International Review of the Red Cross (2026), 1–45.
doi:10.1017/S1816383126101271

IRRC

Supporting mental health in post-conflict situations: Examining the intersection of human rights obligations and victim assistance frameworks

Emily Camins*
Lecturer, University of Western Australia Law School, Perth, Australia
Email: emily.camins@uwa.edu.au

Abstract

The mental health and psychosocial needs of victims of armed conflict remain inadequately addressed in international law, despite growing recognition of their significance.

* The author is grateful to Fiona McGaughey, Genevieve Wilkinson and the editorial team and anonymous reviewers at the *Review*, whose rigorous feedback prompted valuable revisions of the article. Any errors remain the author's alone.

More than one in five people living in post-conflict settings will develop a mental health condition, yet demand for mental health and psychosocial support (MHPSS) frequently outstrips supply. This article examines the intersection between human rights law and victim assistance regimes in disarmament treaties, exploring how the latter could strengthen international legal and policy responses to post-conflict mental health needs. Though it has conceptual and implementation gaps, Article 12 of the International Covenant on Economic, Social and Cultural Rights provides a doctrinal foundation for mental health care; building on this foundation, victim assistance models include features such as explicit prioritization of MHPSS, practical implementation frameworks, and clearer international assistance obligations. These features could inform the development and implementation of the right to health, offering particularity that, if extended beyond specific weapons victims, has the potential to benefit wider post-conflict populations.

Keywords: mental health and psychosocial support, post-conflict, international human rights law, victim assistance, minimum core obligations.

Introduction

The mental health and psychosocial needs of victims and survivors of armed conflict remain inadequately addressed, despite growing recognition of their significance.[1] According to the World Health Organization (WHO), rates of mental health conditions more than double in conflict-affected populations.[2] More than one in five people living in post-conflict settings will develop a mental health condition,[3] and many more suffer from "inextricably interlinked" psychosocial difficulties.[4] Marginalized and vulnerable people are at particular risk.[5] Unmet mental health and

1 33rd International Conference of the Red Cross and Red Crescent (International Conference), Res. 2, "Addressing Mental Health and Psychosocial Needs of People Affected by Armed Conflicts, Natural Disasters and Other Emergencies", 9–12 December 2019.

2 Mark van Ommeren, "Mental Health Conditions in Conflict Situations Are Much More Widespread than We Thought", *WHO Newsroom*, 11 June 2019, available at: www.who.int/news-room/commentaries/detail/mental-health-conditions-in-conflict-situations-are-much-more-widespread-than-we-thought (all internet references were accessed in April 2026). See also Fiona Charlson *et al.*, "New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis", *The Lancet*, Vol. 394, No. 10194, 2019; WHO, "Mental Health in Emergencies", *WHO Newsroom*, 6 May 2025, available at: www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies.

3 F. Charlson *et al.*, above note 2. See also Inka Weissbecker, "Mental Health as a Human Right in the Context of Recovery after Disaster and Conflict", *Counselling Psychology Quarterly*, Vol. 22, No. 1, 2009, p. 77; Sarah Miller, "Mental Health and the Law: What Else is Needed for Particularly Vulnerable Contexts Facing Armed Conflict and Development Obstacles?", *International Review of the Red Cross*, Vol. 105, No. 922, 2023, p. 435.

4 ICRC, *Guidelines on Mental Health and Psychosocial Support*, Geneva, March 2018, pp. 8–9, available at: www.icrc.org/en/publication/4311-guidelines-mental-health-and-psychosocial-support.

5 United Nations Human Rights Council (UNHRC), Final Research-Based Report of the Human Rights Council Advisory Committee on Best Practices and Main Challenges in the Promotion and Protection of Human Rights in Post-Disaster and Post-Conflict Situations, UN Doc. A/HRC/28/76, 10 February 2015,

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

psychosocial needs lead to an increase in substance use and suicide, impact cognitive functionality, livelihood and educational opportunities, and negatively influence the physical health and life expectancy of affected people.[6] They can also have long-term and far-reaching consequences for entire communities and societies, leading to further violence, inequality and social disruption.[7] Through the 2019 International Conference of the Red Cross and Red Crescent (International Conference), the international community has "[expressed] deep concern about these unmet mental health and psychosocial needs [of people affected by armed conflict], stressing the urgent demand for increased efforts in prevention, promotion, protection and assistance".[8] Despite such calls to action, however, the response remains inadequate to meet the needs of victims of armed conflict.[9]

There is an increasing understanding that these needs extend beyond diagnosed mental health conditions to encompass broader psychological and psychosocial concerns. According to the International Committee of the Red Cross (ICRC), the term "mental health" is used to denote psychological well-being, while "psychosocial" refers to the "interconnection between the individual and their environment, interpersonal relationships, community and/or culture (i.e. their social context)".[10] The incidence of both mental health and psychosocial problems increases significantly during armed conflict.[11] Addressing these needs requires a tailored and holistic approach ranging from mental health interventions to psychosocial support, and operationally includes "a range of social activities designed to foster

---

para. 83; I. Weissbecker, above note 3, p. 81; Katherine H. A. Footer and Leonard S. Rubenstein, "A Human Rights Approach to Health Care in Conflict", International Review of the Red Cross, Vol. 95, No. 889, 2013, p. 169.

6 I. Weissbecker, above note 3, p. 77; S. Miller, above note 3.

7 International Red Cross and Red Crescent Movement, Addressing Mental Health and Psychosocial Needs of People Affected by Armed Conflicts, Natural Disasters and Other Emergencies: Background Document, Doc. No. 33IC/19/12.2, 33rd International Conference, June 2019; Dieudonne Bwirire, Rik Crutzen, Edmond Ntabe Namegabe, Rianne Letschert and Nanne de Vries, "Health Inequalities in Post-Conflict Settings: A Systematic Review", PLoS One, Vol. 17, No. 3, 2022; Sonal Singh, James J. Orbinski and Edward J. Mills, "A Paradigm Shift in Global Health and Human Rights", Conflict and Health, Vol. 1, 2007, p. 1; Sanam Naraghi Anderlini and Judy El-Bushra, "Post Conflict Reconstruction", in International Alert and Women Waging Peace, Inclusive Security, Sustainable Peace: A Toolkit for Advocacy and Action, updated ed., Hunt Alternatives Fund and International Alert, London, 2007, p. 51; S. Miller, above note 3, p. 436.

8 33rd International Conference, above note 1. See also UNGA Res. 77/300, "Mental Health and Psychosocial Support", 26 June 2023, para. 2; UN, "With Highest Number of Violent Conflicts Since Second World War, United Nations Must Rethink Efforts to Achieve, Sustain Peace, Speakers Tell Security Council", 26 January 2023, available at: https://press.un.org/en/2023/sc15184.doc.htm; WHO, "Resolution: Strengthening Mental Health and Psychosocial Support Before, During and After Armed Conflicts, Natural and Human-Caused Disasters and Health and Other Emergencies", 77th World Health Assembly Session, Agenda Item 11.2, UN Doc. A77/A/CONF./11, 28 May 2024.

9 This article primarily uses "victim", the term employed in relevant international legal instruments, while acknowledging the preference of many individuals for "victim/survivor" or "survivor" and the ongoing terminological debate. See Wouter Vandenhole, Gamze Erdem Türkelli and Sara Lembrechts, *Children's Rights: A Commentary on the Convention on the Rights of the Child and Its Protocols*, 2nd ed., Edward Elgar, Cheltenham, 2024, pp. 430–431.

10 ICRC, above note 4, p. 8.

11 *Ibid.*, p. 8. See also ICRC, "Mental Health and Psychosocial Support", Geneva, 2016, pp. 2–14, available at: www.icrc.org/sites/default/files/topic/file_plus_list/4174_002_mental-health_web.pdf (noting that people affected by armed conflict might suffer from depression, anxiety, feelings of desperation, conflicts

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

psychological improvement, such as sharing experiences, fostering social support, awareness-raising and psychoeducation".[12] While the ICRC and other organizations aim to provide such support, the needs often far outweigh the response capacity.[13]

This gap invites questions about the role of international law in protecting the mental health and psychosocial needs of victims of armed conflict. Armed conflict is regulated, first and foremost, by international humanitarian law (IHL).[14] However, the obligations established by IHL in respect of mental health are limited, particularly in post-conflict situations (that is, immediately after a conflict ends).[15] Under core IHL treaties and customary IHL, States are required to respect and protect the wounded and sick regardless of nationality, treat them humanely and, "to the fullest extent practicable", provide them with the medical care and attention their condition requires.[16] This obligation extends to mental health care; Article 8(a) of Additional Protocol I (AP I) defines the "wounded" and "sick" as "persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care".[17]

Despite these medical care obligations, IHL's approach to mental health remains limited in two key respects. First, while IHL requires medical treatment for wounded and sick persons with mental disorders or disabilities, it has traditionally treated broader mental health and psychological impacts as inevitable consequences of armed conflict.[18] The provision of psychosocial support (as opposed to medical

within families, somatization and psychosomatic problems, guilt, shame, stigma, fear, anger, aggression, rejection, problems with social reintegration, acute stress, vicarious trauma, problems of self-image, lack of independence, social challenges and damage to self-concept); Leonard S. Rubenstein, *Post-Conflict Health Reconstruction: New Foundations for US Policy*, United States Institute of Peace, Washington, DC, September, 2009, pp. 14–16, available at: www.usip.org/sites/default/files/post-conflict_health_reconstruction_0.pdf.

12 ICRC, above note 4, p. 8; ICRC, above note 11.

13 ICRC, above note 4, p. 8; 33rd International Conference, above note 1, Preamble (expressing deep concern about the unmet mental health and psychosocial needs of people affected by armed conflict, and underscoring the urgent demand to increase efforts to respond to them).

14 On IHL as lex specialis in armed conflict, see International Law Commission, Draft Articles on the Effects of Armed Conflicts on Treaties, with Commentaries, in Yearbook of the International Law Commission, Vol. 2, Part 2, 2011.

15 UNHRC, above note 5, para. 7.

16 Protocol Additional (I) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3, 8 June 1977 (entered into force 7 December 1978) (AP I), Art. 10; Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law*, Vol. 1: *Rules*, Cambridge University Press, Cambridge, 2005, Rule 110, available at: https://ihl-databases.icrc.org/en/customary-ihl/rules.

17 In addition, States are also under a negative obligation not to endanger "by any unjustified act or omission" the mental health and integrity of persons in the power of an adverse party or deprived of liberty as a result of an international armed conflict: AP I, Art. 11(1). See also Giulia Bosi, "Six Ways IHL Protects Mental Health", *Humanitarian Law and Policy Blog*, 16 October 2025, available at: https://blogs.icrc.org/app/uploads/sites/102/2025/10/six-ways-ihl-protects-mental-health.pdf; Janet E. Lord, "Accounting for Disability in International Humanitarian Law", *International Review of the Red Cross*, Vol. 105, No. 922, 2022, p. 60 (noting the "narrow" disability narrative in IHL).

18 See ICRC, International Humanitarian Law and the Challenges of Contemporary Armed Conflicts: Recommitting to Protection in Armed Conflict on the 70th Anniversary of the Geneva Conventions, Geneva, 2019, p. 17, available at: www.icrc.org/sites/default/files/document/file_list/challenges-report_urbanization-of-armed-conflicts.pdf.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

assistance or care), for example, is not explicitly mandated in core IHL treaties.[19] Second, IHL's scope is generally limited to armed conflict, as opposed to post-conflict situations.[20] While protected persons in the hands of the enemy continue to receive protection until their final release and repatriation,[21] this does not address the needs of conflict-affected and post-conflict populations more broadly. In light of these limitations, analysis of the adequacy of the international legal framework should extend beyond the core IHL treaties to other relevant instruments.

To this end, the present article examines the intersection between international human rights law (IHRL) and victim assistance regimes in IHL disarmament treaties in addressing mental health and psychosocial needs in post-conflict situations. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which sets out "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" ("right to health"),[22] provides an important foundation for the right to mental health. However, its overall normative content remains vague and contested,[23] and mental health has historically been neglected within the right to health framework;[24] to the extent that it has been considered, a reductionist biomedical – as opposed to holistic – paradigm has been preferred.[25] Moreover, because this right is subject to progressive realization,[26] its implementation in resource-strained post-conflict settings presents particular challenges, making it difficult to distinguish between a State's unwillingness to fulfil obligations and its inability to do so.[27] To address these challenges and "ensure the satisfaction of, at the very least, minimum essential levels of each of the rights" established in the ICESCR, the Committee on Economic, Social and Cultural Rights

19 Cf. Statutes of the International Red Cross and Red Crescent Movement, 1986 (amended 1995 and 2006) (Statutes of the Movement), Art. 5(2)(d), (3), (4)(b), (5), (6) (setting out the broad humanitarian role of the ICRC).

20 See e.g. AP I, Art. 1; Marko Milanovic, "The End of Application of International Humanitarian Law", *International Review of the Red Cross*, Vol. 96, No. 893, 2014, p. 170.

21 See Geneva Convention (III) relative to the Treatment of Prisoners of War of 12 August 1949, 75 UNTS 135 (entered into force 21 October 1950), Art. 5; AP I, Arts 3(b), 75(6). Such obligations are frequently neglected: see Christian Cardon, Thomas de Saint Maurice and Kelisiana Thynne, "Aftermath of Battles and Conflict: From Challenges to Solutions", *Humanitarian Law and Policy Blog*, 13 September 2022, available at: https://blogs.icrc.org/law-and-policy/2022/09/13/aftermath-battles-conflict-challenges-solutions/.

22 International Covenant on Economic, Social and Cultural Rights, 993 UNTS 3, 16 December 1966 (entered into force 3 January 1976) (ICESCR).

23 John Tobin, *The Right to Health in International Law*, Oxford University Press, Oxford, 2012, p. 5; Judith Bueno de Mesquita, Claire Lougarre and Sharifah Sekalala, "Lodestar in the Time of Coronavirus? Interpreting International Obligations to Realise the Right to Health during the COVID-19 Pandemic", *Human Rights Law Review*, Vol. 23, No. 1, 2023, p. 3 (describing Article 12 as "infamously" vague).

24 Dainius Pūras, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. A/HRC/35/21, 28 March 2017, para. 6 (noting the relative under-investment in mental health vis-à-vis physical health, and the "isolation and abandonment" of mental health); Dainius Pūras, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. A/75/163, 16 July 2020, paras 31, 78, 81.

25 D. Pūras, UN Doc. A/HRC/35/21, above note 24, paras 6, 8.

26 ICESCR, above note 22, Art. 2.

27 Gilles Giacca, *Economic, Social, and Cultural Rights in Armed Conflict*, Oxford University Press, Oxford, 2014, p. 20.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

(CESCR) has identified minimum core obligations applicable in all settings.[28] These minimum core obligations, while subject to varying interpretations,[29] likely include some level of mental health care;[30] however, as will be argued, whether they include broader psychosocial support is, at best, unclear, given the focus of the core obligations on "minimum essential levels" of economic, social and cultural (ESC) rights.[31] Moreover, while minimum core obligations persist in the face of resource challenges,[32] in practice, post-conflict resource constraints make it challenging to meet even these obligations, highlighting the need for stronger supports for populations in post-conflict situations. These factors reveal both conceptual and implementation weaknesses in existing legal frameworks for mental health protection in post-conflict settings, where needs are especially acute.

Victim assistance regimes found in IHL disarmament treaties such as the Convention on Cluster Munitions (CCM)[33] and the Treaty on the Prohibition of Nuclear Weapons (TPNW)[34] provide useful models for comparison, particularizing mental health and social inclusion obligations and setting out international assistance duties. The CCM, for example, requires States Parties to "adequately provide age- and gender-sensitive assistance, including medical care, rehabilitation and psychological support".[35] It also sets out specific measures that States must take to fulfil these obligations, including assessing victims' needs, developing policies and budgets, and establishing national focal points.[36] This article considers whether victim assistance regimes offer useful insights for the development and implementation of IHRL obligations in respect of mental health and psychosocial needs post-conflict. It

28 CESCR, General Comment No. 3, "The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)", UN Doc. E/1991/23, 14 December 1990 (General Comment No. 3), para. 10. For scholarly criticism of this approach, see Katharine G. Young, "The Minimum Core of Economic and Social Rights: A Concept in Search of Content", *Yale Journal of International Law*, Vol. 33, No. 1, 2008, pp. 114, 139 (noting both the lack of consensus in respect of the minimum core and the risks of defining a minimum); Amrei Müller, "The Minimum Core Approach to the Right to Health: Progress and Remaining Challenges", in Sabine Klotz, Heiner Bielefeldt, Martina Schmidhuber and Andreas Frewer (eds), *Healthcare as a Human Rights Issue: Normative Profile, Conflicts and Implementation*, Transcript Verlag, Bielefeld, 2017, pp. 63–64; G. Giacca, above note 27, pp. 67–68 (noting the lack of treaty foundation for the concept); J. Tobin, above note 23; John Tasioulas, *The Minimum Core of the Human Right to Health*, World Bank, October 2017, pp. 7–8, available at: https://documents1.worldbank.org/curated/en/194751515587192833/pdf/122561-WP-Tasioulas-PUBLIC.pdf.

29 K. G. Young, above note 28, pp. 116, 123, 138; A. Müller, above note 28, p. 63.

30 See e.g. CESCR, General Comment No. 14, "The Right to the Highest Attainable Standard of Health (Article 12 of the ICESCR)", UN Doc. E/C.12/2000/4, 11 August 2000 (General Comment No. 14), para. 43(a).

31 See *ibid.*, para. 43; General Comment No. 3, above note 28, para. 10. See also the discussion below at notes 101–110.

32 General Comment No. 14, above note 30, para. 47 (noting that a State cannot use resource constraints to justify non-compliance with core obligations, which are non-derogable); cf. General Comment No. 3, above note 28, paras 10–11.

33 Convention on Cluster Munitions, 2688 UNTS 39, 30 May 2008 (entered into force 1 August 2010) (CCM).

34 Treaty on the Prohibition of Nuclear Weapons, UN Doc. A/CONF.229/2017/8, 7 July 2017 (entered into force 22 January 2021) (TPNW).

35 CCM, above note 33, Art. 5(1).

36 *Ibid.*, Art. 5(2).

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

argues that, while the right to health under the ICESCR provides a doctrinal foundation for mental health support, victim assistance models offer particularization and practical mechanisms that could strengthen the international legal response.

The article proceeds in three substantive parts. First, it sets out the right to health under IHRL, considering the content and scope of obligations that relate to mental health and psychosocial needs in post-conflict situations. It focuses, in particular, on Article 12 of the ICESCR given its general application, while also considering key provisions of the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Second, it explores key practical challenges in applying the right to health in post-conflict situations, particularly in relation to mental health and psychosocial factors. Third, in light of these limitations, it examines the key features of victim assistance regimes that could aid in the interpretation, implementation or development of the right to (mental) health.

The right to (mental) health under international human rights law

This analysis will focus first on the right to health under Article 12 of the ICESCR and how it has been interpreted by the CESCR,[37] before considering particularized regimes under the CRPD, the CRC and CEDAW. While there is a degree of artificiality to separating the right to health from other ESC rights given that human rights are "interdependent, indivisible and interrelated",[38] many of the challenges that apply to the application and implementation of the right to health also hinder the fulfilment of other ESC rights post-conflict.[39]

General obligation under Article 12

This section considers the content of the right to health under ICESCR Article 12 in broad terms, before examining the obligations related to mental health in particular.

Key provisions and concepts

Article 12(1) of the ICESCR provides: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard

37 The ICESCR has 173 States Parties. On the broad scope and high level of acceptance of the ICESCR, see G. Giacca, above note 27, p. 18.

38 Office of the United Nations High Commissioner for Human Rights (UN Human Rights), "The Right to Health", Fact Sheet No. 31, UN Human Rights and WHO, June 2008, p. 6, available at: www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf; see also General Comment No. 14, above note 30, para. 3.

39 G. Giacca, above note 27.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

of physical and mental health."[40] To achieve the full realization of this right, Article 12(2) requires States Parties to, among other measures, take the necessary steps for the "prevention, treatment and control of epidemic, endemic, occupational and other diseases"[41] and "the creation of conditions which would assure to all medical service and medical attention in the event of sickness".[42] As the CESCR's General Comment No. 14 notes, the right to health under Article 12 extends beyond the right to health care to include underlying determinants of health, such as safe water and food, adequate housing, good working conditions, and gender equity.[43] It does not entail a "right to be *healthy*",[44] nor go so far as to require States Parties to guarantee the health of all citizens;[45] rather, Article 12 has been interpreted as imposing on governments a duty to take specific steps to protect and promote health.[46]

As with other ICESCR obligations, States are required to respect, protect and fulfil the right to health under Article 12.[47] The obligation to fulfil, which requires States to adopt legislative, administrative, budgetary and other measures towards the full realization of the right,[48] is of particular relevance in the present context, which is concerned primarily with States' positive duties to assist people with mental health and psychosocial needs post-conflict. To this end, General Comment No. 14 states that the obligation to fulfil the right to health requires States to take positive measures to enable individuals to enjoy that right.[49] It includes "actions that create, maintain and restore the health of the population", such as fostering research, ensuring culturally appropriate training, disseminating appropriate health information and helping people to make informed health choices.[50] The CESCR has, moreover, drawn attention to gross inequalities in health status globally and has exhorted States parties to cooperate internationally with a view to fully realizing the right to health,[51] including through seeking assistance.[52]

40 ICESCR, above note 22, Art. 12(1).

41 *Ibid.*, Art. 12(2)(c).

42 *Ibid.*, Art. 12(2)(d).

43 General Comment No. 14, above note 30, paras 4, 9, 10; see also UN Human Rights, above note 38.

44 General Comment No. 14, above note 30, para. 8 (emphasis in original); Eric Rosenthal and Clarence J. Sundram, *The Role of International Human Rights in Mental Health Legislation*, WHO, Geneva, 2004, p. 27, available at: www.accessible-techcomm.org/wp-content/uploads/intl_rights_in_national_mental_health_legislation.pdf.

45 E. Rosenthal and C. J. Sundram, above note 44, p. 27.

46 General Comment No. 14, above note 30, paras 30, 33, 36–37; E. Rosenthal and C. J. Sundram, above note 44, p. 27.

47 General Comment No. 14, above note 30, paras 33, 36.

48 *Ibid.*, paras 33, 36.

49 *Ibid.*, para. 37.

50 *Ibid.*, para. 37.

51 *Ibid.*, para. 38.

52 General Comment No. 3, above note 28, para. 13.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

Mental health under Article 12 of the ICESCR

Article 12 explicitly refers to the right to the highest attainable standard of health,[53] and requires States to take steps to prevent and treat disease and to create conditions that would assure medical services in the event of sickness.[54] In accordance with the rules of treaty interpretation, which require treaty terms to be given their ordinary meaning in their context and in light of their object and purpose,[55] it is apparent that the references to "disease" and "sickness" would include mental disorder or illness. The term "disease" ordinarily includes anxiety disorders, depression, insomnia disorder, bipolar disorder, post-traumatic stress disorder and schizophrenia;[56] similarly, as the CESCR has noted in respect of Article 12(2)(d), "sickness" may be either physical or mental.[57] Accordingly, under Article 12(2)(c), States must take steps to prevent, treat and control mental disorders, at least to the extent that they may be classified as diseases. Pursuant to Article 12(2)(d), States must create conditions for assuring medical service and medical attention in the event of sickness.[58] The CESCR interprets this clause as including

> provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and *appropriate mental health treatment and care*.[59]

According to General Comment No. 14, the obligation to fulfil the right to health also requires States to ensure "the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country".[60]

Beyond prevention, treatment and medical care, the scope of Article 12's requirements in relation to mental health is not immediately clear. The concept of mental health is not further developed in the ICESCR, nor has the CESCR defined

53 ICESCR, above note 22, Art. 12(1).

54 *Ibid.*, Art. 12(2)(c) and (d) respectively.

55 Vienna Convention on the Law of Treaties, 1155 UNTS 331, 23 May 1969 (entered into force 27 January 1980) (VCLT), Art. 31.

56 See e.g. WHO, *ICD-11: International Classification of Diseases 11th Revision*, 2022, available at: https://icd.who.int/en/; WHO, "Mental Disorders", fact sheet, 8 June 2022, available at: www.who.int/news-room/fact-sheets/detail/mental-disorders. The CESCR has drawn on WHO data and classifications in interpreting Article 12, and has encouraged States to utilize the "extensive information and advisory services of WHO": see General Comment No. 14, above note 30, paras 12(a), 63, 65. On the meaning of mental health conditions and disorders, see, further, S. Miller, above note 3, pp. 435–436.

57 General Comment No. 14, above note 30, para. 17.

58 ICESCR, above note 22, Art. 12(d).

59 General Comment No. 14, above note 30, para. 17 (emphasis added); see also para. 12 (on the general requirements that health services be available in sufficient quantity, accessible without discrimination, acceptable to local peoples and communities, and of good quality). See also E. Rosenthal and C. J. Sundram, above note 44, pp. 29–30 (noting similar requirements for mental health services specifically).

60 General Comment No. 14, above note 30, para. 36.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

the term. The CESCR has, however, stated that the right to health "is not confined to the right to health care", but rather that it

> embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[61]

Whether, as a matter of treaty interpretation, the ICESCR can sustain a more comprehensive definition of mental health, which includes, for example, social well-being,[62] warrants further consideration.

Determining the scope of the obligation regarding mental health depends, to some extent, on one's interpretative focus. On the one hand, drawing on the ICESCR's negotiating history,[63] Michael Krennerich notes that while Article 12 refers to mental health, it does not include "social wellbeing" or "moral wellbeing",[64] and he observes that "social conditions are consequently … determinants for health [rather] than their defining component".[65] This interpretation is consistent with the decision not to adopt the WHO Constitution's broader definition of health ("a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity") in the terms of Article 12.[66] On the other hand, given the human-centric approach of the ICESCR, and its status as a second-generation human rights instrument, a broad interpretation is defensible.[67] The ICESCR refers to "the ideal of free human beings enjoying freedom from fear and want",[68] and protects the right to just working conditions, social security, adequate food, clothing and housing, education, and cultural life.[69] These expansive provisions are consistent with a broad interpretation of mental health, beyond merely the absence of mental illness. Moreover, the CESCR considers that the notion of health has widened in scope since the adoption of the Covenant, and that more determinants of health,

61 *Ibid.*, para. 4.

62 See Constitution of the World Health Organization, 14 UNTS 185, 22 July 1946 (entered into force 7 April 1948) (WHO Constitution), Preamble; and further, WHO and UNICEF, *A Vision for Primary Health Care in the 21st Century: Towards Universal Health Coverage and the Sustainable Development Goal*, 2018, p. 40, available at: www.who.int/docs/default-source/primary-health/vision.pdf (defining mental health as "[a] State of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community").

63 Article 32 of the VCLT, above note 55, permits recourse to preparatory works in the case of interpretive ambiguity.

64 Michael Krennerich, "The Human Right to Health: Fundamentals of a Complex Right", in S. Klotz *et al.* (eds), above note 28.

65 *Ibid.* Some caution against over-reliance on *travaux préparatoires* in treaty interpretation is presented in John Tobin, "Seeking to Persuade: A Constructive Approach to Human Rights Treaty Interpretation", *Harvard Human Rights Journal*, Vol. 23, 2010, p. 24.

66 WHO Constitution, above note 62, Preamble; General Comment No. 14, above note 30, para. 4.

67 Article 31 of the VCLT, above note 55, requires a treaty to be interpreted in light of its object and purpose.

68 ICESCR, above note 22, Preamble.

69 *Ibid.*, Arts 6–15.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

such as resource distribution and gender differences, are being taken into account.[70] In support of a broad interpretation, the CESCR states that Article 12(2)(c) of the ICESCR (on the prevention, treatment and control of diseases) *requires* the "promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity".[71] Likewise, the CESCR's General Comment No. 5, which addresses persons with disabilities, specifies that the right to physical and mental health includes a right for such persons to access medical, social and rehabilitation services.[72] These factors support a broad interpretation of Article 12, which requires the promotion of social determinants of good health. Nevertheless, precisely what it requires for the general population is not readily apparent.

In the context of armed conflict, which gives rise to a wide range of mental health and psychosocial needs, this ambiguity is significant. While ICESCR Article 12 contemplates "mental health treatment and care", it does not explicitly require the broader responses that operational actors view as necessary for post-conflict recovery, such as psychosocial support, community outreach and sensitization activities to address stigma, and social inclusion measures.[73] These psychosocial dimensions could potentially fall within Article 12's scope as underlying determinants of health under General Comment No. 14; in practice, however, biomedical approaches continue to predominate, with public policies neglecting the preconditions of poor mental health such as social exclusion and socio-economic disadvantage.[74] Such approaches may, as the former Special Rapporteur on the Right to Health notes, reinforce medicalized practices and inadequately address structural issues such as poverty and inequality.[75] A legal framework that does not expressly require psychosocial support, and is interpreted through a biomedical lens in practice, may overlook the distinctive mental health needs of post-conflict populations.

70 General Comment No. 14, above note 30, para. 10 (noting also that a wider definition of health takes into account social concerns such as armed conflict). Arguably, General Comments must be taken into account as subsequent practice under Article 31(3)(b) of the VCLT, above note 55: see Helen Keller and Leena Grover, "General Comments of the Human Rights Committee and Their Legitimacy", in Helen Keller and Geir Ulfstein (eds), *UN Human Rights Treaty Bodies*, Cambridge University Press, Cambridge, 2012, pp. 130–131 (though addressing the status of General Comments by the Human Rights Committee (which monitors compliance with the International Covenant on Civil and Political Rights), the reasoning is analogous in respect of the CESCR).

71 General Comment No. 14, above note 30, para. 16, in relation to ICESCR, above note 22, Art. 12(c).

72 CESCR, General Comment No. 5, "Persons with Disabilities", UN Doc. E/1995/22, 9 December 1994, para. 34. See also E. Rosenthal and C. J. Sundram, above note 44, pp. 29–30; *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, UNGA Res. 46/119, 17 December 1991 (Mental Illness Principles), Principle 1(1).

73 On the importance of such measures, see ICRC, above note 11, pp. 3, 5–6. This contrasts with victim assistance models, examined below, which explicitly mandate social and economic inclusion as legal obligations.

74 D. Pūras, UN Doc. A/HRC/35/21, above note 24, paras 12–13.

75 *Ibid.*, para. 40; see also para. 13 (urging policy approaches that attend to social, economic and cultural preconditions of poor mental health, such as social exclusion, isolation and systemic socio-economic disadvantage).

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

Article 12 provides a doctrinal foundation for mental health care, even if it is largely silent on psychosocial support. Whether and how these obligations apply in conflict and post-conflict settings, and to what extent resource constraints and progressive realization qualify them, requires separate consideration.

Limitations on the application of Article 12 to armed conflict and post-conflict situations

Although initially conceived as a framework applicable in peacetime,[76] it is now generally accepted that the ICESCR's obligations do not automatically cease to apply in armed conflict and adjacent situations.[77] Provided the State Party has sovereignty or territorial jurisdiction, it will be bound by the provisions of the ICESCR, including Article 12.[78] This may involve the exercise of extraterritorial jurisdiction, such as in cases of occupation and, potentially, some post-conflict scenarios.[79]

While the ICESCR applies in armed conflict in principle, the existence of conflict has an impact on "the performance of States as required by the Covenant".[80] This section considers two provisions under the ICESCR that may affect the application of the Covenant in armed conflict and adjacent situations: Article 2, which is based on resources available to a State, and Article 4, which recognizes that crises, such as armed conflict, may affect enjoyment of ESC rights. In accordance with Article 5 of the ICESCR, any limitations to Covenant rights must be proportional and as limited as possible.[81]

76 G. Giacca, above note 27, pp. 16, 18 (noting that the ICESCR's "application in wartime was not intended when it was initially drafted and negotiated"); Gerd Oberleitner, *Human Rights in Armed Conflict: Law, Practice, Policy*, Cambridge University Press, Cambridge, 2015, pp. 186–190.

77 International Court of Justice (ICJ), *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory*, Advisory Opinion, *ICJ Reports 2004*, para. 112 (Wall Advisory Opinion); G. Giacca, above note 27, pp. 2, 19, citing CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Israel*, UN Doc. E/C.12/1/Add.90, 26 June 2003, para. 31; Felix E. Torres, "Reparations: To What End? Developing the State's Positive Duties to Address Socio-Economic Harms in Post-Conflict Settings through the European Court of Human Rights", *European Journal of International Law*, Vol. 32, No. 3, 2021, p. 807.

78 Wall Advisory Opinion, above note 77, paras 112, 134 (on the application of the right to health under the ICESCR); ICJ, *Legal Consequences Arising from the Policies and Practices of Israel in the Occupied Palestinian Territory, Including East Jerusalem*, Advisory Opinion, *ICJ Reports 2024*, paras 99, 206; General Comment No. 14, above note 30, paras 12(b), 51.

79 See European Court of Human Rights, *Georgia v. Russia [II]*, Case No. 38263/08, Merits (Grand Chamber), 21 January 2021; Wall Advisory Opinion, above note 77; *Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights*, 28 September 2011 (Maastricht Principles), Principle 9.

80 G. Giacca, above note 27, p. 59. The application of the ICESCR in armed conflict will likely be elucidated in a forthcoming General Comment: see UN Human Rights, "Call for Inputs – Draft General Comment on the Application of the International Covenant on Economic, Social and Cultural Rights in Situations of Armed Conflicts", 2026, available at: www.ohchr.org/en/calls-for-input/2026/call-inputs-draft-general-comment-application-international-covenant-economic.

81 ICESCR, above note 22, Art. 5(1); General Comment No. 14, above note 30, para. 29.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

Progressive realization under Article 2

In recognition of the fact that States may be constrained in the fulfilment of economic and social rights by available resources,[82] almost all the obligations in the ICESCR are subject to "progressive realization".[83] Article 2 of the ICESCR provides:

> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.[84]

According to the influential Limburg Principles, under this provision, States must move as expeditiously as possible towards full realization of rights;[85] the provision must not be "interpreted as implying for States the right to defer indefinitely efforts to ensure full realization".[86] Nonetheless, in accordance with Article 2, the standard that must be met may vary depending on the context.[87] In post-conflict situations, a variety of factors, including the existence of security measures, the degree of control that the State exercises over a territory, and the availability of resources, may legitimately constrain a State's ability to protect and fulfil a right.[88] This can create difficulties in distinguishing between States' unwillingness to fulfil obligations, on the one hand, and their inability to do so, on the other, particularly when resources are depleted post-conflict.[89] As Giacca notes, this remains a key issue in the context of armed conflict.[90]

To address the lack of clarity arising from the progressive nature of the obligation, the CESCR has identified a set of minimum core obligations from which no derogation is possible under any circumstances (including armed conflict). According to General Comment No. 3, States Parties have a "minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights" set out in the ICESCR.[91] This concept, which builds on the

82 UN Human Rights, above note 38; see also General Comment No. 14, above note 30, para. 5.

83 UN Human Rights, above note 38, p. 23; see also G. Giacca, above note 27, pp. 25, 59–60.

84 ICESCR, above note 22, Art. 2.

85 *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, UN Doc. E/CN.4/1987/17, 1987, Annex (Limburg Principles), Principle 21; see also General Comment No. 14, above note 30, para. 31.

86 Limburg Principles, above note 85, Principle 21.

87 G. Giacca, above note 27, pp. 20, 59–60.

88 *Ibid.*, p. 20. See e.g. CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Yemen*, UN Doc. E/C.12/1/Add.92, 12 December 2003, para. 7 (recognizing that "the State party suffered serious difficulties relating to its obligations under the Covenant" as a result of the civil war of 1994 and of the Gulf War of 1990–91, before expressing concern about numerous subjects).

89 G. Giacca, above note 27, p. 20.

90 *Ibid*, p. 20.

91 General Comment No. 3, above note 28, para. 10.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

notion of "minimum subsistence rights" in the Limburg Principles,[92] is intended to prevent States from invoking the principle of progressive realization to avoid their obligations,[93] and it "revolves around the basic level of subsistence necessary for a human being to live in dignity".[94] While both "complex and controversial",[95] the concept provides some guidance on baseline standards for immediate, not progressive, implementation.[96]

However, there is no universal agreement on what constitutes the minimum core obligations for each right, nor, indeed, on the normative foundations of those obligations.[97] In the context of the right to health, the CESCR has stated that "a State party in which any significant number of individuals is deprived … of essential primary health care … is, *prima facie*, failing to discharge its obligations under the Covenant".[98] General Comment No. 14 elaborates on the core obligations relating to the right to health, noting that they include, "at least", the following:

a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
b) To ensure access to the minimum essential food which is nutritionally adequate and safe;
c) To ensure access to shelter, housing and sanitation, and an adequate supply of safe and potable water;
d) To provide essential drugs …;
e) To ensure equitable distribution of all health facilities, goods and services;
f) To adopt and implement a national public health strategy and plan of action … addressing the health concerns of the whole population … [with] particular attention to all vulnerable or marginalized groups.[99]

The CESCR identifies additional obligations as being of "comparable priority", including maternal and child health care, immunization, treatment of endemic diseases, education in relation to health, and training of health personnel.[100]

Whether "essential primary healthcare", as discussed in General Comment No. 3, includes mental health care – and if so, the standard of such care – is

92 Limburg Principles, above note 85, Principle 25.

93 Lisa Forman *et al.*, "What Do Core Obligations under the Right to Health Bring to Universal Health Coverage?", *Health and Human Rights Journal*, Vol. 18, No. 2, 2016, p. 27.

94 G. Giacca, above note 27, p. 68. See also L. Forman *et al.*, above note 93, p. 27; J. Tasioulas, above note 28.

95 G. Giacca, above note 27, p. 67; see also K. G. Young, above note 28; J. Tobin, above note 23.

96 General Comment No. 14, above note 30, para. 43.

97 G. Giacca, above note 27, p. 68; K. G. Young, above note 28, p. 138 (on the contested normative core); Lisa Forman, Luljeta Caraoshi, Audrey R. Chapman and Everaldo Lamprea, "Conceptualising Minimum Core Obligations under the Right to Health: How Should We Define and Implement the 'Morality of the Depths'?", in S. Klotz *et al.* (eds), above note 28, p. 95.

98 General Comment No. 3, above note 28, para. 10. See also Limburg Principles, above note 85, Principle 28.

99 General Comment No. 14, above note 30, para. 43.

100 *Ibid.*, para. 43.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

rarely discussed in detail.[101] Katharine Young, in her nuanced analysis of the differing approaches to the minimum core obligations, considers that the conception in General Comment No. 3 is "suggestive of the more categorical (or more flatly instrumental) formula of 'basic needs' amounting to survival and life".[102] She notes that the

> focus on life and survival is able to transcend the prioritization of civil and political rights over economic and social rights by drawing attention to the moral equivalence of subsistence rights and security rights because of their mutual relation to survival.[103]

The formulation in General Comment No. 14 allows for a more expansive set of minimum core obligations.[104] Of particular relevance to the question of mental health care is its reference to "the right of access to health facilities, goods and services" on a non-discriminatory basis.[105] Depending on the interpretation given to "health", this phrase could conceivably include both mental health and psychosocial support services within its scope; however, like other items on the list, this obligation is "highly indeterminate, both as to the kind of benefits involved and the cost or level at which these benefits must be provided in order to comply with the relevant obligation".[106] Accordingly, while the minimum core clearly includes essential medicines and underlying determinants like food, shelter, and water, it is unclear precisely which health services it encompasses.[107] As Forman *et al.* note,

> [p]rimary health care is not explicitly listed as a core obligation; moreover, much of what we might expect to see in an obligation to provide essential primary health care is explicitly placed outside the core obligations, under obligations of comparable priority.[108]

Whether, and if so to what extent, mental health and psychosocial support (MHPSS) services are included is similarly indeterminate.

Untreated mental health conditions, such as depression, psychosis and acute trauma-related disorders, can be as immediately life-threatening as physical illness or injury, potentially leading to suicide, self-harm, alcohol abuse and/or violence.[109] On this basis, either formulation of the minimum core should necessarily include mental health treatment that addresses immediate threats to life and basic security. However, it is unclear whether, on either formulation, the minimum core would

101 Cf. S. Miller, above note 3.

102 K. G. Young, above note 28, p. 128; see also G. Giacca, above note 27, p. 31.

103 *Ibid.*, p. 130 (noting, however, that this approach "misses the important connections between dignity and human flourishing that are intrinsic to many interpretations of the right to life").

104 J. Tasioulas, above note 28, p. 7.

105 *Ibid..*, p. 7; General Comment No. 14, above note 30, para. 43(a).

106 J. Tasioulas, above note 28, p. 7.

107 L. Forman *et al.*, above note 93. See also L. Forman *et al.*, above note 97, p. 96.

108 L. Forman *et al.*, above note 93.

109 Jaime Moreno-Chaparro *et al.*, "Mental Health Consequences of Armed Conflicts in Adults: An Overview", *Actas Espanolas de Psiquiatria*, Vol. 50, No. 2, 2022.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

encompass the broader, often acute, psychosocial dimensions that are central to recovery in post-conflict contexts, such as addressing stigma, social isolation, relationship conflicts, and facilitating community reintegration.[110] Accordingly, even if mental health treatment necessary for life and security falls within the minimum core of Article 12, it is not apparent whether the concept includes the more comprehensive mental health and psychosocial needs that operational actors like the ICRC identify as essential for post-conflict recovery.

It is important to recognize that by attempting to delineate between minimum core obligations and progressive realization, there is a risk of giving the minimum core concept more determinacy than the concept might indeed sustain.[111] Numerous scholars have pointed to challenges in articulating and defining minimum core content,[112] and have proposed alternative approaches to operationalizing the minimum core.[113] Young, for example, argues that the various operations for which the minimum core concept is invoked, including prescribing content (such as through indicators and benchmarks), ranking obligations and signalling extraterritoriality (including by addressing questions of institutional responsibility, cooperation and interdependence), are obscured by the minimum core concept and may be better served by alternative approaches.[114] As discussed below, victim assistance regimes provide a useful model for addressing these operational needs.

Limitations under Article 4

The application of Covenant rights in armed conflict may also be limited under Article 4 of the ICESCR, which provides that

> the State may subject [Covenant] rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.[115]

In contrast with Article 2, which sets out permissible limitations to ESC rights based on resource issues, Article 4 limits the power of the State to restrict human rights

110 See ICRC, above note 11.

111 See, generally, K. G. Young, above note 28.

112 See *ibid.*, p. 138 (noting that "there are no axioms that can deliver an uncontested minimum core. … [T]he minimum core will look different to an advocate of human flourishing in comparison with an advocate of basic survival, just as the core will look different in various instantiations of both survival and dignity"); Karin Lehmann, "In Defense of the Constitutional Court: Litigating Economic and Social Rights and the Myth of the Minimum Core", *American University International Law Review*, Vol. 22, No. 1, 2006, pp. 165 (describing the concept as "inappropriate as a tool of judicial decision-making"), 179; Kirsteen Shields, *The Minimum Core Obligations of Economic, Social and Cultural Rights: The Rights to Health and Education*, World Bank, October 2017, p. 2 (noting that the lack of definitional certainty has impeded the concept's utility); A. Müller, above note 28, pp. 63–64.

113 K. G. Young, above note 28; Sakiko Fukuda-Parr, Terra Lawson-Remer and Susan Randolph, *Fulfilling Social and Economic Rights*, Oxford University Press, Oxford and New York, 2015.

114 See e.g. K. G. Young, above note 28, pp. 164, 175.

115 ICESCR, above note 22, Art. 4.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

based on other matters.[116] Under Article 4, any such limitations must be determined by law, compatible with the nature of ESC rights, and for the purposes of "promoting the general welfare in a democratic society".[117] General Comment No. 14 emphasizes Article 4 "is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States", and notes that a State Party bears the onus of justifying limitations taken in accordance with Article 4.[118] While the key intention behind the provision is to ensure that States do not limit ICESCR rights arbitrarily, Article 4 is also permissive in that it allows States to impose limits on the enjoyment of those rights.[119]

There is relatively limited information available about how States interpret Article 4.[120] Practically speaking, States invoke national security or public emergencies such as armed conflict to limit ESC rights domestically.[121] While these reasons can legitimately be invoked insofar as they serve the general welfare in a democratic society, State reports suggest that the grounds for such limitations in times of crisis are often not clear.[122] Instead, Cahill-Ripley notes, in crises such as armed conflict, "States tend to utilise Article 4 as a general 'emergency' clause".[123] She observes that the data indicates a lack of understanding of limitations permitted under the ICESCR.[124] This absence of consistent State practice in applying Article 4 hinders the development of a clear understanding of ESC rights such as the right to health in armed conflict.

The application of limitation provisions such as Articles 2 and 4 of the ICESCR may leave broader mental health and psychosocial needs at risk of neglect, particularly in conflict and conflict-adjacent situations, when States are in crisis and resources are constrained. However, it should also be acknowledged that some of these limitations are inherent to the implementation of any legal framework applying in post-conflict settings. Measures to address stigma, social isolation and community

116 Amanda Cahill-Ripley, Socio-Economic Rights in Times of Crisis and Normality: Article 4 Limitations under the International Covenant on Economic, Social and Cultural Rights, Bristol University Press, Bristol, 2025, p. 10. See also ICESCR, above note 22, Art. 5, which further constrains the limitations permitted under the ICESCR.

117 ICESCR, above note 22, Art. 4.

118 General Comment No. 14, above note 30, para. 28 (noting that such restrictions must be in accordance with IHRL, compatible with the nature of Covenant rights, in the interest of legitimate aims, and strictly necessary for the promotion of the general welfare in a democratic society).

119 A. Cahill-Ripley, above note 116, pp. 25–26.

120 Amrei Müller, "Limitations to and Derogations from Economic, Social and Cultural Rights", *Human Rights Law Review*, Vol. 9, No. 4, 2009, p. 566.

121 *Ibid.*; see also A. Cahill-Ripley, above note 116, pp. 40, 92–94.

122 A. Cahill-Ripley, above note 116, pp. 93–94 (referencing reports by Chad, Venezuela, Palestine and Algeria, and noting further that State reports often reference International Covenant on Civil and Political Rights principles such as necessity and proportionality, or grounds such as public order, instead of adopting the language of Article 4).

123 *Ibid.*, p. 95.

124 *Ibid.*, p. 95. This may be compounded by the fact that the CESCR tends to refrain from invoking Article 4 in its State-specific observations: see e.g. CESCR, *Concluding Observations on the Initial Periodic Report of Sudan*, UN Doc. E/C.12/1/Add.48, 1 September 2000, paras 14, 16 (treating armed conflict as a contextual factor affecting implementation rather than referencing Article 4 directly).

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

reintegration will inevitably face significant challenges in immediate post-conflict settings where resources are strained and the population's needs are immense. Yet it is nonetheless worthwhile to identify where the existing framework lacks specificity or remains contested, with a view to strengthening it through greater prioritization and particularization of mental health and psychosocial needs and more concrete implementation or cooperation mechanisms.

Particularized regimes

Building on the general framework provided by Article 12, specialized IHRL treaties such as the CRPD, the CRC and CEDAW further particularize the right to mental health for specific populations. This section examines whether the regimes set out in these treaties provide greater clarity regarding mental health obligations, particularly insofar as they apply in conflict scenarios.

Convention on the Rights of Persons with Disabilities

The CRPD aims to ensure the human rights of all persons with disabilities.[125] Under Article 1(2), this term includes persons who have "long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".[126] Article 25 is of particular importance, providing that "persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability".[127] This includes the provision of the same standard of health care as provided to other persons, and the provision of health services needed by persons with disabilities specifically because of their disabilities.[128] Article 26 requires States to organize and strengthen rehabilitation services and programmes, including in the area of health, so as to support participation and inclusion in the community and society.[129] In this regard, the CRPD goes beyond the provisions of Article 12 of the ICESCR, providing a more socially oriented conception of the right to health.[130]

It is generally accepted that the CRPD applies in situations of armed conflict.[131] Indeed, under Article 11, States Parties must take "all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk,

125 Convention on the Rights of Persons with Disabilities, 2515 UNTS 3, 13 December 2006 (entered into force 3 May 2008) (CRPD). Arts 1, 4(1).

126 *Ibid.*, Art. 1.

127 *Ibid.*, Art. 25.

128 *Ibid.*, Art. 25(a)–(b); see also General Comment No. 14, above note 30, para. 26.

129 CRPD, above note 125, Art. 26.

130 See J. E. Lord, above note 17, p. 66; Robert Mardini, "Persons with Disabilities in Armed Conflicts: From Invisibility to Visibility", *International Review of the Red Cross*, Vol. 105, No. 922, 2023.

131 Gauthier de Beco, "Taking Economic and Social Rights Earnestly: What Does International Human Rights Law Offer Persons with Disabilities in Situations of Armed Conflict?", *International Review of the Red Cross*, Vol. 105, No. 922, 2023, p. 314; ICRC, *How Law Protects Persons with Disabilities in Armed*

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

including situations of armed conflict".[132] The explicit application of Article 11 to situations of armed conflict makes clear that CRPD obligations persist and require active protective measures in such contexts. However, the ESC rights found in the CRPD are, like Article 12 of the ICESCR, subject to progressive realization under Article 4(2),[133] which means that the same uncertainty about baseline obligations in resource-constrained settings applies.

Whether the obligations in the CRPD extend to all those with mental health and psychosocial needs post-conflict is not immediately clear. While the CRPD does not define the phrase "persons with a disability" beyond the description in Article 1, the Committee on the Rights of Persons with Disabilities has recommended "a broad impairment-related definition of disability" that includes those with long-term physical, psychosocial, intellectual or sensory impairments.[134] This would logically extend to those who acquire impairments in the course of armed conflict, but whether it would include those with acute or transient trauma-based mental health and psychosocial needs that are likely to arise during and post-conflict is less clear, with practice from some countries suggesting that it might not.[135] Moreover, many psychosocial support measures, such as efforts to address stigma, social isolation and community reintegration,[136] are based on addressing community challenges that are distinct from the impairment of those likely to benefit from them and therefore fit uncomfortably with the CRPD model. An equally pressing practical issue is the fact that impairments are often not reported (due to stigmatization) or not recorded (due to inadequate data collection).[137] In post-conflict settings, persons with disabilities are often excluded from basic services and are not meaningfully consulted in programme design and implementation.[138]

Convention on the Rights of the Child

The CRC provides particularized obligations in relation to children – that is, generally speaking, persons under the age of 18 years.[139] Several provisions of the

Conflict, Geneva, 13 December 2017, available at: www.icrc.org/en/document/how-law-protects-persons-disabilities-armed-conflict.

132 CRPD, above note 125, Art. 11. For analogous IHL protections, see J. E. Lord, above note 17.

133 CRPD, above note 125, Art. 4(2).

134 See Committee on the Rights of the Child, General Comment No. 6, "Treatment of Unaccompanied and Separated Children Outside Their Country of Origin", UN Doc. CRC/C/GC/2005/6, 1 September 2005 (General Comment No. 6), paras 48, 73(b).

135 See Alice Priddy, *Disability and Armed Conflict*, Geneva Academy Briefing No. 14, Geneva, April 2019, p. 89, available at: https://repository.graduateinstitute.ch/record/297253?v=pdf (noting that in Colombia, witnesses to a violation of IHL or IHRL who have suffered psychosocial harm such as post-traumatic stress disorder as a result are unlikely to qualify as "victims" for the purposes of accessing rehabilitation, social and other services).

136 See ICRC, above note 11, pp. 3, 5–6.

137 A. Priddy, above note 135, p. 11.

138 *Ibid.*, pp. 12–13.

139 Convention on the Rights of the Child, 1577 UNTS 3, 20 November 1989 (entered into force 2 September 1990) (CRC), Art. 1. The CRC has 196 States Parties.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

CRC support the mental health of the child. Article 23(1) provides that a "mentally or physically disabled child" should enjoy a full life, with assistance, including health-care services and rehabilitation, where appropriate; in addition, Article 24(1) recognizes "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". However, like the ICESCR and the CRPD, the right to health under Article 24 of the CRC is subject to progressive realization and its attendant limitations.[140]

The CRC contains an important provision applicable specifically to situations of armed conflict and other potentially traumatic experiences. Article 39 provides:

> States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of … armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.[141]

This provision is especially important given that children who experience armed conflict are at heightened risk of suffering from post-traumatic stress, anxiety and depressive disorders, which may continue into adulthood without available support.[142] Article 39 is supplemented by Article 7 of the Optional Protocol on the Involvement of Children in Armed Conflict, which imposes similar obligations in respect of child soldiers.[143]

From a mental health perspective, Article 39 imposes measures to promote both psychological recovery (which focuses on recreating conditions favourable to psychological development) and reintegration. Both processes are dependent on the child, their personal experience and the context.[144] The Committee on the Rights of the Child (the treaty body for the CRC) notes that to facilitate recovery and reintegration under Article 39, "culturally appropriate and gender-sensitive mental health care should be developed and qualified psycho-social counselling provided".[145] To this end, Article 39 provides a more comprehensive and adapted approach to facilitate children's psychological recovery and social reintegration following armed conflict than the general ICESCR framework. Moreover, it provides a useful framework for addressing mental health and psychosocial needs post-conflict,[146] pointing to the

140 *Ibid.*, Art. 24(4).

141 *Ibid.*, Art. 39.

142 See Panos Vostanis, "Mental Health Provision for Children Affected by War and Armed Conflicts", *European Child and Adolescent Psychiatry*, Vol. 33, No. 9, 2024.

143 Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict, 2173 UNTS 222, 25 May 2000 (entered into force 12 February 2002), Art. 6(3); see also Art. 7(1) (requiring States to cooperate in rehabilitating and reintegrating persons who are victims of acts contrary to the Optional Protocol).

144 W. Vandenhole, G. E. Türkelli and S. Lembrechts, above note 9, p. 424.

145 General Comment No. 6, above note 134, para. 48.

146 See e.g. Committee on the Rights of the Child, *Concluding Observations: Sierra Leone*, UN Doc. CRC/C/15/Add.116, 24 February 2000, paras 73–74 (pressing Sierra Leone to implement recovery and reintegration measures under Article 39); Sierra Leone, *Initial Report of States Parties under Article 8(1) of the Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in*

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

potential for particularization of obligations in respect of the broader post-conflict population.

Convention on the Elimination of all Forms of Discrimination against Women

Part I of CEDAW condemns discrimination against women in all forms, including in the enjoyment or exercise of ESC rights,[147] and requires States to take all appropriate measures to ensure women's full development and advancement on a basis of gender equality.[148] Armed conflict exacerbates the risk of discrimination towards women and girls, including in the form of gender-based violence.[149] In light of this, the Committee on the Elimination of Discrimination against Women has recommended that States Parties "[a]llocate adequate resources and adopt effective measures to ensure that victims of gender-based violence, in particular sexual violence, have access to comprehensive medical treatment, mental health care and psychosocial support".[150] Though limited in scope, this recommendation, like Article 39 of the CRC, demonstrates how ESC rights can be particularized and tailored to the needs of certain groups in conflict-affected societies.

Challenges in applying the right to health in post-conflict situations

The analysis above reveals that while IHRL provides a doctrinal foundation for mental health care (and potentially, though often not explicitly, psychosocial support), particular challenges emerge when applying these obligations in post-conflict situations. Context can affect both the content of ESC obligations and the ability of the State to fulfil those obligations.[151] This part considers the latter challenge, discussing three key issues that arise in relation to the obligation to care for mental health in conflict and post-conflict situations: a lack of prioritization of the right to health and

Armed Conflict, UN Doc. CRC/C/OPAC/SLE/1, 5 April 2009, paras 28–30 (noting the creation of a commission to provide for psychosocial recovery and reintegration of war-affected children); Committee on the Rights of the Child, *Concluding Observations on the Initial Report of Sierra Leone under the Optional Protocol on the Involvement of Children in Armed Conflict*, UN Doc. CRC/C/OPAC/SLE/CO/1, 14 October 2010, paras 27–29 (noting implementation of psychosocial services, training opportunities and reintegration programmes but acknowledging challenges, including fear of stigmatization, eligibility restrictions, and inadequate attention to the physical and psychological recovery needs of former child combatants, particularly girls).

147 Convention on the Elimination of All Forms of Discrimination against Women, 1249 UNTS 13, 18 December 1979 (entered into force 3 September 1981) (CEDAW), Arts 1–2. In relation to health specifically, see Arts 12, 10(h), 11(f).

148 *Ibid.*, Art. 3.

149 Committee on the Elimination of Discrimination against Women, "General Recommendation No. 30 on Women in Conflict Prevention, Conflict and Post-conflict Situations", UN Doc. CEDAW/C/GC/30, 1 November 2013, paras 34–37.

150 *Ibid.*, para. 38(e).

151 G. Giacca, above note 27, p. 20.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

mental health in particular; genuine resource constraints and a lack of international support; and shortcomings in the implementation of human rights post-conflict.[152]

Deprioritization of health and mental health rights

ESC rights are often not prioritized by affected States and the international community in conflict situations.[153] To the extent that human rights are considered in post-conflict settings, ESC rights tend to be viewed as subordinate to civil and political rights such as those protecting life, liberty and security.[154] The rights of marginalized and vulnerable people are particularly neglected in the context of armed conflict.[155]

This lack of prioritization extends to the right to health care in conflict and post-conflict situations.[156] Not only are attacks on health-care facilities a devastating feature of contemporary armed conflict,[157] but many health-care systems lack resilience and capacity to function under duress.[158] Mental health is a particularly underfunded area of health care,[159] and countries impacted by disaster and conflict, where mental health problems are especially widespread, typically have a lower or non-existent budget allocated to improving mental health.[160] Indeed, as Weissbecker notes,

> [m]ental health remains one of the most under-funded areas of health care, especially in low-resource settings. As a result, it is estimated that 75% of individuals

152 This is not intended as a comprehensive list of challenges. In post-conflict situations, a variety of factors, including the existence of security measures and the degree of control that the State exercises over a territory, may legitimately constrain a State's ability to protect and fulfil a right: see *ibid.*, p. 20.

153 I. Weissbecker, above note 3, p. 82.

154 UNHRC, above note 5, para. 83; G. Giacca, above note 27, pp. 1, 4–5. See International Covenant on Civil and Political Rights, 999 UNTS 171, 16 December 1966 (entered into force 23 March 1976), esp. Arts 6–12.

155 UNHRC, above note 5, para. 83; I. Weissbecker, above note 3; K. H. A. Footer and L. S. Rubenstein, above note 5, p. 168. See also A. Müller, above note 28, p. 78 (on the lack of legislative representation of vulnerable groups).

156 See, generally, Richard Brennan and Muhammed Sheraz, "The International Community is Failing to Protect Healthcare in Armed Conflict", *BMJ*, Vol. 387, 2024; Leonard Rubenstein, "War, Political Conflict, and the Right to Health", *Health and Human Rights*, Vol. 22, No. 1, 2020, p. 339.

157 Richard Brennan *et al., In the Line of Fire: Protecting Health in Armed Conflict*, WHO, November 2024, available at: https://cdn.who.int/media/docs/default-source/health-workforce/hwp/in-the-line-of-fire-(1).pdf; R. Brennan and M. Sheraz, above note 156.

158 R. Brennan *et al.*, above note 157, pp. 19–23 (noting the importance of building capacity and resilience, including through emergency preparedness training, supply chain resilience, early warning systems, reinforced physical infrastructure and international collaboration); R. Brennan and M. Sheraz, above note 156. See, generally, Jonathan Wolff, *The Human Right to Health*, W. W. Norton, New York, 2012, p. 105.

159 D. Pūras, UN Doc. A/HRC/35/21, above note 24, para. 6; I. Weissbecker, above note 3, p. 81. See also ICRC, above note 4, p. 8; S. Miller, above note 3, p. 435; WHO, *Mental Health Atlas 2024*, 2025, available at: www.who.int/publications/i/item/9789240114487 (noting that only 2.1% of total government health expenditure globally is allocated to mental health (p. 3); nonetheless, most countries considered their mental health policies and plans to be substantially in compliance with IHRL obligations (pp. 25–26)).

160 I. Weissbecker, above note 3, p. 81.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

with mental health problems in low income countries have no access to mental health services.[161]

While mental health and psychosocial needs are particularly acute post-conflict, they are often overlooked in favour of more visible emergency priorities.[162] This lack of prioritization is especially problematic given the fact that humanitarian activities are mostly developed in the early stage of post-conflict situations.[163]

Genuine resource constraints and insufficient international support obligations

While acknowledging that States will sometimes seek to avoid their human rights obligations for self-serving or political reasons,[164] genuine resource constraints can make even minimum core obligations difficult to implement, especially in times of economic crisis or conflict.[165] Armed conflict can adversely impact basic infrastructure and economic capacity, two factors that States often rely on to justify non-fulfilment of obligations in reports to the CESCR.[166] This section considers these factors in turn, focusing on lack of health infrastructure and lack of financing.

Lack of (health) infrastructure

ESC rights "presuppose the capacity of the State to carry out a range of governmental functions".[167] However, States emerging from conflict often face a lack of resources due to the decimation of their economy and society,[168] with damage to institutional infrastructure being as significant as damage to physical infrastructure.[169] In reports to the CESCR, several States, including Colombia,[170] Somalia,[171] the Democratic

161 *Ibid.*, p. 81.

162 WHO, "Providing Mental Health Support in Humanitarian Emergencies: An Opportunity to Integrate Care in a Sustainable Way", 17 December 2021, available at: www.who.int/news-room/feature-stories/detail/providing-mental-health-support-in-humanitarian-emergencies-an-opportunity-to-integrate-care-in-a-sustainable-way.

163 UNHRC, above note 5, paras 7, 82, 18.

164 See G. Giacca, above note 27, p. 20; General Comment No. 14, above note 30, para. 47.

165 K. G. Young, above note 28; UNHRC, above note 5.

166 G. Giacca, above note 27, pp. 10–11.

167 *Ibid.*, pp. 16, 18.

168 UNHRC, above note 5, para. 10.

169 *Ibid.*, para. 15.

170 CESCR, *Report of Colombia (Fifth Periodic Report)*, UN Doc. E/C.12/COL/5, 22 January 2008, para. 52.

171 CESCR, *Report of Somalia (Initial Report)*, UN Doc. E/C.12/SOM/1, 11 July 2025, paras 8 (noting the impact of decades of conflict on infrastructure, productive sectors, and economic growth), 13 (noting the impact of conflict on implementation of law).

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

Republic of the Congo,[172] Armenia,[173] Azerbaijan[174] and Nepal,[175] have referenced the destructive social, economic and political effects of armed conflict in an attempt to justify non-compliance with obligations under the ICESCR.[176] Armed conflict poses numerous hurdles for States seeking to meet obligations in relation to victims' needs, particularly where conflict is protracted.[177]

Additionally, conflict frequently results in destruction of physical and institutional health-care infrastructure, including hospitals, clinics and medical supply chains.[178] Health-care personnel are also frequently killed, displaced or leave clinical practice during conflict, whether through direct attacks, insecurity or for economic reasons.[179] This loss of both physical infrastructure and human and economic resources further compromises States' capacity to respond effectively to their populations' health-care needs.[180] As Giacca notes,

> even the implementation of the strict minimum core obligations regarding … primary health care appears to be far from affordable for many poor countries, to say nothing of those involved in armed conflict in places such as Afghanistan or the Democratic Republic of the Congo.[181]

This points to a need for external funding to facilitate even minimal health care, as explored below.[182]

Lack of funding

The international community has agreed that the gross inequality in health status globally is unacceptable and of common concern to all countries.[183] In practice, according to the United Nations Human Rights Council (UNHRC), one of the main obstacles to ensuring compliance with human rights in post-conflict or transitional

172 CESCR, *Report of DRC (Combined Second, Third, Fourth and Fifth Reports)*, UN Doc. E/C.12/COD/5, 14 August 2007, para. 186 (noting the economic damage from recurrent conflicts, including through looting and destruction).

173 CESCR, *Report of Armenia (Initial Report)*, UN Doc. E/1990/5/Add.36, 5 December 1998, para. 226.

174 CESCR, *Report of Azerbaijan (Initial Report)*, UN Doc. E/1990/5/Add.30, 17 June 1996, para. 13; CESCR, *Report of Azerbaijan (Second Periodic Report)*, UN Doc. E/1990/6/Add.37, 1 December 2003, paras 8, 466.

175 CESCR, *Report of Nepal (Second Periodic Report)*, UN Doc. E/C.12/NPL/2, 7 August 2006, p. 11 (on the impact of the decade-long "insurgency" on legislative enforcement, development works, physical infrastructure and finances) and para. 122.

176 See, further, G. Giacca, above note 27, pp. 10–11.

177 *Ibid.*, pp. 10–11; UNHRC, above note 5, para. 7; F. Charlson, above note 5, para. 15.

178 See e.g. K. H. A. Footer and L. S. Rubenstein, above note 5, p. 169.

179 See e.g. Mumen Abdalazim Dafallah, Manasik Mamoun, Ola Yaser Mohammed and Omer Ali Mohamed Ahmed, "From Crisis to Opportunity: The Shift of Sudanese Physicians to Non-Clinical Careers and Its Global health implications", *BMJ Global Health*, Vol. 10, No. 7, 2025.

180 *Ibid.*

181 G. Giacca, above note 27, p. 68.

182 See the section below on "International Cooperation and Assistance Obligations".

183 WHO, "Declaration of Alma-Ata International Conference on Primary Health Care", Alma-Ata, USSR, 6–12 September 1978, Art. 2.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

situations is "the allocation of inadequate funds".[184] While States are urged to allocate funding for "emergency response, relief and reconstruction", as well as development, within their own territories,[185] in reality, States will often be dependent on international assistance to implement human rights obligations.[186] The UN has consistently emphasized the importance of international cooperation and assistance to strengthen health systems and services in conflict-affected areas.[187]

International law reflects, in general terms, the importance of cooperation for meeting ESC rights such as the right to health.[188] Building on Articles 55 and 56 of the UN Charter, Article 2(1) of the ICESCR obliges States Parties "to take steps, individually and *through international assistance and co-operation*, especially economic and technical", with a view to achieving the full realization of Covenant rights.[189] The availability of external assistance is a relevant factor in considering whether a State is genuinely unable to meet its obligations under the ICESCR.[190] The CESCR has stated that "in determining whether a State party is truly unable to fulfil its obligations under human rights law, it is necessary to consider both the resources existing within a State and those available from the international community".[191]

However, the obligation to *seek* international assistance should be distinguished from a legally binding obligation on third States to *provide* assistance.[192] While ICESCR Article 2 contemplates the provision of international assistance in general terms,[193] it does not explicitly establish a stand-alone legal obligation to assist in relation to the right to health. This can be contrasted with the obligation under ICESCR Article 11(2), which provides that States "shall take, individually

184 UNHRC, above note 5, para. 94. See also International Labour Organization, *Local Economic Recovery in Post-Conflict: Guidelines*, ILO Programme for Crisis Response and Reconstruction, 2010, pp. 21–22, available at: www.ilo.org/sites/default/files/wcmsp5/groups/public/@ed_emp/documents/instructionalmaterial/wcms_141270.pdf. This reflects a broader shortfall in funding: see UN Office for the Coordination of Humanitarian Affairs, *Global Humanitarian Overview 2025*, December 2024, p. 42, available at: www.unocha.org/publications/report/world/global-humanitarian-overview-2025-enarfres.

185 UNHRC, above note 5, para. 100.

186 Lawrence O. Gostin and Robert Archer, "The Duty of States to Assist Other States in Need: Ethics, Human Rights, and International Law", *Journal of Law, Medicine and Ethics*, Vol. 35, No. 4, 2007; General Comment No. 14, above note 30; Jonathan Wolff, "The Demands of the Human Right to Health", *Proceedings of the Aristotelian Society: Supplementary Volumes*, Vol. 86, 2012, p. 224; Amrei Müller, *The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law: An Analysis of Health Related Issues in Non-International Armed Conflicts*, Brill, Leiden, 2013, p. 239.

187 See e.g. UNGA Res. 79/140, "Strengthening of the Coordination of Emergency Humanitarian Assistance of the United Nations", 12 December 2024, paras 43, 66–69.

188 J. Tobin, above note 23, p. 328.

189 ICESCR, above note 22, Art. 2(1) (emphasis added). See also General Comment No. 14, above note 30, para. 38; General Comment No. 3, above note 28, para. 14; G. Giacca, above note 27, p. 226; CRC, above note 139, Art. 24(4) (undertaking to "promote and encourage" international cooperation on the child's right to health); Maastricht Principles, above note 79, Principle 19.

190 Limburg Principles, above note 85, Principle 26.

191 General Comment No. 3, above note 28, para. 13.

192 See J. Tobin, above note 23, p. 329.

193 ICESCR, above note 22, Art. 2.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

and through international co-operation", measures needed to ensure that food supplies are distributed equitably in relation to need.[194] During the negotiations of the ICESCR, there appears to have been a divergence in understanding between those States in need of assistance and those in a position to provide it; the former considered there to be a legally binding obligation to provide international assistance, while the latter doubted the duty, with some deeming it "merely a moral obligation".[195] More generally, States negotiating the ICESCR did not support the inclusion of international assistance and cooperation as a mandatory obligation.[196] It would therefore be a stretch to read into ICESCR Article 2 a legally enforceable obligation to assist in specific situations.[197]

The CESCR attempts to strengthen or clarify this framework in General Comment No. 14, asserting that States have a joint and individual responsibility to cooperate in providing humanitarian assistance in emergency situations.[198] A State should "contribute to this task to the maximum of its capacities", giving priority to the most vulnerable or marginalized groups.[199] The Committee emphasizes that it is "particularly incumbent on States parties and other actors in a position to assist" to provide assistance and cooperation aimed at enabling developing countries to meet their minimum core and other obligations.[200] Despite this pronouncement, there remains ambiguity about whether – and if so, when – there is a duty on the international community to provide assistance in conflict-related situations.[201] As a non-binding interpretive body, it is problematic to assert that the CESCR can unilaterally create obligations that States declined to accept during negotiations.[202] This points to the need for further development of the international assistance and

194 *Ibid.*, Art. 11(2); see also Art. 11(1) (in weaker terms). And see, further, G. Giacca, above note 27, p. 62.

195 Report of the Open-ended Working Group to Consider Options Regarding the Elaboration of an Optional Protocol to the International Covenant on Economic, Social and Cultural Rights on Its Third Session, UN Doc. E/CN.4/2006/47, 2006, cited in Takhmina Karimova, "The Nature and Meaning of 'International Assistance and Cooperation' under the International Covenant on Economic, Social and Cultural Rights", in Eibe Riedel, Gilles Giacca and Christophe Golay (eds), Economic, Social and Cultural Rights in International Law: Contemporary Issues and Challenges, Oxford University Press, Oxford, 2014, p. 165; W. Vandenhole, G. E. Türkelli and S. Lembrechts, above note 9. See also Sigrun Skogly, Beyond National Borders: States' Human Rights Obligations in International Cooperation, Intersentia, Antwerp and Oxford, 2006, pp. 85–86 (noting debate, but no agreement, during negotiations about whether States lacking resources would have a duty to seek assistance, or whether wealthier States were required to provide such assistance).

196 See T. Karimova, above note 195, p. 166 (noting that such a legal duty would give States an excuse to avoid their primary human rights obligations); J. Tobin, above note 23, p. 329.

197 See, further, J. Tobin, above note 23, p. 329 (noting, in contrast, an obligation to assist under Article 24 of the CRC, above note 139).

198 General Comment No. 14, above note 30, paras 38–40.

199 *Ibid.*, paras 40, 38.

200 *Ibid.*, para. 45.

201 See T. Karimova, above note 195, pp. 186, 190; see also L. Forman *et al.*, above note 93, p. 29 (on the lack of specificity about when any obligation to assist is triggered); J. Tobin, above note 23, pp. 329, 340–343.

202 See J. Tobin, above note 65, p. 2 (arguing that treaty bodies' work, while persuasive *de lege ferenda*, has a limited impact on the *lex lata*); cf. Max Lesch and Nina Reiners, "Informal Human Rights Law-Making: How Treaty Bodies use 'General Comments' to Develop International Law", *Global Constitutionalism*, Vol. 12, No. 2, 2023. See also H. Keller and L. Grover, above note 70.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

cooperation obligations *de lege ferenda*. To this end, soft-law documents such as the Maastricht Principles, which require States to "take action, separately, and jointly through international cooperation, to respect the ESC rights of persons within their territories *and extraterritorially*",[203] may contribute to emerging normative standards.

Weak implementation of human rights post-conflict

According to the UNHRC, there are several systemic shortcomings in the implementation and delivery of human rights post-conflict.[204] This section examines four interconnected implementation challenges: the lack of clarity in legal obligations; the absence of operational frameworks for implementing obligations; the exclusion of affected and vulnerable populations from participation; and weaknesses in monitoring and accountability mechanisms.

Lack of clarity in legal obligations

Shortcomings in domestic implementation of the right to health may be partly attributable to a lack of clarity about what IHRL demands. When it comes to the minimum core obligations, the CESCR has suggested that States set their own national benchmarks rather than following a universal one;[205] however, as Fukuda-Parr *et al.* note, precisely how the minimum core and national benchmarks should be set remains an open question.[206] Miller points to the dispersed nature of the national laws relating to mental health, noting that they are scattered and lack specificity.[207] She observes that "trying to gather mental health laws and socio-economic rights which are spread throughout different laws can make it problematic for enforcement, and protections can become piecemeal and incomplete".[208] Perhaps as a result, in most States, funding arrangements for mental health services are not set out in legislation, but rather are seen as the responsibility of the executive and policy-makers.[209] The lack of consolidation

> also offers States a wide margin of appreciation in implementing standards and incorporating the provisions into domestic legislation. … As a result, there

203 Maastricht Principles, above note 79, Principle 19 (emphasis added). See also Limburg Principles, above note 85, Principles 29–34; Olivier De Schutter *et al.*, Commentary to the Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights", *Human Rights Quarterly*, Vol. 34, No. 4, 2012.

204 UNHRC, above note 5, para. 87.

205 CESCR, General Comment No. 1, "Reporting by States Parties", UN Doc. E/1989/22, 24 February 1989, para. 6; General Comment No. 14, above note 30, paras 57–58.

206 S. Fukuda-Parr, T. Lawson-Remer and S. Randolph, above note 113, p. 212.

207 See S. Miller, above note 3, p. 438.

208 *Ibid.*, p. 438. More generally, see Christine Bell, "Post-Conflict Accountability and the Reshaping of Human Rights and Humanitarian Law", in Orna Ben-Naftali (ed.), *International Humanitarian Law and International Human Rights Law*, Oxford University Press, Oxford, 2011, p. 328.

209 S. Miller, above note 3, p. 438.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

> remains a gap in hard law and its application, and … a gap in mental health protections.[210]

This is particularly important given the competing demands on limited resources in post-conflict settings. In such settings, the absence of clear legislative obligations is likely to mean that mental health is overlooked; clearer obligations addressing the full range of mental health and psychosocial needs, and more specific guidance on their implementation, could help ensure that mental health is not sidelined in favour of executive discretion and competing priorities.[211] While greater specificity carries its own challenges, including questions of how obligations should be calibrated across States with differing capacities and priorities, the current absence of clear legislative obligations likely poses a more immediate risk for mental health care in resource-constrained post-conflict settings.

Inadequate operational frameworks

While the ICESCR provides general duties of implementation,[212] it does not include specific mechanisms for translating them into concrete action. The CESCR has sought to develop these duties, setting out several steps for implementation at the national level. General Comment No. 14 identifies the adoption of a national public health strategy and plan of action for addressing population health concerns as a minimum core obligation.[213] It also recommends that States formulate policies to implement national strategies, and that they consider adopting a framework law to operationalize their right to health strategy which includes targets, time frames and benchmarks.[214] National health strategies should identify right to health indicators and benchmarks in order to monitor the State's obligations under Article 12.[215]

While General Comment No. 14 recommends several broad implementation measures, gaps remain. It does not, for example, specify operational steps such as conducting needs assessments, implementing a budget or designating a national focal point. This lack of specificity allows a significant degree of variation between States – for example, scholars have identified inconsistency in needs assessment processes across States and institutions.[216] The profound impact that conflict has on individuals, communities and infrastructure leads to a particularly complex array of

210 *Ibid.*, p. 438.

211 See the discussion below in the sections "Prioritization of Victims' Mental Health and Psychosocial Needs" and "Practical Implementation Framework".

212 ICESCR, above note 22, Articles 2, 16–23. See also Limburg Principles, above note 85; CESCR, General Comment No. 10, "The Role of National Human Rights Institutions in the Protection of Economic, Social and Cultural Rights", UN Doc. E/C.12/1998/25, 10 December 1998.

213 General Comment No. 14, above note 30, paras 43, 53.

214 *Ibid.*, paras 56–58.

215 *Ibid.*, para. 57.

216 S. N. Anderlini and J. El-Bushra, above note 7, p. 60.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

needs, demanding an integrated and multifaceted understanding.[217] As the ICRC notes, "hardship forces people to choose between such highly intertwined priorities as safety, food, health care, rent, school fees and other essential needs".[218] As the primary entities responsible for meeting their populations' needs,[219] it is essential that States are able to assess needs in a multifaceted and systematic way in order to meet those needs and ensure adherence to human rights standards.[220] This is particularly important for addressing mental health and psychosocial needs, which, the ICRC's operational experience demonstrates, are often "invisible and unspoken problems" that require specialized assessment approaches to detect, as victims are reluctant to reveal psychological distress.[221]

Given that conflict exacerbates existing inequalities and vulnerabilities,[222] particular attention should be paid to the needs of groups such as women, children and adolescents.[223] WHO has stated that "[t]he severe consequences for women's, children's and adolescents' health and well-being wrought by crises such as conflict, contagion and climate change should be anticipated through gender- and age-sensitive risk assessments and contingency planning".[224] To this end, the CESCR has declared that "[p]riority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population".[225] Operational frameworks that include systematic needs assessments and designated focal points can help to ensure that MHPSS reaches the most vulnerable populations.[226]

Early failure to include responses based on human rights such as the right to health can result in increased vulnerability, decreased State legitimacy, and problems in implementing such obligations down the line.[227] This set of challenges is compounded by the complex nature of post-conflict reconstruction itself; as Anderlini and El-Bushra observe, post-conflict reconstruction involves balancing immediate humanitarian needs with longer-term development goals.[228] These dual demands

217 ICRC, *Understanding People's Needs: Guiding Principles for Multidisciplinary Needs Assessments*, Geneva, February 2024, p. 6, available at: www.icrc.org/en/publication/4752-understanding-peoples-needs-guiding-principles-multidisciplinary-needs-assessments.

218 *Ibid.*, p. 6.

219 ICESCR, above note 22, Art. 2(1).

220 See UNHRC, above note 5, paras 86, 95 (noting that a systematic approach to needs assessments provides guard-rails for avoiding political favouritism and discrimination in the distribution of relief).

221 ICRC, above note 4, p. 42.

222 ICRC, above note 217, p. 6.

223 UNHRC, above note 5, para. 95 (noting the importance of "special attention to the needs of at-risk and marginalized groups within the larger set of beneficiaries" under a human rights-based approach).

224 WHO, *Leading the Realization of Human Rights to Health and through Health*, 2017, p. 35, available at: www.ohchr.org/sites/default/files/ReportHLWG-humanrights-health.pdf.

225 General Comment No. 14, above note 30, para. 65.

226 See the section "Practical Implementation Framework" below.

227 See L. S. Rubenstein, above note 11, pp. 17–19, 42–43; see also 33rd International Conference, above note 1; UNHRC, above note 5, para. 7.

228 S. N. Anderlini and J. El-Bushra, above note 7, p. 60.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

make systematic needs assessment all the more critical to ensure that appropriate attention is given to both short- and long-term issues.[229] Without such systematic approaches, mental health and psychosocial needs – which require both immediate intervention and long-term support – risk being overlooked in favour of more visible emergency priorities.

Lack of inclusive victim participation and consultation

The CESCR has affirmed that the "right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component" of any policy or strategy designed to meet obligations under Article 12.[230] This statement reflects extensive scholarship and treaty body guidance setting out the importance of meaningful participation and consultation of those affected in conflict resolution, peace and development processes.[231] However, in practice, there is a noted "[l]ack of inclusiveness of and accessibility to at-risk groups, including women, children, older persons, persons with disabilities and indigenous peoples, as well as [a] lack of involvement and partnership with private actors".[232] This has led the UN Secretary-General to call for increased participation of groups such as women and people with disabilities in humanitarian decision-making.[233]

Ensuring consultation with victims is particularly important in the context of mental health,[234] with research showing that inclusion of local communities and local health-care personnel plays a significant role in ensuring the effectiveness of mental health interventions.[235] In practice, however, reconstruction discussions

229 *Ibid.*, p. 60.

230 General Comment No. 14, above note 30, para. 54; see also para. 43(f).

231 See e.g. UNHRC, above note 5, para. 95; ICRC, above note 4, p. 11; S. N. Anderlini and J. El-Bushra, above note 7, p. 51; Juan E. Méndez, "Victims as Protagonists in Transitional Justice", *International Journal of Transitional Justice*, Vol. 10, No. 1, 2016, p. 1; Maria Suchkova, *The Importance of a Participatory Reparations Process and Its Relationship to the Principles of Reparation*, ed. Clara Sandoval, Briefing Paper No. 5, University of Essex Reparations Unit, August 2011, available at: https://corteidh.or.cr/tablas/r26685.pdf.

232 UNHRC, above note 5, para. 87; S. N. Anderlini and J. El-Bushra, above note 7, p. 51 (noting that "women and grassroots groups at the front lines of recovery are marginalized and excluded").

233 Strengthening of the Coordination of Emergency Humanitarian Assistance of the United Nations: Report of the Secretary-General, UN Doc. A/76/74–E/2021/54, 14 April 2021, paras 72, 108(i), (o).

234 See e.g. ICRC, above note 4, pp. 11–12; Cleothia Caroline Alford and Yuko Otake, "Participants' Experiences of Engagement in Community-Centred Mental Health and Psychosocial Support Programmes in Conflict-Affected Communities within Sub-Saharan Africa: A Qualitative Systematic Review", *BMJ Global Health*, Vol. 6, No. 12, 2021; Kamali Mahdis *et al.*, "Delivering Mental Health and Psychosocial Support Interventions to Women and Children in Conflict Settings: A Systematic Review", *BMJ Global Health*, Vol. 5, No. 3, 2020; UN Development Programme, *Integrating Mental Health and Psychosocial Support into Peacebuilding: Summary Report*, 2022, available at: www.undp.org/sites/g/files/zskgke326/files/2022-05/UNDP-Integrating-Mental-Health-and-Psychosocial-Support-into-Peacebuilding-Summary-Report-V2.pdf.

235 Diana Carolina Rubio-León *et al.*, "'The Professionals Weren't from Here': Provision of Mental Health Services in the Context of the Colombian Armed Conflict", *Archives of Public Health*, Vol. 83, No. 1, 2025.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

often "begin from economic needs assessment and templates derived from international best practices, rather than through engagement with the affected individuals or with the actual realities on the ground especially in the aftermath of civil conflict".[236] This can result in programmes that are – or are perceived to be – disconnected from local realities or interests, and lack local ownership and trust.[237] Moreover, policies described as reconstruction can in fact be "a vehicle for sustaining and perpetuating structures of domination".[238] These participation gaps both result from and contribute to broader failures in post-conflict human rights implementation, and point to the need, identified in General Comment No. 14, for effective inclusion obligations.[239]

Monitoring and oversight gaps

The right to health is subject to the same general reporting and monitoring obligations as other ICESCR rights. Under ICESCR Article 16, States must submit periodic (five-yearly) reports to the UN Secretary-General on the measures adopted and progress made in fulfilling their obligations under the Covenant.[240] This report may indicate factors and difficulties affecting implementation.[241] In addition, while the ICESCR does not itself contain a complaints mechanism, the 2008 Optional Protocol to the ICESCR creates individual and inter-State complaints mechanisms.[242] The CESCR is responsible for carrying out the monitoring functions under the ICESCR and Optional Protocol, including examining State reports, receiving and considering individual and inter-State complaints, and undertaking inquiries on grave or systematic violations.[243] The particularized regimes discussed above, namely those of

236 Maha Yahya *et al., The Politics of Post-Conflict Reconstruction*, Malcolm H. Kerr Carnegie Middle East Centre, Lebanon, 2018.

237 See ICRC, above note 4, p. 12; D. C. Rubio-León *et al.*, above note 235.

238 M. Yahya *et al.*, above note 236.

239 See General Comment No. 14, above note 30, para. 54.

240 ICESCR, above note 22, Art. 16(1). States must submit a report within two years of accepting the Covenant and every five years thereafter: see UN Human Rights, "Introduction to the Committee", available at: www.ohchr.org/en/treaty-bodies/cescr/introduction-committee.

241 ICESCR, above note 22, Art. 17(2); see also Morten Kjaerum, "State Reports", in Gudmundur Alfredsson, Jonas Grimheden, Bertrand G. Ramcharan and Alfred Zayas (eds), *International Human Rights Monitoring Mechanisms: Essays in Honour of Jakob Th. Moller*, 2nd ed., Brill, Leiden, 2009, pp. 18–19.

242 Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, 2922 UNTS 29, 10 December 2008 (entered into force 5 May 2013) (ICESCR Optional Protocol), Arts 2 and 10 respectively.

243 *Ibid.*, Art. 1; UN Human Rights, "The Committee on Economic, Social and Cultural Rights", Fact Sheet No. 16 (Rev. 1), 1991, available at: www.ohchr.org/sites/default/files/Documents/Publications/FactSheet16rev.1en.pdf; UN Human Rights, "Committee on Economic, Social and Cultural Rights", available at: www.ohchr.org/en/treaty-bodies/cescr. On the constitution of the CESCR, see Economic and Social Council, Res. 1985/17, "Review of the Composition, Organization and Administrative Arrangements of the Sessional Working Group of Governmental Experts on the Implementation of the International Covenant on Economic, Social and Cultural Rights", 28 May 1985.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

the CRPD, the CRC and CEDAW, each have their own monitoring and reporting mechanisms.[244]

However, these frameworks have certain limitations.[245] First, the ICESCR's general and intermittent reporting obligations mean that mental health is necessarily addressed in broad terms. Periodic reports from States currently or recently afflicted by conflict give little, if any, attention specifically to mental health in post-conflict contexts;[246] for example, Somalia's initial report to the CESCR, covering the period 1990–2023, acknowledges that "[m]ental healthcare services are almost non-existent, despite the widespread prevalence of trauma-related disorders resulting from decades of violence and displacement",[247] but there is no further engagement as to how these shortcomings might be addressed. Second, individual and inter-State complaints mechanisms created by the 2008 Optional Protocol to the ICESCR have only limited reach, with just thirty-one ratifications.[248] An advanced search of the Office of the UN High Commissioner for Human Rights' JURIS database conducted by the author failed to disclose any admissible complaints to the CESCR dealing with the right to mental health post-conflict under Article 12.[249] Moreover, most complaints to the CESCR address specific, isolated cases, rather than systemic issues, which may obfuscate a broader understanding of the issue. Finally, mental

244 CRPD, above note 125, Art. 35(2) (establishing four-yearly reporting obligations); Optional Protocol to the Convention on the Rights of Persons with Disabilities, 2518 UNTS 283, 13 December 2006 (entered into force 3 May 2008) (currently has 108 States Parties), Arts 1, 6 (establishing individual communication and inquiry procedures); CEDAW, above note 147, Art. 18 (establishing four-yearly reporting obligations); Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, 2131 UNTS 83, 6 October 1999 (entered into force 22 December 2000) (currently has 116 States Parties), Arts 1–2, 8 (establishing individual communication and inquiry procedures); CRC, above note 139, Art. 44(1)(b) (establishing five-yearly reporting obligations); Optional Protocol to the Convention on the Rights of the Child on a Communications Procedure, 2983 UNTS 135, 19 December 2011 (entered into force 14 April 2014) (currently has fifty-three States Parties), Arts 5, 13 (creating an individual communications and inquiry procedure).

245 This discussion will focus on the limitations under the ICESCR as the most universal treaty, while noting similar structural issues under the specialized regimes.

246 See e.g. CESCR, *Fourth Periodic Report Submitted by Azerbaijan under Articles 16 and 17 of the Covenant, Due in 2018*, UN Doc. E/C.12/AZE/4, 29 January 2019, paras 103–105 (summarizing mental health measures in broad terms); CESCR, *Fifth Periodic Report Submitted by Iraq under Articles 16 and 17 of the Covenant, Due in 2020*, UN Doc. E/C.12/IRQ/5, 20 August 2021, para. 58 (noting in a sentence the preparation of a national plan focusing on providing security and delivering MHPSS in emergency situations); CESCR, *Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights: Second Periodic Report of States Parties Due in 2003 (Sudan)*, UN Doc. E/C.12/SDN/2, 18 September 2013 (no consideration given to mental health care).

247 CESCR, above note 171, para. 115. This was Somalia's first report to the CESCR following its accession to the ICESCR on 24 January 1990.

248 UN Human Rights, "Optional Protocol to the International Covenant on Economic, Social and Cultural Rights", *Status of Ratification Interactive Dashboard*, available at: https://indicators.ohchr.org/.

249 UN Human Rights, *JURIS Database*, available at: https://juris.ohchr.org/. A broader search of complaints concerning mental health identified one admissible decision, which concerned reproductive rights: CESCR, *Views on Communication No. 22/2017 (SC and GP v. Italy)*, UN Doc. E/C.12/65/D/22/2017, 7 March 2019.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

health post-conflict is featured in just 0.1% of treaty bodies' recommendations,[250] highlighting its relative invisibility.

In light of the limitations of existing measures, the UNHRC has urged the creation of accountability mechanisms for enforcing rights as a means to help "strengthen political commitment and justifications for resource allocation, and improve incentives for the provision of social services without discrimination".[251] It has additionally noted that accountability processes are a means of identifying what works and what does not, enabling the revision of programmes and processes.[252] These broader effects render accountability and monitoring mechanisms particularly important, both for the enforcement of individual human rights and for achieving broader goals. Accountability for the right to health is a highly topical issue, with the former Special Rapporteur on the issue arguing that the current accountability framework is "seriously deficient and not fit for purpose".[253]

The implementation gaps outlined herein, combined with broader challenges applying the right to health in post-conflict settings, prompt consideration of how the system could be bolstered. To this end, the following part of the present article explores whether victim assistance regimes might offer insights for the implementation or progressive development of mental health obligations under IHRL.

Victim assistance regimes: A complementary framework

As the UNHRC has observed, "[t]o increase the effectiveness and scope of human rights protection in post-disaster and post-conflict situations, a holistic and complementary approach among the different branches of international law is necessary".[254] Victim assistance models help bridge the gap between conflict and peace by combining IHL's protective approach to victims of armed conflict with IHRL's framework for long-term rights realization, reflecting the conceptual frameworks of both branches of international law. Rather than creating individually enforceable rights for victims of violations, victim assistance models impose primary obligations on States Parties[255] and accordingly operate as a complement to, rather than a substitute for, the rights-based framework of the ICESCR. These models offer potential insights

250 See the article by Giulia Bosi in this issue of the *Review*: Giulia Bosi, "Mental Health in Conflict and Post-Conflict Settings: An Analysis of UN Human Rights Treaty Bodies' Concluding Observations", *International Review of the Red Cross*, Vol. 108, No. 932, 2026.

251 UNHRC, above note 5, para. 40(e).

252 *Ibid.*, para. 40(e).

253 Paul Hunt, "Health Rights and Accountability", *The Lancet*, Vol. 406, No. 10510, 2025, p. 1335–1336 (advocating for "a bottom-up approach" to accountability).

254 UNHRC, above note 5, para. 97. See also General Comment No. 14, above note 30, para. 1.

255 Markus Reiterer and Tirza Leibowitz, "Article 5: Victim Assistance", in Gro Nystuen and Stuart Casey-Maslen (eds), *The Convention on Cluster Munitions: A Commentary*, Oxford University Press, Oxford, 2010, p. 353, para. 5.56; Emily Camins, "Addressing Victim Suffering under Disarmament Law: Rights, Reparations and Humanising Trends in International Law", in Treasa Dunworth and Anna Hood (eds), *Disarmament Law: Reviving the Field*, Routledge, Abingdon, 2021, pp. 120–122.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

for the implementation and development of the right to health, and reflect broader global trends urging States to promote MHPSS in conflict and related settings.[256] The following sections provide an overview of victim assistance models as found in the CCM and the TPNW,[257] before identifying some potential insights that these models offer, as well as their limitations.

Overview of victim assistance models

The CCM and TPNW build on a line of "humanitarian disarmament" treaties, such as the Anti-Personnel Mine Ban Convention, which introduced victim assistance obligations to the traditionally security-oriented field of disarmament law.[258] While the CCM and the TPNW each impose similar primary obligations on States Parties,[259] the victim assistance regime under the CCM is slightly more developed and will be the focus of this section. Article 5(1) of the CCM provides:

> Each State Party with respect to cluster munition victims in areas under its jurisdiction or control shall … adequately provide age- and gender-sensitive assistance, including medical care, rehabilitation and psychological support, as well as provide for their social and economic inclusion.[260]

Article 5(2) goes on to specify measures that States must take to fulfil these victim assistance obligations. These include assessing the needs of cluster munitions victims, developing and implementing national laws, policies and budgets, consulting closely with victims in the development of programmes, and establishing a national focal point.[261]

256 See e.g. UNGA Res. 77/300, above note 8; ICRC, above note 4; 33rd International Conference, above note 1; Inter-Agency Standing Committee (IASC), *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, WHO, 2007, available at: www.who.int/publications/i/item/iasc-guidelines-for-mental-health-and-psychosocial-support-in-emergency-settings.

257 These victim assistance regimes have been explored in some detail elsewhere: see Emily Camins, "Bridging Fault Lines: Exploring an Obligation under International Law to Assist Victims of Armed Conflict", *Harvard Human Rights Journal*, Vol. 26, 2023.

258 Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction, 2056 UNTS 211, 18 September 1997 (entered into force 1 March 1999), Art. 6(3); Protocol on Explosive Remnants of War (Protocol V to the 1980 Convention on Certain Conventional Weapons), 2399 UNTS 100, 28 November 2003 (entered into force 12 November 2006), Arts 8(2), 8(3), (6)–(7). See also Bonnie Docherty and Alicia Sanders-Zakre, "The Origins and Influence of Victim Assistance: Contributions of the Mine Ban Treaty, Convention on the Rights of Persons with Disabilities and Convention on Cluster Munitions", *International Review of the Red Cross*, Vol. 195, No. 922, 2023, pp. 253–254.

259 At the time of writing (2026), there were 111 States Parties to the CCM and seventy-four States Parties to the TPNW. For a comprehensive overview of the victim assistance regime under the TPNW, see ICRC, *The Obligation to Assist Victims and Remediate the Environment within a Framework of Shared Responsibility under the Treaty on the Prohibition of Nuclear Weapons*, Briefing Note No. 4702, April 2023, available at: www.icrc.org/sites/default/files/document/file_list/victim_assistance_and_environmental_remediation_obligations_-_briefing_note_-_icrc.pdf.

260 CCM, above note 33, Art. 5(1); see also TPNW, above note 34, Art. 6(1).

261 CCM, above note 33, Art. 5(2). The TPNW does not contain an equivalent provision (cf. Art. 5 on national implementation).

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

The scope of these obligations depends in part on who qualifies as a victim. The CCM adopts an expansive definition of "cluster munition victims" as meaning

> all persons who have been killed or suffered physical or psychological injury, economic loss, social marginalisation or substantial impairment of the realisation of their rights caused by the use of cluster munitions. They include those persons directly impacted by cluster munitions as well as their affected families and communities.[262]

This broad definition is consistent with the obligation in CCM Article 5(1) to provide for economic and social inclusion, and reflects a recognition of the importance of community-based approaches in post-conflict settings.[263]

Hand in hand with the victim assistance obligation, both the CCM and the TPNW establish an international duty for States in a position to do so to provide assistance in implementing the victim assistance obligation.[264] This may be provided through the UN, the Red Cross and/or other international or non-State actors.[265] These international assistance obligations, while slightly more specific than the open-ended assistance obligation in Article 2 of the ICESCR, remain obligations of conduct and relatively indeterminate due to the subjective nature of the obligation ("in a position to do so").[266] Notably, the TPNW goes further than the CCM, creating an obligation for a State Party that "has used or tested nuclear weapons or any other nuclear explosive devices" to provide assistance to affected States Parties, including for the purposes of victim assistance.[267]

States are required to undertake annual reporting to the UN Secretary-General on the implementation status of their victim assistance obligations.[268] The CCM also provides a framework for periodic meetings and five-yearly Review Conferences, convened by the UN Secretary-General.[269] The Review Conferences held to date have provided a platform for the adoption of CCM Action Plans, which are designed to help "gather momentum" and to "guide and help States Parties and other relevant actors in the practical implementation of the Convention".[270] To date, two action plans have been adopted by the First and Second Review Conferences respectively: the Dubrovnik Action Plan (2015) and the Lausanne Action Plan

262 CCM, above note 33, Art. 2(1). For the meaning of "victim" under the TPNW (which does not define the term), see ICRC, above note 259, pp. 3–5.

263 See e.g. International Criminal Court, *Prosecutor v. Thomas Lubanga Dyilo*, Case No. ICC-01/04-01/06-3129, Decision on Reparations (Appeals Chamber), 3 March 2015, para. 215, available at: www.icc-cpi.int/sites/default/files/CourtRecords/CR2015_02631.PDF.

264 CCM, above note 33, Art. 6(7); TPNW, above note 34, Art. 7(4).

265 CCM, above note 33, Art. 6(7); TPNW, above note 34, Art. 7(5).

266 See the section below on "International Cooperation and Assistance Obligations".

267 TPNW, above note 34, Art. 7(6).

268 CCM, above note 33, Art. 7(2).

269 *Ibid.*, Arts 11–12.

270 Convention on Cluster Munitions, "CCM Action Plans", available at: www.clusterconvention.org/action-plans/.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

(2020).[271] The Third Review Conference will take place in the Lao PDR in 2026,[272] at which the Lausanne Action Plan will be reviewed and a new five-year Action Plan adopted.[273]

Insights from victim assistance models

This section sets out three key areas in which insights from victim assistance models could strengthen responses to mental health and psychosocial needs following armed conflict: the prioritization of these needs; a practical implementation framework; and international assistance obligations.

Prioritization of victims' mental health and psychosocial needs

Victim assistance models offer greater specificity in relation to MHPSS than the ICESCR framework. By explicitly including psychological support and social and economic inclusion in the substantive provision, Article 5(1) of the CCM ensures that these measures receive appropriate priority. Victim assistance provisions under the CCM and TPNW specifically identify victims of the eponymous weapons as particularly vulnerable, and mandate age- and gender-sensitive assistance without discrimination.[274] By clearly articulating these key obligations, these provisions actively prioritize victims' psychological and social inclusion needs. Even if psychosocial dimensions could be read into Article 12 of the ICESCR as underlying determinants of health, they do not receive the explicit prioritization and operational content that victim assistance models provide. In this regard, victim assistance models reflect a conception of good mental health which goes beyond the medical model that has predominated under IHRL,[275] aligning more closely with the MHPSS measures recommended by experts[276] and undertaken by operational actors. The ICRC *Guidelines on Mental Health and Psychosocial Support*, for example, outline a broad range of activities that the ICRC undertakes "to protect and promote psychosocial well-being, prevent mental health disorders and treat such disorders when they

271 Second Review Conference of the Convention on Cluster Munitions (Second Part), *Lausanne Action Plan*, UN Doc. CCM/CONF/2021/6, September 2021, Annex II; First Review Conference of the Convention on Cluster Munitions, *Dubrovnik Action Plan*, September 2015 (Dubrovnik Action Plan).

272 Twelfth Meeting of States Parties, *Convention on Cluster Munitions: Final Report*, UN Doc. CCM/MSP/2024/11, 20 September 2024, para. 90.

273 Convention on Cluster Munitions, "CCM Action Plans", available at: www.clusterconvention.org/action-plans/.

274 CCM, above note 33, Art. 5(1); TPNW, above note 34, Art. 6(1).

275 D. Pūras, UN Doc. A/HRC/35/21, above note 24, para. 12 (on the predominance of the biomedical model).

276 See I. Weissbecker, above note 3, p. 82 (recommending "cost-effective interventions at the community level" and integration of mental health care into primary health services); cf. Juan E. Méndez, *Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development: Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc. A/HRC/22/53, 1 February 2013, para. 89(c) (recommending community-based and other options as alternatives to the medical model of mental health care for persons with psychosocial disabilities).

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

occur",[277] including psychosocial support groups, community sensitization activities and individual supports.[278] UN General Assembly Resolution 77/300 on "Mental Health and Psychosocial Support" takes a similarly broad approach.[279]

This breadth and particularization help to ensure that the specific mental health and psychosocial needs of victims of armed conflict receive priority attention rather than being overlooked in favour of more visible emergency priorities. This adds particularity beyond the relative generality (as to both the objects and content of the right to health) of General Comment No. 14. Particularizing these obligations helps to ensure that victims are not sidelined early in the transition phase when their needs are most acute and longer-term priorities are being established.[280]

The selective scope of victim assistance models, focusing primarily on medical care, rehabilitation and psychological support rather than the full range of human rights, might raise questions about prioritization among different rights, and hierarchies among competing needs, in resource-constrained settings. Such questions reflect criticisms of the minimum core concept's tendency to rank various rights while overlooking other important considerations such as macroeconomic growth or defence policies.[281] While acknowledging their selective scope, it is important to note that victim assistance models are complementary to, and do not purport to displace, adjacent human rights obligations, including under the ICESCR.[282] Moreover, a focus on psychological support and social inclusion seeks to rectify a historically neglected area of human need.[283] Enhancing mental health and psychosocial well-being is of increasing priority,[284] and the need is particularly acute in fragile post-conflict settings. Victim assistance models help to bring the often invisible issue of mental health to the fore, and while such models do not address all the issues relevant to mental health support in or after armed conflict,[285] they do provide a review mechanism through which such issues might be addressed.

Practical implementation framework

As demonstrated above, a key challenge in post-conflict mental health support is the gap between broad IHRL obligations and practical implementation measures.[286] While the ICESCR and General Comment No. 14 provide a general framework for implementation, the CCM provides additional specificity in important respects.

277 ICRC, above note 4.

278 *Ibid.*, pp. 1–6.

279 UNGA Res. 77/300, above note 8 (adopting a broad definition of good mental health).

280 See UNHRC, above note 5, para. 7.

281 K. G. Young, above note 28, p. 114.

282 Alexander Breitegger, *Cluster Munitions and International Law: Disarmament with a Human Face?*, Taylor and Francis, Abingdon, 2011, Chap. 5.7.

283 D. Pūras, UN Doc. A/HRC/35/21, above note 24, para. 6.

284 See e.g. 33rd International Conference, above note 1, para. 1.

285 See S. Miller, above note 3, pp. 446–447 (discussing issues requiring clarification); Mental Illness Principles, above note 72.

286 See the discussion in the above section on "Inadequate Operational Frameworks".

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

This might be drawn on to enhance the international legal response to post-conflict mental health and psychosocial needs.

First, Article 5(2) of the CCM requires States to assess the needs of cluster munition victims.[287] This builds on the obligation in Article 5(1) to "make every effort to collect reliable relevant data with respect to cluster munition victims",[288] which must be done without discrimination against or among such victims (or between such victims and those harmed by other causes).[289] Under the Dubrovnik Action Plan, this requires

> [c]ollecting all necessary data, on an ongoing basis, disaggregated by sex and age, assessing the needs and priorities of cluster munition victims, establishing mechanisms to refer victims to existing services, and identifying any methodological gaps in the collection of data. Such data and needs assessment should be made available to all relevant stakeholders and be integrated into or contribute to national injury surveillance and other relevant data collection systems for use in programme planning.[290]

Some measures for implementing these obligations – such as adding relevant questions to national censuses and sharing data with relevant authorities – are relatively inexpensive and have been used to good effect within the CCM framework.[291] Applied to post-conflict mental health, this framework bolsters the general exhortation in General Comment No. 14 to improve "epidemiological surveillance and data collection on a disaggregated basis".[292]

Second, Article 5(2) requires States to develop and implement national laws and policies, as well as a national plan and budget, "with a view to incorporating them within the existing national disability, development and human rights frameworks and mechanisms".[293] This builds on General Comment No. 14, which requires States to adopt a national strategy and formulate corresponding policies, and exhorts States to "consider adopting a framework law".[294] Incorporating victim assistance obligations into existing disability, development and human rights frameworks facilitates

287 CCM, above note 33, Art. 5(2)(a).

288 *Ibid.*, Art. 5(1).

289 *Ibid.*, Art. 5(2)(a). Treatment should be based solely on "medical, rehabilitative, psychological or socio-economic needs": *ibid.*, Art. 5(2)(e).

290 Dubrovnik Action Plan, above note 271, para. 32(a) (Action 4.1).

291 CCM Coordinators on Victim Assistance, *Guidance on an Integrated Approach to Victim Assistance, by States for States*, Australian Aid *et al.*, 2016, pp. 15, 17, available at: www.clusterconvention.org/files/publications/Guidance-on-an-Integrated-Approach-to-Victim-Assistance.pdf (noting the inclusion of a question on unexploded ordnance in Lao PDR's 2015 national census).

292 General Comment No. 14, above note 30, para. 16.

293 CCM, above note 33, Art. 5(2)(b)–(c); see also CCM Coordinators on Victim Assistance, above note 291. On the importance of political planning and budgeting, see S. N. Anderlini and J. El-Bushra, above note 7, p. 60. And see General Comment No. 14, above note 30, para. 36.

294 General Comment No. 14, above note 30, paras 53, 56.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

a sustainable and integrated approach.[295] Good practice under the CCM framework includes policies providing humanitarian and development agencies with a mandate to ensure the inclusion of survivors and indirect victims in aid to affected States.[296]

Third, under CCM Article 5(2)(d), States must also take steps to mobilize national resources;[297] similarly to the above, this builds on the remark in General Comment No. 14 that States must adopt budgetary measures towards the realization of the right to health.[298] Imposing a requirement to mobilize resources goes beyond a budgetary obligation and could militate against attempts to avoid obligations based on progressive realization. This requirement reflects recommendations of the UNHRC regarding funding.[299]

Fourth, Article 5(2) of the CCM requires States to consult closely with and "actively involve" cluster munition victims in fulfilling their victim assistance obligations. This involves ensuring victims' "full, equal and meaningful participation in relevant Convention-related matters".[300] To this end, national legislation or policy should require regular consultation with disability and survivor organizations to ensure that direct and indirect victims and other vulnerable groups are included in initiatives.[301] This obligation reflects the CESCR's recommendation that the formulation and implementation of national health strategies and plans should respect the right of affected groups to participate in decision-making processes which may affect their development.[302] Good practice under the CCM framework includes establishing measures to include victim survivors and indirect victims in projects benefiting affected States, and taking practical steps to eliminate barriers that prevent survivors and indirect victims from accessing services.[303]

Fifth, States must designate a focal point within the government for coordinating victim assistance matters.[304] The provision of MHPSS is likely to involve

295 CCM Coordinators on Victim Assistance, above note 291, pp. 1–2 (noting the importance of realizing victim assistance obligations through broader disability, development and human rights frameworks in order to ensure sustainable support).

296 *Ibid.*, pp. 27–29 (noting, *inter alia*, Australia's practice of encouraging partner governments to integrate victim assistance into national health and disability policy frameworks, Belgium's practice of defining humanitarian aid based on the needs and level of vulnerability of target populations, with a focus on victims and persons with disabilities, and Switzerland's practice of supporting victim assistance through efforts that benefit survivors and indirect victims).

297 CCM, above note 33, Art. 5(2)(d).

298 General Comment No. 14, above note 30, para. 33.

299 See the UNHRC's recommendation on the establishment of funding for emergency response, relief and reconstruction, and the allocation of funds in the annual budget: UNHRC, above note 5, para. 90.

300 Second Review Conference of the Convention on Cluster Munitions (Second Part), above note 271, Action 5.

301 CCM Coordinators on Victim Assistance, above note 291, p. 27.

302 General Comment No. 14, above note 30, para. 43.

303 CCM Coordinators on Victim Assistance, above note 291, pp. 30–31 (noting, *inter alia*, Austria's practice requiring its partners to conduct a self-assessment of proposed projects during the design stage which considers disability, age, gender, minority and displacement as indicators of vulnerability, and requiring partners to ensure inclusion and equal access to services).

304 CCM, above note 33, Art. 5(2)(g).

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

several government ministries, including those of health, social services and education, alongside other agencies.[305] The focal point obligation ensures coherence and representation across a range of government departments, and creates a contact point for victims' organizations and international bodies.[306] There has been relatively strong adherence to this obligation: in 2023, twelve of the fourteen States Parties with cluster munition victims had a victim assistance focal point.[307] Good practice recommends that the victim assistance focal point has a seat on the disability council and is represented on a national development committee which involves all key ministries.[308]

Finally, there appears to have been a reluctance among States in recent years to adopt international measures that confer individual rights enforceable directly against States.[309] The adoption of treaties such as the CCM and the TPNW suggests, however, that States have been willing to commit to reasonably extensive obligations to assist victims, along with transparency measures such as annual reporting to the UN Secretary-General on the implementation status of their victim assistance obligations.[310] Whereas Article 16 of the ICESCR requires periodic reports to the UN Secretary-General, the CCM requires annual reports and Review Conferences every five years.[311] States Parties have recognized that transparency reporting promotes trust and confidence between States, helps to monitor progress in implementing treaty obligations, facilitates international cooperation and assistance, and can foster understanding of assistance needs;[312] it also provides parties with a clear view of relevant developments, enables informed decision-making, demonstrates the practical impact of the CCM, and enables identification and addressing of implementation challenges.[313] Recent reports from affected States Parties have demonstrated

305 IASC, above note 256, p. 34; Dubrovnik Action Plan, above note 271, Action 4.1.

306 Dubrovnik Action Plan, above note 271, Action 4.1.

307 Cluster Munition Coalition, *Cluster Munition Monitor 2024*, Geneva, 2024, pp. 71, 79, available at: https://icblcmc.org/assets/reports/Cluster-Munition-Monitors/CMM2024/Downloads/Cluster-Munition-Monitor-2024-Web.pdf.

308 CCM Coordinators on Victim Assistance, above note 291, p. 14.

309 See Catia Lopes and Noëlle Quénivet, "Individuals as Subjects of International Humanitarian Law and Human Rights Law", in Noëlle N. R. Quénivet and Roberta Arnold (eds), *International Humanitarian Law and Human Rights Law: Towards a New Merger in International Law*, Brill, Leiden, 2008, p. 214 (on States' desire to keep the monopoly on justice); Steven van de Put and Magdalena Pacholska, "Beyond Retribution: Individual Reparations for IHL Violations as Peace Facilitators", *International Review of the Red Cross*, Vol. 106, No. 927, 2024, p. 1198 (arguing that States have historically been reluctant to provide individual reparations for IHL violations, and that an individual right to such reparations can only be established through a political decision of States); Emily Camins, "Between Rights, Sovereignty and Cooperation: Responding to Victims of Armed Conflict", *Journal of International Humanitarian Legal Studies*, Vol. 13, No. 1, 2022.

310 On the benefits of transparency reporting under the CCM, see Australia, Thirteenth Meeting of States Parties, Agenda Item 10(g): Review of the Status and Operation of the Convention and Other Matters Important for Achieving the Aims of the Convention — Transparency Measures, UN Doc. CCM/MSP/2025/12, 12 September 2025.

311 CCM, above note 33, Art. 7.

312 Australia, above note 310, para. 4.

313 *Ibid.*, para. 5.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

relatively high levels of implementation of victim assistance obligations, including by collecting data, establishing national policies and legal frameworks, and creating a national focal point.[314] Eight out of twelve affected States reported well-functioning rehabilitation, psychological and psychosocial services.[315] Despite the benefits of transparency reporting, however, some States face challenges in meeting their obligations, including lack of awareness, lack of capacity and resources, lack of coordination and lack of political support.[316]

International cooperation and assistance obligations

The victim assistance regimes in the CCM and TPNW complement international cooperation and assistance obligations, including Articles 55 and 56 of the UN Charter. Recognizing that post-conflict States may have limited resources, Article 6(1) of the CCM provides that "[i]n fulfilling its obligations under this Convention each State Party has the right to seek *and receive* assistance".[317] Article 6(7) of the CCM proceeds to impose on States Parties "in a position to do so" an obligation to provide assistance as set out in Article 5.[318] This language reflects sovereignty-related concerns, with efforts during negotiations to impose stronger obligations proving unsuccessful.[319] By contrast, the TPNW goes a step further, explicitly requiring that a State Party which has used or tested nuclear weapons has a duty to provide "adequate assistance to affected States Parties" for victim assistance purposes.[320] This inclusion was seen by some as rectifying a shortcoming of the CCM.[321] International assistance may be provided on a bilateral basis or through alternative channels, including the UN system, international, regional or national organizations, the components of the International Red Cross and Red Crescent Movement, and non-governmental organizations.[322] This allows for a coordinated partnership approach, which is consistent with reconstruction best practice.[323]

314 Thirteenth Meeting of States Parties to the CCM, *13MSP Progress Report: Monitoring Progress in Implementing the Lausanne Action Plan*, 16–19 September 2025 (CCM Progress Report), pp. 28–29 (noting that all twelve affected States had established a national focal point and nine had developed victim assistance laws and policies with the inclusion of victims).

315 *Ibid.*, pp. 28–29.

316 Australia, above note 310, para. 14.

317 CCM, above note 33, Art. 6(1) (emphasis added); see also TPNW, above note 34, Art. 7(2).

318 CCM, above note 33, Art. 6(7); TPNW, above note 34, Art. 7(4). The CCM obligation is not dissimilar to the assistance obligation in the ICESCR: see General Comment No. 14, above note 30, para. 39 (exhorting States to "provide the necessary aid when required").

319 See, further, *Diplomatic Conference for the Adoption of a Convention on Cluster Munitions*, Doc. CCM/58 (Botswana), 19 May 2008, p. 310 (arguing that the assistance provision should be strengthened to ensure funding); E. Camins, above note 309.

320 TPNW, above note 34, Art. 7(6).

321 See Bonnie Docherty, "The Legal Content and Impact of the Treaty on the Prohibition of Nuclear Weapons", Nobel Peace Prize legal seminar, 11 December, available at: http://hrp.law.harvard.edu/wp-content/uploads/2017/12/Impact-of-TPNW-Nobel-presentation-Dec-2017.pdf.

322 CCM, above note 33, Art. 6(7).

323 See S. N. Anderlini and J. El-Bushra, above note 7, p. 60.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

Practically speaking, the CCM international cooperation and assistance model appears to have had mixed success in meeting the needs of cluster munitions victims. Like duties under the ICESCR, victim assistance obligations are ultimately subject to resource availability. While progress has been made in respect of medical care and socio-economic inclusion in many countries, "structural constraints, limited resources, and weak coordination continue to hinder implementation of the Lausanne Action Plan's victim assistance commitments".[324] In recent years in particular, declines in funding for the community-based work of local organizations has hampered access to rehabilitation and economic activities under the CCM.[325] Accordingly, victim assistance under the CCM remains "uneven and under-resourced" across affected States Parties.[326] Reports at the 2025 Meeting of States Parties to the CCM indicated that six of the nine affected States which requested international assistance had received such support.[327]

While not a panacea, the content of and practice under victim assistance models nonetheless offer useful insights for addressing the resource constraints that most acutely hinder post-conflict mental health responses. Stronger cooperation and assistance obligations could help address a key challenge in implementing ESC rights post-conflict: the fact that "no distinction is made between violations of ESC rights and the lack of capacity to observe them".[328] As Giacca notes, ESC rights are necessarily dependent to some degree upon a country's level of development given progressive realization.[329] He suggests, however, that notwithstanding their detrimental socio-economic impacts, armed conflict and unrest do not preclude States from sustaining or increasing requests for international cooperation and assistance.[330]

Two related questions arise *de lege ferenda*: when should the obligation to assist be triggered, and on whom does it fall? Giacca's analysis points to the fact that it is not always clear whether States are genuinely unable to fulfil obligations due to lack of resources or are violating them for other reasons. One way to help overcome this lack of clarity might be to allocate and prioritize assistance based on mandated post-conflict needs assessments and national budgets. The principle of impartiality, which mandates that assistance be allocated based on need alone, offers some normative foundation for such an approach.[331] While this approach might help to clarify

324 Cluster Munition Coalition, *Cluster Munition Monitor 2025*, Geneva, 2025, p. 51, available at: https://icblcmc.org/assets/reports/Cluster-Munition-Monitors/CMM2025/Cluster-Munition-Monitor-2025-Web.pdf.

325 *Ibid.*, pp. 79–83; Human Rights Watch, "Cluster Munitions: States Should Uphold Ban Treaty", 15 September 2025, available at: www.hrw.org/news/2025/09/15/cluster-munitions-states-should-uphold-ban-treaty.

326 Cluster Munition Coalition, above note 324, p. 51.

327 CCM Progress Report, above note 314, para. 159. The situation of the remaining three, and the sufficiency and legal basis of the support received, is not specified.

328 G. Giacca, above note 27, p. 11. See also K. G. Young, above note 28, p. 170, noting the importance of addressing questions of cooperation and interdependence.

329 G. Giacca, above note 27, p. 274.

330 *Ibid.*, p. 274.

331 Statutes of the Movement, above note 19, Preamble.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

the first question, however, it does not address the second question of which States should provide the assistance. To this end, a model based loosely on the TPNW – which requires States that have used or tested nuclear weapons to provide assistance – provides an interesting, though perhaps politically unpopular, option.

Operationalizing victim assistance

As Young argues, rather than seeking to fix the content of economic and social rights through a minimum core, a more productive approach may be to develop indicators, benchmarks and institutional mechanisms that give rights operational meaning in specific contexts.[332] The victim assistance frameworks examined above suggest several such mechanisms that could strengthen the international legal and policy response to mental health and psychosocial needs post-conflict. These include a dedicated post-conflict needs assessment obligation, integration of MHPSS obligations into existing national frameworks, creation of a designated focal point, victim consultation requirements, and a more robust international assistance trigger, potentially linked to demonstrated need. These need not await new treaty development and could be advanced, in the first instance, through CESCR guidance or soft-law instruments.[333]

Victim assistance regimes are primarily duty-based rather than individual rights-based.[334] Unlike the ICESCR framework,[335] they do not confer individually enforceable rights, nor do they establish complaints mechanisms through which victims can seek redress directly against a State. This feature may reflect political realities; States have proven more willing to commit to assistance obligations than to create new, individually enforceable entitlements.[336] It nonetheless raises a genuine question about whether drawing on victim assistance models risks prioritizing "assistance" over accountability, potentially weakening the rights-based foundation that IHRL provides.[337] However, the argument advanced in this article is not that victim assistance frameworks should displace IHRL obligations; rather, they should complement them. Victim assistance models offer a detailed application of the obligation to fulfil the right to (mental) health in the specific context of post-conflict populations, giving specific operational content to obligations that, under the ICESCR, remain relatively general. The individually enforceable rights, complaints mechanisms and accountability framework remain those of the ICESCR and associated instruments. What victim assistance models supply are operational mechanisms to help give those rights practical effect; they also bring to the fore aspects of the right to health that tend not to be prioritized (namely mental health and

332 See e.g. K. G. Young, above note 28, pp. 165–166.

333 The CESCR's anticipated General Comment on armed conflict would provide an appropriate platform for such clarification: see UN Human Rights, above note 80.

334 E. Camins, above note 255, pp. 120–122; see also M. Reiterer and T. Leibowitz, above note 255, para. 5.56.

335 ICESCR, above note 22; ICESCR Optional Protocol, above note 242.

336 See E. Camins, above note 309, pp. 17–19.

337 I am grateful for the comments of an anonymous reviewer on this point.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

psychosocial needs),[338] specifically in respect of an under-serviced population. As Françoise Hampson and Ibrahim Salama observe, "[t]wo mutually supportive sets of norms can only enhance the protection of human rights in all circumstances".[339] The CCM and TPNW provide precedents for how victim assistance regimes can operate alongside IHRL in a mutually reinforcing manner: IHRL supplies the rights-based foundation and accountability mechanisms that victim assistance regimes lack, while victim assistance regimes supply the operational specificity and post-conflict adaptation needed to bolster the ICESCR framework. An expansive reading of the obligation to fulfil the right to health under the ICESCR would accommodate many of these features; victim assistance models make them explicit and provide working models for their implementation.[340]

That being said, such measures are unlikely to provide a silver bullet for post-conflict harm. Victim assistance models suffer from the limitations endemic across international law, such as resource constraints and considerations of State sovereignty precluding international assistance. However, the insights and specific measures that victim assistance models offer could nonetheless help to prioritize and operationalize MHPSS for victims of armed conflict.

Conclusion

Despite being both urgent and important, mental health and psychosocial needs are often overlooked in post-conflict situations.[341] While Article 12 of the ICESCR provides a sound doctrinal foundation for the right to health, its impact is limited in the context of mental health post-conflict. It lacks specificity on the scope of mental health as a minimum core obligation, and may not extend to the broader psychosocial needs that are endemic to armed conflict. This risks the deprioritization of mental health and psychosocial needs in favour of more visible demands. In addition to conceptual gaps, practical challenges arise due to resource constraints (genuine or asserted), weak international assistance obligations and inadequate implementation. The conceptual gaps in the legal framework, combined with the practical challenges involved, might contribute to the unmet mental health and psychosocial needs of victims of armed conflict. This invites consideration of how the existing system might be strengthened or improved.

The UNHRC emphasizes the importance of a complementary and holistic approach between the different branches of international law in addressing the needs of victims in post-conflict settings.[342] To this end, victim assistance regimes may

338 D. Pūras, UN Doc. A/HRC/35/21, above note 24, para. 6.

339 Françoise Hampson and Ibrahim Salama, *Working Paper on the Relationship between Human Rights Law and International Humanitarian Law*, UN Doc. E/CN.4/Sub.2/2005/14, 21 June 2005, para. 31.

340 Whether breach of the obligations proposed herein could provide the foundation for individual rights claims is a separate question beyond the scope of this article.

341 S. Miller, above note 3, p. 435. More generally, see D. Pūras, UN Doc. A/HRC/35/21, above note 24, para. 6.

342 UNHRC, above note 5, para. 97.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press

offer insights into particularizing and prioritizing MHPSS. Three features are particularly instructive. First, victim assistance models in humanitarian disarmament treaties explicitly include social and economic inclusion alongside psychological support as a primary obligation. Second, they set out concrete implementation mechanisms for embedding the obligation nationally, including needs assessment frameworks, national focal points, integration within existing frameworks and victim consultation requirements. Third, victim assistance models establish somewhat clearer international assistance obligations, including, in the case of the TPNW, a responsibility on user States to assist. In this regard, victim assistance regimes might be understood as adding specificity to the right to health obligations under the ICESCR. These models are context-specific; accordingly, they are not framed in the language of progressive realization as they provide frameworks designed to apply post-conflict, which limits the scope for resource-based arguments to defer implementation. Of course, it must be acknowledged that this in itself does not overcome the existence of resource limitations, and that it highlights the need for stronger international assistance obligations.

Victim assistance regimes, while imperfect, provide valuable insights for addressing mental health and psychosocial needs post-conflict, whether future developments take the form of new programmes, policies, soft-law instruments or treaties. These regimes' particularized obligations, implementation measures, and international assistance and cooperation frameworks offer practical responses to the challenges of meeting mental health and psychosocial needs in resource-constrained post-conflict environments. Such measures could be advanced through CESCR guidance, soft-law instruments or the progressive development of existing frameworks, building on the model that victim assistance regimes have already established for victims of specific weapons. As the international community grapples with high levels of conflict and its ensuing harms, ensuring adequate mental health support for those affected is not just a humanitarian imperative, but is also essential for sustainable peace and development.

https://doi.org/10.1017/S1816383126101271 Published online by Cambridge University Press