Shadow Submission on the Right to the Highest Attainable Standard of Health in the

UNITED KINGDOM

for the International Committee on Economic, Social and Cultural Rights

Pre-sessional Meeting, 20th -23rd May 2008
Palais Wilson, Geneva

by
The People's Health Movement - UK

In association with
Medact and Doctors for Human Rights

This report has been prepared by the UK circle of the People's Health Movement (PHM UK). PHM- UK has worked with the collaboration and support of the charity, Medact, and gratefully acknowledges the assistance it has received in fulfilling this project.

The People's Health Movement

The People's Health Movement (PHM) is a movement of health activists and campaigners most of whom work at the grassroots in countries of the South. We share a common concern about deepening health inequalities and about the domestic and international policy directions that have a negative impact on health. We call for a renewal of the commitment to the principles and priorities of the Alma Ata declaration on Primary Health Care, and to the call for health for all.

Although a diverse and lose coalition, groups within the PHM share a common vision which is set out in the people's charter for health. The objectives of the PHM are

To promote the Health for All goal through an equitable, participatory and inter-sectoral movement and as a Rights Issue.
To ensure universal access to quality health care, education and social services according to people's needs and not people's ability to pay.
To promote the participation of people and people's organisations in the formulation, implementation and evaluation of all health and social policies and programmes.
To promote health along with equity and sustainable development as top priorities in local, national and international policy-making.
To hold accountable local authorities, national governments, international organisations and corporations.

The PHM is co-ordinated by a global secretariat, with circles at country and regional levels and circles for dialogue based around issues. Local, national and international campaigns bring the groups together. PHM UK is the local circle in the UK. We are health activists, campaigners, researchers and health workers who share the vision set out in the people's charter for health and who use this in our work in different ways. The UK circle is small. We link with the larger PHM Europe circle.

The production of this submission to the Committee on Economic, Social and Cultural Rights is an important focus of the work of the UK circle.

Medact

Medact is a global health charity tackling issues at the centre of international policy debates. Led by its health professional membership it undertakes education, research and advocacy on the health implications of conflict, development and environmental change, with a special focus on the developing world.

Medact was formed by a merger of two older organisations in 1992, the Medical Association for the Prevention of War and the Medical Campaign Against Nuclear Weapons, Medact's work on war and weapons continues today, and is now complemented by action on the health impacts of poverty and environmental change.

Responding to the war on Iraq Medact produced its fourth report in January 2008 Rehabilitation under fire: health care in Iraq 2003-2007. This report describes how the 2003 war and its aftermath continue to have a disastrous effect on the physical and mental health of the Iraqi people. It builds on Medact's previous reports on health in Iraq, and reviews what has happened to the health system in the light of international law and best practice.

Global Health Watch is a call to all health workers to broaden and strengthen the global community of health advocates who are taking action on global ill-health and inequalities, and their underlying political and economic determinants.

Refugee Health Network (RHN) the network aims share information, resources and support. Many of the network's members have years of professional experience and are willing to share this expertise with others

Education on the Covenant on Economic, Social and Cultural Rights for doctors

1. Relevant General Comment Paragraph

Para 44. The Committee also confirms that obligations of comparable priority include the following: (5) to provide appropriate training for health personnel, including education on health and human rights.

2. Facts stated in UK's Fifth Periodic Report 2007

In responding to Para 30 of the Concluding Observations, the UK periodic report paras 91-96 refers to human rights education in a superficial manner but fails to specify economic social and cultural rights.

3. Relevant recommendations from the 2002 Concluding Observations:

30. The Committee urges the State party to ensure that human rights education curricula and training programmes for schoolchildren and for the judiciary, prosecutors, government officials, civil servants and other actors responsible for the implementation of the Covenant give adequate attention to economic, social and cultural rights.

4. Report

1. Thirty two years on from the UK ratifying the International Covenant on Economic Social and Cultural Rights and fourteen years on from the World Conference On Human Rights in Vienna, that recognised the importance of special education in human rights and humanitarian law for health professionals, doctors remain largely ignorant of the significance of Economic, Social and Cultural Rights in general and the right to the highest attainable standard of health in particular. As the UN Special Rapporteur on the right to the highest attainable standard of health reported to the Human Rights Council " To be blunt, most health professionals whom the Special Rapporteur meets have not even heard of the right to health. If they have heard of it, they usually have no idea what it means, either conceptually or operationally. If they have heard of it, they are likely to be worried that it is something that will get them into trouble" (Special Rapporteur on the right to the highest attainable standard of health 2007).

2. There is limited evidence that the UK government's approach to education curricula and training programmes for health professionals has changed, except for the publication of *Human Rights in Healthcare - A Framework for Local Action* in March 2007. This is manifested at the highest level by the failure of the Joint Parliamentary Committee on Human Rights report, which criticised the 2004 Charging Regulations that denied refused asylum seekers free access to secondary healthcare, to mention the Covenant except in passing - preferring to use the European Convention on Human Rights which comprises mostly civil and political rights (Department of Health 2007)

3 The publication *Human rights in healthcare—a framework for local action* misleadingly euphemises when it refers to the "international community" as "agreeing" to human rights treaties, rather than the UK ratifying the International Covenant on Economic, Social and Cultural Rights, It later claims "(t)he responsibility to comply with these treaties lies with the UK Government not with individual NHS organisations". The paper fails to point out that

whilst the state is the ultimate duty bearer, it is obliged to provide the environment within which all members of society can discharge their responsibilities towards the Covenant. Further, the document focuses on the Human Rights Act as imposing a direct legal obligation on NHS Trusts, which, by default, relegates the Covenant to of being of lesser importance. The primary role of the document appears to be to warn trusts of their jurisprudential liabilities with regard to the Human Rights Act, and allows the Covenant suffer in comparison.

4. The failure of the Government to incorporate the International Covenant on Economic Social and Cultural Rights into domestic law, as recommended by the Committee in its 1997 and 2002 Concluding Observations, denies health professionals the existence of case law on the observation of the Covenant, which would have educational value.

5. Of 32 UK medical schools recently asked if they include education on the right to the highest attainable standard of health within their curriculum, only eight replied. Of those, only two responded positively. Warwick University reported it was mentioned briefly in the first year, and Glasgow reported that one diagram from the WHO report: *25 Questions and Answers on Health and Human Rights,* which describes the right to the highest attainable standard of health, was discussed.

6 An editor at the British Medical Journal recently complained that a paper submitted for publication that dealt with the right to the highest attainable standard of health "covers complex concepts and laws that most readers will know nothing about, and the language is dense and filled with jargon". Successful publication of human rights papers in medical journals are rare, and a common reason for rejection is that they are of insufficient interest to the reader. Until the medical profession is taught economic, social and culture rights, they will remain uninterested as a result of having little understanding of the importance of human rights to health.

Recommendation

The government should be asked when health professionals will receive education on the Covenant on Economic, Social and Cultural Rights.

Hunt P, Report on progress and obstacles to the health and human rights movement, in addition to cases on the right to health and other health-related rights. This report (A/HRC/4/28) was submitted to the Human Rights Council on 17 January 2007."http://www2.essex.ac.uk/human_rights_centre/rth/reports.shtm

Equality and Human Rights Group. Human rights in health—a framework for local action. Sn 1.3a. London: Department of Health, 2007. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073473. (accessed April 5th, 2008)

Migrants and Asylum Seekers

1. Relevant Articles from the Covenant and General Comment paragraphs

Article 2 of the Covenant on Economic, Social and Cultural Rights sets out the obligation on the government to provide care to all without discrimination (OHCHR, ICESCR 1966).

Article 12, the Right to the Highest Attainable Standard of health, makes it clear that this applies not only to the prevention, treatment and control of disease, but also with respect to the provision of medical services in the event of sickness. It makes specific mention of measures to limit the still-birth rate, and infant mortality. (OHCHR, ICESCR 1966)

These obligations are elaborated in paragraph 34 of General Comment 14 on the Right to the Highest Attainable Standard of Health. The obligation to respect the right to health must include refraining from denying or limiting equal access for *all* persons. Amongst other vulnerable groups, this paragraph makes specific reference to asylum seekers and illegal immigrants in this regard.(OHCHR, ICESCR, GC 14, 2000)

General Comment 14, paragraph 32 makes it clear that retrogressive measures taken in respect of the right to health are impermissible.(OHCHR, ICESCR GC14, 2000)

2. Relevant Concluding Observations

In the Concluding Observation 25 (2002) directed to the UK government, the Committee recommends a proactive approach to meeting the needs of the vulnerable in society, stating that the obligations under the Covenant should be taken into account at an early stage in the formulation of policy and legislation on welfare issues, including health.(OHCHR, CO UK, 2002)

3. Facts stated in UK's Fifth Periodic Report 2007

A pertinent claim of the UK Government is made in pparagraph 52 of the UK Government's fifth report 2007. Here it states that; ' … as section 8 of this report ("Progress since the fourth report on each of the articles in Parts I, II and III of the Covenant") will explain in detail, the rights contained in the Covenant receive protection and are being progressively realised under domestic legislation or other measures." (Ministry of Justice, 2007)

4. Factual and legislative background

<u>4.1 The introduction of Charges</u>

- In 2004 the Government introduced the NHS (Charges to Overseas Visitors) (Amendment) Regulation. This regulation restricts entitlement to free NHS provision to those people 'ordinary resident' in the UK, those from the EEA, and from countries with reciprocal charging arrangements. Asylum seekers who have been granted asylum in the UK, or those whose applications are in process (or going through appeal) are entitled to free NHS services, as are those granted refugee status or exceptional leave to remain.(Department of Health 2004a)
- Following the amendment in 2004, it became necessary for a person to be able to prove that that they are ordinary resident, and also that they are lawfully resident in the UK.

The guidance suggests that this is ascertained by asking ALL patients presenting for treatment 'Where have you lived in the last twelve months?' and 'Can you show that you have the right to live here?.' (Hargreaves et al, 2006)

- Failed asylum seekers and undocumented migrants are not entitled to primary care, except at the discretion of a GP doctor. Failed asylum seekers are those people whose application has failed to meet the strict requirements of the definition under the terms of the 1951 UN Convention on Refugees. Their lives may be at risk. Being a 'failed asylum seeker' does not mean that their claim is bogus. Undocumented migrants are those whose people who are at risk of being deported as a result of irregularities in their immigration status. Such irregularities might be entering the UK using false documents, avoiding immigration inspection or overstaying a visa.

- The government's own health select committee have criticised the lack of evidence to support the introduction of charging as being cost effective to the NHS (Parliamentary Health Committee 2005), and the Mayor of London has criticised the suggested association that failed asylum seekers were simply 'health tourists.' (Greater London Authority 2004)

4.2 The case of primary care

- According to the Department of Health table of entitlement, 'Health Circular 1999/018, failed asylum seekers (including undocumented migrants) should not be registered with a general practitioner, but equally GP practices have the discretion to accept such people as registered NHS patients. (Department of Health 1999)

- Concern exists that many people entitled to free NHS treatment are not receiving the care to which they are entitled, because of lack of familiarity of practice staff with current guidelines. Project: London is a free and confidential service run by the international medical humanitarian organisation, Médicins du Monde. Project: London is an advocacy project that provides information, advice and practical assistance to vulnerable people to help them access NHS and other services. It also provides some basic primary health care and advocates on behalf of people unable to access NHS services. In a study of its clients, Project: London found that nearly 40% of people attending the service were actually fully entitled to NHS services and yet unable to access them. The lack of access was due in part to confusion over eligibility, and brought about by the failure of primary care providers to distinguish between access to secondary care (which is limited by law) and access to primary care (which is in some cases guaranteed and in other cases within the discretion of the GP). (Medecins du Monde 2006)

- In a study carried out in Newham, 64 GP practices were approached about their registration procedures for Overseas Visitors. In 23.9%, the decisions were made by reception staff only. 54% of GPs interviewed declared that they were unclear about the current guidance on charging. Local residents and asylum seekers interviewed for the study complained of the lack of consistency of registration requirements at different surgeries (for example, home office letters declaring entitlement to remain in the UK were not considered sufficient evidence in some cases.) (Hargreaves et al 2006)

4.3 The provision of secondary care

- Except for services provided in particular locations (- those provided in A+E departments, in sexually transmitted disease clinics and treatment given under the Mental Health Act-) failed asylum seekers and undocumented migrants are also not entitled to secondary care. The exception is receiving 'immediately necessary treatment.' However in this case, the guidance says that, if the services are found chargeable, 'the charge will still apply and recovery should be pursued as far as the trust considers reasonable.'

4.4 Immediate and necessary treatment -the case of Maternity care

- Maternity care is not exempt from charges. Health Service Trusts are required to issue invoices in all cases and many women are intimidated by the prospect of incurring a debt of several thousand pounds when they know it will be impossible to pay it. They choose not to receive care and 'disappear' from maternity services.

- There are numerous examples of women who have been refused care because they are unable to pay in advance. This has continued despite reminders issued to Overseas Visitor Managers by the Department of Health that all maternity care should be treated as immediately necessary treatment. (Joint Committee on Human Rights 2007)

- Women have been deterred from obtaining care by the treatment received from the Overseas Visitor Managers and hospital finance departments. This consists of rude, and in some cases, abusive treatment in meeting with Overseas Visitor Managers; repeated phone calls, often very aggressive in character; and threats to bring in debt collectors prior to the birth. In some cases, the Overseas Visitor Manager has rung the woman's GP during the meeting and advised the GP that the woman is not entitled to free care. For some women this has resulted in loss of access to primary health care services. (Joint Committee on Human Rights 2007)

- The Joint Committee on Human Rights inquiry into the treatment of asylum seekers (2007) concluded: '…the arrangements for levying charges on pregnant women and nursing mothers lead in many cases to the denial of antenatal care to vulnerable women.' The Joint Committee recommended that the Government suspend all charges for maternity care and provide care free of charge to rejected asylum seekers. (Joint Committee on Human Rights 2007)

- The experience of the women coming to Project: London highlights concern about whether pregnant women are in fact able to access primary care and hospital maternity care. Thirty-nine pregnant women (23% of the women who came to the clinics) came to Project: London for help in accessing primary care, antenatal care or termination of pregnancy. Over half of these women (51%) had not had any access to antenatal care before coming to the clinic and of these, two-fifths were at least 20 weeks into their pregnancy. This is significant, given that starting antenatal care past 20 weeks is itself a risk factor for maternal death, as are missing appointments and screenings. Over 70% of all

the pregnant women coming to the clinic had tried to access either primary care or ante-natal services but had experienced difficulties. And at least 30% of the pregnant women had not had access to HIV screening. (Medecins du Monde 2006)

4.5 Destitution and health

- As a result of government policy regarding welfare support, many asylum seekers and failed asylum seekers live below the poverty line, to the point of destitution. Section 4 of the Immigration and Asylum Act 1999 sets out the support available to failed asylum seekers who are unable to return home. It provides only for the most basic forms of support, typically a bed and vouchers and is intended for single adults. Over recent years, however, an increasing number of families have been supported only in this way over long periods of time. (Robinson and Sergott, 2002)

- Section 9 of the Asylum and Immigration (Treatment of Claimants etc) Act 2004 prohibits local authorities from providing support to refused asylum seekers including families.(HM Government 2004) This means those individuals or families become dependent of friends or charities or church groups or mosques for all their needs or else they become destitute. The children either stay with their parents in destitution or else may be taken into care.

- A state of destitution has significant impacts on the health of children including nutrition, growth, hygiene and mental health. A study by the Joseph Rowntree Foundation undertaken in Leeds, (Lewis, 2007) demonstrated that children are among an increasing number of destitution of asylum seekers in that city. Over a 4 week period, 112 destitute asylum seekers and refugees, including 12 children sought assistance from five key agencies in that city.

- In 2004, Medecins Sans Frontiers (MSF) carried out an assessment of the impact of one section of the Immigration and Asylum act on destitution and its effects on the health of asylum seekers in the UK. Under section 55 of the Nationality, Asylum and Immigration Act 2002, support and accommodation could be denied to asylum seekers who were deemed late in making their asylum claim. MSF conducted comprehensive medical assessments of 46 asylum seekers made destitute under section 55. Most has precarious accommodation, most were reliant for food on handouts from charities, churches or mosques. 42 had experienced traumatic events in their country of origin. Their destitution was having profound impacts on their health; 21 of the 46 were depressed, 11 had thought of self harm, and two had made suicide attempts whilst in the UK. 32 required referral to a GP, one to A+E and four to secondary care. 15 required referral to a bi-cultural mental health worker. Although all were entitled to free NHS primary care, only one was registered with a GP. Of 34 who responded to questioning on this subject, 11 had been told they could not register with a GP because they did not have a permanent address. (Hargreaves et al, 2005) Although a court of Appeal Ruling has led to the softening of the Section 55 regulations, it remains clear that many failed asylum seekers and undocumented migrants remain in destitution, and the impacts on their physical and mental health remain profound.

4.6 HIV and the challenge of accessing care

- Current policy states that failed asylum seekers and illegal migrants are not entitled to receive HIV treatment in the UK. (Department of Health 2004b) This policy has been criticised both on ethical and economic grounds. (Refugee Council 2006) Individuals with untreated HIV will require repeated episodes of emergency treatment as their disease progresses. The governments policies in this area appear to contradict their commitment (made alongside other G8 leaders) to advocate for universal access to HIV treatment to all those who need it by 2010.

- The difficulties some women face in accessing maternity care means that they lack the screening for HIV which would usually take place during their pregnancy. This may result in them failing to access the treatment services for HIV that they need, but also in failing access drug treatment to prevent the mother to child transmission of HIV. This has a profound impact on the potential for health of the unborn child.

- The government's policy of dispersal which requires the sudden obligatory relocation of people seeking asylum to other parts of the country can have a profound impact asylum seekers who are eligible for NHS treatment and are receiving antiretroviral treatment for HIV. Suddenly moving to another town interrupts the continuity of care which is essential for the proper treatment of HIV.

5. Violations of obligations under the Covenant

- The UK Government has failed to protect the right to health, by the introduction of the discriminatory policy / regulation that is the NHS (charges to overseas visitors) Regulation and the accompanying confusion in practice effectively denies equality of access to healthcare.

- The UK Government has failed to fulfill the obligation to progressively implement measures to ensure the right to the highest attainable standard of health, by intruding retrogressive regulations / policies.

- The UK government has failed to protect the right to the highest attainable standard of health, by introducing regulations and policies that impact access to healthcare of a vulnerable and marginalised group. The policies actively contribute to increased vulnerability and marginalisation of failed asylum seekers and undocumented migrants.

- The UK government has failed to take steps for the provision of services that decrease the infant mortality rate and prevent maternal mortality, by introducing practices that have effectively denied pregnant women, including women with HIV, access to maternal healthcare.

6. Recommendations.

The Government should be asked to explain why it claims in paragraph 52 of the UK's fifth report that 'the rights contained in the covenant receive protection are progressively being realised under domestic legislation' when its refusal to allow failed asylum seekers

and undocumented migrants the highest attainable standard of health has been a violation of their rights since 2004.

The government should be asked when it will reverse the retrogressive steps in charging for NHS health care.

The government should be asked to explain why it is denying access to secondary medical care in violation of the Covenant.

The government should be asked when it will amend its discriminatory guidance on registration and charging by GPs.

Note

The preparation of this report has benefited from the valuable help of Medecins du Monde Project:London, The Terrence Higgins trust, The National AIDS Trust, The Children's Society, and Medact's 'Reaching Out' project.

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The invasion and occupation of Iraq by the United Kingdom

1. Relevant General Comment Paragraphs

Para 39. To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law.

Para 9. ... Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

Para 50. Violations of the obligation to respect are those state actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality.

Para 51. Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties.

Para 52. Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health.

2. Facts stated in UK's Fifth Periodic Report 2007

No mention of the Iraq invasion and occupation, or of the health of the Iraqi people, was made in the UK's Fifth Periodic Report 2007

3. International law context

A. The UN Charter outlaws the use of force with only two exceptions: individual or collective self defence in response to an armed attack, and action authorised by the Security Council as a collective response to a threat to the peace, breach of the peace or act of aggression. The doctrine of pre-emptive self-defence against an attack that might arise at some hypothetical future time has no basis in International Law. Neither Security Council resolution 1441 nor any prior resolution authorised the use of force. Before Military action could be lawfully undertaken against Iraq, the Security Council must have indicated clearly expressed assent.

B. International humanitarian law is a set of rules which seek, for humanitarian reasons, to limit the effects of armed conflict. The Geneva Conventions have one aim – to protect both soldiers and civilians as much as possible from the horrors of war.

The Geneva Conventions require the occupying powers to ensure public order so they can fulfil the following health-related responsibilities:

i) Civilian hospitals should not be attacked and should be respected and protected at all times (IV, Art 18).
ii) People engaged in the operation of civilian hospitals should be protected (IV, Art 20).
iii) Health workers should be allowed to carry out their duties (I, Art 19, and IV, Art 59).
iv) Consignments of medical stores and foodstuffs should be allowed free passage (IV, Article 23).
v) Health services, public health and hygiene should be maintained (IV Art 56), including facilitating assistance from relief agencies and other states (IV Art 59).
vi) The civilian population is protected under the Geneva Conventions and these protections are not affected by the presence of combatants in the population. (I, Art. 50, Sec. 3) These protections include the right to be free from attacks, reprisals, acts meant to instil terror, and indiscriminate attacks.

After the transfer of authority to an interim Iraqi government in 2004, the conflict was redefined as an 'internationalized internal armed conflict'. When occupying powers operate through a newly appointed government, they are still responsible as outlined above (International Committee of the Red Cross 2005).

4. Relevant recommendations from 2002 Concluding Observations

25. The Committee further recommends, recalling its previous recommendation (see paragraph 33 of its 1997 concluding observations), that the State party review and strengthen its institutional arrangements, within the government administration, which are designed to ensure that its obligations under the Covenant are taken into account, at an early stage, in the Government's formulation of national legislation and policy on issues such as poverty reduction, social welfare, housing, health and education.

5. Relevant events regarding the preparation, invasion and occupation of Iraq

1.0 On March 20, 2003, the United Kingdom (UK) and a coalition of allies led by the United States (US), invaded Iraq and overthrew the government of Saddam Hussein. They claimed they would bring peace, prosperity and democracy, but ever since, violence, civil strife and economic hardship have wracked the land. The grounds upon which the British Parliament voted to go to war, was the allegation, subsequently disproved, that Iraq possessed and was actively developing weapons of mass destruction, supported by an eleventh hour volte face by the UK Attorney General, in which he decided existing Security Council resolutions permitted the invasion.

2.0 This report makes the case that:-

2.1 - the prosecution of the war against Iraq was illegal (pages 12-15)

2.2 - the Geneva Conventions that require the occupying powers to ensure public order so they can fulfil their responsibilities towards the health of the Iraqi people, have been violated (pages 15-19)

2.3- the Butler report and the Hutton inquiry combined, show that when presenting the evidence in public, the British Government made a calculated effort to inflate the danger in order to justify possible military action. To the extent the members of parliament and the public were not properly informed this amounted to deception (appendix)

2.4 - the war against Iraq was prosecuted against the wishes of the majority of the UK population (appendix)

2.5 - the war against Iraq has significantly increased the risk of actual and potential violations of the right to the highest attainable standard of health elsewhere in the world. (appendix)

The evidence making the case that the Iraq war was illegal, and that Geneva Conventions were violated, which together are responsible for the violation of the right to the highest attainable standard of health of the Iraqi people, are presented in the main section of this report. Much of this evidence is of necessity detailed and some nuanced.

*Additional important but less crucial information (***2.3-2.5)** *about how the UK Government misled the UK public and Parliament by inflating the danger Iraq posed in order to justify possible military action; that the war was prosecuted against the wishes of most of the UK population; and that the war has significantly increased the risk of actual and potential violations of the right to the highest attainable standard of health elsewhere in the world, are relegated to the appendix.*

2.1.0 The prosecution of war against Iraq was illegal

2.1.1 The UN Secretary General publicly condemned the war in Iraq as illegal (Annan 2004)

2.1.2 Security council resolution 1441 does not authorise the use of force. Any attack on Iraq would consequently be illegal. Resolution 1441 finds Iraq to be in "material breach" of its disarmament obligations under earlier security council resolutions. It gives Iraq a "final opportunity" to comply with its obligations and, to that end, establishes an onerous and rigidly-timetabled programme of Iraqi disclosures and UN inspections. Failures by Iraq to comply are to be reported to the security council, which must then "convene immediately ... to consider the situation and the need for full compliance". The resolution also recalls that the council has repeatedly warned Iraq of "serious consequences" as a result of its continued violations of its obligations. But the resolution does not authorise the use of force. The term "serious consequences" is not UN code for enforcement action (the term used is "all necessary measures"). And, in their explanations of their votes adopting resolution 1441, council members were careful to say that the resolution did not provide such an authorisation.

A war waged without a clear mandate by the Security Council would constitute a flagrant violation of the prohibition of the use of force. Security Council Resolution 1441 does not authorise the use of force. Upon its adoption, France, Russia and China, three permanent members of the Security Council, issued a declaration indicating that the Resolution excludes such authority. The bottom line is that nine members of the Security Council, including the

five permanent members, need to actively approve the use of force - such support is blatantly lacking (International Commission of Jurists 2003).

2.1.3 In March 2003 the UK Attorney General, Lord Goldsmith, wrote two differing opinions on the legality of war against Iraq only ten days apart.

2.1.4 On March 7, the first sent to the Prime Minister Blair, argued that a new Security Council resolution was safest. "... I remain of the opinion that the safest legal course would be to secure the adoption of a further resolution to authorise the use of force. […] The key point is that it should establish that the Council has concluded that Iraq has failed to take the final opportunity offered by resolution 1441" (Attorney General 2003a).

2.1.5 March 17, 2003, ten days after his first legal minute, the UK Attorney General presented a new opinion in the House of Lords that now claimed the invasion to be legal, even though no new developments had taken place to account for the change of mind. In nine short paragraphs he set out his reasoning: that even without the "second resolution" UK diplomats had been frantically trying to secure, existing UN resolutions permitted an invasion (Attorney General 2003b).

2.1.6 Hans Blix's reports on the Unmovic weapons inspections in Iraq divided Security Council opinion. On March 7 2003, the day Lord Goldsmith suggested a second Security Council resolution to authorise force would offer the "safest legal course", and the day of the final Unmovic report, was the day this second resolution became increasingly unlikely. The British foreign secretary proposed the UN set an ultimatum for Iraq to demonstrate "full, unconditional, immediate and active cooperation" by March 17, but France made it clear it would veto such a resolution.
Britain then proposed setting "six tests" for Iraq to meet if it was to avoid war. The idea galvanised some diplomatic support but not enough to suggest Britain and the US could win a second resolution. On March 12, with the hope of a such a resolution fading, Admiral Sir Michael Boyce, chief of defence staff, asked Prime Minister Blair for an unequivocal statement on the legality of war under resolution 1441. The next day, Lord Goldsmith saw Lord Falconer and Baroness Morgan, two of Prime Minister Blair's closest advisers, at an unminuted Downing Street meeting, and expressed his "clear view" that war would be lawful under 1441 (The Guardian 27/4/05).

2.1.7 March 19, 2003: The foreign ministers of Germany, France and Russia condemned the impending military action in strong terms, saying that the use of force against Iraq had not been approved by any UN resolution (The Guardian online).

2.1.8 When it became clear that the majority of member countries within the Security Council would not sanction war, Prime Minister Blair decided to defy their wishes (The Times 13/3/03).

2.1.9 In going to war before the weapons inspectors had completed their work, the allies prevented their demonstrating that weapons of mass destruction did not exist - as proved to be the case after the invasion. The UN weapon inspections, which began on 27 November 2002, had been mandated by Security Council in resolution 1441 (United Nations 2003).

2.1.10 Hans Blix, the head of Unmovic, had moved to the opinion that Iraq was beginning to comply with 1441's call for it to demonstrate it had disarmed. On February 14, 2003 he delivered a report to the security council listing examples of Iraqi compliance and questioning some of the US intelligence behind Colin Powell's UN presentation on Saddam Hussein's weapons programmes. He followed up on February 28 with a more mixed assessment, but marked out Iraq's commitment to comply with a deadline to destroy its illegal Samoud 2 missiles as a positive development. The Swede's final report to the council, delivered on March 7, was also ambivalent, but Mr Blix stressed the disarmament under way: "We are not watching the destruction of toothpicks," he told the Security Council (The Guardian 27/4/05)

2.1.11 In 2008 Hans Blix resolved "The elimination of weapons of mass destruction was the declared main aim of the war. It is improbable that the governments of the alliance could have sold the war to their parliaments on any other grounds. That they believed in the weapons' existence in the autumn of 2002 is understandable. […] Responsibility for the war must rest though, on what those launching it knew by March 2003. By then, Unmovic inspectors had carried out some 700 inspections at 500 sites without finding prohibited weapons." (The Guardian 20/3/08)

2.1.12 October 7, 2004. Iraq had no stockpiles of biological, chemical or nuclear weapons before last year's US-led invasion, the chief US weapons inspector has concluded (BBC News online 7/10/04).

2.2.0 The violation of the Geneva Conventions

2.2.1 An occupying power has a duty to ensure public order and safety in the territory under its authority. Military commanders on the spot must prevent and where necessary suppress serious violations involving the local population under their control or subject to their authority. The occupying force is responsible for protecting the population from violence by third parties, such as newly formed armed groups or forces of the former regime. Ensuring local security includes protecting persons, including minority groups and former government officials, from reprisals and revenge attacks. Generally, an occupying force has a duty to ensure the food and medical supplies of the population, as well as maintain hospitals and other medical services, "to the fullest extent of the means available to it." This includes protecting civilian hospitals, medical personnel, and the wounded and sick (Human Rights Watch 2004)

2.2.2 Five years after the US-led invasion, Iraq is one of the most dangerous countries in the world. Hundreds of people are being killed every month in the pervasive violence, while countless lives are threatened every day by poverty, cuts to power and water supplies, food and medical shortages, and rising violence against women and girls. Sectarian hatred has torn apart families and neighbourhoods that once lived together in harmony. Tens of thousands of people have been killed, some in targeted assassinations, but the majority in bomb explosions or suicide attacks in crowded areas chosen to maximize civilian casualties. All sides have committed gross human rights violations, including war crimes and crimes against humanity. From early 2006, violence intensified and became increasingly sectarian, with Sunni and Shi'a armed groups targeting adherents of other faiths and driving members of "enemy" communities out of long mixed neighbourhoods (Amnesty International 2008).

2.2.3 Violence is a leading cause of death for Iraqi adults and was the main cause of death in men between the ages of 15 and 59 years during the first 3 years after the 2003 invasion. Three different assessments have reached three different conclusions over the number of excess violent deaths. Over much the same time period mortality ranges from 601,027 from the Lancet survey (Burnham et al 2006), to an excess of 47,668 (The Iraq Body Count) recorded by The Iraq Body Count project, back to 151,000 reported by the Iraq study group survey (Iraq study group survey 2008). The WHO Iraq Family Health Survey found that violence has contributed one death in every eight, and was mainly reported in South/centre of Iraq (WHO 2008a).

Adult mortality: Age and sex specific adult mortality rates for the last 15 years before the survey, overall and by five years show that, the overall adult male mortality rates during this period had more than doubled from 1.23 to 2.7 per 1,000 person years, while the corresponding figures for females had slightly increased (30%). During the last 5 years, males aged 15-49 experienced high mortality rates than females in the same age group with nearly a 3-folds increase (2.70 vs. 0.96 per 1,000 person years). These disproportionate male-female rates could be attributed to the security situation in Iraq following the 2003 war (WHO 2008b)

Iraq's under-5 mortality rate is sliding towards those of sub-Saharan Africa. In 1990, 50 Iraqi children died per 1,000 live births. Today, the rate is 125 per 1,000 births (Save the Children 2007)

According to the World Health Organisation, every day in 2006, an average of 100 Iraqis were killed and many more were seriously injured by gunshots, shrapnel wounds and burns. As the violence continues, these emergency needs are increasing the load on a public health system that is already stretched thin, and people are dying as a result. The Iraqi Government estimates that almost 70% of critically injured patients with violence-related wounds die while in emergency and intensive care units due to a shortage of competent staff and a lack of drugs and equipment (WHO 2007)

2.2.4 Five years after the outbreak of the war in Iraq, the humanitarian situation in most of the country remains among the most critical in the world. Because of the conflict, millions of Iraqis have insufficient access to clean water, sanitation and many Iraqis do not have access to the most basic health care. There is a lack of qualified staff and many hospitals and health-care facilities have not been properly maintained.

Because of poor security conditions in much of the country, the sick and injured are often cut off from access to medical care. In some areas, it has become extremely difficult to provide emergency medical services, supplies or equipment because of numerous checkpoints on the roads and curfews restricting movement. Hospitals and health-care centres often lack drugs and other essential items. There are not enough functioning emergency rooms and operating theatres to cope with mass casualties. There are currently 172 public hospitals with 30,000 beds – well short of the 80,000 beds needed – plus 65 private hospitals. Most of the hospitals were built over 30 years ago and are in sub-standard condition. This is also true of many of the primary health-care centres, which have been using the same equipment for 25 years. Medical facilities and equipment everywhere except in the northern part of the country

are regularly in need of repair and upgrading. Because of the poor security situation, proper maintenance has been impossible

The lack of qualified and experienced medical staff, in particular in the governorates of Najaf, Missan, Anbar, Wasit and Babil, has had a direct impact on the level of care available. For instance, the lack of midwives means that many women giving birth at night must do so without assistance, since poor security conditions and curfews prevent them from going to hospital. Like many other Iraqis, medical doctors, nurses and their families are in danger of being kidnapped or killed. Some have received threats against them. According to official Iraqi sources, of the 34,000 doctors registered in 1990, at least 20,000 have left the country (International Committee of the Red Cross 2008) .

2.2.5 Torture: After a three-year investigation costing more than £20m, the British Ministry of Defense admitted Iraqis detainees were ill-treated. At a six-month court martial, one soldier of the Queen's Lancashire Regiment pleaded guilty, but six others - including Colonel Jorge Mendonca, the commanding officer - were acquitted of negligence and abuse. Nobody was convicted of killing Mousa. The court heard that British soldiers used "conditioning" techniques to "soften up" Iraqi detainees. It revealed that army officers had ignored a 1972 ban on hooding, stressing, sleep deprivation, food deprivation and noise. (The Guardian 28/3/08)

2.2.6 Iraqi refugees throughout the region have become increasingly desperate. Despite a decline in violence in the second half of 2007, only a small number have gone home, often because their resources are exhausted. Of those who returned to Iraq, many found their property occupied and suffered secondary displacement.

UNHCR estimates more than 4.5 million Iraqis have left their homes, many in dire need of humanitarian care. Of these, more than 2.5 million Iraqis are displaced internally, while more than 2 million have fled to neighbouring states, particularly Syria and Jordan. Many were displaced prior to 2003, but the largest number has fled since. In 2006, Iraqis became the leading nationality seeking asylum in Europe (United Nations High Commissioner for Refugees 2008a).

2.2.7 A UNHCR commissioned survey of trauma among Iraqi refugees indicates widespread depression and anxiety among those interviewed. Final results of the study of 754 refugees in Syria "highlight the fact that many of the Iraqi refugees that come to us are suffering from depression, anxiety and post-traumatic stress disorder." He added that "this affects every aspect of their lives. We have seen countless marriages that have not survived this stress, children that no longer attend school and people that find it increasingly difficult to cope with life."

The survey showed that every single person interviewed reported experiencing at least one traumatic event in Iraq. UNHCR estimates that one in five of those registered with the agency in Syria since January last year – more than 19,000 individuals – are classified as "victims of torture and/or violence" in Iraq. The survey showed that depression and anxiety are highly prevalent – 89 percent and 82 respectively. This is linked to terrors endured before they fled Iraq – 77 percent of those interviewed reported being affected by air bombardments and shelling or rocket attacks. Eighty percent reported witnessing a shooting. Sixty-eight percent said they experienced interrogation or harassment by militias or other groups, including receiving death threats, while 16 percent said they had been tortured. Seventy-two

percent were eyewitnesses to a car bombing and 75 percent said they knew someone who had been killed. The report highlighted the many forms of torture suffered by Iraqi refugees, including beatings, electric shocks, objects being placed under fingernails, burns and rape. Most instances of torture were perpetrated by members of militia groups at 69 percent. (United Nations High Commissioner for Refugees 2008b).

In 2006 a study of 1090 adolescents from eight secondary schools in Mosul showed that 30% of girls and 26% of boys had symptoms of post traumatic stress disorder. 92% of the ill adolescents had not received any treatment (Razokhi 2006) .

2.2.8 The mass movement of families - including tens of thousands of children is the largest ever seen in the Middle East since 1948. Iraqis continue to face insecurity and danger and as always in a conflict situation it's children and their mothers who are the most vulnerable. Many children have lost their fathers to relentless and horrific violence and huge numbers of women are widowed facing an uncertain future trying to provide for their children. Children are being forced to leave school to find a job to assist their families. Far too little has been done to address the heightened vulnerability of Iraq's children caught up in this massive displacement (Save the Children 2008).

Lack of prewar planning was responsible for the loss of control over public order and the rehabilitation of public services

2.2.9 Invading Iraq without UN approval meant those who knew most about postwar health planning were mostly excluded from it in those early, critical months. There was no meaningful debate, and full Iraqi participation was lacking. The bombing of the UN’s Baghdad headquarters in 2003 triggered the withdrawal of most UN development personnel. Iraqis had little opportunity to influence the future of their health services and the enforced sacking of Ba’ath party members removed many health experts from senior posts, so that clear and consistent leadership was lacking. (Medact 2008)

2.2.10. In April 2004, after a weekend in which rockets, helicopter attacks and shootings left dozens of Iraqis dead, 52 retired British diplomats, most of them career specialists on the Middle East, wrote an open letter to Prime Minister Blair deploring Britain's lack of proper prewar analysis. “The conduct of the war in Iraq has made it clear that there was no effective plan for the post-Saddam settlement. All those with experience of the area predicted that the occupation of Iraq by the coalition forces would meet serious and stubborn resistance, as has proved to be the case. To describe the resistance as led by terrorists, fanatics and foreigners is neither convincing nor helpful. Policy must take account of the nature and history of Iraq, the most complex country in the region” (The Guardian 27/4/04)

2.2.11 The occupation did not stumble because of a lack of prewar planning. The occupation was doomed from the start. No matter how efficient, sensitive, generous and intelligent the Coalition Provisional Authority had been, it could not have succeeded. Occupations are inherently humiliating. People prefer to run their own affairs; they resent foreigners taking over their country.

The British government got almost everything wrong before the war. A senior Foreign Office official, who saw the few papers that were written about the invasion's likely consequences, told me: "The basic assumption that turned out to be false was that Iraqis felt themselves more Iraqi than Sunni or Shia." Clare Short, the secretary of state for international department who resigned from the government shortly after the invasion, stated that the cabinet had only informal prewar discussions on Iraq. “There were never any papers or proper analysis of the underlying dangers and the political, diplomatic and military options. The whole crisis was handled by Tony Blair and his entourage with considerable informality”.

Peter Hain (cabinet member) confirmed that the cabinet saw no papers on postwar Iraq. “In Iraq the failures of covert intelligence were compounded by the absence of political intelligence: a comprehensive lack of the understanding of sectarian forces and fault lines present across the country” he has said (The Guardian 21/1/08).

2.2.12 Health policy formulation in post-conflict settings should follow some key principles :-

Preparedness: create flexible plans based on local knowledge and understanding of previous policy, to give direction and clarity in the confused postconflict situation;

Relief and recovery: provide immediate relief, and simultaneously plan for longer-term needs and capacity-building;

Participation: fully involve in-country leaders at all levels, in partnership with humanitarian organizations;

Incrementalism: introduce agreed changes at a speed the system can absorb.

These principles were generally ignored in Iraq, with tragic consequences. (Medact 2008)

2.2.13 The British envoy who ran southern Iraq after Saddam fell, complained of a lack of planning and support. Hardly any Whitehall departments got involved with Iraq. There was none of the mobilising of the government machine – with cabinet committees, ministers and individuals nominated to deal with specific tasks, and taskforces – such as happened during the second world war in anticipation of victory. Instead, there was an ad hoc cabinet committee, where both chairmanship and participants changed. The US's early decisions to disband the Iraqi army and implement a de Ba’athification programme that in effect eliminated the top four levels of management in all state-owned enterprises left “an infant bureaucracy, set up from nothing, attempting to run an entire country of more than 25m people (Sunday Times Review, 2/3/08) ”.

2.2.14 Human Rights Watch charged British authorities with failing to plan for or provide adequate forces to carry out their international legal obligation as the occupying power. Eight weeks after entering, Basra's citizens remain fearful for their lives and property (Human Rights Watch 2003).

6. Violations of obligations under the Covenant

The right to the highest attainable standard of health of the Iraqi people has been violated under **paragraph 39** of General Comment 14, in that the UK has failed to comply with Article 12

during the invasion which violates the UN Charter, and the occupation that violates health related aspects of the Geneva Conventions. Further, the UK not only failed to discourage the allies from illegally invading Iraq but positively promoted the illegal invasion against the expressed wishes of many members of the Security Council. Lastly , there is no evidence the the UK tried to discourage their allies from violating those Geneva Conventions which have had such a damaging effect on the health and healthcare infrastructure of the Iraqi people.

The right to the highest attainable standard of health of the Iraqi people has been violated under **paragraph 9** of General Comment 14, in that the illegal invasion and violations of the Geneva Conventions have prevented the Iraqi people from enjoying the variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health

The right to the highest attainable standard of health of the Iraqi people has been violated under **paragraph 50** of General Comment 14, in that the UK has violated its obligation to respect laws that when contravened are likely to result in bodily harm, unnecessary morbidity and preventable mortality. These include the the violation of the UN Charter leading to the invasion of Iraq, and violations of those articles of the Geneva Conventions that provide the facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

The right to the highest attainable standard of health of the Iraqi people has been violated under **paragraph 51** of General Comment 14 in that violations of the obligation to protect follow failure of the UK to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. These include violations of those sections of the Geneva Conventions that provide protection of the people from injury and death, and protection of the facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

The right to the highest attainable standard of health of the Iraqi people has been violated under **paragraph 52** of General Comment 14 due to violations of the obligation to fulfil which have occurred through the failure of the UK to take all necessary steps to ensure the realization of the right to health. These include violations of those sections of the Geneva Conventions that provide the facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

7. Recommendations

Given the obligations engendered by ratification of the Covenant over effective mechanisms of accountability, the Government should be asked when a comprehensive independent public inquiry will take place into the events that led to the invasion, the preparation for the occupation and the occupation itself.

The Government should be asked what resources and by what measures it is providing assistance to the Government of Iraq for the reconstruction and maintenance of the Iraqi health services.

Appendix

Additional evidence is presented showing that **2.3** - the British Government made a calculated effort to inflate the danger in order to justify possible military action, **2.4** - the war against Iraq was prosecuted against the wishes of the majority of the UK population and **2.5** - the war against Iraq has significantly increased the risk of actual and potential violations of the right to the highest attainable standard of health elsewhere in the world.

2.3.0 The British Government misled over the reasons for going to war

The Butler inquiry (Butler Inquiry 2004) which reviewed intelligence on weapons of mass destruction, criticised the information made available in the so-called dossier (The dossier 2002) to the general public and to the British Members of Parliament - a majority of whom voted in support of the invasion of Iraq - as inaccurate and misleading (Butler Inquiry 2004a).

2.3.1 The intelligence upon which the decision to prosecute the war was made was derived from five single sources, three of which proved unreliable, while the two remaining were less worrying than the rest with regard to Iraqi chemical and biological weapons capabilities (Butler Inquiry 2004b).

2.3.2 The report concluded that it was a serious weakness that the Joint Intelligence Committee warnings on the limitations of the intelligence underlying its judgments were not made sufficiently clear in the dossier (Butler Inquiry 2004c).

2.3.3 The Butler report noted that, despite its importance to the determination of whether Iraq was in further material breach of its obligations under Resolution 1441, the Joint Intelligence Committee made no further assessment of the Iraqi declaration beyond its 'Initial Assessment' provided on 18 December 2002. The report also recorded its surprise that policy-makers and the intelligence community did not, as the generally negative results of Unmovic inspections became increasingly apparent, re-evaluate in early 2003 the quality of the intelligence (Butler Inquiry 2004d).

2.3.4 The Hutton Enquiry report states "that the possibility cannot be completely ruled out that the desire of the Prime Minister to have a dossier which, whilst consistent with the available intelligence, was as strong as possible in relation to the threat posed by Saddam Hussein's Weapons of Mass Destruction, may have subconsciously influenced the Joint Intelligence Committee to make the wording of the dossier somewhat stronger than it would have been if it had been contained in a normal Joint Intelligence Committee assessment (Ministry of Justice 2004) .

2.3.5 The dossier was presented to the British Parliament on September 24, 2002 by Prime Minister Blair, who claimed that it represented the disclosure of Joint Intelligence Committee assessments. In fact, few of the dossier's claims were set out in the same terms as the Joint Intelligence Committee's assessments (Butler Inquiry 2004e).

2.3.6 When using the dossier to make his case for war, Prime Minister Blair misled when he presented the intelligence behind it as "extensive, detailed and authoritative." (Butler Inquiry

2004f). In his foreword he claimed that the "assessed intelligence" had "established beyond doubt" that Saddam had continued to produce chemical and biological weapons and continued in his efforts to develop nuclear weapons (The dossier 2002).

2.3.7 The dossier's claim that Iraq's military could deploy weapons of mass destruction within 45 minutes of an order to do so, is the most controversial and notorious of all the claims. It is now known that the 45 minutes claim based on a single source; was included later in the process, after the government's spin doctors got involved; that in the formal Joint Intelligence Committee paper it was made clear that the intelligence was believed to relate to battlefield "munitions" rather than long range weapons of mass destruction; and that the prominence given to it in the dossier - and particularly its status as a judgement - was bitterly disputed from within the "intelligence community" at the time; and that it was withdrawn by SIS/MI6 in July 2003. (Butler Inquiry 2004g).

2.3.8 Prime Minister Blair told the House of Commons that Saddam had "existing and active military plans for the use of chemical and biological weapons…including against his own Shia population." The Joint Intelligence Committee had actually only stated that it was possible that Saddam would use Weapons of Mass Destruction against a Shia uprising (Butler Inquiry 2004h).

2.3.9 Prime Minister Blair told the Commons that UN inspectors had "discovered that Iraq was trying to acquire mobile biological weapons facilities, which of course are easier to conceal. Present intelligence confirms that it has now got such facilities." The UN inspectors had not discovered that Iraq was trying to acquire these facilities but that it had considered developing them well before the 1991 Gulf war and therefore before the inspectors' arrival. The intelligence only indicated that Iraq had developed mobile fermentation systems that could produce biological weapons agent (Butler Inquiry 2004i) .

2.3.10 Prime Minister Blair told the House of Commons that "if he were able to purchase fissile matériel illegally, it would be only a year or two before Saddam acquires a usable nuclear weapon." In fact no formal assessment had been made of the time within which the acquisition of suitable fissile material from abroad could result in the production of a nuclear weapon, other than that it would be shorter than five years (Butler Inquiry 2004j).

<u>Defying the wishes of the public</u>

2.4.0 In going to war against Iraq, Prime Minister Blair was defying the UK public's wishes.

2.4.1 On February 15, 2003 around one million people anti-war protesters march through the British capital to hear speakers address the crowds in Hyde Park, in what is the UK's biggest-ever protest (Guardian 2003a).

2.4.2 In Britain's biggest parliamentary revolt against a governing party in more than a century, 121 Labour MPs vote against Prime Minister Blair's war strategy at the end of a debate on Iraq (Guardian 2003a).

2.4.4 75% of people in Britain would be prepared to support British troops joining any American led military action against Iraq; however, this support is conditional both on UN inspectors finding proof that Iraq is trying to hide weapons of mass destruction, and on the UN Security

Council voting in favour of military action. In the absence of these two conditions, only a quarter (24%) would support British involvement, and opposition rises from 18% to 67%. But opposition falls to two in five (41%) if the inspectors do find evidence that Iraq is hiding weapons of mass destruction — even if the UN still does not vote in favour of action (BBC News online 2003).

Significantly increased risk of violations of right to the highest attainable standard of health elsewhere in the world

2.5.0 The war against Iraq has significantly increased the risk of actual and potential violations of the right to the highest attainable standard of health elsewhere in the world

2.5.1 The war in Iraq has fostered terrorism worldwide. An investigation by *The Independent*, culling four Arabic-language newspapers, official Iraqi statistics, two Beirut news agencies and Western reports, shows that 1,121 Muslim suicide bombers have blown themselves up in Iraq. This is a conservative figure and – given the propensity to report only those suicide bombings that kill dozens of people – the true estimate may be double this number. On several days, six – even nine – suicide bombers have exploded themselves in Iraq.

Suicide bombers in Iraq have killed at least 13,000 men, women and children – our most conservative estimate gives a total figure of 13,132 – and wounded a minimum of 16,112 people. For 529 of the suicide bombings in Iraq, no figures for wounded are available. The killers' ability to terrorise civilians, militiamen and Western troops and mercenaries is incalculable.

The "cult" of the suicide bomber has seeped across national frontiers. Within a year of the Iraqi invasion, Afghan Taliban bombers were blowing themselves up alongside Western troops or bases in Helmand province and in the capital Kabul. The practice leached into Pakistan, striking down thousands of troops and civilians, killing even the principal opposition leader, Benazir Bhutto. The London Tube and bus bombings – despite the denials of Prime Minister Blair – were obviously deeply influenced by events in Iraq (Fisk 2008)

2.5.2 In November of 2006, the U.N. Security Council warned that Afghanistan may become a failed state due to increased Taliban violence, growing illegal drug production, and fragile State institutions. From 2005 to 2006, the number of suicide attacks, direct fire attacks, and improvised explosive devices all increased. While the campaign in Afghanistan successfully unseated the Taliban from power, the country could relapse into conflict again without international support (United Nations 2006).

2.5.3 The invasion of Iraq violated the spirit of international law by defying the expressed views of the Security Council, and many impartial observers including the UN Secretary General insist the invasion was illegal. Additionally, the failure to implement a secure occupation so abject that it has resulted in civil war, amounts to a war crime. Now the impunity those responsible expect to enjoy leaves the world in greater peril by encouraging copycat preemptive strikes—Pakistan and India, both nuclear powers, come to mind (Hall 2007)

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