

The Implications of the Right to Health for Border Management

Emergency Assistance and Medical Screenings in the Context of Forced Migration

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1. INTRODUCTION

Currently, about 300 land borders and numerous sea borders divide states worldwide from one another.¹ These borders are not necessarily permanent as a changing domestic, regional or global political climate can lead to borders which are softer (e.g. the internal borders of the EU) or harder (e.g. the border between Mexico and the United States). In all circumstances, however, these borders are governed by national legislation aiming to construct »the limits of nationality, citizenship and identity« as well as by international human rights law which aims to curtail the power of this inherently exclusionary character of borders.²

In this context, border management has gained increased attention throughout the last years, not lastly because of the war in Syria and the high number of people seeking asylum in Europe.³ People want to cross borders,

1 Paasi (2010), 13.

2 Ibid., 13–16.

3 For the purpose of this study, border management is understood broadly, including not only the physical border context but also border procedures which might

even if there is no legal way to do so. This is not only taking place in the context of war or violent conflict. Rather, individuals might also be trafficked, flee persecution or try to escape environmental hazards, poverty or other life-threatening conditions. It is these irregular and mass migratory movements and their management at the border which the present study is concerned with.⁴ For the purpose of this study, these movements are referred to as forced migration.⁵

Previous authors have argued that border management traditionally focused almost exclusively on security concerns.⁶ However, calls for humanitarian border management are increasing, especially in light of the number of persons who fall within the scope of the abovementioned forced migration context.⁷ Humanitarian border management aims to »ensure that humanitarian principles and accepted international legal standards are increasingly applied by the security sector at times of migration crisis.«⁸ This chapter argues that the right to health can and must play a prominent role in this respect. Whether and how the right to health can contribute to clarify-

already take place within the borders of a state (such as in transit zones, registration centres or immigration detention).

- 4 Hence, the present study does not deal with nationals of a particular state who are crossing the border to return to their own country and whether the state has similar obligations in that respect. The current study is dealing only with the rights and obligations with regard to non-citizens.
- 5 The boundaries and exact definition of forced migration is still issue to academic debate. See e.g. Fiddian-Qasmiyeh et al. (2014), 5–6.
- 6 Paasi (2010), 13; Pottler (2014).
- 7 Border management is understood in line with the International Organization for Migration (IOM) guidelines on health and humanitarian border management to include four different pillars. The present study will focus particularly on the third pillar (the enhanced capacity of health systems and border management services), especially with regard to the points ›Health Screening and Referral System‹ and ›Health Management and Public Health Response‹. cf. IOM (2016), 5.
- 8 Pottler (2014). Although not further explained in the quote cited, humanitarian principles in the context of this paper are understood as human rights principles, i.e. the rights and obligations derived from international human rights law treaties.

ing the individual rights of and state obligations towards forced migrants in order to contribute to humanitarian border management is investigated through outlining the scope of two different aspects of the right to health: first, the rights and obligations with regard to medical care and emergency assistance and second, the rights and obligations with regard to medical screenings. Based on this analysis, the chapter discusses the added value of the right to health: does it indeed have to be viewed as an »empty promise« in the context of border management or does it provide valuable guidance, for instance, as a moral concept, as an advocacy framework and evaluation tool and/or as a legal principle?⁹

In answering this question, Dembour's distinction between four different schools of thought in the field of human rights serves as a valuable guideline. She identifies a natural school, a deliberative school, a protest school and a discourse school of human rights.¹⁰ When simplifying Dembour's distinction into concrete purposes of human rights, it seems like the natural school sees human rights primarily as moral concept, the deliberative school sees them primarily as legal principles, the protest school sees them essentially as advocacy tools and the discourse school dismisses human rights altogether.¹¹ As is outlined in more detail in the discussion section of this chapter, the present study most closely identifies with the protest school in finding the added value of the right to health primarily in the field of advocacy.

In light of this framework and based on an analysis of the right to health at the border, the present study thus aims to highlight two contentious points in which the right to health of the International Covenant on Economic, Social and Cultural Rights (ICESCR) plays a prominent and clarifying role. In so doing, the study hopes to show the limitations and potential of the right to health for clarifying individual rights and state obligations at the border. The aim of this chapter is not to build a comprehensive legal framework on health and border management but to point into two relevant directions which can serve as possible starting points for future inquiries.

The chapter is structured as follows: It starts by clarifying the selection, interpretation and relevance of the applicable legal framework. The chapter

9 Flegar et al. (2016), 17.

10 Dembour (2010), 11.

11 Compare Dembour (2010); Flegar et al. (2016).

then provides an analysis of the individual rights and state obligations with regard to medical care and emergency assistance before, subsequently, scrutinizing the individual rights and state obligations for medical screenings at the border. Lastly, the chapter discusses the findings in light of whether the right to health should be seen as an empty promise or not.

2. SELECTION, INTERPRETATION AND RELEVANCE OF THE APPLICABLE LEGAL FRAMEWORK

The chapter is based on desk research conducted in the period of March until June 2016. It provides a textual analysis of legal sources recognized under Article 38 of the Statute of the International Court of Justice. As such, the documents outlined below are international human rights law treaties as well as supplementary, non-binding but authoritative, General Comments and General Recommendations issued by the treaty bodies monitoring the implementation of these international human rights law treaties.¹² The primary focus remains the right to health enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) as the most authoritative and widely applicable source. This selection is not necessarily complete but aims to highlight some articles and interpretations which might be of particular relevance in the border context. The traditional doctrinal analysis of these documents is supplemented by a more normative discussion at the end of this chapter.

12 The study does not include the Convention Relating to the Status of Refugees as this treaty is primarily relevant for already recognized refugees. In the context of border management, however, the type of persons which fall within the scope of border management measures is much broader and includes many persons who are not protected under that convention. The study therefore focuses on the human rights treaties which are applicable to all persons, regardless of their migration status.

2.1 Territorial Scope

Currently, there exists no clear legal framework that explicitly governs health rights in the border context. Nevertheless, international treaties such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC) can be considered to also explicitly apply at the border through holding that the rights entailed in the treaty apply within the state party's jurisdiction.¹³ In line with the object and purpose of these treaties, it can be concluded that the border domain falls within the jurisdiction of a state. As such, the rights and obligations of these treaties apply.

Other treaties, such as the International Convention on the Elimination of Racial Discrimination (ICERD), the Convention on the Elimination of Discrimination Against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities (CRPD) do not contain a specific territorial limitation. However, Articles 3, 6 and 14 of the ICERD explicitly refer to the scope of their application as within the jurisdiction of a state party and Article 4(5) CRPD holds that it »shall extend to all parts of federal states without any limitations or exceptions«. Moreover, General Recommendation No. 28 on the CEDAW core obligations highlights the fact that the convention applies to »women within the jurisdiction of the state party (including non-citizen, migrant, refugee, asylum-seeking, and stateless women)«¹⁴ and CEDAW General Recommendation No. 32 explicitly asserts that the responsibilities of states towards »women during displacement« does not only comprise »women within their territory« but also »under their effective control or jurisdiction, even if not situated within their territory.«¹⁵

Only the International Convention on the Rights of All Migrant Workers and Their Families (ICMWF) is explicit on the border context in stating in Article 1(2) that the convention applies

13 Compare e.g. E/C.12/2000/4, 11 August 2000, paras. 12 and 51; Article 2(1) CRC.

14 CEDAW/C/GC/28, 16 December 2010, para. 26.

15 CEDAW/C/GC/32, 14 November 2014, para. 7. See also CEDAW/C/2009/WP.1/R, 15 December 2008, para. 3 which refers to responsibilities during the full »migration cycle«.

»during the entire migration process of migrant workers and members of their families, which comprises preparation for migration, departure, transit and the entire period of stay and remunerated activity in the State of employment as well as return to the State of origin or the State of habitual residence.«

However, it must be noted that, while all other treaties are widely accepted and ratified by a large number of states, this convention has only been ratified by migrant sending rather than by migrant receiving states and by only a small number of 50 state parties.¹⁶

2.2 Personal Scope

International human rights law must be considered to apply without discrimination and the personal scope in most treaties is clear in that respect.¹⁷ Yet, as regards the personal scope of the international human rights law treaties discussed below, it should be noted that not all treaties explicitly refer to non-citizens or to persons in the context of forced migration.

The personal scope of the International Convention on the Rights of All Migrant Workers and Their Families (ICMWF) needs particular clarification: Article 3 holds that the convention does not apply to refugees or stateless persons. However, this cannot be interpreted to mean that they are entitled to a lesser standard than the rest of persons covered by the convention as it is simply a different regime under which their rights are protected. Moreover, while the term »migrant workers« suggests that the convention does not apply to all border crossers, the treaty's scope is, nevertheless, broad and, as Ryan and Mantouvalou assert, the fact that it covers everyone »who is to be engaged, is engaged or has been engaged in a remunerated activity« as well as »both employees and the self-employed« and »immediate family members« suggests that this convention closely resembles a treaty which is concerned with the rights of all migrants.¹⁸

16 UN Treaty Collection (2016).

17 Compare Article 2 ICESCR, Article 2 CRC, Articles 1 and 2 CEDAW, Article 1 CERD and Article 1 CRPD.

18 Ryan/Mantouvalou (2014), 186.

2.3 Other Considerations

Like most human rights, the right to health can be limited in certain circumstances and, being an economic, social and cultural right, is subject to progressive realization: Article 2(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) allows states to realize »progressively« the rights and obligations entailed in the convention and »to take steps [...] to the maximum of its available resources«. It is this progressive realization which makes economic, social and cultural rights controversial and which allows states a large margin of appreciation when not complying with the convention. In addition, General Comment No. 14 of the ICESCR's treaty body, the Committee on Economic Social and Cultural Rights, allows for limitations of the right to health if these measures are »strictly necessary for the promotion of the general welfare in a democratic society«. ¹⁹ While most other international human rights law treaties discussed below are less explicit on these issues, the convention is commonly considered the most authoritative standard and therefore also influences the interpretation of these other treaties. These two mentioned provisions which severely limit the applicability of the right to health thus indeed raise the question of whether the right to health is merely an empty promise. The following therefore analyses two aspects of the right to health at the border, first the requirements regarding medical care and emergency assistance and, subsequently, the requirements regarding medical screenings.

3. MEDICAL CARE AND EMERGENCY ASSISTANCE AT THE BORDER

States usually grant emergency medical care as the very least requirement to everyone. ²⁰ However, the term which is used and the scope of what exactly falls within any such definition vary between countries and are still debated. Moreover, the extent to which this treatment also requires any emergency assistance other than medical care is still controversial.

19 E/C.12/2000/4, 11 August 2000, para. 28; Flegar (2015), 92.

20 Compare Spencer/Hughes (2015).

Previous research has outlined the rights and obligations under the right to health with regard to providing medical assistance to undocumented migrants.²¹ Based on these studies it becomes evident that a number of international treaties and subsidiary documents require the provision of at least some sort of medical care to all persons and in all circumstances. It seems that at least some of these rights and obligations should also apply at the border. However, the exact extent and content of these rights and obligations under the right to health, particularly with regard to what medical care and emergency assistance should be provided at the very least, is less clearly defined.

The following therefore asks: To what extent is the provision of medical care and emergency assistance at the border a State obligation under the right to health? Does the right to health clarify the exact content of what should be provided? This section outlines the relevant provisions and tries to identify a minimum level of medical care and emergency assistance which States should provide at the border in order to abide by their human rights obligations. It starts with the most relevant and ends with the least relevant international human rights law treaty in this context.

3.1 International Covenant on Economic, Social and Cultural Rights

The provision of medical care and emergency assistance is most prominently required in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the relevant General Comment which outlines the concrete rights and obligations under the right to health.

Article 12 holds »the right of everyone to the enjoyment of the highest attainable standard of physical and mental health«. Based on this general provision, the article is instructive for further outlining the rights and obligations on the provision of medical care in the border context: States must create »conditions which would assure to all medical service and medical attention in the event of sickness«. ²² However, the extent to which this also refers to the border context and the exact scope of this medical service and attention can only be clarified by looking at the relevant General Comment.

21 Compare Biswas et al. (2012); Flegar (2015).

22 Article 12(2)(d) ICESCR.

»States are under the obligation to *respect* the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services.«²³

This provision suggests that everyone at the border should be granted full access to medical care and that health services should not be limited to only providing emergency treatment. However, it is unlikely that states would recognize such a broad obligation at the border in the near future as these rights are not even granted to persons who have already crossed the border and are clearly on the state territory.²⁴ It is therefore valuable to consider what states would have to provide as a very minimum standard. The so-labelled core obligations under the right to health can be insightful in that regard.

The core obligations of the right to health which must be ensured »at the very least« comprise the duty to provide »essential primary healthcare«. ²⁵ This seems to suggest that states thus have an obligation to provide more than just emergency medical care and rather have to provide essential primary healthcare at the border. Primary healthcare is defined in a footnote as »typically« concerning »common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost«. ²⁶ However, the fact that this definition is only mentioned in a footnote and the fact that it involves the term »typically« suggests that not too much weight should be placed on this definition and that other definitions are also possible and potentially within the scope and meaning. No clear definition of essential primary care is included in the main text. In addition to the obligation of states to provide essential primary healthcare, the core obligations also require states to provide emergency assistance, which comprises the »right of access to health facilities, goods and services« as well as a right to food, shelter and essential drugs. ²⁷ While more clarity on the exact content of these

23 E/C.12/2000/4, 11 August 2000, para. 34.

24 Compare Flegar et al. (2016).

25 E/C.12/2000/4, 11 August 2000, para. 43.

26 Ibid., footnote 9.

27 Ibid., para. 43.

provisions would have been desirable, it must nevertheless be noted that these are far-reaching and innovative core obligations that should not go unnoticed in the border context.

Moving beyond the core obligations, General Comment further clarifies the state obligations with regard to the provision of emergency assistance as having »to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons«. This suggests that states have to cooperate on both sides of the border in order to ensure the right to health of border crossers is not violated. Moreover, it holds that »each State should contribute to this task to the maximum of its capacities«. In addition, states should give priority to persons in vulnerable situations in the provision of »safe and potable water, food and medical supplies, and financial aid«. Although the phrase »to the maximum of its capacities« is always open to interpretation, the responsibility of states to provide emergency assistance at the border is clearly established and especially outspoken with regard to the prioritization of persons in vulnerable situations.²⁸

Summing up, the General Comment is very clear on the state obligations under the right to health at the border. States should provide at the very least essential primary healthcare rather than only emergency medical care and, as regards emergency assistance, states must provide food, shelter and essential drugs. When considering the right to health beyond the core obligations, states should provide access to preventive, curative and palliative health services and, in the provision of emergency assistance, persons in vulnerable situations should be prioritized. While the content of emergency assistance seems to be rather clear the relevant General Comment as comprising the provision of healthcare, food, shelter and essential drugs, the exact content of essential primary healthcare is left undefined in the main text of the convention.

3.2 Convention on the Rights of the Child

For children, the rights and obligations with regard to health at the border are similar but more extensive than Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). The Convention on

28 E/C.12/2000/4, 11 August 2000, para. 40.

the Rights of the Child (CRC) itself is already a lot more specific on the exact content of the right to health of children. Similar to Article 12 ICESCR, Article 24 CRC holds »the right of the child to the enjoyment of the highest attainable standard of health«. Moreover, according to the same article, states »shall pursue full implementation« (which suggests progressive realization) in the fields of infant and child mortality, primary healthcare, disease and malnutrition, health education and preventive healthcare. Additionally, Article 22 CRC is particularly relevant for the border context as it contains specific provisions on asylum-seeking and refugee children. Accordingly, states

»shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights«

of international human rights law. Hence, as part of this emergency assistance, states are obliged to help with family tracing for unaccompanied minors and to afford them the same assistance as national children without family.

The relevant General Comment further clarifies the right to health in the border context in stating that, as a core obligation, states must ensure »universal coverage of quality primary health services, including prevention, health promotion, care and treatment services, and essential drugs«, provide »an adequate response to the underlying determinants of children’s health« and adopt a »human rights-based approach to fulfilling children’s right to health«. ²⁹ As a core minimum, this goes much further than the essential primary healthcare criterion of the core obligations under the ICESCR. Hence, for children, states have even broader obligations that stretch much further than only providing emergency medical care at the border.

Regarding emergency assistance, the General Comment is clear in holding that states must also cooperate internationally to ensure the global implementation of the right to health. Hence, also at the border, states on both sides must collaborate in providing the necessary medical care and emer-

29 CRC/C/GC/15, 17 April 2013, para. 73.

gency assistance.³⁰ The General Comment of the Committee on the Rights of the Child is very similar to General Comment No. 14 of the Committee of Economic, Social and Cultural Rights in clarifying that states must »co-operate in providing disaster relief and humanitarian assistance in times of emergency« and must pay particular attention to persons in vulnerable situations when distributing medical aid and supplies, food, water and shelter.³¹ These provisions are of a similar scope and content as the emergency assistance provisions under the ICESCR.

Overall, the CRC contains much broader provisions regarding the medical care that should be provided to children at all times and therefore also at the border. This contains not only a responsibility for the provision of essential primary healthcare but also, among other aspects, an obligation to address the underlying determinants of health. Regarding the provision of emergency assistance, however, the convention does not go beyond the rights and obligations entailed in the ICESCR.

3.3 Convention on the Elimination of Discrimination Against Women

The Convention on the Elimination of Discrimination Against Women (CEDAW) does not refer to anything border- or migration-related in its treaty. Nevertheless, the right to health is defined in Article 12 and a General Recommendation further clarifies a few aspects that are relevant for the border context. As such, it becomes clear that states have an obligation to pay special attention to the health needs of migrant and refugee women.³² Moreover, states

»should ensure that adequate protection and health services, including trauma treatment and counselling, are provided for women in especially difficult circumstances, such as those trapped in situations of armed conflict and women refugees.«³³

30 CRC/C/GC/15, 17 April 2013, para. 86.

31 Ibid., para. 88.

32 A/54/38/Rev. 1, chap. 1, 1999, para. 6.

33 Ibid., para. 16.

No specific mention is made of emergency assistance except for the need to provide »emergency obstetric services«. ³⁴ However, this refers to an individual emergency situation rather than to an external situation of humanitarian distress. Generally, states »should ensure that the special nutritional needs of all women within their jurisdiction are met«, which suggests that more than only medical care must be provided at the border. ³⁵

The General Recommendation does not define any core obligations. ³⁶ Nevertheless, it can be concluded that it reinforces the right to health of women at the border. This General Recommendation should be read as supplementing the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and as simply specifying some aspects that are of particular relevance to women. Although clearer definitions on the content are lacking, the document thus suggests that women in transit have a right to health beyond only essential primary healthcare which, instead, also includes psychological support and adequate nutrition.

Summing up, this convention thus moves beyond the ICESCR in emphasizing the obligation to provide psychological support and adequate nutrition to women in transit. However, in clarifying any more specific state obligations at the border with regard to medical care and emergency assistance, the convention is not very insightful.

3.4 International Convention on the Rights of All Migrant Workers and Their Families

Article 28 of the International Convention on the Rights of All Migrant Workers and Their Families (ICMWF) is particularly relevant when defining the right to health at the border as it refers to migrants in particular. However, unlike the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of Discrimination Against Women (CEDAW), it limits the essential primary healthcare standard of the Inter-

34 A/54/38/Rev. 1, chap. 1, 1999, para. 27.

35 *Ibid.*, para. 7.

36 Rather, General Recommendation No. 24 talks about key elements. However, these cannot be compared to core obligations as basically anything in this General Recommendation is part of the key elements.

national Covenant on Economic, Social and Cultural Rights (ICESCR) to something even more narrowly defined:

»Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused to them by reason of any irregularity with regard to stay or employment.«³⁷

This is the first and only clear definition of emergency medical care which everyone is entitled to. According to this article, border crossers explicitly have this right to emergency medical care where it is »urgently required for the preservation of their life or the avoidance of irreparable harm«. Although this is the clearest standard so far, one can still ask what the exact definition and content of this phrase is as regards, for instance, the meaning of urgency or irreparable harm.

The Committee on Migrant Workers' General Comment No. 2 is also clear on the fact that access to health services should under no circumstances be used as an instrument of immigration control.³⁸ It clarifies that, in circumstances of extreme poverty and vulnerability, emergency assistance should be provided to irregular migrant workers and their families but any further definition or reference to emergency assistance in the context of immigration control, i.e. at the border, is lacking.³⁹ However, this General Comment emphasizes that the provision of any medical care does not have to be free of charge but exemption rules should apply to migrants in the same way as they would apply for nationals and excessive fees or requesting proof of payment before the service is delivered should be prohibited. It is surprising that the convention as *the* treaty for migrant rights provides a more limited definition of the healthcare that should be provided to everyone than other international human rights law had already established. In this respect, it should be noted that this General Comment clarifies that Article 28 is not to be understood narrowly but that, read in combination with other international human rights law instruments, broader obligations

37 Article 28 ICMWF.

38 CMW/C/GC/2, 23 August 2013, para. 74.

39 Ibid., para. 71.

are created.⁴⁰ It then repeats the abovementioned state obligations under the ICESCR and CRC. Similar to the CEDAW, the convention or its General Comment do not define any core obligations.

Overall, the ICMWF is insightful in providing a clear definition of urgent medical care. However, any further clarification as regards medical care or emergency assistance at the border is lacking. It must be emphasized that the convention must not be read to limit any state obligations already entailed in other treaties but it is worrying that the convention at first glance provides a different and therefore rather confusing standard. This confusion is further enhanced by the distinction of non-citizens into different groups which are suggested to have different rights.⁴¹ This clearly contradicts the universality argument commonly implied in all other international human rights law treaties.

3.5 Convention on the Elimination of Racial Discrimination

The Convention on the Elimination of Racial Discrimination (CERD) does not mention anything border- or migration-related in the treaty itself but the relevant General Recommendation highlights the obligation of states to »respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services«. ⁴² As this entails a general reference to all non-citizens, it must be assumed that residence status plays no role here and that this obligation therefore also applies at the border.

Furthermore, although no reference is made to emergency assistance, states should »remove obstacles that prevent the enjoyment of economic, social and cultural rights by non-citizens« in the fields such as housing, education and employment. ⁴³ However, »removing obstacles« does not seem

40 CMW/C/GC/2, 23 August 2013, para. 72.

41 As outlined above, the ICMWF excludes refugees, distinguishes between undocumented and documented migrants and further limits the scope due to primarily talking about migrant workers.

42 A/59/18, 2004, 23 February - 12 March 2004, para. 36.

43 Ibid., para. 29.

to require the active provision of these rights to non-citizens, which leaves this provision as a rather weak and insufficiently defined right. No further core obligations are defined and no reference is made to medical care or emergency assistance in a more profound manner.

It can thus be concluded that the convention neither clarifies nor contradicts the ICESCR provisions regarding rights and obligations in the field of medical care and emergency assistance at the border in any meaningful way.

3.6 Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities (CRPD) does not mention migrants, asylum seekers, refugees or any other non-citizens in its treaty or General Comments. Nevertheless, Article 11 refers to the obligations of states for persons in humanitarian emergencies which seems to imply a certain responsibility at least towards asylum seekers and refugees. Moreover, as the scope of the convention extends to all persons with disabilities, Article 25 is relevant in clarifying the scope of the right to health for citizens as well as non-citizens with disabilities as having to be at least of the same level as for all other persons – regardless of whether that person is at the border or within the territory of a state. However, no specific mention is made of a minimum standard of medical care or emergency assistance that should be provided.

3.7 Concluding Remarks

The above analysis revealed that none of the international human rights law treaties relevant for the right to health explicitly allow for any differential treatment at the border as compared to within a state. Additionally, it is clear that one does not have to be on the territory of a state for any particular amount of time before the obligations under international human rights law apply.

Moreover, the International Covenant on Economic, Social and Cultural Rights (ICESCR) seems to still offer the clearest standard on what minimum level of medical care and emergency assistance should be provided at the border. Accordingly, medical care should be understood as essential primary healthcare and emergency assistance as medical care, food, shelter

and access to essential drugs. It is clear that the obligation to provide emergency assistance extends beyond the own border so even on the territory between two states both states would be responsible for providing emergency assistance. However, the exact content of the medical care and emergency assistance which should be provided remains unclear. The International Convention on the Rights of All Migrant Workers and Their Families (ICMWF) suggests a definition for urgent medical care, which is any care that is »urgently required for the preservation of their life or the avoidance of irreparable harm«. Yet, it must be emphasized that this approach seems more limited than the provision of essential primary healthcare and cannot be considered to overrule the ICESCR's approach. More extensive rights seem to apply for persons in vulnerable situations – a finding which is also supported by the provisions in the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of Discrimination Against Women (CEDAW).

Despite the diverging standards it is clear that, while progressive realization and derogation might be applicable with regard to more specific treatment at the international level, nothing allows states to not grant any medical care or emergency assistance at the border. It is an established international standard that, as a core minimum, all persons must have access to essential primary healthcare. However, as its content is not further defined, this is left to the discretion of individual states which might harm the enjoyment of the right to health. Clear rules and legal certainty are essential for effective human rights implementation, monitoring and protection. No matter whether rights are seen as legal standards, advocacy tools or moral claims, clarity on the content of the rights and obligations at the border as regards medical care and emergency assistance is favourable to all three purposes of human rights. In order to ensure that the right to health is not an empty promise, it is therefore crucial to clearly define the applicable standard and to give coherent content and meaning to the concepts which are propagated.

Overall, the above section showed how the right to health does help to clarify the rights and obligations in terms of medical care and emergency assistance at the border. At the same time, it revealed that clear definitions and a coherent approach across the different treaties at the international and regional level could contribute to limit any existing allegations about the empty promise of the right to health.

4. MEDICAL SCREENINGS AT THE BORDER

Medical screenings include tests, examinations, or other procedures which can be applied rapidly in order to identify persons likely to have a disease. A screening test is not intended to be diagnostic.⁴⁴ Border screenings, together with isolation and quarantine measures, are implemented to delay or prevent the entry of infected persons to a country or a geographic area or to prevent the global spread of a disease from a source country.⁴⁵ In addition to border screenings, medical screenings can be imposed pre-departure (e.g. for a work or residence permit) and upon stay in the host country (e.g. for a change of visa status). Post-arrival screenings are also undertaken for refugees, humanitarian entrants and undocumented migrants.⁴⁶ The diseases screened for are mainly communicable diseases with a public relevance, such as tuberculosis, but also HIV/AIDS.⁴⁷

Border screenings are a complex matter: not only do infectious diseases affect the public health, but the right to health of migrants is equally at stake when they have to undergo a screening for these diseases. The following section therefore focuses on the individual rights and state obligations under the right to health with regard to medical screenings at the border: To what extent are medical screenings upon entering a country a state obligation under the right to health? Does the right to health clarify the conditions for applying them? Based on international human rights law treaties and subsidiary documents, this section tries to delineate the state obligations under the right to health with regard to migration-related medical screenings. This is done on the basis of the traditional understanding of medical screening of migrants as measures aimed at protecting the host population. The main focus is thus on infectious disease control upon arrival at the border rather than on any other types of screening, such as, for instance, psy-

44 Porta (2014), 275.

45 Selvey et al. (2015), 197.

46 WHO et al. (2013), 33; Wickramage/Mosca (2014), 9955.

47 For example, some EU countries screen migrants before, at or after entry for tuberculosis: van der Werf/Zellweger (2016), 2. According to UNAIDS some 35 countries, territories and areas impose some form of restriction on the entry, stay and residence of people with HIV based on their HIV status: UNAIDS (2015).

chological screenings. When deemed relevant for humanitarian border management, other health assessments are included in the overview as some international human rights law treaties adopt a broader understanding of medical screenings. However, the denial to enter a country for the protection of public health goes beyond the scope of this analysis.

4.1 International Covenant on Economic, Social and Cultural Rights

No explicit reference is made to medical screenings under the right to health in the International Covenant on Economic, Social and Cultural Rights (ICESCR). However, Article 12(2)(c) obliges states, in order to achieve the full realization of the right to health, to take steps »for the prevention, treatment and control of epidemic, endemic, occupational and other diseases«.

The relevant General Comment provides further clarification as to how the »control of diseases« has to be understood, namely as »States' individual and joint efforts« which include, but are not limited to,

»making available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, implementing or enhancing of immunization programmes and other strategies of infectious disease control.«⁴⁸

It can be assumed that medical screenings are included in the term »other strategies of infectious disease control«. In this regard, it should be noted that the General Comment focuses on »infectious« disease control, whereas the wording in the convention is broader and also includes control measures for non-communicable diseases.⁴⁹

While not all obligations under the right to health are of immediate effect or enforceable, the Committee on Economic, Social and Cultural Rights refers to the obligation »to take measures to prevent, treat and control epidemic and endemic diseases« as an obligation of »comparable prior-

48 E/C.12/2000/4, 11 August 2000, para. 16.

49 An infectious disease is »a disease due to an infectious agent. While some infectious diseases are contagious, others are noncontagious. All infections and infestations are communicable [Syn: transmissible] diseases.« Porta (2014), 148.

ity« to the core obligations.⁵⁰ Furthermore, it calls not only for individual, but also for »joint efforts«, which is further explained as collective responsibility of the international community to address the spread of transmissible diseases.⁵¹ This extends State obligations to the control of infectious diseases beyond their borders.

In addition to providing at least this minimum of necessary measures at the border, states also have to respect the right to free and informed consent of border crossers when imposing medical screenings.⁵² As such, the General Comment states that »the right to control one's health and body, [...] the right to be free from interference, such as the right to be free from [...] non-consensual medical treatment« and the right to privacy and information are integral components of the right to health.⁵³ Yet, this does not automatically mean that states cannot screen someone who is crossing a border and refuses to give his free and informed consent to a medical screening for an infectious disease: Article 4 of the convention only allows for limitations »for the purpose of general welfare«. Accordingly, restrictions for public health reasons must be legitimate, in the interest of »legitimate aims« and strictly necessary for the general welfare.⁵⁴ In addition, Article 5(1) requires that the limitation is »proportional«, this means that the least restrictive alternative must be adopted and they should be of limited duration and subject to review.⁵⁵ General Comment No. 14 further clarifies that coercive treatment for the prevention and control of communicable diseases is allowed »on an exceptional basis«. ⁵⁶ Nevertheless, this is no general permission as such exceptional coercive treatment should be »subject to specific and restrictive conditions, respecting best practices and applicable international standards«. ⁵⁷

In this context, it is also worth pointing out that, even where other screenings might be allowed without consent, General Comment No. 22 is

50 E/C.12/2000/4, 11 August 2000, para. 44.

51 Ibid., paras. 16 and 40.

52 Henrard (2008), 169.

53 E/C.12/2000/4, 11 August 2000, paras. 3 and 8.

54 Ibid., para. 28.

55 Ibid., para. 29.

56 Ibid., para. 34.

57 Ibid.

clear on prohibiting any »mandatory HIV/AIDS, virginity or pregnancy testing«. ⁵⁸ Moreover, it is a core obligation to ensure privacy, confidentiality and free, informed consent for sexual and reproductive needs« and to »repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine individual's or particular group's access to sexual and reproductive health«. ⁵⁹ Thereby the Committee on Economic, Social and Cultural Rights excludes in its latest General Comment all mandatory screening related to sexual and reproductive health.

To sum up, the ICESCR contributes significantly to the clarification of the obligation of states to control the spread of infectious diseases at the border. States should take at least a minimum of measures at their borders in order to control the spread of epidemic and endemic diseases. Screenings require a free and informed consent under the right to health. Nevertheless, medical screenings for other infectious diseases might be allowed for the protection of public health and in accordance with the conditions set forth in Article 4 and 5(1) of the convention. Yet, all sexual health-related mandatory screening is prohibited.

4.2 Convention on the Rights of the Child

The right to health as enshrined in the Convention on the Rights of the Child (CRC) contains no explicit reference to either medical screenings or to the control of diseases. However, under Article 24(2)(c) states have the obligation to take measures to combat diseases within the framework of primary healthcare. ⁶⁰ According to paragraph VII(3) of the Alma-Ata Declaration, such primary healthcare includes at least, *inter alia*, »the control of locally endemic diseases«. General Comment No. 15 lists ensuring »universal coverage of primary health services« among the core obligations, which suggests that, when read in combination with the Alma-Ata

58 E/C.12/GC/22, 14 March 2016, para. 57.

59 *Ibid.*, para. 49(d).

60 The Committee on the Rights of the Child refers to the Alma-Ata Declaration where the approach to primary healthcare was defined to also include the control of infectious diseases. CRC/C/GC/15, 17 April 2013, para. 4.

Declaration, the control of locally endemic diseases falls within the minimum a state should ensure at its border.⁶¹

Similar to General Comment No. 14 of the Committee on Economic, Social and Cultural Rights, General Comment No. 15 clarifies that children's right to health includes the right »to control one's health and body«. ⁶² Children's right to consent to certain medical treatments and interventions might nevertheless be conditional on the permission or assistance of a parent, caregiver or guardian, depending on the child's age and maturity. ⁶³ However, with regard to HIV testing, states should consider to allow children to consent without the permission of a parent or caregiver. ⁶⁴ State parties must thereby protect the confidentiality of HIV test results and information on the HIV status of children may not be disclosed without the child's consent to third parties, including parents. ⁶⁵ In addition, states should ensure that girls can make autonomous and informed decisions on their reproductive health. ⁶⁶ Moreover, General Comment No. 3 is very clear in stating that mandatory HIV/AIDS testing of children is prohibited *under all circumstances* and that states should ensure protection against it. ⁶⁷

In addition to the screening for infectious diseases, General Comment No. 6 requires states to conduct additional screenings in the border context: it calls upon states, with the best interests of the child as a guiding principle, to prioritize the identification of unaccompanied and separated children »upon arrival at ports of entry or as soon as their presence in the country becomes known to the authorities«. ⁶⁸ Subsequently, states are required to assess and record during the »necessary initial assessment process«, »particular vulnerabilities, including health, physical, psychosocial [...] needs, including those deriving from domestic violence, trafficking or trauma«. The aim of this kind of assessment is to meet the specific needs of the

61 CRC/C/GC/15, 17 April 2013, para. 73.

62 Ibid., para. 24.

63 Ibid., para. 21.

64 Ibid., para. 31.

65 CRC/GC/2003/3, 17 March 2003, para. 24.

66 CRC/C/GC/15, 17 April 2013, para. 56.

67 CRC/GC/2003/3, 17 March 2003, para. 23.

68 CRC/GC/2005/6, 1 September 2005, para. 31.

child.⁶⁹ Furthermore, in order to ensure their access to health services – which must be the same as for children who are nationals – states should »assess and address the particular plight and vulnerabilities of such children«. ⁷⁰ States should pay particular attention to the psychological condition of unaccompanied and separated children and to specific gender-related needs of girls.⁷¹ Hence, the convention focuses not only on infectious disease control, but obligates states also to make health(-related) assessments in the interest of the child crossing the border.

In conclusion, interesting new insights can be drawn from the analysis of this convention. In contrast to the International Covenant on Economic, Social and Cultural Rights (ICESCR), the CRC does not explicitly mention the obligation to control diseases under the right to health. Rather, it incorporates it in primary healthcare and shifts the emphasis from control to care. Thus, voluntary and confidential testing is stressed as a means to prevent diseases and to ensure children's access to health services.⁷² Both the CRC and the ICESCR require a free and informed consent to medical screenings and explicitly prohibit mandatory HIV/AIDS testing. However, whereas the ICESCR leaves room in Article 4 and 5(1) for mandatory screenings – with the exception of screenings related to sexual health – the CRC does not. Finally, and particularly relevant, the CRC imposes a duty upon states to prioritize early identification of unaccompanied and separated children in order to guarantee their access to health services.

4.3 Convention on the Elimination of Discrimination Against Women

The right to health in Article 12 of the Convention on the Elimination of Discrimination Against Women (CEDAW) does not specify any obligation for the control of infectious diseases. However, the relevant General Recommendation states that »State parties should report on what they have done to address the magnitude of women's ill-health, in particular when it

69 CRC/GC/2005/6, 1 September 2005, para. 31.

70 Ibid., para. 47.

71 Ibid., paras. 46–47.

72 See specifically about HIV/AIDS testing: CRC/GC/2003/3, 17 March 2003, para. 22.

arises from preventable conditions, such as tuberculosis and HIV/AIDS». ⁷³ Notwithstanding that this General Recommendation is not explicit on the reach of this obligation, paragraph 6 highlights that special attention should be paid to *inter alia* the health needs and rights of migrant women and refugee women. ⁷⁴

In addition, this General Recommendation prohibits coercive measures such as mandatory testing for sexually transmitted diseases. ⁷⁵ States are required to ensure women's »right to autonomy, privacy, confidentiality, informed consent and choice« in all health services. ⁷⁶ However, it is unclear if border screenings would fall within the definition of a health service.

General Recommendation No. 26 defines state obligations on pre-departure health screenings of women migrant workers: where pre-departure HIV/AIDS testing and pre-departure health examinations are required by the country of destination, they must be respectful of the human rights of women migrants. Here, special attention should be paid to voluntariness and to problems of stigmatization. ⁷⁷ In referring to the obligation to respect women's human rights and voluntariness, this General Recommendation provides a solution for the possibly conflicting interests of public health and the individual. Thus, even in cases of mandatory screenings, free and informed consent is required.

Moreover, General Recommendation No. 32 urges states to establish adequate screening mechanisms for the early identification of women asylum seekers »with specific protection and assistance needs, including women with disabilities, unaccompanied girls, victims of trauma, victims of trafficking and/or forced prostitution, victims of sexual violence and victims of torture and/or ill-treatment«. ⁷⁸ However, the convention does not specifically link this requirement to the right to health.

In conclusion, the convention provides significant clarification on migration-related screenings. Particularly remarkable is the fact that it also requires free and informed consent for obligatory pre-departure medical

73 A/54/38/Rev. 1, chap. 1, 1999, para. 17.

74 Ibid., para. 6.

75 Ibid., para. 22.

76 Ibid., para. 31(e).

77 CEDAW/C/2009/WP.1/R, 15 December 2008, para. 24(d).

78 Ibid., para. 46.

screenings. The International Covenant on Economic, Social and Cultural Rights is far less specific on this subject and even allows for forced medical interventions, with the exclusion of screenings related to sexual and reproductive health. Similar to the Convention on the Rights of the Child (CRC), the CEDAW links medical screenings with the obligation to ensure access to care. Moreover, it also explicates that obligatory screenings have to be free of charge. Finally, the CEDAW, like the CRC, calls for early identification of vulnerability at the border.

4.4 The International Convention on the Rights of All Migrant Workers and Their Families

The International Convention on the Rights of All Migrant Workers and their Families (ICMWF) provides no *prima facie* guidance on infectious disease control. As outlined above, Article 28 of the convention limits migrant workers and their families' right to health to medical care which is urgently required.

Although the Committee on Migrant Workers has not (yet) issued a General Comment on the right to health, General Comment No.1 is instructive on states' limitations regarding medical screenings at the border. Thus, medical testing of female migrant domestic workers, including tests for pregnancy or HIV, is *only* allowed with their free and informed consent. Additionally, state parties should »repeal discriminatory laws, regulations and practices related to HIV«. ⁷⁹ Thus, the loss of work visas based on HIV status is prohibited. ⁸⁰

In summary, contrary to the International Covenant on Economic, Social and Cultural Rights, but like the Convention on the Elimination of Discrimination Against Women (CEDAW), the convention is not informative on the public health aspects of disease control. But, like the Convention on the Rights of the Child (CRC) and the CEDAW, it explicitly demands free and informed consent for migration-related medical screenings. However, unlike the CEDAW, it gives no further clarification on the conditions and costs of screenings when required before or upon arrival or stay in a coun-

79 CMW/C/GC/1, 3 February 2011, para. 61.

80 Ibid.

try. In contrast to the CRC and the CEDAW, no reference is made to any obligation to identify particular vulnerabilities of migrants.

4.5 Convention about the Rights of Persons with Disabilities

The Convention about the Rights of Persons with Disabilities (CRPD) does not add anything specific with regard to the border-related control of diseases. However, Article 25(b) requires another kind of assessment. Accordingly, states are obliged to provide disability-related health services, including early identification. Its wording resembles the calls by General Comment No. 6 of the Committee of the Rights of the Child and General Recommendation No. 24 of the Committee on the Elimination of Discrimination Against Women to identify vulnerable women and children at the border in order to ensure their access to health services. By comparison, the obligation under Article 25(b) might imply that states should also actively screen for persons with disabilities at their borders in case they would be in need of access to health services.

Furthermore, it is worth noting that Article 25(d) prescribes states to »[r]equire health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent«. This is the first treaty which contains an explicit reference to the right to free and informed consent. The Committee on the Rights of Persons with Disabilities's General Comment No. 1 outlines the extent of this obligation as applying to all health and medical professionals.⁸¹ Moreover, this General Comment recognizes the right to free and informed consent »everywhere« and »on an equal basis with others«.⁸² However, considering the wording of Article 25(d) of the convention, the question remains whether medical screenings at the border would fall within the definition of »care» or whether any compulsory screening would not be considered to constitute a provision of care within the meaning of this article.

To summarize, the convention highlights two aspects of the right to health relevant for border medical screenings. First, like General Comment No. 6 of the Committee on the Rights of the Child and General Recommen-

81 CRPD/C/GC/1, 19 May 2014, para. 41.

82 Ibid., paras. 5, 8 and 41.

dation No. 32 of the Committee on the Elimination of Discrimination Against Women, it calls for the early identification of persons with specific needs, i.e. disability. Second, it is the first treaty to explicitly guarantee the right to free and informed consent. However, it remains questionable whether the scope of this provision would also extend to border screenings. In this regard, General Recommendation No. 26 of the Committee on the Elimination of Discrimination Against Women and the Committee on Migrant Workers' General Comment No. 2 provide stronger guidelines as they require free and informed consent even for obligatory migration-related medical screenings.

4.6 International Convention on the Elimination of Racial Discrimination

Article 5(e)(iv) of the International Convention on the Elimination of Racial Discrimination (ICERD) stipulates that States should guarantee the right of everyone to »public health«. General Recommendation No. 20 explains that Article 5(e)(iv) does not create »new« rights, as their existence and recognition is presumed by listing them.⁸³ Upon first reflection, this seems disappointing, as no clarification of the content of »the right to public health« is provided. Nevertheless, it is not an empty concept, as it refers to all the other treaties incorporating it.

In addition, General Recommendation No. 30 stipulates under which conditions different treatment based on citizenship or immigration status constitutes discrimination.⁸⁴ Accordingly, medical screenings of (certain groups of) migrants crossing the border, is a discrimination if it is not in accordance with a »legitimate aim« and not »proportional to the achievement of this aim«. These criteria are similar to the criteria that allow for limitations of rights under Article 4 and 5(1) of the International Covenant on Economic, Social and Cultural Rights.

Altogether, the ICERD does not shed light on the content of »the right to public health« as such. It only provides general criteria to discern discriminating measures.

83 A/51/18, annex VIII, sect. A, 1996, 26 February - 15 March 1996, para. 1.

84 A/59/18, 2004, 23 February - 12 March 2004, para. 4.

4.7 Concluding Remarks

Overall, international human rights law provides fragmentary clarifications about medical border screenings for infectious diseases. Nevertheless, some important conclusions can be drawn from the above analysis.

The clearest reference to medical screenings is found in Article 12(2)(2) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) that enshrines the obligation »to control diseases«. Surprisingly, this obligation is much broader than its literal meaning, including availability of technological measures, data collection and surveillance, immunization and other strategies. This description is trend-setting for an overall approach in international human rights law that consider screenings as an obligation that does not come solely. Thus, the link between medical screenings and ensuring access to care is made under the ICESCR, the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of Discrimination Against Women (CEDAW). Only the CEDAW and the International Convention on the Rights of All Migrant Workers and their Families (ICMWF) specifically state that migration-related health assessments should be free of costs. Moving away from screenings related to (infectious) diseases, the CRC, CEDAW and the Convention about the Rights of Persons with Disabilities (CRPD) require the identification of certain categories of vulnerable people at the border in order to assess their health needs and ensure their access at the border.

Altogether, the treaties highlight different aspects of the conditions that should accompany medical border screenings. However, only the Committee on Economic Social and Cultural Rights (CESCR) has given a – rather blurred – explanation regarding the enforceability of the obligation »to control endemic and epidemic diseases« by calling it an obligation of »comparable priority« to a core obligation. In order to ensure that the right to health in relation to border screenings does not become an empty promise, it would therefore be useful to be crystal-clear about the exact extent (core obligation or not) and the exact content of the obligation to control diseases (in relation to the obligation to ensure access to care).

A second important conclusion is that the right to free and informed consent is implied as a general obligation in all treaties under the right to health. It is, nevertheless, only expressly stated in the newest treaty, the CRPD. The extent to which states can derogate from the right to free and

informed consent is therefore difficult to determine. This might also point to the fact that some international human rights law standards are getting outdated and, in light of the CRPD and the General Comments and General Recommendations of other treaty bodies, a new and authoritative interpretation of the limitation clause in CESCR General Comment No. 14 regarding forced medical interventions could prove to be useful.⁸⁵ Ideally, this interpretation would take into account the criteria already set forth in other treaty bodies.

More generally, it is also worth to consider in more depth in the future to what extent and how human rights should relate to so-called public health evidence and to the recommendations or even enforceable regulations from specialized agencies such as WHO.⁸⁶

5. DISCUSSION

Based on the above analysis of the rights and obligations in international human rights law with regard to medical care and emergency assistance as well as medical screenings at the border, the following pinpoints four aspects of particular relevance when discussing whether the right to health is an empty promise. These aspects are: clarity and consistency, the margin of appreciation, vulnerability and human rights as advocacy tools.

5.1 Clarity and Consistency

States are generally reluctant to accept international human rights law obligations, particularly in the field of economic, social and cultural rights, and enforcement mechanisms for human rights are generally weak. For the right to health to constitute more than an empty promise, it is therefore necessary to establish clear guidelines. Preferably, the guidelines should be consistent across different treaties in order to build one single comprehensive framework and avoid confusion about the applicable standard. The example of

85 See also Minkowitz (2007), 407.

86 See e.g. Article 32 of the International Health Regulations (2005) which balances the right to informed consent against public health interests.

the rights and obligations under the right to health has shown that such a clear standard does not yet exist in the border context.

There is a clear obligation to provide some sort of medical care and emergency assistance to everyone, regardless of their legal status. However, the exact content of these two terms differs depending on the treaty that is considered. It currently seems to be left to the discretion of the medical practitioner – or even to a border agent – to judge what treatment or assistance is necessary. If international human rights law treaty bodies were to adopt a coherent definition of the content of medical care and emergency assistance, this certainly could contribute to the right to health not becoming an empty promise.

With regard to medical border screenings, it is clear that States are allowed – and even required – to conduct medical screenings at the border. However, it is unclear to what extent States can screen a person who has not given her/his informed consent. Moreover, some international human rights law treaty bodies relate medical screening to access to healthcare but this is not yet highlighted consistently across the different international human rights law treaties. Connecting medical screenings more prominently to the access to healthcare would be pivotal to ensure the effective realization of the right to health.

5.2 The Margin of Appreciation

Whether the provisions of the right to health are an empty promise also depends on the margin of appreciation granted to member states to diverge from the treaty obligations and to interpret the treaty in their own terms. The right to health remains a right which is not absolute and, in accordance with the Committee on Economic Social and Cultural Rights' General Comment No. 14, can thus be limited in the general public interest. This means that limitations to the rights to medical care and emergency assistance are not completely ruled out under all circumstances. However, any such measures must be »in accordance with the law«, for a legitimate aim and »strictly necessary for the promotion of the general welfare«. ⁸⁷ Also in the context of medical screenings, coercive medical treatment is allowed in »exceptional cases« for »the prevention and control of communicable dis-

87 E/C.12/2000/4, 11 August 2000, para. 28.

eases«. ⁸⁸ Such measures must be »proportional«, »of limited duration« and »subject to review«. ⁸⁹ The right to health thus offers a rather clear guide on the conditions which have to be met by states in order to allow for any limitation of the right to health. Nevertheless, states can thus potentially limit the scope and possible impact of the right to health in the context of humanitarian border management.

5.3 Vulnerability

In light of insufficient clarity and the margin of appreciation granted to states in the field of health, the question remains whether there are any additional safeguards which could help to ensure the right to health is not an empty promise. This is even more so the case in contexts such as at the border where states are particularly reluctant to grant extensive rights because of state sovereignty concerns. Particular consideration for persons in vulnerable situations seems to provide a helpful additional safeguard in that respect.

Many of the treaties discussed above recognize that states have a special responsibility for persons who might be in a situation of vulnerability and that, due to that vulnerability, these persons should be treated on a preferential basis. Moreover, most of the specialized treaties such as the Convention on the Rights of the Child or the Convention on the Elimination of Discrimination Against Women even exist because of this very understanding of the need of particular attention to these vulnerable groups. Generally, the scope of the right to health thus seems to be more easily acceptable for states with regard to particular vulnerable groups, such as women or children. However, such a group-based approach has often been criticized as »paternalistic«, »stigmatizing« and static. ⁹⁰ Moreover, although treaties which deal with particular vulnerable groups might sometimes go beyond the standard of the International Covenant on Economic Social and Cultural Rights, the question for future research remains whether this also leads to a higher level of protection in practice.

88 E/C.12/2000/4, 11 August 2000, para. 34.

89 Ibid., para. 29.

90 Brown (2011), 316; Peroni/Timmer (2013), 1057; Flegar (2016).

The extent to which the conditions at the border or during a migratory journey may put persons in a vulnerable position is not (yet) explicitly recognized in most treaties.

While concern for particular vulnerable groups can thus certainly be considered to constitute a first step towards the realization of the right to health of those persons who are most needy of protection, the lack of a more nuanced understanding of vulnerability currently increases the arguments in favour of the right to health as an empty promise in the border context.

5.4 Human Rights as Advocacy Tools

The above analysis showed the difficulties in defining any clear standard. Wherever the state sovereignty to control its territory is (perceived as) threatened, it is less likely that extensive rights are granted. Despite the above critique and limitations of the right to health, the present analysis tried to show some of the potential the right to health still has.

Returning to Dembour's four schools of human rights, the present analysis suggests that human rights can generally be perceived as a legal tool, advocacy framework or moral claim. Although the four types Dembour identifies are ideal types and the present study cannot solely be ascribed to one of the four schools, the study considers the right to health within the protest school paradigm. The above analysis revealed that the right to health is more than just a moral principle (as the natural school would suggest). However, it is not yet an enforceable legal claim (as the deliberative school would suggest). Framing the right to health within the protest school thus best underlines the current effectiveness of the right to health in viewing it as a constantly fought for principle which is valuable because of its expression of far-reaching claims and aspirations.⁹¹ Following this approach would lead to the conclusion that the right to health is more than just an empty promise. It is a guideline which clarifies states' human rights obligations in the field of health. Even if these are in many cases not (yet) enforceable, this guideline provides useful principles to strive for in policy and practice.

91 Compare Dembour (2010).

In lack of sufficiently clear legal guidelines or enforcement mechanisms, the right to health can thus be understood as deriving particular value from being an advocacy tool that can support the fight for human rights not only in the context of humanitarian border management but also in more general terms. While the legal enforceability of human rights is often problematic and especially the progressive realization of economic, social and cultural rights feeds criticism on the right to health, certain aspects are clearly defined and can provide strong arguments when, for instance, monitoring compliance with or promoting the right to health.

This is not to say that there are no possibilities to further improve the role of the right to health in order to counter any criticism of it being an empty promise: the issues of clarity, proportionality and vulnerability as well as other limitations which were not addressed in this chapter might still have to be considered in more depth for the right to health to become a stronger legal rule. Overall, however, the right to health should be acknowledged for providing valuable arguments and concrete suggestions that can contribute to improving the health of every individual human being.

6. CONCLUSION

The present chapter tried to highlight the scope and content of the rights and obligations under the right to health at the border. It focused, first, on medical care and emergency assistance before clarifying the issue of medical screenings. In so doing, it tried to answer the question of whether the right to health does indeed have to be viewed as an empty promise in the context of border management or whether it provides valuable guidance. Three problematic issues were highlighted which should be addressed if the right to health is to be strengthened: clarity and consistency, the margin of appreciation and vulnerability. Placing the right to health into the context of a broader debate on the added value of human rights, the present study follows Dembour's protest school and would argue that the right to health is certainly not an empty promise if understood as advocacy tool. The present study revealed that, even if the right to health is not yet a reality, it is certainly valuable and an essential factor for clarifying individual rights and state obligations at the border – if not (yet) as purely legal criteria, then at least as claims and aspirations worth fighting for.

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