ 40-42, U.N. Doc. CRC/C/GTM/CO/3-4 (Oct. 25, 2010); CRC, *Concluding Observations: Burundi*, ¶¶ 26-27, U.N. Doc. CRC/C/15/Add.133 (Oct. 16, 2000); CRC, *Concluding Observations: Sudan*, ¶¶ 6, 29-30, U.N. Doc. CRC/C/SDN/CO/3-4 (Oct. 22, 2010).

This can include the non-implementation of CERD in the health sector.

IHL also contains a considerable number of strong rules aiming to ensure that providing health care remains neutral ground in armed conflicts. For example, the peacetime obligation to teach the basic principles of IHL to the civilian population at large, among other things, aims at safeguarding the neutrality of medical assistance.[152] It intends to ensure that the population realizes that there are certain rules under international law that protect even the worst enemy, among them are rules that demand respect for and protection of the wounded and sick, and provision of adequate care, no matter which party of the conflict they belong to. The ICRC study even establishes the prohibition of "adverse distinction" in the application of IHL as a self-standing customary norm of IHL,[153] based on Common Article 3 of the GCI-IV, as well as on the fact that this norm is recognised among the fundamental guarantees set out in the API and II.[154] "Adverse distinction" prohibits discrimination on any ground, but allows distinctions giving priority to those in need of most urgent care to be made.[155] Concerning health care in particular, parties to armed conflicts are obliged to "search for, collect and evacuate the wounded and sick *without adverse distinction*."[156] None other than medical grounds are allowed for making a distinction in the provision of medical care to the wounded and sick.[157] Moreover, IHL contains specific rules to ensure the non-discriminatory provision of health care by giving special protection to "medical activities," demanding respect for medical ethics, and protecting those who provide health care. Article 16(1) of API and article 10 of APII establish that, "under no circumstances" shall anybody be punished for providing medical care compatible with medical ethics, "regardless of the person benefitting therefrom."[158] This includes civilians who provide such care.[159]

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[152] As discussed above, see the text accompanying *supra* notes 54-64 and 77-85.

[153] ICRC Study, *supra* 52, Rule 88.

[154] AP I, *supra* note 51, art. 75(1); AP II, *supra* note 49, art. 4(1).

[155] ICRC Study, *supra* note 52, at 309 (Rule 88).

[156] ICRC Study,*supra* note 52, Rule 109 [emphasis added] (reiterating states' parallel treaty obligations under GC I, art. 15); GC II, *supra* note 48, art.18; GC IV, *surpa* note 48, art.16; AP I, *supra* note 51, art.10; AP II, *supra* note 49, art.8.

[157] ICRC Study, *supra* note 52, 400–03, Rule 110; *See e.g.*, GC I, *supra* note 48, arts. 12, 15; GC II, *supra* note 48, arts. 12, 18; GC IV, *supra* note 48, art. 18; ICRC Commentary to AP I/AP II, *supra* note 53, AP I, art. 10; ICRC Commentary to API/AP II, *supra* note 53, AP II, arts. 7, 8.

[158] ICRC Study, *supra* note 52, at 86-87 (establishing Rule 26 as a rule of customary IHL).

Furthermore, medical personnel may not be required to give priority to any person when providing care, except on medical grounds.[160]

In summary, states should already take into account and implement the very robust IHL rules that aim to ensure equal treatment of all wounded and sick in times of armed conflict during peacetime. This can strongly reinforce the principle of non-discrimination that has to be realised as one important component of the effective health system that states are required to build under the right to health. The more equal access people have to a health system, the more likely it is that the system can become an institution that promotes social cohesion and contributes to the building of a peaceful society.[161]

5. Comprehensive National Health Plan and Strategy

As mentioned previously, against the background of states' general obligation to take targeted steps to realise ESC rights progressively, in line with available resources, the obligation to develop a comprehensive health plan and strategy to build an effective and integrated health system compatible with the requirements of the right to health becomes very important.[162] As noted by the UN Special Rapporteur on the Right to Health, a health plan should include "clear objectives and how they are to be achieved, time frames, indicators and benchmarks to measure achievement, effective coordination mechanisms, reporting procedures, a detailed budget that is attached to the plan, financing arrangements, evaluation arrangements, and one or more accountability devices."[163] Prioritising competing health needs must also be part of the process of making a comprehensive health plan.[164] This is particularly so when resources are limited.

IHL does not know any progressive planning obligations for the implementation of health-related IHL obligations as such, that need to be

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[159] AP I, *supra* note 51, art. 17(1); GC I, *supra* note 48, art. 18.

[160] AP I, *supra* note 51, art. 15(3); AP II, *supra* note 49, art. 9(2).

[161] *See* Kruk et. al., *supra* note 6, at 92–93 (citing many further references); CESCR, General Comment 14, *supra* note 26, ¶¶ 43(f), 53–56; *see also Report of the U.N. Special Rapporteur on the Right to Health*, *supra* note 27, ¶¶ 47, 88-98; Declaration of Alma-Ata, *supra* note 123, ¶ VIII.

[162] CESCR, *General Comment 14*, ¶¶ 43(f) and 53-56; see also *Report of the U.N. Special Rapporteur on the Right to Health*, *supra* note 27, ¶¶ 47 and 88-98; and Alma-Ata Declaration, *supra* note 123, ¶ VIII.

[163] *Report of the U.N. Special Rapporteur on the Right to Health*, *supra* note 27, ¶ 96.

[164] *Id.*

realized in times of peace. The health-related obligations in IHL are, however, based on a picture of a well-functioning, integrated health system, many elements of which were mentioned in the foregoing sections. They should be taken into account in the peacetime planning process, with the primary aim of ensuring that states live up to their obligations to progressively realize the right to health. This can contribute significantly to ensure that the planning process is comprehensive and finds an appropriate balance between realizing long-term and short-term goals, as well as between more and less resource-demanding measures.[165]

Where health planning is concerned, a parallel consideration of the right to health and IHL could also contribute to the development and integration of an effective contingency plan into the health system. Such a plan can then be followed once an armed conflict or other natural or man-made disaster occurs. Without going into details, areas where the right to health and IHL can complement each other in this context concern, for instance, the re-allocation of resources to meet emergency health needs; guiding the setting of priorities in health interventions in emergencies; [166] and the coordination and integration of international assistance into the domestic system. The latter would prevent, as far as possible,[167] the establishment of parallel health systems, run by international humanitarian organisations that could undermine longer-term goals to build a sustainable and comprehensive *national* health system.[168]

On the institutional side, taking IHL and the right to health into account together when plans and strategies are developed to build a comprehensive health system might also encourage cooperation between responsible domestic authorities. For example, the governmental

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[165] *See* analysis *supra* Part II.A.1; *see also* Murray Wesson, *Grootboom and Beyond: Reassessing the Socio-Economic Jurisprudence of the South African Constitutional Court*, 20 S. AFR. J. ON HUM. RTS. 284, 304 (2004).

[166] On the latter two points, *see infra* Part II.B.3.

[167] In some armed conflicts, in particular non-international conflicts, integrating the provision international assistance into the domestic health system might be impossible, if this undermines the perception of these organisations as neutral actors.

[168] MÜLLER, *supra* note 19, at 239–70 (analyzing this topic in more detail). The establishment of such parallel health systems can also result in long-term dependencies on international assistance, a situation that would not be in line with states' obligations under the right to health. The right to health poses the obligations for the realization of this right, first and foremost, on states themselves, who should, in line with the principle of participation, consult their populations in the development of the best strategies for the building of an effective national health system.

departments (health, finance, and justice) that are most likely to be responsible for developing and implementing national health legislation, plans, and strategies, could cooperate with National Human Rights Institutions and National Commissions for the domestic implementation of IHL on the relevant questions. National Human Rights Institutions with mandates to secure the domestic implementation of IHRL exist in many countries today,[169] and National Commissions for the implementation of IHL are also being established in more and more states.[170] When civil servants from the same relevant departments are involved in developing and implementing a national health plan for the realization of the right to health and of IHL obligations, there may be hope that the planning process will produce some synergy effects. The resulting creation of a comprehensive health system would be conducive to building a peaceful society.

B. WHEN AN ARMED CONFLICT IS IMMINENT: THE RIGHT TO HEALTH (AND IHL) ENCOURAGING NON-VIOLENT SOLUTIONS?

This section engages with a slightly different question; it analyses how obligations flowing primarily from the right to health can encourage states to solve conflicts by non-violent means, in situations where there is a considerable likelihood of an outbreak of an international or non-international armed conflict. In other words, this section asks about the extent to which obligations under the right to health and other ESC rights could contribute to keeping peace in the negative sense (i.e., preventing imminent armed clashes between two states or a government and a non-state armed group). In general, states' obligations under the right to health seem to be more relevant in this regard, since they more directly regulate a situation, for example, where a state considers diverting resources from health care, education, social security, or the implementation of a national food strategy towards military spending. Most IHL obligations, by contrast, are applicable only

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[169] As of July 13, 2013, one hundred and three NHRIs were accredited with the International Coordination Committee of National Institutions for the Promotion and Protection of Human Rights. Sixty-nine of these institutions complied with the Paris Principles Relating to the Status of National Human Rights Institutions. For a list of the countries that have established a NHRI, *see* Int'l Coordinating Comm. for Nat'l Human Rights Insts. [ICC], *Chart of the Status of National Institutions: Accreditation Status as of July, 19, 2013* (Jan. 28, 2014), *available at* http://nhri.ohchr.org/EN/Contact/NHRIs/Documents/Chart%20of%20the%20Status%20of%20NHRIs%20%2819%20July%202013%29.pdf.

[170] *See* ICRC, *supra* note 86.

after an armed conflict has started, and such diversion has already taken place. It will be argued below that it is through the former obligations that the right to health and other ESC rights can encourage states to try their utmost to prevent armed conflicts. To set the scene for the argument, a short summary of the effects that armed conflicts can have on states' allocation of resources to health care follows.

1. Armed Conflicts and the Allocation of Resources to Health Care

Armed conflicts can have a considerable influence on states' budget allocations. For example, states involved in international or non-international armed conflicts are regularly more likely to allocate more resources to military and security policies, to military build-up and training, purchase of weapons, counterinsurgency operations, intelligence gathering, etc. than states not engaged in conflicts. Among other things, this usually results in under-resourced health systems in countries affected by armed conflicts.[171] Studies from Latin American countries that experienced non-international armed conflicts on their territories show, for instance, that ministries of health budgets shrank during these conflicts.[172] Observations from North and South Vietnam during the 1970s,[173] and the United States during the invasion of Iraq in 2003, confirm these tendencies,[174] as do studies reviewing governmental spending in different conflict-affected countries.[175]

Resources required to respond to the health consequences of an armed conflict will also often be high, adding to the funds required for the maintenance of a functioning health system in times of conflict. Studies show that the treatment of injuries caused by different weapons

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[171] *See* Francis Adeola, *Military Expenditures, Health and Education: Bedfellows or Antagonists in Third World Development*, 22 ARMED FORCES & SOC'Y 441, 257–58 (1996) (explaining the theoretical and empirical assessment of the influence of military factors on education, health and development in low-income countries by Adeola, holding that "the opportunity cost of higher military spending includes lower budgetary allocation to health and other social services, and the consequent poor social well-being of the people in [least developed countries]").

[172] Charlie Celements & Tim Takaro, *Wars in Latin America*, *in* WAR AND PUBLIC HEALTH 288 (Barry S. Levy & Victor W. Sidel, eds., 2008).

[173] Myron Aluukian Jr. & Paul L. Atwood, *The Vietnam War*, *in* WAR AND PUBLIC HEALTH 313 (Barry S. Levy & Victor W. Sidel, eds., 2008).

[174] Barry S. Levy & Victor W. Sidel, *The Iraq War*, *in* WAR AND PUBLIC HEALTH 243, 259–60 (Barry S. Levy & Victor W. Sidel, eds., 2008).

[175] Sanjeev Gupta, et al., *The Elusive Peace Dividend*, 39(3) FIN. & DEV. - A QUARTERLY MAGAZINE OF THE IMF (2002), *available at* https://www.imf.org/external/pubs/ft/fandd/2002/12/gupta.htm (chart 3).

is considerably more expensive than basic primary health-care interventions that benefit the larger population,[176] not to mention the high cost for rehabilitative care to address the physical and mental wounds caused by armed conflicts.[177] Moreover, armed conflicts have a negative effect on economic performance of the affected countries and will therefore frequently also result in shrinking health budgets.[178] In the following sections it is shown that some of the obligations under the right to health and other ESC rights that set procedural and material limits to the extent to which states can divert resources from health care and other social services toward military spending can also contribute to finding peaceful solutions in situations when tensions between states, or between non-state armed groups and governments, arise.

2. *IHRL Principles Applicable to the Diversion of Resources*

Neither IHL, nor the right to health, nor other ESC rights directly prohibit the diversion of resources from health care, education, social security, etc. toward military spending. On the contrary, many of the CESR's concluding observations recognize that the existence of an armed conflict can be detrimental to the amount of resources available for the implementation of the right to health and other ESC rights,[179] and

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[176] *E.g.*, Maria Valenti et al, *Armed Violence: A Health Problem, a Public Health Approach*, 28 J. OF PUB. HEALTH POL'Y 389, 393 (2007).

[177] *See, e.g.*, James Geiling, et al., *Medical Costs of War in 2035: Long-term Care Challenges for Veterans of Iraq and Afghanistan*, 177 MIL. MED. 1235, 1239 (2012) (studying future rehabilitative health care costs for Afghanistan and Iraq veterans in the U.S.).

[178] James C. Murdoch & Todd Sandler, *Civil Wars, Economic Growth and the Spatial Spill-Over*, 46 J. OF CONFLICT RESOL. 91, 106–7 (2002) (concluding that non-international armed conflicts have severe short-term negative impact on economic growth); *see also* Christopher Blattman & Edward Miguel, *Civil War*, 48 J. OF ECON. LITERATURE 3, 37 (2010) (giving overview of economic literature on civil war, and in particular Part 4 on "Economic Legacies of Civil War").

[179] *See* CESCR, *Concluding Observations: Armenia*, ¶¶ 3, 6–7, U.N. Doc. E/C.12/1/Add.39, (Dec. 8, 1999) (concerning non-international armed conflicts); CESCR, *Concluding Observations: Bosnia and Herzegovina*, ¶ 7, U.N. Doc. E/C.12/BHI/CO/1 (Jan. 14, 2006); CESCR, *Concluding Observations: Sri Lanka*, ¶ 5, U.N. Doc. E/C.12/1/Add.24 (June 16, 1998); CESCR, *Concluding Observations: Russian Federation*, ¶ 10, U.N. Doc. E/C.12/1/Add.94 (Dec. 12, 2003); CESCR, *Concluding Observations: Kyrgyzstan*, ¶ 11, U.N. Doc. E/C.12/1/Add.49 (Sept. 1, 2000); CESCR, *Concluding Observations: Guatemala*, ¶ 9, U.N. Doc. E/C.12/1/Add.93 (Dec. 12, 2003); CESCR, *Concluding Observations: Afghanistan*, ¶ 12, U.N. Doc. E/C.12/ AFG/CO/2–4 (June 7, 2010); CESCR, *Concluding Observations: Chad*, ¶ 7, U.N. Doc. E/C.12/TCD/CO/3 (Dec. 16, 2009); CESCR, *Concluding Observations: Cambodia*, ¶ 11, U.N. Doc. E/C.12/KHM/CO/1 (June 12, 2009); CESCR, *Concluding Observations: Kuwait*, ¶ 7, U.N. Doc. E/C.12/1/Add.98 (June 7, 2004) (concerning international armed conflicts); CESCR, *Concluding Observations: Azerbaijan*, ¶ 11, U.N. Doc. E/C.12/1/Add.104 (Dec. 14, 2004).

that resource constraints resulting from armed conflicts can underlie so-called retrogressive measures.[180] From these statements, it seems that the CESCR accepts, to some extent, that retrogressive measures (or limitations)[181] affecting the realisation of the right to health due to the existence of an armed conflict, can be justified. Nonetheless, the ICESCR sets limits to such a diversion of resources. This is clear from states' obligations under article 4 of the ICESCR, as well as the notion of progressive realisation of article 2(1) of the ICESCR and the implication of non-retrogression arising from this notion.[182] This notion requires that, in general, at least the present level of enjoyment of the right to health and other ESC rights must be maintained, and only in exceptional circumstances are retrogressive measures permitted.[183] In other words, so-called retrogressive measures (or limitations) are only allowed when states follow the requirements set forth in article 4 of the ICESCR, which were discussed above.

It will now be shown how the requirement that retrogressive measures to ESC rights can only be imposed for the purpose of "promoting general welfare" in a "democratic society,"[184] can potentially contribute to solving tensions between different states or between governments and non-state armed groups in a peaceful manner. This is particularly so when this requirement is taken into account in determining whether resources can be diverted from health care toward military spending. It shall be noted beforehand though that the CESCR and other UN treaty bodies rarely relate their comments to the ICESCR's general limitation clause (article 4 of the ICESCR) when analysing budget allocations and/or when calling on states to consider peaceful

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[180] *See e.g.*, CESCR, *An Evaluation of the Obligation to Take Steps to the "Maximum of Available Resources" Under an Optional Protocol to the Covenant*, ¶ 10, U.N. Doc. E/C.12/2007/1 (Sept. 21, 2007); *see also* SSENYONJO, *supra* note 33, at 64.

[181] The present author has argued elsewhere that what the CESCR's calls "retrogressive measures" and/or limitations to ESC rights shall be governed by the same principles set out in article 4 of the ICESCR. It would be preferred if the CESCR would label all limitations to ESC rights as such, and not draw an artificial distinction between on the one hand retrogressive measures (which are due to resource constraints) and on the other hand other limitations of ESC rights (due to any other reason). See MÜLLER, *supra* note 19, at 115-37. The terms "retrogressive measures" and "limitations" are therefore used interchangeably in the following.

[182] *Id.*; *see also* discussion *supra*, Part I.A.

[183] MÜLLER, *supra* note 183, at 130–33; discussion *supra*, Part I.A.

[184] ICESCR, *supra* note 37, art. 4.

means to solve conflicts.[185] In order to strengthen the rule of law, the Committee could be advised to do so more explicitly.

3. The Question of Alternatives to the Use of Armed Force, Conducive to the "Promotion of General Welfare"

Under article 4 of the ICESCR, the "promotion of general welfare" is the only purpose for which ESC rights can be limited, including when these limitations occur due to resource scarcity.[186] While there is an inherent contradiction in stating that retrogressive measures (or limitations) prompted by scarce resources are only justified when they "promote general welfare," it can be expected that the notion of general welfare may still be used as a guiding maxim. It seems appropriate to require that states organize unavoidable retrogressive measures in a way that promotes general welfare in the prevailing circumstances—or, at least, limit its erosion as effectively as possible.[187]

The general understanding of "general welfare" as the economic and social well-being of a society under article 4 of the ICESCR,[188] and various comments of the CESCR, give some indication of what the notion of general welfare implies for the context of limiting the right to health due to the diversion of resources towards the fighting of an international or non-international armed conflict. The CESCR's statements require for example that, in order to comply with the notion of general welfare, limitations can only be introduced after the "most careful consideration of all alternatives," including seeking to identify "low-cost options" and the mobilisation of international assistance.[189]

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[185] This is clear from the CESCR's and other UN treaty bodies' concluding observations concerning countries affected by armed conflicts, or concerning countries emerging from armed conflict, cited *infra* notes 194-204.

[186] MÜLLER, *supra* note 19, at 116-120 and 130-133.

[187] *Id.* (An analysis of different documents of the CESCR and other UN treaty bodies, as well as domestic courts' jurisprudence supporting this interpretation of arts. 4, 2(1) of the ICESCR has been conducted by the present author elsewhere. The following arguments build on the findings of this research.).

[188] MÜLLER, *supra* note 19, at 116-20 (analysing this provision in detail).

[189] *See e.g.*, CESCR General Comment 15: The Right to Water, ¶ 19, U.N. Doc. E/C.12/2002/11 (Jan. 20, 2003); CESCR, General Comment 13: The Right to Education, ¶ 9, U.N. Doc. E/C.12/1999/10 (Dec. 8, 1999); CESCR, General Comment 14, *supra* note 26, ¶ 32; CESCR, General Comment 19: The Right to Social Security, ¶ 42, U.N. Doc. E/C.12/GC/19, (Feb. 4, 2008); CESCR, *Statement on "Maximum of Available Resources"*, *supra* note 181, ¶ 10 (e)–(f); U.N. Special Rapporteur on the Right to Food, *Building resilience: a human rights framework for world food and nutrition security*, ¶ 5, U.N. Doc. A/HRC/9/23, Annex II, (Sept. 8, 2008).

Thus, in situations where shifting resources toward military spending is foreseen, for example because tensions exist that could result in an international or non-international armed conflict, the question arises of what alternatives could be more conducive to the preservation of general welfare. For our context, one question is particularly relevant here: Do states have an obligation to negotiate with non-state armed groups (or other states) instead of engaging them with armed force? Negotiations may limit the diversion of resources, could be described as a "low-cost option," and would therefore be likely to be more conducive to the protection of general welfare than engaging non-state armed groups or other states with armed force. Specifically, this question seems legitimate when it is recalled that many non-international armed conflicts have their roots, at least partially, in lasting non-implementation of ESC rights and civil and political rights, or the discriminatory implementation of these rights.[190] It seems unjustified to allow states to use their failure to implement ESC rights in the first place as a reason for limiting them further, in order to free resources to engage non-state armed groups militarily. Moreover, negotiations could prevent not only the detrimental consequences of armed conflicts for health budgets mentioned above but also the possible destruction of existing elements of a health system and infrastructure that may result from the hostilities.[191] Such destruction undoubtedly undermines the promotion of general welfare.[192]

The CESCR has indeed encouraged states confronted with unstable situations to solve them by peaceful means. In its *Concluding Observations on Colombia* state report in 2001, the Committee recommended that Colombia "seek appropriate means to reduce the extreme social inequalities and increase its efforts to put an end to the armed conflict *by political negotiation*, which is the only way effectively to guarantee the economic, social and cultural rights of all citizens."[193] Similarly, in its 1998 *Concluding Observations on Sri Lanka*, the CESCR observed that it was "fully aware of the human and material

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[190] *See generally* CESCR, *supra* note 151.

[191] *See* Müller, *supra* note 19, ch. VI–VII (showing States' obligations under IHL and the right to health to mitigate these effects have been thoroughly analysed by the present author before).

[192] *See* ICRC, *Health Care in Danger: Making the Case*, (Aug. 2011), *available at* http://www.icrc.org/eng/assets/files/publications/icrc-002-4072.pdf (highlighting that these far-reaching, tragic effects have been documented recently by the ICRC).

[193] CESCR, *Concluding Observations: Colombia*, ¶ 30, U.N. Doc. E/C.12/1/Add.74 (Dec. 6, 2001) (emphasis added); CESCR, *Concluding Observations: Colombia*, ¶ 7, U.N. Doc. E/C.12/COL/CO/5 (June 10, 2010) (documenting the Committee which called on the government to urgently implement its plans to end the internal violence).

costs of the armed conflict in Sri Lanka and the deleterious effects this has on the ESC rights of every person living in the country."[194] It went on to express its hope for a "just, speedy and peaceful solution of the war," urging the government "as a matter of the highest priority, to *negotiate* the acceptance by all concerned of its proposed *peace plan* involving devolution of authority to regional governments."[195] In other words, it urged the Sri-Lankan government to speed up its negotiations with The Liberation Tigers of Tamil Eelam (LTTE) to end the armed conflict, and to thereby remove one of the main obstacles to the implementation of ESC rights in the country. In these and other concluding observations,[196] the Committee noted explicitly that the strain on resources available for the implementation of ESC rights was due to the existence of armed hostilities in the state party's territory.

In other concluding observations, the CESCR welcomed the adoption of peace agreements in more general terms, holding that they will contribute to creating a better environment for the implementation of ESC rights.[197] The appeals for seeking peaceful solutions to on-going or imminent armed conflicts are also reiterated by UN human rights treaty bodies other than the CESCR. For example, the UN Committee on the Elimination of Racial Discrimination has called on different factions in societies to solve tensions and conflicts by peaceful means,[198] as have the Committees on the Elimination of the Discrimination against Women[199]

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[194] CESCR, *Concluding Observations: Sri Lanka*, ¶ 21, U.N. Doc. E/C.12/1/Add.24 (June 16, 1998) (emphasis added).

[195] *Id.*

[196] *E.g.*, CESCR, *Concluding Observations: Democratic Republic of the Congo*, ¶ 16, U.N. Doc. E/C.12/COD/CO/4 (Dec. 16, 2009); CESCR, *Concluding Observations: Guatemala*, ¶ 11, U.N. Doc. E/C.12/1/Add.3 (May 28, 1996); CESCR, *Concluding Observations: Serbia and Montenegro*, ¶ 8, U.N. Doc. E/C.12/1/Add.108 (June 23, 2005).

[197] *See, e.g.*, CESCR, *Concluding Observations: Nepal*, ¶ 4, U.N. Doc. E/C.12/NPL/CO/2 (Jan. 16, 2008); CESCR, *Concluding Observations: Republic of Congo*, ¶ 12, U.N. Doc. E/C.12/1/Add.45 (May 23, 2000); CESCR, *Concluding Observations: Sudan*, ¶ 9, U.N. Doc. E/C.12/1/Add.48 (Sept. 1, 2000); CESCR, *Concluding Observations: Guatemala*, *supra* note 196, ¶¶ 4–5.

[198] *See, e.g.*, CERDCttee, *Concluding Observations: Côte d'Ivoire*, ¶ 20, U.N. Doc. CERD/C/62/CO/1 (June 3, 2003); CERDCttee, *Concluding Observations: Uganda*, ¶ 16, U.N. Doc. CERD/C/62/CO/11 (June 6, 2003); CERDCttee, *Concluding Observation: Lao People's Democratic Republic*, ¶ 21, U.N. Doc. CERD/C/LAO/CO/15 (Apr. 18, 2005); CERDCttee, *Concluding Observations: Cyprus*, ¶ 7, U.N. Doc. CERD/C/CYP/CO/17-22 (Sept. 23, 2013).

[199] *See, e.g.*, U.N. Committee on the Elimination of Discrimination against Women [CEDAWCttee], *Concluding Comments: Israel*, ¶¶ 21–22, U.N. Doc. CEDAW/C/ISR/CO/3 (July 22, 2005); CEDAWCttee, *Concluding Observations: Israel*, ¶¶ 14–15, U.N. Doc. CEDAW/C/ISR/CO/5 (Apr. 5, 2011) (reiterating CEDAWCttee's previous Israel report); CEDAWCttee, *Concluding Observations: Cyprus*, ¶ 23, U.N. Doc. CEDAW/C/CYP/CO/6-7 (March 25, 2013) (calling in particular for the participation of women in the peace process).

and the Committee on the Rights of the Child.[200] These examples suggest that the CESCR (and other UN treaty bodies) at least expect governments to make serious attempts to solve conflicts and tensions through negotiations. Arguably, this is because such a strategy would pose fewer threats to the population's enjoyment of the right to health and other ESC rights, including those due to the reduction of available resources, if military force were used. Negotiations could therefore be described as a "low-cost option"[201] that promote general welfare in an unstable situation better than the use of military force.

This cannot, however, mean that the ICESCR directly prohibits the use of force. In its above-mentioned concluding observations, the Committee accepts the reality that armed conflicts do occur, including the fact that in some situations the alternative of negotiation may not be possible.[202] There may be situations in which engaging non-state armed groups with armed force is justified by the claim that it will end violations of ESC and civil and political rights by such groups. This may be the case, for example, when a state has lost control over parts of its territory to a non-state armed group that is unwilling to participate in negotiations, or is preventing humanitarian organizations from assisting affected civilians. The CESCR has also recognized this, occasionally calling on states to protect civilians from violations of human rights (and IHL) committed by these groups.[203] It can be argued that in such a case, the use of force, including the related diversion of resources towards military spending, contributes to the "promotion of general welfare," as required under article 4 of the ICESCR. It might be a precondition for enabling the respective government to implement the ESC rights of people living in areas controlled by non-state armed groups. Under the ICESCR, states are obliged to commit themselves to the protection of those people's ESC rights to the same extent that they must protect the ESC rights of people in areas under governmental control. In this

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[200] *See, e.g.*, U.N. Committee on the Rights of the Child [CRC], *Concluding Observations: Niger*, ¶ 62, U.N. Doc. CRC/C/15/Add.179 (June 13, 2002); CRC, *Concluding Observations: Sri Lanka*, ¶ 3, U.N. Doc. CRC/C/15/Add.207 (July 2, 2002); CRC, *Concluding Observations: Nigeria*, ¶¶ 65–66, U.N. Doc. CRC/C/15/Add.257 (Apr. 13, 2005).

[201] *Cf. generally supra*, note 190.

[202] *See generally supra* notes 180-81; *infra* note 203; *see also* MÜLLER, *supra* note 19, at 130–33.

[203] *See e.g.*, CESCR, *Concluding Observations: Guatemala*, ¶ 11, U.N. Doc. E/C.12/1/Add.3 (May 28, 1996); CESCR, *Concluding Observations: Democratic Republic of the Congo*, ¶ 6, U.N. Doc. E/C.12/COD/CO/4 (Dec. 16, 2009); U.N. Committee Against Torture [CAT], *Conclusions and Recommendations of the Committee Against Torture: Colombia*, ¶¶ 9(b),10(c), U.N. Doc. CA T/C/CR/31/1 (Feb. 4, 2004).

context, some UN treaty bodies,[204] and also the European Court of Human Rights, have encouraged states to regain control over territory that has come under the control of rebel forces or third states by "taking all the political, judicial and other measures" at their disposal.[205] While not directly mentioning military means, these means are not per se excluded.

The other criteria states need to take into account under article 4 of the ICESCR when limiting ESC rights might also contribute to the prevention of armed conflict. For example, the requirement that limitations have to be "determined by law" could strengthen the obligation mentioned above, to develop a contingency plan that allows for the adaptation of a domestic health system to the necessities of an emergency, if such an emergency occurs. The requirement "in a democratic society" could ensure that domestic legislation on the contingency plan is the result of a consultative and participatory process, taking into account the particular needs of "marginalised and disadvantaged groups." Last, the requirement that limitations should never interfere with "the nature of these [ESC] rights" can ensure that minimum core ESC rights are always protected, even in times of crisis, including armed conflicts. Arguably, if a contingency plan follows these principles, it will contribute to limit the public health consequences of armed conflicts and other emergencies. Thereby, the chances to re-establish peaceful relations between different groups of the population by giving everyone equal access to good quality health services could also be increased.

III. CONCLUDING REMARKS

This analyzed some areas where obligations flowing from the right to health and IHL in peacetime can arguably contribute to

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[204] *See e.g.*, CESCR, *Concluding Observations: Colombia*, ¶ 7, U.N. Doc. E/C.12/COL/CO/5 (June 7, 2010) (recommending taking 'immediate and effective measures' to address the on-going armed violence in Colombia); *see also* U.N. Human Rights Committee [HRCttee], *Concluding Observations: Moldova*, ¶ 5, U.N. Doc. CCPR/MDA/CO/2 (Oct. 29, 2009); *see* HRCttee, *Concluding Observations: Georgia*, ¶ 6, U.N. Doc. CCPR/C/GEO/CO/3 (Nov. 15, 2007); HRCttee, *Concluding Observations: Uganda*, ¶ 12, U.N. Doc. CCPR/CO/80/UGA (May 4, 2004).

[205] Case of Ilaşcu & Others v. Moldova & Russia, App. No. 48787/99, Eur. Ct. H.R. §§ 340–341 (July 8, 2004); *see also* Case of Ivanţoc & Others v. Moldova & Russia, App. No. 23687/05, Eur. Ct. H.R. §§ 105–111, (Nov. 15, 2011); Case of Catan & Others v. Moldova & Russia, App. Nos. 43370/04, 18454/06 8252/05 § 109, (Oct. 19, 2012).

preventing armed conflict and to creating lasting (positive) peace. Both bodies of law can contribute to the progressive development and strengthening of an effective, integrated, and responsive health system of good quality that is accessible to all. Direct IHL obligation on states to "take all necessary measures for the execution" of IHL "without delay"[206] can strengthen obligations under the right to health to adopt strong domestic laws protecting individuals' existing access to health care and setting out a plan for the building and further development of an effective health system. Moreover, the picture of a well-functioning health system that underlies IHL can supplement and concretize obligations under the right to health in times of peace to actively take measures to build a comprehensive health system, even if it cannot be claimed that states have far-reaching (positive) obligations directly under IHL in times of peace. An integrated approach to the implementation of the right to health and health-related IHL obligations at all times, even in times of peace, can be supported by the principle of systemic integration under article 31(3)(c) of the VCLT. It has also been indicated that taking account of health-related IHL obligations in times of peace, together with obligations under the right to health, can arguably contribute to strengthening a health system's capacity to react to and cope with emergency situations. If an armed conflict breaks out, this could help to limit the direct and indirect public health consequences of such a conflict, and also lead to a swifter re-building of health infrastructure after the conflict has ended. All in all, proactively taking account of the right to health *and IHL* in peacetime can assist states to make use of the full complementary protection that both bodies of law offer to individuals, in times of war and peace.

The article also analysed how obligations under article 4 of the ICESCR that set procedural and material limits to states' rights to restrict the right to health due to resource constraints, can induce states to solve conflicts by peaceful means instead of by resorting to armed force. The analysis of relevant CESCR documents revealed that this potential exists, but that the CESCR could, at times, more explicitly relate its observations on retrogressive measures (or limitations) and peace processes to the relevant criteria in article 4 of the ICESCR, in order to strengthen the rule of law in this area. This would make states more directly aware of their legal obligations in this regard.

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[206] AP I, *supra* note 51, art. 80.

The discussion in this article has been of a more theoretical, doctrinal nature, primarily analysing some relevant legal provisions under the ICESCR and IHL, and how they could relate to building peaceful societies and preventing imminent conflicts. As a next step, it would be desirable to conduct a more practice-informed analysis, for example, in the form of case studies. As part of such studies, the question of whether and how, the right to health, as well as IHL peacetime implementation obligations, are used and/or should be used in the development of health policies concerning the building of domestic health systems, could be examined in greater detail. In this process, particular attention should be paid to the elements of a health system that are recognized to contribute to peace-building. The same could be done concerning the question of whether states take account of their obligations under the ICESCR when they decide whether or not to engage an armed group or another state with armed force, and what role the CESCR could play to encourage such consideration. The theoretical discussion of the relevant provisions in IHRL and IHL in this paper revealed that the parallel application of both bodies of law even *before* an armed conflict breaks out, can contribute to building more integrated and peaceful societies. This can be achieved mainly through their contributions to constructing and developing such a critically important social institution as a well-functioning health system; and through encouraging peaceful solutions once inter- or intra-state tensions arise.