

Incorporating the Guiding Principles on Internal Displacement into Domestic Law: Issues and Challenges

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Chapter 6

The Right to Health and Basic Services

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INTRODUCTION

Health as a human right does not mean the right to be healthy nor does it assert an unlimited right to be treated for every medical condition.¹ Rather, the right to health may be seen as having two components: a right to health care and a right to healthy conditions.² The rights-based approach to health incorporates both a clinical, curative perspective focusing on health care and health services, and a public health, preventive perspective focusing on the social determinants of health—including water, sanitation, nutrition, and health education.

Internally displaced persons (IDPs) have the right to health and other basic services, including the right to a standard of living adequate to maintain health and well-being. This chapter focuses on how these rights are, or should be, implemented in domestic law and policy for the provision of essential health and other basic services to IDPs in various contexts. For the purposes of this chapter, the definition of health is that contained in the Preamble to the Constitution of the World Health Organization (WHO). “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”³ The chapter’s definition of “basic services” draws from the *Sphere Project Humanitarian Charter and Minimum Standards in Disaster Response* (hereinafter the *Sphere Handbook*), which seeks to ensure that

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¹ Special Rapporteur, *Report of the Special Rapporteur on the Right to Health*, E/CN.4/2006/48/Add. 1 (Dec. 22, 2005).

² Judith Asher, *The Right to Health: A Resource Manual for NGOs*, 2004 INT’L HEALTH & HUMAN RTS. ORG. 17, available at http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

³ Constitution of the World Health Organization (July 22, 1946).

people affected by disasters “have access to at least the minimum requirements (water, sanitation, food, nutrition, shelter and health care) to satisfy their basic right to life with dignity.”⁴

LEGAL FRAMEWORK

The right of IDPs to health and other basic services, including the right to a standard of living adequate to maintain health and well-being, is affirmed in the *Guiding Principles on Internal Displacement* (the *Guiding Principles*) and is established in various instruments of international human rights and humanitarian law.⁵ Emerging standards in humanitarian action and practice seek to establish a regulatory framework for ensuring that the basic health and survival needs of displaced populations are met.⁶ The *Guiding Principles* reflect the convergence of clinical, curative perspectives and public health, preventive perspectives by affirming both the right to health and the right to an adequate standard of living.

Relevant Guiding Principles

The Principles that affirm the right to health and basic services before, during, and after displacement are Principle 4, which provides for protection and assistance to especially vulnerable populations;⁷ Principle 7, which relates to

⁴ ISOBEL MCCONNAN, *THE SPHERE PROJECT: HUMANITARIAN CHARTER AND MINIMUM STANDARDS IN DISASTER RESPONSE* 19 (2000) [hereinafter the SPHERE PROJECT].

⁵ United Nations, *Guiding Principles on Internal Displacement*, E/CN.4/1998/53/Add.2.

⁶ See SPHERE PROJECT, *supra* note 4, at 6.

⁷ Principle 4 states that “Certain internally displaced persons ... shall be entitled to protection and assistance required by their condition and to treatment which takes into account their special needs.”

conditions necessary to undertake displacement in safety and dignity,⁸ Principles 18 and 19 which relate to protection during displacement,⁹ and Principle 29 which relates to access to public services after displacement.¹⁰ The right to health is continuous through all phases of internal displacement, although providing access to basic humanitarian aid during displacement preoccupies the attention and resources of most organizations and institutions assisting IDPs.

⁸ Principle 7(2) states that “The authorities undertaking...displacement shall ensure, to the greatest practicable extent ... that such displacements are effected in satisfactory conditions of safety, nutrition, health and hygiene.”

⁹ Principle 18 states that all IDPs have the right to an adequate standard of living and that “At the minimum, regardless of the circumstances, and without discrimination, competent authorities shall provide internally displaced persons with and ensure safe access to (a) essential food and potable water; (b) basic shelter and housing; (c) Appropriate clothing; and (d) Essential medical services and sanitation.” Principle 19 reads as follows:

1. All wounded and sick internally displaced persons as well as those with disabilities shall receive to the fullest extent practicable and with the least possible delay, the medical care and attention they require, without distinction on any grounds other than medical ones. When necessary, internally displaced persons shall have access to psychological and social services.
2. Special attention should be paid to the health needs of women, including access to female health care providers and services, such as reproductive health care, as well as appropriate counseling for victims of sexual or other abuses.
3. Special attention should also be given to the prevention of contagious and infectious diseases, including AIDS, among internally displaced persons.

¹⁰ Principle 29 does not make explicit reference to health and basic services but it does assert the right of IDPs to “have equal access to public services,” which could be assumed to include any health care that would be available through public services and facilities.

Relevant International Law

International Human Rights Law

The Universal Declaration of Human Rights (UDHR) Article 25(1) states that “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”¹¹ The International Covenant on Economic, Social and Cultural Rights (ICESCR) affirms the right to an adequate standard of living in similar terms to the UDHR in Article 11. Article 12.1 of the ICESCR recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹² Numerous provisions of regional human rights treaties also set out the right to health and an adequate standard of living.¹³

In 2000, General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) noted that “the right to health is closely related to and dependent on the realization of other human rights” and that reference to the “highest attainable standard of physical and mental health” extends “not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, and adequate supply of safe food, nutrition and

¹¹ Universal Declaration of Human Rights, A. Res. 217A (III), U.N. GAOR, 3d Sess., 67th plen. mtg., ¶ 71, U.N. Doc. A/810 (1948) [hereinafter Universal Declaration].

¹² International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, G.A. Res. 2200A, 21 U.N. GOAR Supp. No. 16 at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, 6 I.L.M. 368 (1967) 1966, Jan. 3 1976 [hereinafter ICESCR].

¹³ See Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (“Protocol of San Salvador”), art. 10, O.A.S. Treaty Series No. 69 (1988), 29 I.L.M. 156 (1989); African Charter on Human and Peoples’ Rights, June 26, 1981, art. 16, O.A.U. Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) [hereinafter African Charter]; European Social Charter, Oct. 18, 1961, arts. 11, 30, 529 U.N.T.S. 89.

housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.”¹⁴ The Committee also noted the evolution of “a wider definition of health [that] also takes account such socially-related concerns as violence and armed conflict.”

In delineating actions to be taken by states, General Comment 14 noted that the right to prevention, treatment, and control of epidemic, endemic, occupational, and other diseases “includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations.” General Comment 14 also set out a number of “core obligations” under the ICESCR that require immediate rather than progressive implementation. In its prior General Comment 3, the Committee affirmed that “a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary care, of basic shelter and housing, or the most basic forms of education is, *prima facie*, failing to discharge its obligations.”¹⁵

Discrimination in enjoyment of the right to health is specifically banned by both the Convention on the Elimination of All Forms of Racial Discrimination (CERD)¹⁶ and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).¹⁷ CEDAW Article 6 calls on states parties to “take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.” Though

¹⁴ UNCESCR, General Comment No. 14, *The Right to the Highest Attainable Standard of Health*, E/C.12/2000/4 (Nov. 2000) [hereinafter CESCR, General Comment No. 14].

¹⁵ General Comment 3 of the Committee on Economic, Social and Cultural Rights, U.N. Doc. E/C.12/1990/12, n. 24, ¶ 10.

¹⁶ ICERD, G.A. res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, Jan. 4, 1969.

¹⁷ CEDAW, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force Sept. 3, 1981.

not all aspects of trafficking and sexual exploitation of women are health-related, the fundamental health risks are well documented, including the risk of sexually transmitted infections, rape, and other forms of gender-based violence, unwanted pregnancy, and physical and psychological trauma. The Committee on the Elimination of All Forms of Discrimination against Women's General Recommendation No. 24¹⁸ expands upon the right to health in a variety of respects, including by saying that "special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women, and women with physical or mental disabilities."

The Convention on the Rights of the Child (CRC) obligates states to "ensure to the maximum extent possible the survival and development of the child."¹⁹ Article 24(1) calls upon states parties to recognize "the right of the child to the enjoyment of the highest attainable standard of health, and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services." CRC, Article 19(1) requires states parties to "take all appropriate ... measures to protect the child from all forms of physical or mental violence, injury or abuse...." While the full scope of this chapter extends beyond curative or preventive health, virtually all forms of child abuse, exploitation, or neglect have a distinct health component, especially in the context of humanitarian emergencies. Article 39 requires that "States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts."

¹⁸ CEDAW, General Recommendation No. 24 (20th sess., 1999), *available at* <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24>.

¹⁹ Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. No. 49 at 167, art. 6, U.N. Doc. A/44/49 (1989), 1577 U.N.T.S. 3, 28 I.L.M. 1456 (1989).

The Committee on the Rights of the Child General Comment No.4 elaborates on adolescent health and development in the context of the CRC, noting, *inter alia*, that:

[s]ystematic data collection is necessary for States parties to be able to monitor the health and development of adolescents. States parties should adopt data-collection mechanisms that allow disaggregation by sex, age, origin, and socio-economic status so that the situation of different groups can be followed. Data should also be collected to study the situation of specific groups such as ethnic and/or indigenous minorities, migrant or refugee adolescents, adolescents with disabilities, working adolescents, etc.²⁰

International Humanitarian Law

International humanitarian law also incorporates the right to health for victims of international and civil conflict. Protocols I and II of the Convention (IV) Relative to the Protection of Civilian Persons in Time of War (the Fourth Geneva Convention) state that “all the wounded, sick and shipwrecked...shall be respected and protected. In all circumstances they shall be treated humanely and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.”²¹ Article 16 of the Fourth Geneva Convention states that “the wounded and sick as well as the infirm, and expectant mothers, shall be the object of particular protection and respect.” The *Annotations to the Guiding Principles*

²⁰ United Nations Convention on the Rights of the Child, Comm. on the Rights of the Child, General Comment No. 4 (2003), *Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, CRC/GC/2003/4.

²¹ Protocol I, art. 10; Protocol II, art. 7

notes that:

[U]nlike human rights law, humanitarian law does not explicitly set forth a right to an adequate standard of living. The basic supplies for survival such as food, water and shelter, however, are expressly protected by several rather specific provisions of the Geneva Conventions and Protocols....Thus humanitarian law does implicitly guarantee a right to an adequate standard of living.²²

Other Relevant Principles and Guidelines

The Millennium Development Goals (MDGs) adopted by the UN General Assembly in September 2000 include undertakings to reduce poverty, malnutrition, and lack of access to water, as well as to reduce maternal and child mortality and halt the spread of major diseases such as HIV/AIDS and malaria.²³ The MDGs also resolve to “ensure that children and all civilian populations that suffer disproportionately the consequences of natural disasters, genocide, armed conflicts and other humanitarian emergencies are given every assistance and protection so that they can resume normal life as soon as possible.”

The *Sphere Handbook* reflects a commitment by humanitarian agencies “to ensure that people affected by disasters have access to at least the minimum requirements (water, sanitation, food, nutrition, shelter and health care) to satisfy their basic right to life with dignity.”²⁴ Minimum standards related to health include the following:

²² WALTER KÄLIN, GUIDING PRINCIPLES ON INTERNAL DISPLACEMENT: ANNOTATIONS (2d ed., 2007), at 45.

²³ United Nations Millennium Declaration: Resolution adopted by the General Assembly, A/Res/55/2.

²⁴ See SPHERE PROJECT, *supra* note 4, at 17-19.

- Establishing health systems and infrastructure: prioritizing health services; supporting national and local health systems; coordination; primary health care; clinical services; and health information systems.
- Controlling infectious diseases through prevention; measles prevention; diagnosis and case management; outbreak preparedness; outbreak detection, investigation, and response; and HIV/AIDS.
- Controlling non-communicable diseases through addressing injury; reproductive health; mental and social aspects of health; and chronic diseases.

The 58th World Health Assembly passed a May 2005 resolution on health action in relation to crises and disasters, which urged member states to:

ensure that—in times of crisis—all affected populations, including displaced persons, have equitable access to essential health care, focusing on saving those whose lives are endangered and sustaining the lives of those who have survived, and paying attention to the specific needs of women and children, older people, and persons with acute physical and psychological trauma, communicable diseases, chronic illnesses, or disability.²⁵

The Madrid International Plan of Action on Ageing (2002) calls for “[e]qual access by older persons to food, shelter and medical care and other services during and after natural disasters and other humanitarian emergencies.”²⁶

²⁵ World Health Organization, Fifty-eighth World Health Assembly Resolutions and Decisions, *Health Action in Relation to Crises and Disasters, with Particular Emphasis on the Earthquakes and Tsunamis of 26 December 2004*, WHA58/2005/REC/1.

²⁶ Report of the Second World Assembly on Ageing, Madrid, Spain, Apr. 8-12, 2002, A/CONF/197/9, Priority Direction I, Issue 8, Objective 1.

In cases of displacement caused by development projects, the World Bank's Operational Directive 4.30 on Involuntary Resettlement states that "[t]o ensure the economic and social viability of the relocated communities, adequate resources should be allocated to provide shelter, infrastructure (e.g. water supply, feeder roads), and social services (e.g. schools, health care centers)." A footnote comments further that "health care services, particularly for pregnant women, infants, and the elderly, may be important during and after relocation to prevent increases in morbidity and mortality due to malnutrition, the stress of being uprooted, and the usually increased risk of water-borne diseases."²⁷

OVERVIEW OF OBSTACLES TO THE IMPLEMENTATION OF THE GUIDING PRINCIPLES

Availability

According to the CESCR, "[f]unctioning public health and health-care facilities, goods and services, as well as programs, have to be available in sufficient quantity within the State party."²⁸ The great majority of the world's IDPs are in developing countries where health facilities, goods, and services are inadequate or essentially unavailable. Conflict can lead to the destruction of health facilities and supplies, flight of health workers, and a breakdown in services for displaced and non-displaced populations alike. Internal displacement can carry an additional burden as, within an already resource-poor environment, it can push populations into even more deprived circumstances where health services are lacking or where they must compete with local residents for limited supplies and assistance.²⁹

²⁷ World Bank Operational Manual, OD4.30—Involuntary Resettlement (June 1990), at 6.

²⁸ CESCR, General Comment No. 14, *supra* note 14, at 3.

²⁹ IDMC, Health and IDPs, *available at* [http://www.internal-displacement.org/8025708F004D404D/\(httpPages\)/27E7C556E3549FC8802570A100471F33?OpenDocument](http://www.internal-displacement.org/8025708F004D404D/(httpPages)/27E7C556E3549FC8802570A100471F33?OpenDocument).

For instance, in Iraq, a January 2007 study noted that “[a]lready poorly equipped and inadequately staffed, health centers located in areas of high IDP concentration are unable to cope with the increased caseloads. There is a chronic shortage of medication, lab materials and X-ray films in the country, which renders many health facilities useless.”³⁰ A 2006 assessment in Iraq found that 10 percent of IDPs reported that there were no health care services in their area of displacement, 70 percent said they had not been visited by a health care worker within the past 45 days, and 55 percent had not been involved in any vaccination campaigns.³¹

In northern Uganda, despite the existence of a national policy on IDPs as well as large-scale international assistance, a 2005 study found mortality rates in the camps well above emergency thresholds (with malaria/fever, AIDS, and violence the top three reported causes of death), leading the sponsoring organizations to state that “a very serious humanitarian emergency” was occurring in the IDP camps and “extremely urgent action was needed to reduce mortality to non-crisis levels.”³² The limited availability of functioning public health and health-care facilities, goods and services was by no means the only problem identified in the northern Uganda IDP camps, but it contributed significantly to the serious humanitarian emergency in the camps, despite the long-running and large-scale presence of the relief community.

Accessibility

According to the CESC, health facilities, goods and services must be accessible to everyone, taking into account four overlapping dimensions. Those dimensions are (1) non-discrimination,³³ (2) the provision of health

³⁰ International Medical Corps [IMC], *Iraqis on the Move: Sectarian Displacement in Baghdad*, at 4 (Jan. 2007).

³¹ International Organization for Migration [IOM], *Iraqi Displacement: 2006 Year in Review*, at 16 (Feb. 2007).

³² WHO, *Health and Mortality Survey among Internally Displaced Persons in Gulu, Kitgum and Pader Districts, Northern Uganda* (July 2005), iv, 33-34.

³³ CESC, General Comment No. 14, *supra* note 14, at 3.

facilities “within safe physical reach for all sections of the population, especially vulnerable or marginalized groups...including in rural areas”,³⁴ (3) economic accessibility or affordability, meaning that costs for health care services “whether privately or publicly provided, are affordable to all, including socially disadvantaged groups”,³⁵ and (4) “the right to seek, receive and impart information and ideas concerning health issues.”³⁶

Examples abound of IDPs facing accessibility barriers to health care and an adequate standard of living. In Colombia, for instance, an IDP Law (387/97, passed in 1997) established that IDPs should have access to health services to the maximum of the funds available and a 2000 regulation guaranteed that registered IDPs would have free and unlimited access to health care and medicines. However, a 2003 government decree limited the range of medical services available to IDPs, restricted access to health care to those IDPs who had health insurance but were unable to make payments, and decentralized responsibility for IDP health care to local municipalities without allocating adequate resources.³⁷ Moreover, the precondition of registration as an IDP was complicated by a lack of coherent guidelines and resources.³⁸ It is estimated that less than 22 percent of IDPs are registered and receive some form of government assistance. As a 2005 report noted, “[o]ne of the reasons for low levels of assistance, apart from issues relating to registration, is that IDPs are not always aware of their rights, entitlements and obligations.”³⁹

³⁴ *Id.* at 3-4.

³⁵ *Id.* at 4.

³⁶ *Id.*

³⁷ IDMC, Colombia, *Government “Peace Process” Cements Injustice for IDPs*, at 160, 288 (June 30, 2006).

³⁸ Support Group for Displaced People Organizations [GAD], *Report on Forced Displacement in Colombia*, at 16, 52 (1999).

³⁹ ICRC, *IDPs in Colombia: A Joint Needs Assessment by the ICRC and the World Food Programme*, at 4 (Apr. 22, 2005).

A multi-country study of displacement in the Balkans found that the proportion of displaced households with inadequate water and sanitation was far higher than that in non-displaced households and far below MDG targets for countries in the region. Displaced populations also reported greater distances to health facilities as compared to majority households.⁴⁰ Displaced Roma have faced particular vulnerability. As a 2005 report noted, “[l]iving conditions of Roma IDPs are appalling; many live in illegal settlements or unofficial collective centers without electricity, water and sewage systems. In the absence of legal status, Roma cannot register their place of residence and are at risk of eviction at any time. The absence of a registered address is an additional element preventing them from accessing their rights,” including the right to health care.⁴¹

Acceptability

According to the CESCR, “all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.”⁴² IDPs have a right to health care and a standard of living that are not only available and accessible but acceptable as well. The extent to which health services respect culture, ethnicity, gender, age, and individual preferences can have significant impacts not only on health care utilization and health-seeking behavior but on health outcomes as well. Services that are not acceptable—whether because they ignore issues of gender-based violence or dietary preferences—are

⁴⁰ UNDP Regional Bureau for Europe, *At Risk: Roma and the Displaced in Southeast Europe*, at 92-92 (2006).

⁴¹ IDMC, *Roma Lead Poisoning in North Mitrovica Illustrates Roma’s Disastrous Health and Shelter Conditions* (2005), available at [http://www.internal-displacement.org/idmc/website/countries.nsf/\(httpEnvelopes\)/3B1B9AB0D4A9C586802570B8005AAA8A?OpenDocument](http://www.internal-displacement.org/idmc/website/countries.nsf/(httpEnvelopes)/3B1B9AB0D4A9C586802570B8005AAA8A?OpenDocument).

⁴² CESCR, General Comment No. 14, *supra* note 14, at 4.

commonplace in IDP settings and present another obstacle to the fulfillment of the right to health.

In 2004, the Inter-Agency Working Group on Reproductive Health in Refugee Situations evaluated coverage, quality, accessibility, and utilization of reproductive health services for refugees and IDPs.⁴³ While the working group had a “generally favorable impression” of reproductive health services for refugees, those for IDPs “appeared, in general, to be severely lacking, requiring much more attention if the [reproductive health] needs of these persons are to be met.” Among the factors found to influence the health-seeking behaviors of displaced persons were “cultural and religious barriers to family planning, preference for using TBAs (Traditional Birth Attendants), lack of time (e.g., busy at home or at work) to attend health facilities for antenatal care, and dislike of the lithotomy position and fear of having an episiotomy during childbirth.”⁴⁴

A study conducted after the December 2004 tsunami found that older displaced people were rarely consulted on their needs or views and often were seen as helpless, passive victims rather than as resources for counseling, support to family members, and community rebuilding. This resulted not only in the neglect of an important source of counsel and support to the community but also a heightened sense of isolation.⁴⁵ Likewise, in Serbia, a 2001 assessment of elderly IDPs found that, in collective centers, older people felt isolated and invisible. “In one centre, older people were concerned that the

⁴³ The Office of the UN High Commissioner for Refugees [UNHCR], *Inter-Agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons* (Sept. 2004), available at <http://www.rhrc.org/resources/iawg/documents/Summary-Nov04.pdf>.

⁴⁴ *Id.* at 4.

⁴⁵ HelpAge International, *The Impact of the Indian Ocean Tsunami on Older People: Issues and Recommendations* (2005).

sort of food they were given—for example, fatty foods, with few fresh fruits and vegetables—would increase their rates of heart disease.⁴⁶

In Liberia, food rations to IDPs included bulgur wheat, an unfamiliar food to a population for which rice is the staple food. A 2002 study found that bulgur wheat was not only deemed inappropriate but had two specific impacts on health. First, it was identified as a cause of diarrhea. Second: “To adjust their diets, bulgur wheat is exchanged for meat and rice. However, the frequency of food sales has lowered the market value of bulgur apparently contributing to a reduction of the food ration.”⁴⁷

Quality

According to the CESCR, “as well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality.”⁴⁸ Properly understood, quality health care in developing countries—and this applies as much or more so to vulnerable, displaced populations—is not a luxury but a necessity.

Good quality means that providers are able to manage an individual’s or a population’s health care by timely, skillful application of medical technology in a culturally sensitive manner within the available resource constraints...A sadly unique feature of quality is that poor quality can obviate all the implied benefits of good access and effective treatment. At its best, poor quality is wasteful—a tragedy in severely

⁴⁶ HelpAge International, *Building a Better Future: Older People in Serbia*, at 14 (2001).

⁴⁷ Carlos Valderrama, *International Rescue Committee Health Unit, Health Assessment: Internally Displaced Camps in Liberia*, at 19 (Sept. 2002).

⁴⁸ CESCR, General Comment No. 14, *supra* note 14, at 4.

resource-constrained health systems. At its worst, it causes actual harm.⁴⁹

The IDP Law of Georgia (adopted 1996) provides that vulnerable IDPs are entitled to free medical treatment, with benefits including basic medicines and in-patient services.⁵⁰ Although it appears that a majority of IDPs have publicly provided health care benefits, and enjoy relatively good access to and availability of health services, much evidence suggests that the overall health status of IDPs is worse than that of the general population.⁵¹ This is due to several factors. Many IDPs (and some health providers) are not aware of the policies or have incomplete or inaccurate information.⁵² Since 2005, many non-emergency medical interventions, such as chronic conditions, have not been covered; and many of the clinics serving IDPs, especially in rural areas, “often lack modern and adequate medical equipment and other resources.”⁵³ A 2004 report noted that “quality healthcare services are largely inaccessible to IDPs, mainly because of the high costs involved...The quality of medical treatment for IDPs is negatively influenced by the insufficient material-technical base of healthcare institutions for IDPs and lack of medicines.”⁵⁴

⁴⁹ John W. Peabody et al., *Improving the Quality of Care in Developing Countries*, in DISEASE CONTROL PRIORITIES IN DEVELOPING COUNTRIES 1304 (Dean T. Jamison et al. eds., 2006), available at <http://files.dcp2.org/pdf/DCP/DCP70.pdf>.

⁵⁰ J. Kharashvili et al., *Study on IDP Rights*, 22 and Annex B, 39-40 (2006).

⁵¹ Akaki Zoidze & Mamuka Djibuti, *IDP Health Profile Review in Georgia*, at 19 (2004).

⁵² Kharashvili et al., *supra* note 50, at 22.

⁵³ United Nations Country Team in Georgia, *Georgia: Humanitarian Situation and Transition to Development 2006—Consolidated Policy Recommendations* (Nov. 2005).

⁵⁴ UN Office for the Coordination of Humanitarian Affairs, *Georgia Humanitarian Situation and Strategy 2005*, at 19 (Nov. 2004).

Among the proximate causes identified by the 2005 WHO study on IDP camps in northern Uganda for excess mortality were insufficient quality and quantity of health care.⁵⁵ The study noted that one-fifth of all sick children were taken to private providers despite the presence of free health services in the camps. In Kitgum district, more than half of the people interviewed said they were dissatisfied with health services, citing an absence of qualified staff and essential drugs. Timely referral to hospitals was also noted as a challenge.

The issue of quality of services—whether it be health care, water, or sanitation—can also be an obstacle to return. As the Minister for Disaster Preparedness in Uganda noted, in the context of the signing of a ceasefire in late August 2006 that raised the prospect of large-scale return, “while people were suffering in the camps, the humanitarian groups and the government were able to give them at least safe water. Going home should not be like punishment; pushing them to drink from unprotected wells, swamp water and valley water is not the intention of government.”⁵⁶

In some cases, faulty coordination alone can reduce the quantity and quality of available medical care. For instance, in the wake of Hurricane Katrina in the United States in 2005, substantial difficulties arose as thousands of volunteer health personnel (VHPs) in Louisiana, Mississippi, and Texas were confronted with red tape and institutional inertia at federal, state, and local levels.

REGULATORY FRAMEWORK

The rights of IDPs to health and an adequate standard of living should be safeguarded by existing national public health systems and regulatory frameworks. Public health systems are meant to fulfill a number of key functions, including reducing the impact of emergencies and disasters on

⁵⁵ WHO, *supra* note 32, at iv, 33-34.

⁵⁶ UN Office for the Coordination of Humanitarian Affairs, *Uganda: Daunting Post-conflict Challenges in the North*, IRINNEWS.ORG, Sept. 1, 2006.

health.⁵⁷ This function, which has particular relevance to displaced persons, refers to public health activities in risk assessment, prevention, mitigation, preparedness, and response. The state regulatory system, including the national health authority (typically the Ministry of Health, although other ministries and departments may be involved as well) should, in other words, incorporate into its essential functions a capacity to prevent, prepare for, and respond to emergencies. Likewise, the state's response to emergencies and disasters, including those that involve internal displacement, should incorporate the broadest possible participation of the health system and other sectors to reduce the impacts on the population's health.

SUBSTANTIVE AND PROCEDURAL ELEMENTS OF STATE REGULATION

Prior to Displacement

The right to health and an adequate standard of living should be incorporated into national law for the entire population so that these basic rights can be more clearly articulated in the context of emergencies and disasters and other events involving internal displacement. As of 2005, at least thirteen states had codified the right to health into their national constitutions.⁵⁸ The Ugandan Constitution, for example, commits the State to “endeavour to fulfill” key developmental and health-related rights.⁵⁹ Uganda's National Policy for Internally Displaced Persons (hereinafter Uganda's IDP Policy), moreover,

⁵⁷ See Pan American Health Organization [PAHO], National Level Instrument for Measuring Essential Public Health Functions, *Public Health in the Americas* (May 2000).

⁵⁸ Iain Byrne, *Making the Right to Health a Reality: Legal Strategies for Effective Implementation*, Paper presented at the Commonwealth Law Conference, Sept. 2005, available at <http://www.interights.org/doc/health%20paper.doc>.

⁵⁹ *Id.*

reflects these commitments through direct reference to the rights to adequate food, water and sanitation, basic shelter, appropriate clothing, and health.⁶⁰

The establishment of an integrated health support system should extend to the areas of mental health and reproductive health. The Inter-Agency Standing Committee (IASC) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (the *IASC Mental Health Guidelines*) notes that “activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc) tend to reach more people, often are sustainable, and tend to carry less stigma.”⁶¹ Similarly, the WHO recommends during all phases of conflict and displacement that:

reproductive health is treated as an integral component of primary health care, and the solutions to reproductive health needs are sought both in the health sector and elsewhere...Among refugees and displaced persons, an integrated approach means including the interactions between host and displaced communities in program planning. It also means that wherever possible, vertical programs, such as maternal and child health, family planning, and STI/HIV control and prevention should be linked or integrated to ensure that reproductive health care needs are met by the provision of a holistic service.⁶²

⁶⁰ Uganda National Policy for Internally Displaced Persons, Office of the Prime Minister, Department of Disaster Preparedness and Refugees, Aug. 2004, at 29-30.

⁶¹ Inter-Agency Standing Committee, *Guidelines on Mental Health and Psycho-Social Support in Emergency Settings*, at 8, IASC-WG Approved, Feb. 25, 2007.

⁶² World Health Organization [WHO], *Reproductive Health in Conflict: Guidelines for Programme Managers*, at 21 (2003).

The *Hyogo Framework for Action 2005-2015* (the *Hyogo Framework*) spells out priorities for risk reduction in both natural and human-made disasters.⁶³ As part of reducing underlying risk factors, the *Hyogo Framework* identifies a range of key activities including, within the context of social and economic development practices, integrating disaster risk reduction planning into the health sector. This includes mitigation measures to reinforce existing health facilities, particularly those providing primary health care; protecting and strengthening critical public facilities, including clinics and hospitals; and strengthening “the implementation of social safety-net mechanisms to assist the poor, the elderly and disabled, and other populations affected by disasters,” including psycho-social training programs to mitigate the psychological impact on vulnerable populations.

Disaster preparedness and risk reduction efforts in the health sector should apply equally to mitigating the effects of both natural and human-made calamities, though state self-interest might interpret the contexts differently. In Nepal, for example, a three-year program to reduce hospital vulnerability following earthquakes has provided for structural and non-structural assessments of selected hospitals for seismic vulnerability.⁶⁴ UN inter-agency assessments of hospital and clinic-based care for IDPs displaced by civil conflict, however, suggest that access to health care has been hampered by restrictive eligibility criteria and that there has been little to no special care for IDPs traumatized by violence.⁶⁵

⁶³ United Nations International Strategy for Disaster Reduction [UNISDR], *Hyogo Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disasters*, Extract from the final report of the World Conference on Disaster Reduction, A/CONF.206.6, available at http://www.icsu-asiapacific.org/resource_centre/ISDR_Hyogo-framework-for-action_HFA.pdf.

⁶⁴ See *Risk Reduction in the Health Sector and Status of Progress*, available at http://www.preventionweb.net/globalplatform/firstsession/docs/Workshops/4_2_1_Reducing_risk_health/Background_Paper.pdf.

⁶⁵ UNHCR, UNICEF, OHCHR, WHO, UNDP, OCHA, SNV, INSEC, Inter-Agency Mission Report, Eastern Region, May 18-29, 2006, available at [http://www.internal-displacement.org/idmc/website/countries.nsf/\(httpEnvelopes\)/355A3F3D4756FA52802570B8005AAAE1?OpenDocument](http://www.internal-displacement.org/idmc/website/countries.nsf/(httpEnvelopes)/355A3F3D4756FA52802570B8005AAAE1?OpenDocument).

One important means of preparing for displacement-related health emergencies is the active collection of health-related data and development of criteria and techniques for assessing the health needs of populations affected by emergencies. WHO's Department for Health Action in Crises (WHO/HAC) has recommended that all countries in which the health sector has been disrupted by a natural or human-made disaster should, prior to or at the beginning of a crisis, develop a Health Sector Profile (HSP) which should include the health needs of the population and the status of health facilities, goods, and services.⁶⁶ The Special Rapporteur on the Right to Health has noted that "...with a view to monitoring its progress [towards the progressive realization of the right to the highest attainable standard of health], a State needs a device to measure this variable dimension of the right to health," and recommended "the combined application of indicators and benchmarks." In the context of the right to health, indicators can help national health officials, legislative bodies as they monitor the performance of the executive, courts, human right institutions and other national adjudicating bodies, specialized agencies and other UN bodies working in partnership with states, UN human rights treaty bodies and non-governmental organizations.

In order to monitor the progressive realization of the right to health, the Special Rapporteur recommended that indicators should correspond to a right to health norm. They should be disaggregated at least by sex, race, ethnicity, rural/urban, and socio-economic status. Examples of indicators to measure the right to health included child mortality rates, maternal mortality ratios, and the proportion of births attended by skilled health personnel. For each health indicator identified, the state should set appropriate national targets or benchmarks.⁶⁷ Such targets and benchmarks should be established not only for "normal" times, but calibrated for times of emergency and disaster.

⁶⁶ See Enrico Pavignani, Module 13: Producing a Health Sector Profile, *available at* http://www.who.int/hac/techguidance/tools/disrupted_sectors/module_13/en/print.htm

⁶⁷ The Special Rapporteur, *Report of the Special Rapporteur on the Right to Health*, E/CN.4/2006/48/Add.1 (Dec. 22, 2005).

States should articulate priority health services in disasters and complex emergencies and establish minimum standards of health care as well as indicators for measuring whether these standards have been attained. The *Sphere Handbook* includes minimum standards related to the prioritization and support of health services and control of both infectious and non-communicable disease.⁶⁸ The *Sphere Handbook's* minimum standard for health systems and infrastructure is that “[a]ll people have access to health services that are prioritized to address the main causes of excess mortality and morbidity.” Indicators that show whether this standard has been met include that the major causes of mortality and morbidity are identified, documented and monitored; that priority health services include the most appropriate and effective interventions to reduce excess morbidity and mortality; and that all members of the community, including vulnerable groups, have access to priority health interventions. The *Sphere Handbook* specifies that priority public health interventions include “adequate supplies of safe water, sanitation, food and shelter, infectious disease control (e.g. measles vaccination), basic clinical care and disease surveillance. Expanded clinical services, including trauma care, are given higher priority following disasters that are associated with large numbers of injuries, e.g. earthquakes.” Vulnerable groups typically include “women, children, older people, disabled people and people living with HIV/AIDS,” but may also include people made vulnerable by reason of “ethnic origin, religious or political affiliation, or displacement.”⁶⁹

The right to health and to an adequate standard of living, once established substantively in national law and policy frameworks, require procedural and administrative safeguards if they are to be effective, especially in the context of displacement, either planned or unplanned. Procedures must establish how public health powers are to be articulated consistent with four standards that Professor Larry Gostin refers to as “public health necessity, reasonable means, proportionality, and harm avoidance.”⁷⁰

⁶⁸ See SPHERE PROJECT, *supra* note 4.

⁶⁹ See *id.* at 256-260.

⁷⁰ LARRY GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 68 (2000).

Procedural due process should be articulated and made available where authorities interfere with freedom of movement, whether in the form of isolation and quarantine or evacuations and other compulsory population movements.⁷¹ Second, it is incumbent on states that displacement is effected in satisfactory conditions of safety, nutrition, health, and hygiene. State procedures should spell out the roles of police and law enforcement authorities, health departments and Red Cross/Red Crescent societies, as well as the media (radio, television and newspapers) and civic organizations to ensure that displacements necessary to maintain public health and safety are carried out with full information, appropriate coordination, and minimal coercion. In Uganda, for example, the Department of Disaster Management and Refugees implemented awareness and sensitization meetings in districts where landslides were prevalent.⁷²

Procedural safeguards of the right to health and an adequate standard of living should also include systems for gathering and maintaining population and health data, both for purposes of vulnerability-mapping and for ensuring that proper monitoring of health status can be maintained. Population and individual-level health information and documentation storage systems should ensure that back-up copies are maintained and that clear procedures are established for provision of replacement documents in the event of disaster and/or displacement.

⁷¹ See chapter two of this volume on movement-related rights.

⁷² The Department of Disaster Management and Refugees, Office of the Prime Minister, *Uganda National Report and Information on Disaster Risk Reduction Efforts for the World Conference on Disaster Reduction*, Kobe, Japan, Jan. 19-22, 2005, ¶ 2.1.1, available at <http://www.unisdr.org/eng/mdgs-drr/national-reports/Uganda-report.pdf>.

During Displacement

Eligibility for Services

In the acute phase of a disaster or complex emergency, IDPs should be considered presumptively eligible for priority public health interventions, including adequate supplies of safe water, sanitation, food and shelter, infectious disease control, basic clinical care, and disease surveillance to the maximum extent necessary through national, international, and non-governmental resources. It may be possible, in the case of some natural disasters or limited conflicts, for IDPs to return reasonably promptly to their places of permanent or habitual residence, where access to basic health services should be restored. In many more cases, however, it is likely that the acute phase of emergency will transition into a chronic phase, marked by longer-term displacement, with uncertain prospects of return or permanent settlement in new locations. In such cases, it may become necessary for national authorities to establish eligibility criteria for on-going access to health services for displaced populations.

While eligibility criteria for IDP access to on-going health services in displacement may be subject to local conditions and circumstances, certain principles should apply, consistent with core obligations of the right to health.⁷³ More specifically, eligibility and service-delivery criteria should ensure the following:

- Basic health services are available in sufficient quantity. In the context of displacement, services should not be subject to arbitrary time limits and should be available such that displaced and resident populations are not placed in competition against one another.
- Health facilities, goods, and services are accessible to IDPs without discrimination.
- Health facilities, goods, and services are within safe physical reach of all sections of the IDP populations, including vulnerable groups and

⁷³ CESCR, General Comment No. 14, *supra* note 14, at 3.

those in temporary shelter settings. Generally, however, establishment of special or parallel services for IDPs should be only a short-term, emergency measure; in the longer term, health services to IDPs and local populations should be integrated in such a way that any preference given is not on the basis of status but health needs.

- Payment for health care services—as well as water, sanitation, food, shelter, and other services relating to the underlying determinants of health—is provided on the basis of the principle of equity. IDPs should not be expected to pay for services in the acute phase of an emergency. Over time, however, as more durable solutions are being developed, it is appropriate to begin to harmonize payment (and ongoing social support) mechanisms with those available for local populations.⁷⁴
- IDPs have the right to seek, receive, and impart information and ideas concerning health issues. Such information accessibility should not impair the right to have personal health data treated with confidentiality. In the context of displacement, accurate and up-to-date information about availability of and access to health services—as well as eligibility criteria for such services—is essential to maintain appropriate use of services by those who need them. In particular, if eligibility criteria are changed over time, this should be done with full participation and involvement of IDP populations.
- Health facilities, goods, and services for IDPs are respectful of medical ethics and culturally appropriate, including being sensitive to gender and life-cycle requirements. Health information, as well as information collected for purposes of assessing eligibility for services, should be collected in a culturally sensitive manner and stored confidentially. This is particularly important in the context of reproductive health services, which may include the gathering and storing of information about such sensitive issues as fertility and contraception, HIV/AIDS and other sexually transmitted infections (STIs), and sexual and gender-based violence.

⁷⁴ See SPHERE PROJECT, *supra* note 4, at 260.

- Health facilities, goods, and services to IDPs are scientifically and medically appropriate and of good quality. This should include attention to the elements of patient safety, effectiveness of care, patient centeredness, timeliness of service delivery, efficiency, and equity.⁷⁵
- Clear, streamlined procedures for IDPs and other affected populations are established to maintain necessary health documentation and eligibility for services. These procedures should be broadly disseminated through all available media with adequate opportunity for community participation and input.

Collection of Information

An effective and integrated health system requires functional health information systems, without which it is nearly impossible to measure over time whether the health system is accessible to all of the population. Emergencies and disasters pose a special challenge to the development or maintenance of health information systems but such systems are even more vital in times of crisis. The *Sphere Handbook's* key indicators for health information systems in humanitarian emergencies include (1) a standardized health information system (HIS) implemented by all health agencies to routinely collect relevant data on demographics, mortality, morbidity, and health services; (2) a designated HIS coordinating agency (or agencies) to organize and supervise the system; (3) regular submission of surveillance data by health facilities and agencies to the designated HIS coordinating agency; (4) production and dissemination of a regular epidemiological report, including analysis and interpretation of the data by the HIS agency; and (5) data protection precautions to guarantee the rights and safety of individuals and/or populations.

Wherever possible, the health information system should build upon pre-existing surveillance systems. In some emergencies, a new or parallel health information system may be necessary, but this should be determined by and/or in consultation with the lead health authority. Data should be disaggregated by

⁷⁵ See Institute of Medicine, Committee on Quality Health Care in America, *Crossing the Quality Chasm* (2001).

age and sex, to be able to capture morbidity and mortality data for children under five from the outset of the emergency. Gradually, more detailed disaggregation can be developed to detect gender-specific differences as well as other possibly vulnerable population sub-groups.⁷⁶

Standards and Indicators

Having identified priority health services in disasters and complex emergencies, established minimum standards for services, and defined indicators for measuring progress and accountability, states should articulate the procedures for collecting, analyzing, and disseminating health indicators for IDP and other affected populations. As noted previously, the *Sphere Handbook* has recommended that, in emergencies, a standardized health information system (HIS) should be implemented under the authority of a designated HIS coordinating agency.⁷⁷

It is recommended that, wherever possible, the HIS should build upon pre-existing public health surveillance and vital registration systems. These can and should be supplemented by national census data, Demographic and Health Surveys, as well as health information gathered by international and non-governmental organizations in the course of their work. In some complex emergencies, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), on behalf of IASC, serves as the steward of Humanitarian Information Centers (HICs), which have been launched in more than twelve countries since 2003. The main aim of the HICs is “to ensure that individuals at [the] field and strategic level[s] have access to the benefits of information management tools to assess, plan, implement and monitor humanitarian assistance.”⁷⁸ While not limited to health information, HICs have been instrumental in coordinating data-tracking of some key health indicators.

⁷⁶ See SPHERE PROJECT, *supra* note 4, at 270-271.

⁷⁷ *Id.*

⁷⁸ United Nations Office for the Coordination of Humanitarian Affairs [UN-OCHA], *Humanitarian Information Centers (HICs), available at* <http://www.ochaonline.un.org>.

In the Context of Durable Solutions

In the context of return or resettlement after displacement, it might be appropriate to view re-connecting IDPs with health services as a process involving interim and long-term elements. Health services in the context of durable solutions should involve systematic delivery of essential health services, while more comprehensive rehabilitation work on the health system itself is carried out. In Mozambique, priority services following conflict included the Expanded Programme on Immunization (EPI) for children under five, tetanus immunization for pregnant women, vitamin A supplementation for high-risk populations, deworming for children, and initial health education campaigns. In Afghanistan, the Basic Health Services Package (BHSP) includes maternal and newborn health; traditional birth attendants (TBAs); additional emergency obstetric services; child health and immunizations; nutritional supplements including vitamin A, folic acid, and iron; growth monitoring; supplementary feeding programs; communicable disease control (including bednets for malaria prevention); community health workers trained in the diagnosis and treatment of common conditions; mental health treatment; and a defined set of essential drugs.⁷⁹ States should also be sure that the transition from the delivery of health services during displacement to their delivery in the context of durable solutions does not lead to a diminution of availability or quality of health services, nor to circumstances that perpetuate or exacerbate inequities in accessing care.

As IDPs are able to return home or offered permanent resettlement in another location, states should establish procedures to integrate them back into the health systems that are, or at least should be, in place for local residents. Procedures should spell out mechanisms for transitioning from IDP status—and the special services and assistance that may entail—to ordinary citizens, while also recognizing that displacement *per se* can impose additional physical

⁷⁹ See Hugh Waters et al., *Rehabilitating Health Systems in Post-Conflict Situations*, at 7 (Jan. 2007), available at http://www.wider.unu.edu/publications/working-papers/research-papers/2007/en_GB/rp2007-06/files/78091828154141008/default/rp2007-06.pdf; see also Ronald Waldman & Homaira Hanif, *The Public Health System in Afghanistan*, Kabul: Afghanistan Research and Evaluation Unit (2000).

and psychological burdens, which a state should take into account through means tests and/or vulnerability assessments to identify those especially vulnerable households and individuals who may need sustained special assistance in the context of transition.

INSTITUTIONAL ELEMENTS OF STATE REGULATION

Prior to Displacement

In the area of disaster preparedness, one of the key points for action in the *Hyogo Framework* was to “ensure that disaster risk reduction is a national and a local priority with a strong institutional basis for implementation.” In this regard, states are recommended to develop national institutional and legislative frameworks, such as “multi-sectoral national platforms,” with designated responsibilities from the national to the local levels to facilitate coordination across sectors. It is also recommended that states integrate risk reduction, as appropriate, into development policies and planning at all levels of government, including in poverty reduction strategies.⁸⁰

The Pan American Health Organization recommends that one of the key public health functions of a national health care system is “reducing the impact of emergencies and disasters on health.”⁸¹ The state regulatory system, including the bodies responsible for health issues, should incorporate into its essential functions a capacity to prevent, prepare for, and respond to emergencies. Before the beginning of a crisis (or during a current one), the national health authority should develop a Health Sector Profile (HSP) which should identify health sector financing; health delivery systems; regulatory and management systems; health networks (including patterns of urban and rural networks, hospitals and primary health care facilities, referral capacity,

⁸⁰ UNISDR, *supra* note 3.

⁸¹ See Pan American Health Organization [PAHO], *National Level Instrument for Measuring Essential Public Health Functions, Public Health in the Americas* (May 2000).

and support infrastructure); human resources; the pharmaceutical area; and priorities for action.⁸²

During Displacement

Role of National, Provincial and Local Government

Whether states implement stand-alone laws and policies for IDPs or incorporate them into existing institutional frameworks, the roles of national, provincial, and local government should be spelled out clearly (with appropriate budgetary authority) so that a chain-of-command can function efficiently up and down the line. Uganda's IDP Policy, for example, spells out government responsibilities at the national, district, and county levels. At the national level, the Office of the Prime Minister, Department of Disaster Preparedness and Refugees, is the lead agency. The national policy also establishes an Inter-Ministerial Policy Committee, an Inter-Agency Technical Committee, and a Human Rights Promotion and Protection Sub-Committee. At the district level, Uganda's IDP Policy calls for the District Disaster Management Committee (DDMC) to be the lead agency and provides that "[t]he DDMC shall be constituted by all relevant heads of Government Departments, humanitarian and development agencies and the private sector resident in a district."⁸³

States will need to decide whether to establish a separate department or ministry for processing assistance to IDPs or to incorporate such functions within existing entities. In general, states should be discouraged from instituting parallel systems and services, although, in the case of long-term displacement, specialized departments and functions may be necessary. The IDP Law of Georgia, for example, established the Ministry of Refugees and Accommodation (MoRA) in 1996, more than four years after displacement took place. MoRA is tasked, along with other relevant bodies, to ensure

⁸² See Pavignani, *supra* note 66.

⁸³ Uganda's National Policy for IDPs, *supra* note 60, at § 2.4.

implementation of IDPs' rights at the place of temporary residence.⁸⁴ More than ten years later, MoRA is still in existence, although, in the context of Georgia's new strategy of integrating IDPs, it is possible that the Ministry's specialized functions will be phased out.

Role of Health and Relief Personnel

It is particularly important during displacement for a state to articulate a plan for deploying health personnel for both shorter-term and longer-term interventions, including how state personnel will interact with other actors such as national Red Cross and Red Crescent Societies and personnel from international and non-governmental organizations. Coordination is key in the health sector, as effective health care delivery in an emergency involves coordinated decision-making and information-sharing about prioritizing public health interventions, harmonizing health education messages, establishing consistent drug treatment protocols, and maintaining patient confidentiality.

In order to coordinate the roles and responsibilities of government agencies working at various levels with that of other actors, states should develop an Emergency Health Action Plan, either incorporated within or coordinated with a national health action plan. The Emergency Health Action Plan should lay out a clear regulatory framework for responding to the health needs of populations affected by disasters and complex emergencies. One model that states should consider is that of the Committee for the Coordination of Services to Displaced Persons in Thailand (CCSDPT), which was first established in 1977 as a coordinating body for NGOs, international organizations, and government agencies and is still in existence. Another useful model is the Consortium of Humanitarian Agencies (CHA) in Sri Lanka, which has a national and international membership and a mandate.⁸⁵

⁸⁴ Kharashvili et al., *supra* note 50, at 40-41.

⁸⁵ Consortium of Humanitarian Agencies in Sri Lanka, <http://www.humanitarian-srilanka.org>.

Role of National Human Rights Institutions

To protect IDPs' right to health and an adequate standard of living, states should establish linkages with national human rights commissions to provide a forum where complaints may be lodged and redress may be sought. In Uganda, for example, the National Policy for IDPs establishes a Human Rights Promotion and Protection Sub Committee (HRPP) which, in collaboration with the Uganda Human Rights Commission, monitors protection of the human rights of IDPs including the right to medical care.⁸⁶

In India, the National Human Rights Commission has recommended that the government adopt a National Action Plan to Operationalize the Right to Health Care that delineates essential health services and supplies, outlines a basic set of health sector reform measures essential for universal and equitable access to quality health care, and would recognize and legally protect the health rights of various sections of the population, including persons facing displacement.⁸⁷

In the Context of Durable Solutions

When IDPs begin to return home or resettle permanently in a new location, institutional frameworks regulating such movements must have in place some means to monitor the conditions under which such movements take place and to be able to maintain health and basic services that meet core human rights obligations. In some cases, return and resettlement do not take place in conditions of full safety or to places that are fully prepared to accommodate arrivals. To clarify the frameworks within which return and resettlement can be supported as durable solutions, states should develop clear guidelines and regulations spelling out what returning and resettling IDPs can expect in terms of access to health services. In Colombia, for example, the Social Solidarity

⁸⁶ Uganda's National Policy for IDPs, *supra* note 60, at 10.

⁸⁷ National Human Rights Commission, *Recommendations of National Action Plan to Operationalize the Right to Health Care*, available at <http://www.nhrc.nic.in/dispArchive.asp?fno=874>.

Network (now Social Action) has prepared a Return Manual which lays out how state institutions can guarantee integrated assistance that includes health.⁸⁸

Institutional frameworks, in the early stages of return and resettlement, may need to incorporate immediate relief interventions into health services planning. If the situation continues to stabilize, the state health authority—supported as needed by international and non-governmental organizations—can shift toward more systematic delivery of essential health services (like the Basic Health Services Package in Afghanistan), and eventually into more comprehensive rehabilitation work on the health system itself.

INTERNATIONAL ROLE

There are a number of roles that the international community could play in supporting IDP rights to health and an adequate standard of living. The international community can help develop national laws and policies, build national and local capacity, and strengthen monitoring of state compliance with international human rights standards.

United Nations

OCHA/IASC

The mandate of the Office for the Coordination of Humanitarian Affairs (OCHA) includes the coordination of humanitarian response, policy development, and humanitarian advocacy. OCHA carries out its coordination function primarily through the Inter-Agency Standing Committee (IASC), which is chaired by the Emergency Relief Coordinator (ERC). Participants include all humanitarian partners, from UN agencies, funds and programs to the Red Cross Movement and NGOs. The IASC ensures inter-agency decision-making in response to complex emergencies. These responses include needs assessments, consolidated appeals, field coordination arrangements, and the development of humanitarian policies. The IASC has

⁸⁸ Report on the Inter-Agency Internal Displacement Division Mission to Colombia (Jan. 17-27, 2005), Summary of Recommendations.

developed a number of resources that provide useful guidelines for governmental and non-governmental organizations working with IDPs.

UNFPA

Within the coordinated, inter-agency response to disasters, the United Nations Population Fund (UNFPA) takes the lead in providing supplies and services to protect reproductive health. Priority areas include safe motherhood; prevention of sexually transmitted infections, including HIV; adolescent health; and gender-based violence. UNFPA also encourages the full participation of women and young people in efforts to rebuild their societies. One of the three major objectives of the UNFPA reproductive health program for 2003-2007 is improved access to sexual and reproductive health services for displaced populations, particularly adolescents. Activities will include training and institutional capacity building of organizations working with IDPs to educate IDPs about their reproductive health rights and to implement integrated sexual and reproductive health services with particular emphasis on adolescents.⁸⁹

UNICEF

Within the United Nations Children's Fund (UNICEF), the Office of Emergency Programmes (EMOPS) is the focal point for emergency assistance, humanitarian policies, staff security, and support to UNICEF offices in the field, as well as strategic coordination with external humanitarian partners both within and outside the UN system. EMOPS coordinates headquarters support to country and regional offices dealing with emergencies in terms of staffing, funding, donor relations, inter-agency issues, or technical guidance. Through the IASC and other coordination entities established among the United Nations family, EMOPS works to ensure that children's interests are at the center of the humanitarian policy debate both within the UN and among NGO forums.

⁸⁹ Executive Board of the United Nations Development Programme and of the United Nations Population Fund, United Nations Population Fund Country Programme for Colombia, Oct. 2002.

UNHCR

The mandate of the UN High Commissioner for Refugees (UNHCR) to provide international protection and seek durable solutions for refugees includes IDPs and, thus, UNHCR has played an active role in many IDP situations. In terms of health services, UNHCR has been particularly active on the issue of HIV/AIDS. In cooperation with its partners, UNHCR has developed the *Framework for Durable Solutions for Refugees and Persons of Concern* (the Framework).⁹⁰ The *Framework* consists of the following three tools: Development Assistance for Refugees (DAR); the 4Rs (Repatriation, Reintegration, Rehabilitation, and Reconstruction); and Development through Local Integration (DLI). The 4Rs initiative—found in countries such as Afghanistan, Eritrea, Sierra Leone, and Sri Lanka—facilitates the return and sustainable reintegration of refugees and internally displaced persons and is intended to ensure “that UNHCR’s relatively short-term reintegration programs are linked to longer-term reconstruction and development efforts.”⁹¹

WHO

WHO plays a number of roles that relate, directly or indirectly, to IDPs. First, WHO serves as the chair of the IASC Global Health Cluster which is designed to provide health leadership in emergency and crisis preparedness, response and recovery; prevent and reduce emergency-related morbidity and mortality; ensure evidence-based actions, gap filling and sound coordination; and enhance accountability, predictability, and effectiveness of humanitarian health actions. Second, WHO has created a Department for Health Action in Crises (HAC) with objectives that include building efficient partnerships for emergency management, developing evidence-based guidance for all phases

⁹⁰ Executive Committee of the High Commissioner’s Programme, Standing Committee, 28th Meeting, EC/53/SC/INF.3, Sept. 16, 2003.

⁹¹ The Office of the UN High Commissioner for Refugees [UNHCR], *Activities of the UNHCR in the Area of International Migration and Development*, Fourth Coordination Meeting on International Migration, UN/POP/MIG-FCM/2005/05 (Oct. 13, 2005).

of emergency work in the health sector, and strengthening capacity and resilience of health systems and countries to mitigate and manage disasters.⁹²

Special Rapporteur on the Right to Health

The Special Rapporteur's office has tried to make the right to health more specific, accessible, practical, and operational. His reports to date have focused on such issues as the right to reproductive health, access to essential medicines, the rights of people with mental disabilities, health-related Millennium Development Goals, and the development of a human rights-based approach to health indicators. Country reports have included Mozambique, Peru, Uganda, Romania, and Sweden.

Red Cross/Red Crescent Movement

International Committee of the Red Cross (ICRC)

The ICRC's position on IDPs, as articulated in May 2006, notes that its main mode of action consists of:

persuading the authorities and armed groups through confidential dialogue, to fulfill their obligation not to displace civilians or commit other violations of the relevant bodies of law that would result in displacement. If displacement occurs, the authorities must ensure that IDPs are protected, their rights respected and their essential needs met. They must also promote voluntary return whenever it is safe and whenever adequate living conditions are in place.⁹³

⁹² World Health Organization [WHO], *Health Action in Crisis*, available at <http://www.who.int/disasters>.

⁹³ ICRC Position on Internally Displaced Persons (IDPs) (May 2006), available at [http://www.icrc.org/Web/eng/siteeng0.nsf/htmlall/idp-icrc-position030706/\\$File/2006_IDPs_EN_ICRCExternalPosition.pdf](http://www.icrc.org/Web/eng/siteeng0.nsf/htmlall/idp-icrc-position030706/$File/2006_IDPs_EN_ICRCExternalPosition.pdf).

International Federation of Red Cross and Red Crescent Societies (IFRC)

The IFRC's three key areas of activity—health, disaster management, and promoting humanitarian principles and values—all serve to promote the rights of IDPs to health and to an adequate standard of living. In their commitment to disaster management and humanitarian response, the IFRC, in conjunction with the national Red Cross and Red Crescent Societies, have pledged to:

make certain that physical, mental and social health care are incorporated and are an integral part of all other humanitarian work and programs; ensure that all health care services provided in a disaster context shall take the long-term sustainability of services into consideration, with the assurance that services provided in any prolonged emergencies will develop into sustainable, integrated community-based primary care; [and] recognize the need to prepare and train communities for rapid response to public health emergencies and disease outbreaks and to strengthen the preventive capacity of communities.⁹⁴

Private Organizations

Global Action on Aging

Global Action on Aging's International Human Rights Education Group has prepared a report on international legal standards, principles, and commitments relating to the human rights of older people in armed conflict.⁹⁵

⁹⁴ The IFRC Health Policy was adopted by the 15th session of the General Assembly of the International Federation of the Red Cross and Red Crescent Societies (2005), available at <http://www.ifrc.org/Docs/pubs/who/policies/health-policy-en.pdf>.

⁹⁵ Global Action on Aging, International Legal Standards, Principles and Commitments, available at <http://www.globalaging.org/armedconflict/internationalstandards.htm>.

HelpAge International

HelpAge International has published a handbook, *Older People in Disasters and Humanitarian Crises: Guidelines for Best Practice*, that includes an emphasis on ensuring the human rights of older people in disasters and humanitarian emergencies. HelpAge International has also published *Equal Treatment, Equal Rights: Ten Actions to End Age Discrimination*, which includes the action to “include and consult older people in emergency aid and rehabilitation planning after disasters and humanitarian crises.”⁹⁶

International Council of Nurses

The International Council of Nurses (ICN) has committed to “work in all appropriate ways to promote the development of timely health and social programs for migrants, refugees and displaced persons (MRDPs), for example, emergency treatment, care and maintenance, repatriation/integration/resettlement, bank of nursing experts [*sic*].” The ICN also pledges to work with national nursing associations and encourages them to examine the extent of the problem regarding the development of health and social programs for MRDPs in their countries and to undertake cooperative action to provide adequate services to MRDPs.⁹⁷

Women’s Commission for Refugee Women and Children

The Women’s Commission for Refugee Women and Children has developed a Reproductive Health Program which works to improve services in the following four primary areas of reproductive health care: safe motherhood, including emergency obstetric care; family planning; gender-based violence; and sexually transmitted infections, including HIV/AIDS. Over the past two years, the Women’s Commission has collaborated with the Inter-agency

⁹⁶ HelpAge International, *Equal Treatment, Equal Rights: Ten Actions to End Age Discrimination*, at 3 (Nov. 2001).

⁹⁷ International Council of Nurses, *Position Statement on Health Services for Migrants, Refugees and Displaced Persons*, available at <http://www.icn.ch/psmigrants00.htm>.

Working Group (IAWG) on Reproductive Health in Refugee Situations to produce the report *Global Evaluation of Reproductive Health for Refugees and Internally Displaced Persons*. The Women's Commission continues to coordinate the Reproductive Health Response in Conflict (RHRC) Consortium. The Reproductive Health Program includes a variety of projects geared toward improving the reproductive health care of refugee women, children, and youth. They include ending gender-based violence, preventing sexually transmitted infections and HIV, emergency health for displaced women and girls, safe motherhood, and youth.⁹⁸

SUMMARY OF RECOMMENDATIONS

1. Governments should provide the necessary assistance to guarantee the rights of IDPs to health, an adequate standard of living, and to social security.
2. Governments should remove obstacles that hinder IDPs from accessing essential services, including food and nutrition, water and sanitation, health (including psycho-social and mental health services, and sexual and reproductive health services), shelter, and appropriate clothing.
3. Governments should remove obstacles that hinder IDPs from accessing pension entitlements and other social security benefits, regardless of their place of residence in the country.
4. Governments should adopt a definition of internally displaced person consistent with that of the *Guiding Principles* and incorporate that definition into national laws and into regulatory frameworks governing the delivery of essential humanitarian services, recognizing that it is not appropriate to discriminate between and among displaced populations according to their cause of displacement (natural disaster, conflict, etc.)
5. Governments should ensure that the registration procedures for receipt of essential humanitarian services provide for delivery of all essential aid in a non-discriminatory, transparent, and expeditious manner, with a particular

⁹⁸ Women's Commission on Refugee Women and Children, *Reproductive Health Program*, available at <http://www.womenscommission.org/projects/rh>.

focus on assistance to especially vulnerable groups. Entitlement to government benefits should be based on humanitarian need, not on eligibility status or other criteria.

6. Governments should commit to the full involvement of affected populations in consultation and planning after disasters and humanitarian crises. This should especially involve marginalized and vulnerable populations, and minority and indigenous peoples.

7. Governments should establish minimum humanitarian standards for essential services based on the standards in the *Sphere Handbook*. These standards should be translated and disseminated to all appropriate national and international stakeholders.

8. Governments should incorporate validated indicators and vulnerability assessment tools to measure population needs and programmatic impact in the delivery of essential services, including food and nutrition, water and sanitation, health, shelter, and clothing. Data on internally displaced populations should be collected in such a way that it can be disaggregated by age and sex, at minimum, and by other characteristics deemed necessary for an understanding of vulnerability.

9. Governments should establish mechanisms to ensure that the delivery of essential humanitarian services is coordinated and consistent with established minimum humanitarian standards.

10. Governments should ensure that the return of IDPs should take place only under agreed minimum conditions (voluntary, safe, dignified, sustainable) and that shorter-term reintegration measures are linked to longer-term reconstruction and development efforts.

11. Governments should coordinate their activities with existing international agencies and private organizations.