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International Health Law: International, Regional, and National Perspectives

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Dear Readers,

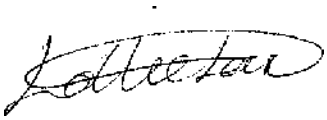
I am very pleased to be writing the Presidential Note for Volume 3, Issue 2 of the *Groningen Journal of International Law*: International Health Law. As a developing field in its own right, the area of international health law itself reflects the ethos of GroJIL, striving to provide innovative insights into contemporary challenges facing international law.

This issue of GroJIL features a fantastic Guest Editorial Note by Marie Elske Gispen, which introduces the topic of international health law and the articles constituting Volume 3, Issue 2. It has been a pleasure for GroJIL to work with the authors of this issue's articles, whom I would like to thank for their fantastic contributions.

I would also like to express my gratitude to the Editorial Board, the Editing and PR Committees and our Graphic Designer for their continuous hard work and enthusiasm throughout the publication process. The issue would not have been possible without the dedication of each member of the GroJIL team.

As Volume 3, Issue 2 will be my last issue as President and Editor-in-Chief of GroJIL, I would like to reiterate what a pleasure it has been to work with all of the members of the GroJIL team since I joined the Journal in 2012. Though I am very sad to be leaving GroJIL, I am also very excited to be passing the positions of President and Editor-in-Chief to Ms. Júlia Ortí and Mr. Ferdinand Quist. I wish them the very best of luck and success in their new positions, and hope that they will enjoy the excitement and the challenges as much as I have over the last two years.

Happy reading!



Lottie Lane
President and Editor-in-Chief
Groningen Journal of International Law

Editorial

International Health Law: International, Regional, and National Perspectives

Marie Elske Gispen*

In general but especially in times of conflict, crisis, natural disaster, or austerity access to health care is important but also complex all over the world. For, at a very practical level, access to health care presupposes well-functioning and appropriate designed health systems and necessary infrastructure, but also institutional and bureaucratic functioning (at organisation and state level). At a policy level, access to health care implies appropriate priority setting in line with international standards and addressing the key health priorities of a country with due respect for vulnerable and marginalised groups, and equitable distribution of financial and human resources. At a legal level, access to health care means a human right to the highest attainable standard of health (hereafter: the right to health), which is enforceable and justiciable, equipped to hold account those violating the right to health, and determines a framework of state obligations on the basis of which law and policy on health matters should be further designed.

International health law is a vast developing area of law. The normative scope and content of the right to health has been carefully elaborated in, amongst others, General Comment 14 of the Committee on Economic Social and Cultural Rights (CESCR) in 2000.[1] Yet, the question today is whether this document is still fully up to date to really help shape state obligations and effective realisation in the area of health law.[2] Such a question is particularly acute because aspects of health threats and the provision of access to health facilities, goods, and services, are regulated by, or fall within the remit of, different areas of law. For instance, intellectual property law, trade law, environmental law, international standardisation guidelines, and international drug control law are all standard setting in the area of health but are not necessarily based on, realised by, and enforced through the standards, principles, and mechanisms of human rights law.[3] Especially because access to health services is thus subject to an often complex interplay of international standards, it is even more so important to further the understanding of the right to health in a variety of perspectives including international, regional, and domestic levels as well as different sub areas of health including maternal care, palliative

* MEC (Marie Elske) Gispen, LL.M., Ph.D. Researcher Netherlands Institute of Human Rights (SIM) and the Ethics Institute of Utrecht University (NL). Marie Elske is a senior research associate of the International Centre on Human Rights and Drug Policy, an independent research-institute of the University of Essex (UK) and research associate of Global Health Law Groningen. Contact: m.e.c.gispen@uu.nl.

1 CESCR, General Comment 14 (2000), E/C.12/2000/4.

2 See also Toebes, B, "Access to Health Services – what are the legal milestones?" Keynote lecture, European Health Law Conference, Riga, 28 April 2014, *at* <papers.ssrn.com/sol3/papers.cfm?abstract_id=2432156> accessed 15 December 2015. Toebes flags that from a normative perspective the right to health is widely adopted, however, the real question on the table is how to enhance its realisation, ie. how to foster better access to health services within the existing framework of law.

3 See for recent debates on these various interplays, for instance, Sellin, J, *Access to Medicines* (Intersentia: Antwerp, 2014); Gispen, MEC, "Reconciling international obligations and local realities: the provision of pain control medication in resource constrained countries – experiences from Uganda" *in* Hesselman, M, Toebes, B, Hallo de Wolf, AG, eds, *Essential Public Service Provision* (Routledge, forthcoming).

care, primary care, and the health priorities and treatment of vulnerable and marginalised groups, to mention just a few.

The diversity of perspectives from which the normative content of international health law and in particular the right to health as such can be furthered is the red threat of this very timely volume. The topics addressed are structured in international, regional, and country level perspectives. None of the articles in this volume are peer-reviewed, except for the submission of Shamiso Zinzombe ('Harnessing the Human Rights Reasonableness Principle for Access to Medicine').

As a start, Shamiso Zinzombe ('Harnessing the Human Rights Reasonableness Principle for Access to Medicine')[4] discusses the central role of the principle of reasonableness by adoption of the Optional Protocol to the International Convention on Economic, Social, and Cultural Rights in light of as access to medicine. In doing so, Zinzombe focuses on the interplay between patent law and human rights law. Zinzombe proposes interim measures, or strategies that could be used until a human rights-based approach to patent law has been developed. Zinzombe describes the role of reasonableness by using examples like the seizure of generic medicine and route from India to Brazil whilst in transit in Rotterdam, and also addresses issues around the accountability of pharmaceutical companies.

Remaining largely at the international level but from an international criminal law perspective instead, Juan Pablo Pérez-Léon Acevedo ('Realizing the Right to Health for Victims of International Crimes. The Case of Medical Rehabilitation Reparations Ordered by International Courts: Challenges, Possibilities and Ways of Improvement') focuses on the severe harm on physical and mental health as a result of international crimes and serious human rights violations. Acevedo analyses the state of play of health related reparations and realisation of the right to health for victims in international (criminal) law by analysing the case law of three international/regional courts. Namely, the Inter-American Court of Human Rights, the International Criminal Court, and the Extraordinary Chambers in the Courts of Cambodia. In discussing the practices of these courts in issuing medical rehabilitation reparations, Acevedo suggests both ways to improve the current practice of issuing medical rehabilitation, and proposes particular steps states and the international community as a whole should take to better secure their implementation. Acevedo traces links to standards of the human right to health throughout the analysis.

Then focusing at the regional level, Carmelo Danisi ('Protecting the Human Rights of People Living with HIV/Aids an European Approach?') aims to extract whether or not a common European approach is emerging and/or whether such approach is complicit with a human rights-based approach to HIV/Aids. Danisi elucidates similarities and differences in the various ways in which people living with HIV/Aids can or lack to receive protection from the European Convention on Human Rights (ECHR) and European Union Law. Whereas recognition of a certain vulnerability allows the European Court of Human Rights (ECtHR) to apply Article 14 (non-discrimination) in relation to other provisions, a more restrictive approach is yielded in relation to, for instance, the principle of non-refoulement under Article 3 of the ECHR. Danisi then demonstrates the way in which the European Court of Justice recently reinforced the emerging disparities between substantial guarantees and procedural obligations in light of the special needs of people living with HIV/Aids. Danisi particularly analyses a human rights-based approach to HIV/Aids and aims to create greater understanding as to whether or not the perhaps shaky European approach to this matter complies with such approach, or not.

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[4] This submission is peer-reviewed upon request of the author.

Finally, at the country level closest to the 'home ground' of this Journal, Veronika Flegar ('The Principle- of Non-Discrimination – An Empty Promise for the Preventive Health Care of Asylum-seeking and Undocumented children?) elucidates the important issue of differences in access to health care in particular preventive health care of asylum-seeking and undocumented children in the Netherlands. According to Flegar there is evidence, which suggests that in the Netherlands, access to health care for children depends on their legal status. This could be problematic in particular in light of Article 2 of the Convention on the Rights of the Child (CRC) – stating all rights as enshrined in the CRC are equally applicable to all children. Flegar first examines the scope and content of the principle of non-discrimination after which she turns to elaborating the scope and content of a right to preventive care for asylum seeking and undocumented as compared to national children. Ultimately, Flegar aims to bring greater clarity to understanding state obligations of access to health care for children with different legal statuses by zooming into the analysing the compatibility of state obligations to provide preventive care and those obligations deriving from the principle of non-discrimination for both asylum-seeking children as compared to undocumented children.

A special word of appreciation goes out to the Board of Editors for compiling such a stimulating and interesting volume demonstrating only a sample of the wide variety of perspectives in which I believe the right to health can be discussed and should be understood. I also thank them for their kind invitation to write the editorial to this volume. Enjoy reading!

Groningen Journal of International Law

Crafting Horizons

ABOUT

The Groningen Journal of International Law (GroJIL) is a Dutch foundation (Stichting), founded in 2012. The Journal is a not-for-profit, open-access, electronic publication. GroJIL is run entirely by students at the University of Groningen, the Netherlands, with supervision conducted by an Advisory Board of academics. The Journal is edited by volunteering students from several different countries and reflects the broader internationalisation of law.

MISSION

The Groningen Journal of International Law aims to promote knowledge, innovation and development. It seeks to achieve this by serving as a catalyst for author-generated ideas about where international law should or could move in order for it to successfully address the challenges of the 21st century. To this end, each issue of the Journal is focused on a current and relevant topic of international law.

The Journal aims to become a recognised platform for legal innovation and problem-solving with the purpose of developing and promoting the rule of international law through engaging analysis, innovative ideas, academic creativity, and exploratory scholarship.

PUBLISHING PROFILE

The Groningen Journal of International Law is not a traditional journal, which means that the articles we accept are not traditional either. We invite writers to focus on what the law could be or should be, and to apply their creativity in presenting solutions, models and theories that in their view would strengthen the role and effectiveness of international law, however it may come to be defined.

To this end, the Journal requires its authors to submit articles written in an exploratory and non-descriptive style. For general queries or for information regarding submissions, visit www.grojil.org or contact groningenjil@gmail.com.

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Harnessing the Human Rights Reasonableness Principle for Access to Medicine

Shamiso Zinzombe*

Keywords
ACCESS TO MEDICINE; PHARMACEUTICAL CORPORATIONS; REASONABLENESS PRINCIPLE; INTELLECTUAL PROPERTY; ECONOMIC, SOCIAL AND CULTURAL RIGHTS; THE RIGHT TO HEALTH; IN-TRANSIT; IINTERCEPTION; SEIZURE.

Abstract
The reasonableness principle has come to the fore in human rights law with the entry into force of a much anticipated Optional Protocol to the International Covenant on Economic, Social and Cultural Rights. While the Committee on Economic, Social and Cultural Rights, monitoring implementation of the treaty, has maintained a similar principle in documents such as its statements, this is the first time that the reasonableness principle has been formally enumerated in human rights treaty law. The manner in which pharmaceutical corporations exploit patents in the context of the human right entitlement to access medicine is an interesting area to examine using this principle. The application of patents to medicine is controversial and rightly challenged for creating a system of innovation that prioritises profits over people. This unconscionable system is one for which activists, scholars and commentators are correctly calling for a human rights based open system of innovation that ensures access to medicine for all in need. This article, however, explores strategies that could be used in the meantime. These strategies speak to some causes of this problem related to decisions to use intellectual property in certain contexts. For example, the seizure of generic medicine *en route* from India to Brazil whilst in transit in Rotterdam, the use of multiple patents through strategies known as 'evergreening', patent 'thicketing' or 'clustering' to thwart the entry of generic medicine, or restrictions on voluntary licences such as geographic restrictions that prevent supply of medicine to certain territories. At the same time, it is worthwhile noting that the Agreement on Trade-Related Aspects of Intellectual Property contains provisions which could work with the reasonableness principle. Thus, this article argues, in addition to other principles advanced in the human rights community in this area, it is also possible to apply a reasonableness principle to the use of intellectual property in the area of medicine. It does so by using seizure of in-transit generic medicine as a case study with which to extrapolate the potential application of the reasonableness principle. This paper sets out an introduction, explains the practice of intercepting or seizing generic medicine in-transit, discusses the reasonableness principle and explores the reasonableness principle as a mechanism to hold pharmaceutical corporations to account in order to promote, rather than hinder access to medicine.

I. Introduction

Over the past two decades, serious problems associated with the way in which intellectual property is exercised over medicine have been observed and well

documented.[1] This has also highlighted a continuing need for a different system, to ensure that innovation and access to medicine take place in tandem consistently with international human rights legal norms, like those enumerated in the right to health.[2] This article, however, considers what else could be done, in the meantime, to promote access within the current limited framework. It does so by looking at a case study concerning the practice of intercepting in-transit generic medicine.[3] It is a matter that has engaged the interest not only of the immediately affected nations of India and Brazil,[4] but also other medicine producing nations, such as Canada and Japan.[5] Consultations on disputes concerning the practice of interception are presently ongoing at the World Trade Organization (WTO).

This article examines the potential of the reasonableness principle as a mechanism to promote access to medicine, in the context of some pharmaceutical corporate activities in relation to the manner in which they use patents. Sources of law of the reasonableness principle in international law include jurisprudence from the International Court of Justice and now the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights. The activity studied in this article is the practice whereby pharmaceutical companies direct customs officials to intercept or seize in-transit generic medicine destined for developing countries. This paper asks how the reasonableness principle might be harnessed in order to promote access to medicine in relation to the manner in which pharmaceutical corporations exploit patents on medicine. How can the reasonableness principle inform law and policy makers? What should pharmaceutical corporations do in order to integrate elements of the reasonableness principle into their decision-making processes in order to avoid taking decisions and executing actions that impede access to medicine, like intercepting or seizing generic medicine in-transit to developing countries? Thus, this paper outlines the practice of intercepting in-transit generic medicine, discusses the reasonableness principle, and considers ways in which the reasonableness principle might be a useful way to address this particular problem. This is an exercise, which may also serve as an interesting template for other issues raised by the current system of innovation and access to medicine.

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* PhD Researcher, Erasmus University Rotterdam, this article is based in parts on a paper presented at a seminar hosted by the Netherlands School of Human Rights Research Working Group on Economic, Social and Cultural Rights and Erasmus Observatory on Health Law on 22 November 2013 in Rotterdam. The author is grateful for any comments received from participants and acknowledges any mistakes are her own.

1 Hestermeyer, H, *Human Rights and the WTO: The Case of Patents and Access to Medicines,* (Oxford University Press, New York, 2007).

2 t'Hoen, E, *The Global Politics of Pharmaceutical Monopoly Power,* (AMB, Diemen, 2009).

3 Baker, BK, "Settlement of India/EU WTO Dispute Re Seizures of Generic Medicines: Why the proposed EU Border Regulation Isn't Good Enough", *PIJIP Research Paper Series* (2012) *at* <digitalcommons.wcl.american.edu/research> (accessed 16 September 2015), 3.

4 World Trade Organization (WTO), *European Union and a Member State - Seizure of Generic Drugs in transit (Request to Join Consultations by Brazil),* WT/DS409/1/IP/D/29 and G/L/922 (*Brazil-EU Seizure of Generic Drugs*), 19 May 2010; WTO *European Union and a Member State - Seizure of Generic Drugs in transit (Request to Join Consultations by India),* WT/DS408/1/G/L/921 and IP/D/28 (*India-EU Seizure of Generic Drugs*), 19 May 2010.

5 WTO, *European Union and a Member State - Seizure of Generic Drugs in transit (Request to Join Consultations by Canada),* WT/DS409/2, 1 June 2010; WTO, *European Union and a Member State - Seizure of Generic Drugs in transit (Request to Join Consultations by Japan),* WT/DS409/7, 3 June 2010.

II. The Practice of Seizing In-Transit Generic Medicine

An illustration of the practice of seizing in-transit generic medicine is the incident that took place on 4 December 2008. While *en route* from India to Brazil, a consignment of the generic hypertension medicine, Losartan, was seized in the Netherlands Port of Rotterdam. The public authorities of the Netherlands' customs services carried out the seizure. The consignment was in-transit, thus the jurisdiction of the Netherlands customs authorities over such goods was questionable. This particular consignment was 570 kilograms and earmarked for 300, 000 Brazilian people in need of this particular hypertension treatment. The consignment was detained for 36 days before it was released and returned to India. This deprived the 300, 000 Brazilians for whom it was intended from accessing it. This seizure took place at the behest of the pharmaceutical company holding the patent for the non-generic form of medicine, in the Netherlands. In this case the company was Merck, a large American multinational company. The reason for the seizure was an allegation that the medicine was counterfeit medicine, which violated the intellectual property rights of Merck,[6] as protected by the Agreement on Trade- Related Aspects of Intellectual Property Rights (TRIPS Agreement/TRIPS),[7] a treaty that makes up part of the WTO body of law. The Netherlands, which is a member state of the WTO, was apparently obliged to comply with TRIPS. Losartan was not patent protected in India, nor in Brazil, the two countries involved in trading the medication at the time of its seizure.[8]

Generic medicine is an important addition to a health system because it is medicine equivalent to patented medicine in safety, quality, efficacy, and, at a more affordable, often considerably reduced price. Counterfeit medication, a serious cause of concern for all countries committed to health, is not the same thing as generic medicine. Counterfeit medicine is detrimental to health and has no proven quality, safety and efficacy.[9] This was not the case with the Losartan consignment at issue. It was made by the Indian generic company Dr Reddys Laboratories Ltd. This seizure took place notwithstanding the fact that within the TRIPS framework for public health purposes, countries also have a right to use generic medication. This seizure was not the first, nor was it the last such seizure of generic medicine. According to prominent international non-governmental organisations working on access to medicine in 2008, at least 17 shipments of generic medicine were detained in Rotterdam alone. Rotterdam, or the Netherlands for that matter, is also not the only port or country to detain generic medicine in-transit.[10]

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6 De Volkskrant, Vos, C, *Patently Cruel,* 19 June 2009, <volkskrant.nl> (accessed 20 October 2011) (Vos); International Centre for Trade and Sustainable Development, "Dutch Seizure of Generic Drugs Sparks Controversy", 13(3) *Bridges Weekly Trade News Digest* (2009) 5 *at* <ictsd.org> (accessed 20 October 2011) (Bridges Weekly Trade News Digest (2009) 5); WTO, *European Union and a Member State - Seizure of Generic Drugs in transit (Request to Join Consultations by Brazil),* WT/DS409/1/IP/D/29 and G/L/922 (*Brazil-EU Seizure of Generic Drugs*), 19 May 2010, 1; WTO, *European Union and a Member State - Seizure of Generic Drugs in transit(Request to Join Consultations by India),* WT/DS408/1/G/L/921 and IP/D/28 (*India-EU Seizure of Generic Drugs*), 19 May 2010, 4.

7 *Agreement on Trade-Related Aspects of Intellectual Property Rights*, 15 April 1994,LT/UR/A-1C/IP/1 (TRIPS).

8 Vos, Bridges Weekly Trade News Digest, *supra* nt 6, 5.

9 The Telegraph, Akhtar, S, *Blowing the whistle on fake drugs*, 31 August 2009, *at* <telegraphindia.com> (accessed 15 December 2011). Generic Companies and Countries that produce generic medicine such as India are also concerned about fake drugs which are identified because they lack the correct pharmaceutical composition and can thus be detrimental to health.

10 Vos, Bridges Weekly Trade News Digest *supra* nt 7, 5; WTO, *European Union and a Member State - Seizure of Generic Drugs in transit (Request to Join Consultations by Brazil),* WT/DS409/1/IP/D/29 and G/L/922 (*Brazil-EU Seizure of Generic Drugs*), 19 May 2010, 1; WTO, *European Union and a Member*

Finally, this seizure took place notwithstanding the fact that the TRIPS Agreement does not oblige its Member States to institute border proceedings against goods in-transit, like medicine.[11] Thus, States are not required to institute border proceedings on in-transit medicine. However, some scholars also point out that it also does not preclude member States from doing the same.[12] Hence, TRIPS does not prevent member States from instituting such measures. This appears to create a gap in law or suggest that the law is silent on this issue, with the consequence that some States argue that they may institute such measures without falling foul of TRIPS. At the same time, even if TRIPS may be regarded as neither obliging nor precluding in-transit proceedings, patents apply territorially and not extra-territorially. Thus, patents apply only in the territory in which they have been granted. International scholars are correct in their unanimous assertion that intercepting in-transit generic medicine, on the basis of a patent protected in the jurisdiction of a third party, contravenes the territorial application of patents within TRIPS.[13] Moreover, whether or not intellectual property can be said to have been violated, international scholars also rightly argue, should depend on the law of the trading nations and not that of a third party.[14] Finally, it is also important to point out, as discussed by Baker, the Memorandum of Understanding between India and the European Union. Baker states that it provides, '[p]ursuant to the announced Understanding, the European Union will no longer intercept in-transit generic medicines unless there is adequate evidence to satisfy customs authorities that there is a substantial likelihood of diversion of such medicines to the EU market.'[15]

As seen above, much of the focus has been on the role of the State, yet it is also important to examine the role of the pharmaceutical company in this context. It is an important factor, as interception often takes place in response to a complaint from pharmaceutical companies, and in a few instances customs officials acted in the absence of such a complaint.[16] This raises the question, even if TRIPS law were silent or had a gap: is this in any event a reasonable way for pharmaceutical companies to conduct themselves given the impact on access to medicine?

III. The Reasonableness Principle

Reasonableness is a term with legal effect used in international law by at least two different institutions. The International Court of Justice (ICJ) and the Committee on

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State - Seizure of Generic Drugs in transit(Request to Join Consultations by India), WT/DS408/1/G/L/921 and IP/D/28 (*India-EU Seizure of Generic Drugs*), 19 May 2010, 4.

11 Article 51 [see especially footnote 13], *Agreement on Trade Related Aspects of Intellectual Property Rights*, 15 April 1994,LT/UR/A-1C/IP/1; Ho, C, *Access to Medicine in the Global Economy: International Agreements on Patents and Related Rights* (Oxford University Press, 2011), 303-305, 314; However, the United Nations Convention on the Law of the Sea (adopted 10 December 1982, entry into force 16 November 1994) 1833 UNTS 397, regulates treatment of goods in-transit and during innocent passage by customs officials. It lists the circumstances in which customs authorities may interfere with such goods. Alleged violations of intellectual property rights are not listed as a ground. This is important because the skeletal facts shared with the public over the seizures of generic medicine in Rotterdam do not indicate whether these provisions would be excluded. The TRIPS Agreement should have specified this if it intended such powers.

12 *Ibid*.

13 Baker, *supra* nt 4, 6-7. He also outlines other legal arguments relevant to this discussion including a violation of international human rights law on access to medicine.

14 *Id*, 7.

15 *Id*, 3.

16 *Id*, 5.

Economic, Social and Cultural Rights (CteeESCR) have both used it in differing contexts. It is also very popular in South African constitutional law jurisprudence in the area of economic, social and cultural rights. At the same time, it is important to mention, the TRIPS Agreement may very well have a corresponding yet hitherto undeveloped reasonableness principle. Each of these representations of reasonableness, in domestic and international law, shall now be discussed in turn.

III.1. The International Court of Justice

The *Barcelona Light and Traction Company case*[17] is one such example where reasonableness was used by the ICJ in order to settle a legal question before it. In particular, this term was used in the Court's consideration of an argument raised by Belgium, in an attempt to found standing on behalf of certain shareholders that were its nationals. Belgium argued the principle of equity should be enough to found jurisdiction. The court did not accept that the principle of equity founded jurisdiction in this case. In reaching this decision, it considered what the practical consequences might be if equity were to be applied. The court found applying the principle of equity would be *unreasonable* because the effect would be impractical.[18]

One reason the effect would be impractical was because quantitatively, equity did not allow for distinctions. First, companies typically have various unequal shares among shareholders ranging from small (1% share) to a large (90%) share. Applying equity, the state would be allowed to intervene in respect of both instances; the size of the share would not be the deciding factor. However, the point for the Court was that what mattered was that international law should be applied reasonably. This included consideration of the impact on the ground. Second, applying the argument of the Belgian government, given also the frequency in which shares, including international shares, changed hands would make international law simply unworkable.[19] Gros J, in his dissenting opinion, also noted that in such matters reasonableness in law and economics should be applied.[20]

The *Barcelona Light and Traction Company case* introduces the idea of reasonableness in the way in which international law is applied. Moreover, the manner in which the Court applied this concept suggests reasonableness as a principle that has certain practical implications. This may be derived from the Court's main judgment and a dissenting opinion to reject equity given the impact on the ground of applying it in that context.

III.2. Committee on Economic, Social and Cultural Rights (CteeESCR)

The CteeESCR has clearly embraced a reasonableness principle through two different international legal instruments. Prior to the Optional Protocol to the International

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17 International Court of Justice, *Barcelona Light and Traction Company case (Belgium v Spain)* ICJ Reports 1970, 5 February 1970 (*Barcelona Light and Traction Company case*).

18 *Id,* paras 93-94, 96.

19 *Ibid*.

20 *Id*, (Dissenting Opinion, Gros J), para 20.

Covenant on Economic, Social and Cultural Rights (OP ICESCR)[21] a reasonableness principle was used in the Committee's statements of its understanding of the legal term 'maximum available resources'. Of course in the OP ICESCR the reasonableness principle is expressly articulated as a mechanism which the Committee shall use when assessing communications.

Article 2(1) of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) provides,

> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the *maximum of its available resources*, with a view to achieving progressively the full realization of the rights recognized in the present Covenant[22]

During the process of negotiations for the OP ICESCR, the CteeESCR issued a statement with regard to the interpretation of the term, 'maximum available resources'. In the statement the CteeESCR also discussed reasonableness; stating, in a non-exhaustive list, that

> [i]n assessing whether they are "adequate" or "reasonable", the Committee may take into account, *inter alia*, the following considerations:
> (a) the extent to which the measures taken were deliberate, concrete and targeted towards the fulfilment of economic, social and cultural rights;
> (b) whether the State party exercised its discretion in a non-discriminatory and nonarbitrary manner;
> (c) whether the State party's decision (not) to allocate available resources is in accordance with international human rights standards;
> (d) where several policy options are available, whether the State party adopts the option that least restricts Covenant rights;
> (e) the time frame in which the steps were taken;
> (f) whether the steps had taken into account the precarious situation of disadvantaged and marginalized individuals or groups and, whether they were non-discriminatory, and whether they prioritized grave situations or situations of risk.[23]

Article 8(4) of the OP ICESCR provides,

> When examining communications under the present Protocol, the Committee shall consider the reasonableness of the steps taken by the State Party in accordance with part II of the Covenant. In doing so, the Committee shall bear in

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21 UN General Assembly (UNGA), *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights* adopted 10 December 2008, entered into force 5 May 2013, Resolution A/RES/63/117.

22 *International Covenant on Economic, Social and Cultural Rights* (ICESCR) 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3 [emphasis added].

23 UNCHR 'Statement An Evaluation of the Obligation to take steps to the "Maximum available resources" under an Optional Protocol to the Covenant' 10 May 2007 UN Doc E/C.12/2007.1, para 8; see also Griffey, B, "The 'Reasonableness' Test: Assessing Violations of State obligations under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights", 11(2) *Human Rights Law Review* (2011) 275,321-322; treats this as the Ctee ESCR's approach to the reasonableness standard and remarks on its similarity to the same Committee's long-established approach to interpreting the ICESCR.

> mind that the State Party may adopt a range of possible policy measures for the implementation of the rights set forth in the Covenant.[24]

Based on the text of Article 8(4), reasonableness is a principle that applies to measures adopted by States as they implement provisions of the ICESCR. Moreover, scholars agree that the reasonableness principle presupposes that for the most part there is more than one option for the State to choose from.[25] According to Porter this includes recognising various actors, including private actors, and other systems of entitlement that are involved in the implementation of economic, social and cultural rights and in failures associated with such implementation.[26] The reasonableness principle is thus also applied to private actors, like a pharmaceutical corporation, in the way in which their activities impact the realisation of an economic, social and cultural right.

Further, human dignity and equality are central to assessment of the reasonableness principle.[27] Another way of putting it is that the centrality of the right holder's context is important. Porter and Liebenberg describe it in this way

> [t]he analysis [of what is reasonable] must be framed by and fully grounded in the context of the petitioner's circumstances, the content of the right and the broader values and purposes of the ICESCR.…[it is] the standard of decision-making that is required for full compliance with the ICESCR, both procedurally and substantively, with respect to the content of the petitioners' rights and the use of the maximum available resources.[28]

The concept and implementation of any policy or programme must be also reasonable. Therefore, means and outcomes matter too.[29] Porter and Liebenberg also identify the criteria useful in establishing substantive compliance with the Article 8(4) principle. These criteria are: availability, accessibility, acceptability and adaptability.[30] With the exception of adaptability these appear to be similar to the availability, accessibility, acceptability and quality (AAAQ) criteria in General Comment 14.[31] In the most recent General Comment on the ICESCR, the right to take part in cultural life, the concept of adaptability is introduced in the AAAQ framework. There adaptability refers *inter alia* to the flexibility and relevance of the programmes and policies adopted by the state in relation to specific cultures.[32]

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24 Article 8(4), *International Covenant on Economic, Social and Cultural Rights*; Porter, B, "The Reasonableness of Article 8 (4) – Adjudicating Claims from the Margins", 27(1) *Nordic Journal of Human Rights* (2009) 39, 52; also observes the Optional Protocol to the International Convention on Disability also has a principle of reasonable accommodation in relation to disability.

25 *Id*, 52-53; ESCR-NET, Porter, B and Liebenberg, S, *Consideration of the merits Under the OP-ICESCR: Reasonableness Review under 8 (4) and the Maximum available resources standard Notes for discussion at the Workshop on Strategic Litigation under the OP-ICESCR*, *at* <escr-net.org> (accessed 31 October 2012), 1.

26 Porter, *supra* nt 21, 50, 52-53.

27 *Id*, 51.

28 Porter and Liebenberg, *supra* nt 22, 5, 6, 8.

29 Porter, *supra* nt 21, 51.

30 Porter and Liebenberg, *supra* nt 22, 8.

31 General Comment 14 paras 12, 33, 34, 35, Koch, IE, "Dichotomies, Trichotomies or Waves of Duties?", 5(1) *Human Rights Law Review* (2005) 81, 81-82, 103; the value of the tripartite obligations is as an analytical tool.

32 UN Committee on Economic, Social and Cultural Rights 'General Comment 21' (21 December 2009) UN Doc E/C.12/GC/12 para 16 (d).

Griffey[33] and Porter and Liebenberg[34] agree that the inspiration for this article on reasonableness in the OP ICESCR is the *Grootboom Case*.[35] Interpretation of what this principle means is already the topic of much debate, as the writing of these three authors indicates. However, all three authors reject the narrow interpretation that would relegate reasonableness to nothing more than a standard of procedural judicial review.[36]

III.3 TRIPS

It may be worthwhile to mention that the TRIPS Agreement has a notion of unreasonableness specifically intended for the use of patents. It provides for a limited exception that fulfils this criteria: 'such exceptions do not *unreasonably* conflict with a normal exploitation of the patent and do not *unreasonably prejudice* the *legitimate interests* of the patent owner, taking account of the *legitimate interests* of third parties'.[37]

Moreover, reasonableness also appears with regard to Article 31 TRIPS Agreement. The article, in particular, references 'reasonable commercial terms and conditions', 'reasonable period of time' and 'reasonably practicable'.[38] In the *Canadian Stockpiling Case* the panel had an opportunity to interpret the term reasonableness with regard to Article 30. However, it elected not to do so because it reached its findings based on other criteria.[39] Even so, the interventions of third party States provide some suggestion of how at least some member States interpret reasonableness in Article 30 TRIPS Agreement. Australia argued that the provision contained a reasonableness test. In this regard it considered the, 'steps involved in obtaining regulatory approval….were allowable exceptions under Article 30, since any detriment to the patentee was reasonable'.[40] Furthermore, the context of the application of this test was in their view, '[t]he range of permissible Article 30 exceptions should be determined with reference to the overall objectives and balance of interests in the TRIPS Agreement and the availability of other

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33 Griffey, *supra* nt 20, 302.

34 Porter and Liebenberg, *supra* nt 22, 1-2; share their experience in contributing to the drafting process of the OP ICESCR, they note that Article 8(4) is inspired by para 41 of the *Grootboom Case* of which all participants were in agreement. They also note,

> It has been read by some as a strong affirmation of substantive rights that require positive measures well beyond, but including, concrete core entitlements. It has been read by others as a relatively weak form of justiciability that substitutes a "good governance" standard of review" for a requirement of "rights compliance", leaving claimants with "a right to a reasonable housing policy" rather than a right to adequate housing." Differences in interpretation of what the reasonableness standard means.

35 *Government of the Republic of South Africa and Others v Grootboom and Others* [2000] ZACC 19.

36 Porter and Liebenberg, *supra* nt 22, 2-5; Griffey, *supra* nt 20, 305-307; he further points out that the United Kingdom's notion of unreasonableness limited to judicial review was also vetoed by the European Court of Human Rights.

37 Article 30 *Agreement on Trade Related Aspects of Intellectual Property Rights* [emphasis added].

38 Article 31 (b) *Agreement on Trade Related Aspects of Intellectual Property Rights*.

39 WTO, *Canada – Patent Protection of Pharmaceutical Products* (*Canadian Stockpiling Case*) WT/DSI14/R, 17 March 2000, 152-153, 155-162, 164-165, 168 the panel had to decide whether Canadian stockpiling and regulatory review provisions satisfied TRIPS Article 30 which provides for limited exceptions to patent rights conferred. In terms of law the panel interpreted the term limited exception narrowly. It determined an exception that results in a small attenuation of the right complied with the standard. Factually, stockpiling was regarded as falling outside the bounds of a limited exception whereas the regulatory review exception was found to fall within the permissible bounds of the exception; Articles 30, 31, *Agreement on Trade Related Aspects of Intellectual Property Rights;* Doha Declaration notwithstanding the *Canadian Stockpiling Case*, the Doha Declaration paragraph 5 (a) provides weight in support of a broader interpretation of Article 30 for public health purposes, at least provided that it is consistent with TRIPS Agreement objectives and principles .

40 *Canadian Stockpiling Case supra* nt 40, paras 94-95.

forms of authorized use'.[41] Colombia submitted that reasonableness should be established as follows,

> [f]or an exception to have an unreasonable impact on the right to exploitation of the patent, it would have to unjustifiably and substantially affect the rights derived by the patent owner. The word "unreasonable" meant "going beyond the limits of what is reasonable" as would be the case of: (i) an unjustified exception; (ii) an exception whose scope went beyond the rights directly connected with the aim pursued; or (iii) an exception applied in such a way as to damage substantially the economic right derived from the exploitation of the patent.[42]

Cuba argued, 'exceptions were legitimate if they were considered "reasonable". However, the qualification of "reasonable" was given by national law, within its own framework, in accordance with Article 1.1 of the TRIPS Agreement'.[43] Switzerland argued 'unreasonable' referenced an unjustified limitation of the patent.[44] Depending on how this is eventually interpreted by the WTO DSB, it appears to provide, if not explicitly at least implicitly, for some form of reasonableness test or assessment mechanism. The exception in Article 30 allows for legitimate third party interests to override the rights conferred on a patent when certain criteria are satisfied. The only *prima facie* criteria are that the interests of third parties should be legitimate and reasonableness should be applied to the impact of these interests on the rights conferred to the patent holder. Thus, for as long as the impact is reasonable, then the limitation based on that legitimate interest should be acceptable. In the author's opinion, it would be consistent with international law if this provision were interpreted in light of other reasonableness standards in operation.

III.4. Republic of South Africa

The *Grootboom Case,* as already mentioned above, was the first case in which the reasonableness standard was applied by the constitutional court.[45] The first case to concern the right to health in which the reasonableness principle was applied is the famous *TAC judgment*.[46] This case concerned, access to Nevirapine, a medicine given to mothers at point of birth in order to prevent transmission of HIV/AIDS to the child. Nevirapine was taken as a single dose in contrast to medicine taken regularly to treat a chronic condition. The pharmaceutical manufacturer offered the government a free supply of the medicine for a period of five years. The government, however, created a policy wherein the medicine was only made freely available to the private sector. However, only 18 sites were selected to make the medicine available in the public sector. These 18 sites were also treated as clinical trial sites by the government. It was this decision to restrict access in the public sector that brought this case before the constitutional court.[47]

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41 *Id,* 95.
42 *Id,* 110.
43 *Id,* 117-118.
44 *Id,* 131.
45 Porter and Liebenberg, *supra* nt 22, 1-2.
46 *Minister of Health and Others v Treatment Action Campaign and Others* [2002] ZACC 15 (*TAC Case 2002*).
47 *Id*, paras 2, 4-5, 10-12, 17-19, 25, 44- 45, 47, 50.

The government articulated four reasons for limiting access to 18 sites. First, the government claimed that it did not have the resources to roll out a comprehensive package which included antibiotics and formula for the child beyond the current 18 sites. Second, it raised 'efficacy' concerns; in particular it feared patients may develop resistance to Nevirapine and other antiretroviral drugs (ARVs). The third reason raised by the government was safety concerns related to the drug. Finally, fourth, the government was concerned whether it would be appropriate to provide Nevirapine without the other components that make up the planned comprehensive package.[48]

Applying the reasonableness standard, to the policy of the government, in this case the Court reinforced the line adopted in the *Grootboom Case*. It affirmed the notion that the Constitution places a negative duty on the State and *all other persons* not to impair or prevent, in this case, the right to access healthcare and services. Thus, when the Court evaluates challenges made against measures taken by the State, for instance, this principle applies.[49] One may also highlight the *obiter dictum* of the Court that this approach applies in respect of private persons, particularly given the *Bertie van Zyl case*, which affirms linkages between a constitutionally protected right (the right to freedom and security of the person), and the duty of a private actor like private security companies whose role complemented policing functions.[50] Furthermore, the Court's evaluation of what is reasonable is context-specific and evidence-based in light of the impact on the right. For example, as noted above, one of the reasons that the government did not want to provide medicine to the public was because it was concerned about the efficacy of the medicine. However, scientific material presented by both parties showed this claim to have no evidentiary base. It found Nevirapine worked; however, if the mother breast-fed the child then it was likely, in some cases, that the child might contract the disease from this act.[51] Thus, reasonableness also requires an examination of any evidence including technical data to see whether or not it supports the claim in that context.

Moreover, the Court discussed considerations it identified as relevant to reasonableness. These considerations included: 1. the consequence of the action or conduct; 2. identifying who is impacted by the conduct; 3. why and how the person has been impacted; and 4. the extent of the impact on the individual. In the case, the consequence of the State's policy was to deny access to Nevirapine to mothers and their new-borns that could not afford to pay for it and lived outside the 18 research sites. The consequences of the impact were that their children were denied lifesaving treatment.[52] A programme to realise economic, social and cultural rights is also reasonable because it is, 'balanced and flexible and make[s] appropriate provision for attention to…crises and to short, medium and long term needs. A programme that excludes a significant segment of society cannot be said to be reasonable'.[53]

Thus, from the *Grootboom Case* and the *TAC Case* the following elements are central to a reasonableness evaluation of a programme designed to implement or realise economic, social and cultural rights: context, evidence, impact, identity of the person or group impacted, degree of impact, balance and flexibility of the programme and inclusivity.

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48 *Id*, paras 51-55.

49 *Id*, paras 36, 46. It may also be relevant to note that the pharmaceutical manufacturer of the medicine Nevirapine had offered it to RSA authorities for free for a period of five years.

50 *Bertie van Zyl (PTY) Ltd and Montina Boerdery (PTY) Ltd v Minister for Safety and Security and Four Others* Z ACC 11.

51 *TAC Case, supra* nt 47, paras 57-63 consider the evidence in relation to the other arguments brought by the government.

52 *Id*, paras 67-68, 70, 72-73.

53 *Id*, para 68.

In the *Water Case*[54] the Court added to its articulation of the reasonableness approach. To briefly explain, the *Water Case* concerned the introduction by the Johannesburg City Council of a new policy for providing water services in Soweto. The new policy had three kinds of water services, one of which included a prepaid meter. The policy at the time of proceedings was at the pilot phase.[55] In its reasoning, the Court made the following important statements with regard to the application of the reasonableness standard,

> [t]he purpose of the constitutional entrenchment of social and economic rights was thus to ensure that the state *continue* to take reasonable legislative and other measures progressively to achieve the realisation of the rights to the basic necessities of life. It was not expected, nor could it have been, that the state would be able to furnish citizens immediately with all the basic necessities of life. Social and economic rights empower citizens to demand of the state that it acts reasonably and progressively to ensure that all enjoy the basic necessities of life. In so doing, the *social and economic rights enable citizens to hold government to account for the manner in which it seeks to pursue the achievement of social and economic rights.*[56]

There is no expectation of immediate gratification or rather satisfaction of a basic necessity. However, there is ensured a right to hold the State to account in relation to activities it organises with a view to making such a right a reality. The State, in this regard, is expected to act reasonably in its planning among other measures designed to implement economic, social and cultural rights. This is a continuous process. Litigation of economic, social and cultural rights is also a means of holding the government to account.[57]

> Moreover, what the right requires will vary over time and context. Fixing a quantified content might, in a rigid and counter-productive manner, prevent an analysis of context. The concept of reasonableness places context at the centre of the enquiry and permits an assessment of context to determine whether a government programme is indeed reasonable.[58]

The context in which the right is realised is also always an important consideration. Flexibility is always required, as is constant evaluation of progress and remedial measures along the way. This too applies to the private sector like a pharmaceutical corporation working in the provision of a right.

According to the Court, positive obligations from economic, social and cultural rights will be enforced in one of the following four ways,

> [i]f government takes no steps to realise the rights, the courts will require government to take steps. If government's adopted measures are unreasonable, the courts will similarly require that they be reviewed so as to meet the constitutional standard of reasonableness. From *Grootboom,* it is clear that a measure will be unreasonable if it makes no provision for those most desperately in need. If

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54 *Lindiwe Mazibuko and Others v City of Johannesburg and Others* [2009] ZACC 28 (*Water Case*).

55 *Id*, paras 9-16.

56 *Id,* para 59 [emphasis added].

57 *Id.* paras 159-164.

58 *Id,* paras 60, 64, 163. Contexts change and the government always has to be aware of this when implementing a programme. In fact, failure to review policies in light of current contexts would make a policy unreasonable.

> government adopts a policy with unreasonable limitations or exclusions, as in *Treatment Action Campaign No* 2, the Court may order that those are removed. Finally, the obligation of progressive realisation imposes a duty upon government continually to review its policies to ensure that the achievement of the right is progressively realised.[59]

Forman points out that 'reasonableness applies to all elements of governance; not only the content of legislation, programs and policies, but also their manner of implementation'.[60] She makes this observation during her discussion on the interpretation of the reasonableness principle by the Constitutional Court. Thus, taking Forman's observation and the discussion on the elements that make up the reasonableness standard, in relation to ICJ, ICESCR and lessons from South Africa's application of this standard, into account, one may begin to extrapolate its application to pharmaceutical corporations and their use of intellectual property. For example, it is possible to argue that pharmaceutical corporations should integrate these elements into their decision-making processes. This would allow them to consider the impact of decisions they are about to make and take remedial action to avert negative impacts on access to medicine. A fuller discussion of this has been set out below in Section 4 of this paper.

III.5 Conclusion on the Reasonableness Principle

In conclusion, to the discussion on the reasonableness principle, this paper has identified 3 different international law sources of this principle, namely the ICJ, TRIPS and ICESCR. With the exception of TRIPS, each source adds elements which are useful to those seeking to know what the principle is and how it might work in various contexts. It is because the WTO DSB has yet to elaborate on reasonableness in Article 30 and 31 of TRIPS that lessons from this treaty on this point are unknown. However, intervening states in *the Canadian Stockpiling Case* shared their conceptualisations of this principle. It is from this that it is possible to conclude at a minimum that some States interpret Article 30 TRIPS as mandating development of a reasonableness test or assessment mechanism. In the *Barcelona Light and Traction Company Case* the ICJ applied a reasonableness principle in its main judgment and one dissenting opinion. Based on the ICJ's application one possible conclusion is that the reasonableness principle relates to practical implications in relation to implementation of certain laws. It is interesting to note the laws at issue concerned economic actors, in particular Belgian shareholders.

The CteeESCR uses a reasonableness principle in its interpretation of the principle 'maximum available resources' and it shall use the reasonableness principle when assessing communications in terms of Article 8(4) OP ICESCR. In relation to the 'maximum available resources' reasonableness requires an inquiry into: 1. the degree to which measures taken were intended to advance an economic, social and cultural; 2. the absence of arbitrariness and discrimination in the manner in which a State exercised its discretion; 3, compliance with international human rights law when States decide whether or not to allocate resources; 4., selection of the least restrictive means to economic, social and cultural rights if several policy options exist; 5. the, time frame in which steps were taken; and 6. whether the steps taken took account of the needs of vulnerable and marginalised individuals and groups.

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59 *Id,* para 67.

60 L. Forman, 'Ensuring Reasonable Health: Health Rights, the Judiciary and South Africa's HIV/AIDS Policy' *Journal of Law, Medicine and Ethics* (2005) 711, 714; *TAC Case supra* nt 47, para 100.

Article 8(4) OP ICESCR adds further to our understanding by reinforcing previously articulated understandings and adding new elements. For example, scholars anticipate that reasonableness will be applied to measures adopted by a State in its efforts to implement economic, social and cultural rights. Moreover, States should always consider a diversity of options in order to successfully implement economic, social and cultural rights. These two illustrations reinforce the CteeESCR previously articulated understanding of the reasonableness principle. However, Porter in his writing specifies a new element, namely reasonableness that extends to private actors whose activities are part of the States implementation framework in relation to a specific right. A pertinent example, given the case study of seizure of generic medicine, is a pharmaceutical corporation. Porter and Liebenberg also highlight the context of the right holder as a key element to a reasonableness inquiry. Applying this to the context of generic seizures, the right holder in question should be the patients in the importing developing country.

Finally, lessons were also drawn from the domestic experience of South Africa, where the reasonableness principle was first applied in *the Grootboom Case*. This case is significant because scholars like Griffey, Porter and Liebenberg all agree that it was the inspiration for Article 8(4) OP ICESCR. In the case law of the Constitutional Court the following elements are central to a reasonableness evaluation of a programme designed to implement or realise economic, social and cultural rights: context, evidence, impact, identity of the person or group impacted, degree of impact, balance and flexibility of the programme and inclusivity. An *obiter dictum* in *the TAC Case* confirms that reasonableness applies not just to the State but to all other persons. Now that the discussion on the reasonableness principle is concluded, it is appropriate to consider application of the principle in relation to pharmaceutical corporations. The next section examines the potential application of this principle in relation to the case study concerning in-transit seizure of generic medicine and the role of pharmaceutical corporations.

IV. General Application

Reasonableness in the OP ICESCR is a principle that applies to measures adopted by States as they implement provisions of the ICESCR. Thus, reasonableness applies to the tools, for instance pharmaceutical corporations and their use of intellectual property, as it affects access to medicine.[61] Hunt, writing with Khosla, includes an illustration of the notion of reasonableness in application in their understanding of the Guidelines for Pharmaceutical Corporations. In particular, they state that in regard to life saving medicine, '[t]he seminal right-to-health responsibility is to take all reasonable steps to make medicine as accessible as possible, as soon as possible, to all those in need, within a viable business model'.[62]

Given this, States should ratify the OP ICESCR because this will strengthen accountability mechanisms in their jurisdictions on economic, social and cultural rights. Further, States should enact legislation and develop policies requiring pharmaceutical corporations to integrate elements of the reasonableness principle into their decision-making processes. This will guide pharmaceutical corporations to implement this kind of analysis in their decision-making processes concerning access to medicine. Moreover, it will also guide customs officials placing them in a position to request this kind of

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61 Porter, *supra* nt 25, 50, 52-53; Forman, *supra* nt 61, 714; TAC *Case supra* nt 47, para 100.

62 Paul Hunt and Rajat Khosla, '*Are Drug Companies Living Up to Their Human Rights Responsibilities? The Perspective of the Former United Nations Special Rapporteur* (2002 -2008)' PLoS Med 7(9) 2010, 2.

information from the pharmaceutical corporation before taking steps, such as intercepting generic medicine.

IV.1 Specific Application – Seizure of Generic Medicine in Transit

Before in-transit generic medicine is intercepted by customs authorities, a decision has to be taken within a pharmaceutical company to lodge such a complaint. Pharmaceutical companies can incorporate elements of a reasonableness analysis during this decision-making process. They can do this by taking note of the common elements of a reasonableness analysis and learning from lessons for specific application of the principle in domestic law.

Based on the analysis set out in Section 3 above, common features of a reasonableness analysis in international law include:

(a) Consideration of the practical application of a legal principle and its impact on the ground in relation to the operation of law;
(b) Consistency with international human rights law;
(c) Whether or not several policy options existed and whether the least restrictive option was selected; and
(d) Consideration of the interests of vulnerable and marginalised groups.

In addition, lessons from the domestic application of a reasonableness principle add considerations of evidence to the framework.

According to the Access to Medicine Index, all pharmaceutical companies assessed are in the process of developing and integrating access to medicine strategies into their structures. The report analysed 'how companies integrate access to medicine into their business strategies, governance structures, management systems and incentive structures'.[63] It analysed four aspects, two of which present opportunities for corporations to integrate a reasonableness analysis into their decision-making in relation to in-transit generic medicine, in particular managing for access-to-medicine outcomes and access-to-medicine strategy.[64] Increasingly, there is board representation on access issues and in some cases committees dedicated to access issues composed of personnel from various divisions of the corporation have been created.[65] These developments demonstrate on the face of it a growing serious commitment and to some extent a concerted effort to contribute toward global access to medicine. This awareness is evolving with respect to their own products, as reflected in the reports. It also needs to extend to some of the ways in which they have interacted with the products of others like initiating interception of in-transit generic medicine. Thus, analysing the decision to intercept in-transit generic medicine is something which can be built into evolving strategies to promote access to medicine.

Based on the outline of reasonableness principle, critical questions they need to ask themselves before initiating interception include:

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63 Access to Medicine Foundation, REPORT: *Access to Medicine Index 2014*, *at* <accesstomedicineindex.org/sites/2015.atmindex.org/files/2014_accesstomedicineindex_fullreport_clickablepdf.pdf> (accessed 11 December 2015), 41-44.

64 *Id*, 41.

65 *Id*, 45-46.

- What, if any is the legal basis of their complaint?
- Who will be impacted by the decision to complain to the authorities?
- How will the intended recipients of the medication be impacted by the decision to complain to the authorities?
- How will the decision to complain to the authorities affect wider overall objectives like increasing access to medicine?
- What evidence do they have to justify a complaint to the authorities?
- Are there alternatives to making a complaint with the authorities?

V. Conclusion

This paper explored the role the reasonableness principle could play to promote access to medicine given limitations of the current flawed system of innovation and access. It did so by outlining the case study concerning interception of in-transit generic medicine, discussing the reasonableness principle in international and domestic law and finally, considering the case study in light of the reasonableness principle. Moreover, its focus was on the role of pharmaceutical corporations in relation to their exploitation of intellectual property because generic medicine interception often takes place at their behest, customs officials seldom intercept in-transit generic medicine on their own volition. The case study is important because it illustrates a method by which pharmaceutical companies hinder access to medicine in developing countries through intellectual property use. For example, the generic hypertension medicine Losartan was detained in Rotterdam and returned to India, the exporting State thereby depriving patients in the importing State, Brazil, from accessing it. The prevalence of this practice is such that consultations, which have attracted the attention of other medicine producing nations, are ongoing at the World Trade Organisation concerning the parties India, Brazil and the European Union.

In international law the reasonableness principle has at least three sources of law, namely the jurisprudence of the International Court of Justice, the Agreement on Trade-Related Aspects of Intellectual Property Rights and the CteeESCR and its treaty mechanisms. In comparison to the former two sources the CteeESCR has been developing its conception of the reasonableness principle over the years. This is to such an extent that the principle has been integrated into the Optional Protocol to the Covenant on Economic, Social and Cultural Rights where it will become a key element used by the CteeESCR to examine communications. Finally, lessons from South African domestic constitutional law are also instructive. These lessons are particularly instructive because reasonableness has been used in relation to economic, social and cultural rights, such as the right to health, one of the sources of the human right entitlement to access medicine. Key components of the reasonableness principle in South African law are: 1. context; 2. international human rights law principles; 3. evidence; 4. alternative policy options; and 5. selecting the least restrictive means.

States should ratify the Optional Protocol to the Covenant on Economic, Social and Cultural Rights. This will strengthen their accountability mechanisms in favour of the human rights holders they are duty bound to protect, clarify the role of State authorities like customs officials in relation to requests to intercept in-transit generic medicine and determine pharmaceutical corporate decision-making on the same issue. Indications from the Access to Medicine Index are that pharmaceutical companies are increasingly developing access to medicine management strategies and access to medicine is

increasingly discussed within the board. This kind of information illustrates a practical way in which pharmaceutical corporations could integrate this into their management thinking. This, however, is only a start; much more still needs to be done given the flawed nature of the innovation and access system to medication and continuing need for medicine on a global scale.

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Realising the Right to Health for Victims of International Crimes. The Case of Medical Rehabilitation Reparations Ordered by International Courts: Challenges, Possibilities and Ways of Improvement

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Keywords
RIGHT TO HEALTH; REHABILITATION; REPARATIONS; HARM; INTERNATIONAL CRIMES; SERIOUS HUMAN RIGHTS VIOLATIONS

Abstract
In the last few decades, international crimes, ie, serious human rights violations, have inflicted severe harm on both the physical and mental health of large numbers of victims around the world. In attempting to redress these damages, international courts, within their respective mandates, have issued reparations orders in favour of victims and their communities. Precisely, an important modality of reparations has consisted of rehabilitation which includes measures of a medical nature for victims. This means physical and psychological rehabilitation including treatment, care and support. At three international level courts, namely, the Inter-American Court of Human Rights (IACtHR), International Criminal Court (ICC), and Extraordinary Chambers in the Courts of Cambodia (ECCC), important developments in the field of medical rehabilitative reparations have taken place. This article critically analyses the practices on medical rehabilitation reparations at those courts, suggests which steps should be taken to improve those practices and proposes which actions States and other international community actors should adopt to better implement and/or contribute towards the implementation of orders on medical rehabilitation reparations. Attention is also given to international human rights law, particularly the obligation to cooperate and the right to health standards and principles.

I. Introduction

The obligation to provide reparations (medical rehabilitation included) as a consequence of a violation of an international obligation is a principle of international law,[1] and a rule of customary international law.[2] For example, regional courts, such as the IACtHR and European Court of Human Rights (ECtHR), have implemented this obligation by ordering reparations against States based on their constitutive instruments, for example,

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1 Permanent Court of International Justice, *Factory at Chorzow*, *Germany v. Poland*, Judgment No. 13 PCIJ Series A No 17, 13 September 1928, 29; International Law Commission, *Draft Articles on Responsibility of States for Internationally Wrongful Acts*, November 2001, (53d session) A/56/10.

2 International Committee of the Red Cross (ICRC), *Customary International Humanitarian Rules*, rule 150, see for this: Henckaerts, JM, "Study on International Humanitarian Law", 87(857) *International Review of the Red Cross* (2005) 198, 211.

the American Convention on Human Rights (ACHR) and the European Convention on Human Rights (ECHR),[3] in serious human rights violations cases. The Convention against Torture mentions 'full rehabilitation'.[4] Under the United Nations Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (UN Basic Principles and Guidelines), reparations modalities are: 1. restitution; 2. compensation; 3. rehabilitation; 4. satisfaction; and 5. guarantees of non-repetition.[5] Under Principle 8, rehabilitation 'should include medical and psychological care'. In this article, the expressions 'rehabilitative reparations' or 'medical rehabilitation' are used interchangeably and include medical and psychological health care.

Reparations, including rehabilitation, are central to the IACtHR's mandate. Victims can claim medical rehabilitation against a State and the IACtHR has the mandate under Article 63(1) of the ACHR to order the defendant State to assure that:

> the injured party be ensured the enjoyment of his right or freedom that was violated. It shall also rule, if appropriate, that the consequences of the measure or situation that constituted the breach of such right or freedom be remedied and that fair compensation be paid to the injured party.

International instruments and practice have generally applied the reparations right in the State-individual relation. However, at international/hybrid criminal courts, an individual can claim rehabilitative reparations against another individual. Individuals found guilty shall provide reparations, including rehabilitation, for the harm inflicted on victims.[6] National and international practice supports obtaining reparations from individuals claimed by victims before (international) criminal and national civil courts.[7]

The ICC Statute contains the first reparations regime among international/hybrid criminal courts. This is based on Article 75 (Reparations to victims) of the ICC Statute, alongside other dispositions including Article 79 (establishing a Trust Fund for Victims (TFV)) plus ICC Rules of Procedure and Evidence (RPE). Although international/hybrid criminal courts reparations regimes are unique, the ICC and ECCC have considered human rights courts' reparations jurisprudence and the UN Basic Principles and Guidelines. Among the existing international/hybrid criminal courts, the ICC and ECCC are the only ones before which victims may claim (rehabilitative) reparations. Reparations orders can only be made against persons convicted by the ICC and ECCC,[8] ie, not against States. The implementation of reparations orders may be conducted by the TFV (ICC) or with external funds involving State/non-State cooperation and the Victims

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3 Article 63(1), Organization of American States, *American Convention on Human Rights*, 22 November 1969, B-32 (ACHR); Article 41, Council of Europe, *European Convention for the protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos 11 and 14* (1950) ETS 5 (ECHR).

4 Article 14(1), United Nations, *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment* (1984) 1465 UNTS 85 (CAT).

5 UN General Assembly, *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*, 16 December 2005, (60th Session) A/RES/60/147, Principles 19-23.

6 Zegveld, L, "Victims' Reparations Claims and International Criminal Courts", 8(1) *Journal of International Criminal Justice* (2010) 79, 85.

7 Henckaerts, JM and Doswald-Beck, L, *Customary International Humanitarian Law* (Cambridge University Press, vol I, Cambridge, 2005), 554-555 (ICRC).

8 Article 75(2), United Nations, *Rome Statute of the International Criminal Court* (1998) 2187 UNTS 3 (ICC Statute); Rule 23*quinquies*(1), Extraordinary Chambers in the Courts of Cambodia, *Internal Rules* (Rev. 9 2015) (ECCC Internal Rules).

Support Section (VSS) (ECCC). The importance of the ICC and ECCC reparations regimes, including rehabilitation, has been highlighted by these courts,[9] and reparations claimants.[10]

How medical rehabilitative reparations realise the right to health is discussed in the four sections of this Article. The first defines who qualifies as a victim, with regard to the right to health and medical rehabilitative reparations. In the second section, medical rehabilitation as reparation and its implementation are examined. The third evaluates rehabilitative reparations under international human rights law, including, international cooperation/assistance obligation and right to health standards/principles. The fourth section contains final assessments and recommendations.

II. Defining Victims with Regard to the Right to Health and Medical Rehabilitative Reparations

II.1. The IACtHR

Two provisions are relevant in the definition of victims as reparations claimants of rehabilitative measures. First, under the IACtHR Rules of Procedure (Article 2.2.5), the expression 'alleged victim' refers to the person whose rights under the Convention or another treaty of the Inter-American System have been allegedly violated. Second, 'injured parties' (ACHR, Article 63(1)) are those who must receive reparations. Thus, an injured party is an individual who has been declared to be a victim of the ACHR/other Inter-American human rights treaties violations, particularly those against torture, enforced disappearance and violence against women.

Cases of serious human rights violations such as widespread and/or systematic practices of torture and other inhumane, cruel and degrading treatment, rape, forced displacement, forced disappearance and extrajudicial execution at the IACtHR, involve serious breaches of, among others, the right to health not only of those directly victimised but also of their loved ones. A major contribution of the IACtHR's case-law to the international law of rehabilitative reparations is the consideration of not only direct victims but also indirect victims. A direct victim is '[a]n individual against whom the illegal conduct of the State agent is directed immediately, explicitly and deliberately'.[11] It is clear that serious human rights violations breach the core components of the direct victims' right to physical and mental health, generating physical and psychological injuries to be redressed via medical rehabilitation. The right to health of direct victims, ie, those against whom human rights abuses were originally perpetrated, is in the first place seriously violated. In turn, an indirect victim is someone 'who does not suffer this illegal conduct in the same way-immediately, directly and deliberately-but who also see his own rights affected or violated from the impact on the so-called direct victim'.[12]

The IACtHR Rules of Procedure authorised both direct victims and also their next of kin to participate autonomously throughout the proceedings to get *inter alia* rehabilitative

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9 International Criminal Court (ICC), *Lubanga (Decision Concerning Pre-Trial Chamber I's Decision of 10 February 2006 and the Incorporation of Documents into the Record of the Case against Mr Thomas Lubanga Dyilo)*, ICC-01/04-01/06-8-US-Corr, 24 February 2006, para 136.

10 ECCC, *Civil Parties*, E125/2, 12 March 2012, para 99.

11 Inter-American Court of Human Rights (IACtHR), *Ituango Massacres v Colombia*, Series C No. 148, 29 June 2006, Separate Concurring Opinion of Judge S. García Ramírez, para 11.

12 *Ibid.*

reparations. Article 2(15) (previous version) explicitly defined 'next of kin' as: 'the immediate family, that is direct ascendants and descendants, siblings, spouses or permanent companions, or those determined by the Court, if applicable'. References to next of kin were deleted in 2009 to avoid misunderstandings about the scope of potential rehabilitative reparations beneficiaries. This is found appropriate since the definition of indirect victims as rehabilitative reparations beneficiaries may include not only family members provided that there is a proven causal link between the harm inflicted and a violation. As the IACtHR's practice evidences, persons who are not close family members may receive reparations,[13] rehabilitation included. Close relative members in cases of torture, extrajudicial executions, or enforced disappearance, are entitled to receive rehabilitative reparations in two ways: in their own right, and as heirs, even if they did not participate in the proceedings.[14]

The IACtHR has presumed that close family members or next of kin have suffered on account of the direct victim's harm in cases of enforced disappearance, torture and extrajudicial executions.[15] Indirect victims suffered psychological injury as a result of the temporary or permanent injury inflicted on their loved ones.[16] Psychological harm or injury is the consequence of uncertainty or fear about the fate of the direct victim, as well as the indirect victim's knowledge of the direct victim's suffering and/or a loss of sense of safety and moral integrity.[17]

Concerning cases of forced disappearance, which were pandemic for a number of years across Latin America in, among others, Chile, Argentina, Brazil, Peru and Central America, the IACtHR paid special attention to the terrible impact of this heinous State practice on the (mental) health of the families of those disappeared. Due weight was afforded to the anguish, sense of insecurity, frustration and impotence caused by the State authorities' reluctance or failure to investigate and prosecute.[18] In these appalling circumstances, attacks on victims' mental and moral integrity and, thus, serious violations of their right to health constituted a direct consequence of practices of forced disappearance compounded by the lack of effective investigative or prosecutorial activities. When examining reparations claims, including rehabilitation, the IACtHR has applied a rebuttable presumption whereby the direct victim's direct family members, ie. including parents, children, spouses and permanent companions, have suffered harm as a result of violations of their right to mental and moral integrity,[19] which compromised their overall health, mental and physical. Thus, the State has the burden of proof to rebut this presumption. This rebuttable presumption is considered important in helping victims get rehabilitative reparations in situations of asymmetric litigation, ie, victims vs State. Where victims who are not direct family members of the direct victim are concerned, they must prove their close relationship with the direct victims. As for them, there is no presumption of their suffering violations of human rights.[20] Thus, the IACtHR evaluates their situation according to the evidence filed and the case circumstances. The concept of

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13 IACtHR, *19 Tradesmen v. Colombia*, Series C No. 109, 5 July 2004, para 229.
14 IACtHR, *'Street Children' et al v Guatemala*, Series C No. 77, 26 May 2001, para 67.
15 IACtHR, *La Cantuta v Peru*, Series C No. 162, 9 November 2006, para 218.
16 IACtHR, *Bulacio v Argentina*, Series C No. 100, 18 September 2003, para 98.
17 IACtHR, *Caracazo v Venezuela*, Series C No. 95, 29 August 2002, para 97(b).
18 IACtHR, *Bámaca Velásquez v Guatemala*, Series C No. 70, 25 November 2000, para 160.
19 IACtHR, *Valle Jaramillo et al v Colombia*, Series C No. 192, 27 November 2008, para 119. See also: Pasqualucci, Jo M, *The Practice and Procedure of the Inter-American Court of Human Rights* (Cambridge University Press, Cambridge, New York, 2013), 194-195.
20 IACtHR, *Kawas Fernández v Honduras*, Series C No. 196, 3 April 2009, para 128.

'family' has many cultural variations and attention should be paid to applicable social and family structures, as reflected in the IACtHR's jurisprudence.[21]

IACtHR's case law has identified physical and mental injury,[22] emotional suffering,[23] and economic loss[24] as harm to be redressed. Harm may be suffered individually or collectively.[25] Concerning the causal link between the human rights violation and the harm inflicted, the IACtHR has applied a 'directness' standard.[26]

The IACtHR has approached the scope of beneficiaries of rehabilitative reparations with flexibility and has occasionally accepted a category of beneficiaries not completely defined when rendering its judgment. This approach has been adopted considering the particular circumstances surrounding the cases, especially massacres, and/or indigenous people-related cases.[27]

Members of indigenous communities or massacre victims as a whole have been considered as injured parties for rehabilitative reparations. The IACtHR has undergone an important evolution concerning the way it deals with the scope of reparations beneficiaries, including rehabilitation. The IACtHR was initially quite careful to single out each and every victim and also each and every close member of the direct victim's family member.[28] However, the IACtHR has progressively recognised the significance of collective rehabilitative reparations for members of victimised communities as a whole. *Inter alia* the size and geographic diversity of members of victimised indigenous communities and the collective nature of reparations have been considered. The IACtHR found it unnecessary to individualise the members of victimised indigenous communities to recognise them as the injured party and those affected communities have thus been considered as such as collective beneficiaries of reparations,[29] including rehabilitation.

That the IACtHR no longer always requires to the individualisation of victims when to granting collective reparations at the moment of the judgment is correct.[30] It normally takes some time for the IACtHR's reparations judgments to be fully known by potential rehabilitative reparations claimants, and all potential individual beneficiaries of collective rehabilitative reparations may not necessarily be identified in cases involving difficult circumstances such as massacres.[31]

II.2. The ICC

International crimes under the ICC's jurisdiction, ie, genocide, crimes against humanity, war crimes and crime of aggression, inflict severe harm on victims and seriously affect their physical and mental health. The ICC definition of victims is analysed paying attention to the elements most relevant to the right to health and medical rehabilitative reparations. Under Rule 85(a) of the RPE, victims are defined as '(a) […] natural persons who have

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21 IACtHR, *Aloeboetoe et al v Suriname*, Series C No. 15, 10 September 1993, paras 58-59, 62.
22 IACtHR, *Velásquez-Rodríguez v Honduras*, Series C No. 4, 29 July 1988, paras 156, 175 and 187.
23 IACtHR, *Aloeboetoe et al v Suriname*, Series C No. 15, 10 September 1993, para 20.
24 IACtHR, *El Amparo v Venezuela*, Series C No. 28, 14 September 1996, paras 28-63.
25 IACtHR, *Ituango Massacres v Colombia*, Series C No. 148, 1 July 2006, para 386.
26 IACtHR, *Aloeboetoe et al v Suriname*, Series C No. 15, 10 September 1993, para 48.
27 IACtHR, *Plan de Sánchez Massacre v Guatemala*, Series C No. 116, 19 November 2004, para 92.
28 Burgorgue-Larsen, L and Ubeda, A, *The Inter-American Court of Human Rights* (Oxford University Press, Oxford, 2011), 228 (Burgorgue-Larsen and Ubeda 2011).
29 IACtHR, *Plan de Sánchez Massacre v Guatemala*, Series C No. 116, 19 November 2004, para 86; IACtHR, *Saramaka People v Suriname*, Series C No. 172, 28 November 2007, paras 188 and 189. See also: Burgorgue-Larsen and Ubeda 2011, 227-228.
30 Pasqualucci 2013, 195.
31 *Id*, 196.

suffered harm as a result of the commission of any crime within the jurisdiction of the Court'. Hospitals or other places and objects for humanitarian purposes may also be victims when sustaining 'direct harm to any of their property' (Rule 85(b)). As the immense majority of victims are natural persons, the analysis is limited to them. Concerning the scope of reparations beneficiaries, Trial Chamber I found that:

> Pursuant to Rule 85 of the Rules, reparations may be granted to direct and indirect victims, including the family members of direct victims […]; anyone who attempted to prevent the commission of one or more of the crimes under consideration; and those who suffered personal harm as a result of these offences, regardless of whether they participated in the trial proceedings.[32]

This paragraph reflects the broad scope of potential rehabilitative reparations claimants and beneficiaries. The United Nations Basic Principles and Guidelines, invoked by the ICC Chambers,[33] contain a definition of victims similar to the ICC Statute's.[34] Thus, the ICC definition of victims works for rehabilitative reparations purposes.

The victim must be a natural person and prove his or her identity. Rule 89(3) states the possibility for a victim who is a child or a disabled person to have his or her application made by a person acting with his/her consent on his/her behalf.[35] The list of documents accepted as proof of identity by the ICC has included official, non-official identification documents and other documents and, thus, documents relating to medical treatment have been admitted.[36]

Concerning harm, although Article 75 of the ICC Statute mentions 'damage, loss or injury', there are no further details on the type of harm for reparations. The Appeals Chamber (A.Ch) and Trial Chamber in *Lubanga* identified physical harm (including reproductive capacity loss), mental and emotional suffering,[37] which are also listed in the participation and reparation standard application form,[38] and have been considered by the Office of Public Counsel for Victims (OPCV).[39] Harm can be direct and indirect, ie, harm 'attach to both direct and indirect victims'.[40]

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32 ICC, *Lubanga (Decision Establishing the Principles and Procedures to be applied to Reparations, Trial Chamber I)*, ICC-01/04-01/06-2904, 7 August 2012, para 194.

33 ICC, *Lubanga (Judgment on the Appeals of the Prosecutor and The Defense against Trial Chamber I's Decision, on Victims' Participation of 18 January 2008, Appeals Chamber)*, ICC-01/04-01/06-1432, 11 July 2008, paras 33-35.

34 UN General Assembly, *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*, 21 March 2006, (60th Session) A/RES/60/147, Principle 8 (UN Basic Principles and Guidelines).

35 ICC, *Lubanga (Decision on the Applications by Victims to Participate in the Proceedings, Trial Chamber I)*, ICC-01/04-01/06-1556, 15 December 2008, para 67.

36 ICC, *Lubanga (Decision on Victims' Participation, Trial Chamber I)*, ICC-01/04-01/06-1119, 18 January 2008, paras 87-89.

37 ICC, *Lubanga (Judgment on the appeals against the "Decision establishing the principles and procedures to be applied to reparations" of 7 August 2012-Order for Reparations, Appeals Chamber)*, ICC-01/04-01/06-3129-AnxA, 3 March 2015, para 10; ICC, *Lubanga* (ICC-01/04-01/06-2904) *supra* nt 32, paras 230 and 231.

38 ICC, *Application Form for Individuals. Request for Participation in Proceedings and Reparations*, *at* <icc-cpi.int/NR/rdonlyres/48A75CF0-E38E-48A7-A9E0-026ADD32553D/0/SAFIndividualEng.pdf> (accessed 17 October 2015).

39 ICC, *Lubanga (Observations on Issues Concerning Reparations)*, ICC-01/04-01/06-2863, 18 April 2012, paras 36-37, 47-60, 62-71.

40 ICC, *Lubanga*, ICC-01/04-01/06-3129-AnxA *supra* nt 37, para 6.

Trial Chamber I provided for 'indirect victims', ie, victims who suffered harm as a result of the harm suffered by direct victims, to be included in the reparations scheme. Thus, the ICC has to determine whether there was a close personal relationship between the direct and the indirect victims, for example, the parents of child soldiers.[41] Moreover, Trial Chamber I appropriately reasoned that since the concept of 'family' presents many cultural variations, the ICC should pay attention to applicable social and family structures,[42] which is similar to the IACtHR's jurisprudence. Trial Chamber I and the A.Ch established that indirect victims may also include individuals who 'suffered harm when helping or intervening on behalf of direct victims'.[43]

Concerning causation for claiming and receiving rehabilitative reparations, ie, the causal link between the crimes for which the accused is convicted and the harm inflicted on the victims, Rule 85(a) does not provide a 'direct' legal causation standard as it only lays down that 'victims' are those who have suffered harm 'as a result' of the commission of a crime within the ICC's jurisdiction.[44] Indeed, the A.Ch noted that this 'does not necessarily imply the existence of direct harm'.[45] Trial Chamber I closely examined the situation of victims of sexual violence.[46] Unlike the IACtHR which has applied the 'immediate effects' standard, Trial Chamber I considered that reparations should not be limited to 'direct harm' or 'the immediate effects' of the crimes, and instead applied a proximate cause standard,[47] as the A.Ch confirmed.[48]

The damage, loss and injury constituting the basis for rehabilitative reparations claims must have resulted from the crimes upon which the accused was convicted.[49] In applying the 'proximate cause' standard, reparations should not be limited to 'direct harm or immediate effects'.[50] However, it is necessary to adopt precautions to avoid denaturalising the case-based reparations regime and to avoid a highly exponential increase in reparations claimants and beneficiaries who can render the ICC reparations system inefficient.

The TFV established that '[…] victims who suffered harm from sexualized violence occurring during their enlistment, conscription, or use to participate actively in hostilities as children under the age of 15 are entitled to reparations addressing this specific harm'.[51] However, the A.Ch did not consider sexual and gender-based violence as harm resulting from the crimes for which Lubanga was convicted.[52] Considering that there is no direct causal link requirement before the ICC and that this sexual exploitation was arguably linked to the child soldier-related crimes for which Lubanga was convicted, the A.Ch should have upheld the Trial Chamber's finding of reparable harm from sexual and gender violence. This would have been important to redress some specific dimensions of the harm which affected victims' mental and physical health and was caused by sexual/gender violence.

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41 ICC, *Lubanga*, (ICC-01/04-01/06-2904) *supra* nt 32, para 195.

42 *Ibid.*

43 *Id,* para 196; *Lubanga*, ICC-01/04-01/06-3129-AnxA *supra* nt 37, para 6.

44 McCarthy, C, *Reparations and Victim Support in the International Criminal Court* (Cambridge University Press, Cambridge, 2012), 150.

45 ICC, *Lubanga*, ICC-01/04-01/06-1432, 11 July 2008, para 35.

46 ICC, *Lubanga* (ICC-01/04-01/06-2904) *supra* nt 32, paras 207-209.

47 *Id*, para 249.

48 ICC, *Lubanga*, ICC-01/04-01/06-3129, *supra* nt 37, paras 126-129.

49 *Id,* para 181.

50 ICC, *Lubanga*, (ICC-01/04-01/06-2904) *supra* nt 32, para 249.

51 ICC, *Lubanga (Observations of the Trust Fund for Victims on the Appeals Against Trial Chamber I's "Decision Establishing the Principles and Procedures to be Applied to Reparations")*, ICC-01/04-01/06-3009, 8 April 2013, para 158.

52 ICC, *Lubanga*, ICC-01/04-01/06-3129 *supra* nt 37, paras 196-198.

The application process for reparations is individualised, which means that each victim must file a separate reparations request form. However, the type of harm/injury inflicted on a large number of victims may be of a collective nature. Rule 94(1) lists the requirements and items for victims who want to claim reparations. Those directly related to the right to health and medical rehabilitative measures are a 'description of the injury, loss or harm' and 'claims for rehabilitation and other forms of remedy'.[53] Submissions by legal representatives of victims have included, *inter alia*, individual and collective reparations as well as modalities of reparations, including rehabilitation, as examined later.

Rehabilitative reparations awards must identify victims eligible to benefit from rehabilitative reparations or set out the eligibility criteria based on the link between the harm suffered by the victims and the crimes for which the accused was convicted.[54] The A.Ch considered that when a rehabilitative reparations award benefits a community, only members of the community meeting the relevant criteria are eligible.[55] Thus, the A.Ch's approach is more limited than the IACtHR's as the latter has ordered rehabilitative awards for entire affected communities.

II.3. The ECCC

The ECCC has jurisdiction over international and domestic crimes committed by senior Khmer Rouge leaders. To become a civil party and claim rehabilitative reparations before the ECCC, victims according to internal rule 23*bis*(1) must: 'demonstrate that as a direct consequence of at least one of the crimes alleged against the Charged Person, that he or she has in fact suffered physical, material or psychological injury upon which a claim of collective and moral reparation might be based'. Civil parties' interests 'are principally the pursuit of reparations' provided that there is a criminal conviction.[56] Under the ECCC rules, victims are entitled to '[s]eek collective and moral reparations',[57] which is their primary interest, alongside supporting the Prosecutor. As established in the ECCC's jurisprudence, civil participation includes 'both the right for victims to participate in the criminal trial of an accused, and to pursue a related civil action for collective and moral reparations'.[58] Only victims who have been granted civil party status may claim rehabilitative reparations. However, similar to the ICC, some modalities of collective reparations may potentially be enjoyed by victims who could not apply to become civil parties and, thus, were not reparations claimants at the ECCC as the Supreme Court Chamber suggested,[59] for example, health care services for members of an affected community. A similar approach was put forward by the civil parties' lead co-lawyers in *Case 002* when discussing the implementation of collective reparations projects: 'In addition to civil parties, it could also benefit victims in a broader sense as awarding collective and moral reparations to civil parties implies that they can benefit many

53 RPE, rules 94(1)(b) and (f).
54 ICC, *Lubanga*, ICC-01/04-01/06-3129) *supra* nt 37, para 1.
55 *Id,* para 8.
56 Extraordinary Chambers in the Courts of Cambodia (ECCC), *Prosecutor v Kaing Guek Eav* (2009), 001/18-07-2007/ECCC/TC, Case 001; Decision on Civil Party Co-Lawyers' Joint Request for a Ruling on the Standing of Civil Party Lawyers to Make Submissions on Sentencing and Directions Concerning the Questioning of the Accused, Experts and Witnesses Testifying on Character, Trial Chamber, para 33.
57 Rule 23(1)(a).
58 ECCC, *Prosecutor v Kaing Guek Eav* (2012), 001/18-07-2007/ECCC/TC, Case 001, Appeal Judgment, Supreme Court Chamber, para 639.
59 Case 001, para 659.

victims'.[60] Thus, some collective rehabilitative reparations could benefit a larger group than just civil parties, for example, building medical facilities or testimonial therapy of civil parties read aloud in public ceremonies with the participation of community members, survivors and relatives.[61]

Harm or injury relevant to reparations may be 'physical, material or psychological'.[62] The injury has to be 'a *direct* consequence of at least one of the crimes alleged against the Charged Person' and, thus, concerning causation, the perpetrator's liability is limited to 'direct losses'.[63] The Supreme Court Chamber concluded that: i) it is necessary to establish a causal link between the prohibited conduct giving rise to reparations and the form of reparations sought;[64] and ii) the type of the causal link 'that needs to be demonstrated for the purpose of admissibility of civil party applications concerns the presence of an injury suffered as a direct consequence of the crime. The presence of the injury is conducive to the right to seek reparation.'[65] Further, responsibility is not limited to persons against whom crimes were perpetrated 'but may also be the direct cause of injury to a larger group of victims'.[66]

The requirements for civil party constitution and, therefore, the possibility to claim rehabilitative reparations before the ECCC are not formal references to a specific class of individuals but instead substantive criteria of an actual injury that results as a direct consequence of the crime.[67] The injury resulting from the crime charged is the defining and limiting criterion for admissibility of the civil party application before the ECCC,[68] and for claiming and receiving rehabilitative reparations if the accused is convicted. To be granted (rehabilitative) reparations, the harm inflicted on victims must be directly linked to the crime(s) for which the accused was convicted.[69]

Based on the existence of an injury thus considered, the next question is whether not only direct but also indirect victims may be civil parties,[70] and claim rehabilitative reparations to realise their right to health. The ECCC's case law has answered in the affirmative. Accordingly, indirect victims, as civil parties, can also claim rehabilitative reparations at the ECCC and receive them if the accused is convicted. Therefore, the requirement of injury as a direct consequence of the offence (rule 23*bis*(1)(b)) does not limit the admissibility of civil parties to direct victims and, thus, indirect victims can be included and claim rehabilitation.[71]

The Supreme Court Chamber has found that indirect victims are those who 'actually suffered psychological injury, for example, as a result of the injury, whether temporary or permanent, of their loved ones'.[72] Psychological injury is the result of uncertainty or fear about the direct victim's fate, knowledge of their suffering or loss of sense of safety and

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60 ECCC, *Prosecutor v Sampah et al* (2012), 002/19-09-2007/ECCC/TC, Case 002, E125/2, para 84.

61 ECCC, *Prosecutor v Sampah et al* (2013) 002/19-09-2007-ECCC/TC, Case 002/01 Lead Co-Lawyers' Indication to the Trial Chamber of the Priority Projects for Implementation as Reparations, Civil Parties, para 16.

62 Rule 23*bis*1.

63 War Crimes Research Office (WCRO), SáCouto, S and Cleary, K, REPORT: *The Case-Based Reparations Scheme at the International Criminal Court*, June 2010, *at* <wcl.american.edu/warcrimes/icc/documents/report12.pdf> (accessed 17 October 2015), 38-39.

64 Case 001, Appeal Judgment, para 699.

65 *Ibid.*

66 Case 001, Judgment, para 642.

67 Case 001, Appeal Judgment, para 411.

68 Case 001, Appeal Judgment, para 415.

69 Case 001, Judgment, para 660.

70 Case 001, Appeal Judgment, para 417.

71 Case 001, Appeal Judgment, para 418.

72 Case 001, Appeal Judgment, para 417.

moral integrity.[73] Moreover, in grave or prolonged cases, psychological injury may lead to physical injury by causing several ailments.[74] Thus, the harm inflicted violates the overall right to health.

Vulnerable groups such as infants, children, the elderly and sick may have suffered psychological and physical injury as their caregivers were taken away from them.[75] Indirect victims' rights, including claiming rehabilitative reparations, once constituted as civil parties, are independent of the direct victims' rights, ie, indirect victims can be granted civil party status and claim reparations even 'where the direct victim is alive and does not pursue the civil party action him or herself'.[76]

Questions directly related to the right to health and rehabilitative reparations under the civil party application form are: 1. whether the applicant was examined by a doctor after the event(s) took place; 2. whether the applicant received any medical or psychological treatment; 3. whether the applicant has any records concerning any medical or psychological treatment such as a medical report from a doctor, hospital or health centre, X-rays, prescriptions or invoices for medicines; and 4. whether his or her condition persists to date and, if so, provision of details is needed.[77] Rule 23(4) lays down that all civil parties' applications must *inter alia* 'attach evidence of the injury suffered'.

The ECCC's case law, like the IACtHR's, has considered the cultural context to examine the nature of familial relationships, particularly, extended family members,[78] to grant civil parties status and, therefore, expand the scope of civil parties who can claim rehabilitative reparations.

III. Medical Rehabilitation as Reparation and Implementation

III.1. The IACtHR

Rehabilitation as reparation has been ordered by the IACtHR to treat psychological and physical harm caused by serious human rights violations constitutive of international crimes and inflicted on victims. As previously discussed, the universe of rehabilitative reparations claimants and beneficiaries has included not only direct victims but also indirect victims such as the next of kin of executed or disappeared persons. Effective and appropriate medical and psychological treatment as well as necessary medication have normally been part of rehabilitative reparations awards. Thus, the IACtHR has granted rehabilitative reparations awards covering the cost of future medical treatment of the direct victims and also of the next of kin of deceased or executed persons.[79] Free life-long access to a variety of health services focused on traumatisation has also been granted and, thus, health care areas have included 'out-patient consultation, diagnostic support procedures, medicine, specialized care, diagnostic procedures, hospitalization, surgery, childbirth, traumatological rehabilitation, and mental health'.[80] The IACtHR has ordered the respective defendant State to afford medical and psychological care as this is found to be

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73 *Ibid.*
74 *Ibid.*
75 *Ibid.*
76 Case 001, Appeal Judgment, para 418.
77 Questions 3-7.
78 Case 001, Judgment, para 643.
79 Inter-American Court of Human Rights (IACtHR), Case of the *Caracazo v Venezuela,* Reparations and Costs, IACHR Series C No 95, 29 August 2002, paras 86-87.
80 IACtHR, Case of *Barrios Altos v Peru*, Reparations and Costs, IACHR Series C No 87, 30 November 2001, para 42.

an appropriate form of reparations and has been given as part of individual and collective reparations awards.[81]

Importantly, rehabilitative reparations claimants and beneficiaries have to be consulted concerning the kind of treatment, and the respective health care needs to be free, individualised, specialised and integrated.[82] Each victim's very personal needs and circumstances should be evaluated and, thus, appropriate individual, family and/or collective health care/treatment may be provided according to specific needs.[83]

The IACtHR has ordered States to constitute a committee to examine victims' physical and mental health and grant them treatment for a five-year period.[84] The IACtHR occasionally established that victims had to request medical treatment within a specific period, for example, within two years after the IACtHR's judgment; however, the IACtHR also guaranteed its continuation as long as needed.[85] Nevertheless, the IACtHR no longer requires a time limit for requesting medical treatment. This change of position is appropriate as the trauma generated on the victims may prevent them from further proceeding for some years or even 'might not manifest themselves for a period of years'.[86]

Psychological treatment is afforded by psychologists or psychiatrists who are specialists in the specific kind of violence endured by the victims,[87] and if there are no available State personnel, the State has to guarantee it via private health care.[88] Treatment is generally speaking given without charge in national public facilities located near the victim's residence.[89]

When the harm inflicted is caused by serious human rights violations which fell short of the IACtHR's temporal jurisdiction, the IACtHR has not ordered the State to provide rehabilitation; however, it has urged the State in question to provide either rehabilitation or a monetary sum to cover rehabilitation costs and expenses.[90]

In the case of serious human rights violations in which direct victims survive, for example, torture or prolonged illegal detention, the IACtHR has provided rehabilitative measures for both direct and indirect victims. Nevertheless, whereas concerning direct victims rehabilitative measures have normally consisted of both medical and psychiatric/psychological treatment, for indirect victims rehabilitative measures have been mainly limited to psychiatric/psychological treatment.[91]

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81 IACtHR, Case of the *Plan de Sánchez Massacre v Guatemala*, Reparations, IACHR Series C No 116, 19 November 2004, para 107.

82 IACtHR, Case of *Chitay Nech et al v Guatemala*, Preliminary Objections, Merits, Reparations, and Costs, IACHR Series C No 212, 25 May 2010, para 256.

83 IACtHR, Case of the *'Las Dos Erres' Massacre v Guatemala*, Preliminary Objection, Merits, Reparations and Costs, IACHR Series C No 211, 24 November 2009, para 270.

84 *Plan de Sánchez Massacre v Guatemala*, paras 106-108, 117.

85 IACtHR, Case of *Kawas Fernández v Honduras*, Merits, Reparations and Costs, IACHR Series C No 196, 3 April 2009.

86 Pasqualucci *supra* nt 20.

87 IACtHR, Case of *Anzualdo-Castro v Peru*, Preliminary Objection, Merits, Reparations and costs, IACHR Series C No 202, 22 September 2009, para 203.

88 IACtHR, Case of *Manuel Cepeda Vargas v Colombia*, Preliminary Objections, Merits, Reparations and Costs, IACHR Series C No 213, 26 May 2010, para 403.

89 IACtHR, Case of the *Ituango Massacres v Colombia*, Preliminary Objection, Merits, Reparations and Costs, IACHR Series C No 1481 July 2006, para 16.

90 IACtHR, Case of *García Lucero et al v Chile*, Monitoring Compliance with Judgment, 17 April 2015, para 37.

91 IACtHR, Case of *Gutiérrez Soler v Colombia*, Merits, Reparations and Costs, IACHR Series C No 132, 12 September 2005, paras 101-103.

Should the victim be a national of the defendant State but not a resident thereof, psychological and medical care are still provided in the facilities of that State, which involves return of the victim.[92] This may however be criticised considering the traumatic experiences suffered by the victim and, thus, some other alternatives should be considered.[93] For example, coordination with the national health authorities of the country where the victim is resident. Another option could be provision of a monetary sum to the victim to be used for medical treatment in his or her country of residence. Be that as it may, when the victim is a migrant in relation to the defendant State, provision of a monetary sum has been afforded to enable him or her to be granted medical or psychological treatment and medication in the State of residence. Indeed, in cases where the victim lives in a State other than his or her home country, the IACtHR's practice has recently showed a predominant trend whereby medical and psychological treatment in serious human rights violations cases has been reflected as monetary sums to cover reasonable costs of that treatment in the country of residence of the victims.[94] In any case, victims should always be consulted on which option to follow.

Serious human rights violations constitutive of international crimes have been part and parcel of the IACtHR's case law and due to the characteristics of these atrocities, the right to health, both physical and mental, of not only an individual or a group of individuals but also of entire communities have been severely affected. Thus, the IACtHR has appropriately granted collective rehabilitative reparations to favour entire affected communities. This was the situation in *Plan de Sánchez Massacre* in which Mayan ethnic group members were victims of genocide. The IACtHR ordered Guatemala to provide *inter alia*

> (c) sewage system and potable water supply […] (e) the establishment of a health centre in the village of Plan de Sánchez with adequate personnel and conditions, as well as training for the personnel of the Rabina Municipal Health Centre so that they can provide medical and psychological care to those who have been affected and who require this kind of treatment.[95]

Some of the collective rehabilitative measures, such as those detailed in the quoted paragraph, may resemble development policies or State charitable assistance.[96] Accordingly, attention should be paid by the IACtHR when supervising and monitoring the implementation of reparations so that these are not politically manipulated. By doing so, the IACtHR should ensure that the provision of health care services and/or infrastructure and related services and works are afforded by the State as part of the rehabilitative reparations ordered. This is different from, albeit complementary to and linked with, the actions to be undertaken by any State to foster the development of communities.

Since the IACtHR may order a State to provide rehabilitative reparations to victims for State violations of Inter-American human rights treaties, it can monitor the State implementation of rehabilitative reparations ordered. States must inform the IACtHR

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92 IACtHR, Case of *Valle Jaramillo et al v Colombia*, Interpretation of the Judgment on the Merits, Reparations and Costs, 7 July 2009, para 32.

93 See also Pasqualucci *supra* nt 20*,* 203.

94 *Gutiérrez Soler v Colombia*, para 102.

95 *Plan de Sánchez Massacre v Guatemala*, para 110.

96 International Centre for Transnational Justice, Lisa Magarell, REPORT: *Reparations in Theory and Practice*, New York*,* 9 January 2007, *at* <ictj.org/sites/default/files/ICTJ-Global-Reparations-Practice-2007-English.pdf> accessed at 17 October 2015, 6.

about compliance with its judgments and decisions, including rehabilitative reparations awards. Under the principle of *pacta sunt servanda*, States abide by treaty obligations. When States proceed to fully implement rehabilitative reparations orders, they guarantee observance of the provisions and inherent effects (*effet utile*) within their national systems, ie, substantive and procedural norms, of the ACHR and other regional human rights treaties. The IACtHR may note non-compliance in its Annual Report. The Organization of American States (OAS) General Assembly takes no action to oblige States to comply; however, it obliges States to inform the IACtHR on compliance. Conversely, the Council of Europe Committee of Ministers supervises the implementation of the ECtHR's judgments,[97] which enhances rehabilitative reparations monitoring/implementation as it puts political pressure on States. Nevertheless, an important advantage of the IACtHR's judicial monitoring of implementation of rehabilitative reparations is that it directly ensures that its awards are implemented by the State in line with the principles, contents and scheme provided for in the original reparations order.[98]

Since implementation of rehabilitative reparations has to be undertaken by States, there is at least in theory a sophisticated administrative State structure to implement and execute rehabilitative awards ordered by the IACtHR.[99]

Monitoring compliance with rehabilitative reparations orders involves the defendant State providing a report detailing whether and to what extent that State has enforced the rehabilitative measures ordered and which must be within a time limit detailed by the IACtHR in its judgment.[100] Thus, the IACtHR in its powers of supervision of its judgments has established some timeframe in which the State has to nationally implement the rehabilitative reparations ordered. For instance, concerning the construction of a health centre in a village whose inhabitants were massacred, the IACtHR required the defendant State to implement this within five years of the IACtHR's merits judgment notification and to report in detail on the progressive implementation thereof to the IACtHR every year.[101]

Importantly, victims' participation concerning implementation of rehabilitative measures and, therefore, participation in aspects related to dimensions of their right to health is present as the IACtHR collects observations of victims or their representatives and then employs this data to effectively evaluate the level of compliance and inform the respective State of what still shall be done.[102] Additionally, under the ACHR (Article 65), the IACtHR using the same information provided by the victims informs the OAS General Assembly of outstanding problems. Furthermore, an extra avenue for victims seeking to receive effective and full rehabilitation consists of holding public hearings or, depending on the circumstances, private hearings, with participation of the victims and/or their legal representatives.

An additional important question is whether this well-established procedural framework is in practice effective, ie, whether the States in accordance with the ACHR (Article 68) fully meet their obligation of observance of rehabilitative reparations ordered by the IACtHR. The fact that there are a significant number of cases being monitored is not necessarily synonymous with lack of State compliance with the IACtHR's

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97 ECHR, Articles 41, 46.

98 See also, McCarthy *supra* nt 45, 174.

99 IACtHR, Case of *Serrano-Cruz Sisters v El Salvador*, Merits, Reparations and Costs, IACHR Series C No 120, 1 March 2005, para 198.

100 See, Burgorgue-Larsen and Úbeda *supra* nt 29, 182.

101 *Plan de Sánchez Massacre v Guatemala*, para 111.

102 See Burgorgue-Larsen and Úbeda *supra* nt 29, 182.

rehabilitative reparations.[103] However, States have only partially implemented rehabilitative reparations awards granted by the IACtHR.[104] The uncertainty of future medical expenses in principle makes using the national health care system preferable to paying a monetary sum.[105]

Practice within the Latin-American region demonstrates that compliance with the IACtHR's reparations orders depends on some factors such as State willingness and capacity to do so as well as the modality of reparations.[106] As for the latter, unlike compensation, which presents a high level of State compliance or symbolic measures which involve a medium level of State compliance, rehabilitative measures consisting of provision of medical or psychological health care to victims has reported a low level of compliance.[107] For example, concerning the IACtHR's reparations orders against Peru, whereas compensation registered 46% full implementation, rehabilitation only reached 12% as of 2015.[108] A factor that explains the low rate of implementation is the need for coordination between the national ministries of health and the local bureaucracies who run the local health care services and centres.[109]

The timeframe for full implementation of rehabilitative reparations may substantially vary from country to country and from judgment to judgment. On some occasions, delay in implementation of rehabilitative measures has led to serious consequences for the right to health of the victims. For example, in *Sawhoyamaxa Indigenous Community*, notwithstanding the IACtHR's reparations award, Paraguay did not provide the members of the indigenous community with health care, food and water and, thus, they became incapable of continuing to live on their ancestral lands.[110] As a consequence, four vulnerable persons, including three children, perished, for which the IACtHR severely criticised Paraguay.[111] Although the IACtHR issued injunction orders in subsequent compliance orders, other community members' health deteriorated to the point that a number of them also died.[112] This difficult situation prompted the IACtHR's President to call a public hearing so that Paraguay could present an explanation of the events. This was an extreme example of a trend which seemingly and often indicates incomplete compliance with rehabilitative reparations.[113]

Sometimes State efforts proved to be insufficient. Colombia failed to implement the IACtHR's orders to afford free medical and psychological treatment via the national

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103 Pasqualucci *supra* nt 20, 305.

104 *Ibid.*

105 *Id,* 314.

106 Burgorgue-Larsen and Úbeda *supra* nt 29, 183.

107 Pasqualucci *supra* nt 20, 305-306; Beristain, CM, *Diálogos sobre la reparación: Experiencias en el sistema interamericano de derechos humanos*(Instituto Interamericano de Derechos Humanos, Costa Rica, 2008) 548.

108 Instituto de Democracia y Derechos Humanos-Universidad Católica del Perú (IDEHPUCP), Bulletin on Implementation of Reparations by the Inter-American Court (15 August 2015),*at* <idehpucp.pucp.edu.pe/wp-content/uploads/2013/07/Bolet%C3%ADn-Per%C3%BA-2015.pdf> (accessed 5 December 2015).

109 Pasqualucci *supra* nt 20, 314.

110 IACtHR, Case of the *Sawhoyamaxa Indigenous Community v Paraguay*, Merits, Reparations and Costs, IACHR Series C No 146,29 March 2006; See also Burgorgue-Larsen and Úbeda *supra* nt 29, 183.

111 IACtHR, Case of the *Sawhoyamaxa Indigenous Community v Paraguay*, Monitoring Compliance with Judgments,Order of the President,recitals 11, 12.

112 *Id,* 37.

113 Burgorgue-Larsen and Úbeda *supra* nt 29, 183; IACtHR, *Annual Report 2008*, OEA/Ser.L/V/II.134, Doc. 5, rev. 1, 25 February 2009, *at* <cidh.org/annualrep/2008eng/TOC.htm> (accessed 17 October 2015), 75; Cavallaro, J, and Breyer, S, "Reevaluating regional human rights litigation in the twenty-first century: the case of the Inter-American Court", 102 *American Journal of International Law* (2008), 768-827.

health system. In *Vargas Areco*, the hospital in which the victim was enrolled was hundreds of kilometres away from his home.[114] In *Cantoral Benavides*, Peru's efforts were insufficient as the victim had to wait for several hours each session due to the required registration and was not immediately provided medication.[115] In *Juvenile Reeducation Institute*, only 43 victims out of thousands of potential beneficiaries were registered to receive medical attention.[116]

The enforcement of rehabilitative reparations awards is continuously monitored until the IACtHR considers that they have been fulfilled and, thus, constitutes one of the IACtHR's most demanding activities.[117]

III.2. The ICC

Under Article 75 of the ICC Statute and related ICC RPE, reparations, including rehabilitation, can be individual or collective. Although individual awards in principle seem to be of a monetary nature, individual victims can also claim rehabilitation and other forms of remedy. Indeed, victims in *Lubanga* considered not only compensation as part of individual awards.[118] When collective reparations awards are granted, 'these should address the harm the victims suffered on an individual and collective basis'.[119] Furthermore, the Trial Chamber considered that the ICC should provide medical services (psychiatric and psychological care included), in addition to assistance on rehabilitation, housing, education and training.[120] Collective awards can also be made up of restitution, rehabilitation or other remedies awarded to a group of victims.[121] Article 75(2) lists the modalities of restitution, compensation and rehabilitation. However, this enumeration is only illustrative and not exhaustive since the word 'including' is used and is interpreted by Trial Chamber I.[122] Besides a gender-sensitive approach, other reparations modalities with symbolic, preventive or transformative value are appropriate.[123] Reparations modalities, including rehabilitation, identified and discussed by Trial Chamber I were consistent with those asked/suggested by the victims,[124] the OPCV,[125] and the TFV.[126]

Reparations in the form of assistance or rehabilitation programmes, as individual or collective awards, may be better than compensation, especially when the amount of payment is nominal.[127] The TFV has indeed considered that compensation, as a modality

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114 IACtHR, Case of *Vargas Areco v Paraguay*, Monitoring Compliance, Order of the IACtHR, 24 November 2010, para 19.

115 IACtHR, Case of *Cantoral Benavides v Peru*, Monitoring Compliance, Order of the IACtHR, 14 November 2010, para 14.

116 IACtHR, Case of the *'Juvenile Reeducation Institute' v Paraguay*, Monitoring Compliance, Order of the IACtHR, 19 November 2009, paras 18, 19, 24.

117 IACtHR, *Annual Report 2011*, OEA/Ser.L/V/II., Doc. 69, 30 December 2011, *at* <oas.org/en/iachr/docs/annual/2011/toc.asp> (accessed 17 October 2015), 19.

118 *Lubanga* (ICC-01/04-01/06-2869), 18 April 2012, paras 16 and 20.

119 *Id*, para 221.

120 *Ibid.*

121 Dwertmann, E, *The Reparation System of the International Criminal Court* (Martinus Nijhoff Publishers, 2010), 124.

122 *Lubanga* (ICC-01/04-01/06-2904) *supra* nt 32, para 222.

123 *Ibid.*

124 *Lubanga* (ICC-01/04-01/06-2869), Observations du Groupe de Victimes V02 Concernant la Fixation de la Peine et des Réparations, 18 April 2012, paras 13-20.

125 *Lubanga* (ICC-01/04-01/06-2863), 18 April 2012, paras 45-121.

126 *Lubanga* (ICC-01/04-01/06-2872), Observations on Reparations in Response to the Scheduling Order of 14 March 2012, 25 April 2012, paras 55-58.

127 Roth-Arriaza, N, "Reparations, Decisions and Dilemmas", 27 *Hastings International and Comparative Law Review* (2004) 157, 162.

of reparation, may be less suitable than rehabilitation.[128] However, it is herein argued that a reparations programme should usually, and when feasible, include measures integrating monetary, rehabilitative and symbolic components rather than relying exclusively on or excluding a modality of reparations altogether.[129] The UN Basic Principles and Guidelines refer to 'adequate, appropriate and prompt reparation',[130] which indicates the need for some appropriate combination of medical and psychological rehabilitation with other forms of reparations.[131]

Trial Chamber I, relying on, *inter alia*, the IACtHR's case law and UN Basic Principles and Guidelines, found rehabilitation to include: 1. the provision of medical services and health care, in particular treatment of HIV and AIDS; 2. psychological, psychiatric and social assistance to support victims enduring grief and trauma; and 3. any relevant legal and social services.[132] Rehabilitation has to be implemented by the ICC in correspondence with the non-discrimination principle, which includes a gender inclusive approach encompassing males and females of all ages.[133] Rehabilitation steps may also include communities of victims to the extent that rehabilitative reparations programmes are implemented where their communities are located.[134] Programmes with transformative objectives, regardless of how limited they may be, can actually help to prevent future victimisation and symbolic measures, such as commemorations and tributes, may also contribute to rehabilitation.[135]

As for vulnerable groups of victims, for example, former child soldiers, rehabilitation should include measures directed at facilitating their reintegration to society, bearing in mind the differences in the impact of those crimes on boys and girls.[136] Indeed, as the Trial Chamber recognised, priority may be afforded to vulnerable victims including severely traumatised children, sexual/gender-based violence victims and to those who require medical care, particularly when plastic surgery or HIV treatment is needed.[137]

Rehabilitative measures should include manners of addressing the shame that victims may feel and, indeed, they 'should be directed at avoiding further victimisation of the boys and girls who suffered harm as a consequence of their recruitment [as child soldiers]'.[138] Trial Chamber I considered collective rehabilitative measures, including child soldiers' communities, in steps taken to rehabilitate and re-integrate child soldiers, as those programmes are implemented in the respective communities.[139] Moreover, as for children beneficiaries of rehabilitative reparations, the principle of the 'best interests of the child' embedded in the Convention on the Rights of the Child should *inter alia* guide the ICC's decisions.[140] Furthermore, reparations proceedings, orders and programmes that benefit child soldiers should guarantee the development of the victims' personalities, help them obtain rehabilitation and reintegrate them into society.[141]

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128 *Lubanga* (ICC-01/04-01/06-2803), 1 September 2011, para 344.
129 Magarrell, *supra* nt 97, 4.
130 *UN Basic Principles and Guidelines*, *supra* nt 34, Principle 15.
131 *Ibid.*
132 *Lubanga* (ICC-01/04-01/06-2904) *supra* nt 32, para 233.
133 *Id*, para 232.
134 *Id*, para 236.
135 *Ibid.*
136 *Id*, para 234.
137 ,*Id*, para 200.
138 *Id*, para 235.
139 *Id*, paras 236–240.
140 Article 3, United Nations, *Convention on the Rights of the Child* (1990) 1; *Lubanga* (ICC-01/04-01/06-2904) *supra* nt 32, para 210.
141 *Lubanga* (ICC-01/04-01/06-2904) *supra* nt 32, paras 213 and 216.

Concerning implementation of rehabilitative reparations such as medical, social and psychological rehabilitation, these require a considerable amount of money to be funded. Thus, it is not quite realistic to assume that the convicted individual or individuals can finance them, let alone the fact that the States are expected to provide social security or health care services.[142]

Regarding implementation of rehabilitative reparations at the ICC, the TFV is a key institution as it serves for the 'benefit of victims of crimes within the jurisdiction of the Court, and of the families of such victims'.[143] The TFV's mandate is twofold and reflects its relationship with the ICC. Its first mandate is to ensure the existence of sufficient available funds in case the ICC orders reparations in accordance with Article 75(2) of the ICC Statute,[144] which provides that 'where appropriate, the Court may order that the award for reparations be made through the Trust Fund provided for in Article 79'. This has been the case in *Lubanga*, as detailed by the A.Ch.[145] This 'reparations mandate' is linked to specific ICC cases.[146] Under this mandate, the TFV implements reparations awards for victims ordered by the Court against the convicted in accordance with ICC's specific criteria. The TFV's second function, ie, the general assistance function,[147] is of a non-judicial or humanitarian nature.[148] Under the TFV's case-based reparations mandate, the ICC can direct the TFV to use resources deposited with it to implement ICC-ordered reparations against a convicted person. Conversely, under its general assistance mandate, the TFV may use voluntary contributions to provide general assistance, ie, technically-speaking not reparations, to all victims of the ICC situations.

The TFV has gathered experience with rehabilitation programmes implemented under its assistance mandate, highlighting this as important know-how when implementing similar initiatives concerning reparations orders.[149] Accordingly, an option is to implement and finance similar rehabilitation programmes under the TFV's management for case-based reparations claimants and beneficiaries. A second alternative is to incorporate reparations beneficiaries to programmes already run by the TFV for victims of situations in general, while always making it clear that the former category of victims are reparations beneficiaries and not general assistance beneficiaries. If the convicted is found to have funds, she or he can be ordered to at least partially finance the rehabilitation of victims or a rehabilitative programme as part of a collective reparations award.[150]

The exact scope of beneficiaries of rehabilitative measures, ie, total identification of eligible individual beneficiaries, in *Lubanga* is yet to be determined via the implementation of TFV's reparations plan under the ICC Trial Chamber's monitoring and oversight. Not restricting the universe of potential claimants and beneficiaries of rehabilitation to only those who are/were victim participants also corresponds to

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142 Dwertmann, *supra* nt 122, 148-149.

143 ICC Statute, article 79(1).

144 Situation in the DRC (ICC-01/04-492), Decision on the Notification of the Board of Directors of the Trust Fund for Victims in accordance with Regulation 50 of the Regulations of the Trust Fund, 11 April 2008, 7.

145 *Lubanga* (ICC-01/04-01/06-2953), Decision on the Admissibility of the Appeals Against Trial Chamber I's "Decision Establishing the Principles and Procedures to be Applied to Reparations" and Directions on the Further Conduct of Proceedings, Appeals Chamber, 14 December 2012, para 55.

146 ICC Assembly of State Parties, *Report to the Assembly of States Parties on the Activities and Projects of the Board of Directors of the Trust Fund for Victims for the Period 1 July 2011 to 30 June 2012*, ICC-ASP/10/14, 7 August 2012, paras 3-8.

147 *Id,* paras 9-13.

148 Zegveld, *supra* nt 7, 88.

149 *Lubanga* (ICC-01/04-01/06-2803), Trust Fund for Victims' First Report on Reparations, 1 September 2011, paras 319-326.

150 Dwertmann, *supra* nt 122, 149.

minimum considerations of non-discrimination, as 'it would be inappropriate to limit reparations to the relatively small group of victims that participated in the trial and those who applied for reparations'.[151] Considering factors such as on-going armed violence, remoteness and intimidation that may have prevented victims from participating during the trial, this is also a realistic approach. Accordingly, victims, as defined in Rule 85, have to be given equal access to any information relating to their right to rehabilitative reparations and the ICC's assistance,[152] which is also in line with the UN Basic Principles and Guidelines.[153] Concerning those who lost their victim participant status due to problems with their testimonies in *Lubanga*, they may still claim and benefit from rehabilitative reparations if the respective causal link is proved, as noted by the A.Ch.[154]

As previously said, the ICC cannot issue rehabilitative reparations against the States Parties to the ICC Statute. However, concerning enforcement of those orders, the ICC can oblige the States Parties to conduct certain measures as they are required to cooperate with the ICC.[155] Article 75(4) of the ICC Statute states that the ICC 'may […] determine whether, in order to give effect to a [reparations] order which it may make under this article, it is necessary to seek measures under article 93 [Other forms of cooperation]'. The ICC *motu proprio*, the Prosecutor or victims who claimed/will claim rehabilitative reparations via application may request State cooperation.[156] Seizure of assets may be used to enforce reparations orders.[157] Article 75(5) states that the enforcement regime for fines and forfeiture order (Article 109) shall apply to the ICC's reparations orders and States Parties shall fully enforce ICC rehabilitative reparations orders. In enforcing these orders, national authorities cannot modify them.[158] This is related to the dependence of the ICC's efficacy on State cooperation.

Under its general assistance mandate, the TFV may consider it necessary 'to provide physical or psychological rehabilitation […] for the benefit of victims and their families'.[159] Thus, the TFV notified the ICC of its plans to conduct assessments of needs as part of specific projects to provide physical, psychological and material support to victims in two ICC country situations: Uganda and the Democratic Republic of Congo (DRC). The TFV Board of Directors estimated that those projects would benefit more than 380,000 victims,[160] and similar projects in the Central African Republic (CAR) were prepared,[161] and approved.[162] Those estimations should be taken carefully since the notion of beneficiaries 'is probably being used rather loosely'.[163] Nonetheless, the nature

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151 *Lubanga* (ICC-01/04-01/06-2904) *supra* nt 32, para 187.

152 ,*Id*, para 188.

153 *UN Basic Principles and Guidelines*, *supra* nt 34, Principles 11, 12 and 24.

154 *Lubanga* (ICC-01/04-01/06-2953), 14 December 2012, para 70.

155 *ICC Statute*, Part 9 (International Cooperation and Judicial Assistance), particularly, Articles 93 and 109. See also Articles 86 and 88.

156 Schabas, W, *The International Criminal Court. A Commentary on the Rome Statute* (Oxford University Press, 2010), 883.

157 RPE, Rule 99.

158 RPE, Rule 219.

159 *TFV Regulation* 56.

160 ICC Assembly of State Parties, *Report to the Assembly of States Parties on the Activities and Projects of the Board of Directors of the Trust Fund for Victims for the period 1 July 2007 to 30 June 2008*, ICC-ASP/7/13, 3 September 2008, para 22.

161 ICC Assembly of State Parties, *Report to the Assembly of States Parties on the projects and the activities of the Board of Directors of the Trust Fund for Victims for the period 1 July 2011 to 30 June 2012*, ICC-ASP/11/14, 7 August 2012, 1.

162 Situation in the CAR (ICC-01/05-41), Decision on the 'Notification by the Board of Directors in Accordance with Regulation 50 a) of the Regulations of the Trust Fund for Victims to Undertake Activities in the Central African Republic', Pre-Trial Chamber II, 23 October 2012.

163 Schabas, *supra* nt 156, 915.

and scale of projects handled by the TFV show the great potential that such institutions have to bring restorative justice via rehabilitative reparations to a much larger number of victims in contexts involving thousands or millions of victims. Among others, the TFV has set out the following categories of programmes directly related to the right to health and consistent with rehabilitative measures.

> *Physical rehabilitation,* which includes reconstructive surgery, general surgery, bullet and bomb fragment removal, prosthetic and orthopedic devices, referrals to services such as fistula repair and HIV and AIDS screening, treatment, care and support;
> *Psychosocial rehabilitation*, which includes both individual and group-based trauma counselling […].[164]
> *Implementing special initiatives for children born out of rape and children* who themselves have been victimized by sexual and gender-based crimes […] including access to basic services […] nutrition support […].[165]

The target beneficiaries/victims have been categorised in groups including: 1. children and youth; 2. victims of physical trauma; 3. other war victims; 4. community peace builders; v) former child soldiers;[166] and 5. victims of sexual and gender-based violence.[167] Most beneficiaries/victims receive a combination of integrated physical and psychological rehabilitation and/or material support.[168]

As to the kind of support provided by the TFV in pursuit of its general assistance mandate outside case-based reparations, the provision of resources does not amount to 'reparations' as it belongs to a separate, broader mandate which covers the 'provision of assistance of victims in general'.[169] Support outside a case litigated before the ICC does not qualify as rehabilitative reparations under the ICC reparations scheme.[170] However, it is argued herein that such assistance redresses harm of victims of crimes relating to the ICC situations since any support by the TFV 'must seek to redress the harm victims have suffered as a result of the crime to which they or their loved ones were subjected'.[171] The TFV rehabilitative programmes implemented under its general assistance mandate are *mutatis mutandis* similar to rehabilitative reparations. Indeed, Trial Chamber I acknowledged the importance of the TFV's general assistance programmes involving '[…] child soldiers rehabilitation, sustained by the TFV, which provide support to former child soldiers'.[172] Accordingly, the TFV's rehabilitation initiatives under its assistance and case-based reparations mandates attempt to redress the damage caused to the victims' right to health.

In any case, transferring funds from the TFV's general assistance mandate to case-based rehabilitative reparations falls within the sole discretion of TFV's Board of Directors and, thus, when the accused is indigent, the TFV may advance its 'other

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164 ICC Assembly of State Parties, *Report to the Assembly of States Parties on the activities and projects of the Board of Directors of the Trust Fund for Victims for the period 1 July 2009 to 30 June 2010*, 28 July 2010, ICC-ASP/9/2, 28 July 2010, para 4.
165 ICC-ASP/11/14, 7 August 2012, para 10.
166 ICC-ASP/7/13, 3 September 2008, para 9.
167 ICC-ASP/11/14, 7 August 2012, para 10.
168 ICC-ASP/7/13, 3 September 2008, para 10.
169 ICC-ASP/7/13, 3 September 2008, paras 15–17.
170 McCarthy, C, "Reparations under the Rome Statute of the International Criminal Court and Reparative Justice Theory", 3 *International Journal of Transitional Justice* (2009) 250, 269.
171 *Ibid.*
172 *Lubanga* (ICC-01/04-01/06-2904) *supra* nt 32, para 275.

resources'.[173] This intervention does not exonerate the convicted from liability and he or she is expected to reimburse the TFV.[174] This has been the proceeding followed in *Lubanga* and, thus, timely and adequate rehabilitative reparations can be provided to the victims.

It is expected and advisable that TFV allocates part of its general assistance mandate funds to complete, if needed, the necessary funds to enforce rehabilitative reparations awards and/or, as previously suggested, to allow rehabilitative reparations beneficiaries to benefit from its assistance mandate rehabilitative measures to get their harm redressed. The TFV approved EUR 1.9 million for its assistance mandate projects and EUR 3.6 million for its reparations preparation reserve.[175] In any case, the two TFV's mandates should work closely to maximise victims' rehabilitation and also reduce the fragmentation of the victims' universe, avoiding tension among victims, as much as possible.

III.3. The ECCC

Modalities of reparations at the ECCC mainly fall under the categories of satisfaction and rehabilitation following the UN Basic Principles and Guidelines. Rule 23(2) explicitly lays down that '[t]he right to take civil action may be exercised without any distinction based on criteria such a current residence or nationality'. This rule is particularly important as it specifically implements the principle of non-discrimination. By making it explicit that the reparations regime, including rehabilitation, under the ECCC is led by the principle of non-discrimination, the ECCC Internal Rules drafters reached a standard coherent with the UN Basic Principles and Guidelines.[176]

Unlike the ECCC's current reparations regime in which an external funding/implementing mechanism is feasible, under the ECCC's original regime, reparations could only be funded by the convicted. Thus, requests for the provision of access to free medical care were rejected by the Trial Chamber in *Case 001* as, by their nature, they were designed to benefit a large number of individual victims and, thus, those reparations requests were outside available reparations at the ECCC's previous reparations regime.[177] When appealing this decision, civil party group 2 argued, *inter alia*, that the Trial Chamber misunderstood its claim as they only requested treatment for 17 people and not for a larger number of individual victims.[178] The Supreme Court Chamber emphasised the requirement of a causal link between the reparation measures sought by each civil party appellant and the injury caused by the crimes for which the accused was convicted.[179] The Chamber found the provision of physical and/or psychological treatment of the injury to be a suitable modality of reparations since the injury inflicted on the victims is the damage to their physical and/or psychological health.[180] The Chamber then examined whether the reparations measure request qualified as 'collective

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173 *Lubanga* (ICC-01/04-01/06-3129) *supra* nt 37, para 4.

174 *Id*, para 5.

175 ICC Assembly of State Parties, *Report to the Assembly of States Parties on the Activities and Projects of the Board of Directors of the Trust Fund for Victims for the Period 1 July 2013 to 30 June 2014*, ICC-ASP/12/14, 31 July 2013, 1-2.

176 *UN Principles and Guidelines*, *supra* nt 34 Principles 12 and 25.

177 *Case 001*, Judgment, 26 July 2010, para 674.

178 *Case 001*, Appeal against Judgment on Reparations by Co-Lawyers for Civil Parties – Group 2, 2 November 2010, para 90.

179 *Case 001*, Appeal Judgment, 3 February 2012, para 699.

180 *Ibid.*

and moral'.[181] Relying on the IACtHR's jurisprudence, the Supreme Court Chamber concluded that the provision of medical and psychological care is an appropriate form of reparations and that it falls under the term 'collective and moral' reparations under the Internal Rules.[182] Rehabilitation is especially suitable when it is not possible for the competent court to identify the totality of victims, ie, the totality of all rehabilitative reparations beneficiaries and, thus, to order rehabilitative measures, alongside other modalities of reparations, rather than provide individual compensation.[183]

The last analytical step of the Supreme Court Chamber was 'enforceability' of the rehabilitative reparations sought.[184] Unlike the IACtHR's case law, where there is normally a sophisticated administrative structure to be implemented and executed by the State, the ECCC 'is not vested with powers to render binding orders against the Cambodian State […]'.[185] Nor did the ECCC have an explicit State's proposal in *Case 001* to be able to assist a potentially large, undefined category of beneficiaries,[186] unlike the IACtHR's practice.[187] These previous considerations must be read '[i]n the context of the ECCC [where] orders can only be borne by convicted persons',[188] under the previous reparations implementation regime. The Supreme Court Chamber concluded that although the provision of medical care constitutes in general an appropriate modality of reparations, the reparations request is not maturate enough to be singled out for the Chamber's individual endorsement due to the lack of, *inter alia*, information on the estimated cost of the rehabilitative reparations, number and identities of beneficiaries and duration and modality of the treatments needed.[189]

Like the ECCC's original regime,[190] when the reparations awards under the new regime are ordered by the Chamber to be borne by the accused,[191] the ECCC lacks competence to enforce reparations awards and, accordingly, they can only be enforced, where necessary, within the ordinary Cambodian court system pursuant to, and satisfying, enforcement requirements under Cambodian domestic law – including with regard to specificity.[192]

However, the crucial difference is that, unlike the original reparations implementation regime, reparations awards, including rehabilitation, cannot only be borne by the accused under the current regime. A decisive factor to reject collective rehabilitative reparations requested by civil parties in *Case 001* was (almost) insurmountable obstacles for their implementation – due to the ECCC framework and the convicted's indigence – although rehabilitative proposals were, in principle, considered appropriate by the Supreme Court Chamber. Nevertheless, the regime of implementation of reparations awards at the ECCC was amended on 17 September 2010 and is applicable to *Case 002.* Internal Rule 23*quinquies*(3)(b) lays down that

> 3. In deciding the modes of implementation of the awards, the Chamber may, in respect of each award, either:

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181 *Id*, para 700.
182 *Id*, paras 700-701.
183 *Plan de Sánchez Massacre v Guatemala*, Reparations, Judgment, 19 November 2004, paras 62 and 92.
184 *Case 001*, Appeal Judgment, *supra* nt 179, paras 702-703.
185 *Id*, para 703.
186 *Ibid.*
187 *Plan de Sánchez Massacre v Guatemala*, Reparations, Judgment, 19 November 2004, para 92.
188 *Case 001*, Appeal Judgment, *supra* nt 179 para 703.
189 *Id*, para 704.
190 Rule 23(11)(Rev. 3); rule 23*quinquies*(1)(Rev. 5).
191 Rule 23*quinquies*(3)(a).
192 *Case 001*, Judgment, 26 July 2010, para 661.

> a) order that the costs of the award shall be borne by the convicted person; *or*
> *b) recognise that a specific project appropriately gives effect to the award sought by the Lead Co-Lawyers and may be implemented. Such project shall have been designed or identified in cooperation with the Victims Support Section and have secured sufficient external funding*.[193]

The VSS may, in liaison with an external entity, (having secured funding) implement reparations awards, as established under internal Rule 12*bis*(2): 'The Victims Support Section shall, in co-operation with the Lead Co-Lawyers and, where appropriate, in liaison with governmental and non-governmental organisations, endeavour to identify, design and later implement projects envisaged by Rule 23*quinquies*(3)(b)'.

The Supreme Court Chamber in *Case 001*, concerning the request for provision of medical treatment and psychological services for civil parties, remarked that a workable solution (for *Case 002* and other ongoing or future cases) may be setting up an externally-subsidised trust fund whose administrative structure would be tasked with the implementation of measures asked.[194] As the Chamber appropriately highlighted,[195] the amendments to the Internal Rules established that the ECCC may recognise reparations projects designed and identified by the civil parties' lead co-lawyers in cooperation with the VSS under internal Rule 23*quinquies*(3)(b). Although the Supreme Court Chamber welcomed this new innovative regime, the Chamber noted that it was inapplicable in *Case 001*.[196] Thus, it found that the Trial Chamber in *Case 001* correctly dismissed the request to establish a trust fund.[197] Accordingly, the Supreme Court Chamber merely encouraged the civil parties in *Case 001*, many of whom are also civil parties in *Case 002*, and to which case internal Rule 23*quinquies*(3)(b) applies, to seek, for example, the provision of access to free medical care via the amended system.[198]

In applying the new reparations implementation regime, the civil parties' lead co-lawyers, in collaboration with the VSS, analysed the requests from the 11 legal teams representing civil parties in *Case 002* and identified four main categories of projects to be implemented.[199] The second category was rehabilitation and consisted of a range of awards aiming to restore the victims' mental and physical health, or at least mitigate their harm, ie projects to establish psychological and physical health services and to support a self-help group.[200] In *Case 002/01*, upon the Trial Chamber's request, the civil parties' lead co-lawyers submitted a prioritised list of reparations projects. To endorse the reparations projects, the Trial Chamber set the following requirements:

> 1) Proof of consent and cooperation of any involved third party has to be demonstrated;
> 2) Funding has to be fully secured, as the Chamber cannot endorse a reparation project that has secured partial funding only;

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193 Emphasis added.
194 *Case 001*, Appeal Judgment, 3 February 2012, 315, footnote 1430.
195 *Ibid.*
196 *Ibid.*
197 *Case 001*, Judgment, 26 July 2010, para 670.
198 *Case 001*, Appeal Judgment, *supra* nt 179, 315, footnote 1430.
199 ECCC, *Case 002*, Initial Specification of Substance of the Awards that the Civil Party Lead Co-Lawyers Intend to Seek filed on 12 March 2012 by the Civil Party Lead Co-Lawyers, E125/2 (Awards Sought by Civil Party Lead Co-Lawyers) in para 55.
200 ECCC, *Case 002,* Awards Sought by Civil Party Lead Co-Lawyers, 12 March 2012, paras 66-69.

> 3) Any necessary additional information shall be provided to the Chamber, such as detailed descriptions […] and budget plans of proposals.[201]

The second category (rehabilitation) in turn consisted of two projects. First, testimonial therapy, which aimed to provide civil parties in *Case 002/01* 'the means to address the psychological suffering caused by the crimes perpetrated against them by talking [about] and recording the traumatic experiences with mental health workers'. Such testimonials 'would later be read aloud in public ceremonies in accordance with religious or spiritual beliefs and cultural practices'.[202] It had received partial funding (from Germany) but the Trial Chamber requested clarification of whether that funding would be sufficient to cover the 36 months to implement the project planned in conjunction with the Transcultural Psychological Organization Cambodia, a non-governmental organisation active in the mental health area in Cambodia, or, in case of no further funding, for how long the project could continue.[203] Second, self-help groups, which would provide the civil parties in *Case 002/01* 'with collective therapy through participation in eight group sessions, permitting them to talk about their suffering'[204], and about which the same situation/observations concerning the previous project were applicable.[205]

Civil parties finally managed to secure funding from Australia, Germany and Switzerland for the testimonial therapy in both projects, the second of which to be provided via therapy developed by the Transcultural Psychosocial Organization.[206] Civil parties' lawyers also expressed that they were seeking funds to expand the rehabilitative projects outside Phnom Penh. Considering the funds obtained, the Trial Chamber endorsed the rehabilitative reparations projects and authorised their expansion provided that, in the latter case, funds are secured.[207]

With regard to whether the ECCC can issue rehabilitative reparations orders, the enforcement of which may require governmental administrative assistance, the Supreme Court Chamber stressed that it lacks jurisdiction over matters that are not statutorily conferred on it and, thus, reiterated its absence of a mandate and jurisdiction over Cambodia or its Government to compel it to administer a reparations scheme.[208] The Government cannot be engaged by the ECCC as a civil defendant, nor can the ECCC exercise jurisdiction such as encroachment of statutory competence over the Executive.[209] Accordingly, the Supreme Court Chamber concluded that

> any reparation claim is predestined for rejection that *necessarily* requires the intervention of […] [Cambodia] to the extent that, in effect, such request predominantly seeks a measure falling within governmental prerogatives. This is

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201 ECCC, *Case 002/01*, Trial Chamber's Subsequent and Final Order on the Updated Specification of Civil Party Priority Projects as Reparations (Trial Chamber's Subsequent and Final Order), E218/7/4, 6 September 2013, para 3.

202 ECCC, *Case 002/01*, Trial Chamber's Response to the Lead Co-Lawyers' Initial Specification of Civil Party Priority Projects as Reparations (Trial Chamber's Response), 1 August 2013, E218/7/2, para 3.

203 ECCC, *Case 002/01*, Trial Chamber's Subsequent and Final Order, 6 September 2013, para 5.

204 ECCC, *Case 002/01*, Trial Chamber's Response, *supra* nt 202, para 3.

205 ECCC, *Case 002/01*, Trial Chamber's Subsequent and Final Order, *supra* nt 203, para 5.

206 ECCC, *Case 002/01*, Judgment (Trial Chamber), 7 August 2014, paras 1131-1133.

207 *Id*, paras 1154-1155.

208 ECCC, *Case 001*, Appeal Judgment, *supra* nt 179, para 663.

209 *Ibid*.

> the case, for instance, with respect to requests for […] organization of health care.[210]

However, the Supreme Court Chamber also concluded that domestic courts are bound to give effect to ECCC reparations orders against convicted persons, similar to any other reparations order delivered by Cambodian domestic courts.[211]

IV. Rehabilitative Reparations and International Human Rights Law, Particularly, the Obligation to Cooperate and the Right to Health Standards/Principles

In the previous sections, substantive and procedural law on medical rehabilitation as reparation at the IACtHR, ICC and ECCC has been exhaustively examined. A crucial factor in the success of implementation of rehabilitative reparations awards and the related realisation of the right to health is funding. Whereas rehabilitative reparations awards ordered by the IACtHR must be financed by the respective State found internationally responsible, rehabilitative reparations awards ordered by the ICC and ECCC cannot be addressed to States. There is certainly an obligation for the States Parties to the ICC Statute to cooperate with the ICC but not a direct obligation to fund the ICC rehabilitative reparations awards or the rehabilitative humanitarian programmes implemented by the TFV. At the ECCC, the situation is even more precarious due to its much narrower scope. Even medical rehabilitative reparations awards rendered by the IACtHR, ordering, for example, construction of hospitals, have found no few difficulties to be implemented because of the lack of economic/technical resources across Latin-American countries. These difficulties are clear obstacles to the realisation of the right of health of victims as rehabilitative reparations claimants.

In this section, it is first argued that States, particularly developed ones, should contribute to implementing medical rehabilitation reparations. This lies in the fact that these reparations measures realise the victims' right to health and developed States have an obligation to cooperate to fulfil such a right. Secondly, rehabilitative reparations are considered in light of the right to health standards and principles established by the UN Committee on Economic, Social and Cultural Rights (CESCR).

Article 2(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) establishes binding legal obligations of international assistance and cooperation upon its States Parties, which must 'take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of [their] available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means'. In turn, Article 22 provides that the Economic and Social Council may bring to the UN bodies and agencies competent to furnish technical assistance any information out of the State reports under the ICESCR which 'may assist such bodies […] on the advisability of international measures likely to contribute to the effective progressive implementation of the present Covenant'. Article 23 mentions several forms of international action to fulfil

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210 *Id*, para 664.
211 *Id*, para 665.

the ICESCR, ie the right to health (ICESCR, Article 12), including 'the furnishing of technical assistance'.[212]

Thus, the obligations of international assistance and cooperation would arguably demand the States Parties to the ICESCR, particularly those most affluent, to contribute funding to rehabilitative reparations ordered by the ICC, ECCC and IACtHR and/or provide technical assistance to meet some of their obligations to ensure the right to health and/or to help developing States meet those obligations. Obligations under the right to health require States to undertake actions not only concerning individuals under their jurisdiction but also beyond. Indeed, there is an increasing trend consisting of the State obligation to protect human rights beyond its national territory, as recognised by both scholars[213] and the CESCR.[214] Accordingly, the ICESCR States Parties' obligations to adopt measures to the maximum of their available resources include not only resources available within a country but also those from the international community via international cooperation and assistance.[215]

The CESCR has highlighted that States Parties and other actors that can assist should give 'international assistance and cooperation, especially economic and technical', which in turn enables developing countries to meet their core obligations.[216] Thus, the obligations of international assistance and cooperation are directly related to the obligation to comply with 'core obligations', which ensures the minimum level of the right to health.[217] These obligations equally correspond to all States Parties to the ICESCR; however, the specific obligations of international assistance and cooperation differ based on the level of development/wealth, ie wealthier States vis-à-vis those States that normally receive assistance and cooperation.[218] Additionally, the CESCR has arguably broadly interpreted Article 2(1) as also setting up international obligations of assistance and cooperation on entities other than States Parties to the ICESCR, and which can collaborate.[219]

The duty to fulfil or provide requires developed States to give, within the availability of their resources, assistance to other States.[220] In examining the reports submitted by developed States, the CECSR has strongly encouraged them to reach the target of 0.7% of their GNP set by the UN.[221] Concerning the right to health, the CESCR has highlighted that 'depending on the availability of resources, States should [...] provide the necessary aid when required'.[222] Thus, regarding the right to health, the CESCR has

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212 See de Schutter, O, *International Human Rights Law* (Cambridge University Press, Cambridge, 2010), 172-178; CESCR, General Comment No 2*, International Technical Assistance*, 2 February 1990, E/1990/23.

213 De Schutter, *supra* nt 212, 162-172; S. Skogly, *Beyond National Borders: States' Human Rights Obligations in International Cooperation* (Intersentia-Hart, 2006).

214 CESCR, *General Comment No. 14, The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4, para 39; CESCR, *General Comment No. 15, The Right to Water (Arts. 11 and 12 of the Covenant)*, 20 January 2003, E/C.12/2002, para 31.

215 Sepúlveda, M, "The Obligations of 'International Assistance and Cooperation' under the International Covenant on Economic, Social and Cultural Rights: A Possible Entry Point to a Human Rights Based Approach to Millennium Development Goal 8" 13 *International Journal of Human Rights* (2009) 87.

216 CESCR, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: Poverty and the International Covenant on Economic, Social and Cultural Rights*, 4 May 2001 E/C.12/2001/10.

217 CESCR, *General Comment No 15*, *supra* nt 214 para 38.

218 Sepúlveda, *supra* nt 215, 89.

219 *Ibid.*

220 *Id*, 93.

221 CESCR, *Concluding Observations: France*, 30 November 2001, E/C.12/1/Add.72, paras 14, 24.

222 CESCR, *General Comment No 14*, *supra* nt 214, para 40.

interpreted the need for international assistance and cooperation as an obligation to fulfil or provide, although the CESCR paraphrased it as a recommendation: 'States should'.[223]

In any case, channelling funds from international cooperation and assistance to fully implement medical rehabilitation awards rendered by the ICC, ECCC and IACtHR requires a coordinated effort of developed and developing States. This is consistent with 2000 Millennium Development Goal 8 which calls for the 'creat[ion] [of] a global partnership for development'. Having examined the obligations corresponding to developed States, it is necessary to briefly review those obligations related to developing States. Developing States are expected to seek assistance and, once they have received it, are obliged to establish their own viable development or assistance programmes setting up benchmarks to evaluate performance in realising the right to health.[224] Benchmarks and indicators enable international monitoring (CESCR, IACtHR) of State obligations to progressively realise the right to health as an economic and social right. Developing States are also obliged to monitor that there is no illegal diversion of resources obtained via international cooperation.[225] Thus, related risks should be avoided, such as poorly designed health care projects, which may do more harm than good to the beneficiaries of medical rehabilitative reparations.

The international obligations to cooperate and assist to realise the right to health can be directly enforced. This occurs when a developing State ordered by the IACtHR to implement rehabilitative reparations measures receives international cooperation/technical assistance from developed countries to compensate any lack of financial/technical resources. When it comes to the ICC and ECCC, the obligations to cooperate and assist can be indirectly implemented, as international practice has demonstrated. Thus, at the ICC, via donations and contributions of States and other actors to the TFV for both its case-based reparations and assistance mandates, rehabilitative reparations/measures have benefited and/or will benefit a significant number of victims in some of the poorest African countries, such as the DRC, Uganda and CAR. Without this cooperation via the TFV, realising the right to health of victims of international crimes under the ICC's jurisdiction would not be possible. At the ECCC, donations from developed countries made it feasible to meet rehabilitation requests. This would have been impossible if Cambodia had been left alone to foot the bill for reparations. Thus, these funds channelled via international criminal courts/institutions indirectly fulfil the obligations of international assistance and cooperation concerning the right to health.

Rehabilitative reparations have been, and should be, consistent with international principles and standards on the right to health set up in *inter alia* the CESCR General Comment No. 14 ('The Right to the Highest Attainable Standard of Health'), considered as follows. In designing and implementing rehabilitative reparations, the following four interrelated and essential elements of the right to health must be considered:[226] 1. availability, ie functioning health care facilities and programmes paying attention to the underlying determinants of health, such as potable water, adequate sanitation facilities, hospitals, clinics, trained personnel, and essential drugs; i2. accessibility, so that health care facilities, goods and services are accessible to every reparations claimant/beneficiary without discrimination, and guaranteeing physical, economic (affordability) and information accessibility; 3. acceptability, ie medical rehabilitative reparations must

223 Sepúlveda, *supra* nt 215, 93.
224 *Id*, 95.
225 *Id*, 96.
226 CESCR, *General Comment No 14*, *supra* nt 214, para 12.

respect the beneficiaries' culture; and 4. quality, ie rehabilitation of good scientific and medical quality.

Rehabilitative reparations must be guided by the principle of non-discrimination and equal treatment, giving special protection to the most vulnerable members within the universe of reparations claimants.[227] Thus, access to rehabilitative reparations such as health care excludes any kind of discrimination.[228] Rehabilitative reparations must also integrate gender perspective approaches, recognising biological and socio-cultural factors, and eliminate discrimination against women concerning access to health care, departing from harmful cultural practices.[229] Rehabilitative reparations must also consider the child's superior interest as recognised under the Convention on the Rights of Child. Moreover, non-discrimination, attention to disabilities and abolition of harmful practices need to be implemented for children when designing and implementing rehabilitative reparations.[230] As for the elderly, attention should be paid to an integrated approach including preventive, curative and rehabilitative health treatment.[231] Regarding persons with disabilities, the principle of non-discrimination is also pivotal.[232] When granting rehabilitative reparations to indigenous people, measures must consider their traditional medical knowledge and relation with their land and environment.[233]

Rehabilitative reparations are needed not only to fulfil the victims' right to health but also other human rights closely linked to it, such as the right to life, non-discrimination, prohibition of torture and medical experimentation, sexual and reproductive freedom and the rights to food and water.[234] Serious human rights violations/international crimes are grave breaches of basic human rights, including the right to health. Rehabilitative reparations correspond to a wider definition of health that should take into account socially related concerns such as violence and armed conflict,[235] which are the background to massive abuses. As realising the right to health is broader than health care, underlying determinants of health, such as access to safe and potable water, adequate sanitation, and adequate supply of food and nutrition, should also be considered in rehabilitative reparations.[236]

Those principles and standards which orient the obligations of respect, protection and fulfilment of the right to health have to a larger or lesser extent guided the work of the IACtHR, ICC and ECCC when rendering rehabilitative reparations. For example, the ICC A.Ch in its Order for Reparations fleshed out most of these principles and standards. Thus, principles of dignity, non-discrimination, non-stigmatisation together with the principle of the best interests of the child, a gender approach, accessibility, and consultation with victims and their communities were presented as fundamental to rehabilitative reparations in international crimes cases.[237] The rehabilitative reparations ordered by the IACtHR and ECCC have also been consistent with those principles and

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227 *Id*, para 18.
228 ICESCR, Articles 2.2 and 3.
229 CESCR, *General Comment No 14*, *supra* nt 214, paras 20 and 21.
230 *Id*, para 22.
231 *Id*, para 25.
232 *Id*, para 26.
233 *Id*, para 27.
234 *Id*, paras 3 and 8.
235 *Id*, para 10.
236 *Id*, para 11.
237 ICC, Appeals Chamber, *Prosecutor v Thomas Lubanga Dyilo (Lubanga),* Order for Reparations, 3 March 2015, ICC-01/04-01/06-3129-AnxA, paras 12-19, 23-32.

standards.[238] This speaks volumes about a grammar common to rehabilitative reparations across international courts.

Rehabilitative reparations are channels for States to implement directly (IACtHR's reparations) or indirectly (ICC's and ECCC's reparations) their international obligations concerning the right to health. This involves the obligations to respect, protect and fulfil. Particularly, the obligation to fulfil is intertwined with implementation and/or cooperation to implement rehabilitative reparations. Among other features,[239] provision of a sufficient number of hospitals and other related facilities and trained personnel, with respect for sexual and reproductive health and attention to the needs of vulnerable or marginalised groups, should guide the complex mechanisms of rehabilitative measures. The realisation of the right to health via rehabilitative reparations contributes to fulfil the core contents of the right to health of victims of the most serious atrocities who mainly also belong to the most vulnerable or marginalised groups. Thus, respect for the principle of non-discrimination is also met. Should one consider that States have joint and individual responsibilities under international law to provide disaster relief/humanitarian assistance in times of emergency,[240] it may be argued that there exists a relatively similar obligation to cooperate with medical rehabilitation of victims of serious human rights violations/international crimes no matter where these may have taken place.

If the respective defendant State does not implement rehabilitative reparations ordered by the IACtHR, this triggers a violation of the right to health. Arguably, States, especially those wealthy enough to cooperate with funding/implementation of rehabilitative reparations ordered by the ICC and ECCC, may violate victims' right to health if they remain inactive. This would be the case if those States are unwilling to use the maximum of their available resources for the realisation of the right to health, omit to adopt necessary measures arising from international obligations affecting the core components of the right to health and, in turn, the obligations to respect, protect and fulfil.[241] Certainly, these obligations primarily compromise a State as for individuals under its jurisdiction. However, considering that rehabilitative reparations at the ICC, ECCC and in some IACtHR cases try to redress harm out of violations of *ius cogens* rules, such as the prohibitions of genocide, torture or crimes against humanity, the related obligations to realise the right to health arguably include all States.

This of course means cooperation within the respective States' available resources. Indeed, within the remedies and accountability mechanisms to realise the right to health, victims' access to reparations mechanisms is recognised as a key element to implement the right to health.[242] Moreover, the ICC A.Ch, under the ICC Statute, reminded the ICC Statute States Parties of their obligation to cooperate fully with the enforcement of reparations orders and not to interfere with their implementation.[243] Other international law subjects such as the UN, other international organisations, and additionally civil society entities, have also been considered actors with obligations to realise the right to health.[244] This is true when rehabilitative reparations endeavour to address harm causally linked to violations of *ius cogens* rules and *erga omnes* obligations, which involve not only all States but also all international law subjects within their differentiated capacities and/or mandates.

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238 See case law analysed previously.
239 CESCR, *General Comment No 14*, *supra* nt 214, paras 37, 39.
240 *Id*, paras 39, 40.
241 *Id*, paras 47-52.
242 *Id*, paras 54, 59-62.
243 ICC, Appeals Chamber, *Lubanga*, Order for Reparations, para 50.
244 CESCR, *General Comment No 14*, *supra* nt 214, paras 63-64.

V. Final Assessment and Recommendations

The following steps and actions should be adopted to increase the impact of medical rehabilitative measures on realising the right to health of victims of international crimes/serious human rights violations.

First, States' role in the successful implementation of rehabilitative reparations, as complemented by other actors of the international community, is crucial. Thus, States which have to implement IACtHR's rehabilitative reparations need to substantially increase their degree of implementation of rehabilitation and, thus, reverse the low rate of implementation of medical rehabilitative reparations which has characterised Latin-America. If the defendant State lacks sufficient resources to proceed with that implementation, it should seek to receive financial/technical assistance from other States, particularly, those developed and also from international organisations. As for rehabilitative reparations granted by the ICC and ECCC, States should and, indeed, must arguably cooperate financially towards the implementation of the respective rehabilitative reparations awards. This cooperation can also be via non-financial or technical means, for example, organising training of medical and health care personnel, helping to build hospitals and other health care facilities, and providing medicines. International and civil society organisations, especially those working on the fulfilment of the right to health, should also contribute with their expertise to joint projects with States or on their own. Thus, these efforts should expedite and enhance the current, on-going process of planning and implementation of rehabilitative reparations awards at the ICC and maximise the good work so far done by the TFV in the field. In turn, the external funding mechanism at the ECCC may be strengthened to avoid previous negative outcomes, reduce the delay of rehabilitative reparations implementation and go further, for example, limited not only to mental health but also physical health.

Second, lawyers advising/representing victims in their rehabilitative reparations claims should fully address the core elements of the right to health. Rehabilitative reparations by the IACtHR, ICC and ECCC have generally speaking met the general international principles and standards of the right to health. However, these courts should progressively, in further detail and more explicitly pay attention to specific components of the obligations stemming from the right to health when designing, approving, ordering and/or monitoring rehabilitative reparations. This has to be conducted within their respective mandates. Be that as it may, those three courts should go beyond general references to principles and standards on the right to health. Thus, they should discuss in detail how the obligations of the right to health may be fulfilled via rehabilitative reparations awards (IACtHR), and should seek creative methods to tailor the right to health obligations, originally intended for States, to the reparations systems of international/hybrid criminal courts (ICC, ECCC).

Finally, there must be a synergy of efforts among the institutions examined, as well as others that have the power to order rehabilitative reparations for international crimes/serious human rights violations, for example, the ECtHR and African Court of Human and People's Rights. Indeed, for example, the ICC Statue refers to a complementarity between its own mandate and other mechanisms to provide rehabilitative reparations to the victims.[245] This corresponds to the fact that the same set of events, the same physical and mental harm inflicted on the health of victims of international crimes/serious human rights violations may be redressed via mechanisms not limited to just one court. For example, if the situation in Colombia under ICC

[245] ICC Statute, Articles 75(6) and 25(4).

preliminary investigation finally joins the set of situations and cases at the ICC, victims of heinous atrocities in Colombia will be able to claim and receive medical rehabilitation at both the IACtHR and ICC. Thus, it is important to increase the dialogue among regional, national, hybrid and international courts to maximise the positive benefits stemming from rehabilitative reparations on the right to health of a very large number of victims across the world.

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Protecting the Human Rights of People Living with HIV/AIDS: A European Approach?

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Keywords
HIV/AIDS; HUMAN RIGHTS-BASED APPROACH; VULNERABILITY; NON-DISCRIMINATION; NON-REFOULEMENT

Abstract
HIV/AIDS is a medical matter as well as a human rights issue.
Recent developments in the interpretation of the European Convention on Human Rights (ECHR) have contributed to better define the level of protection that people living with HIV/AIDS may currently derive from it. Thanks to the recognition of the condition of vulnerability suffered by this group, the European Court of Human Rights (ECtHR) has been able to apply the non-discrimination complementary provision (Article 14) to contrast the social stigma and prejudice associated with HIV/AIDS in Europe and, in some situations, to develop positive obligations.

A different restrictive approach has been adopted towards a specific part of the ECHR, that is the prohibition of *refoulement*. While this approach can be reassessed, taking into account the interpretation of the ECHR as a 'living instrument' and the necessity to read the ECHR as a coherent whole, recently the European Court of Justice has expressly referred to it to define the level of protection provided by European Union (EU) law to people living with HIV/AIDS in the field of migration. As a result, it reinforced the emerging divide between substantial guarantees and procedural obligations, which grant a wide protection pending expulsion and are defined in light of the special needs of people living with the infection, as required by a vulnerability approach.

If a common 'European approach' to the issue of HIV/AIDS and human rights is thus emerging, until now it seems to have been guided by conflicting views. At the same time, in relation to some issues, the mutual influence between ECHR and EU law has served to narrow the protection to people living with HIV/AIDS instead of setting higher standards through an inclusive interpretation of human rights.

This article explores a human rights-based approach to HIV/AIDS and whether the emerging European attitude matches it or not. While it calls for enhancing the role of vulnerability in the interpretation of the fundamental rights catalogue taken as a whole, it investigates the possible evolution within the two European systems of protection when the needs of this specific group are at stake, especially in the fields of non-discrimination and migration. The result does not provide given solutions but suggests a methodology for a consistent and genuine 'European approach' which, in turn, may positively influence the evolution of the international response to HIV/AIDS.

I. Introduction

According to statistics recently published by UNAIDS, the international response to AIDS has reached a defining moment globally, leading to the fall of new HIV infections and of AIDS-related deaths.[1] At a deeper level, this optimistic picture hides the fact that rates of newly diagnosed cases of HIV infection vary widely in the different regions of the world. In particular, as for Europe, the same report shows an increasing trend in new infections; although, from 2000 to 2014 there was a 20% drop in 28 of 47 Member States of the Council of Europe (CoE). At the same time, a similar trend has been reported in some non-European countries, where many people are forced to escape their home country to seek international protection or decide to emigrate to Europe. What is certain is that, thanks to scientific research, a person who is infected with HIV has a longer life expectancy than in the past, provided that therapies are available and accessible in his or her country.

The move from an epidemic emergency to a life-long condition in a society that has to coexist with the virus has progressively changed the target of the international answer to HIV/AIDS, directly calling into question international human rights law. In fact, the first attempts to break the silence around this phenomenon at an international level have gone side by side with the identification of the groups most exposed to the virus.[2] While this focus was instrumental to a better control of the spread of HIV/AIDS worldwide, it has indirectly contributed to attaching a stigma to already vulnerable groups that, today, is at the heart of most human rights violations suffered by people living with HIV/AIDS. Hence, the current challenge is the need to grant adequate qualitative standards of life to those living with the infection, starting with the extension of the prohibition of discrimination to remove obstacles to their full participation in society.[3]

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* Carmelo Danisi, University of Bologna (Italy). Part of this research has been conducted within the framework of the Australian Government's Endeavour Fellowship at the Australian National University (ANU), College of Law.

1 Joint United Nations Programme on HIV/AIDS (UNAIDS), REPORT: *How AIDS Changed Everything – MDG6: 15 Years, 15 Lessons of Hope from the AIDS Response*, New York, 2015, *at* <unaids.org/en/resources/documents/2015/MDG6_15years-15lessonsfromtheAIDSresponse> (accessed 13 November 2015). UNAIDS was established by UN Economic and Social Council Resolution 1994/24 and it is the first – and so far the only – co-sponsored joint program of the United Nations (UN) system. It is worth noting that data may understate the true extent of the epidemic as a large number of HIV infections and AIDS cases are never reported at a national level, partly because a significant number of people are not aware of their HIV status.

2 UN Security Council, *Resolution on HIV/AIDS and International Peace-keeping Operations*, 17 July 2000, (4172nd meeting), S/RES/1308 (2000). The first related to a health issue identified expressly as posing 'a risk to stability and security', (Res. no. 1308/2000). In the same year, the fight against AIDS, together with tuberculosis and malaria, became one of the eight international development goals (MDG6). The UN Security Council has addressed the topic on two other occasions: in 2003 through Resolution 1460 on *Children in Armed Conflict* and in 2011 with Resolution 1983 on *HIV and Peacekeeping Operations*.

3 As the President of the CoE's Parliamentary Assembly (PACE) put it,

> *'Mais la particularité du SIDA reste toujours d'être beaucoup plus qu'un problème médical ; c'est aussi une maladie de société, tant elle est liée à la honte, à la discrimination et à la stigmatisation. La discrimination reste présente partout : de la part des employeurs, des membres de la famille ou des amis et même des prestataires de santé'*

[Translation: However, the peculiarity of HIV/AIDS lies in the fact that it is more than a mere medical problem: it is also a social disease, for being attached to shame, discrimination and stigma. No place is free from discrimination: it comes from employers, family members, friends and even health providers.]: Proceedings of the Conference *VIH/Sida – L'humanité n'est pas divisible*, Zurich, 14 November 2012, *at* <website-pace.net/web/apce/bureau/-/asset_publisher/9ZEIfGQwSswb/content/2012-11-14-zurich-french-only-;jsessionid=21426A8B53F6C7F56F3CB5D83048C1A2?redirect=http%3A%2F%2Fwebsite-pace.net%2Fweb%2Fapce%2Fbureau%3Bjsessionid%3D21426A8B53F6C7F56F3CB5D83048C1A2%3F

It is therefore not surprising that the European Court of Human Rights (ECtHR) is increasingly involved in examining alleged violations of the human rights enshrined in the European Convention on Human Rights (ECHR) by people living with HIV/AIDS. At the same time, the European Court of Justice (ECJ) has also recently been faced with questions related to the virus providing significant interpretation of EU law thanks to the application of the EU Charter of Fundamental Rights (CFR or the Charter).[4]

This article argues that these developments can be identified as parts of a broader European common strategy to face HIV/AIDS in light of the promotion at an institutional level, by the CoE and the European Union (EU), of a rights-based approach to HIV/AIDS as the best method to tackle most concerns surrounding affected people. Starting from an analysis of the specific rationale and of the basic content of this approach (Part II), it investigates the influence between the two European systems of protection that has not always proven effective in achieving genuine protection of people living with HIV/AIDS. For this reason, two main areas will be examined comparatively: first, an ambit of mutual positive influence, ie the prohibition of discrimination and its likely evolution to address the needs of this specific group, especially in relation to those instruments that do not expressly refer to HIV/AIDS (Part III); second, an ambit where the reciprocal influence proved to be dangerous for the definition of genuine standards of protection, ie the interpretation of the prohibition of *refoulement* (Part IV).

While this analysis calls into question the current relationship between the ECHR and the CFR, it suggests the application of a human rights-based approach to HIV/AIDS in the interpretation of these European instruments taken as a whole. Indeed, if a common European approach is under construction, it should be built keeping in mind the specific social, as well as medical, conditions experienced by affected people, instead of relying on the idea of minimum standards of protection as an easy way out.

II. A human rights-based approach to HIV/AIDS

Although several declarations have been elaborated by different international bodies in relation to HIV/AIDS,[5] cooperation agreements and soft law instruments only

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4 European Union, *Charter of Fundamental Rights of the European Union* (2012) OJ C326/02. As confirmed by the ECJ in *Åklagaren v Hans Åkerberg Fransson*, the Charter obliges EU institutions to respect human rights *while* exerting the competences provided to the Union by the founding Treaties as well as EU Member States *when* they implement EU law: ECJ, C-617/10, *Åklagaren v Hans Åkerberg Fransson,* 26 February 2013. On the Charter, see generally, Peers, S, Hervey, T, Kenner, J and Ward, A, eds, *The EU Charter of Fundamental Rights: A Commentary* (Hart Publishing, Oxford, 2014).

5 For example, the UN General Assembly (UNGA) adopted the *Declaration of Commitment on HIV/AIDS* (2 August 2001, A/RES/S-26/2) in 2001, followed by the *Political Declaration on HIV/AIDS* (15 June 2006, A/RES/60/262) in 2006 and the *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS* (8 July 2011, A/RES/65/277) in 2011; UN Commission on Human Rights, *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)*, 3 March 1995, Resolution 1995/44; UN High Commission for Human Rights, Sub-Commission on Prevention of Discrimination and Protection of Minorities, *Discrimination in the context of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS)*, 24 August 1995, (35th meeting) Resolution 1995/21; UN Human Rights Council, *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)*, 13 April 2011, (16th session) A/HRC/RES/16/28, followed by the UN High Commissioner for Human Rights,

"constrain" domestic authorities to act in this field from a human rights perspective.[6] At the international level, the leading instrument is a non-binding guideline that generally recommends national authorities to address discrimination against people living with HIV/AIDS, both in public and private life, and to set up effective mechanisms for reparation.[7] Notwithstanding the positive impact of these soft law tools for raising awareness worldwide, a more effective attempt was made by some international human rights committees: the Committee on Economic, Social and Cultural Rights (CESCR); the Committee on the Rights of the Child (CRC); and the Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW).[8] However, while they successfully addressed some problematic human rights issues caused by the spread of the virus, their efforts have not provided a wide framework and a consistent rationale for the consideration of the consequences of the spread of the virus from a holistic human rights perspective.

For this reason, the recent developments that have occurred within the European systems may shape a milestone in this 'evolving' human rights challenge.[9] Interestingly, the ongoing European process seems able to address what may be analytically summarised as the following: 1. identifying the interests at stake and the rights whose enjoyment is problematic; 2. providing the rationale for actions in this field; and 3. setting the procedural steps for overcoming potential human rights violations. The examination of these three main issues will set the stage for the analysis of the European Courts' approach to HIV/AIDS.

II.1 Which rights?

Without calling into question the application of the whole human rights catalogue to people living with HIV/AIDS as a basic and starting principle, the most important task

REPORT: *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)*, 2011, A/HRC/19/37.

6 For example, the tools developed by UNAIDS, *Reducing HIV Stigma and Discrimination: A Critical Part of National AIDS Programmes. A Resource for National Stakeholders in the HIV Response*, New York, 2009 *at* <unaids.org/en/resources/documents/2009/20090401_jc1521_stigmatisation_en.pdf> (accessed 13 November 2015). Therefore, each country has its own strategy that may address HIV/AIDS-related issues in a global way or by considering only specific aspects. See, for a global account, UN Secretary General, *Report on the Protection of Human Rights in the context of HIV and AIDS*, 2010 (16th session of the Human Rights Council) A/HRC/16/69. The case of the United States (US) is significant for the recent change based on a human rights perspective: while some HIV-specific restrictions on entry, stay and residence have been lifted recently, a wider strategy has been adopted for granting a 'just and equitable life': US Government, *Strategy on AIDS*, July 2015 *at* <aids.gov/federal-resources/policies/national-hiv-aids-strategy> (accessed 13 November 2015).

7 UNAIDS and UN High Commissioner for Human Rights, *International Guidelines on HIV/AIDS and Human Rights,* consolidated version, 2006 *at* <ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf> (accessed 13 November 2015).

8 CESCR, *General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights*, 2 July 2009, E/C.12/GC/20, where HIV status is mentioned as a specific ground; CRC, *General Comment No. 3: HIV/AIDS and the Rights of the Child*, 17 March 2003, CRC/GC/2003/3; CRC, *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, 1 July 2003, CRC/GC/2003/4; CEDAW, *General Recommendation No. 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, 1990, A/45/38; CEDAW, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, 1999, A/54/38/Rev.1, para 18.

9 For a first comprehensive study on the relationship between human rights and HIV/AIDS, taking into account the situation before the developments in medical care, see Gostin, L and Lazzarini, Z, *Public Health and Human Rights in the HIV Pandemic* (Oxford University Press, Oxford, 1997); Danish Centre on Human Rights, *AIDS and Human Rights* (Akademisk Forlag, Copenhagen, 1988).

of a human rights-based approach to HIV/AIDS seems to be the identification of those rights, whose protection creates specific concerns for affected people, and that are more likely to be violated. Taking into account both the ECHR and the Charter, in Europe such an effort has been made mainly at an institutional level.[10]

First, the prohibition of torture and inhuman and degrading treatment (Article 4 CFR and Article 3 ECHR) comes into play. It protects against treatment that may amount up to torture when the basic needs of people living with HIV/AIDS are not addressed. For instance, it applies in the context of detention, provided that, according to available statistics, detainees include a high percentage of HIV-positive people. The same prohibition also enshrines the principle of *non-refoulement*. When a person living with HIV/AIDS is involved, it applies due to the risk that he or she may be exposed to torture or inhuman or degrading treatment in his or her country because of his or her health conditions. In fact, the infection itself may generate this risk in case he or she would not be able, in the country of destination, to get the necessary medication and therapy.

Second, specific attention should be given to the right to respect for private and family life, and for personal data (Articles 7 and 8 CFR and Article 8 ECHR).[11] While the right to respect for private and family life can be restricted by a public authority for the protection of public safety and health, personal data – including health information – must be processed fairly for specified purposes and with the consent of the person involved. These aspects may be particularly relevant in the context of blood donations. However, as with any other limitation in the exercise of these rights, when HIV/AIDS is the reason for interfering in their enjoyment, a necessity test applies, concerning the legitimate aim and proportional measures.

Third, where it also effects the prevention of the spread of the virus,[12] the prohibition of discrimination may apply in at least three ways (Article 21 CFR and Article 14 ECHR). A primary development should lead to the recognition that HIV/AIDS can in itself put affected people in a disadvantaged position. Hence, such an approach calls for the inclusion of HIV/AIDS status within the prohibited grounds on which a differential treatment can be based. However, where this development is not possible due to the formulation of the prohibition of discrimination itself, the inclusion of HIV/AIDS through other prohibited grounds should be investigated. An interesting proposal looks at the notion of disability, which is expressly protected by the prohibition of discrimination

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10 Within the CoE, these attempts have been made since the 1980s with an increasingly inclusive catalogue: PACE, *AIDS and Human Rights*, 29 September 1989, (21st sitting) Recommendation 1116; PACE, *HIV/AIDS in Europe*, 25 January 2007, (8th sitting) Resolution 1536 and Recommendation 1784; CoE, Committee of Ministers, *HIV/AIDS in Europe: Reply from the Committee of Ministers*, 1 October 2007, (1005th meeting of the Ministers' Deputies) Document 11389. Within the EU, the question has been addressed more recently: European Parliament, *A Rights-based Approach to the EU's response to HIV/AIDS*, 8 July 2010, Resolution P7_TA(2010)0284; EU Agency for Fundamental Rights (FRA), Factsheet: *A Rights-based Approach to HIV in the European Union*, 2010 *at* <fra.europa.eu/sites/default/files/fra_uploads/945-AIDS_2010_FRA_factsheet.pdf> (accessed 13 November 2015).

11 Although the Charter is explicit in affirming respect for personal data while the ECHR is not, the ECtHR has interpreted Article 8 ECHR as also encompassing this protection. See, for example, ECtHR, *Z v Finland,* 22009/93, 25 February 1997; ECtHR (Grand Chamber), ECtHR, *S and Marper v United Kingdom,* 30562/04 and 30566/04, 4 December 2008; ECtHR, ECtHR, *Avilkina and Others v Russia,* 1585/09, 6 June 2013. Therefore, the disclosure of medical information of a HIV-positive person, in the context of proceedings concerning a sexual assault, can give rise to a violation of the right to respect for private life if his or her identity is revealed.

12 On 'non-discrimination as prevention', see Kjaerum, M, *Discrimination Aspects and their Potential Contribution to the Spread of HIV*, AIDS World Congress 2010, Wien, available *at* <fra.europa.eu/sites/default/files/fra_uploads/958-MK_Speech_AIDS_Satellite_Session.pdf> (accessed 13 November 2015).

both under the ECHR and the CFR. While this possibility will be tested below in relation to the application of the relevant EU secondary law to people living with HIV/AIDS, an important consequence of such a development is the possibility to apply to them the obligation to take positive action in favour of people with disabilities (Article 26 of the Charter).[13]

Two more rights, expressly affirmed in the CFR, acquire a specific importance for people living with HIV/AIDS. First, the right of access to preventive health care and the right to benefit from medical treatment can play a significant role (Article 35 CFR). Indeed, the Charter recognises expressly this right to 'everyone', thus preventing – if it applies – limitations based on European citizenship or on other grounds. Second, attention should be paid to the right to move and reside freely within the territory of a European State, which may be seriously limited because of a person's HIV-positive status.[14] As a consequence, any ban or restriction on entry to a European State's territory of a third-country national, due to his or her health condition, should be considered in conflict with the Charter. Both situations may also be covered by the protection of the ECHR through its prohibition of discrimination, as explored below.

II.2 Which rationale?

A central point in the application of a rights-based approach to HIV/AIDS is the identification of the reasons behind it. Depending on their content, the interpretation of human rights law may follow different paths for the rise of negative or positive obligations or for requiring a more intense scrutiny on contracting States' behaviour. In other words, the rationale seems to be itself a guide to how the needs of people living with HIV/AIDS should be addressed under human rights law.

At the European level, perhaps in an attempt to follow the indications expressed in the soft law international texts dedicated to the topic, this rationale corresponds to the recognition of the condition of vulnerability experienced by people living with HIV/AIDS. The concept of vulnerability has been used to identify common personal characteristics as worthy to be treated as suspected grounds in order to apply the prohibition of discrimination. Perhaps more importantly, it is used to focus attention on the specific experience of the group involved within the wider social context. A number of factors have been referred to in order to understand if a person is a member of a vulnerable group: 1. the history of past discrimination; 2. the prejudices attached to his or her personal characteristics; 3. the feelings of humiliation, anxiety, fear or inferiority experienced; and 4. the social context to which he or she belongs.[15] Considered together,

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13 The ECHR does not include a similar provision but, since HIV/AIDS has been recognised as an autonomous factor (see below), there is no need for such an interpretation. Interestingly, these two European developments may coexist leading to a cumulative protection against forms of multi-discrimination, ie based on HIV/AIDS *and* disability. On the other hand, in some cases, the ECtHR has also gone beyond the negative prohibition, developing positive obligations: ECtHR, *Kjartan Ásmundsson v Iceland*, 60669/00, 12 October 2004; ECtHR, *Budina v Russia,* 45603/05, 18 June 2009.

14 Wormann, T and Kramer, A, "Communicable Diseases" *in* Rechel, B, Mladovsky, P, Deville, W, Rijks, B, Petrova-Benedict, R and McKee, M, eds, *Migration and Health in the European Union* (Open University Press, Maidenhead, 2011) 121–137.

15 For an initial comprehensive analysis of this concept as well as a review of some critical elements in relation to the ECHR, see Timmer, A and Peroni, L, "Vulnerable Groups: The Promise of an Emerging Concept in European Human Rights Convention Law", 4 *International Journal of Constitutional Law* (2013) 1056. More broadly, Fineman, MA and Grear, A, *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics* (Ashgate, Farnham, 2013). Although being aware of its problematic aspects, as analysed by these authors, here the attention is placed on the positive effects of a vulnerability approach to address the needs of people living with HIV/AIDS.

all of these elements may help to define, both at a substantive and a procedural level, the most appropriate actions to overcome the disadvantaged position suffered by the group and to combat prejudice. Put in this way, the condition of vulnerability of people living with HIV/AIDS does not derive from the health condition itself, but mostly from the stigma associated with it. While this concept appears to be essentially connected to the prohibition of discrimination, it can inform the interpretation of other rights and freedoms enshrined in human rights instruments.

This aspect of a rights-based approach to HIV/AIDS can be clarified by referring to *Kiyutin v Russia* which, for the first time, has given the ECtHR the possibility to investigate the relationship between HIV/AIDS status and the ECHR. On that occasion, the applicant questioned the legitimacy of restrictions imposed on the freedom of movement of people living with HIV/AIDS.[16] The Court was asked to apply the prohibition of discrimination in conjunction with Article 8 ECHR, since the alleged discriminatory treatment was hampering the applicant's enjoyment of the right to respect for family life.[17] According to its case-law,[18] the ECtHR could easily limit its evaluation to the alleged violation of Article 8 alone, relying on the need to balance the competing interests at stake: the applicant's exigency to maintain family unity opposed to the defendant State's right to control its boundaries. Instead, while affirming that HIV/AIDS status is covered by the prohibition of discrimination, the ECtHR explained the rationale behind this interpretation:

> From the onset of the epidemic in the 1980s, people living with HIV/AIDS have suffered from widespread stigma and exclusion … As the information on ways of transmission accumulated, HIV infection has been traced back to behaviours – such as same-sex intercourse, drug injection, prostitution or promiscuity – that were already stigmatised in many societies, creating a false nexus between the infection and personal irresponsibility and reinforcing other forms of stigma and discrimination, such as racism, homophobia or misogyny … The Court therefore considers that people living with HIV are a vulnerable group.[19]

As a consequence, justifications relying on stigma and prejudices for maintaining people living with HIV/AIDS in a disadvantaged position cannot be accepted as reasonable. Thus, against the Russian Constitutional Court's decision that confirmed the proportionality of such restrictions as being in line with international human rights law,

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16 ECtHR, *Kiyutin v Russia*, 2700/10, 10 March 2011. Mr Kiyutin married a Russian woman and applied for a residence permit in her country. Being obliged to undergo a medical examination, he was found HIV-positive and, as a consequence, his request was refused. According to a UN report, similar restrictions concern at least 50 States worldwide: see UNAIDS, *Mapping of Restrictions on the Entry, Stay and Residence of People Living with HIV,* 2009 *at* <unaids.org/en/resources/documents/2009/20090818_jc1727_mapping_en.pdf> (accessed 13 November 2015). At least seven CoE Member States impose restrictions on entry and residence because of a person's HIV status.

17 As is well known, Article 14 has no independent existence because it applies only when a situation falls within the ambit of one or more of the rights and freedoms safeguarded by the ECHR and its Protocols. See, among others, Wintemute, R, "Within the Ambit: How Big is the 'Gap' in Article 14 European Convention on Human Rights?", 4 *European Human Rights Law Review* (2004) 366; Schokkenbroek, J, "The Prohibition of Discrimination in Article 14 of the Convention and the Margin of Appreciation", 19 *Human Rights Law Journal* (1998) 20; Livingstone, S, "Article 14 and the Prevention of Discrimination in the European Convention on Human Rights", 1 *European Human Rights Law Review* (1997) 25.

18 ECtHR, *Hamidovic v Italy,* 31956/05, 4 December 2012; ECtHR, *Udeh v Switzerland*, 12020/09, 16 April 2013.

19 ECtHR, *Kiyutin v Russia*, *supra* nt 16, para 64.

the ECtHR rejected what the domestic legislation took as its premise: 'HIV has grave socio-economic and demographic consequences for the Russian Federation, [and] poses a threat to personal, public and national security, and a threat to the existence of humankind'.[20] Relying on international scientific recommendations, the ECtHR found that Russian restrictions on entry and residence have the dangerous effect of reinforcing prejudices and foster social exclusion, because the presence of people living with HIV/AIDS in a country's territory cannot lead to a greater spread of the virus.

On that occasion, maybe as in a few others, the Court powerfully affirmed the need to combat all kind of stereotypes and prejudices aimed at hampering a person from living his or her everyday life in equality with others. To this end, it gave important guidance on how to combat the identified condition of vulnerability: instead of relying on general assumptions, it suggested the need to individualise the evaluation of the situation of people living with HIV/AIDS. While it may include health conditions as one of the elements for consideration, other relevant aspects of one's personal life cannot be certainly excluded.

II.3 How can the Recognised Protection be Granted?

Having explored the primary rationale for a rights approach to HIV/AIDS, a third point should be addressed: how the recognised protection can be granted.

While all European institutions have recommended that domestic authorities adopt specific measures to address the needs of people living with HIV/AIDS, setting the stage for the rise of positive obligations, other ways can be envisaged here. In particular, as suggested by the ECtHR, a rights-based approach to HIV/AIDS requires the refusal of reasons based on a negative bias against this specific group. Concretely, this attempt may follow two – cumulative – paths. First, it applies when people experience violations of human rights directly based on their HIV/AIDS status. In those circumstances, applicants did not have an additional vulnerable background other than living with HIV/AIDS. Second, it may apply to unveil covert prejudices, embedded in widespread social habits. This kind of stigmatisation appears as more complex and involves those minority groups, already identified as socially vulnerable, that are associated with HIV/AIDS.

Taking into account the wider backlash that this specific method to overcome vulnerability may grant, it is necessary to recall these minority groups. At the international level, all relevant organisations refer to people who experience human rights violations more frequently: detainees, men who have sex with other men (MSM),[21] ethnic minorities, sex workers, injecting drug users (IDUs), immigrants, and, often, women. According to them, being already exposed to social exclusion, their health situation may not be adequately monitored and/or access to medical treatment may be restricted or hampered by discriminatory treatment.[22] Hence, the violation of these basic

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20 *Id*, paras 16-18.

21 This terminology is used to avoid referring only to homosexuals, with the consequence of identifying their sexual orientation with an easier exposure to the virus: Saavedra, J, Izazola-Licea, JA and Beyrer, C, "Sex Between Men in the Context of HIV: The AIDS 2008 Jonathan Mann Memorial Lecture in Health and Human Rights", 11 *Journal of the International AIDS Society* (2008) 9.

22 For example, at the European level, research conducted by the FRA on the situation of Roma has revealed that almost 20% of the interviewees have been discriminated against when using health services: FRA, *The Situation of Roma in 11 EU Member States*, May 2012 *at* <fra.europa.eu/en/publication/2012/situation-roma-11-eu-member-states-survey-results-glance> (accessed 13 November 2015). Additional risks concern: irregular or illegal immigrants, who can be prevented from accessing health structures because of the danger of expulsion if intercepted; detainees, who in some States live in overcrowded detention

rights can itself expose them to a higher risk of being infected with HIV and, in turn, can indirectly contribute to the spread of the virus.

It is therefore surprising that, in the attempt to face this topic, international human rights mechanisms have not taken in due account the situation of groups at risk of social exclusion. Interestingly, a study made on the activity of the most important human rights bodies found that although a gradual engagement has emerged with a high number of texts adopted (89 recommendations and 127 reports), international human rights bodies have dealt mainly with the rights of children and women while lacking consistency in relation to other groups, especially MSM, IDUs or sex workers.[23] At the same time, no attempts have been made to verify whether, thanks to recent trends and scientific progress, this classification of people at risk is still valid or is grounded on outdated common beliefs.

Instead, a more consistent approach seems to have been adopted at European level, where the attention to more "traditional" groups of people, such as children and women, has gone hand by hand with specific consideration to other minorities already subjected to social stigma.[24] For example, since the 1980's, CoE's institutions have called for a coordinated European health policy to prevent the spread of HIV in prisons[25] and have stressed the importance of a horizontal approach to combating AIDS, making it clear that human rights should not be jeopardised on account of the fear aroused by the virus.[26] More recently, they have addressed the specific concerns experienced by migrants - taken generally as a group but also specifically through the identification of sub-groups who may suffer multiple forms of discrimination and stigmatisation, including in accessing HIV prevention and treatment – women, MSM, sex workers, undocumented migrants and refugees.[27] Most importantly, when those institutions have dealt with the more "traditional" group composed by girls and women, they have embedded "non-traditional" perspectives considering, for instance, the consequences of domestic violence

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facilities with negative consequences for the spread of the infection; sex workers who, being often criminalised, may have to face a hostile environment when accessing health facilities.

23 The study was reported during a Conference at the Kaiser Family Foundation, Wien, on 20 July 2010: UN Special Rapporteur on torture, *What Have You Done for HIV/AIDS Lately? The Role of Human Rights Mechanisms in Advancing the AIDS Response*, *at* <kff.org/global-health-policy/event/aids-2010-what-have-you-done-for-hivaids-lately-the-role-of-human-rights-mechanisms-in-advancing-the-aids-response/> (accessed 21 October 2015).

24 To this regard a significant statement was made by the Rapporteur of the explanatory memorandum of the PACE report on HIV/AIDS and women in Europe: 'The lack of ability […] to control the spread of the disease is to some extent linked to these moralistic debates. … It is only recently that the WHO has started imposing a non-discriminatory attitude towards prostitutes as the only way HIV/AIDS can be successfully prevented': Council of Europe, Committee for Equal Opportunities for Women and Men, REPORT: *The Spread of the HIV/AIDS Epidemic to Women and Girls in Europe*, Doc 11108, 15 December 2007, *at* <assembly.coe.int/nw/xml/XRef/X2H-Xref-ViewHTML.asp?FileID=11367&Lang=EN> (accessed 21 October 2015), para 8.

25 Among others things, it invited CoE's Member States to: providing regular information to all prison staff and to prisoners about HIV infection and its consequences; making HIV tests and counselling available to all prisoners; ensuring that hygiene and food in prisons are of such a standard as not to increase the risk of developing AIDS in prisoners who are already HIV-positive: Council of Europe, Parliamentary Assembly, *Acquired Immune Deficiency Syndrome (AIDS)*, 23 November 1983, Resolution 812(1983); and *A Co-ordinated European Health Policy to Prevent the Spread of AIDS in Prisons*, 30 June 1988, Recommendation 1080(1988).

26 Among positive actions, CoE's Member States were invited to: adopting laws to define national standards of protection; disseminating information in schools; banning compulsory HIV/AIDS screening for people applying for travel visas, asylum and jobs. Council of Europe, Parliamentary Assembly, *AIDS and Human Rights*, 29 September 1989, Recommendation 1116(1989).

27 Council of Europe, Parliamentary Assembly, *Migrants and Refugees and the Fight against AIDS*, 23 May 2014, Resolution 1997(2014); and annexed Report.

and gender inequality for the spread of the virus.[28] The same is true for the EU, whose institutions have asked national authorities to protect the human rights of the most disadvantaged groups – detainees, immigrants, MSM, ethnic minorities, sex workers, and IDUs, while adopting positive measures for people already living with HIV/AIDS. Interestingly, the EU Parliament has recommended that the EU Council and Commission also take legislative action to remove the main economic, legal and social obstacles to a rights-based approach strategy.[29]

Although this "added value" of the European approach to HIV/AIDS has not yet questioned the prudence of the classification of most exposed groups itself, which has had the consequence of indirectly reproducing certain stereotypes,[30] the application of a human rights-based approach to HIV/AIDS by European Courts seems to have slightly overshot the mark, as analysed below.

III. Building Bridges: The Prohibition of Discrimination as a Cross-cutting Guarantee between ECHR and EU Law

Having defined the rationale and the possible content of a human rights approach to HIV/AIDS, we should verify whether and how it has been applied by the ECtHR and the ECJ or, alternatively, what solutions are available for an interpretation of European human rights law in line with it.

The prohibition of discrimination seems a good starting point. It works as a Trojan horse: once HIV/AIDS status is identified as worthy to be covered by this prohibition, it may serve also as an interpretative tool for other human rights enshrined in the ECHR and the Charter.

In general terms, we have mentioned that the prohibition of discrimination can be applied in this field either by the addition of HIV/AIDS status to the grounds of protection or through the re-interpretation of another factor already expressly covered. The first hypothesis applies both to Article 14 ECHR and Article 21 CFR, in light of its open formulation. In fact, in line with the forward-looking proposal of the CoE's Parliamentary Assembly to reinforce the non-discrimination clause in ECHR 'either by adding health to the prohibited grounds of discrimination or by drawing up a general clause on equality of treatment before the law',[31] the ECtHR stated in *Kiyutin*:

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28 Council of Europe, Parliamentary Assembly, *The Spread of the HIV/AIDS Epidemic to Women and Girls in Europe*, 25 January 2007, Recommendation 1785(2007).

29 EU Parliament, *A Rights-based Approach to the EU's Response to HIV/AIDS*, *supra* nt 10. However, until today, only broad strategies were adopted by the Commission: see European Commission, *Action Plan on HIV/AIDS in the EU and Neighbouring Countries 2014-2016*, 14 March 2014, *at* <ec.europa.eu/health/sti_prevention/docs/ec_hiv_actionplan_2014_en.pdf> (accessed 21th October 2015). Among the suggested measures, we may recall: fostering the access to work and to education and professional training; promoting the participation of people living with HIV/AIDS in the elaboration or evaluation of the actions adopted in their favour; decriminalising the transmission of HIV as well as of the use of illegal drugs.

30 See for example the content of the EU Commission's 2014 Action Plan, *ibid*. It is interesting that also Advocate General P. Mengozzi, in his exam of the preliminary ruling in *Leger*, *infra*, has indirectly addressed this point when he noticed that the CoE's Resolution CM/RES(2013) of 27 March 2013 on sexual behaviour of blood donors has still referred to 'MSM as a high risk group'. This has led the French Government to use before the ECJ the CoE's resolution as a way of justification for a permanent exclusion of MSM from blood's donation. However, the same Advocate General seemed to stigmatise sex workers for the alleged role in spreading the virus. See his *Conclusions*, 17 July 2014, points 36 and 45.

31 CoE, *supra* nt 3, para 8. The general clause has been added through ECHR's Protocol no. 12 but, although it entered into force, a low number of CoE's Member States have ratified it. However, taken into account

> The Court notes the view of the United Nations Commission on Human Rights that the term "other status" in non-discrimination provisions in international legal instruments can be interpreted to cover health status, including HIV infection …. This approach is compatible … with the United Nations Convention on the Rights of Persons with Disabilities which imposed on its States Parties a general prohibition of discrimination on the basis of disability …. Accordingly, the Court considers that a distinction made on account of an individual's health status, including such conditions as HIV infection, should be covered – either as a disability or a form thereof – by the term "other status" in the text of Article 14 of the Convention.[32]

On many occasions, the ECtHR has already found that the list of grounds contained in Article 14 is not exhaustive and, relying on other international human rights treaties as well as on Article 21 CFR, has gradually expanded them. Hence, thanks to this interpretation of the Convention as a 'living instrument' able to catch developments in society, all 'identifiable, objective or personal characteristic, or 'status', by which persons or groups of persons are distinguishable from one another' may receive protection under the ECHR.[33] Even more importantly, since these grounds are not limited to characteristics that are "innate", it was not difficult to conclude that treatment based solely on HIV status is also covered by the prohibition of discrimination.[34] When other vulnerable groups sharing a common characteristic already covered by Article 14 are at stake, this interpretation is nonetheless important because it allows attention to be focused directly on HIV/AIDS status, when this is the reason for treating people differently without an adequate justification.

Although the ECJ has not yet been called upon to apply Article 21 CFR in relation to HIV/AIDS, its formulation does not raise any doubt on its potential application. It contains a general prohibition of discrimination ending with an open clause which allows the progressive inclusion of such characteristics as may become socially intolerable reasons for distinctions. Therefore, the Charter also covers HIV/AIDS status. Going even further from the ECHR, the CFR's prohibition of discrimination expressly includes all grounds associated with the mentioned groups most exposed to infection, such as sex, race, colour, ethnic or social origin, genetic features, birth, disability and sexual orientation. However, if EU Member States are bound by the Charter only when implementing EU law, an effective protection for people living with HIV/AIDS may be better realised through those EU directives that were adopted to give concrete expression to Article 21 CFR and/or to the general principle of EU law having the same content.

Clearly, a shared European approach in this field cannot be limited to a common understanding of the prohibition of discrimination. In light of this general framework, a more composite picture of legal consequences and reciprocal influences may be defined:

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the developments occurred in the ECtHR's case law, the lack of a general clause has been overcome through an inclusive interpretation of Art. 14. See recently Arnardóttir, OM, "Discrimination as a Magnifyng Lens: Scope and Ambit under Article 14 and Protocol No. 12", in Brems, E and Gerards, J (eds), *Shaping Rights in the ECHR: The Role of the European Court of Human Rights in Determining the Scope of Human Rights* (Cambridge University Press, Cambridge, 2013).

32 ECtHR, *Kiyutin v Russia*, *supra* nt 16, para 57.

33 For instance, disability (ECtHR, *Glor v Switzerland*, 13444/04, 30 April 2009, para 80); gender identity (ECtHR, *P.V. v Spain*, 35159/09, 30 November 2010); genetic characteristic ECtHR, *G.N. and Others v Italy*, 43134/05, 1 December 2009, para 126.

34 Gerards, J, "The Discrimination Grounds of Article 14 of the European Convention on Human Rights", 13(1) *Human Rights Law Review* (2013) 99, 109.

first, it seems necessary to investigate how Article 14 ECHR and Article 21 CFR can be applied to grant the protection envisaged by a rights-based approach to HIV/AIDS and, second, how it is possible to "build bridges" to reach a similar, if not higher, standard of protection through the application of EU secondary law. In both contexts, we will consider the group composed of people living with HIV/AIDS as well as other mentioned vulnerable groups.

III.1. A Common Aim: Fighting against Stigma

In line with the defined approach to HIV/AIDS, both European Courts have used the principle of non-discrimination to unmask stigma and to prohibit treatment based on prejudice. After, the ECtHR confirmed this perspective in *I.B. v Greece*,[35] related to an employee dismissed because of his HIV status. Significantly, a similar path has been followed by the ECJ through the application of Article 21 CFR to a group usually associated with the virus, as it can be seen in *Léger*.[36]

In *I.B.* the applicant alleged that he was dismissed because his colleagues refused to work with him after his health conditions became public knowledge. Although the employer did not agree, they pressed him to fire Mr. I.B.. According to the ECtHR, while it is true that the ECHR does not directly protect working conditions, the applicant's dismissal could be nonetheless evaluated under the Convention because the alleged violation fell within the ambit of Article 8. Hence, since 'all the issues related to HIV/AIDS fall within the ambit of private life',[37] the prohibition of discrimination as protected in the ECHR can apply to every situation of the life of people living with HIV/AIDS when this status is the reason for their stigmatisation. Perhaps most importantly, although *I.B.* concerns employment, the procedural steps defined by the Court can be applied to any other kind of differential treatment. In fact, when a distinction is made, only very serious reasons may be advanced and no room can be granted to stereotypes as justification. Thus, in *I.B.* the ECtHR could not accept that the applicant's dismissal was necessary to maintain a peaceful working environment, as claimed by domestic authorities. The refusal of other employees to work with the applicant relied on prejudices against HIV-positive people and the decision to fire him only had the effect of reinforcing the negative bias towards people suffering from the virus. While the ECtHR called on national authorities to prevent similar treatment, it also suggested how to balance competing interests when HIV/AIDS is involved. Accordingly, the specific condition of vulnerability suffered by this group justifies the recognition of a different and greater weight of their needs. Therefore, as for Mr. I.B.'s case, other employees' interests and the necessity to ensure a pleasant working environment could not exceed the "human right-based interest" to maintain the vulnerable position of employees living with HIV/AIDS.

As a result, the identified rationale for protection of people living with HIV/AIDS has concrete consequences in the evaluation of alleged violations of the ECHR. First, it calls

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35 ECtHR, *I.B. v Greece*, 552/10, 3 January 2014.

36 The preliminary ruling concerned the interpretation of Directive 2004/33/CE implementing Directive 2002/98/EC of the European Parliament and of the Council as regards certain technical requirements for blood and blood components, especially point 2.1 of Annex III on the criteria for permanent exclusion from donation: CJEU, C-528/13 *Geoffrey Léger v Ministre des Affaires sociales, de la Santé et des Droits des femmes and Établissement français du sang*, ECLI:EU:C:2015:288, 29 April 2015.

37 *I.B. v Greece, supra* nt 35, para 70. This finding may, nonetheless, be problematic for fostering the rights of people living with HIV/AIDS. While it is instrumental for the application of Article 14, it may also prove to be an obstacle to a rights approach if it is finally understood as limiting HIV/AIDS to the "closet" of private matter downsizing its public social dimension.

for the application of the same approach elaborated for other "traditional" grounds such as sex, race/ethnic origin or sexual orientation, because of the history of past discrimination suffered by groups sharing these characteristics. This means that, in the evaluation of mistreatment based directly or indirectly on HIV/AIDS status, only very weighty reasons can be submitted as justification and, perhaps more importantly, the margin of appreciation of contracting States in establishing distinctions is considerably narrow.[38] For instance, in *Kiyutin*, although the aim pursued by Russia – ie. the defence of public health – was legitimate, the measures adopted did not satisfy the necessity test.[39] In the same way, the dismissal of Mr. I.B. was not necessary to protect other employees' health since, moving from general assumptions to individualised evaluations, it was clear that his general conditions did not have any effect on the execution of his tasks, and neither were they contagious. Second, if we look beyond the procedural aspects, the recourse to vulnerability has consequences on the concept of discrimination itself. Indeed, it downsizes the relevance of discriminatory treatment as a comparative concept. If the aim of sanctioning discrimination is overcoming a situation of historical disadvantage, there is no need to search for comparable situations. In other words, why should we establish a comparable situation *if* the discrimination suffered by the vulnerable group has prevented individuals from reaching the majoritarian living condition or from sharing in all the experiences which the life of the community can provide them?

Interestingly, a similar approach in the application of the principle of non-discrimination has been explored by the ECJ in the identification of more deeply-rooted stigma associated to HIV/AIDS. The *Léger* case – a preliminary ruling on the compliance with EU law of domestic measures adopted to prevent the spread of the virus – brought to the attention of the ECJ the issue of the permanent refusal of blood donation by MSM. In the national referring Tribunal's view, it was not clear if EU law allowed for a permanent refusal of blood donation instead of a temporary deferral when a donor reports such a sexual behaviour. In fact, while the applicable French law provided for a blanket exclusion of the MSM group, interfering with Mr. Léger's life, the relevant EU Directives (2004/33/CE and 2002/98) do not include any kind of classification for the purpose of exclusion. Both Directives bind instead Member States to monitor donations in light of the sexual behaviour of donors because it may expose them to a higher risk of being infected by HIV.

Considering that the relevant French law was meant to implement EU law, the Charter applied and the ECJ referred expressly to it for protecting human rights of MSM while granting an appropriate level of concern for public health. Through an anti-stereotyping approach, the EU Court has focused its attention on the risk behaviour rather than on the classification of people for their alleged role in the spread of the virus. In this way, the ECJ has avoided to equate a risk behaviour with a specific group and, in turn, with a specific sexual orientation. Accordingly, the fact that a man has or may have sex with another man cannot lead automatically to the conclusion that all MSM are at a high risk of infection, and thus of transmitting, HIV. Instead, in the same way other risky

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38 See, among others, ECtHR, *Kozak v Poland*, 13102/02, 2 June 2010. Among others, Gerards, J, "Pluralism, Deference and the Margin of Appreciation Doctrine", 17(1) *European Law Journal* (2011) 80-120; Danisi, C, "How Far Can the European Court of Human Rights Go in the Fight against Discrimination? Defining New Standards in its Non-discrimination Jurisprudence", 9(3-4) *International Journal of Constitutional Law* (2011) 793.

39 Interestingly, the defendant State referred also to economic reasons due to the hypothetic higher expenditure in public care. The Court found that they do not apply because when such resources are at stake a case-by-case analysis must be preferred rather than a general ban. See also, ECtHR, *Kiyutin v Russia*, *supra* nt 16, para 70.

sexual activities are treated,[40] a person like Mr. Léger can be prevented from donating blood permanently or for a limited period of time *only if* it is verified that a very serious risk for transmitting infectious diseases exists *and* while 'respecting the fundamental rights recognised by the EU legal order'.[41]

Two considerations follow from this premise. First, this high risk must be demonstrated by reliable data as well as scientific and medical knowledge. Thus, the ECJ called upon the referring Tribunal to verify whether the information provided by the French Government was trustworthy and relevant *at the moment* the domestic law was effectively applied. Second, according to the Charter, any permanent or temporary refusal of blood donation for MSM must respect, specifically, Article 21 as far as it enshrined the prohibition of discrimination based on sexual orientation. In fact, through a direct reference to MSM, the domestic law made a distinction based on the sexual orientation of potential donors and put homosexual people in a disadvantaged position. Such a distinction must be justified to be in compliance with EU law.

Going perhaps even further than what Article 52.1 CFR provides, the ECJ has defined a kind of strict scrutiny test to the treatment established by French law, similar to the one elaborated on by the ECtHR in its case law. Since the French exclusion does not call into question the principle of non-discrimination as such and is aimed to protect public health, proportionality *in terms of necessity* becomes the decisive point in ECJ's view. Not only should it be demonstrated that there are no other ways to detect HIV with the goal of granting high standards of protection of public health, but the practical consequences of such a limitation must also not put an entire group in an extremely disadvantaged position. For these reasons, the ECJ has envisaged at least two ways to eliminate such a disadvantage. Thanks to scientific progress, people who have undertaken high-risk behaviour can undergo through new and more effective examinations in order to ascertain the presence of the virus in the donated blood. Then, if these techniques are not available yet, a deeper investigation into a donor's personal history, through specific and clear-cut questions, can be realised by competent medical staff, thus obtaining the same level of protection of public health without imposing any form of exclusion from donation.

Briefly, in the same way as that used in *Kiyutin* and *I.B.*, the application of the prohibition of discrimination to people usually identified as being a danger for public health has been used to "individualise" the risk connected with the spread of HIV/AIDS. Even without expressly mentioning it, EU judges have *de facto* refused prejudice as a way of justification of a suspect discrimination. Thanks to a rights-based approach, they have been able to identify the harmful categorisation of a specific group embedded in French law on blood donation and have rehabilitated an entire, already vulnerable, group. Significantly, this result has been achieved even without any reference to the prohibition of discrimination as interpreted by the ECtHR in line with the usual way of reasoning of the ECJ when a right affirmed in the Charter has the same meaning of the corresponding right set forth in ECHR, as it is the case for Article 21 CFR.[42] The reason for such an

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40 The Advocate General, P. Mengozzi, referred on the different treatment provided for unprotected sexual conduct, occasional sexual activities and relationships with more than a partner: for all these sexual behaviors, necessarily involving heterosexual people, the French law provided only a temporary exclusion from donations (four months). Thus, he suggested the application of a similar limitation for 'those MSM' who, after an individual screening, have been exposed to high risk sexual behaviors. Interestingly, he found also a potential discrimination on the ground of sex, since only male donors were excluded, while no limitation was in place for lesbian women. See his *Conclusions*, issued on 17 July 2014, points 44 and 56-62.

41 *Léger*, *supra* nt 36, points 39-40.

42 Explanations relating to the Charter of Fundamental Rights 2007/C 303/02 (2007) OJ C303/17.

approach likely depends on the fact that this (higher) standard of protection could be set more appropriately through an autonomous interpretation of the Charter.

III.2. The Relationship with Other Rights: The Rise of Positive Obligations under the ECHR

The interpretation of the prohibition of discrimination in this field is not limited to covering HIV/AIDS as a protected ground or to the refusal of prejudice as justification for discrimination. As anticipated, the condition of vulnerability associated with the virus obliges domestic authorities to take an active involvement in addressing the special needs of people living with HIV/AIDS but also in fighting stigma looking at the consequences for groups at high risk of infection. Notwithstanding the relevant recommendations of European institutions, the ECtHR and the ECJ have not yet developed a clear case law, at least from the standpoint of the principle of non-discrimination. However, new developments in this field may be expected in line with a rights-based approach to HIV/AIDS, especially if we look at the relationship to other rights enshrined in the ECHR or, as analysed in the following paragraph, to other grounds of discrimination as far as EU law is concerned.

A first important signal emerges from the *I.B.* case. Considering that the violation was perpetrated by an individual, Mr. I.B.'s employer, the Court found that the respondent State had failed in fulfilling its (positive) obligations under the Convention. Indeed, it did not prevent the employer from dismissing the applicant because of his HIV-positive status. At the same time, through legislative acts, it failed to ensure that the interests of workers living with HIV/AIDS could be correctly balanced with other workers' interests, thus indirectly permitting their exclusion from employment in violation of Article 14 ECHR. In other words, the ECtHR recognised that the condition of vulnerability in employment cannot be broken up without the active involvement of domestic authorities.

Other indications may be derived from the case law developed by the ECtHR in connection with applicants suffering from different forms of marginalisation, including those arising from their HIV/AIDS status. On different occasions, the ECtHR has faced the needs of people living with the virus by calling on the respondent States to find appropriate solutions for respecting the specific rights at issue. In this way, although it is not explicitly stated, it may be possible to avoid discrimination on HIV/AIDS status. As such, these attempts entail the question of the relationship between the particular right involved and the prohibition of discrimination, especially when groups exposed at higher risk of infection are involved. In order to clarify this point, it seems useful to refer to the ECtHR's role in addressing HIV-positive prisoners' needs through the interpretation of the prohibition of torture and cruel, inhuman and degrading treatment (Article 3 ECHR), read alone or in conjunction with the prohibition of discrimination.[43]

From a number of judgments, it follows that the lack of appropriate medical care for prisoners living with HIV/AIDS amounts *in itself* to a form of inhuman and degrading

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[43] See the relevant proposals issued by the Madrid recommendation, World Health Organization, *Health protection in prisons as an essential part of public health*, 2010 *at* <euro.who.int/__data/assets/pdf_file/0012/111360/E93574.pdf> (accessed 20 November 2015*)*. It is not surprising that the rate of people living with HIV/AIDS is higher in prisons. Many groups considered at higher risk of infection, such as sex workers and IDUs, are more likely to be imprisoned being their conduct often criminalised. It is not coincidence that a human rights-based approach calls for their decriminalisation.

treatment in contrast with the Convention.[44] As a consequence, respondent States failing to ensure prompt and accurate diagnosis as well as regular and systematic supervision for HIV/AIDS sufferers, *in addition* to appropriate living standards in prisons, do not fulfil the obligations deriving from the Convention. In fact, although it cannot impose a general obligation to release detainees on health grounds, Article 3 ECHR entails nonetheless an obligation to protect the physical well-being of prisoners, especially when they have already developed AIDS because of the risk of exposing prisoners to other associated serious diseases.

The recent judgment in *Martazaklis and Others v Greece* confirms the assumed relationship between the obligations derived by Article 3 taken alone and the positive obligations that may result from the prohibition of discrimination when HIV/AIDS is involved.[45] The case was brought before the ECtHR by several detainees who were placed in a specific area of the prison's hospital, together with other prisoners with infective diseases, where no specialised medical staff and medications were available and no individualised therapies were prescribed. Instead of focusing only on the precarious conditions of detention of the applicants, which amounted to a violation of the prohibition of degrading and inhuman treatment, the ECtHR deemed it appropriate to examine the alleged violations from the standpoint of Article 3 read in combination with the prohibition of discrimination. Interestingly, the Court accepted that a contracting State is allowed under the Convention to treat prisoners living with HIV/AIDS differently in order to improve their health conditions by separating them from other detainees. However, if no appropriate measures are simultaneously adopted to pursue this legitimate aim, such a separation only reinforces an already widespread belief of the alleged necessity to ghettoise people living with HIV/AIDS. As such, it is in contrast with the prohibition of discrimination.

Stated differently, HIV/AIDS may be the reason for requiring contracting States to provide additional standards of protection when an already vulnerable group is involved, going beyond the specific right at stake to raise an issue under Article 14 ECHR. Put this way, the positive obligations defined through the substantive provisions of the Convention may be a first step towards the elaboration of the same kinds of obligations from the standpoint of the prohibition of discrimination itself. As the ECtHR's case law on other suspect grounds shows[46], the very reason lies in the need to treat situations that are not similar differently when a personal condition, which defines a vulnerable group, is involved.

III.3. The Relationship with Other Grounds: The Potential Application of EU Secondary Law

A different path may be envisaged for the rise of positive obligations in EU law. Although Article 21 CFR may cover HIV/AIDS status, it does not contain any

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44 Among others, ECtHR, *Kozhokar v Russia*, 33099/08, 14 December 2010; ECtHR, *Khudobin v Russia*, 59696/00, 26 October 2006, para 93; ECtHR, *A.B. v Russia*, 1439/06, 14 October 2010; ECtHR. *Logvinenko v Ukraine*, 13448/07, 17 June 2006. For an analysis of the standards set out by the CoE's Committee for the Prevention of Torture (ECPT), see Casale-Katzman, E-A, ed, "Preventing Torture in the 21st Century: Monitoring in Europe Two Decades On, Monitoring Globally Two Years On", 6(2) *Essex Human Rights Review* (2010) *at* <projects.essex.ac.uk/ehrr/Vol6No2.html> (accessed 22 October 2015).

45 ECtHR, *Martazaklis and Others v Greece*, 18748/91, 9 July 2015. See also ECPT, *Report on Greece*, CPT/Inf (2014) 26, 5 July 2013 *at* <cpt.coe.int/documents/grc/2014-26-inf-eng.pdf> (accessed 22 October 2015).

46 For example, ECtHR, *Orsus and Others v Croatia*, 15766/03, 16 March 2010.

obligation of this kind, nor has it been given this meaning by the ECJ. At the same time, the prohibition of discrimination which was affirmed by the ECJ as 'a general principle of the EU legal order' does not provide for positive obligations since it works, also after the entering into force of the Charter, as a primary tool for legitimacy of EU law.[47] Therefore, it seems necessary to look at the relationship between HIV/AIDS and other grounds covered by the prohibition of discrimination as expressed in relevant EU secondary law.

An interesting proposal may come from the broadening of the notion of disability that has occurred within the EU order. Indeed, if disability is interpreted as encompassing HIV/AIDS status, at least two important consequences may be derived in terms of obligations for the EU's institutions and Member States. First, regarding the Charter, Article 26 provides for a strong basis for the adoption of positive actions since it affirms that the Union 'recognises and respects the right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community'. Second, among the grounds of discrimination taken into account by Article 19 of the Treaty on the Functioning of the European Union (formerly Article 13 of the Treaty on the European Community), the question of disability has attracted a wide consensus on the need for an active involvement of the European Union itself.[48] For similar reasons, it has also been granted protection through EU secondary law by Directive 2000/78, ie. the so-called horizontal anti-discrimination directive establishing a general framework for the prohibition of discrimination in employment and working conditions.[49] Although its scope is limited to this specific field and covers only treatment based on disability, sexual orientation, age, religion or beliefs, the Directive addresses the specific needs of people with disabilities through an obligation for EU Member States to act for their full inclusion in employment.

Since the EU complements national efforts in relation to disability issues, it is no coincidence that it decided to adhere to the UN Convention on the Rights of Persons with Disabilities (CRPD),[50] thereby taking a greater commitment to respect and protect the rights enshrined in the Convention and – we may add – the provisions of the EU law providing protection for people living with disabilities.[51] Since the latter should be read in

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47 See, in relation to gender, CJEU, *Test-Achats ASBL and Others v Conseil des Ministres,* C-236/09, [2011] ECR I-00773.

48 Ellis, E and Watson, P, *EU Anti-discrimination Law* (2nd ed, Oxford University Press, Oxford, 2012); Bell, M *et al*, *Developing Anti-discrimination Law in Europe: the 25 EU Member States Compared* (EU Commission, Bruxelles, 2007).

49 Directive 2000/78/EC of the European Council of 27 November 2000 establishing a general framework for equal treatment in employment and occupation, OJ L303/16. On the ECJ's related case law: Eriksson, A, "European Court of Justice: Broadening the Scope of European Non-discrimination Law", 7(4) *International Journal of Constitutional Law* (2009) 731.

50 UN General Assembly, *Convention on the Rights of Persons with Disabilities* (2008) 2515 UNTS 3. See EU Council, *Decision concerning the conclusion, by the European Community, of the UN Convention on the Rights of Persons with Disabilities*, 2010/48/CE, in *OJ*, 27 January 2010, L23/35. The EU is bound by the Convention from 22 January 2011, only to the extent of its competences. On EU and disability issues, Mabbett, D, "The Development of Rights-based Social Policy in the European Union: The Example of Disability Rights", in 43(1) *Journal of Common Market Studies* (2005) 97.

51 It is worth mentioning that, even before the ratification, the EU Commission's strategy to disability issues included the same priority areas characterising the CRPD: accessibility; participation; equality; employment; education and training; social protection; health; external action. Interestingly, the core elements of this strategy recall the EU rights-based approach to HIV/AIDS: see comparatively the EU, European Commission, *European Disability Strategy 2010-2020*, 15 November 2010, *at* <eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0636:FIN:en:PDF> (accessed 14 October 2015) and EU, European Commission, *Action Plan on HIV/AIDS in the EU and neighbouring countries:2014-*

line with the UN Convention (Article 216.2 TFUE), interestingly the first point for broadening the notion of disability to include HIV/AIDS status for the purpose of positive obligations comes from the same CRPD.[52] A second insight emerges from the ECJ's case-law that seems to pave the way for granting people living with HIV/AIDS the additional protection that Directive 2000/78 may provide them.

As for the UN Convention, it has outlined for the first time in a binding instrument that disability is not only a matter of social welfare, but also a human rights issue. While HIV/AIDS status can be relatively easy to define in medical terms, no specific definition of disability can be found in the CRPD. Interestingly, avoiding any medical definition, it has been thought of as an "evolving concept"[53] to be read in with the preamble of the Convention: 'disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others' (subsection e). Therefore, the CRPD applies where a person's impairments and attitudinal barriers limit his/her participation in the life of his/her community. However, nothing is said on the *nature* of such impairments. As a consequence, it cannot be excluded that they may also derive from an illness or a disease, as well as from the HIV-positive status. Indeed, enjoying a margin of discretion on the real ambit of the notion of disability, from contracting States' practice, it seems that in some countries HIV-positive people are covered by the legislation protecting disability.[54] At the same time, other countries may recognise disability-related benefits gradually and only at a late stage of the infection a full disability status, ie. when AIDS has already developed (for instance, Italy).

Although HIV/AIDS status has not come directly into play yet, the suggested application of the notion of disability is supported by the ECJ's interpretation of Directive 2000/78. In one of the first judgments – *Chacón Navas*,[55] the Court excluded that sickness may be covered by the concept of disability because this must be understood as referring to a long-term limitation which results in particular from physical, mental or psychological impairments and which hinders the participation of the person concerned in professional life. As the ECJ put it, although the EU recognises and respects human rights as general principles of the EU legal order, the protection provided by the Directive could not be extended by analogy to any factor on which a discriminatory treatment is based. As a consequence, if sickness is the only reason for receiving a disadvantageous treatment in employment, Directive 2000/78 cannot apply.

While it became clear that the horizontal non-discrimination Directive's list of grounds is exhaustive, the ECJ did not exclude that the included grounds – disability, sexual orientation, age, religion or beliefs – may evolve. Therefore, as for disability, after

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2016, *at* <ec.europa.eu/health/sti_prevention/docs/ec_hiv_actionplan_2014_en.pdf> (accessed 14 October 2015).

52 Although today a more consistent reasoning may support such a proposal, it is worth recalling that a similar approach has been advanced by the UN Human Rights Commission before the elaboration of the UN Convention. See UNAIDS, Sub-Commission on Prevention of Discrimination and Protection of Minorities, *HIV/AIDS and Disability*, 1996. On the relationship between HIV/AIDS and disability, see Hanass-Hancock, J and Nixon, S A, "The Fields of HIV and Disability: Past, Present and Future", 12 *Journal of the International AIDS Society* (2009) 28.

53 On the definition(s) of disability, see Human Resources Development Canada, REPORT: *Defining Disability: A Complex Issue*, Ottawa, 2003, *at* <publications.gc.ca/collections/Collection/RH37-4-3-2003E.pdf> (accessed 14 October 2015).

54 We may refer, for instance, to Canada, USA, Germany, United Kingdom, Norway. Other countries have adopted separate legislations for HIV/AIDS status and disability, such as South Africa and Russia. See Elliot, R, Utyasheva, L and Zack, E, "HIV, Disability and Discrimination: Making the Links in International and Domestic Human Rights Law", 12 *Journal of the International AIDS Society* (2009) 29.

55 ECJ, *Sonia Chacón Navas v. Eurest Colectividades SA*, C-13/05, 11 July 2006, paras 43-45.

the EU ratification of CRPD, the ECJ redefined its previous position on the very first occasion. In *HK Danmark*,[56] when asked if the Directive applies in relation to 'a state of health of a person who, because of physical, mental or psychological impairments, cannot or can only to a limited extent carry out his work, at least for a long time', the ECJ affirmed that the Directive might apply in case this state of health has the same consequences envisaged in the UN Convention's preamble for disability. This is why the concept of disability contained in Directive 2000/78 refers also to 'a condition caused by an illness medically diagnosed as curable or incurable', where that illness entails a long-term limitation resulting *in particular,* from physical, mental or psychological impairments, which in interaction with various barriers may hinder the full and effective participation of the person concerned in professional life on an equal basis with other workers. As later confirmed in *FOA,* in relation to that state of health corresponding to obesity,[57] the Court does not rely anymore on the physical, mental or psychological impairments hampering the inclusion of a person in professional life but on 'interaction' as the central element of the 'social' concept of disability underling the CRPD. In fact, it is the relation with the outside environment, specifically defined for persons without disabilities, that limits the participation of people with disabilities in many spheres of life, including employment.

Having also regard to the reasoning followed by the ECtHR in *Kiyutin*, where it has associated disability to HIV status, Directive 2000/78 may thus apply to the situation of people living with HIV/AIDS through the prohibition of discrimination based on disability. To this end, it seems essential that their state of health, in interaction with physical or social barriers, must limit their effective participation in professional life. Although this can lead to the conclusion that HIV-positive people may experience this limitation only at a late stage of AIDS, it cannot be excluded that these limitations may be also experienced by the entire group of people living with HIV in light of the effects produced by the stigma associated with the virus. Furthermore, not only such limitations can hamper people's interaction since the beginning of the infection, but it may also regard groups that are simply associated with AIDS without effectively being HIV-positive[58].

If Directive 2000/78 applies, EU Member States will be bound by EU law, among other things, to ensure that people living with HIV/AIDS are not dismissed or denied a promotion, to assure the reversal of the burden of proof when a discriminatory treatment is alleged and always if their condition amounts to disability, to ensure that 'reasonable accommodations' are adopted when needed. This fundamental obligation refers to all effective and practical measures that all employers, public as well private, must put in place to enable the person concerned to access, participate and advance in employment (Article 5 Directive 2000/78). Adapting premises and equipment, providing training or integration resources, establishing a different distribution of tasks, as well as reducing

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56 ECJ, joined cases *HK Danmark v Dansk almennyttigt Boligselskab* and *HK Danmark v Dansk Arbejdsgiverforening*, C-335/11 and C-337/11, 11 April 2013, points 38-39, 41.

57 ECJ, *FOA*, C-354/13, 18 December 2014.

58 If it is correct, this interpretation may in turn lead to foster the application the CRPD to people living with HIV/AIDS. As a consequence, specific obligations would be derived also from the UN Convention. Other than the general duty to remove all obstacles in every-day life and to operate for tackling the prejudices and social disfavour, the CRPD binds contracting States to respect: the right to life; the right to privacy and respect for private and family life; the right to health; the right to work; the right to take part to the public, political and cultural life of the country; the right to adequate living standards and the freedom of movement. See Office of the High Commissioner of Human Rights, World Health Organization and UNAIDS, *Disability and HIV*, April 2009, *at* <who.int/disabilities/jc1632_policy_brief_disability_en.pdf> (accessed 14 October 2015).

working hours, are different examples of reasonable accommodations. Interestingly, as the ECJ affirmed in *Commission v Italian Republic*, being a general obligation, it applies to all persons with disabilities, without reference of any kind to the level of disability resulting from medical classification as it happens, in some countries, also for people living with HIV/AIDS.[59]

Clearly, in addition to Directive 2000/78, the whole EU secondary law providing protection for people living with disability may come into play for people living with HIV/AIDS, including the new Directive implementing the principle of equal treatment outside employment when it will be adopted.[60] In addition to the prohibition of direct and indirect discrimination, as well as harassment in the access to social protection, goods and services, health care and education, the new instrument will require EU States to take a proactive role in eliminating in these fields of all unjustified differential treatment on the grounds of disability, as well as sexual orientation, age, religion or belief. Perhaps more importantly, the new EU instrument is intended to prohibit also multi-discrimination, ie. when a person is treated less favourably on the grounds of two or more factors covered by the Directive. Interestingly, this situation can be directly experienced by people living with HIV/AIDS when they belong to other vulnerable groups, like for instance "MSM", who may be discriminated against cumulatively on the grounds of their effective or alleged HIV-positive status (through disability) and sexual orientation.

IV. Setting Common Standards: The Interpretation of the Prohibition of *Refoulement*

With this emerging common framework in mind, we turn now to the analysis of a less clear obligation for European States when a person living with HIV/AIDS is involved.

It is well-known that, until today, the ECtHR has given an extremely restrictive interpretation of the prohibition of *refoulement* that downsizes the relevance of the specific health and social condition of the person subject to expulsion, return or rejection in a third or another European State, while giving more weight to his or her *status* as 'irregular migrant'.[61] While a more consistent position is gaining strength within the ECtHR itself, the ECJ has recently decided to follow the ECtHR's indications in the interpretation of the relevant EU secondary law. As a result, the ECJ has followed a different path when compared to the *Léger* case, where the Charter played an "autonomous" role, thus relying to the ECHR to define what standards of protection the EU law may provide.

While this development may seem like an attempt to reach a common approach with a clear preference for European minimum standards, from the perspective of people concerned and their need for protection under human rights law, it raises the question of *which* European approach to HIV/AIDS is under construction. In fact, leaving a wide

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59 ECJ, *European Commission v Italian Republic*, C-312/11, 4 July 2014.

60 See, for the other relevant pieces of legislation, European Union, Commission, *First Report on the Implementation of the UN CRPD by the EU*, 26 June 2014. The draft of the new Directive is available *at* <eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0426:FIN:IT:PDF> (accessed 14 October 2015).

61 Although the terms expulsion, return and rejection are clearly different in meaning, for the purpose of this analysis they are used in an interchangeable way because the focus is placed on their equal effect on the person involved. Among others, Da Lomba, S, "Vulnerability, Irregular Migrants' Health-Related Rights and the European Court of Human Rights", 21(4) *European Journal of Health Law* (2014)339.

margin of appreciation to European States, it neglects the specific needs of people living with HIV/AIDS and excludes the possibility to grant an individualised examination of a person's health condition in contrast with the developments in the interpretation of other substantive rights.

In other words, it is not clear whether the condition of an irregular migrant taken alone may explain the preference for an interpretation which sets general common standards at their lowest content only for some rights, rejecting the idea of a holistic approach based on the specific vulnerability of this group.[62]

Although it is generally referred to as a monolithic interpretation of the prohibition of *refoulement,* in case of expulsion of irregular ill migrants some distinctive elements have emerged in both systems of protection when people living with HIV/AIDS are involved. These elements may set the stage for a more genuine development which will be able to grant a more consistent interpretation of the whole (European) human rights catalogue, as recommended by CoE's institutions. Indeed, moving from the universal nature of the right to health, the Parliamentary Assembly stressed the condition of vulnerability of people living with HIV/AIDS having a migratory background and the need for special treatment to overcome the multiple forms of discrimination and stigmatisation to which they are exposed. Moreover, after rejecting the myth of "health tourism" through an analysis of available data, it called for adequate and individual assurances on the effective availability of health care in the country of destination as an essential precondition for sending them back.[63]

This is why we investigate in this section, how the interpretation of the prohibition of *refoulement* may evolve in light of the new rights approach to the virus when the person to be returned is living with HIV/AIDS.

IV.1. People Living with HIV/AIDS or Irregular Migrants?

Both the ECHR (Article 3) and the Charter (Article 4) enshrine the prohibition of torture and inhuman and degrading treatment in absolute terms. It is a well-established principle of international law that States cannot escape this obligation by sending people to a country where they may suffer such treatment. In general terms, for evaluating the existence of the risk at stake, a person must show that the general situation of the country of destination, coupled with his or her specific condition, would expose him/her to a serious degree of suffering. When the risk is directly connected to a person's health condition, a very high level of pain is required to apply the guarantees provided by the principle of *non-refoulement.*[64]

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62 According to S. Da Lomba, in this specific field related to health needs, irregular migrants are not regarded as vulnerable subject because 'their immigration status locates them outside the national community', *Id*, 360. However, the same author founds the variety of approaches of the ECtHR when migrants are involved being also identified as vulnerable, especially when they are asylum seekers: see ECtHR, *M.S.S. v Belgium and Greece*, 30696/09, 21 January 2011.

63 See Council of Europe, Parliamentary Assembly (PACE), *Migrants and Refugees and the Fight against AIDS*, 23 May 2014, Resolution 1997, points 7; 9.1.3, Council of Europe, Committee on Migration, Refugees and Displaced Persons, Migrants and refugees and the fight against AIDS, Doc 13391, 22 January 2014, points 4,6, and PACE, *Refugee and the Fight against AIDS: Motion for Resolution*, Doc 12867, 1 February 2012.

64 See Webster, E, "Medical-related expulsion and interpretation of article 3 of the ECHR", 6(1-2) *Inter-American and European Human Rights Journal* (2013) 36; Battjes, H, "In search of a fair balance: the absolute character of the prohibition of refoulement under Article 3 reassessed", 22(3) *Leiden Journal of International Law* (2009) 583.

Within the ECHR system, *D. v UK* was the first case involving a person living with HIV, who alleged a violation of Article 3 in case of expulsion to Saint-Kitts.[65] Despite being dangerous to suspend or to stop medical treatment, the relevant British authorities rejected his request aimed to obtain a permit to stay on humanitarian grounds. In the ECtHR's view, while contracting States have the right to control and protect their boundaries, they are obliged nonetheless to protect 'one of the fundamental values of democratic societies'. In fact, when the prohibition of *non-refoulement* is at stake, the evaluation of the situation in the country of destination cannot be limited to public authorities' intentional acts or to their inability to prevent the prohibited treatment. Therefore, in order to reaffirm its absolute nature, the ECtHR declared to be free to consider all relevant circumstances of a person subject to expulsion, including the kind and the seriousness of his/her illness. As a result, in that case, taking into account the stage reached by the infection, the consequences of ending medical treatment in a healthy environment and the lack of social and moral support in the country of origin, the ECtHR concluded that the applicant's expulsion would have caused a violation of the Convention.

Interestingly, even if the Court tried to narrow the implications of this judgment underlying the exceptional circumstances of the case, some points can be highlighted. First, HIV/AIDS played a key role in the definition of what the applicant required in the UK as well as in St. Kitts, going beyond the simple medical treatment and including *social* support. Second, the ECtHR found inconsistent the idea that the family could replace the State of destination's protection or, even worse, that its existence excludes *per se* a serious level of suffering. Third, irrespective of the situation in St. Kitts, it was the *deprivation* of an appropriate environment for the applicant's personal HIV condition that amounted to an inhuman treatment.[66]

It is this background that explains the reason for the adoption of a more restrictive approach in *N. v UK* (*N.*).[67] In fact, the Grand Chamber gave its own interpretation of the *D.*'s judgment reversing the reasoning followed in that case. First, it tried to define a general approach to expulsion of ill persons, irrespective of the disease at stake. Being oversimplified, no considerations were made as to the social consequences of being a person living with HIV/AIDS in the country of arrival or to the kind of complex environment needed by the applicant. As a result, the availability of medical treatment *per se* became the main focus. Second, while defining the applicant's defence as speculative, the Court itself used speculation to affirm that, in the country of origin, she could rely on family support or have access to expensive medical treatment. Third, the Grand Chamber did not consider the responsibility of the defendant State for the deprivation caused to the applicant through the expulsion and the related transfer from a safe environment. Instead, it stressed her capability to travel.

Most importantly, in *N.* the Court was able to make a subtle change of paradigm. If in *D.* the aim was to confirm the absolute nature of the prohibition of *refoulement* and the provision of medical and social care was only a mean among many others to realise it, in *N.* the essential issue became the lack of an obligation under the ECHR to grant free and unlimited health care to aliens. This aspect has led the ECtHR to combine the exam of the existence of an individual risk of torture or inhuman and degrading treatment with

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65 ECtHR, *D. v United Kingdom*, 30240/96, 2 May 1997.

66 For similar reasons, the European Commission of Human Rights found a violation of the principle of *non-refoulement* in *B.B. v France*, 47/1998/950/1165, 7 September 1998, related to a Congolese national living with AIDS. For the Commission, it was impossible for the applicant to maintain human dignity, 'as the disease ran its course', in his country of origin.

67 ECtHR, *N. v United Kingdom*, 26565/05, 27 May 2008.

general considerations on the 'natural' origin of the harm, both in terms of *natural* disease and of *natural* historical and economic differences between contracting States and countries of destination.[68]

With one significant exception, it is worth noting that all the following applications did not involve people living with HIV/AIDS, but different kinds of curable diseases.[69] In these cases, the evaluation of the ECtHRfocused on the appropriateness of the measures designed for the execution of the expulsion having regard to the applicants' particular needs. Although put in a different way, this attention is the reaffirmation of the responsibility of the contracting State for a direct perpetration of a prohibited treatment.[70]

In light of the Grand Chamber's interpretation in *N.*, the ECJ evaluated the *M'Bodj* case,[71] involving a Mauritanian national who was seriously ill but, interestingly, was not living with HIV/AIDS. This preliminary ruling does not concern the principle of *non-refoulement* in itself but the question whether a permit to stay on the grounds of serious illness may be granted through the recognition of subsidiary protection as provided by EU law. It is clear that, if such protection is refused, the person may risk being exposed to ill-treatment according to his/her specific situation. The ECJ's reasoning has been mainly aimed at identifying the harm to which an ill alien would be exposed if returned to his/her country of origin. In its view, Directive 2004/38 on the standards for the recognition of the refugee status and subsidiary protection is designed for granting protection against serious pain caused, directly or indirectly, *by* the State of destination. Put in these terms, only when a deliberative deprivation of medical treatment is at stake, a third-country national may raise a claim for the recognition of protection under EU law. For the same reasons, this conclusion cannot be reversed by the obligation to respect Article 19.2 of the Charter, related to the principle of *non-refoulement*, if read in combination with the ECtHR's case-law. Recalling *only* the ECtHR's well-known statement on the inexistence in international law of a right to stay in a European country to benefit from medical treatment, EU judges focused the attention on the availability of these treatments in the country of destination as sufficient to reject the claim. As a result, they set at its highest point the distinction between the condition of a human having a disease *versus* the status of non-citizen, in the same way it has already emerged in the ECtHR's case-law. It has been thus easy to rule that, while Member States may autonomously allow seriously ill aliens to stay in their territories on humanitarian grounds, they are not obliged to grant them subsidiarity protection nor the rights to social or health care as provided by Directive 2004/38.

As a consequence, the ECJ has not questioned at all the kind of risk a seriously ill person is exposed to when returned to his/her country. At the same time, the idea that a protection cannot be grounded on any harm which does not take place in the country of destination disregards the implications of depriving a person of his or her basic needs. It rules out even the possibility that the transferal itself may amount to a serious pain for the purpose of EU law. Moreover, no attention was paid to the specific illness at stake nor to

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68 This point was made by the House of Lord in its consideration of the case and it is now a recurring argument in the ECtHR's case-law: *id*, para 17.

69 For the last recent judgments: ECtHR, *M.T. v Sweden*, 1412/12, 26 February 2015, and ECtHR, *Tatar v Switzerland*, 65692/12, 14 April 2015, both related to mental health; ECtHR, *A.S. v Switzerland*, 39350/13, 30 June 2015, related to post-traumatic stress disorder.

70 Therefore, once the countries involved grant adequate and specific arrangements for the transferal, the ECtHR considered that the risk to be subjected to ill treatment contrary to Article 3 could not be said to be real anymore. See an example of this kind of reasoning involving the same person with mental health problem: ECtHR, *Aswat v United Kingdom*, 17299/12, 16 April 2013, compared to the following ECtHR, *Aswat v United Kingdom,* 62176/14, 6 January 2015.

71 ECJ, *M'Bodj v Belgium*, C-542/13, 18 December 2014.

the condition of vulnerability suffered by the people seeking protection. In sum, taking for granted the interpretation of the principle of *non-refoulement* given by the ECtHR, it did not investigate the possibility to develop EU-specific standards through Article 19 CFR, thus giving to the relevant Directive a wider scope through the prohibition of *refoulement*.[72]

IV.2. A Starting Point: The Recognition of Specific Needs Pending Expulsion

In light of this background, it is striking that both European Courts have recently reached a "common" interpretation of procedural rights to be granted under both systems to people living with HIV/AIDS facing expulsion. The *ratio* underling these developments is the specific kind of "irreversible" harm to which these people may be exposed, ie. the condition of vulnerability related to their specific health conditions and not to their status of irregular migrants trying to exploit European States' economic and social resources. As such, they can be viewed as a potential first step for the application of a rights-based approach to HIV/AIDS also to the interpretation of the prohibition of *non-refoulement* itself. Notwithstanding a common conclusion, it is worth noting that the ECJ went even further thanks to an autonomous application of the Charter.

In *S.J. v Belgium* (*S.J.*), after acknowledging that the lack of adequate medical care for people living with HIV/AIDS deprived of their liberty pending expulsion amounts to a degrading treatment,[73] the ECtHR has evaluated their condition under the standpoint of Article 13, read in combination with Article 3.[74] The application was submitted by a Nigerian asylum seeker who was diagnosed with HIV after arriving in Europe, where she gave birth to three children. Although she was hosted with her children by an association specialised in social and medical support to people living with HIV/AIDS and she was in need of continuous care, Belgian authorities refused to deliver a permit to stay on health grounds. Instead, they asked Malta to evaluate her asylum request in compliance with EU law. After being assured that all necessary medical treatment were available in that country as well as in Nigeria, and that her life was not a risk in case of transferal, Belgian authorities adopted an order of expulsion. Although the ECtHR reiterated that the applicant's situation did not amount to a critical stage and did not raise an issue from the standpoint of Article 3, it reckoned the specific condition of people living with HIV/AIDS affirming that 'the deprivation of medical treatment itself can lead even to their death'.[75] This is why, taking into account the *irreversible nature* of the harm to which

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72 The ECJ has already proven to be ready to interpret the relevant Directives in light of present day's conditions. Thus, a protection under EU law has been granted when persecution is based on sexual orientation irrespective of its inclusion in the Geneva Convention: see ECJ, *X., Y. and Z. v Minister voor Immigratie en Asiel,* joined cases C-199/12 to C-201/12, 7 November 2013. Although it is true that the UNHCR has not yet elaborated standards on HIV/AIDS status, the ECJ is not prevented to define higher standards through subsidiary protection. In fact, although this form was designed to complement the protection provided by the refugee Convention, its definition is not bound by that international Convention. As it was affirmed for the ECHR, we may notice that the refugee Convention 'does not constitute, as long as the EU has not acceded to it, a legal instrument which has been formally incorporated into EU law': *supra* nt 4, Fransson, para 44.

73 ECtHR, *Yoh-Ekale Mwanje v Belgium,* 10486/10, 20 December 2011.

74 ECtHR, *S.J. v Belgium, 70055/10,* 27 February 2014. Perhaps, it is the recognition of the condition of vulnerability of the applicant at the heart of the decision to reconsider the case before the Grand Chamber. Among others, Marguenaud, J P, "L'éloignement des étrangers maladies du sida: la Cour européenne des droits de l'homme sur «les sentiers de la glorie»", *Revue trimestrielle des droits de l'homme* (2014) 977.

75 *Id*, para 123.

they may be exposed as well as their condition of vulnerability, the ECHR required that the remedy for the review of the expulsion decision must have a suspensive effect on its execution.

Relying on this finding, also the ECJ gave an interpretation of EU law that goes well beyond the restrictive general approach adopted in *M'Bodj*.[76] Interestingly, the ruling involved a Nigerian national living with HIV/AIDS who also was denied a permit to stay on health grounds. This decision led, in turn, to an end of the free provision of social assistance and health care previously granted. In this context, the ECJ was asked if EU law requires Member States to ensure an effective remedy with suspensive effect, as well as the free provision of social assistance and health care until the appeal against expulsion is evaluated. In the EU Court's view, the need to protect the fundamental rights and individual dignity of people waiting expulsion is at the heart of the application of Directive 2008/115 on common standards and procedures in Member States for returning illegally staying third-country nationals. Although it is true that this Directive does not impose on Member States to put in place a remedy against expulsion with suspensive effects when there is a risk of sending a person to a country where he/she would be exposed to torture or inhuman and degrading treatment, such an effective remedy is required.

Hence, in line with the ECtHR, also for the ECJ it is the nature of the danger which is not excluded *a priori* that justifies a high standard of protection. As the Advocate General stated in his conclusions, the obligation to suspend the execution is paramount to grant a seriously ill person to have his primary needs taken into account. As a result, at least indirectly, it is recognised that part of the harm suffered by the applicant comes from the serious deterioration of his already precarious health condition that may be caused by the deprivation of social and medical support received in the hosting States. Going even further, the ECJ Member States have to provide not only urgent care, but also all basic needs when a person is not able to meet them because of his or her health conditions. In addition to the appropriate medical treatment, this obligation entails the provision of sufficient means to grant a decent and adequate standard of living for a person with specific health needs. Although national authorities enjoy discretion on how concretely they provide these means, they must respect the Charter.

In sum, when they focus on people as human beings with specific health needs, both courts are able to recognise that the enjoyment of fundamental rights cannot depend on their migratory status.[77] If the circumstances for exposing people living with HIV/AIDS to degrading treatment had not been so exceptional as it emerges from *N.* onwards, there would have been no need to provide such a level of protection. Instead, these developments are inspiring and are intended to reaffirm the absolute character of the prohibition of *refoulement*. Hence, this sets the stage for a further move consistently with a rights-based approach to HIV/AIDS.

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[76] ECJ, *Centre public d'action sociale d'Ottignies-Louvain-la-Neuve v Moussa Abdida*, C-562/13, 18 December 2014. See also the AG's Conclusions, 4 September 2014.

[77] These developments are therefore consistent with the previous "common" case-law where vulnerability played a central role: *M.S.S. v Belgium, supra* nt 62, especially para 251; ECJ, *N.S v Secretary of State for the Home Department*, C-411/10, 21 December 2011. Among others, Mink, J, "EU Asylum Law and Human Rights Protection: Revisiting the Principle of Torture and Other Forms of Ill-Treatment"14(2) *European Journal of Migration and Law* (2012) 119.

IV.3. Moving Forward

If also in this field a common approach seems under construction, the European Courts have defined the standards of protection through a different balancing of the interests at stake. At the same time, a division in treatment is emerging between the protection of people waiting for expulsion and those who are held 'apt' to be returned.

At least four points may be advanced for moving beyond the idea of minimum standards of protection, setting them more in line with the rest of the emerging common European approach to HIV/AIDS. Although both systems are equally concerned, a special attention should be given to EU law, which could play a wider role influencing, in turn, a more genuine interpretation of the ECHR.

a) Embedding Vulnerability

A first step for the application of a rights-based approach to HIV/AIDS calls for a clear distinction that takes into account the complex situation of HIV-positive people. It does not lead to the simplistic conclusion that every member of this group must not be returned to his or her country of origin or to a third State. Instead, it calls for a more composite evaluation that goes beyond the availability of medical treatment as the only relevant element.

After *Kiyutin*, the identification as a vulnerable group has made clear that the suffering experienced by people living with HIV/AIDS is not only related to their health status but also by the exposure to social stigma. Until today, the cases of return of members of these groups have not included any considerations on the existence of a general climate of discrimination in the receiving country. However, it is common for both European Courts to consider that certain groups are more exposed than others to serious violations of human rights in the country of destination. For instance, when evaluating the existence of a hostile environment in case of expulsion for the purpose of Article 3 ECHR, the ECtHR usually refers to all information at its disposal to verify whether the person is a member of a vulnerable group. In this case, a presumption of exposing him or her to prohibited treatment as a matter of principle is often raised.[78] As a consequence, the sending State is called to demonstrate that the risk is inexistent, providing either general and verified information on the complex situation suffered by the involved group in the country of destination and specific assurances on the situation of the applicant.[79]

In other words, in the same way that stereotypes are refused as justification, general assumptions cannot be deemed sufficient to deny the existence of a risk of exposure to degrading and inhuman treatment when the condition of vulnerability is embedded in the evaluation. For example, as for the fear of imposing an excessive burden to contracting States, the economic consequences and the excessive demand on the publicly funded health-care system should be clearly demonstrated, considering also the kind of national health-care scheme as the ECtHR pointed out in *Kiyutin*.[80] Interestingly, in light of CoE's

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78 For the most recent case laws, see ECtHR, *A.A. v France* and *A.F. v France*; *Id*, *Khamrakulov v Russia*; *Id*, ECtHR, *Mukhitdinov v Russia,* 20999/14, 21 May 2015. See also ECtHR, *Soering v UK*, 14038/88, 7 July 1989.

79 For instance, although it does not involve a person living with HIV/AIDS, it is worth noting the partial dissenting opinion in *Tatar*, *supra* nt 69, where Judge Lemmens applied a vulnerability approach to the situation of a severely mental ill person finding 'incumbent', in case of expulsion, the reception of assurances from receiving authorities on the 'special protection' required by his condition. Interestingly, also in *S.J*, *supra* nt 75, in his concurring opinion the same Judge invited the Belgian authorities to 'use their discretionary power' to give 'the due weight' to humanitarian aspects of the case.

80 ECtHR, *Kiyutin*, *supra* nt 16, para 70.

rejection of the myth of health tourism as unfounded, the idea of wasting resources should be analysed to ensure that this fear is not motivated by prejudices, like the need to remove a 'danger' from the community.[81]

Hence, also in relation to the prohibition of *refoulement* a rights-based approach requires an individualised evaluation. Clearly, this analysis has not prearranged conclusions or solutions but may be influenced by the level reached by the infection as well as by the specific needs in terms of social support. Moreover, it must include a consideration of the background of the person living with HIV/AIDS and whether, simultaneously, he/she belongs to an already vulnerable group, such as asylum seekers.

In sum, the focus on vulnerability seems to fill the gap that emerged in *N.* where, following an ambiguous identification of the harm, no clear criteria were defined for evaluating the risk at stake resulting in a wide discretion for European States.[82] Consequently, it calls for a different qualification of prohibited treatment for the purpose of the principle of *refoulement*.

b) Redefining the Treatment

From the previous analysis, it seems that the ECtHR reviewed its initial interpretation of what is inhuman and degrading treatment when a person living with HIV/AIDS is involved for considerations that are more connected with its legitimacy *vis-à-vis* contracting States than with the harm itself. That Court is worried to impose 'a too great burden' on them, thus acknowledging that the treatment *per se* raises an issue under Article 3 ECHR. However, due to the absolute nature of the prohibition of torture, the ECtHRs approach has always been characterised by pushing the threshold of severity in light of present-day conditions and of the greater firmness in assessing breaches of the fundamental values of democratic societies.[83] Moreover, the qualification of the harm has always depended on the specific circumstances of the person concerned, such as sex, age or health conditions. As a consequence, the question is how the expulsion impacts on the person *in light of* her or his health conditions and of *present-day* standards in human rights protection.

Taking into account their special needs, the *deprivation* of what is necessary for a person's integrity caused by expulsion is at the heart of the violation of the prohibition of torture when people living with HIV/AIDS are involved.[84] Both asylum seekers and detainees have thus been protected by this part of the Convention *without* any consideration of budgetary constraints or the availability of a family/social network that could alleviate the suffering provoked by national authorities. Instead, the ECtHR was firm in recalling that, as a general principle of international law, contracting States cannot rely on the lack of economic resources to justify the violation of their human rights obligations.[85]

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81 See the dissenting opinion of Judge De Albuquerque in *S.J.* (dec.), *supra* nt 75, where he refers to 'undesirable illness': '*ils deviennent alors des parias dont les gouvernments s'emploient à se débarrasser au plus vite*', para 12.

82 Webster, *supra* nt 64, 45. According to this author, the lack of clear criteria derives from the ambiguity of the ECtHR's reasoning in *D.* However, as explained above, the Grand Chamber in *N.* seemed aimed by the desire to restrict *D.* consequences providing in that occasion its own reading of the previous case. Therefore, the absence of 'a clear and transparent is the outcome of a deliberate interpretative strategy.

83 See ECtHR, *Selmouni v France*, 25803/94, 28 July1999, para 101.

84 In this regard, the dissenting opinion in *S.J.*, *supra* nt 74, of Judge Power Ford is worth noting: '*Le fait crucial qui déterminera si elle vivra ou mourra est l'exécution de la décision d'expulsion prise par l'État*'. Interestingly, the Judge applies a vulnerability approach taking into account the applicant's condition.

85 Among others, ECtHR, *Tchokontio Happi v France*, 65829/12, 9 April 2015, para 50.

As already stated in *D.*, expulsion may exacerbate physical and mental pain deriving from illness. Being a starting point of a redefinition of the treatment from a rights approach to HIV/AIDS, this consideration focuses on the condition of the person as having special needs and looks at the expulsion as being in itself a form of deprivation for which contracting States are directly responsible. As a consequence, *only* clear and specific information from the authorities of the receiving country about the availability of medical and social support during the transferal and *in loco* are useful to eliminate the risk of exposure to degrading or inhuman treatment.[86] Clearly, the level of pain required seems nonetheless proportional to the stage reached by the infection. As such, expulsion *as* deprivation applies – certainly, although not exclusively – in those situations where a critical stage of AIDS has been reached. In some very serious cases, even the availability of clear and specific assurance cannot be enough to eliminate a potential violation of the principle of *non-refoulement*.

When the expulsion does not exacerbate the suffering to a level amounting in itself to a violation of the prohibition of inhuman or degrading treatment, a more composite exam is required by a rights approach to HIV/AIDS. In this case, the aim becomes reconciling the right of the State to control immigration with the respect of the absolute nature of the prohibition of torture. In this evaluation, the environment where the person with specific health and social needs is expected to return must be a central issue. In fact, in light of the special development of the infection, a complex environment is needed to avoid significant harm and it can be dependent on the societal acceptance of people living with HIV/AIDS.[87] To use the words of the Grand Chamber in *N.*, the 'exceptional circumstances' cannot arise from the forthcoming (and certain) death but from a situation of widespread discrimination that may prevent the person to access medical treatment and social care and, more importantly, to what is essential for satisfying his/her basic needs.[88] As a result, the care provided by contracting States is not the recognition of economic or social rights to aliens but the essential *means* for reaffirming a legitimate aim: the absolute prohibition of *refoulement*.

Again, the ECtHR's case law has already investigated appropriate solutions. For instance, in *Aswat* the Court considered that the deterioration in mental and physical health caused by the extradition would have reached Article 3's threshold because in the country of destination he would have been placed in a 'different and more hostile' environment, although some medical treatment was available. Interestingly, the Court examined the case requiring *certainty* as to the conditions of destination. Provided that this deterioration could not be alleviated 'by the demonstration of' supporting family and

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86 The ECtHR has already accepted this solution in a case involving a terrorist, suffering of serious mental problems, who had to be extradited to the USA for being tried: ECtHR, *Aswat v UK*, *supra* nt 70, para 57. See the following decision, issued on 6 January 2015, which excludes the risk of violation of Article 3 ECHR *after* having received very specific information on the special treatment to be granted by the US Government.

87 Interestingly, faced with the issue at stake, the Inter-American Commission on Human Rights paid due attention to this aspect: 'conditions for people with HIV in Jamaica have improved since 2002, but the country's health care system is still insufficient to meet Ms. Mortlock's medical needs. Moreover of greater concerning, are the reports that people with HIV/AIDS in Jamaica suffer from stigma and discrimination', concluding that sending the applicant back 'would constitute a de facto sentence to protracted suffering and unnecessarily premature death' in contrast with 'a civilized State'. See Inter-American Commission on Human Rights, *Andrea Mortlock v USA*, *affaire* 12.534, 25 July 2008, paras 91, 94-95.

88 The UNHCR has recognised that, in some countries, violence and discrimination may be based on a person's HIV-positive status: UNHCR, *Guidelines no. 9: Refugee Claims Relating to Sexual Orientation and Gender Identity*, 23 October 2012, HCR/GIP/12/09, para 3. As reported by dissenting Judge De Albuquerque in *S.J.* (dec.), *supra* nt 82, it is not surprising that Ms. N. died right after her transferal in Uganda.

friends, the ECtHR deemed appropriate for the applicant to remain in the host European State 'for his own health and safety'.[89] At the same time, when a hostile environment exists against a specific group, the ECtHR has already held that, in some circumstances, the risk may stem from the receiving "society" as a whole[90] while, in others, discrimination may be so serious as to constitute in itself degrading treatment.[91] This may be the case when discriminatory treatment causes prolonged deplorable living conditions, humiliation and debasement[92] and, irrespective of the availability of economic resources, the country of destination's authorities does not try to prevent them.[93]

c) Weighing Other Rights

As pointed out, a rights approach to HIV/AIDS calls for a holistic perspective that puts the consequences of the return of the person concerned even beyond the prohibition of *refoulement* itself. This aspect is particularly important because, as shown, an evaluation which entails vulnerability as a specific element can lead also to the conclusion that the expulsion does not cause degrading or inhuman treatment. However, this does not mean that the person concerned will not be affected in the enjoyment of other human rights. In this regard, the specific situation of people living with HIV/AIDS is also covered by the right to respect for private life, taking into account the interpretation given to Article 8 ECHR.

On more than one occasion, the ECtHR held that a measure may breach Article 8 in its private component where it has sufficiently adverse effects on the physical and moral integrity of the person concerned.[94] As the protection afforded by this provision is wider than that provided by Article 3 ECHR, the level of adverse effects does not have to reach the same minimum sufferance. Even more radically, it was affirmed that the preservation of moral – as well as physical – stability is a precondition for the effective enjoyment of that right.[95] Moreover, considering other facets of the right to respect for private life, Article 8 has been interpreted as protecting the right to establish and develop relationships with other human beings and the outside world and also as embracing an individual's social identity.[96] Considering the situation of a person that has lived in the hosting country for a sufficient period of time before been subject to expulsion, the totality of his/her social ties and the community where he/she has lived is also covered by Article 8 ECHR.

Put in these terms, it is undisputed that the harm generated by an expulsion has adverse effects on a person living with HIV/AIDS, irrespective of the time she/he has spent in the country. In light of his/her condition of vulnerability and the further damage to the health, the person's moral and physical integrity can be substantially affected to a degree as to constitute an issue under Article 8 ECHR, as well as under Article 7 CFR if read in the same terms. Moreover, when a person living with HIV/AIDS is involved, the availability of medical treatment in the host State is often accompanied by social support. Since the situation may be further aggravated in the country of destination by a climate of

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89 ECtHR, *Aswat v UK*, *supra* nt 70, para 56. See also the dissenting opinion of Judges Tulkens, Bonello and Spielmann in *N.*, *supra* nt 67, paras 5-8.

90 ECtHR, *N. v Sweden*, 23505/09, 20 July 2010, para 62.

91 European Commission of Human Rights, *East African Asians v UK,* 3 EHRR 76, 14 December 1970.

92 ECtHR, *Moldovan and Others v Romania (2)*, 4113/98 and 64320/01, 30 November 2005, paras 110-111.

93 All these considerations may have played a role for stopping the expulsion of Ms. S.J. before her case could be ruled by the Grand Chamber: see, ECtHR, Grand Chamber, *S.J. v. Belgium* (dec.), *supra* nt 81.

94 ECtHR, *Costello-Roberts v UK*, 13134/87, 25 March 1993, para 36.

95 ECtHR, *Bensaid v UK*, 44599/98, 6 February 2001, para 61.

96 ECtHR, *Khan v Germany*, 38030/12, 23 April 2015, para 37.

widespread discrimination, the compliance of a measure under the ECHR and the CFR should also be assessed in light of the consequences of the return to a State without a functioning social network.[97]

As a result, it seems that an expulsion of a person living with HIV/AIDS must be evaluated as an interference in the enjoyment of the right to respect for private life,[98] which requires an appropriate justification, instead of from the standpoint of positive obligations under the same provisions.

Taking into account the conditions provided by Article 8 ECHR, two points should be carefully assessed through a case by case analysis. First, the legitimacy of the aim pursued cannot be given as granted. The protection of the rights and freedoms of others or the protection of the health or morals should not play any role if we do not accept, from an anti-stereotyping perspective, that their presence creates damage in regard to them. Nor does the wellbeing of the country seem appropriate to be advanced considering the minor level of economic burden requested. Therefore, only national security, public safety or the prevention of disorder or crime may come into play if sufficient elements, especially relating to the irregular presence in the territory, are demonstrated. In such a scenario, the necessity in a democratic society of the expulsion becomes the second essential point of the analysis to be undertaken. It is acknowledged that contracting States enjoy a margin of appreciation in balancing the rights of the community with the rights of the individual. If the more compelling interest of the community is certainly the right of the State to control its boundaries, only an evaluation that includes the specific situation suffered by a person living with HIV/AIDS may grant that his or her expulsion does not deprive the right to respect of private life of its essential meaning and effect. Again, the *hypothetical* availability of medical treatment or family support exposes European judges to the same level of speculation that is often reproached to applicants and cannot be part of a thoughtful evaluation.[99]

d) The Role of the EU Charter

As shown above, in the interpretation of the principle of *non-refoulement* protected by Article 19.2 CFR, the ECJ decided to follow the ECtHR's ambiguous indications emerged in HIV/AIDS-related cases. Thus, it followed Article 53.2 CFR which grants the Charter's provisions the same meaning and scope of the corresponding rights enshrined in the ECHR. In other words, the ECJ deemed to be satisfied with a minimum level of protection derived by the interpretation given to Article 3 ECHR *without* questioning the *rationale* underling the ECtHR's case law. Referring generally to expulsions of seriously ill people, in *M'Bodj* the EU Court seems to have limited even further the entire issue to the consideration of the availability of medical care in the country of destination.[100] As a result, the ECJ did not take advantage of the second part of the same Article 53.2 CFR that admits the possibility for Union law to provide a more

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97 ECtHR, *Emre v Switzerland*, 5056/10, 22 May 2008, para 83.

98 See ECtHR, *S.J.*, *supra* nt 75, para 145, where the evaluation in these terms of the Court was dependent on the alleged violation of the right for respect for family life.

99 For example, in *Yoh-Ekale Mwanje*, *supra* nt 74, the ECtHR found that the necessary treatment was available in Cameroun only for 2% of the people in need. Nonetheless, it concluded that expulsion could not expose the applicant to degrading or inhuman treatment. No evaluation from the standpoint of Article 8 was laid out.

100 ECJ, *M'Bodj*, *supra* nt 71, point 39. By contrast, no references were made to the conditions of transferal which in the ECtHR's case law have a significant role.

extensive protection than the one guaranteed by the minimum standards defined by the ECtHR.[101]

However, if we consider *Léger* and *Abdida*, the ECJ moved from a different perspective focused on the vulnerability of involved groups, thus granting an inclusive protection. The reason cannot be reduced to the inexistence of previous judgments in the ECtHR's case law on the same issue. Instead, in *Léger* it was the need to respect the Charter at the heart of the application of the prohibition of discriminatory treatment against a group most exposed to prejudice and social stigma. In the same way, in *Abdida* it was the precarious condition of people waiting for expulsion that set the starting point for the interpretation of EU law. In this case, in line with the Charter the ECJ went beyond the protection already granted by the ECHR because, as analysed above, it read EU law as imposing the obligation to satisfy all needs of a person living with HIV/AIDS where he or she lacks the means to make such provision for him or herself.

More importantly, *Abdida* seems to suggest three points. First, in contrast with *M'Bodj*, EU judges did focus on the effect of the expulsion that may exacerbate the health conditions of the person concerned *independently* of the availability of medical treatment in the country of destination. Second, it did not consider economic consequences or the fear of imposing an excessive burden on EU Member States. Instead, the provision of the means for an adequate standard of living to all people in the same situation of Mr. Abdida is only instrumental to achieve the primary aim of protecting their fundamental rights.[102] Interestingly, although the Charter includes also social rights, it is no coincidence that solely the provision related to the principle of *non-refoulement* was recalled. Third, in light of the interpretation given in *Abdida*, the ECJ seems aware of the need to provide specific response to people living with HIV/AIDS. The acknowledgement that a person in the condition of Mr. Abdida cannot be able to satisfy his basic needs is, at least implicitly, a recognition that the deprivation of the means imposed to Member States by EU law can amount to a degrading treatment prohibited by Article 4 CFR.

Provided that the Charter applies in this field, from these premises the ECJ can provide its own interpretation of Article 19.2 CFR when people living with HIV/AIDS are involved. Considering the aim of this provision, it has already made clear in *M'Bodj* that, in defining the risk for the purpose of the principle of *non-refoulement*, the role of receiving authorities cannot be the same as the one required for the recognition of refugee status or other forms or international protection. If read in light of Articles 1 to 4 of the Charter, the ECJ can define other specific criteria for the application of the principle of *non-refoulement*, thus granting a uniform level of protection in EU Member States. Since an interpretation in line with a human rights approach to HIV/AIDS does not call necessarily for an obligation to grant a permit to stay on humanitarian grounds, the ECJ

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101 See ECJ, *McB.*, C-400/10 PPU, 5 October 2010, point 53; *Id*, *Melloni*, C-399/11, 26 February 2013; *Id*, *Åkerberg on*, *supra* nt 4, on which see Hancox, E, "The meaning of "implementing" EU law under Article 51(1) of the Charter: Åkerberg Fransson", *Common Market Law Review* (2013), 1429. See also, den Heijer, M, "*N.S.*", *Common Market Law Review* (2012), 1749 who, considering the ECJ's decision in *N.S.* in light of the ECtHR's *M.S.S.*, highlights how the EU Court is reticent in giving Article 19.2 an autonomous scope.

102 The ECtHR took a similar approach in *Airey v Ireland*, 6289/73, 9 October 1979, para 26: 'the Convention must be interpreted in the light of present-day conditions and it is designed to safeguard the individual in a real and practical way as regards those areas with which it deals. Whilst the Convention sets forth what are essentially civil and political rights, many of them have implications of a social or economic nature. […] the mere fact that an interpretation of the Convention may extend into the sphere of social and economic rights should not be a decisive factor against such an interpretation; there is no water-tight division separating that sphere from the field covered by the Convention'.

may leave it to Member States to decide the forms through which Article 19.2 CFR is respected when a person living with HIV/AIDS cannot be returned to his/her country.[103] In doing so, not only the ECJ would operate within the 'constitutional framework' set for the interpretation and the application of fundamental rights in the EU,[104] but would also (at least indirectly) realise what Article 35 CFR imposes to the Union. As immigration and asylum are EU policies, this part of the Charter obliges Union's institutions to guarantee a high level of protection of human health. As already pointed out, this provision has not been placed under the head of citizenship because its primary aim is to recognise the right to access and benefit from medical treatment to 'everyone'.

In other words, the adoption of a rights-based approach to HIV/AIDS calls the ECJ to question the indications elaborated by the ECtHR instead of simply following them, especially when they are not in line with its well-established case-law on the necessity for individual evaluation in expulsion decisions. If the ECJ will be able to develop substantial standards before the ECtHR will review its own,[105] not only would it give consistency to the emerging European common approach to HIV/AIDS but would also set a significant development in the relationship between the ECHR and the Charter.

V. (Why) A European Approach?

Considering the change in the effects of the infection, HIV/AIDS has moved from a "security threat" to a human rights issue. European institutions, including the ECtHR and the ECJ, have mostly adopted an anti-stereotyping approach that intends to overcome the condition of vulnerability of people living with HIV/AIDS through also the elaboration of positive obligations. As a result, they seem to fill the existing gap in international human rights law due to the lack of any binding holistic instrument specifically aimed to protect the 'new' needs of HIVpositive people.

As explored, new positive developments may be expected in both European systems of protection. Indeed, after setting the stage for an inclusive interpretation of ECHR and EU law, the issue is now to identify *which* European approach adheres better to the human rights *rationale*. If the prohibition of discrimination has worked within the ECHR as a 'Trojan horse' to include HIV/AIDS-related needs, and the same may apply to EU law directly and indirectly through the protection of disability, the interpretation of the prohibition of *refoulement* is still problematic in this field. The focus of the European Courts on the migratory status instead of the health conditions of those people living with HIV/AIDS to be expelled has generated different levels of protection. While procedural rights were granted in light of the primary aim of respecting fundamental rights and of addressing the condition of vulnerability, from a substantial point of view the definition of prohibited treatment remains unclear. Relying on the interpretation provided by the

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103 See, eg. the recent case of: ECJ, *H.T. v Land Baden-Württemberg*, C 373/13, 24 June 2015.

104 ECJ, *Opinion no. 2/2013*, 18 December 2014, points 155-176.

105 For instance, although it is not obliged to follow ECtHR's case law, it is common for the Inter-American Commission of Human Rights to refer to the ECtHR. However, when it was called to evaluate the issue of expulsion of a person living with AIDS, it went beyond ECtHR's indication stating that:

> While Ms. Mortlock's case is not one dealing with the dignity of death, it would be illogical to confine the scope of relief to such cases. […] due to the recent medical advancements, HIV/AIDS can be effectively and indefinitely treated by the administration of antiretroviral drugs and, therefore, in most cases while the treatment is being delivered the patient will be found in good health. However, stopping the treatment would lead to a revival of the symptoms and an earlier death. Therefore […] the effects of terminating the antiretroviral treatment may well be fatal.

See Inter-American Commission on Human Rights, *Andrea Mortlock*, *supra* nt 88, para 90.

ECtHR to Article 3 ECHR, the ECJ failed to give its own interpretation to the relevant CFR's provisions and to influence, in turn, the development of higher standards of protection within the ECHR system itself.

Hence, while the European Courts have been able to incorporate the principles promoted through soft law instruments into the interpretation of the European human rights catalogue, they are now called on to take those additional steps that can grant consistency to what is emerging as a genuine common European approach to HIV/AIDS.

Fostering a human rights approach based on vulnerability may pave the way for such developments. It requires to re-focus the attention on the person in need of protection within the social context to which he or she belongs and suggests a method rather than pre-arranged solutions. It 1. addresses the issue from an holistic perspective, irrespective of the right at stake; 2. requests special treatment, unmasking prejudice and fighting stigma; and 3. demands for an individual evaluation, that looks also at the intersection with the rights of those people usually identified as most exposed to infection.

If successful, the European efforts may, in turn, be the grounds for a change in the worldwide response to the human rights issues raised by the spread of the virus.

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The Principle of Non-discrimination: An Empty Promise for the Preventive Health Care of Asylum Seekers and Undocumented Migrants?

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Keywords
PREVENTIVE HEALTH CARE; ASYLUM SEEKER; UNDOCUMENTED MIGRANT; RIGHT TO HEALTH; GENERAL COMMENT 14; NON-DISCRIMINATION; GENERAL COMMENT 20

Abstract
The principle of non-discrimination in Article 2 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) holds that its rights are equally applicable to 'everyone'. Nevertheless, evidence from the national context suggests that access to health care for asylum seekers and undocumented migrants depends on their legal status and in particular, preventive health care is often inaccessible to them.[1] This has led to several hitherto under-investigated questions concerning the right to health in this context: Does a right to preventive health care exist at the international level? If so, what individual rights and State obligations are involved in this right? How does the principle of non-discrimination relate to this right? Does this principle offer (additional) protection to asylum seekers and undocumented migrants in terms of a possible right to preventive health care? *Method:* The main issue is what the principle of non-discrimination has to offer for the preventive health care of persons without a regular residence status. Based on an analysis of the non-binding, but authoritative, General Comments of the United Nations (UN) Committee on Economic, Social and Cultural Rights (CESCR), the paper takes an exploratory style that goes beyond traditional legal analysis and investigates how the law should be interpreted in order to enhance its effectiveness and relevance. *Results and Discussion:* Strictly speaking, there is no explicit, binding right to preventive health care for asylum seekers or undocumented migrants in the ICESCR itself.[2] Nevertheless, implications can be found in the CESCR General Comments Number 14 and 20.[3] Particularly, if one takes into account how the law should be interpreted according to CESCR General Comment 14 (CESCR GC 14), there should be a right to preventive health care for asylum seekers and undocumented

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1 See, for instance, Centre on Migration Policy and Society (COMPAS), Spencer, S, and Hughes, V, REPORT: *Outside and In: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe*, University of Oxford, July 2015, *at* <compas.ox.ac.uk/research/welfare/service-provision-to-irregular-migrants-in-europe/> (accessed 1 October 2015).

2 UN General Assembly, *International Covenant on Economic, Social and Cultural Rights* (1966) 993 UNTS 3 (ICESCR).

3 Committee on Economic Social and Cultural Rights (CESCR), *General Comment 14: The Right to the Highest Attainable Standard of Health*, UN Document E/C.12/2000/4, 11 August 2000 (GC 14); and CESCR, *General Comment 20: Non-Discrimination in Economic, Social and Cultural Rights*, UN Document E/C.12/GC/20, 2 July 2009 (GC 20).

migrants. The exact content of such a right, however, is less clearly defined. Further, the principle of non-discrimination is not conclusive as to whether the right to health would apply equally to asylum seekers and/or undocumented migrants as it would to nationals. *Conclusion:* For non-discrimination to be truly unambiguous with regard to the preventive health care of asylum seekers and undocumented migrants, it would be necessary to strike out the 'general welfare' provision of CESCR General Comment 20 (CESCR GC 20) and to clearly state that the 'other status' criterion also entails 'residence status'. In that sense, the principle of non-discrimination is, indeed, an empty promise and the right to preventive health care for asylum seekers and undocumented migrants seems to be much better protected under the CESCR GC 14's non-discriminatory interpretation of the right to health itself.

I. Introduction

Differences in access to health care are especially discomforting when it comes to persons in situations of vulnerability. This is also the case with regard to individuals who have had to leave their home country involuntarily (asylum seekers) or who find themselves in an irregular situation (undocumented migrants).[4] It is apparent that a substantial amount of internationally relocated persons are asylum seekers or individuals without a residence status. In 2014, 1.7 million asylum seekers were recorded worldwide.[5] Numbers on undocumented persons are a lot harder to acquire due to the very nature of their undocumented status. Estimates on undocumented persons worldwide figure around 10-15% of the 214 million international migrants (2010).[6] Asylum seekers are not residing in the host country irregularly for the duration of their asylum procedure and are entitled to more explicit rights during their stay.[7] On the contrary, the residence status and rights of undocumented persons are much less clearly defined, which usually leaves them in a more precarious situation.[8]

Being located outside of their country of origin makes asylum seekers and undocumented migrants particularly vulnerable to harm.[9] This can be due to the

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4 For the purpose of this paper, 'leaving their home country involuntarily' is considered to refer to persons applying for asylum on the grounds of Article 1(A)2 of the Convention Relating to the Status of Refugees or applying for subsidiary protection in accordance with the (regionally) applicable subsidiary protection regime. Persons in an irregular situation or 'undocumented migrants', refers to individuals outside their country of nationality who are not in transit but reside in another country without a legally valid residence permit. People can have become irregular for various reasons such as having entered the country illegally, being born in the country to undocumented parents, having overstayed a visa, being a rejected asylum seeker or having lost a previous regular or asylum residence permit.

5 UN High Commissioner for Refugees (UNHCR), REPORT: *UNHCR Global Trends: Forced Displacement in 2014*, 18 June 2015, *at* <unhcr.org/556725e69.html> (accessed 1 October 2015), 3.

6 International Organization for Migration (IOM), *World Migration Report 2010*, 2010, *at* <publications.iom.int/bookstore/free/WMR_2010_ENGLISH.pdf> (accessed 1 October 2015), 29.

7 Regional examples include the EU Reception Conditions Directive, which lays down the rights of asylum seekers while their asylum request is pending. Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 lays down standards for the reception of applicants for international protection, OJ L180/96.

8 See, for instance, Biswas, D, Toebes, B and Hjern, A *et al.*, "Access to Health Care for Undocumented Migrants from a Health Perspective: A Comparative Study of Denmark, Sweden, and the Netherlands" 14(2) *Health and Human Rights* (2012) 49.

9 See, for instance, Pitkin Derose, K, Escarce, J, and Lurie, N, "Immigrants And Health Care: Sources of Vulnerability" 26(5) *Health Affairs* (2007) 1258-.

experiences in their home country, during the flight or upon arrival in the host country.[10] According to Suurmond, asylum seekers have 'unique and complex health needs' of which 'inadequate vaccinations, nutritional deficiencies and infectious diseases' are only a few examples.[11] Additional problems may arise due to 'physical and mental health problems, language and cultural barriers, unfamiliarity with the healthcare system and limited health literacy'.[12] Dang points out that asylum-seeking children in particular face 'an increased risk for many infectious diseases' due to traumatic experiences, malnutrition and inadequate previous health care.[13] Although the situation of undocumented migrants is much harder to assess due to their irregular status, it can be assumed that most of the above assertions regarding health care hold equally true for them as they often find themselves in an even more difficult situation than asylum seekers.[14]

Considering that the preamble of the Universal Declaration of Human Rights (UDHR) refers to the 'equal and inalienable rights of all members of the human family', one would assume that the rights of all persons are equally protected by international human rights law.[15] Similarly, the non-discrimination clauses built into most international human rights treaties, combined with the extra non-discrimination clauses included in some substantive rights, suggest extra protection to those most susceptible to discrimination and unequal treatment.[16] However, examples from the national context in the field of health care sketch a less positive picture.[17]

Not only is limited or inadequate health care a problem in itself, but the limiting of health services may also restrict the possibility to enjoy other rights. CESCR GC 14 on the right to health recognizes that '[h]ealth is a fundamental human right indispensable for the exercise of other human rights'.[18] Yet, many countries only provide emergency care to 'non-citizens'.[19] Other aspects of primary care, especially preventive care, receive much less attention.[20] Even in countries with universal healthcare coverage, asylum

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10 Zwi, K and Mares, S, "Commentary: Reducing further Harm to Asylum-seeking Children. The Global Human Rights Context" 43(1) *International Journal of Epidemiology* (2013), 105.

11 Suurmond, J, Rupp, I and Seeleman, C *et al*., "The first contacts between healthcare providers and newly-arrived asylum seekers: a qualitative study about which issues need to be addressed" 127(7) *Public Health* (2013), 668.

12 *Id,* 668-669.

13 Dang, K and Tribble, A, "Strategies in Infectious Disease Prevention and Management Among US-Bound Refugee Children" 44(7) *Current Problems in Pediatric and Adolescent Health Care* (2014), 196.

14 See, for instance, the recent discussion in the Netherlands about whether undocumented migrants should enjoy basic rights. The discussion was sparked by the European Committee of Social Rights' (ECSR) decision in *Conference of European Churches (CEC) v the Netherlands* Complaint No. 90/2013, 10 November 2014.

15 Preamble, UN General Assembly, *Universal Declaration of Human Rights* (1948) 217 A (III) (UDHR).

16 In addition to Article 2 ICESCR, a separate non-discrimination article can be found in Article 1, UN General Assembly, *International Convention on the Elimination of All Forms of Racial Discrimination* (1965) 660 UNTS 195 (CERD); Article 2, UN General Assembly, *International Covenant on Civil and Political Rights* (1966) 999 UNTS 171 (ICCPR); Article 1, UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women* (1979) 1249 UNTS 13 (CEDAW); Article 2, UN General Assembly, *Convention on the Rights of the Child* (1989) 1577 UNTS 3 (CRC); Article 1, UN General Assembly, *International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families* (1990) 2220 UNTS 3; UN General Assembly, *Convention on the Rights of Persons with Disabilities* (2006) 2515 UNTS 3.

17 Spencer and Hughes, *supra* nt 1.

18 CESCR GC 14, *supra* nt 3, para 1.

19 UN Office of the High Commissioner for Human Rights (OHCHR), *Fact Sheet No. 31: The Right to Health,* June 2008, at <http://www.refworld.org/docid/48625a742.html> (accessed 13 August 2015), 19.

20 Compare Spencer and Hughes, *supra* nt 1. See also De Nationale Ombudsman, van der Bijl, N *et al*., REPORT: *Medische Zorg voor Vreemdelingen – Over toegang en continuiteit van medische zorg voor*

seekers and undocumented migrants receive less preventive health care than nationals.[21] In addition, even if States allow for broader access to health care for non-nationals, many practical barriers remain.[22] This is especially problematic as the abovementioned additional health risks and needs of asylum seekers and undocumented migrants would suggest the necessity of increased, rather than limited, care compared to nationals.

Rose *et al.* argue that '[t]he primary determinants of disease are mainly economic and social' which implies that asylum seekers and undocumented migrants, who usually find themselves in a weak social and economic position, are more likely to become ill.[23] In order to avoid this, Rose *et al.* claim that social and economic measures must be taken, of which preventive measures should constitute an essential component.[24] However, preventive health care is often neglected and not considered as an aspect of health care requiring separate attention. Discussing preventive health care as a separate issue and not only in the trinity of preventive, curative and palliative health care, is innovative and extremely necessary to increase its visibility and highlight its relevance. It goes beyond the scope of this analysis to discuss the medical necessities, usefulness and content of preventive health care in more detail. Rather, this normative study investigates what the right to preventive health care should look like according to CESCR GC 14 on the right to health and whether this should also be applicable to asylum seekers and undocumented migrants in accordance with CESCR GC 20 on the principle of non-discrimination.

The present analysis does not provide an all-encompassing view of the legal situation and does not focus on the content of the principle of non-discrimination or of the right to health in more general terms, which has been discussed extensively elsewhere.[25] Rather, the study refers to preventive health care and non-discrimination in the context of asylum seekers and undocumented migrants to provide a starting point for further discussion on the existence, content and effectiveness of these concepts. This approach is chosen in order to contribute to the visibility of these concepts and to ensure increased clarity on State obligations and individual rights in this regard. Eventually, this might lead to a better application and realisation of the right to health for asylum seekers, undocumented migrants and all other persons in a vulnerable situation.[26]

To enhance the clarity of this study and promote the focus on widely recognised and authoritative international documents, the analysis refrains from reference to regional or national legal documents and international human rights treaties other than the ICESCR.

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asielzoekers en uitgeprocedeerde asielzoekers, Report Number 2013/125, 3 October 2013, *at* <nationaleombudsman.nl/uploads/2013-125_rapport_medische_zorg_vreemdelingen_webversie_0.pdf> (accessed 1 October 2015).

21 Martin, Y, Collet, T and Bodenmann, P *et al*., "The Lower Quality of Preventive Care among Forced Migrants in a Country with Universal Healthcare Coverage" 59 *Preventive Medicine* (2014), 19.

22 Such barriers can potentially be identified at the 'patient level', the 'provider level' and the 'system level'. Scheppers, E, van Dongen, E and Dekker, J *et al*., "Potential Barriers to the Use of Health Services among Ethnic Minorities: a Review" 23(3) *Family Practice* (2006) 325.

23 Rose, G, Khaw, K and Marmot, M, Rose's Strategy of Preventive Medicine (2nd ed, Oxford University Press, New York, 2008), 162.

24 *Ibid.*

25 See, for instance, on the right to health Toebes, B, *The Right to Health as a Human Right in International Law* (Intersentia, Antwerp, 1999) and on the principle of non-discrimination Vandenhole, W, *Non-discrimination and Equality in the View of the UN Human Rights Treaty Bodies* (Intersentia, Antwerp, 2005).

26 The paper uses the term 'right to health' as an abbreviation for the 'right to the highest attainable standard of physical and mental health' as mentioned in Article 12 ICESCR. While it is apparent that the right entails much more than only a right to health care, the present study neglects these other aspects in order to highlight the importance of the right to preventive care.

Through outlining the ICESCR's legal framework with regard to preventive health care, this paper nevertheless tries to provide a starting point for further discussion on regional and national policies, practices of preventive health care in general, and, particularly, asylum seekers and undocumented migrants.

Against this background, the research investigates the following two questions: What individual rights and State obligations are involved in the right to preventive health care? Does the principle of non-discrimination offer (additional) protection to asylum seekers and undocumented migrants in terms of the right to preventive health care?

II. Method

This normative study is innovative in that it takes a forward-looking human rights-based approach that calls for a full implementation of the right to health beyond any State interest limitations. The general method of interpretation used for the documents under investigation is the doctrinal legal method, which attempts to systematise and generalise the law in order to find inconsistencies and gaps in the existing framework.[27] Based on this, the article takes an exploratory style that goes beyond traditional legal analysis and investigates how the law should be formulated and interpreted based on the soft law of the CESCR General Comments in order to enhance its effectiveness and relevance. The goal of this analysis is to highlight some of the identified inconsistencies and possibilities but the study does not have the ambition to be all-encompassing in that respect.

The principle of non-discrimination was identified as a potentially valuable concept for clarifying individual rights and State obligations for the preventive health care of asylum seekers and undocumented migrants. This is due to the fact that it commonly suggests equality of treatment and could therefore provide insights on the legality of differential treatment of these persons compared to nationals. Consequently, the desk research conducted in July 2015 embarked upon the identification of the relevant binding and non-binding documents on the right to health and non-discrimination at the international level. This was accomplished through a review of academic literature related to the search terms 'preventive health care', 'health + migration', 'health + undocumented migrants', 'health + asylum seekers', and 'the right to health'. In addition, the websites of relevant international institutions and organizations, namely the CESCR, the UN Committee on the Rights of the Child (UNCRC), the World Health Organization (WHO), the International Organization for Migration (IOM), the UN High Commissioner for Refugees (UNHCR), the UN Children's Fund (UNICEF), and the UN High Commissioner for Human Rights (UNHCHR), were searched for documents on the basis of similar search terms.

Subsequently, a qualitative content analysis was conducted in which the relevant binding treaties and related General Comments were identified and scanned for reference to non-discrimination, preventive health, migration, and asylum. On this basis, the documents were sorted according to their relevance for the case of asylum seekers and undocumented migrants. While other specific UN treaties, such as the UN Convention on the Rights of the Child (CRC), the International Convention on the Protection of the Rights of All Migrant Workers and their Families (ICPMW), and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) were considered relevant for background knowledge, the decision was made to focus exclusively on the ICESCR as the most relevant, authoritative and generally applicable

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[27] Compare with Hutchinson, T, "Doctrinal Research: Researching the Jury" *in* Watkins, D and Burton, M, eds, *Research Methods in Law* (Routledge, London, 2013).

international legal framework which contains both the right to health and the principle of non-discrimination.[28]

Based on this preliminary inquiry, suggestions were articulated as to how international human rights law should be formulated and interpreted if a non-discriminatory approach to preventive health care for asylum seekers and undocumented migrants is to be followed. These suggestions are outlined in the results section below.

III. Results and Discussion

Due to the abovementioned findings regarding the relevant documents, the results section of this paper focuses on the ICESCR and the relevant General Comments of its treaty body, the CESCR. The results are divided into two parts: Part I outlines the scope and content of the right to preventive health care in general. Part II examines the scope and content of the non-discrimination principle in light of preventive health care with regard to asylum seekers and undocumented migrants.

III.1. The Right to Preventive Health Care

As it is necessary to first clarify the substantive provision in order to point out possible starting points for the principle of non-discrimination, the first part of the results section outlines the scope and content of the right to preventive health care in general. It tries to answer the following question: Which individual rights and State obligations are involved in the right to preventive health care? First, the study sketches what preventive health care can entail from a medical perspective before considering the most relevant article, Article 12 ICESCR on the highest attainable standard of physical and mental health, and the respective considerations in CESCR GC 14 as to how the article should be interpreted.

The study does not engage in any debate on the cost-effectiveness or medical usefulness of preventive health care in general or of specific preventive health care measures, unless the legal documents scrutinised explicitly refer to such issues. Rather, it assumes that for especially susceptible persons, such as asylum seekers or undocumented migrants, preventive measures are indispensable.[29]

Although the analysis focuses on the legal sphere, it contributes to a better contextual understanding of the medical perspective in that respect. Previous research on preventive health care seems to have primarily focused on related issues from a public health perspective rather than from an individual rights perspective. In a similar context, Patterson and Chambers define preventive health care as being either

> primary (lifestyle counselling and immunizations), secondary (early detection of subclinical disease by screening or case finding to prevent disability), or tertiary (minimising disability and handicap from established disease).[30]

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28 With currently 164 ratifications, the ICESCR is the most widely recognised general instrument on the right to health. UN Treaty Collection, *International Covenant on Economic, Social and Cultural Rights*, 1 October 2015, *at* <treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en> (accessed 1 October 2015).

29 See above section 'Background'.

30 Patterson, C, and Chambers, LW, "Preventive Health Care", 345 *The Lancet* (1995) 1611.

A perspective on the individual benefits of preventive medicine can be found in several medical encyclopaedias. As such, the medical encyclopaedia of the US National Library of Medicine suggests that preventive health care has the purpose to

> [s]creen for diseases, such as high blood pressure or diabetes; [l]ook for future disease risks, such as high cholesterol and obesity; [d]iscuss alcohol use and safe drinking and tips on how to quit smoking; [e]ncourage a healthy lifestyle, such as healthy eating and exercise; [u]pdate vaccinations; [m]aintain a relationship with [a] health care provider in case of illness.[31]

The medical encyclopedia of the University of Rochester provides detailed suggestions of prevention measures to be taken depending on age and gender.[32] It goes beyond the scope of this paper to go into detail on the advised measures. Nevertheless, one should keep in mind that preventive health care has to be tailored to the needs of the specific individual, depending on factors such as age and gender but also depending on other individual risk factors such as the socio-economic situation or the (family's) medical history. Unfortunately, no academic literature discussing such tailored preventive measures for asylum seekers or undocumented migrants seem to exist, yet.[33]

Moving from academic research and recommendations by medical experts to the policy area, the US-American 'Obamacare package' offers an example of what concrete measures preventive health care can entail in practice: the package includes a list of 18 'preventive health services for adults', all of which are offered free of charge.[34] The following highlights whether the international level attaches similar importance to preventive health care and if so, in what way. In so doing, the section outlines preventive health care in the ICESCR.

Although not legally binding, WHO Fact Sheet 31 not only recognises preventive health care as part of primary health care or as one of many aspects of the right to health that should be taken into account, but rather clearly names a 'right to prevention'.[35] However, the ICESCR and its General Comments are less outspoken on this matter.

According to Article 12(1) ICESCR, everyone is entitled 'to the enjoyment of the highest attainable standard of physical and mental health.' Article 12(2) ICESCR further specifies that provisions necessary for the prevention 'of epidemic, endemic, occupational and other diseases' should be included in the steps that States take towards the right's implementation. This means that there is an actual, binding legal basis for the right to

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31 Some of the measures could include (but the list is by no means exhaustive): 'Blood pressure, Blood sugar, Cholesterol (blood), Colon cancer screening test, Depression screening, Genetic testing for breast cancer or ovarian cancer in certain women, HIV test, mammogram, Osteoporosis screening, Pap smear, Tests for Chlamydia, gonorrhoea, syphilis, and other sexually transmitted diseases'. MedlinePlus, *'Preventive Health Care'*, U.S. National Library of Medicine, 22 January 2013, *at* <nlm.nih.gov/medlineplus/ency/article/001921.htm> (accessed 11 November 2015).

32 University of Rochester Medical Center, *Health Encyclopedia*, 2015, *at* <urmc.rochester.edu/encyclopedia/SearchResults.aspx?queryText=prevention&xsltPath=/encyclopedia/EncyclopediaResults.xslt&searchIn=encyclopedia&start=0> (accessed 11 November 2015).

33 Feldman provides a valuable starting point in discussing the primary health care of asylum seekers. However, a special focus on preventive health care and a similar discussion of undocumented migrants could be a valuable addition of future research. Feldman, R, "Primary Health Care for Refugees and Asylum Seekers: A Review of the Literature and a Framework for Services", 120 *Public Health* (2006) 809-816.

34 Healthcare.gov, *'Preventive Health Services for Adults'*, U.S. Centers for Medicare & Medicaid Services, 2015, *at* <healthcare.gov/preventive-care-benefits/adults/> (accessed on 11 November 2015).

35 OHCHR, *supra* nt 19, 3.

preventive health care in the ICESCR. However, the interpretation thereof is left to soft law instruments, of which CESCR GC 14 is the most important one.

The right to preventive health care is more explicitly stated in the CESCR GC 14 which holds that Article 12(2) 'requires the establishment of prevention and education programmes for behavior-related health concerns […] and the promotion of social determinants of good health'.[36] Moreover, CESCR GC 14 recognises that a large variety of social and economic aspects is involved in keeping people healthy.[37] Based on this reasoning, the CESCR assumes that the right to health also entails 'underlying determinants of health' which include the availability of information and education on health, one important aspect of preventive health care.[38]

CESCR GC 14 also recognises that the right to health involves the right to a broad range of 'facilities, goods, services and conditions' which are essential for realising 'the highest attainable standard of health'.[39] This also extends to 'the provision of equal and timely access to basic preventive […] services and health education, [and] regular screening programmes'.[40] An important addition is made through the statement that States should not disproportionately invest in the provision of curative health care, which is very expensive and can often only be accessed by the more privileged layers of society, while preventive health care is beneficial to a much larger proportion of society.[41] This emphasises the importance of preventive health care especially to the more vulnerable parts of the population – such as asylum seekers and undocumented migrants. However, CESCR GC 14 does not state what exactly preventive health care should entail or how far it should stretch.

With regard to the State obligations entailed in the right to health, CESCR GC 14 clearly states that preventive health care forms part of primary health care and is therefore a core obligation of the right to health.[42] This core obligation includes the requirement to maintain immunisation programmes, to prevent diseases and to educate and inform the population about health challenges and prevention possibilities.[43] With regard to the obligation to fulfil, CESCR GC 14 not only recurrently mentions that States have to provide immunisation, but also that States have to make sure that the 'underlying determinants of health' are equally accessible to all.[44]

The analysis suggests that Article 12 ICESCR should entail a right to preventive health care, that there exists a binding legal basis for such a right and that, as part of primary health care, it should be considered a core obligation of the right to health. It is clear from CESCR GC 14 that preventive health care includes measures such as immunisation, education and attention to the underlying determinants of health. However, the exact measures to be taken remain unspecified.

Nevertheless, based on the analysis of CESCR GC 14, one can conclude that preventive health care as a human right can be summarized to encompass the prevention of epidemic, endemic, occupational and other diseases. Measures should at least include:

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36 *Id*, para 16.
37 *Id*, para 4.
38 *Id*, paras 4 and 11.
39 *Id*, para 9.
40 *Id*, para 17.
41 *Id*, para 19.
42 *Id,* paras 44(b), (c), (d).
43 *Ibid.*
44 CESCR, GC 14, *supra* nt 3, para 36.

- Immunisation
- Education and information on health and behavior-related health concerns
- Regular screening programmes
- Promotion of the social determinants of health.

Overall, this shows that States have much leeway in complying with the right to preventive health care and it seems hard to discover a violation if the criteria are so broadly defined. Nevertheless, these criteria provide a valuable starting point which emphasises that preventive health care forms an integral part of the right to health. Based on this starting point, it is possible to further outline whether the non-discrimination principle can contribute towards clarifying preventive health care of asylum seekers and undocumented migrants.

III.2. The Principle of Non-discrimination

The second part of this section focuses on the question of whether the principle of non-discrimination offers (additional) protection to asylum seekers and undocumented migrants in terms of the right to preventive health care. The analysis does not discuss the content of the principle of non-discrimination in more general terms.[45] Rather, the following focuses on three largely intertwined aspects of the principle of non-discrimination that are relevant for detecting any links with the preventive health care of asylum seekers and undocumented migrants: 1. the reach of the material scope of non-discrimination with regard to preventive health care; 2. the extent of the personal scope of non-discrimination in terms of residence status; and 3. the reference to non-discrimination in the right to health itself.

According to Abramson, the principle of non-discrimination can be seen as one of the 'umbrella right[s]' of international law which increases the protection of the 'sectoral rights'.[46] As such, non-discrimination usually receives attention in relation to another human right, which is why the following analysis of the principle in relation to the right to preventive health care is well suited. With regard to the question whether the material scope of the principle of non-discrimination stretches to the right to health in general, the answer seems thus quite clear. Also the right to health of Article 12 ICESCR 'recognize[s] the right of *everyone* to the enjoyment of the highest attainable standard of physical and mental health'.[47] However, the article does not explicitly refer to any specific criteria on the basis of which any particular person should not be excluded. While one would easily assume that 'everyone' really includes every human being, which would make any relation to non-discrimination in Article 2(2) ICESCR irrelevant, examples from practice show that States do not necessarily agree – especially when it comes to persons with a temporary or no residence status.[48] What is more, judging from this article it is not explicit whether non-discrimination equally applies to preventive health care. In order to clarify this issue, the following tries to reveal how the criteria of non-discrimination relate to the right to preventive health care and whether 'everyone' also includes asylum seekers and undocumented migrants.

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45 On the principle of non-discrimination in more general terms see, for instance, Vandenhole, *supra* nt 25.

46 Abramson, B, "Article 2: The Right to Non-Discrimination" *in* Alen, A, Vande Lanotte, J, Verhellen, E, Ang, F, Berghmans, E and Verheyde, M, eds, *A Commentary on the Convention on the Rights of the Child*, (Martinus Nijhoff Publishers, Leiden, 2008), 7.

47 Emphasis added.

48 See, for instance, Spencer and Hughes, *supra* nt 1.

In addition to reference to 'equal and inalienable rights' in the preamble of the UDHR, the principle of non-discrimination is laid down in Article 2 UDHR which asserts that all human beings are entitled to 'all the rights and freedoms […] without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'.

The term 'all the rights' suggests that no differentiation or hierarchy of rights should be introduced but that everyone is entitled to enjoy the same, full and unlimited rights international human rights law has to offer. Based on this article, most of the subsequent international human rights treaties have adopted a similar provision.[49] Due to the more concrete relationship with the right to health, the following again focuses on the ICESCR as the most relevant framework in that respect.

Article 2(2) ICESCR holds that,

> [t]he States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Since no specific mention is made of any right that is included or excluded from the principle completely or to a certain degree, it is apparent from the article that the prohibition equally applies to all rights of the ICESCR, regardless of any additional mentioning of non-discrimination in the article on the substantive right. Hence, the principle of non-discrimination should apply equally to all aspects of the right to health, including preventive health care.

CESCR GC 20 on the principle of non-discrimination equally suggests that Article 2(2) ICESCR should be read as applying to the right to health and entailing that 'States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind'.[50] Non-discrimination is seen as 'an immediate and cross-cutting obligation' and consists of

> any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights.[51]

While this once more suggests that non-discrimination is very inclusive, no explicit link to preventive health care is made. No further explanation is offered with regard to what the right to health entails or what exactly falls within the scope of non-discrimination. Nevertheless, as outlined above, CESCR GC 14 indicates that the right to preventive health care should be seen as a clear core obligation of the right to health. This suggests that even if it is not explicitly referred to in the context of non-discrimination, it should be seen as equally falling within its scope as part of the right to health which is clearly linked to non-discrimination. This is supported by the emphasis on inclusivity of the principle of non-discrimination.

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49 See CESCR, *supra* nt 16.
50 CESCR, GC 14, *supra* nt 3, para 30.
51 CESCR, GC 20, *supra* nt 3, para 7.

The question of whether the personal scope of the article also extends to asylum seekers and undocumented migrants is less clear: the list of prohibited grounds for discrimination does not explicitly refer to residence status or to a similar category that would imply their inclusion and the article does not explicitly mention that the list of prohibited grounds can be expanded any further. However, Article 2(3) ICESCR allows developing countries to limit access to the economic rights of the ICESCR for non-nationals. Although not explicitly stated, this suggests that no such limitation is allowed for developed countries.[52] It is also important to note that no exclusion clause for foreigners as in, for instance, the Appendix of the European Social Charter, exists with regard to the ICESCR.[53]

Regarding the prohibited grounds of discrimination, important differences in Article 2(2) ICESCR as compared to the Article 2 UDHR should be noted: the most apparent difference is the reference to 'distinction' in the UDHR whereas the ICESCR refers to 'discrimination'. One might assume that 'discrimination' is a stronger term which necessitates a higher standard of proof than 'distinction'. However, Abramson argues that in practice both terms are used interchangeably.[54] The present analysis does therefore not go into more detail on this issue as it is not directly relevant to the question under investigation. Yet, this is not the only difference between the two Articles. Another discernible difference is that the UDHR mentions distinction 'such as', whereas the ICESCR refers to discrimination 'as to'. This suggests that while the former sees discrimination on the basis of the explicitly mentioned prohibited grounds only as examples and considers all forms of distinction to be prohibited, the latter is much more limited and the term 'as to' refers to a much more exclusive list of the prohibited grounds of discrimination. Nevertheless, both documents include the term 'other status', which the following presents as indicating some possible leeway for interpretation.

While the term 'other status' could have been considered to entail a prohibition of discrimination on the grounds of residence status, this is not explicitly mentioned. Nevertheless, the CESCR sees the prohibited grounds of discrimination as expandable. Accordingly, CESCR GC 20 holds that the term 'other status' suggests an incomplete list of prohibited grounds of discrimination and even states that this list 'is not intended to be exhaustive'.[55] The CESCR's interpretation is based on the argument that '[t]he nature of discrimination varies according to context and evolves over time', which necessitates a more 'flexible approach'.[56] Hence, the criteria for discrimination should 'reflect the experience of social groups that are vulnerable and have suffered and continue to suffer marginalization'.[57] Judging from this argumentation it is not surprising that CESCR GC 20 suggests that the term 'everyone' should include 'non-nationals, such as refugees, asylum seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and documentation'.[58]

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52 While the present study does not explicitly refer to a particular country, the rights and State obligations for asylum seekers and undocumented migrants it tries to uncover are primarily directed at developed countries (ie, those with a functioning health care system) as developing countries display different problems and access to health care might not even be ensured for nationals.

53 Although refuted by later case law, the European Social Charter holds that foreigners are only included 'in so far as they are nationals of other Parties lawfully resident or working regularly within the territory of the Party concerned': Appendix 1, Council of Europe, *European Social Charter* (revised) (1996) ETS 163.

54 Abramson, *supra* nt 46, 8.

55 CESCR GC 20, *supra* nt 3, paras 15 and 27.

56 *Id*, para 27.

57 *Ibid*.

58 *Id*, para 30.

In addition, it is not difficult to imagine that the, in CESCR GC 20 under the 'other status' criterion mentioned, prohibited grounds of discrimination 'place of residence' and 'economic and social situation' can also be considered to entail possible grounds that prohibit any form of discrimination against asylum seekers and undocumented migrants.[59] Within the additional categories which the CESCR considers to be implied by the 'other status' ground, CESCR GC 20 also makes the remarkable addition of 'nationality'.[60] This seems confusing, as 'national origin' is already entailed as an explicit separate category in Article 2(2) ICESCR. The 'national origin' ground does not mention asylum seekers or undocumented migrants and rather states that it 'refers to a person's State, nation, or place of origin'.[61] Nevertheless, one can easily conclude that in particular circumstances – namely if discrimination really takes place on the basis of such 'national origin' – asylum seekers and undocumented migrants might equally fall within the scope of this prohibited ground. The term 'national origin' seems to be even more inclusive than 'nationality' and one could see nationality as only one part of national origin. It is therefore unclear why CESCR GC 20 mentions 'nationality' again as a separate ground under the 'other status' criterion.

While one can only speculate on the question of why the CESCR chose this – arguably problematic – classification of 'nationality' within the scope of the 'other status' ground, it is important to note the CESCR's view of what this criterion should comprise. In its reference to nationality as a prohibited ground of discrimination, CESCR GC 20 explicitly refers to undocumented migrant children. As such, 'all children within a state, including those with an undocumented status, have a right to … affordable health care.'[62] Again, no explicit reference to preventive health care is made and the term 'affordable health care' is left undefined. Still, it seems a bold move by the CESCR to explicitly mention undocumented migrant children while not specifically acknowledging all other children who could find themselves in a similarly vulnerable situation due to their nationality. This seems to exhibit the CESCR's conviction that these children deserve particular attention and that hitherto this has been insufficiently acknowledged.

Apart from the overlap of 'nationality' with the 'national origin' ground, one might also ask whether the approach of including undocumented children under nationality-related discrimination is legally sound: asylum seekers and undocumented migrants are usually not limited in their access to economic, social and cultural rights because of their nationality or because of the fact that they originate from a particular country. Rather, States sometimes limit the access to these rights because the person requesting access has no (permanent) legal status in the host country: regardless of their country of origin, differential treatment is usually applied equally to persons from, for instance, Pakistan, China or Venezuela if they have no residence permit.[63] Thus, such an exclusion from the enjoyment of ICESCR rights constitutes discrimination on the basis of legal or residence status rather than discrimination on the basis of nationality. An additional problem is posed by the fact that asylum seekers are not mentioned under the 'nationality' ground and that it is unclear whether the reference to undocumented children suggests that undocumented migrants should have the same rights or whether undocumented migrant children enjoy more rights than their parents (and if so, on what basis?).

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59 *Id*, paras 34 and 35.

60 *Id*, para 30.

61 *Id*, para 24.

62 *Id*, para 30.

63 Obviously, once they do have a residence permit and are still discriminated against, the situation becomes different and would most probably fall within the scope of 'nationality' or 'national origin'.

Whereas this nevertheless generally suggests that the principle of non-discrimination at least partially also applies to non-nationals, CESCR GC 20 entails another problematic provision that suggests the opposite and protects State interests rather than individual rights. As such, CESCR GC 20 holds that discrimination is not to be seen as discrimination if the purpose of this discrimination is 'promoting the general welfare in a democratic society'.[64] This seems to almost nullify the previously outlined inclusive protection against discrimination. 'General welfare' seems to be a broad concept that allows for far-reaching interpretations.[65] Even arguments for only providing emergency care to undocumented persons or asylum seekers in order to not irrevocably strain the national health care system seem to lend themselves to legitimation under this provision as a functioning health care system is generally seen to be promoting the general welfare.[66] While the provision further limits the justification of any such discrimination as having to be 'reasonable and objective', its 'aim and effects' having to be 'legitimate, compatible with the nature of the Covenant rights' and having 'a clear and reasonable relationship of proportionality', this nevertheless seems a serious limitation of one of the core provisions of international human rights law.[67] Simultaneously, the effective implementation of the right to health requires that the discrimination has to be 'compatible with the nature of the Covenant rights'. Thus, in order to assess whether any distinctive application of the right to health would ever be compatible with this 'general welfare' provision, it is necessary to further elaborate upon the non-discrimination provision entailed in the right to health itself.

Regarding the provisions on non-discrimination entailed in the right to health itself, it has been noted above that Article 12 ICESCR holds that 'everyone' has the right to health but does not entail any explicit prohibition of discrimination in the article itself. However, CESCR GC 14 on the right to health similarly holds that '[e]very human being is entitled to the enjoyment of the highest attainable standard of health'[68] and additionally explicitly states that this right is 'closely related to and dependent upon' the principle of non-discrimination.[69]

What exactly this should entail for the right to health becomes clear in the CESCR GC 14 provisions related to non-discrimination in which frequent reference to 'health facilities, goods and services' is made.[70] While this is a valuable starting point, the broadness of this phrase might lead to uncertainty about which health facilities are actually contained in this definition. This is especially problematic with regard to preventive health care. However, a footnote in CESCR GC 14 states that unless indicated otherwise, the term 'health facilities, goods and services' should be considered to include the 'underlying determinants of health'.[71] CESCR GC 14 offers additional guidance through stating that the right to health 'proscribes any discrimination in access to health care and underlying determinants of health'.[72] Keeping in mind the previously mentioned link between preventive health care and the underlying determinants of health, it is therefore important to note that the 'underlying determinants of health' are explicitly mentioned here.

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64 *Id*, para 13.
65 States repeatedly assert that they cannot or do not want to award non-nationals similar rights as nationals: OHCHR, *supra* nt 19, 19.
66 *Ibid*.
67 CESCR GC 20, *supra* nt 3, para 13.
68 CESCR GC 14, *supra* nt 3, para 1.
69 *Id*, para 3.
70 See, for instance, CESCR GC 14, *supra* nt 3, paras 12(b), 43(a) and 50.
71 *Id,* footnote 6.
72 *Id*, para 18.

In addition, CESCR GC 14 not only refers to non-discrimination but also to 'equality of opportunity for people to enjoy the highest attainable level of health', which seems to go beyond the primarily negative obligation of States to refrain from discriminatory treatment and implies a positive obligation for states to ensure equality.[73] Moreover, the examples of violations mentioned in CESCR GC 14 clearly show that national non-discriminatory laws alone are not enough but that the State has to actively prevent discrimination as the 'denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination' is considered a violation of the right to health.[74] Based on this argument, the abovementioned limitation of the non-discrimination principle of CESCR GC 20 in the interest of 'general welfare' would not be legitimate under the right to health and therefore not 'compatible with Convention rights' if it limits the access to 'health facilities, goods and services' in any way.

CESCR GC 14 even explicitly asserts that States are not allowed to deny or limit the 'equal access for all persons, including … asylum seekers and illegal immigrants to preventive, curative and palliative health services'.[75] This shows that the CESCR clearly considers asylum seekers and undocumented migrants to fall within the scope of the principle of non-discrimination and that this holds true for the whole spectrum of health, including preventive health care. Consequently, asylum seekers and undocumented migrants should be entitled to the same rights as all other subjects of human rights law and hence to all the preventive health care measures identified above.

This is confirmed by CESCR GC 14's core obligation for States '[t]o ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups'.[76] Moreover, CESCR GC 14 holds that health care must be 'accessible to everyone without discrimination, within the jurisdiction of the State party' and 'to all, especially the most vulnerable and marginalized sections of the population'.[77] While no specific 'sections of the population' are mentioned, one can easily assume that asylum seekers and undocumented migrants would fall within this definition. The reference to 'within the jurisdiction of the State party' seems to further define the term 'everyone' and leads to the assumption that no distinction in relation to the right to health should be made on the basis of residence status. Rather, based on these criteria, everyone present in the territory of a State that has signed and ratified the ICESCR would then be entitled to the same rights as nationals of that State. Furthermore, it is not difficult to argue that asylum seekers and undocumented migrants are usually in a vulnerable and marginalized situation that would result in them falling within the scope of this provision. However, in a different paragraph, the CESCR refers to the entitlements of 'the vulnerable members of society', which leads to the question of whether someone without a (permanent) residence permit could be considered a 'member of society'.[78] In order to clarify how these and related terms are to be interpreted, it would be necessary for future research to further engage with the concept of vulnerability.

Overall, based on the ICESCR and CESCR GC 14 and 20, one can conclude that asylum seekers and undocumented migrants *should* enjoy the same health rights as 'everyone'. Yet, the references to asylum seekers and/or undocumented migrants are

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73 *Id*, para 8.
74 *Id*, para 50.
75 *Id*, para 34.
76 *Id*, para 43(a).
77 *Id*, para 12(b).
78 *Id*, para 18.

inconsistent, which makes it difficult to see whether asylum seekers and undocumented migrants should be placed on an equal footing or whether one of the two groups has more rights than the other: sometimes the CESCR refers to asylum seekers and sometimes to undocumented migrants, but this is not always done simultaneously or in the same way.

The previous analysis suggests that the possibility of derogation on the grounds of 'general welfare' in the non-discrimination principle is problematic because it can easily be employed to justify the differential treatment of asylum seekers and undocumented migrants. However, if one takes a close look at the connection of the right to health and non-discrimination, it becomes apparent that it should be considered contrary to the right to health to limit access to health care in any way. This was even found to be true with regard to preventive health care.

IV. Conclusion

The present study tried to answer the question of what the principle of non-discrimination has to offer for the preventive health care of asylum seekers and undocumented migrants. In so doing, it referred to two subquestions. First, what individual rights and State obligations are involved in the right to preventive health care? Second, does the principle of non-discrimination offer (additional) protection to asylum seekers and undocumented migrants in terms of the right to preventive health care? Through a doctrinal analysis which not only tried to point at inconsistencies but also elaborate upon how the law should be understood according to the CESCR's General Comments, the following conclusions could be drawn.

While there is a legal basis for the right to preventive health care in Article 12 ICESCR, there is, strictly speaking, no such right for asylum seekers or undocumented migrants explicitly mentioned in the ICESCR itself. Nevertheless, implications for such a right can be found in the non-binding but authoritative CESCR GC 14 and 20. It is therefore beyond question that if one were to take due account of how the law should be interpreted according to CESCR GC 14, then there should be recognition of a right to preventive health care. State compliance with such a right should at least entail immunisation, education and information on health and behaviour-related health concerns, regular screening programmes and the promotion of the social determinants of health. However, any more extensive or more detailed content of the right to preventive health care is left undefined and should be laid down in an additional international document that explicitly deals with the right to preventive health care.

The principle of non-discrimination clearly applies to the right to health and should therefore implicitly also apply to preventive health care. However, the principle is not conclusive in answering whether the right to preventive health care would apply to asylum seekers and/or undocumented migrants in an equal manner as it would apply to nationals. Although, generally, the rights of asylum seekers are considered to be less controversial than those of undocumented migrants due to the temporary legal residence status of asylum seekers, reference to these groups is inconsistent. Generally, the CESCR seems to be more concerned with undocumented migrants and assumes asylum seekers are implicitly considered to enjoy at least the same rights.

Non-discrimination can contribute to clarifying the rights and obligations with regard to asylum seekers and undocumented migrants but also blurs these through allowing States to discriminate in the interest of 'general welfare'. The 'general welfare' limitation of the principle of non-discrimination does not seem to exist under the right to health and

CESCR GC 14 seems to be more far-reaching and comprehensive than CESCR GC 20 in that respect. Non-discrimination in the right to health itself does not allow for such a general welfare limitation and CESCR GC 14 is much more outspoken in prohibiting any limitation of the right to health. While the 'other status' requirement of the principle of non-discrimination in CESCR GC 20 might offer some additional leeway of interpretation, it is also confusing through the double reference to 'nationality' and 'national origin'. If one sticks to the interpretation of CESCR GC 14, such a broadening of the 'other status' ground is not even necessary as under the right to health asylum seekers and undocumented migrants are explicitly included. As such, CESCR GC 14 asserts that States are not allowed to deny or limit the 'equal access for all persons, including … asylum seekers and illegal immigrants to preventive, curative and palliative health services'.[79] While this is a far-reaching approach under CESCR GC 14, it would contribute to the acceptance of the existence and content as well as to the effectiveness of a non-discriminatory right to preventive health care for everyone, including asylum seekers and undocumented migrants, to not only envisage such a right under the right to health itself but to also make it more explicit under the 'umbrella right' of non-discrimination.

For non-discrimination to be truly unambiguous with regard to the right to health of asylum seekers and undocumented migrants, it would be necessary to strike out the 'general welfare' provision of CESCR GC 20 and to clearly state that the 'other status' criterion also entails 'residence status' as a prohibited ground of discrimination rather than only repetitively 'nationality'. Hence, it can be concluded that it is not so much the principle of non-discrimination that has to offer protection for the preventive health care of asylum seekers and undocumented migrants, but rather the other way round: the right to health can and should offer additional clarification on the non-discrimination of asylum seekers and undocumented migrants.

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79 CESCR GC 14, *supra* nt 3, para 34.

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