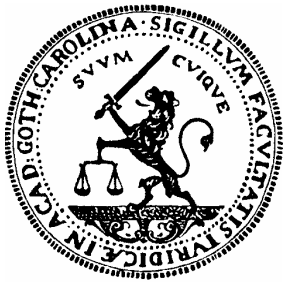

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APPEASING ARISTOTLE: ANALYSING THE EU RECEPTION DIRECTIVE'S FAILURE TO UPHOLD THE RIGHT TO HEALTH FOR ASYLUM SEEKERS

Master thesis
20 credits (30 ECTS)

Supervisor: Ilaria Bottigliero

Master Programme in Human Rights Law

Fall 2007

To Jim and Marie Breslin, for presenting the world as my oyster.

To Adam Foster, for being a pearl in the oyster's folds.

To my grandmother, Julie Malear, for helping me see life as a story unfolding before our eyes.

CONTENTS

Acknowledgement

Thank you to Ilaria Bottigliero, for giving me guidance and reassurance whenever I began floundering. Thank you, also, to Paola Pace of the International Organization for Migrants for granting me early access to her publication entitled *Migration and the Right to Health*. Its clarity and completeness aided my understanding of European Union laws and policies.

Summary

The European Union is working towards creating a Common European Asylum System for the purpose of harmonizing the domestic asylum laws of its Member States and creating a system in which asylum status may be determined justly. The Reception Directive of 2003 is the EU legislation that, among other things sets minimum standards of health care for asylum seekers in EU Member States.

All EU Member States are also State Parties to the International Covenant on Economic, Social and Cultural Rights, and as such they may not derogate from the minimum core obligations of the right to health under article 12 of the covenant. The Member States also have an overriding obligation to progressively fulfil the right to health for all persons within their jurisdictions to the maximum of available resources. However, there are three provisions of the Reception Directive that permit Member States to fall below these international obligations: article 9, which makes initial medical screenings of incoming asylum seekers discretionary; article 15, which requires only emergency care as the minimum standard of care for asylum seekers; and article 16, which permits withdrawal of benefits in certain specified situations. These provisions ignore the unique health needs of asylum seekers, in particular those of women and children.

Currently there are few methods of enforcing human rights, in particular economic and social rights, and the international community relies upon the good faith efforts of states and encouragement from regional human rights bodies to fulfil this role. As it stands, the Reception Directive is encouraging impunity for violations of international human rights at the domestic level by legalizing the offending asylum policies of Member States at an international level. To avoid this, the European Union should make efforts to align the minimum standards of the Reception Directive with the international obligations of its Member States.

Abbreviations

CEAS	Common European Asylum System
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CERD	Convention on the Elimination of Racial Discrimination
CoE	Council of Europe
CRC	Convention on the Rights of the Child
EC	European Community
ECJ	European Court of Justice
ESC	Economic and Social Committee
EU	European Union
HRC	Human Rights Committee
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
EC Treaty	Treaty establishing the European Community
TEU	Treaty on European Union
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNTS	United Nations Treaty Series
VCLT	Vienna Convention on the Law of Treaties
WHO	World Health Organization

1. INTRODUCTION, SCOPE AND METHODOLOGY

1.1 Introduction

The right to health is one of the economic and social rights that has intermittently enjoyed state protection for hundreds, if not thousands, of years. Aristotle recognized the fundamental nature of the right to health in the fourth century, B.C., stating "[i]f we believe that men have any personal rights at all as human beings, they have an absolute right to such a measure of good health as society, and society alone is able to provide".[1] Involvement by the state regarding health began humbly with public sanitation initiatives, but it has grown to include health education, public health initiatives intended to wipe out infectious diseases, and in many nations has even grown to include state-sponsored health care coverage.[2]

Today the right to the highest attainable standard of mental and physical health (the right to health) is considered a fundamental right in international human rights law, one that is to be enjoyed by all without discrimination.[3] The International Covenant on Economic, Social and Cultural Rights (ICESCR) requires that States Parties progressively achieve the rights embodied in the Covenant,[4] "guarantee" that the rights are able to

[1] S. Shah, 'Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India", 32 *Vanderbilt Journal of Transnational Law* (March 1999) p. 436.
[2] B. Toebes, 'The Right to Health' in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001), pp. 169-171 [hereinafter "Toebes"].
[3] P. Hunt, Special Rapporteur on the Right to Health, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Addendum MISSION TO SWEDEN*, U.N. Doc. A/HRC/4/28/Add.2 (28 February 2007) [hereinafter "Hunt *Mission to Sweden*"]; World Health Organization Constitution, preamble, available at: http://www.who.int/governance/eb/who_constitution_en.pdf.
[4] International Covenant on Economic, Social and Cultural Rights, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, art. 2(1) (*entered into force* Jan. 3, 1976) [hereinafter "ICESCR"].

be exercised without discrimination of any kind,[5] and protect the needs of the most vulnerable even in times of economic recession.[6]

Despite the long history and the universal nature of the right to health there are currently few enforcement mechanisms regarding economic, social and cultural rights, meaning violations of the right to health have traditionally gone unpunished;[7] instead, the international community has grown to depend on regional and domestic human rights enforcement mechanisms.[8] The Common European Asylum System (CEAS) is a creation of the European Union (EU) intended to create an area of freedom, security and justice by harmonising the Member States' domestic asylum laws regarding refugee status qualification requirements and reception conditions for asylum seekers during the status determination process.[9]

Lately, however, the CEAS had been heavily criticized by human rights defenders for creating overly restrictive regulations that prevent asylum seekers from ever reaching EU territory.[10] Although the global number of asylum applications rose throughout the world in 2006, the EU Member States reached a 20-year low for asylum applications.[11] The international community has recognized the human rights implications of the CEAS's draconian qualifications and procedures legislation,[12] but many human rights defenders have failed to challenge the treatment of asylum

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[5] *Ibid.*, art. 2(3).
[6] International Covenant on Civil and Political Rights, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, art. 2 (*entered into force* Mar. 23, 1976)[hereinafter "ICCPR"]; A. Hendriks and B. Toebes, 'Towards a Universal Definition of the Right to Health', 17 *Medicine and Law* (1998) p. 329 [hereinafter "Hendriks"].
[7] M. Scheinin, 'Economic and Social Rights as Legal Rights' in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed., 2001), p. 31.
[8] *Ibid*.
[9] Council of Europe Tampere Conclusions, 15-16 October 1999, introduction, available at: http://www.europarl.europa.eu/summits/tam_en.htm, last visited on 19 January 2008 [hereinafter "Tampere Conclusions"]; Council Directive 2003/9/EC of 27 on the Reception Standards of Asylum Seekers, January 2003, OJ L 031, 6.2.2003, preamble para. 7 [hereinafter "Reception Directive"].
[10] European Council on Refugees and Exiles, *Response to the Green Paper on the Common European Asylum System*, AD5/9/2007/Ext/RW (2007), available at: www.ecre.org./files/ECRE%20Green%20paper%20response%20final%20-%20Read%20only.pdf, last visited on 19 January 2008, p. 2 [hereinafter "ECRE *Green Paper Response*"].
[11] *Ibid.*
[12] S. Peers, *EU Justice and Home Affairs Law* (Oxford University Press, 2006, 2nd ed.), p. 341 [hereinafter "Peers"].

seekers that actually succeed in accessing protection in an EU Member State.[13] In particular a paucity of attention has been paid regarding whether the "Council Directive laying down minimum standards for the reception of asylum seekers" (the Reception Directive), which sets minimum reception standards for asylum seekers, sets standards for health care that actually satisfy the EU Member States' obligations under the right to health.

In an era where few enforcement mechanisms exist regarding economic, social and cultural rights, an analysis of this kind is necessary given the widespread impact that the CEAS will have. The Reception Directive provides the EU with the unique opportunity to enforce the right to health for asylum seekers at a regional level. This thesis hypothesizes that the EU fails to take advantage of this opportunity because the Reception directive sets minimum standards of health care for asylum seekers that fall below the Member States' international human rights obligations.

Several determinations of law are necessary to prove this hypothesis: what obligations the Member States have; who is entitled to benefit from these obligations; and whether and how the minimum standards of the Reception Directive violate these obligations. Chapter two analyses the right to health under international human rights law in order to determine the obligations it levies upon the EU Member States. Chapter three identifies the particular health needs of women and children and determines that a state must adequately address these needs to satisfy its obligations under the right to health. Chapter four discusses an asylum seeker's legal entitlement to health care under both international human rights law and refugee law. Finally, chapter five establishes the minimum standards set forth in the Reception Directive and highlights how these standards fall short of the Member States' international obligations.

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[13] *See* Amnesty International, *Response to the Green Paper on the future of the Common European Asylum System*, available at: www.amnesty-eu.org/static/documents/2007/AllResponseGreen_Paper_Sept07.pdf, last visited on 19 January 2008, pp. 3-4 [hereinafter "AI *Green Paper Response*"] (completely omitting the Reception Directive from their analysis of the human rights implications of the CEAS); *see also* ECRE *Green Paper Response*, *supra* note 10, p. 12-17 (limiting discussion of the reception of asylum seekers to five pages).

1.2 Scope

The scope of this thesis has been narrowed to primarily address the right of access to health care for asylum seekers within the European Union, with an emphasis placed on the health care rights and needs of women and children. The following subsections explain the rationale behind each limiting factor.

1.2.1 Access to Health Care

It is generally recognized that there are two components that make up the right to health – the right to healthy living conditions and the right to health care.[14] As evidence of this, the Committee on Economic, Social and Cultural Rights (the ESC Committee), the monitoring body of the ICESCR, defines the right to the highest attainable standard of health very broadly and includes "a wide range of socio-economic factors that promote conditions in which people can lead a healthy life."[15] While this thesis recognizes the inherently intertwined nature of the right to health and one's environment, its scope is predominantly limited to an asylum seeker's legal entitlement to health care and non-discriminatory access there to.

1.2.2 Asylum Seekers

Asylum seekers were chosen as the central subject of this thesis because of their sheer numbers within the European Union and their pressing health needs. According to the United Nations High Commissioner for Refugees (UNHCR), 199,850 new asylum applications were lodged in the 27 Member States of the European Union in 2006 alone.[16] Additionally,

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[14] J.A. Vita, *Discussion paper with particular emphasis on the implications of the principle of non-discrimination and of the concept that there is a minimum core content of each right which constitutes a 'floor' below which the conditions should not be permitted to fall in any State Party*, UN Doc. E/C.12/1993/WP.22, para. 22 [hereinafter "Vita *Discussion Paper*"].
[15] Committee on Economic, Social and Cultural Rights, General Comment 14, *The right to the highest attainable standard of health*, UN Doc. E/C.12/2000/4, para. 4 [hereinafter "ESC General Comment 14"].
[16] United Nations High Council on Refugees, *Asylum Levels and Trends in Industrialized Countries 2006*, available at www.unhcr.org/statistics/STATISTICS/460150272.pdf, last visited on 18 January 2008 [hereinafter "UNHCR *Industrialized Asylum Levels 2006*] p. 10,

asylum seekers are likely to have health issues that require immediate and ongoing medical attention due to pre- and post-migration factors such as a heightened risk of exposure to infectious diseases, lack of childhood inoculations, inadequate access to health care in their countries of origin, mental health issues such as depression and Post Traumatic Stress Disorder, and possible negative cultural health care practices such as female genital mutilation.[17] Combined, these two factors highlight the importance of protecting the health rights of asylum seekers in the EU.

This thesis does not directly address detained asylum seekers because statistics and facts regarding their actual treatment in detention centres are difficult to obtain. Instead, this paper concentrates on those asylum seekers that commingle with the citizens of the state in which they currently reside.

1.2.3 Women and Children's Health

Within the field of human rights law and refugee and asylum law, women and children are often times lumped together because they are both viewed as "vulnerable" portions of society.[18] However, their health care needs are distinct from one another, as evidenced by both the Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW Committee) and the Committee on the Rights of the Child (CRC Committee) in their General Comments regarding the right to health for these specific populations. As such, they will be addressed separately in the section that analyses the standard of care necessary to satisfy the distinct health needs of women and children.

Gender plays a role in accessing health care where, for instance, gender differences in job type and familial duties restrict adequate recuperation time after illnesses, or where symptoms are dismissed because

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table 1; *see generally* C. Kemp and J. Walgren, *Refugee and Immigrant Health*, (University Press, Cambridge 2004).

[17] M. Norredam, A. Mygind, A. Krasnik, 'Ethnic Disparities in Health: Access to health care for asylum seekers in the European Union – a comparative study of country policies', 16:3 *European Journal of Public Health* (2005), p. 285 [hereinafter "Norredam"].

[18] J. Bhabba, 'Demography and Rights: Women, Children, and Access to Asylum', 16 *International Journal on Refugee Law* (2004) p. 227 [hereinafter "Bhabba"].

they are analysed using a male norm.[19] While recognizing gender perspective regarding cultural and societal barriers to access to health care, this thesis primarily analyses legal, state-imposed barriers; social and cultural barriers (though equally important) are addressed only in a cursory manner where they are exacerbated by state policies.

'Women', as used in this thesis, includes girls, adolescents and adults.[20] For the purposes of the Convention on the Rights of the Child (CRC), children are any humans under the age of 18 unless the applicable law makes the age of majority earlier.[21]

1.2.4 A Focus on the European Union

The EU is the geo-political area of focus for many reasons. First, the CEAS is a relatively recent creation whose policies may still be pliable. Second, the concept of the state responsibility for providing health care is firmly established throughout most of the European Union but is not the norm in many other parts of the world. Third, there are very few enforcement mechanisms for international human rights, in particular economic and social rights, so enforcement mechanisms at regional levels are vital to the success of the human rights regime. As such, it is important for the CEAS to uphold the human rights law or else risk setting a precedent whereby regional law encourages individual states to undermine their international legal obligations.

Finally, the EU has been selected because it potentially has the economic resources necessary to fully realize the right to health for asylum seekers within its populations. These resources have increased dramatically in recent years for the very reason that the EU has nearly halved the number

[19] B. Babitsch and G. Dennert, 'Access to health care: Contributions from a Gender Perspective', 8:2 *Euro Observer* (Summer 2006) p. 5 [hereinafter "Babitsch"]. For instance, women complaining of symptoms of a myocardial infarction are often ignored or inadequately treated because heart attacks in women are labelled as 'atypical'.
[20] Committee on the Elimination of Discrimination Against Women, General Comment 24, *Women and Health*, UN Doc. No. A/54/38/ Rev.1, para. 8 [hereinafter "CEDAW General Comment 24"].
[21] International Convention on the Rights of the Child, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990), art. 1 [hereinafter "CRC"].

of asylum seekers it hosts over the past five years.[22] Inherently, this means that the resources available for each asylum seeker have doubled; a lack of resources may no longer be used as an excuse for inaction, unlike many other areas of the world.

1.3 Method

This thesis analyses whether the European Union's asylum legislation satisfies the international human rights obligations of the EU Member States in regards to the right to health. The original hypothesis was that the Reception Directive of 2003 set minimum standards of health care for asylum seekers below the Member States' minimum core obligations arising under the right to health.

To determine whether this hypothesis was correct, qualitative doctrinal research was used to answer to the following questions of law:

1. What are the minimum core obligations of the right to health under international human rights law?
2. What standard of health is owed to women and children to satisfy their right to health?
3. To what extent are non-nationals entitled to enjoy benefits under the International Covenant on Economic, Social and Cultural Rights?
4. What are the minimum standards of health for asylum seekers as provided in European Union legislation?

In determining the answers to these questions of law, primary sources such as international human rights treaties and EU legislation, secondary sources such as expert opinions, treatises, and articles from scholarly journals, and 'soft law' sources such as non-binding declarations were consulted. Inspiration for the topic stemmed from Ryzard Cholewinski's 'Economic and Social Rights of Refugees and Asylum Seekers in Europe', which

[22] ECRE *Green Paper Response*, *supra* note 10, p. 4. The number of asylum applications received by France in the first quarter of 2007 (14,000) was the lowest since 1999. *See also* United Nations High Commission on Refugees, *Asylum Levels and Trends in Industrialized Countries, Second Quarter 2007*, (September 2007), available at: www.unhcr.org/statistics/STATISTICS/46f0e0dd2.pdf, last visited on 18 January 2008 [hereinafter UNHCR *Industrialised Asylum Levels 2007*].

addressed European country's inadequacies regarding the economic and social rights of asylum seekers three years before the Reception Directive was drafted. [23] Eight years later, it is necessary to reassess the situation and determine what impact the Reception Directive has had on the right to health for asylum seekers.

In addition to doctrinal research, this thesis uses non-doctrinal research to determine problems in the current law, identify the policy behind these problems, and suggest legal reform to solve the problems. In particular, chapter six analyses the Common European Asylum System's shortcomings regarding asylum laws, investigates the policy that underpins the laws as they currently exists and suggests legal reforms necessary to align the EU Member States' obligations under the CEAS with its obligations under international human rights law.

[23] R. Cholewinski, 'Economic and Social Rights of Refugees and Asylum Seekers in Europe', 14 *Georgetown Immigration Law Journal* (Spring 2000) p. 717 [hereinafter "Cholewinski"].

2. DEFINING THE RIGHT TO HEALTH UNDER INTERNATIONAL HUMAN RIGHTS LAW

This chapter determines what obligations the Member States of the European Union have under the right to health as it is embodied in international human rights law. This is a necessary prerequisite to understanding in what way the Reception Directive's minimum standards violate the Member States' international obligations.

2.1 The Development of the Right to Health in International Human Rights Law

The 1948 Universal Declaration of Human Rights (UDHR) is one of the first documents to established the right to health under international law, determining that everyone has the right to a "standard of living adequate for the health and well-being of himself and his family" which includes medical care and necessary social services amongst other enumerated requirements.[24] The UDHR also identified motherhood and childhood as periods during the life cycle where special care and assistance is required.[25]

Since then, the right to health has been enshrined in a variety of binding international instruments, including the International Covenant on Economic, Social and Cultural Rights (ICESCR),[26] the International Convention on the Elimination of All Forms of Racial Discrimination,[27]

[24] Universal Declaration of Human Rights, G.A. res. 217A (III), U.N. Doc A/810 at 71, art. 25(1) (1948)[hereinafter "UDHR"].
[25] *Ibid.*, art. 25(2).
[26] IESCR, *supra* note 4, art. 12.
[27] International Covenant on the Elimination of All Forms of Racial Discrimination, 660 U.N.T.S. 195, art. 5(e)(iv) (requiring states to undertake to guarantee to all persons the right to public health, medical care, social security and social services without distinction based on race, colour, or national or ethnic origin) (*entered into force* Jan. 4, 1969).

Convention on the Rights of the Child (CRC)[28] and the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW).[29]

Highlighting the interdependence and indivisibility of human rights, the right to health is directly dependent on protection of certain rights contained within the International Covenant on Civil and Political Rights (ICCPR). Similar to the right to life (ICCPR article 6(1)), the right to health obligates states to combat child mortality, gender violence that threatens the lives of women, and certain environmental health threats, and promote non-discrimination and equality in the application of the right.[30] Similarly, the right to health and the prohibition against torture and inhuman or degrading treatment as embodied in article 7 of the ICCPR act together as protection against harmful traditional practices such as female genital mutilation.[31]

Further evidence of the universal application of the right to health is the proliferation of regional instruments that contain it, such as the European Social Charter,[32] the African Charter on Human and Peoples' Rights,[33] and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.[34] Such widespread acceptance of the right indicates its increasingly universal nature.

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[28] International Convention on the Rights of the Child, U.N. Doc. A/44/49 (1989) art. 24 (*entered into force* Sept. 2, 1990) (child's right to the highest attainable standard of health)[hereinafter "CRC"].

[29] Convention on the Elimination of All Forms of Discrimination Against Women, U.N. Doc. A/34/46, art. 12 (access to health care) and art. 10 (education required, including information to help ensure the health and well-being of families, including information and advice on family planning)(*entered into force* Sept. 3, 1981)[hereinafter "CEDAW"].

[30] Toebes, *supra* note 2, p. 175 (citing J. Smith, *Visions and Discussions on Genital Mutilation in Girls: An International Survey*, 1995, pp. 21-22).

[31] *Ibid.*

[32] European Social Charter, (ETS No. 35), Turin, 18.X.1961, art. 11.

[33] African Charter on Human and Peoples' Rights, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), art. 16 (adopted June 27, 1981, *entered into force* Oct. 21, 1986).

[34] Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, O.A.S. Treaty Series No. 69 (1988), *reprinted in* Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc.6 rev.1 at 67 (1992), art. 9.

2.2 The Right to Health as Embodied in the ICESCR

All Member States of the EU are States Parties to the ICESCR and are thereby bound to uphold obligations arising from the convention.[35] The right to health is contained in article 12 of the ICESCR and is interpreted extensively by the Economic, Social and Cultural Rights Committee (ESC Committee), the monitoring body for the convention that is charged with the duty to provide clarity on state obligations arising from the ICESCR.

Article 12(1) states that all States Parties to the ICESCR "recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Article 12(2) contains a non-exhaustive list of actions to be taken by the state in carrying out its duty under the covenant for progressive realization of the right using a maximum of its resources.[36] Together, these provisions make the ICESCR the seminal instrument embodying the right to health under international law.[37]

2.2.1 Normative Content of the Right to Health

In ESC General Comment 14 regarding the right to the highest attainable standard of health, the ESC Committee has defined the right to health as both the right to be healthy, i.e. the right to timely and appropriate health care, and the right to healthy living conditions.[38] The ESC Committee also found that the right to health requires adequate representation and participation by the state's population regarding all

[35] ICESCR ratification status available at: www2.ohchr.org/english/bodies/ratification/3.htm, last visited on 18 January 2008.
[36] ICESCR, *supra* note 4, art. 12(2): "The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."
[37] ESC General Comment 14, *supra* note 15, para. 1.
[38] *Ibid.*, para. 11 (healthy living conditions include: "access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health".

"health-related decision-making at the community, national and international levels".[39]

The ESC Committee states that the following four broad "interrelated and essential elements" are necessarily contained within the right to health as part of its definition under article 12(1) of the ICESCR: 1) availability, 2) accessibility, which in turn includes elements of non-discrimination, physical accessibility, economic accessibility, information accessibility, 3) acceptability, and 4) quality.[40] By determining that these elements are inherent to the right to health, but permitting their precise application is dependent upon "the conditions prevailing in a particular State party", the ESC Committee makes them universally applicable while allowing for state-specific levels of satisfaction.[41]

2.2.1.1 Availability

The ESC Committee requires "functioning public health and health-care facilities, goods, services" to be available in "sufficient quantity within the State party", although a state's stage of development, among other things, factors into satisfaction of this requirement.[42] For the purposes of ESC General Comment 14, "health facilities, goods and services" also include the underlying determinants of health: potable drinking water, adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained staff, and essential drugs.[43]

In accordance with article 12(2)(a) of the ICESCR, available services should inherently include motherhood and prenatal care, including obstetrics. Antenatal checks and care, any treatment required by the foetus for its development, and postnatal care of the child throughout its infancy and adolescence should also be available.[44] Additionally, those services

[39] *Ibid.*, para. 11.
[40] *Ibid.*, para. 12.
[41] *Ibid*.
[42] *Ibid.*, art. 12(a).
[43] *Ibid.*, art. 12(a) and fn. 6.
[44] Vita *Discussion Paper*, *supra* note 14, para. 95; World Health Organization, *Global Strategy for Health for All by the Year 2000*, adopted in WHO resolution WHA.34.36, ch. 3, para. 1 (1981).

necessary to the prevention, treatment and control of disease should be available.[45]

2.2.1.2 Accessibility

There are four "overlapping dimensions" of the element of accessibility in regards to the right to health: 1) non-discrimination, 2) physical accessibility, 3) economic accessibility, and 4) information accessibility.[46] Only when all four of these dimensions are fulfilled is accessibility truly realized.

Non-discriminatory accessibility requires that all persons, especially those in "vulnerable or marginalized sections of the population" have access to health facilities, goods and services without discrimination in law and in fact.[47] Non-discrimination is tagged as an area of concern for the ESC Committee.[48] Physical accessibility requires that health facilities, goods and services must all be within "safe physical reach" of all portions of society, including "especially vulnerable or marginalized groups" and those parts of the population in rural areas.[49] Meanwhile, economic accessibility requires affordability for all portions of society, including the "socially disadvantaged", whether health care be a public or private service.[50]

Finally, the ESC Committee states that information accessibility includes "the right to seek, receive and impart information and ideas concerning health issues" without compromising the right to medical confidentiality.[51] This ties the importance of confidentiality with the well-known fact that a high level of health is associated with access to education generally and health education in particular [52]

[45] ICESCR, *supra* note 4, art. 12(2)(a).
[46] ESC General Comment 14, *supra* note 15, para. 12(b).
[47] *Ibid.*, para. 12(b).
[48] *Ibid.*, para 18.
[49] *Ibid.*, para. 12(b).
[50] *Ibid.*,
[51] *Ibid.*
[52] Vita *Discussion Paper*, *supra* note 14, para. 100.

2.2.1.3 Acceptability

ESC General Comment 14 states that for health facilities, goods and services to be acceptable, they must be medically ethical, culturally appropriate, and "respectful of the culture of individuals, minorities, peoples and communities" and must be "designed to respect confidentiality and improve the health status of those concerned". To be acceptable, health facilities, goods and services must also be "sensitive" to the needs of women and children by requiring "gender and life-cycle" awareness.[53]

2.2.1.4 Quality

Quality deals with medical and scientific criteria necessary for the effective fulfilment of the right to health, requiring "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation".[54]

Under the ICESCR, states must implement the right to health progressively and to the maximum of their available resources.[55] By breaking the right to health down into these digestible elements, it is easier to monitor whether a state is progressing, regressing, or remaining stagnant regarding fulfilment of the right to health.[56]

2.2.2 State Obligations Arising from the Right to Health

Under the ICESCR, states have two layers of obligations arising from the right to health: those arising immediately and the ongoing obligation to respect, protect and fulfil.[57]

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[53] ESC General Comment 14, *supra* note 15, para. 12(b).
[54] *Ibid.*
[55] ICESCR, *supra* note 4, art. 2; ESC General Comment 3, *The nature of States Parties obligations*, UN Doc. E/1991/23, para. 13 [hereinafter "ESC General Comment 3"].
[56] Vita *Discussion Paper*, *supra* note 14, para. 140(9).
[57] M. Dowell-Jones, *Contextualising the International Covenant on Economic, Social and Cultural Rights: Assessing the Economic Deficit*, (2004 Martinus Nihoff Publishers) pp. 19-38 [hereinafter "Dowell-Jones"].

2.2.2.1 Minimum Core Content and other Obligations Arising Immediately

Contrary to the belief that economic, social and cultural rights could only be realized progressively, the ESC Committee identified several rights contained in the ICESCR that must be implemented immediately.[58] Of those, three rights of 'immediate effect' are implicated in this thesis: the article 2(2) obligation of non-discrimination, the article 3 obligation to create equal rights for men and women, and the article 10(3) obligation of non-discrimination in the protection of children.[59]

The ESC Committee also identified two other immediate obligations, although they are not rights per se: the obligation to progressively 'take steps' towards realizing the rights within the ICESCR using a maximum of available resources[60] and the obligation to satisfy the minimum core content of every right.[61] The Committee's determination is supported by the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (Limburg Principles).[62] Principle 16 emphasises the need to immediately take steps towards realization of the right while principle 25 requires states to ensure "respect for minimum subsistence rights for all" regardless of their level of economic development.[63]

Although the majority of these immediate obligations are self-explanatory, there is much debate over determining the 'minimum core content' or 'minimum threshold' of the rights contained within the ICESCR.[64] The minimum core content of a right is that right's 'nucleus' without which the right loses meaning.[65] Meanwhile, the minimum

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[58] ESC General Comment 3, *supra* note 55, para. 5.
[59] *Ibid.* Also included, but irrelevant to the current thesis, are: art. 7(a)(i) equal pay for equal work, art. 8 right to form and join trade unions, most of article 13, and article 15(3) freedom of research/creative activity.
[60] *Ibid*., para. 2.
[61] Dowell-Jones, *supra* note 57, p. 21.
[62] The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, *Human Rights Quarterly*, 1987, vol. 9, pp. 122-135.
[63] *Ibid.* at pp. 125-6.
[64] Dowell-Jones, *supra* note 57, pp. 21-28.
[65] K. Arambulo, *Strengthening the supervision of the International Covenant on Economic, Social and Cultural Rights: theoretical and procedural aspects* (Intersentia/Hart, Antwerp, 1999), p.130 [hereinafter "Arambulo"].

threshold is a state-specific minimum level of compliance beneath which the state would be violating its obligations under a given right.[66] In practice, determining the minimum core content of rights, let alone the minimum threshold, has proven difficult because there is confusion regarding the legal obligations involved. The ongoing question is whether the obligation to uphold the minimum core content is derogable upon a showing of lack of resources.

The ESC Committee has wavered regarding the non-derogability and universal application of the minimum core content obligation.[67] ESC General Comment 3 requires "satisfaction of … the minimum essential levels of each of the rights" by the State Parties, and failure to implement these minimal essential levels must be justified by a showing of lack of resources, taking into account those resources available by international cooperation and assistance.[68] This seems to make application of the minimum core obligation requirement dependent on available resources.[69] However, seven years later the 1997 Maastricht Guidelines on Violations of Economic, Social and Cultural Rights permit no such leniency.[70] It requires states to uphold their minimum core obligations "irrespective of the availability of resources" or any other factor.[71]

The ESC General Comments that have been issued subsequent to the Maastricht Guidelines have wavered between these two interpretations of the minimum core content. ESC General Comments 12 (on the right to adequate food) and 15 (on the right to water) both state that violations of state obligations exist where the minimum essential levels are not satisfied, but both Comments then make such violations excusable where the state

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[66] *Ibid.*; A. Eide, 'Realization of Social and Economic Rights and the Minimum Threshold Approach', 10 *Human Rights Law Journal* (1989) p. 35.
[67] *See* Dowell-Jones, *supra* note 57, pp. 21-28. 'Minimum core obligation' is the terminology usually used in General Comments when the ESC Committee refers to minimum core content.
[68] ESC General Comment 3, *supra* note 55, para. 10.
[69] M. Craven, *The International Covenant on Economic, Social and Cultural Rights*, p. 134 (1995 Claredon Press).
[70] The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, vol. 15 Netherlands Quarterly of Human Rights (1997) p. 245.
[71] *Ibid.*, p. 245, 247-248.

demonstrate that resource constraints make compliance impossible.[72] However, ESC General Comment 14 on the right to health states that the minimum obligations set forth in the comment are non-derogable and no reason justifies non-compliance, an interpretation more in line with the Maastricht Guidelines.[73]

Despite these differing interpretations, this thesis adopts the position that the minimum core obligations as recognized by the ESC Committee in their General Comments will constitute the non-derogable 'nucleus' of the right, the elements necessary for the right to retain its worth.[74] If a state fails to uphold these minimum core obligations, the state is in fact violating the right itself, but as an affirmative defence the state may offer that resource constraints make compliance impossible.[75] Much like self-defence excuses homicide without negating the importance of criminal homicide laws, so too will this 'resource constraints' defence uphold the worth of the rights within the ICESCR without levying unreasonable expectations upon destitute states.

Determining that the duty to uphold the minimum core content is non-derogable refutes the idea that asylum seekers have no right to health under the ICESCR. This is important because many states argue that they are not obligated to uphold an asylum seekers right to health at all, let alone at a level elevated above the minimum core content. However, it should not be forgotten that the derogable nature of the remaining normative content of the right to health is an independent issue from state obligations regarding the minimum core content.

Turning specifically to the minimum core content of the right to health, it has been recognized that there is a "health baseline below which

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[72] Economic, Social and Cultural Committee, General Comment 12, *The right to food*, UN Doc. E/C.12/1999/5, para. 17 [hereinafter "ESC General Comment 12"]; Economic, Social and Cultural Committee General Comment 15, *The right to water*, UN Doc. E/C.12/2002/11, paras. 37, 40 [hereinafter "ESC General Comment 15"].
[73] ESC General Comment 14, *supra* note 15, para. 47.
[74] ESC General Comment 3, *supra* note 55, para 10; ESC General Comment 14, *supra* note 15, para. 43.
[75] A. Eide, *Report Regarding the Right to Adequate Food and to be Free from Hunger*, para. 54, UN Doc. E/CN.4/Sub2/1998/9; ESC General Comment 3, *supra* note 55, para. 13: proof must also be offered that resource constraints exist despite making every effort to secure "international cooperation and assistance".

no individuals in any country should find themselves".[76] In realizing this, the ESC Committee has determined that the minimum core obligations necessary for a state to uphold the article 12 right to health are the duties:

- To ensure "the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups";
- To provide "essential drugs" as defined by the WHO Action Programme on Essential Drugs;
- To ensure "equitable distribution of all health facilities, goods and services"; and
- To adopt a national health care "strategy and plan of action" that addresses the health concerns of the whole population that uses indicators and benchmarks by which progress can be tracked; the plan's origins and content must give particular attention to "all vulnerable or marginalized groups"[77]

The ESC Committee then goes on to outline several more obligations of "comparable priority":

- Ensuring reproductive, maternal (pre-natal as well as post-natal) and child health care;
- Providing "immunizations against the major infectious diseases occurring in the community";
- Taking measures to "prevent, treat and control epidemic and endemic diseases";
- Providing "education and access to information concerning the main health problems in the community, including methods of preventing and controlling them"; and
- Providing "appropriate training for health personnel, including education on health and human rights".

[76] World Health Organization, *Global Strategy for Health for All by the Year 2000*, adopted in WHO resolution WHA.34.36, ch. 3, para. 1 (1981).
[77] ESC General Comment 14, *supra* note 15, para. 43. This thesis only includes obligations relevant to the current topic; other obligations listed within para. 43 have been omitted.

Because it has been recognized that countries with more resources owe more immediate duties than those with fewer resources,[78] these obligations of 'comparable priority' should be considered part of the minimum core content for countries that are sufficiently wealthy, taking into account the "international assistance and cooperation" available to them.[79]

The European Union requires applicant states to reach a minimal level of development and stability before they are permitted to accede to the Union.[80] Additionally, the EU Member States are bound to provide financial assistance to one another in a variety of ways.[81] As such, the EU Member States have enough capacity, development and assistance available to them for these obligations of 'comparable priority' to be considered part of their minimum core obligations.

2.2.2.2 The Ongoing Duty to Respect, Protect and Fulfil

The tripartite approach towards progressive realization of rights – the obligation to respect, protect, and fulfil – was first applied to state obligations arising under the ICESCR in the UN through Asbjørn Eide's report to the Sub-Commission on the Prevention of Discrimination and Protection of Minorities on the right to food.[82] Previously, international human rights were viewed as a dichotomy of positive and negative obligations; this tripartite approach provides a way to analyse all rights, whether they be political or economic, using the same backdrop.[83] The ESC

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[78] A. Eide, 'Economic, Social and Cultural Rights as Human Rights' in A. Eide, *et al*, (eds.) *Economic, Social and Cultural Rights, a Textbook*, (2nd Ed. 2001) p. 27.
[79] ESC General Comment 14, *supra* note 15, para. 43; *see also* Hunt *Mission to Sweden*, *supra* note 3, p. 27, para. 110.
[80] Copenhagen Criteria for Accession to the European Union, available at: stats.oecd/glossary/detail.asp?ID=3048, last visited on 19 January 2008; for full text, *see generally* European Council in Copenhagen, Conclusions of the Presidency, (21-22 June 1993), available at: ue.eu.int/useDocs/cms_Data/docs/pressdata/en/ec/72921.pdf, last visited on 19 January 2008.
[81] European Council, *Resolution of the European Council of 13 December 1997, on economic policy coordination in stage 3 of economic and monetary union and on Articles 111 and 113 of the EC Treaty, OJ C 35 of 2.2.1998*; European Council, *Council Regulation (EC) No. 1783/1999 of the European Parliament and of the Council of 12 June 1999 on the European Regional Development Fund*, OJ L 213 of 13.08.1999.
[82] A. Eide, *The new international economic order and the promotion of human rights*, Report by the Special Rapporteur on the right to food, UN Doc. E/CN.4/Sub.2/1987/23, p. 14-15, paras. 66-69 [hereinafter "Eide *Economic Order*"].
[83] Dowell-Jones, *supra* note 57, p. 29.

Committee has adopted this approach in their analysis of social, economic and cultural rights[84] and uses it in ESC General Comment 14 to delineate the duties of states in regards to the right to health.[85]

The obligation to *respect g*enerally requires states to refrain from encroaching upon the rights of persons within its jurisdiction.[86] In the context of the right to health, the ESC Committee finds the duty to respect requires state to, among other things: refrain from denying or limiting equal access for *all* persons, including asylum seekers, to "preventative, curative and palliative health services"; to abstain from discriminatory practices relating to women's health; to abstain from limiting access to contraceptives and other means of maintaining sexual and reproductive health; and to abstain from "censoring, withholding or intentionally misrepresenting health-related matters".[87]

The obligation to *protect* requires states to make efforts to protect persons within its jurisdiction from the actions of third party, non-state actors.[88] The state may use legislative, administrative, or other measure to prevent third party actors from harming individuals' "integrity, dignity, well-being or other human rights".[89] Regarding the right to health, the ESC Committee has interpreted this obligation to include: the duty of states to take measures, legislative or otherwise, to ensure equal access to health care, whether provided publicly or privately; to ensure "that privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services"; to prevent family planning, pre- and post- natal care from being interfered with through "harmful social or traditional practices"; to prevent practices such as female genital mutilation from occurring by preventing "third parties from coercing women to undergo harmful traditional practices"; and to take measures

[84] ESC General Comment 12, *supra* note 72, para. 15.
[85] ESC General Comment 14, *supra* note 15, para. 33.
[86] Hendriks, *supra* note 6, p. 328.
[87] ESC General Comment 14, *supra* note 15, para. 34.
[88] Hendriks, *supra* note 6, p. 328.
[89] *Ibid.*

protecting vulnerable or marginalized groups of society "in light of gender-based expressions of violence".[90]

Generally, the duty to *fulfil* obligates states to take all necessary steps to progressively ensure that the persons within their jurisdiction have the opportunity to realize their rights under human rights law.[91] Regarding the right to health, this obligation includes the duty to recognize the importance of the right to health in national legislation and to create a detailed national health policy aimed at full realisation of this right.[92] Among other things, the duty to fulfil requires states to provide adequate immunization programmes to protect against the "major infectious diseases", sexual and reproductive health services and education, and the provision of a medical health system that is affordable to *all* persons, regardless of whether the system is public, private or mixed.[93]

The duty to *fulfil* also includes the duty to facilitate, provide and promote.[94] The duty to *facilitate* requires states to use positive measures "that enable and assist individuals and communities to enjoy the right to health"; the duty to *provide* requires states to provide a right where "individuals or groups are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal"; and the duty to *promote* requires states to "create, maintain and restore" their population's health.[95]

[90] ESC General Comment 14, *supra* note 15, para. 35.
[91] Hendriks, *supra* note 6, p. 328.
[92] ESC General Comment 14, *supra* note 15, para. 36.
[93] *Ibid*.
[94] *Ibid*., para. 33; Eide *Economic Order*, *supra* note 82, p. 14-15, paras. 66-69.
[95] ESC General Comment 14, *supra* note 15, para. 37.

3. THE RIGHT TO HEALTH FOR WOMEN AND CHILDREN AS DISTINCT POPULATIONS

The UDHR put forth the idea that in order to fulfil the right to health for women and children, their special needs must be appropriately addressed[96] – only then do these populations achieve enjoyment of the right to health equal to that of similarly situated men. This dichotomy continues to be recognized today, and the ICESCR's article 12 right to health has been supplemented by article 24 of the Convention on the Rights of the Child (CRC)[97] and article 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW).[98] Additionally, an array of 'soft law' documents, although not binding, are used to help determine what constitutes an adequate standard of health for women and children.

Women and children, particularly as asylum seekers and refugees, are often times clumped together as a single entity entitled to protection under international law.[99] In international refugee law, these two groups are seen as 'particularly disadvantaged' due to, *inter alia*, the "adult male paradigm governing international refugee law" as evidenced by the lack of gender or age as a basis for persecution under the 1951 Convention on the Status of Refugees (the 1951 Refugee Convention).[100] However, creating a 'women-and-children' legal entity in an attempt to remedy this is inappropriate as they are two distinct populations that have different needs, entitlements and interests. In the area of health, they have differing medical needs that states must accommodate and particular social prejudices and assumptions to overcome in their quest for adequate health care.

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[96] UDHR, *supra* note 24, art. 25 (identifying motherhood and childhood as parts of the lifecycle that require special health care and assistance).
[97] CRC, *supra* note 28, art. 24.
[98] CEDAW, *supra* note 29, art. 12 (access to health care) and art. 10 (education required, including information to healp ensure the health and well-being of families, including information and advice on family planning).
[99] Bhabba, *supra* note 18, pp. 227-8.
[100] *Ibid*., p. 228.

It is often true that age and gender inequality mix. For instance, there exists a cultural preference for boys over girls in many countries, which may manifest itself in the disparate mental and physical health of the girl child.[101] Rationale for this belief varies,[102] but regardless of the reason behind the practice, girls under the age of five had a higher mortality rate in many countries where this cultural preference is known to exist.[103] For instance, nearly 15 percent more girls died than boys in the first few years of life in Bangladesh[104] because scarce household resources, such as limited food and access to health care, are generally allocated to the health of the boy child over the girl child.[105]

Cultural preferences are often imported into a host state on the backs of asylum seekers and other immigrants. For instance, approximately 8,000 girls of immigrant families in Europe have been subjected to female genital mutilation.[106] Additionally, the cultural practice of 'honour killings', where a male family member or community head murders girls or women out of honour, has been transplanted into immigrant populations in countries like Germany, France and the United Kingdom.[107] These are illustrative examples of the 'double discrimination' based on both gender and age that the girl child is subjected to. Scarce resources only worsen these situations,[108] meaning that states restricting resources to an unreasonably

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[101] Vita *Discussion Paper*, *supra* note 14, para. 46(b). This practice has been proven to exist in Bangladesh, India, Nepal, Pakistan, Algeria, Egypt, Jordan, Libya, Morocco, Syria, Tunisia, Turkey, Cameroon, Liberia, Madagascar and Senegal); *see also* Beijing Declaration and Plan of Action, Beijing Declaration and Platform of Action, UN Doc. A/CONF.177/20 (1995) and UN Doc. A/CONF.177/20/Add.1 (1995), paras. 93, 266 [hereinafter Beijing DPA]; United Nations International Research and Training Institute for of Women (Instraw) 'The Girl Child: New Challenges' in *Beijing at 10: Putting Policy into Practice*, available at un.instraw.org/en/images/stories/Beijing/thegirlchild.pdf, last visited on 19 January 2008, p. 10 [hereinafter "*Beijing Revisited*"].

[102] Vita *Discussion Paper*, *supra* note , para. 46(b); some reasons include the cultural ideas that women make a smaller economic contribution to the family, that women cut themselves off from their families upon marriage, and that men perpetuate the family line.

[103] 1993 Human Development Report, available at: hdr.undp.org/en/reports/global/hdr1993, last visited on 19 January 2008 (five percent higher in Nepal, four percent higher in Pakistan and India, and two percent in Bhutan).

[104] *Ibid.*

[105] *Beijing Revisited*, *supra* note 101, p. 10.

[106] *Ibid.* (citing "Genital Mutilation 'On the Increase in Europe'", *The Scotsman*, 26 November 2004).

[107] *Ibid.* (citing ECOSOC 2002, www.unhcr.ch/html/menu2/7/b/women/documents.htm).

[108] *Ibid.*, p. 3.

low level subject the girl child to 'triple discrimination' based on age, gender and asylum status.

Despite the inherent overlap of age and gender bias, this thesis primarily treats women and children as separate entities. The state has the same obligation towards these populations as to all others: to provide an adequate standard of health. However, because the needs of these populations differ, the acts necessary to satisfy the state obligations under international law differ accordingly. This chapter first determines how the health care needs of women vary from the general population and what actions a state must take to satisfy a woman asylum seeker's right to health. The second section analyses a child's right to health by defining children's health and argues that the Convention on the Rights of the Child affords child asylum seekers access to health care on par with child citizens.

3.1 Defining a Woman's Right to Health in Light of the Principles of Equality and Non-Discrimination

A woman's right to the highest attainable standard of health is addressed in article 12 of CEDAW,[109] and the CEDAW Committee develops this right in its General Comment 24.[110] The CEDAW Committee reaffirms "access to health care" as a basic right under CEDAW that should be provided in a non-discriminatory manner.[111] For the purposes of CEDAW, 'women' includes girls, adolescents and adult women, and their right to health is protected under the Convention throughout their life cycle.[112]

A state's failure to adequately address the health needs of women is not only a violation of the right to health, it also constitutes discrimination and a violation of the principle of equality. Discrimination under the ICESCR is defined as prohibited differential treatment of person on the

[109] CEDAW, *supra* note 29, art. 12.
[110] CEDAW General Comment 24, *supra* note 20.
[111] *Ibid.*, paras. 1-2.
[112] *Ibid.*, para. 8.

basis of, among other things, "sex…age…refugee or migrant status".[113] Discrimination against women in particular is defined under CEDAW as any distinction, exclusion or restriction made on the basis of sex resulting in the impairment or nullification of the recognition, enjoyment or exercise by women of their human rights and fundamental freedoms on the basis of equality with men.[114] This includes human rights in the "political, social, cultural, civil or any other field".[115]

The principles of non-discrimination and equality, as enshrined in articles 2 and 3 respectively of the ICESCR, are "integrally related and mutually reinforcing".[116] Classically, equality requires equal treatment of men and women; however, proper analysis under this classical approach requires a 'comparable man' against which a typical woman can be compared.[117] This entirely ignores situations in which no man is available to be compared against, such as maternity, menstruation, female circumcision, and reproductive rights.[118] Using a gender-sensitive approach, discrimination should be found where gender-neutral acts by government affect women disproportionately to men "due to their place in a sexual or gender hierarchy".[119]

Gender biases in culture can play a large part in inequality between the sexes, leaving women unable to behave freely as autonomous creatures, independent of their husbands, fathers, brothers, or male counterparts in society.[120] Equality requires that states address these "gender-based social and cultural prejudices", provide for equal allocation of resources, and

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[113] Economic, Social and Cultural Committee, General Comment 16, *The equal right of men and women to the enjoyment of all economic, social and cultural rights*, UN Doc. E/C.12/2005/4 [hereinafter "ESC General Comment 16"].
[114] CEDAW, *supra* note , art. 1.
[115] *Ibid.*
[116] ESC General Comment 16, *supra* note 113, para. 3.
[117] K. Frostell and M. Scheinin, 'Women', in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001), p. 336 (A. Eide, *et al*, (eds.)) [hereinafter "Frostell"].
[118] *Ibid.*, p. 336.
[119] *Ibid.*, p. 336 (citing R. Cook, 'State Responsibility for Violations of Women's Human Rights', 7 *Harvard Human Rights Journal* (1994) p. 156).
[120] ESC General Comment 16, *supra* note 113, para. 14. 'Gender' is term used to describe the cultural "expectations and assumptions about the behaviour, attitude, personality traits, and physical and intellectual capacities of men and women, based solely on their identity as men or women".

promote equal sharing of responsibilities in the "family, community and public life".[121] Consequently, the ESC Committee and CEDAW Committees require both: 1) *de jure* equality, meaning that the laws of a government must be facially neutral; and 2) *de facto* equality, meaning that the practices, laws and policies of a given state must actually treat women with equality in fact and alleviate the inherent economic, social and cultural inequalities that exist between men and women.[122] States are consistently required to address situations where women are affected disproportionately to men in the same population, i.e. where they are subjected to 'multiple discrimination' based on their gender and an additional aggravating circumstance such as being an asylum seeker.[123]

In order to eliminate discrimination against women, comprehensive national strategies regarding a woman's right to health must be developed and implemented to address health needs throughout the woman's life span.[124] Under the ICESCR,[125] access to health care and the "means and entitlements for [its] procurement" cannot be provided in a discriminatory manner where such discrimination has the "intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health".[126]

Non-discrimination is one of the provisions of the ICESCR that must be implemented immediately rather than progressively, so the very definition of a woman's right to health must incorporate this principle.[127] As mentioned in the previous chapter, the interrelated elements of the right to health are availability, accessibility, acceptability and quality of health care.[128] Women are entitled to the enjoyment of these elements on an equal basis with men.[129] For the element of availability, this requires that services,

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[121] *Ibid.*, para. 16.
[122] *Ibid.*, paras. 7,8.
[123] *Ibid.*, para. 10; CEDAW General Comment 24, *supra* note 20, para. 6.
[124] ESC General Comment 14, *supra* note 15, art. 21.
[125] ICESCR, *supra* note 4, art. 2.2 (proscribing discrimination based on, *inter alia*, sex and national origin) and art. 3 (ensuring equal enjoyment of both men and women to all rights contained within the covenant).
[126] ESC General Comment 14, *supra* note 15, para. 18.
[127] ICESCR, *supra* note 4, art. 2(2); ESC General Comment 3, *supra* note 55, para 1.
[128] ESC General Comment 14, *supra* note 15, para. 12.
[129] ICESCR, *supra* note 4, art. 3; United Nations Charter, art. 1(3) (open for signature on 26 June 1945, entered into force on 24 October 1945, available at:

particularly reproductive services, and information that are needed by women be "equally available in sufficient quantity" as those provided to men.[130] Equality in accessibility requires that women no longer be faced with barriers to access to health services, education and information, including in the area of sexual and reproductive health.[131] These barriers include "lack of availability, legal restrictions, excessive regulation, third-party consent requirements, cost, lack of adequate insurance coverage and violence or coercion in the health-care context".[132]

To be acceptable, health care providers, facilities, goods and services must be "respectful and appropriately sensitive" to women's health needs.[133] Finally, establishing equality in quality of health facilities, goods and services requires that those differing "medical personnel, medications, and equipment" necessary to meet women's health care needs be on par with those necessary to meet the needs of men.[134]

There are four areas in which women's health care needs and interests may differ from those of men: biological factors, socio-economic factors, psychosocial factors, and the deterrent effect of lack of confidentiality on women choosing to exercise their right to health.[135] For asylum seekers these factors may be exacerbated by seclusion in immigrant communities that have transplanted their native cultural beliefs and taboos, which may exist independent of the societal and cultural environment found within the state itself. State-imposed barriers to access to health care can worsen this seclusion and the corresponding effect it has on women's health.

The CEDAW Committee has also recognized the importance of several non-binding soft-law documents that help determine the differing health care needs of women so that they may be adequately addressed by the

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www.un.org/aboutun/charter/, last visited on 18 January 2008); UDHR, *supra* note 24, art. 2; ICESCR, *supra* note 4, art. 3; ESC General Comment 16, *supra* note 113.

[130] *Equal Enjoyment of the Right to Health*, Background paper submitted by the Center for Reproductive Law and Policy (USA), UN Doc. E/C.12/2002/7, para.3 (citing ESC General Comment 14, *supra* note , para. 12(a))[hereinafter "*Equal Enjoyment* background paper"].

[131] ESC General Comment 14, *supra* note 15, para. 21.

[132] *Equal Enjoyment* background paper, *supra* note 120, para. 4.

[133] *Ibid.*, para. 5.

[134] *Ibid.*, para. 6.

[135] CEDAW General Comment 24, *supra* note 20, para. 12.

state in its quest for equality.[136] These include the Vienna Declaration and Programme of Action of 1993 (Vienna DPA),[137] the Programme of Action of the International Conference on Population and Development held at Cairo (Cairo Programme of Action),[138] and the Declaration and Programme of Action of the Fourth World Conference on Women held in Beijing (Beijing DPA).[139]

The Vienna DPA reaffirms the importance of the enjoyment by women of the highest standard of physical and mental health on the basis of equality between men and women, including accessible and adequate health care and the widest range of family planning options.[140] Women's health is "determined by the social, political and economic context of their lives" and involves both a biological element as well as their "emotional, social and physical well-being".[141] The Cairo Programme of Action specifically recognizes the vulnerable position of women and children refugees and internally displaced persons.[142] Two of the objectives identified in the Cairo Programme are to provide adequate health, education and social services for refugees and displaced persons[143] and "to integrate refugee and returnee assistance and rehabilitation programmes into development planning, with due attention to gender equity".[144]

The WHO, the Cairo Programme of Action and the Beijing DPA all define reproductive health as involving elements of physical, mental, and social well-being and "not merely the absence of disease or infirmity"

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[136] *Ibid.*, para. 3.
[137] Vienna Declaration and Programme of Action, Vienna, 14 - 25 June 1993, U.N. Doc. A/CONF.157/24 (Part I) at 20 (1993), para. 41 (recognizing the importance of the enjoyment by women of the highest standard of physical and mental health on the basis of equality between men and women, including accessible and adequate health care and the widest range of family planning)[hereinafter "Vienna DPA"].
[138] Cairo Programme of Action of the International Conference on Population and Development (1994), para. 7.2 (defining reproductive health), available at: http://www.iisd.ca/Cairo/program/p00000.html [hereinafter 'Cairo Programme of Action"].
[139] Beijing DPA, *supra* note 101, para. 89 (defining women's health).
[140] Vienna Declaration, *supra* note 137, para. 41.
[141] Beijing DPA, *supra* note 101, para. 89.
[142] Cairo Programme of Action, *supra* note 138, para. 10.12.
[143] *Ibid*., para. 10.22(e).
[144] *Ibid.*, para. 10.22(f).

regarding the reproductive system, its functions and its processes.[145] Inherent to this is the right of access to health care services necessary and appropriate for safe motherhood – from conception to childbirth and beyond.[146] Reproductive health care includes those "methods, techniques and services that contribute to the reproductive health and well-being by preventing and solving reproductive health problems" while sexual health care includes, *inter alia*, education, care and counselling regarding sexually transmitted diseases and reproduction.[147]

The right to health can only be fully realized for women when the principles of non-discrimination and equality are fully satisfied, which requires states to identify and treat the special health needs of women. Although they are not binding, the various soft law documents mentioned above should be used by states for this purpose in fulfilling their duties under the right to health for women.

3.2 The Principles of the CRC and a Child's Right to Health

A child's right to the highest attainable standard of health is contained within article 24 of the CRC. This is meant to supplement, not substitute, the general right to health as embodied in the ICESCR. The duty to uphold obligations arising under the ICESCR is qualified by the phrase "progressive realization",[148] but no such qualifying statement exists for the CRC.[149] Instead, the CRC's economic, social and cultural rights should be realized immediately so long as the state is acting "within its means", i.e. is using the "maximum" of the its available resources, including those provided by international assistance.[150]

This immediacy requirement applies to the article 24 right to the highest attainable standard of health care. Consequently, when article 24

[145] Beijing DPA, *supra* note 101, para. 94; Cairo Programme of Action, *supra* note 138, para. 7.2; L. Gilbert, 'Rights, Refugee Women and Reproductive Health', 44 *American University Law Review* (April 1995) p. 1239.
[146] Beijing DPA, *supra* note 101, para. 94.
[147] *Ibid*., para. 94.
[148] ICESCR, *supra* note 4, art. 2(1).
[149] CRC, *supra* note 28, art. 4.
[150] *Ibid*., art. 4.

states that states "shall strive" to ensure that no child is left without access to health care, that duty is immediate.[151] The word 'strive' means to try very hard to achieve something, [152] and although it does not require instant satisfaction of the right in its entirety, 'shall strive' indicates that inaction is not an option and that efforts towards the ultimate goal of removing all barriers to access to health care for children must be visible immediately.

Under the ICESCR, an adequate standard of health care requires antenatal checks and care and any treatment required by the foetus for its development, and postnatal care of the child throughout its infancy and adolescence.[153] Supplementing this, the CRC requires that states "shall take appropriate measures to": (a) diminish infant and child mortality; (b) ensure necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) combat disease and malnutrition; (d) ensure appropriate pre-natal and post-natal health care for mothers; (e) ensure that all segments of society are informed, have access to education and are supported in basic knowledge regarding, *inter alia*, child health and nutrition; (f) develop preventative health care, guidance for family planning education and services.[154]

Regardless of their legal status, all children are entitled to satisfaction of the right to health as it has been described above. The CRC recognizes that children as a population are discriminated against by states and require "special protection under international law if their rights are to be realised".[155] The Committee on the Rights of the Child (the CRC Committee) has established four underlying principles necessary to the proper interpretation of all other rights in the convention: non-discrimination (article 2), best interest of the child (article 3), the right to survival and development (article 6), and the right to be listened to and

[151] *Ibid.*, art. 24(1).
[152] Oxford Advanced Learner's Dictionary, S. Wehmaeier (ed.) (Oxford University Press 2000, 6th ed.), p.1289.
[153] Vita *Discussion Paper*, *supra* note 14, para. 95.
[154] CRC, *supra* note 28, art. 24(2).
[155] S. Muscroft (ed.), *Children's Rights: Equal Rights?*, International Save the Children Alliance publication (Impressions 2000)[hereinafter "Muscroft"].

taken seriously (article 12).[156] Under article 2(1) of the CRC, all the rights contained in the convention are owed to all children within the state's jurisdiction without discrimination of any kind.[157] The CRC Committee interprets this article to require that states grant refugee children, children of indigenous or minority groups, and both boys and girls rights on par with child citizens of the state.[158]

This interpretation is supported by article 22 of the CRC, which directly addresses the rights of the child asylum seeker.[159] States Parties are required to "take appropriate measures to ensure" that children asylum seekers and refugees receive appropriate protection in the enjoyment of the applicable rights set forth in the CRC and other international human rights and humanitarian instruments.[160] Article 22 also imposes an obligation to cooperate with any organisations that provide such protection or assistance.[161]

Asylum seeking children are also entitled to an array of rights under the CRC that supplement the general right to health under the ICESCR. These include the right to life and optimum development (article 6), the right to privacy (article 16, reaffirming the necessity of confidentiality in health care proceedings), the right to information, the right to education, and the right to an education promoting fullest potential and respect for human rights (articles 17, 28, and 30 respectively, extending the right to health care education to children and removing stereotyping and gender bias from educational materials), the right to protection from all forms of violence (article 19), the right to protection from sexual exploitation and abduction, sale, or trafficking (articles 33 and 34,

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[156] *Ibid* ,pp. 26-31; *General guidelines regarding the form and content of initial reports to be submitted by States Parties under Article 44, paragraph 1(a), of the Convention*, UN Doc. CRC/C/5 (1991)[hereinafter "CRC *Initial Reporting Guidelines*"]; *General guidelines regarding the form and content of periodic reports to be submitted by States Parties under Article 44, paragraph 1(a), of the Convention*, UN Doc. CRC/C/58 (1996)[hereinafter "CRC *Periodic Reporting Guidelines*"].

[157] CRC, *supra* note , art. 2(1).

[158] T. Hammarberg, 'Children' in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001), p. 357; Muscroft, *supra* note 155, pp. 26, 32.

[159] CRC, *supra* note 28, art. 22.

[160] *Ibid*., art. 22(1).

[161] *Ibid*., art. 22(2); S. Muscroft (ed.), *Children's Rights: Reality or Rhetoric*, International Save the Children Alliance publication, p. 89.

respectively), the protection from torture, cruel, inhuman and degrading treatment and the use of imprisonment only as a measure of last resort (article 37).

Although discrimination is prohibited, distinctions between differing groups are permissible where they meet certain legal requirements.[162] However, under the CRC, any distinction must take into account the best interest of the child and the child's right to survival and development, two of its guiding principles.[163] Consequently, any distinction that removes the basic means of survival from a child, i.e. access to health care, is a violation of that child's rights under the CRC.

The CRC is the most widely ratified convention ever, with every single nation state in the world ratifying it except the United States and Somalia. [164] All EU Member States are also State Parties to the CRC and as such are under a duty to uphold the child's right to the highest attainable standard of health by striving to provide access to health care and by immediately taking measures to address the mentioned concerns. This includes providing pre- and post-natal checks for the child from conception to adolescence[165] and ensuring necessary medical and health care to all children with an emphasis on primary and preventative care, combating disease and malnutrition, and ensuring health education for all segments of society regarding child health and nutrition and family planning.[166] Anything less constitutes a violation of their obligations under international human rights law.

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[162] The *Nottebohm* case (*Liechtenstein* v. *Guatemala*) (1951-1955) ICJ R. 4, p. 23 [hereinafter "*Nottebohm* case"]; Human Rights Committee General Comment 18(37) on Non-Discrimination, UN Doc. A/45/40, para. 13 (1990)[hereinafter "HRC Comment 18(37)"]; Human Rights Committee Communication No. 182/1984, *Zwaan de Vries v. Netherlands*, U.N. Doc. CCPR/C/29/D/182/1984, para. 13 (1987)[hereinafter "*Zwaan*"].
[163] CRC *Initial Reporting Guidelines*, *supra* note 156; CRC *Periodic Reporting Guidelines*, *supra* note 156.
[164] The United States has signed the treaty, but has not ratified it. CRC ratifications available at: www.unhchr.ch/pdf/report.pdf, last visited on 18 January 2008.
[165] Vita *Discussion Paper*, *supra* note 14, para. 95.
[166] CRC, *supra* note 28, art. 24(2).

4. LEGAL ENTITLEMENT OF ASYLUM SEEKERS TO THE RIGHT TO HEALTH

To claim that the Reception Directive violates the EU Member States' international obligations arising from the right to health, those obligations must extend to non-nationals. This chapter establishes that asylum seekers are at least entitled to the minimum core content of the right to health immediately, but also argues that the 1951 Refugee Convention should be interpreted in a manner that entitles asylum seekers to social security benefits, and thus access to health care in many EU Member States, on par with nationals.

4.1 Application of the ICESCR to Non-Nationals

There is a general prohibition against discrimination in article 2(2) of the ICESCR, and access to health care and the "means and entitlements for [its] procurement" cannot be provided in a discriminatory manner that has the "intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health".[167] In particular, the ESC Committee has increasingly expressed concern at discrimination against asylum seekers and refugees regarding economic rights.[168] The International Labour Organization (the ILO) reinforces this prohibition of discrimination against non-nationals. ILO Convention No. 130 prohibits such discrimination where the non-national normally resides or works in the territory of a State

[167] ICESCR, *supra* note 4, art. 2(2) (proscribing discrimination based on, *inter alia*, sex and national origin) and art. 3 (ensuring equal enjoyment of both men and women to all rights contained within the covenant); ESC General Comment 14, *supra* note 15, para. 18.
[168] *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Belgium*, UN Doc. E/C.12/1994/7 ("…the Committee strongly urges that... refugees and asylum seekers are fully protected from any acts or laws which in any way result in discriminatory treatment within the housing sector").

party.[169] Additionally, Convention No. 118 requires equality of treatment in regards to social security, and therefore access to health care, between nationals and foreigners.[170]

However, international law generally permits distinctions between groups of people a) where there is the pursuit of a legitimate aim, b) where it is based on reasonable and objective criteria, and c) where it is proportionate to the purpose provided.[171] The question then turns on to what extent states may differentiate between non-nationals and citizens before it constitutes discrimination and a violation of the right to health.[172]

As an international human rights instrument, the ICESCR is intended to apply to people and thus to nationals and non-nationals alike, both asylum seekers and refugees. States must satisfy their minimum core obligations under each right for all persons within their territory; to require anything less would eviscerate the purpose of the ICESCR.[173] Directly contradicting this, the Declaration on Human Rights of Individuals Who are not Nationals of the Country in which They Live makes health care for non-nationals conditional upon fulfilment of domestic participation regulations and permissible only where it does not overly strain the resources of the state.[174] However, this Declaration is non-binding and cannot override the ICESCR, meaning that a limited right to health care should not fall below the minimum core content of the right to health even where the domestic participation scheme has not been satisfied.

Supporting this, the ESC Committee has determined that states have a "special" obligation to provide for those who cannot provide for themselves, such as asylum seekers, particularly in respect to the "core

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[169] International Labour Organisation Convention 130, *Medical Care and Sickness benefits Convention*, art. 32 (1969), available at: www.ilo.org/ilolex/english/convdisp2.htm, last visited on 19 January 2008.
[170] International Labour Organisation Convention 118, *Equality of Treatment (Social Security)Convention* (1962), available at: www.ilo.org/ilolex/english/convdisp2.htm, last visited on 19 January 2008.
[171] Cholewinski, *supra* note 23, p. 717; *see also, supra* note 162.
[172] In this case, nationality describes citizenship, not national origin; discrimination based on national origin is generally recognized as prohibited grounds for distinction.
[173] ESC General Comment 3, *supra* note 55, para. 10.
[174] *Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live*, General Assembly Resolution 40/144 (December 1985), art. 8(1)(c).

obligations of the right to health".[175] The subsequent work of the ESC Committee has indicated that distinction between nationals and non-nationals is impermissible where non-nationals are denied "the very means of subsistence", and inadequate access to health care would do just that.[176]

As previously discussed, all persons are entitled to the minimum core content of ICESCR rights.[177] As States Parties to the ICESCR, EU Member States must prove that "every effort has been made to use all resources",[178] including those available "through international cooperation and assistance",[179] to permissibly deviate below their minimum obligations under international human rights law. Additionally, the EU Member States have the ongoing duty to *respect* the right to health by refraining from "denying or limiting equal access – on economic, physical and cultural grounds – for all persons, including… asylum seekers… to preventative, curative and palliative health care."[180] Anything less constitutes a violation of their duties under international human rights law.

4.2 The 1951 Refugee Convention as Entitlement to Access to Health Care for Asylum Seekers

Article 24 of the 1951 Refugee Convention grants refugees 'lawfully staying' in the territory of Party States the right to social security on the same level as nationals, providing refugees with access to health care where such is included within the nation's social security scheme.[181] To be 'lawfully staying' within State Parties, a person must be a resident, a recognized refugee, or have some other state-issued proof that indicates that their stay will be of an extended duration. Although asylum seekers living in the EU satisfy this requirement, they are refused national treatment in the

[175] ESC General Comment 14, *supra* note 15, para. 19.
[176] Cholewinski, *supra* note 23, p. 719.
[177] ESC General Comment 3, *supra* note 55, para. 10; *see also* General Comment 14, *supra* note , paras. 43, 47.
[178] *Ibid.*, para. 10.
[179] *Ibid.*, para. 13.
[180] *Ibid.*, para. 34.
[181] Geneva Convention Relating to the Status of Refugees, 189 U.N.T.S. 150 (*entered into force* April 22, 1954), *supra* note , art. 24 [hereinafter "1951 Refugee Convention"].

area of social security in most EU Member State countries.[182] This subsection argues that treaty interpretation and equity considerations entitle asylum seekers to article 24 benefits.

The term 'social security' as used in this section includes both 'social insurance' (i.e. the "'earned' social security benefits of workers their families") and 'social assistance' (i.e. public funds raised through tax revenues for the purpose of aiding specific individuals on the basis of need).[183]

4.2.1 Treaty Interpretation

Under the 1951 Refugee Convention, certain 'levels' of legal presence must be obtained within a Contracting State's territory before rights may be bestowed.[184] 'Simple presence' of a refugee, recognized or unrecognised, is enough for benefits such as the principle of *non-refoulment* to accrue under article 33.[185] 'Lawful presence' is required for a refugee to be entitled to freedom of movement within the territory under article 26 and is considered to be admission to a state for a temporary basis "in accordance with the applicable immigration laws".[186] Article 24, however, requires a refugee to be 'lawfully staying' in the State Party for its benefits to accrue.

Professor Guy S. Goodwin-Gill argues that for refugee to be 'lawfully staying' in the territory of a State Party, there must be evidence that the person has residence "plus some level of lasting protection".[187] This means that to be entitled to social security benefits of the state, one must

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[182] G. S. Goodwin-Gill, *The Refugee in International Law*, pp. 524-526 (2007 Oxford University Press, 3rd ed. 2007)[hereinafter "Goodwin-Gill"]; J. A. Dent, European Council for Refugees and Exiles, *Research Paper on the Social and Economic Rights of Non-Nationals in Europe*, p. 21 (1998), available at: http://www.ecre.org/resources/research_paper/3560).

[183] M. Scheinin, 'The Right to Social Security', in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001) p. 211.

[184] Goodwin-Gill, *supra* note 182, pp. 524-526.

[185] 1951 Refugee Convention, *supra* note 181, art. 33: "No Contracting State shall expel or return ("refouler") a refugee in any manner whatsoever…". The benefit extends to all persons claiming to be refugees regardless of their legal status within the territory of a Contracting State.

[186] Goodwin-Gill, *supra* note 182, p. 525; 1951 Refugee Convention, *supra* note , art. 33: "Each Contracting State shall accord to refugees lawfully in its territory the right to choose their place of residence to move freely within its territory".

[187] *Ibid.*, p. 525.

have a "permanent, indefinite, unrestricted or other residence status, recognition as a refugee, issue of a travel document, or grant of a re-entry visa" in order to raise a presumption of lawful residence.[188] Under Goodwin-Gills interpretation, asylum seekers are generally considered to be 'lawfully present' and not 'lawfully staying' in a given territory, and Contracting States have used this rationale to justify domestic laws denying asylum seekers the corresponding benefits.[189]

However, the plain text of the 1951 Refugee Convention indicates that the term 'lawfully staying' does not require formal recognition as a refugee.[190] Instead, 'lawfully staying' should be interpreted to require proof of settling down in the host country and a certain length of *stay* – not residence, a legal term that is, by all accounts, wrought with contradictions.[191] In fact, the term 'lawfully staying', a direct translation of the French version of the 1951 Convention, was used because the drafters wanted to avoid the word 'residence' and the interpretive difficulties it would bring.[192] By refusing to use the term 'residence', the drafters made it clear that formal 'residence' should not be required for persons to be entitled to the rights under the 1951 Convention. Instead, 'lawfully staying' should require asylum seekers to have proof of lawful presence for an inherently indefinite length of stay that is likely to be of a duration long enough to

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[188] *Ibid.*, p. 526.

[189] *R v. Secretary of State for Social Security*, ex parte *Joint Council for the Welfare of Immigrants*, 4 All E.R. 385, 40th (1996) ("[N]o obligation arises under article 24 of the 1951 Convention [national treatment regarding social security] until asylum seekers are recognised as refugees."); Canadian reservation to arts. 23, 24 of the 1951 Refugee Convention, interpreting 'lawfully staying' as only applying to refugees granted permanent, rather than temporary, status (reservations available at: www.unhcr.org/protect/PROTECTION/3d9abe177.pdf , last visited on 19 January 2008).

[190] Vienna Convention on the Law of Treaties, 1115 U.N.T.S. 331, art. 31(1) (*entered into force* January 27, 1969)[hereinafter VCLT]. It is generally accepted that the intentions of the parties "*as expressed in the text*" of a given treaty controls the situation, and this 'textual approach' has found favour in the decisions of the International Court of Justice (I. Brownlie, *Principles of Public International Law*, p. 580 (6th Ed. 2003)[hereinafter "Brownlie"]).

[191] Brownlie, *supra* note 190.

[192] Goodwin-Gill, *supra* note 182, p. 525; ; VCLT, *supra* note 190, art. 33(1). Where treaties are authenticated in multiple languages, such as the 1951 Refugee Convention, all versions of the treaty are equally legally authoritative.

warrant the need for benefits.[193] Anything more stringent would implicate serious equity and policy considerations, as discussed below.

Asylum seekers in the European Union satisfy this interpretation of the term 'lawfully staying'. First, EU asylum seekers satisfy the temporal requirement because the process for status determination often exceeds eighteen months in some EU Member States.[194] The drafters of the 1951 Refugee Convention intended all refugees, recognized or not, to benefit from social security where the expected duration of their stay warranted such a need.[195] It is unlikely that they envisioned or intended unrecognized refugees to be without access to social security benefits for more than a year.

Second, article 6(1) of the Reception Directive requires that Member States provide asylum seekers with a document proving the legality of their presence on the territory within three days of lodging an asylum application.[196] The Reception Directive never refers to the 1951 Refugee Convention directly. However, when taken in conjunction with the inherently indefinite period required for status determination, this document provides enough proof of regular residence to satisfy the above-mentioned interpretation of 'lawfully staying'.

4.2.2 Equity and Policy Considerations

Equity considerations further support this interpretation of 'lawfully staying'. In interpreting the 1951 Refugee Convention, parties are permitted to look to any applicable, relevant rules of international law, and equity is considered a general principle of international law.[197] Although equity is not

[193] This thesis does not attempt to establish what length of stay would be necessary for asylum seekers to change from 'legally residing' to 'lawfully present', but three months has been suggested. *See* H. Battjes, *European Asylum and International Law* (Martinus Nijhoff Publishers, 2006) p. 495 [hereinafter "Battjes"].
[194] Hunt *Mission to Sweden*, *supra* note 3, p. 19, para. 68.
[195] Battjes, *supra* note 193, p. 494-495.
[196] Reception Directive, *supra* note 9, art. 6(1); Battjes, *supra* note 193, p. 495 (citing Reception Directive art. 6(2); where applicants are not considered lawfully present, this document is denied).
[197] VCLT, *supra* note , art. 31(3); Statute of the International Court of Justice, Statute of the International Court of Justice, available at: www.icj-cij.org/documents/index.php?p1=4&p2=2&p3=0, last visited on 18 January 2008, art. 38(1)(d).

a source of law in itself, it should play a role in the application of laws by using "considerations of fairness, reasonableness and policy".[198] As such, equity is implicated when interpreting a residence or temporal requirement into 'lawfully staying', in particular where refugee status determination could take months or years.

Asylum seekers are persons who have fled to another country and applied for state protection by claiming refugee status in that other country, but are awaiting determination of such status.[199] Refugees are persons who meet the definition of a refugee under the 1951 Convention Relating to the Status of Refugees as modified by its 1967 Protocol, which is any person who:

> "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such a fear, is unwilling to avail himself upon the protection of that country".[200]

A person is a refugee based on facts, not a legal determination. Therefore, many asylum seekers are actually refugees prior to receiving official state recognition, but despite this, the benefits of the 1951 Refugee Convention are rarely passed to them.[201]

Under the current interpretation of the Refugee Convention, unrecognised refugees are denied access to health care during their most vulnerable period despite requiring on average more medical attention than any other segment of society and who, by virtue of their status, are likely to be lacking in means to care for themselves. Additionally, asylum seekers are legally and factually distinguishable from the other persons Goodwin-Gill describes as 'legally staying' in the territory of a nation, such as students or tourists.[202] They have different needs, different health concerns, and a

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[198] Brownlie, *supra* note 190, p. 25.
[199] United Nations High Commissioner for Refugees, *Statistical Yearbook 2006*, available at: www.unhcr.org/statistics/STATISTICS/478cda572.html, last visited on 19 January 2008 [hereinafter "UNHCR *2006 Stats*"].
[200] 1951 Refugee Convention, *supra* note 181, art. 1; Protocol Relating to the Status of Refugees, 606 U.N.T.S. 267, art. 1(removing temporal and geographical restrictions from the definition) (*entered into force* Oct. 4, 1967).
[201] Battjes, *supra* note 193, p. 494.
[202] Goodwin-Gill, *supra* note 182, p. 524 ("a student, a visitor or recipient of medical attention").

different legal status within the international community. Equity requires recognition of these differences in interpreting the legal status of asylum seekers under the 1951 Refugee Convention. It is manifestly absurd to interpret the Refugee Convention to grant asylum seekers the same status as tourists and runs contrary to the human rights considerations at the heart of the 1951 Refugee Convention.

5. EUROPEAN UNION AND THE RIGHT TO HEALTH: THE RECEPTION DIRECTIVE AND ITS DOMESTIC IMPLEMENTATION

As mentioned earlier, there currently exist few international enforcement mechanisms for human rights violations, if any. Instead, the international community relies upon the good faith efforts of states and encouragement from regional human rights bodies to fulfil this role. As it stands, the Reception Directive is encouraging impunity for violations of international human rights at the domestic level by legalizing the offending asylum policies of Member States at an international level.

Within the European Union, the Reception Directive of 2003 controls minimum standards for health care of asylum seekers in Member States. This chapter argues that the minimum standards regarding asylum policies within EU Member States as set by European Community (EC) legislation should conform to the minimum international human rights obligations of the Member States or else risk setting a precedence for future regional agreements that encourages impunity for human rights violations.

The European Community has legal personality both in its European Union relations and within the international community.[203] It has the capacity to, among other things, enter into international agreements, submit claims or act before an international court or judge, and the right to enjoy immunities.[204] Whether the European Union has legal personality has been under great debate, however authorities on EU law such as Professor Gráinne de Búrca argue that it exists because the EU's activities satisfy the

[203] Treaty establishing the European Community, European Union, arts. 281, 282, *Consolidated Version of the Treaty Establishing the European Community*, available at: europa.eu.int/eur-lex/lex/en/treaties/dat/12002E/pdf/12002E_EN.pdf, last visited on 18 January 2008. [hereinafter "EC Treaty"]; ECJ Case 22/70 *Commission* v. *Council(AETR/ERTA)*, 1971 ECR 263; P. Craig and G. de Búrca, *EU Law, Text, Cases and Materials*, (Oxford University Press, Inc., New York 2008, 4th ed.), p. 170 [hereinafter "de Búrca"].

[204] De Búrca, *supra* note , p. 171.

requirements necessary for an intergovernmental organization to have legal personality.[205] Either way, this is significant when allocating responsibility for violations of human rights committed by Member States but actively validated by EC legislation.

The first section discusses the historical movements of the EU towards creating a Common European Asylum System (CEAS) and how this has slowly removed asylum policy from the sole jurisdiction of individual Member States. The second section discusses the EC's competency in the area of health and asylum seekers' entitlement to the right to health under EC legislation. Finally, the third section specifically analyses the Reception Directive and its impact on the domestic legislation of EU Member States.

5.1 Movement Towards the Common European Asylum System

The various EU institutions have extensive powers over the asylum policy that binds the Member States. This section determines which institutions have what type of power and how their legislative acts affect the domestic laws of Member States regarding asylum policy. The first subsection explains how the idea for the future Common European Asylum System originated and its current status. The second subsection describes the movement of power over asylum policy issues from the absolute control of individual Member States to the collective control of the EU institutions as a matter of 'supranational' concern.

5.1.1 Making Asylum Policy a Community Issue

European Community law can be broken down into four layers: *primary legislation,* consisting of the treaties making up the EU; *secondary legislation,* consisting of both binding (regulations and directives) and soft law provisions; and the *EC's international agreements*, i.e. between the Community and other organizations or non-member states; and general

[205] *Ibid.*; *Reparations for Injuries Suffered in the Service of the United Nations* [1949] ICJ Rep. 174, 179-180.

principles of administrative law and conventions executed between the Member States themselves.[206]

The *primary legislation* of the EU consists of the Treaty of Rome (1957), the Single European Act (1986), the Treaty of Maastricht (1992), the Treaty of Amsterdam (1997), the Treaty of Nice (2001), and their attached "annexes and protocols… and subsequent additions and amendments".[207] Together, these treaties have had a major impact on the EU asylum policy as it exists today.

European asylum policy essentially consists of the Treaty establishing the European Community (EC Treaty) as amended by the Treaty of Amsterdam and the subsequent EC legislation based upon it.[208] Where possible, this thesis will cite to articles in the specific treaties (i.e. article 4 of the Treaty of Amsterdam). However, the EC Treaty as a whole will be cited where it is necessary to refer to sections hat have been modified by multiple treaties (i.e. Title IV of the TEC).

In 1992, the Treaty on European Union (Treaty of Maastricht)[209] first introduced asylum policy as a matter of common interest to the EU.[210] This treaty established the pillar system of organisation where the first pillar, containing the European Community, is 'supranational' in nature, while the second and third pillars, concerning the common foreign and security policy and policies on justice and home affairs (JHA), respectively, are 'intranational' in nature.[211] Within the third JHA pillar, Member States identified matters of 'common interest', including asylum policy and

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[206] O. Sidorenko, *The Common European Asylum System, Background, Current State of Affairs, Future Directions* (T.M.C.Asser Press , The Hague, 2007) p. 46-7 [hereinafter "Sidorenko"](citing: Borchardt, K.-D., *The ABC's of Community Law*, pp. 58-71, http://europa.eu.int/eur-lex/en/about/abc_en.pdf; Phinnemore, D. And L. McGowan, *A Dictionary of the European Union* (2d ed. 2004)).

[207] P. Pace, *Migration and the Right to Health: A Review of European Community law and Council of Europe Instruments*, International Organization for Migration, International Migration Law publication No. 12, p. 46 (available to public sometime in December 2008)[hereinafter "Pace"].

[208] Battjes, *supra* note , p. 25; EC Treaty, *supra* note .

[209] Treaty of Maastricht (formerly the Treaty on European Union) OJ C 191, 29.07.1992 (*signed on* 7 Feb 1992 between members of the EC and *entered into force on* 1 Nov 1993). This is the treaty that led to the EU [hereinafter "Treaty of Maastricht"].

[210] Sidorenko, *supra* note 206, p. 20.

[211] *Ibid.*, p. 19. The JHA was later renamed to Police and Judicial Cooperation in Criminal Matters, but for the purpose of discussing the Treaty of Maastricht, it will be referred to by its previous title.

immigration policy, and required that the European Convention on Human Rights and the 1951 Refugee Convention be accounted for when addressing these matters.[212] In so doing, the Treaty of Maastricht sets the stage for the European Union to act as protector of vulnerable third country nationals.

Later, the Treaty of Amsterdam[213] transferred policies relating to the free movement of persons, judicial cooperation and civil matters from the third 'intranational' pillar to the first pillar.[214] Consequently, asylum policy became an area of concern to the European Community. Moving these issues to the EU's 'supranational' pillar further reaffirmed the notion that the EU is an area where people in need of international protection can seek refuge, an important element towards the realisation of the CEAS.[215]

In 1999, the Council of Europe (CoE) met in Tampere during the Finnish EU Presidency.[216] Although the CoE is not a direct participant in the EU legislative process, its Conclusions provide the framework for specific legislative actions made by the EU institutions.[217] The EU and the CoE are two distinct organizations with differing memberships, but they have worked together on a parallel, comparative basis for years.[218] As such, the Tampere European Council moved asylum policy to the forefront of the EU agenda in its efforts to create an 'area of freedom, security and justice' in line with the goals of the Treaty of Amsterdam.[219] It was in the Tampere Conclusions that the idea of a formal 'Common European Asylum System' was introduced for the first time, a system to be "based on full and inclusive application" of the 1951 Refugee Convention and its 1967 Protocol.[220]

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[212] *Ibid.*, p. 20. Other areas of 'common interest' include: immigration policy and policy regarding third country nationals, judicial cooperation in civil and criminal matters, and police cooperation for the purposes of preventing and combating terrorism, unlawful drug trafficking, and other serious forms of international crime.
[213] The Treaty of Amsterdam, OJ C 340, 10.11.1997 (*signed on* 2 Oct 1997, *entered into force* 1 May 1999).
[214] Sidorenko, *supra* note 206, p. 20.
[215] *Ibid.*, p. 20-21.
[216] Council of Europe Tampere Conclusions, 15-16 October 1999, available at: http://www.europarl.europa.eu/summits/tam_en.htm.
[217] Sidorenko, *supra* note 206, p. 37.
[218] Pace, *supra* note 207, p. 1 at fn. 1. The EU has 27 Member States as of January 1, 2007, while the CoE has 47 Member States.
[219] Tampere Conclusions, *supra* note 9, preamble.
[220] Sidorenko, *supra* note 206, p. 28 (citing Tampere, *supra* note 9, para. 13).

The Tampere Conclusions state that the free movement of persons throughout the EU should be a right of all persons on the condition of security and justice for all, in line with the Treaty of Amsterdam.[221] Freedoms would no longer be reserved solely for European citizens where persons such as asylum seekers justifiably sought protection within the EU.[222] The envisaged purpose of this system was to create an "open and secure" EU through comprehensive improvements regarding asylum and immigration policies[223] and by addressing political, human rights and development issues in migrants' countries of origin, transit and final (European) destination.[224] Great import was placed on partnership between countries in securing the success of a policy aimed at "combating poverty, improving living conditions and job opportunities, preventing conflicts and consolidating democratic states, as well as ensuring respect for human rights".[225] The EU Member States must remember this partnership when they are realizing their duties under the ICESCR to the maximum of their international resources.[226]

The Tampere CoE identified several legislative measures necessary for the realization of the CEAS, including determining common minimum conditions, such as health care, for reception of asylum seekers.[227] These reception standards would later be realized in the Reception Directive of 2003.[228] A directive is a form of *secondary legislation* that must be adopted pursuant to the *primary legislation* and is binding upon those Members to whom it is directed.[229] It sets minimum requirements for harmonization of domestic legislation but permits discretion regarding how the objective is to

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[221] Tampere, *supra* note 9,para. 2.
[222] *Ibid.*, para. 3.
[223] *Ibid.*, para. 10; *see* Sidorenko, *supra* note 9, p. 29, for the premise that art. 10 is important because disaggregates asylum and immigration from one another, despite them being two interrelated notions.
[224] Sidorenko, *supra* note 9, p. 28 (citing Tampere, *supra* note , paras. 11, 12).
[225] *Ibid.*
[226] ICESCR, *supra* note 4, art. 2(1); ESC General Comment 14, *supra* note 15, paras. 38, 45.
[227] Sidorenko, *supra* note 206, p. 29, 58 (citing Tampere, *supra* note 9, para. 14). Other necessary legislative measures identified were: Determination of State responsibility for the examination of asylum applications, common standards for a fair and efficient asylum procedure, and common minimum conditions of reception of asylum seekers.
[228] Reception Directive, *supra* note 9.
[229] Battjes, *supra* note 193, p. 35.

be incorporated into the Member State's legal system.[230] The purpose of the Reception Directive is to harmonize minimum conditions regarding initial health care and living conditions available to asylum seekers such that they obtain a sustainable, adequate standard of living, thereby reducing the incentive to choose a host country based on differing standards of reception conditions.[231]

The Reception Directive is the main legislative act under scrutiny within this thesis, as are its implications for an asylum seeker's right to health in the EU. Its transposition deadline was February 2005, but some Member States have yet to transpose the Directive into national legislation. Ireland and Denmark have both opted out of the Reception Directive and are not accountable for the minimum standards contained therein.[232]

5.1.2 The Loss of Member State Autonomy Regarding Asylum

European Union institutions involved in the asylum decision-making procedure include the European Council, the European Commission and the European Parliament.[233] Each of these bodies has distinct powers regarding the establishment and enforcement of the CEAS. Two additional institutions, the Council of Europe (CoE) and the European Court of Justice (ECJ), play a periphery role in the EU's asylum procedure. The power wielded by these institutions highlights the EU's responsibility for the areas of the CEAS that fail to uphold the Member States' legal obligations.

The European Council (not to be mistaken with the Council of Europe) is made up of the Member States' ministers, who must agree to legislative proposals before they may become law within the European Parliament.[234] Member States' votes have differing weights based upon population, and a qualified majority vote is now required to pass legislation regarding measures on asylum, refugees and displaced persons, immigration

[230] EC Treaty, *supra* note 203, art. 249.
[231] Reception Directive, *supra* note 9, preamble, paras. 7-8.
[232] Battjes, *supra* note 193, p. 208 (citing Reception Directive, *supra* note 9, art. 21 (Denmark); *Ibid*. art. 20 (Ireland)).
[233] Sidorenko, *supra* note 206, p. 32.
[234] *Ibid*., p. 33.

policy, and the rights of third country nationals residing legally within a Member State.[235] Permitting a qualified majority vote recognizes how difficult it would be to come to a unanimous decision now that the EU had expanded to 27 Member States; to retain the unanimity requirement would be to stagnate the creation of a CEAS.[236]

The European Commission has a right of legislative initiative, which is the key to its influence over the CEAS.[237] In accordance with the Treaty of Amsterdam, as of May 2004, the Council can only act upon direct proposals from the Commission, replacing the previous system whereby the Council could act on initiatives from Member States or the Commission.[238] However, the Commission must examine any requests made by Member States.[239] In this sense, legislation on asylum policy is now entirely a Community issue, i.e. an issue for the EU in its 'supranational' capacity under the first pillar.

The European Parliament has considerable weight in asylum policy matters due to the codecision procedure within the EU system. Where the Council wishes to act on a matter covered by Title IV of the EC Treaty, regarding policies related to the free movement of people, the Parliament must first approve the proposal.[240] Without this approval, the Council is unable to act upon the proposal independently. The issue of 'burden sharing' was added to the area of codecision by the Council Decision of 22 December 2004, a decision implementing a commitment laid down in The Hague Programme of November 2004.[241]

As mentioned earlier, the European Court of Justice (ECJ) has a periphery influence on asylum procedure within the EU. Generally, the ECJ "has the final say on all matters concerning validity and interpretation of all

[235] *Ibid.*, p. 33 (citing the EC Treaty, *supra* note , art. 205(2) (weight of votes), art. 67 (qualified majority vote), and art. 63 (areas of law in regarding which the Council may adopt measures)).
[236] *Ibid.*, p. 34.
[237] *Ibid.*, p. 35 (citing art. 67 of the EC Treaty).
[238] EC Treaty, *supra* note 203, art. 67(2).
[239] *Ibid.*
[240] *Ibid.*, art. 67(2), 67(5).
[241] *Ibid.*, art. 63(2)(b)

Community law".[242] Under the Treaty of Amsterdam, the ECJ specifically gained jurisdiction over interpretation of Title IV of the EC Treaty or any acts of the EC institutions based on Title IV of the EC Treaty, thereby gaining jurisdiction over EU asylum policy.[243] However the ECJ may not initiate such interpretive inquiry; instead, the Council, the Commission or a Member State must request the ECJ to act.[244] Thus far, such a request has never been made, but it theoretically permits the ECJ to contribute to the legal legitimacy of asylum policy within the European system.[245]

As a consequence of the Treaty of Amsterdam and other primary EU legislation amending the EC Treaty, the Member States are increasingly losing direct power of the asylum policy of the EU. Although Member States retain power to implement asylum policy domestically within the confines set forth in EU legislation, they must at least satisfy the minimum standards set by that legislation. Therefore, complaints against treatment of asylum seekers by Member States of the EU should, at least in part, be addressed to the EU itself where the minimum conditions that it sets in legislation falls below Member States' obligations under international human rights law.

5.2 European Union Competency over Health Care for Asylum Seekers

The previous section discusses how the EU and its Institutions gained power over asylum policy. This section specifically discusses in what way the EU has competency to control the minimum standards of health care for asylum seekers in its Member States and how it has exercised this control. The first subsection specifically discusses the EU's competency regarding regulation of health care standards in its Member States. The second subsection discusses the right of non-nationals to an adequate standard of health in the EU by virtue of EU instruments, rather than international human rights law. The final subsection discusses the specific

[242] *Ibid.*, arts. 234, 240.
[243] *Ibid.*, art. 68(3).
[244] *Ibid.*, arts. 68(3), 234.
[245] Battjes, *supra* note 193, p. 42.

legislative acts taken by these institutions regarding the portions of the asylum policy affecting the right to health for asylum seekers and discusses the binding nature of these acts upon Member States.

5.2.1 European Union Competency in the Area of Health

The EU gained competency over health matters within the domestic realm of its Member States progressively. Originally, the EU's competency in public health matters was limited to the prevention of diseases and the Community's contribution towards a high level of health protection through the encouragement of cooperation and aid between Member States.[246] However, the Treaty of Amsterdam readdressed the situation in article 152, which ensures that a "high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities".[247] This includes the Community duty to take actions protecting public health, including fighting against "major health scourges" by promoting research and disseminating health information and education.[248]

This power of the EU over health policies is limited by the principles of subsidiarity, proportionality, and territoriality, which attempt to keep all Community decisions as close to individual citizens as possible by providing checks on Community action. The subsidiarity principle requires that where an area does not fall within the EC's *exclusive* competences, such as asylum law, the EC will only take actions in that area that "cannot be sufficiently achieved by the Member States" due to the "scale or effects of the proposed action".[249] By virtue of this principle, health care policy remains predominantly controlled in the domestic realms. For instance, the EC Treaty acknowledges "direct Community competence within the field of health, although it only allows for action that supports or completes action

[246] Treaty of Maastricht, *supra* note 209, art. 129.
[247] EC Treaty, *supra* note 203, art. 152.
[248] *Ibid.*, art. 152.
[249] *Ibid.*, art. 5.

taken by Member States".[250] The principle of proportionality requires all EC action to be directly proportional to the aim that it pursues – i.e. using a regulation instead of a directive.[251] Additionally, the principle of territoriality means that responsibility for providing access to health care also remains with the Member States.[252]

Regardless, the EC is slowly gaining power over health care policies. For instance, recently health care policy issues have ridden on the back of more "mainstream" issues such as social protection and employment where the public health concerns raised in article 152 of the EC Treaty are involved. Additionally, the ECJ has recognized that the health issues are not exclusively a national matter.[253] This is indicative that the issue of health is increasingly becoming an issue of communal concern and is increasingly controlled by the EC, the 'supranational' third pillar of the EU.

5.2.2 Non-Nationals and Entitlement to Health Care in the European Union

It has already been established that States Parties to the ICESCR must satisfy their obligations under the right to health without discrimination in regards to nationality or legal status. As mentioned earlier, all European Union Member States are also States Parties to the ICESCR, CEDAW and CRC, the major documents establishing the right to health under international human rights law.[254] Within the European system the right to health is protected for all persons under the Council of Europe Convention on Human Rights and Biomedicine; as State Parties to the Convention, all EU Member States and the EC itself are obligated to use their best

[250] Pace, *supra* note 207, p. 13 (citing EC Treaty, *supra* note , art. 137).
[251] Battjes, *supra* note 193, p. 35.
[252] Pace, *supra* note 207, p. 13.
[253] *Ibid.*, (citing R.-M. Hämäläinen, M. Koivusalo, E. Ollila, "EU Policies and Health", *Themes from Finland* 1/2004, Helsinki, Finland, STAKES, p. 6, and E. Mossialos, M. McKee, EU Law and the Social Character of Health Care, Brussels, P.I.E. Lang, 2002).
[254] ICESCR ratification available at: http://www2.ohchr.org/english/bodies/ratification/3.htm.

endeavours to satisfy its aim to ensure "equitable access to health care of appropriate quality in accordance with the person's medical needs".[255]

Additionally, there are a variety of EU instruments regarding the right to health care and access to health care for non-nationals. Reaffirming the fact that these rights are not reserved solely to EU nationals, the Tampere Conclusions state that third-country nationals (TCNs) residing legally within a Member State should have rights and obligations comparable to those of EU citizens, and that non-discrimination in the economic, social and cultural fields should be enhanced.[256] Echoing this sentiment, the European Parliament asks for fair treatment for TCNs and the enhancement of their legal status to one that entitles them as much as possible to uniform rights on par with EU citizens.[257] Finally, the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) applies to all persons within the territory of a State Party, regardless of their legal status.[258] The European Court of Human Rights, charged with the duty to implement the ECHR, has found that the ECHR has a health dimension applicable to non-nationals where access to health care is so limited as to violate one of the rights embodied within it.[259]

Finally, in regards to the policy driving the EU asylum legislation, the European Parliament has recognized that the reform of health care systems in Europe should be based on "the values of human dignity, equity, solidarity and professional ethics", with an aim towards universal coverage and equitable access, and with an emphasis on primary health care.[260] The Parliament identifies the main criterion necessary for a successful health care system: effective access to health care for all without discrimination, a

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[255] Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine, ETS no. 164, art. 3.
[256] *See generally* Tampere Conclusion, *supra* note 9.
[257] European Parliament Resolution of 29 October 1999, OJ 2000 C154, p. 63.
[258] European Convention for the Protection of Human Rights and Fundamental Freedoms, ETS No. 5 (*adopted* 4 November 1950, *entered into force* 3 September 1953).
[259] Pace, *supra* n. 207, p. 19 (citing *D.* v. *United Kingdom*, 24 EHRR 423 (1997), where the Court held that removal of an AIDS-infected asylum applicant to St. Kitts where no medical treatment was available would violate the prohibition against torture enshrined in article 3 of the ECHR).
[260] Recommendation 1626(2003) of the Parliamentary Assembly on the reform of health care systems in Europe: reconciling equity, quality and efficiency, para. 2; text available at: http://www.coe.int or in Pace, *supra* note 207, p. 274.

recognized basic human right, the realization of which will improve "the general standard of health and welfare of the entire population".[261] In fleshing out the applicability of this "basic human right", the European Parliament determined that the right to health associated with access to health care should be "equally applied to all people, including migrants, refugees and displaced persons".[262]

5.3 The Reception Directive's Impact on the Right to Health for Asylum Seekers

The EU in its supranational capacity has gained control over EU asylum policy regarding minimum standards of health care owed to asylum seekers and refugees. This section attempts to prove in what way these minimum standards fail to uphold the right to health for asylum seekers and attempts to quantify the Reception Directive's impact by discussing the provisions that can be and have been transposed into national legislation in a manner contrary to the international legal obligations of Member States.

5.3.1 The Reception Directive, Generally

The Common European Asylum System is intended to establish "an area of freedom, security and justice open to those who, forced by circumstances, legitimately seek protection in the Community".[263] The Reception Directive was adopted on 27 January 2003 for the purpose of fulfilling the Tampere Conclusions' short-term goal of determining common minimum standards of reception for asylum seekers so that a dignified standard of living may be ensured.[264] The preamble to the Reception Directive reminds Member States of their ongoing international legal

[261] *Ibid.*, para. 4.
[262] Recommendation 1503(2001) of the Parliamentary Assembly on health conditions of migrants and refugees in Europe, para. 6, text available at: http://www.coe.int/ or in Pace, *supra* note , p. 265.
[263] Reception Directive, *supra* note 9, preamble para. 1.
[264] *Ibid.*, preamble paras. 3-4, 7; Ireland and Denmark opted out (Reception Directive, *supra* note , paras. 20-1).

obligations and notes that reception of groups with special needs should be "specifically designed to meet those needs".[265]

As mentioned earlier, a directive is a form of *secondary legislation* in the EU and its objectives are binding only on those Members to whom it is directed. It sets minimum requirements for harmonization of domestic legislation but permits discretion regarding how the objective is to be incorporated into the Member State's legal system.[266] Directives require national measures, either administrative, legislative, or otherwise, for the effect to be felt within the Member States' territories such that it may be invoked against an individual by the state, or may be used by a judge to invalidate a law of the state. However, an element of direct effect exists with directives: an *individual* may invoke the directive against a Member State that fails to transpose it into national law where the directive's provisions are sufficiently clear and precise.[267] This is known as the 'vertical direct effect of a directive' as opposed to the more broadly known 'horizontal direct effect' provided by a regulation'.[268] In this manner, the Reception Directive could potentially provide a mechanism for enforcing human rights. If its provisions were sufficiently clear and precise enough to protect the at least the minimum core content of the right to health, it could be invoked by an individual before the ECJ against state that had not transposed the directly correctly.[269]

The Reception Directive should have been transposed into national legislation by 6 February 2005, but as of April 2006, Portugal, Greece and Belgium had yet to comply.[270]

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[265] *Ibid.*, preamble paras. 6, 9.
[266] P.S.R.F. Mathijsen, *A Guide to European Union Law*, p. 26 (Thompson, Sweet and Maxwell, 8th Ed., 2004)[hereinafter "Mathijsen"].
[267] De Búrca, *supra* note 203, pp. 280-281; *Van Duyn v. Home Office* [1974] ECR 1227, para. 12 (the first case in which the ECJ recognized the direct effect of directives).
[268] Mathijsen, *supra* note 266, p. 27-8.
[269] De Búrca, *supra* note 203, p. 283; Case 152/84 *Marshall v. Southampton and South-West Hampshire Area Health Authority (Teaching)*, [1986] ECR 723, para. 48.
[270] J. Bowring, *European Council on Refugees and Exiles 2005 Country Report*, European Council on Refugees and Exiles publication (Carolyn Baker (ed.)), available at: http://www.ecre.org/files/ECRE%20Country%20Report%202005rev.pdf., , last visited on 19 January 2008 [hereinafter "ECRE *2005 Country Report*"].

5.3.2 Articles 9 and 15: Minimum Standards of the Reception Directive as Violations of International Obligations

Due to their discretionary wording, articles 9 and 15 of the Reception Directive both have potential to negatively impact health care provided for asylum seekers in Member States. Article 9 gives Member States discretion regarding whether or not to supply initial medical screenings to asylum applicants upon arrival at reception centres.[271] Article 15 addresses the right to health care for asylum seekers, stating that asylum applicants are entitled to necessary health care that includes, at a minimum, emergency care and 'essential treatment of illness'.[272] It also provides that applicants with 'special needs' must have necessary medical or 'other' assistance provided to them by the Member States.[273] The sections below establish that Member States that have 'emergency health care only' policy violate the right to health for asylum seekers and quantifies how many asylum seekers are affected by states that practice this policy.

5.3.2.1 Legal Consequences of Supplying the Minimum – 'Emergency Health Care Only' and Discretionary Medical Screenings

Providing initial medical screenings for asylum applicants is the first opportunity a state has to uphold the right to health for this vulnerable portion of society. As discussed earlier, asylum seekers are persons that are particularly likely to have been subjected to pre-migration trauma and to have untreated infectious diseases due to both a lack of access to health care in their originating countries and the conditions they experienced during travel to the EU. [274] Such screenings have intercepted carriers of tuberculosis, HIV/AIDS, hepatitis A and B, a variety of parasitic diseases, and many mental health problems.[275] These initial screenings are vital in order to ensure asylum seekers' needs are addressed. By identifying the

[271] Reception Directive, *supra* note 9, art. 9.
[272] *Ibid.*, art. 15(1).
[273] *Ibid.*, art. 15(2).
[274] Pace, *supra* note 207, p. 28; Norredam, *supra* note 17, p. 285.
[275] Pace, *supra* note 207, p. 28.

illnesses and providing treatment for them without using them as rationale for refusal of admission, a country simultaneously upholds the right to health for asylum seekers and their duties under the 1951 Refugee Convention. Failing to do so, however, violates an asylum seeker's right to health and the right to health for all persons who may be infected by untreated diseases.

'Emergency health care only' policies also fail to address the health concerns of the "whole population", thereby violating another obligation necessary to uphold the minimum core content of the right to health.[276] Where a state provides only emergency care for asylum seekers, the right to health of both asylum seekers *and* the state's citizens are violated. This policy infringes on the citizens' right to access health care because the policy creates an inefficient use of health services by straining the emergency care utilized by both citizens and immigrants.[277]

Additionally, this policy infringes on the states' minimum core obligation to stop infectious diseases and epidemics. Stopping infectious diseases requires public health initiatives, and to be effective, public health initiatives require universality.[278] Preventing access to all but emergency health care encourages asylum seekers to wait until they are ill enough to necessitate emergency care before they seek treatment,[279] seriously limiting the effectiveness of "outreach, case finding, and prevention and treatment programs related to infectious diseases".[280] The relationship between tuberculosis (TB) and access to health care is an ideal example of the need for universality: in multiple countries around the world, the decline in TB has stagnated due to the existence of TB in untreated immigrants.[281]

As a comparatively rich group of nations, the EU Member States should also include within their minimum core obligations those

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[276] ESC General Comment 14, *supra* note 15, para. 43.
[277] World Health Organization publication, *International Migration, Health and Human Rights*, 22, June 2004, available at: http://www.who.int/hhr/activities/en/intl_migration_hhr.pdf [hereinafter "WHO *International Migration*"] p. 21.
[278] *Ibid.* (citing Committee on Community Health Services, Health Care for Children of Immigrant Families, *Pediatrics*, 1997, 100(1):153-156).
[279] *Ibid.*
[280] *Ibid.*
[281] *Ibid*., p. 22 (citing UNAIDS/IOM, *Migrants' Right to Health*, 18 (2001)).

'obligations of comparable priority' identified by the ESC Committee.[282] Amongst these secondary obligations are: the duty to ensure reproductive, maternal and child health care; the duty to provide immunizations against major infectious diseases; and the duty to provide education and access to information regarding health concerns.[283] Emergency medical care alone violates each of these duties.

The Reception Directive does require 'persons with special needs' to be taken into account in the national legislation of Member States implementing health care, a positive step towards the realization of the right to health in the EU. Such persons include "minors, unaccompanied minors…pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence".[284] However, the loose wording of this provision fails to create identifiable, enforceable standards, and some Member States have transposed it in such a manner that denies children access to adequate health care service as is discussed below.

One of the aims of the Reception Directive is to harmonize the domestic legislation of Member States in such a manner that asylum seekers no longer have the incentive to choose host countries based on differing standards of care.[285] This goal cannot be satisfied by the imprecise wording of the provisions of the Reception Directive because they do nothing to actively reduce the gap between "countries with higher and those with lower standards concerning reception".[286]

5.3.2.2 Member States that Adhere to the Minimum Standards

In 2004, a survey was sent to ministries and NGO's in the EU Member States to determine: 1) how many EU Member States offer medical screenings to arriving asylum applicants, and 2) what type of health care the

[282] *Infra* section 2.2.2.3.
[283] ESC General Comment 14, *supra* note 15, para. 44.
[284] Reception Directive, *supra* note 9, art. 17(1).
[285] *Ibid*., preamble, para.8.
[286] De Búrca, *supra* note 203, p. 258 (citing Peers, *supra* note , p. 327).

EU Member States offered to asylum seekers.[287] Of the existing 25 EU Member States, only Portugal failed to reply.[288]

Of those that responded, all provided some form of medical screening for asylum seekers at arrival except Greece, which only provided screenings to asylum seekers applying for work permits.[289] In Austria, France, Spain and Britain, medical screenings were systematically offered at reception centres only, while asylum seekers not staying in those facilities were tested randomly.[290] In several other countries, the screenings were provided systematically.[291] In Germany and Italy, the type of screening provided varied by regions.[292] State officials generally oversaw the screening process, except in Denmark where screenings were conducted by the Danish Red Cross.[293]

The survey looked at whether the screening programmes tested for HIV, TB, physical exam, mental exam, and "other" screenings.[294] Twenty-two countries screened for TB, ten making it compulsory; HIV screenings were carried out in nineteen countries, eleven making it compulsory.[295] "Other" medical screenings offered by the Member States included children's vaccination programmes, bacteria and parasite tests, hepatitis B, syphilis, and malaria.[296] Only twelve countries offered "other" screening, clearly indicating that childhood inoculations are low on the priority list of EU Member States, despite this being the key to battling epidemics of infectious diseases.

According to the same 2004 study, nine EU Member States provided only emergency health care for asylum applicants.[297] These nine countries

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[287] Norredam, *supra* note 17, pp. 285-286.
[288] *Ibid.*, p. 286.
[289] *Ibid.*
[290] *Ibid.*
[291] *Ibid.*
[292] *Ibid.* Germany's individual federal states may determine whether and how to offer medical screening.
[293] *Ibid.*
[294] *Ibid.*, p. 286 (table 1).
[295] *Ibid*., p. 286.
[296] *Ibid.*
[297] *Ibid*. pp. 285-289. The survey consisted of a questionnaire sent to the ministries of and related NGO's within the Member States of the EU. Twenty-four out of the 25 Member States existing at the time replied; Portugal did not. The study analysed both the medical

were Denmark, Estonia, Finland, Germany, Hungary, Luxembourg, Malta, Spain and Sweden.[298] Of these, five restricted access to health care for pregnant asylum seeking women[299] and seven restricted access to health care for asylum seeking children as compared to citizens.[300] In 2004, Sweden provided children access to health care on par with children 'domiciled' in Sweden, but not asylum seeking adults.[301] The Special Rapporteur on Health, Paul Hunt, found that this differential treatment constitutes discrimination under international human rights law.[302]

As of April 2006, the following countries had not changed their 'emergency health care only' policy for asylum seekers: Denmark,[303] Finland,[304] Hungary,[305] Luxembourg,[306] Spain,[307] and Sweden.[308] No further information could be found regarding Estonia and Germany.[309]

Austria restricted health benefits to emergency care where asylum applicants left reception centres prior to being assigned residence or upon switching residence/travelling from one federal state to another.[310] Since then, Austria has permitted basic care to be refused to asylum seekers where they arrived with a visa, regardless of whether the visa was sponsored; it is unclear whether 'basic care' includes health care.[311] Within Austria, the basic care provided is so little in comparison to Austrian citizens and persons with social rights that it has raised concern in the ESC Committee.[312]

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screening provided upon initial entry into the country and the subsequent access to health care enjoyed by asylum seekers.

[298] Norredam, *supra* note , p. 286.

[299] *Ibid.*, p. 286 (table 2).

[300] *Ibid.*, p. 286. Information regarding which countries restricted which population is not available.

[301] Hunt *Mission to Sweden*, *supra* note 3, p. 19.

[302] *Ibid.*, p. 19.

[303] ECRE *2005 Country Report*, *supra* note 270, pp. 90-91.

[304] *Ibid.*, p. 101.

[305] *Ibid.*, p. 146.

[306] *Ibid.*, p. 191.

[307] *Ibid.*, p. 297.

[308] *Ibid.*, p. 306.

[309] *Ibid.*, p. 122 (Estonia is not discussed).

[310] Norredam, *supra* note 17, p. 286.

[311] ECRE *2005 Country Report*, *supra* note 270, p. 32-33.

[312] *Ibid.*, p. 49 (citing ESC Committee report E.C./12/AUT/CO/3).

As of April 2006, France offered access to *aide médicale d'état* (the basic medical care offered by the state) only where asylum seekers could prove residence in France for three continuous months, meaning all asylum seekers were restricted to emergency care during a time when medical and mental health care is most important.[313] In late 2005 a debate began about eventually changing this policy and relaxing the temporal requirements.[314]

In Malta, there continue to be major issues regarding care for asylum seekers, which are primarily Libyans that have arrived in rafts.[315] All asylum seekers are detained in reception centres during the duration of their status determinations.[316] They are currently deprived of access to information regarding their rights, including their right to basic health services.[317] No additional information has been found regarding asylum seekers' right to health in Malta's legislation, but these reports indicate that it is unlikely that asylum seekers have access to even emergency health care.

5.3.3 Article 16 Conditions for Withdrawal of Benefits

Article 16 of the Reception Directive permits reduction or withdrawal of reception conditions where certain situations arise, including those situations where an asylum seeker failed to place a claim "as soon as reasonably practicable" after arrival in that Member State.[318] Although the Reception Directive requires that emergency care be available regardless of withdrawal of additional benefits, this particular provision may be abused where it is transposed into national legislation in an unreasonable manner.[319]

The United Kingdom, for one, initially invoked this article as justification for the practice of revoking all welfare and accommodation

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[313] *Ibid.*, p. 112.
[314] *Ibid.*, (citing DGAS/DSS/DHOS n°2005-407, 27 September 2005).
[315] *Ibid.*, pp. 195-196.
[316] *Ibid.*
[317] *Ibid.*
[318] Reception Directive, *supra* note 9, art. 16(2).
[319] *Ibid.*, art. 16(4) (emergency health care may not be removed); I. Higgens (ed.), *Migration and Immigration Law and Policy in the European Union*, Fédération Internationale de Droit Européene National Reports 2004, p. 450 [hereinafter FIDE *National Reports 2004*].

benefits for anyone found to have applied 'unreasonably' late for asylum protection, although this was left undefined.[320] Subsequently, the UK courts determined that three days was the 'reasonable' period of time permitted to pass before benefits are revoked.[321] This is a clear example of how the Reception Directive's provision permitting withdrawal of benefits may be invoked in a manner that violates the Member State's international duties.

Additionally, this withdrawal of benefits violates the ICSCR prohibition against deliberately retrogressive measures because no justification is offered for this measure based upon the "totality of the rights" in the ICESCR and in the "context of the full use of the maximum available resources".[322]

[320] Nationality Immigration and Asylum Act 2002, Chapter 41, §55.
[321] FIDE *National Reports 2004*, *supra* note 319, p. 450. UK national courts further limited the ability to revoke benefits where such persons are left without the ability to otherwise fend for themselves in violation of the ECHR article 3 prohibition against inhuman or degrading treatment (citing: *R (Q and others)* v. *Secretary of State for the Home Department* (2003) 2 All ER 905 (Court of Appeals); *R (T)* v. *Secretary of State for the Home Department*, *R (T)* v. *Secretary of State for the Home Department*, EWCA Civ 1285 (Court of Appeals).
[322] ESC General Comment 3, *supra* note 55, para. 9.

6. CONCLUSION

The EU Member States took on a heavy burden when ratifying the ICESCR and are now required to uphold two layers of obligations arising from the right to health. First, the Member States are immediately obligated to uphold the minimum core content of the right to health as it is modified by the 'obligations of comparable priority' delineated in ESC General Comment 14. Amongst these minimum core obligations are the duties to: provide access to health care on a non-discriminatory basis, especially for vulnerable or marginalized groups; provide essential drugs; adopt a national health care strategy that will address the health concerns of the whole population; ensure reproductive, maternal (pre-natal as well as post-natal) and child health care; providing "immunizations against the major infectious diseases occurring in the community"; take measures to "prevent, treat and control epidemic and endemic diseases"; provide "education and access to information concerning the main health problems in the community, including methods of preventing and controlling them"; and to provide "appropriate training for health personnel, including education on health and human rights".[323]

Second, the Member States must progressively takes steps towards the realization of the right to health as it is defined by the ESC Committee by respecting, protecting and fulfilling the right. Included within the duty to respect the right to health is the duty to refrain from denying or limiting equal access to preventative, curative and palliative health services for all persons, including asylum seekers. Only then will they fulfil the obligations that they willingly took on by becoming State Parties to the ICESCR.

Asylum seekers are legally entitled to enjoy these provisions because non-nationals are entitled to *at least* the minimum core content of the rights contained with the ICESCR.[324] However, asylum seekers within the EU should be entitled to social security benefits, and therefore access to health care, on par with nationals of their host state by virtue of article 24 of the

[323] ESC General Comment 14, *supra* note 15, paras. 43-44.
[324] General Comment 3, *supra* note 55, para. 10.

1951 Refugee Convention. ‘Lawfully staying’ should be interpreted to require asylum seekers to have proof of lawful presence for an inherently indefinite length of stay that is likely to be of a duration long enough to warrant the need for benefits. Article 6(2) of the Reception Directive provides enough documentation for asylum seekers to be ‘lawfully staying’ in their host countries. As it stands, the EU Reception Directive sets minimum standards that fail to satisfy the minimum core content of the right to health, thereby permitting (if not endorsing) Member States to violate their obligations under international human rights law.

The EU Reception Directive sets ‘emergency care’ as the minimum standard of health care for asylum seekers, permits states to decide whether to offer medical screenings for newly arrived asylum seekers, and permits withdrawal of benefits in certain situations. Each one of these provisions violates the minimum core content of the right to health as it is defined above. In particular, ‘emergency only health care’ policies fail to take into consideration the health needs specific to asylum seekers, women and children. Additionally, permitting discretion regarding medical screenings of arriving asylum seekers severely limits the states’ ability to uphold its obligation to provide immunizations for the community and prevent, treat and control epidemic and endemic diseases. Finally, withdrawal of benefits violates the prohibition against retroactive measures in the area of economic, social and cultural rights.

Clearly, the Reception Directive’s minimum standards fall below the legal obligations of the EU Member States. This conclusion raises a question regarding allocation of responsibility for violations of human rights committed by the Member States. Are they solely responsible for their domestic acts anymore, or has the EC’s legal responsibility been implicated? After all, the Reception Directive actively legalizes at the regional level violations of human rights obligations committed by Member States.

A corollary to that question is whether allocating some responsibility to regional bodies for the abuse of human rights in individual states is the best thing for the asylum seeker or whether it takes too much focus off of

state practices. The answer would be case-specific and it would be necessary to examine the structure of the regional bodies to determine whether enough direct power exists to warrant such allocation of fault.

The European Union's efforts regarding the reception standards for asylum seekers are commendable in the sense that it incorporates an overriding sense of protection into the system. The purpose of this thesis is not to lambaste the efforts made, but to urge the EU towards further human rights protection in the system. The EU's *sui generis* status makes the CEAS, with its goal of harmonizing the domestic asylum laws of the EU Member States, an experiment of monumental proportions. However, the Reception Directive grants Member States such a wide range of discretion that this goal is rendered illusory. For true harmonization to occur, more stringent minimum standards are necessary.

There is a very real possibility that the Common European Asylum System will have a positive influence on the domestic laws of EU Member States, but currently, the Reception Directive does little to protect the right to health for asylum seekers. Instead, it encourages impunity for violations by validating inadequate domestic laws, and Member States are consequently permitted to regress, or at a minimum stagnate, in regards to the right to health of asylum seekers with no consequences at the EU level. To appease Aristotle's hopes regarding society's role in securing the "absolute" right to good health, changes must be made to the Reception Directive to align the minimum standards contained therein with the minimum obligations of the EU Member States.

Bibliography

Books	
Arambulo, Kitty	*Strengthening the supervision of the International Covenant on Economic, Social and Cultural Rights: theoretical and procedural aspects* (Intersentia/Hart, Antwerp, 1999).
Brownlie, Ian	*Principles of Public International Law* (Oxford University Press, 6th ed., 2003).
Battjes, Hemme	*European Asylum and International Law* (Martinus Nijhoff Publishers, 2006).
Craig, Paul Gráinne de Búrca	*EU Law, Text, Cases and Materials*, (Oxford University Press, Inc., New York 2008, 4th ed.).
Craven, Matthew	*The International Covenant on Economic, Social and Cultural Rights* (Claredon Press, 1995).
Dowell-Jones, Mary	*Contextualising the International Covenant on Economic, Social and Cultural Rights: Assessing the Economic Deficit*, (Martinus Nihoff Publishers. 2004).
Dowell-Jones, Mary	*Contextualising the International Covenant on Economic, Social and Cultural Rights: Assessing the Economic Deficit*, (Martinus Nihoff Publishers. 2004).
Eide, Asbjørn (ed.) Krause, Katerina (ed.) Rossas, Allan (ed.)	*Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001).

Goodwin-Gill, Guy S.	*The Refugee in International Law*, (Oxford University Press, 3rd ed. 2007)
Higgins, Imelda (ed.) Hailbronner, Kay (ed.)	*Migration and Immigration Law and Policy in the European Union*, Fédération Internationale de Droit Européene National Reports (Cambridge University Press 2004).
Kemp, Charles Rasbridge, Lance	*Refugee and Immigrant Health*, (University Press, Cambridge, 2004).
Mathijsen, P.S.R.F.	*A Guide to European Union Law* (Thompson, Sweet and Maxwell, 8th ed., 2004)
Muscroft, Sarah (ed.)	*Children's Rights: Equal Rights?* International Save the Children Alliance publication (Impressions 2000).
Muscroft, Sarah (ed.)	*Children's Rights: Reality or Rhetoric?* (International Save the Children Alliance publication 2000).
Peers, Steve	*EU Justice and Home Affairs Law* (Oxford University Press, 2006, 2nd ed.).
Sidorenko, Olga	*The Common European Asylum System, Background, Current State of Affairs, Future Directions* (T.M.C.Asser Press, The Hague, 2007).
Wehmaeier, S. (ed.)	*Oxford Advanced Learner's Dictionary*, (Oxford University Press 2000, 6th ed.).

Articles

Babitsch, Birgit Dennert, Gabriele	'Access to health care: Contributions from a Gender Perspective', 8:2 *Euro Observer* (Summer 2006) p. 5.
Bhabba, Jacqueline	'Demography and Rights: Women, Children, and Access to Asylum', 16 *International Journal on Refugee Law* (2004) p. 227.
Cholewinski, Ryszard	'Economic and Social Rights of Refugees and Asylum Seekers in Europe', 14 *Georgetown Immigration Law Journal* (Spring 2000) p. 717
Eide, Asbjørn	'Realization of Social and Economic Rights and the Minimum Threshold Approach', 10 *Human Rights Law Journal* (1989) p. 35.
Eide, Asbjørn Rosas, Allan	'Economic and Social Rights as Human Rights' in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001), pp. 3-28.
Frostell, Katarina Scheinin, Martin	'Women' in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001), pp. 331-352.
Gilbert, Lauren	'Rights, Refugee Women and Reproductive Health', 44 *American University Law Review* (April 1995) p. 1239.
Guild, Elspeth	'The Europeanisation of Europe's Asylum Policy', 18 *International Journal of Refugee Law* (September/December 2006) p. 631.

Hammarberg, Thomas	'Children' in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001), pp. 353-372.
Hendriks, Aart Toebes, Brigit	'Towards a Universal Definition of the Right to Health', 17 *Medicine and Law* (1998) p. 329.
Norredam, Marie Mygind, Anna Krasnik, Allan	'Ethnic Disparities in Health: Access to health care for asylum seekers in the European Union – a comparative study of country policies', 16:3 *European Journal of Public Health* (2005) pp. 285-289.
Shah, Sheetal B.	'Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India', 32 *Vanderbilt Journal of Transnational Law* (March 1999) p. 435.
Scheinin, Martin	'Economic and Social Rights as Legal Rights' in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001), pp. 29-54.
Scheinin, Martin	'The Right to Social Security' in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001), pp. 29-54.
Toebes, Brigit	'The Right to Health' in A. Eide, *et al*, (eds.), *Economic, Social and Cultural Rights, a Textbook* (Klewer Law International, 2nd ed, 2001), pp. 169-190.

International Documents

African Charter on Human and Peoples' Rights, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), art. 16 (adopted June 27, 1981, *entered into force* Oct. 21, 1986).

Beijing Declaration and Platform of Action, UN Doc. A/CONF.177/20 (1995) and UN Doc. A/CONF.177/20/Add.1 (1995).

Cairo Programme of Action of the International Conference on Population and Development (1994) available at: http://www.iisd.ca/Cairo/program/p00000.html, last visited on 19 January 2008.

Council Directive 2003/9/EC of 27 on the Reception Standards of Asylum Seekers, January 2003, OJ L 031, 6.2.2003, 18 (transposition deadline into domestic legislation was 6 February 2005).

Copenhagen Criteria for Accession to the European Union, available at: stats.oecd/glossary/detail.asp?ID=3048, last visited on 19 January 2008.

Council of Europe Tampere Conclusions, 15-16 October 1999, available at: http://www.europarl.europa.eu/summits/tam_en.htm, last visited on 19 January 2008.

Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine, ETS no. 164.

European Convention for the Protection of Human Rights and Fundamental Freedoms, ETS no. 5 (*adopted* 4 November 1950, *entered into force* 3 September 1953).

European Council, *Copenhagen Conclusions of the Presidency*, (21-22 June 1993), available at: ue.eu.int/useDocs/cms_Data/docs/pressdata/en/ec/72921.pdf, last visited on 19 January 2008.

European Council, *Council Regulation (EC) No. 1783/1999 of the European Parliament and of the Council of 12 June 1999 on the European Regional Development Fund*, OJ L 213 of 13.08.1999.

European Council, *Resolution of the European Council of 13 December 1997, on economic policy coordination in stage 3 of economic and monetary union and on Articles 111 and 113 of the EC Treaty*, OJ C 35 of 2.2.1998.

European Social Charter, (ETS No. 35), Turin, 18.X.1961.

European Parliament, Recommendation 1503(2001) of the Parliamentary Assembly on health conditions of migrants and refugees in Europe, available at: www.refugeelawreader.org/inventory.d2?start=400&target =search&I_doctype[]=0, last visited on 19 January 2008.

European Parliament, Recommendation 1626(2003) of the Parliamentary Assembly on the reform of health care systems in Europe: reconciling equity, quality and efficiency; available at www.coe.int, last visited on 19 January 2008.

European Parliament, Resolution of 29 October 1999, OJ 2000 C154, p. 63.

European Union, *Treaty of Amsterdam*, OJ C 340, 10.11.1997 (*signed on* 2 Oct 1997, *entered into force* 1 May 1999).

European Union, *Consolidated Version of the Treaty Establishing the European Community*, available at: europa.eu.int/eur-lex/lex/en/treaties/dat/12002E/pdf/12002E_EN.pdf, last visited on 18 January 2008.

European Union, *Treaty of Maastricht*, OJ C 191, 29.07.1992 (*signed on* 7 Feb 1992 between members of the EC and *entered into force on* 1 Nov 1993).

European Union, *Treaty of Nice*, OJ C 80, 10.3.2001.

Geneva Convention Relating to the Status of Refugees, 189 U.N.T.S. 150 (*entered into force* April 22, 1954) (reservations available at: www.unhcr.org/protect/PROTECTION/3d9abe177.pdf , last visited on 19 January 2008).

International Labour Organisation Convention 118, *Equality of Treatment (Social Security)Convention* (1962), available at: www.ilo.org/ilolex/english/convdisp2.htm, last visited on 19 January 2008.

International Labour Organisation Convention 130, *Medical Care and Sickness benefits Convention,* art. 32 (1969), available at: www.ilo.org/ilolex/english/convdisp2.htm, last visited on 19 January 2008.

The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, *Human Rights Quarterly,* 1987, vol. 9, pp. 122-135.

The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, vol. 15 Netherlands Quarterly of Human Rights (1997) p. 245.

Organization of American States, *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights,* O.A.S. Treaty Series No. 69 (1988), *reprinted in* Basic Documents

Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc.6 rev.1 at 67 (1992).

Protocol Relating to the Status of Refugees, 606 U.N.T.S. 267, (*entered into force* Oct. 4, 1967).

Statute of the International Court of Justice, available at: www.icj-cij.org/documents/index.php?p1=4&p2=2&p3=0, last visited on 18 January 2008.

United Nations Charter, open for signature on 26 June 1945, entered into force on 24 October 1945, available at: www.un.org/aboutun/charter/, last visited on 18 January 2008.

United Nations, *Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live*, G.A. Res. 40/144 (December 1985).

United Nations, *International Covenant on Civil and Political Rights*, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, art. 2 (*entered into force* 23 March 1976).

United Nations, *International Covenant on Economic, Social and Cultural Rights*, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (*entered into force* 3 January 1976)(ratification status available at: www2.ohchr.org/english/bodies/ratification/3.htm, last visited on 18 January 2008).

United Nations, *International Convention on the Rights of the Child*, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990)(ratifications available at: www.unhchr.ch/pdf/report.pdf, last visited on 18 January 2008).

United Nations, *International Convention on the Elimination of All Forms of Discrimination Against Women*, UN Doc. A/34/46, (*entered into force* 3 September 1981).

United Nations, *International Covenant on the Elimination of All Forms of Racial Discrimination*, 660 U.N.T.S. 195 (*entered into force* 4 January 1969).

United Nations, *Universal Declaration of Human Rights*, G.A. res. 217A (III), UN Doc A/810 at 71 (1948).

Vienna Declaration and Programme of Action, Vienna, 14 - 25 June 1993, UN Doc. A/CONF.157/24 (Part I) at 20 (1993).

Vienna Convention on the Law of Treaties, 1115 U.N.T.S. 331, (*entered into force* 27 January 1969).

World Health Organization *Constitution*, available at: www.who.int/governance/eb/who_constitution_en.pdf (last visited on 18 January 2008).
World Health Organization, *Global Strategy for Health for All by the Year 2000*, adopted in WHO resolution WHA.34.36 (1981).

Opinions, Guidelines and General Comments from UN Monitoring Bodies

A. Committee on the Elimination of All forms of Discrimination Against Women
CEDAW General Comment 24, *Women and Health*, UN Doc. No. A/54/38/ Rev.1.
B. Committee on Economic and Social and Cultural Rights
Concluding Observations of the Committee on Economic, Social and Cultural Rights: Belgium, UN Doc. E/C.12/1994/7 ("the Committee strongly urges that... refugees and asylum seekers are fully protected from any acts or laws which in any way result in discriminatory treatment within the housing sector").
ESC General Comment 3, *The nature of state parties obligations* (Fifth session, 1990) UN Doc. E/1991/23, annex III at 86 (1991).
ESC General Comment 12, *The right to food*, UN Doc. E/C.12/1999/5.
ESC General Comment 14, *The right to the highest attainable standard of health*, UN Doc. E/C.12/2000/4.
ESC General Comment 15, *The right to water*, UN Doc. E/C.12/2002/11.
ESC General Comment 16, *The equal right of men and women to the enjoyment of all economic, social and cultural rights*, UN Doc. E/C.12/2005/4.
C. Committee on the Rights of the Child
General guidelines regarding the form and content of initial reports to be submitted by States Parties under Article 44, paragraph 1(a), of the Convention, UN Doc. CRC/C/5 (1991).
General guidelines regarding the form and content of periodic reports to be submitted by States Parties under Article 44, paragraph 1(a), of the Convention, UN Doc. CRC/C/58 (1996).

C. Human Rights Committee
Human Rights Committee General Comment 18(37), *Non-Discrimination*, UN Doc. A/45/40 (1990).
HRC Communication No. 182/1984, *Zwaan de Vries v. Netherlands*, U.N. Doc. CCPR/C/29/D/182/1984, para. 13 (1987).

Reports and Statistics

Amnesty International	*Response to the Green Paper on the future of the Common European Asylum System*, available at: www.amnesty-eu.org/static/documents/2007/AllResponseGreen_Paper_Sept07.pdf, last visited on 19 January 2008.
Bowring, J.	*European Council on Refugees and Exiles 2005 Country Report*, (Carolyn Baker (ed.)), available at: http://www.ecre.org/files/ECRE%20Country%20Report%202005rev.pdf, last visited on 19 January 2008.
Dent, J.A.	European Council for Refugees and Exiles, *Research Paper on the Social and Economic Rights of Non-Nationals in Europe*, p. 21 (1998), available at: http://www.ecre.org/resources/research_paper/356, last visited on 19 January 2008.
Eide, Asbjørn	Report by the Special Rapporteur on the right to food, *The new international economic order and the promotion of human rights*, UN Doc. E/CN.4/Sub.2/1987/23.
Center for Reproductive Law and Policy	*Equal Enjoyment of the Right to Health*, Background paper submitted by the Center for Reproductive Law and Policy, UN Doc. E/C.12/2002/7.

European Council on Refugees and Exiles	*Response to the Green Paper on the Common European Asylum System*, AD5/9/2007/Ext/RW (2007), available at: www.ecre.org./files/ECRE%20Green%20paper%20response%20final%20-%20Read%20only.pdf, last visited on 19 January 2008.
Human Rights Watch	*World Report 2006, Country Summary on European Union*, available at:www.hrw.org/wr2k6/wr2006.pdf, last visited on 19 January 2008.
Hunt, Paul	Special Rapporteur on the Right to Health, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, addendum MISSION TO SWEDEN*, U.N. Doc. A/HRC/4/28/Add.2 (28 February 2007).
United Nations High Commissioner for Refugees	*Asylum Levels and Trends in Industrialized Countries 2006,* available at: www.unhcr.org/statistics/STATISTICS/460150272.pdf, last visited on 18 January 2008.
United Nations High Commissioner for Refugees	*Asylum Levels and Trends in Industrialized Countries, Second Quarter 2007*, (September 2007), available at: www.unhcr.org/statistics/STATISTICS/46f0e0dd2.pdf, last visited on 18 January 2008.
United Nations High Commissioner for Refugees	*Statistical Yearbook 2006*, available at: www.unhcr.org/statistics/STATISTICS/478cda572.html, last visited on 19 January 2008.

United Nations International Research and Training Institute for of Women ('Instraw')	''The Girl Child: New Challenges' in *Beijing at 10: Putting Policy into Practice*', available at un.instraw.org/en/images/stories/Beijing/thegirlchild.pdf, last visited on 19 January 2008.
United Nations Development Programme	1993 Human Development Report, available at: hdr.undp.org/en/reports/global/hdr1993, last visited on 19 January 2008.
Vita, J.A.	*Discussion paper with particular emphasis on the implications of the principle of non-discrimination and of the concept that there is a minimum core content of each right which constitutes a 'floor' below which the conditions should not be permitted to fall in any State Party*, UN Doc. E/C.12/1993/WP.22.
World Health Organization	*International Migration, Health and Human Rights*, 22, June 2004, available at: www.who.int/hhr/activities/en/intl_migration, last visited on 18 January 2008.

Table of Cases