



**Physicians for
Human Rights**

520 8th Avenue Suite 2301,
23rd Floor
New York, NY
10018

+1.646.564.3720
phr.org

**Submission to the U.N. Committee on Economic, Social and Cultural Rights
for the Draft General Comment on the Application of the International Covenant
on Economic, Social and Cultural Rights in Situations of Armed Conflict**

Physicians for Human Rights

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This submission addresses the application of the right to the highest attainable standard of physical and mental health under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) in situations of armed conflict, with a particular focus on the reverberating impacts of attacks on health.

Physicians for Human Rights (PHR) is a human rights organization working at the intersection of science, medicine, forensics, public health, and the law to conduct research, launch fact-finding investigations, and mobilize health professionals and allies in other fields to confront humanitarian emergencies and support justice for victims and survivors of human rights violations.

This submission draws on PHR's work on documenting attacks on health and health-enabling infrastructure and their reverberating health impacts in Ukraine; reproductive and child health in Gaza; and sexual and reproductive health in Syria.

Confidentiality is not required for this submission.

I. Impact of armed conflicts on right to health

1. Attacks on health have increasingly become a feature of military strategies with significant impacts on civilian protection. In 2024, the Safeguarding Health in

Conflict Coalition documented 3,623 incidents of violence against, or obstruction of, health care across 36 countries and territories, the highest annual total since global monitoring began in 2014.¹

2. Despite their scale, the lawfulness and impacts of attacks on health are often assessed only through visible structural damage and immediate casualties. However, this assessment underestimates impacts on health and obscures how armed conflict destroys conditions necessary for the enjoyment of the right to health.
3. Some of the gravest harms to health and health care arise through repercussive or reverberating effects that ripple through systems over time and space as a result of destruction of infrastructure and/or harm to civilians.² These include individual harms, such as untreated long-term and chronic diseases; psychological trauma, avoidant health-seeking behaviors; and, ultimately, morbidity and mortality – as well as harms to health systems, including interrupted care and referrals; supply shortages; challenges in health workforce retention and morale; delayed diagnostics; and lost preventive care.³ Such impacts, especially in prolonged conflicts, are often foreseeable, cumulative, and devastating.
4. PHR’s research on Gaza, with the University of Chicago Law School’s Global Human Rights Clinic, demonstrates how attacks on health facilities, restrictions on medical supplies, damage to basic infrastructure, and deprivation of food and other essential commodities combine to produce severe and foreseeable harms for pregnant, postpartum, and lactating women and newborns.⁴ These harms include restricted access to antenatal care, emergency obstetric care, contraception, menstrual hygiene supplies, and abortion care, along with heightened risks of infection, anemia, hemorrhage, sepsis, miscarriage, developmental harm, and long-term intergenerational harm.
5. In Ukraine, PHR and Truth Hounds documented how attacks on energy infrastructure produced widespread and foreseeable health harms, including in facilities that were not directly struck. Ninety-two percent of over 2,200 surveyed healthcare workers reported power outages at facilities where they worked due to attacks on energy infrastructure; sixty-six percent reported outages affected medical procedures.⁵ Reported consequences included disruption of water supply, heating, ventilation, communications, elevators, diagnostics, medicine storage, planned procedures, and surgeries, as well as permanent health harms and deaths. Harm

¹ “Epidemic of Violence: Violence Against Health Care in Conflict,” Safeguarding Health in Conflict Coalition, May 2024, <https://insecurityinsight.org/wp-content/uploads/2025/04/2024-SHCC-Annual-Report.pdf>

² Haar R et al, “Methodologies for evaluating impacts of attacks on health in conflict,” RIAH Working Paper 2, March 2026, https://riah.manchester.ac.uk/wp-content/uploads/2026/03/METHODS-PAPER_Evaluating-Health-Impacts-of-Conflict-Final.pdf

³ Haar R et al, “The cascading impacts of attacks on health in Syria: A qualitative study of health system and community impacts,” PLOS Glob Public Health. 2024 Jun 13;4(6):e0002967. doi: 10.1371/journal.pgph.0002967.

⁴ “Destroying Hope for the Future: Reproductive Violence in Gaza,” Physicians for Human Rights and the Global Human Rights Clinic at the University of Chicago Law School, January 2026, <https://phr.org/our-work/resources/destroying-hope-for-the-future-reproductive-violence-in-gaza/>.

⁵ “Health Care in the Dark: The Impact of Russian Attacks on Energy in Ukraine,” Physicians for Human Rights and Truth Hounds, December 2024, <https://phr.org/our-work/resources/health-care-in-the-dark-attacks-on-energy-in-ukraine/>.

extended beyond clinical setting: interruptions to power and essential services affected people relying on home-based medical devices and regular treatment routines, older people, people with disabilities, and those living with chronic illnesses who faced heightened risks of treatment interruption and worsening physical and mental health.⁶

6. PHR's research in northwest Syria showed how attacks on health reshape reproductive decision-making and produce serious downstream harms. Women reported avoiding prenatal visits out of fear of bombardment, kidnapping, or exploitation.⁷ In the months following a March 2021 attack on al-Atareb Hospital in Aleppo governate, reproductive and neonatal care consultations dropped seventy-eight percent.⁸ Some chose cesarean sections to reduce the time needed inside facilities they believed were unsafe.
7. Following the recent developments in the Middle East, there are serious concerns about health and environmental risks to civilian populations due to attacks on energy infrastructure in the Persian Gulf region.⁹ Such targeting, including of fossil fuel facilities such as oil and gas fields, refineries, and power plants, poses severe and long-lasting health and environmental risks. The attacks threaten widespread civilian harm through explosions, toxic releases, air and water contamination, and disruptions to essential services including electricity, water treatment, and healthcare delivery.

II. Obligations to respect, protect, fulfill, and prevent

8. ICESCR Article 12 guarantees the right to the highest attainable standard of physical and mental health.¹⁰ As elaborated in General Comment No. 14, under no circumstances may a State justify non-compliance with the obligations to: (i) ensure access to health facilities and goods and services on a non-discriminatory basis; (ii) ensure access to the minimum essential food; (iii) ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; and (iv) provide essential drugs.¹¹

⁶ Submissions by PHR and Truth Hounds to the Independent International Commission of Inquiry on Ukraine, December 2025 and April 2026 (unpublished).

⁷ "She Pays the Highest Price: The Toll of Conflict on Sexual and Reproductive Health in Northwest Syria," Physicians for Human Rights, March 2023, <https://phr.org/our-work/resources/sexual-and-reproductive-health-in-northwest-syria/>.

⁸ "No Place Is Safe for Health Care": The Attack on Syria's al-Atareb Hospital," Physicians for Human Rights, Syrian American Medical Society, 2021, <https://phr.org/issues/health-under-attack/attacks-in-syria/al-atareb-surgical-hospital-no-place-in-syria-is-safe-for-health-care/>

⁹ "U.S., Israel, and Iran Must Refrain from Attacks on Civilian Energy Infrastructure, Which Endanger Public Health: Joint Statement by PHR and HRA," April 2, 2025, <https://phr.org/news/u-s-israel-and-iran-must-refrain-from-attacks-on-civilian-energy-infrastructure-which-endanger-public-health-joint-statement-by-phr-and-hra/>.

¹⁰ ICESCR Article 12. See also CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12).

¹¹ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), paras. 43, 47. The Committee confirms that obligations of comparable priority include the obligations to ensure reproductive, maternal (prenatal as well as post-natal) and child health care; to provide immunization against the major infectious diseases occurring in the community; to take measures to prevent, treat and control epidemic and endemic diseases. *See ibid.*, para. 44.

9. In situations of armed conflict, the enjoyment of the right to health depends not only on hospitals, ambulances, medicines, and personnel, but also on the civilian systems and services that ensure the underlying determinants of health, including electricity, fuel, water, sanitation, communications, transport, functioning referral pathways, and humanitarian access. It also depends on “the environmental conditions in which an individual lives.”¹² Attacks on these can predictably impair the provision of care and consequently result in long-term impacts on health.
10. The tripartite obligations to respect, protect, and fulfill the right to health impose specific requirements during armed conflict. The obligation to *respect* requires States and parties to a conflict to refrain from interfering, directly or indirectly, with the enjoyment of the right to health, including by abstaining from attacks on medical facilities, personnel, and transports as well as from measures that obstruct access to care. The obligation to *protect* requires preventing third-parties, including non-State armed groups and corporate actors, from impairing the right to health, including through regulation, oversight, and accountability. The obligation to *fulfill* requires positive measures to ensure availability and continuity of essential health services and underlying determinants of health. This includes contingency planning for foreseeable conflict-related disruptions, restoration of damaged systems, and recourse to international assistance and cooperation to the maximum extent possible given available domestic capacity. These obligations also require taking into account and addressing the significant environmental impacts resulting from armed conflict and military activities, which, in turn, can impact the right to health.¹³
11. Each of these obligations applies in situations of armed conflict and occupation, alongside international humanitarian law (IHL).¹⁴ The International Court of Justice (ICJ) has affirmed that “protection offered by human rights conventions does not cease in case of armed conflict or of occupation” and that while “some rights may be exclusively matters of international humanitarian law; others may be exclusively matters of human rights law; yet others may concern both these branches of international law.”¹⁵
12. States’ obligations under ICESCR Article 12 are not confined to their sovereign territory. As a matter of general principle, “international human rights instruments are applicable ‘in respect of acts done by a State in the exercise of its jurisdiction

¹² *Obligations of States in respect of Climate Change*, Advisory Opinion of 23 July 2025, para. 379.

¹³ *Obligations of States in respect of Climate Change*, Declaration of Judge Cleveland, paras. 15-20.

¹⁴ International human rights law serves to “support, strengthen, and clarify analogous principles of international humanitarian law”: ICRC Customary Law Study, Vol. 1, p. xxxvii., <https://www.icrc.org/sites/default/files/external/doc/en/assets/files/other/customary-international-humanitarian-law-i-icrc-eng.pdf>. This reinforces the complementary nature of these legal frameworks in protecting civilians and health systems during conflict.

¹⁵ *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory*, Advisory Opinion, *I.C.J. Reports 2004 (I)*, p. 178, para. 106; *Legal Consequences arising from the Policies and Practices of Israel in the Occupied Palestinian Territory, including East Jerusalem*, Advisory Opinion, *I.C.J. Reports 2024*, p. 792, para. 99. See generally, e.g., United Nations Human Rights Committee, *General Comment No. 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, UN Doc. CCPR/C/21/Rev.1/Add.13 (26 May 2004), para. 11; ICRC. “IHL and Human Rights Law” (2010), available at: <https://www.icrc.org/en/document/ihl-human-rights-law>.

outside its own territory’, particularly in occupied territories.”¹⁶ The ICESCR, in particular, applies “both to territories over which a State party has sovereignty and to those over which that State exercises territorial jurisdiction.”¹⁷

13. On this basis, the ICJ has considered Israel bound by the ICESCR, including the right to health of the local population, in respect of its conduct in the Occupied Palestinian Territory.¹⁸ The European Court of Human Rights similarly recognized that effective control over territory or persons triggers the full spectrum of human rights obligations, including positive duties to protect and fulfill.¹⁹ Even absent territorial control, a State’s conduct can engage its obligation to respect, protect, and fulfill the right to health where it foreseeably contributes to violations abroad. Arms transfers, including authorization, brokering, financing, or transit of arms, are a paradigmatic example. Similarly, the targeting and/or logistical, financial, or operational support to a party whose conduct foreseeably contributes to attacks on health or health-enabling infrastructure may engage the supplying State’s responsibility.²⁰
14. The obligation to respect, protect, and fulfill the right to health operates alongside, and is reinforced by, specific protections under IHL. While IHL provides specific rules governing medical protection, humanitarian access, and supplies essential to survival, the right to health provides broader protection and fills areas unregulated by IHL. Article 18 of Geneva Convention IV (GCIV) provides that civilian hospitals organized to give care to the wounded and sick, the infirm, and maternity cases may in no circumstances be the object of attack. Article 20 extends protection to staff engaged in their operation.²¹ Articles 12, 15, and 21 of Additional Protocol I (API) extend protection to civilian medical personnel, units, and transports. Article 14 restricts requisitioning of civilian medical resources where doing so would deprive the civilian population of adequate care.²² Customary IHL enshrines these protections in Rules 25, 28, 29, and 30; Rule 54 prohibits attacks on objects indispensable to the survival of the civilian population, including drinking water installations and supplies.²³
15. The duties of an occupying power, set out principally in Articles 42-56 of the 1907 Hague Regulations and Articles 27-78 of GCIV, require territory to be administered

¹⁶ *Armed Activities on the Territory of the Congo (Democratic Republic of the Congo v. Uganda)*, Judgment, I.C.J. Reports 2005, p. 243, para. 216.

¹⁷ *Construction of a Wall*, p. 180, para. 112.

¹⁸ *Construction of a Wall*, I.C.J. Reports 2004 (I), pp. 180-181, paras. 111-112; *Policies and Practices of Israel in the Occupied Palestinian Territory*, I.C.J. Reports 2024, p. 792, para. 100; *Obligations of Israel in relation to the Presence and Activities of the United Nations, Other International Organizations and Third States in and in relation to the Occupied Palestinian Territory*, Advisory Opinion of 22 October 2025, paras. 151-152.

¹⁹ See, e.g., *Case of Loizidou v. Turkey (Preliminary Objections)*, Application No. 15318/89, Judgment (23 March 1995), para. 62.

²⁰ See Articles on the Responsibility of States for Internationally Wrongful Acts, Articles 16-17.

²¹ *Geneva Convention Relative to the Protection of Civilian Persons in Time of War* (adopted 12 August 1949, entered into force 21 October 1950) 75 UNTS 287 (GCIV), arts. 18, 20.

²² *Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I)* (adopted 8 June 1977, entered into force 7 December 1979) 1125 UNTS 3, arts. 12, 14, 15, 21.

²³ Jean-Marie Henckaerts and Louise Doswald-Beck, *Customary International Humanitarian Law, Volume I: Rules* (Cambridge University Press/ICRC 2005), rules 25, 28, 29, 30, 54.

for the benefit of the local population. Articles 55 and 56 of GCIV impose positive obligations to ensure food and medical supplies “to the fullest extent of the means available” and to maintain medical, hospital, and public health services; Article 59 imposes an unconditional duty to facilitate relief. Article 69 of API extends protected relief to “clothing, bedding, means of shelter, [and] other supplies essential to the survival of the civilian population of the occupied territory.”

16. The conduct of hostilities is governed by the principles of distinction, proportionality, and precaution, which apply whether or not a strike directly targets medical infrastructure or personnel. When targeting a military objective, a combatant may not launch “an attack which may be expected to cause incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof, which would be excessive in relation to the concrete and direct military advantage anticipated.”²⁴ Civilian harm extends beyond immediate physical injury; it encompasses cumulative, indirect, and reverberating effects²⁵ “insofar as they are reasonably foreseeable in the circumstances.”²⁶ These indirect and reverberating effects may include “interruptions of electricity, gas, heating and water supplies ... including their impact on the health system.”²⁷
17. Attacks on hospitals, energy, water and sanitation infrastructure, and transport networks are liable to produce cascading consequences for the health of the civilian population that far exceed the immediate damage. These foreseeable effects must be incorporated into the proportionality calculus.
18. The principle of precaution requires parties to take all feasible precautions in choosing means and methods of warfare with a view to avoiding, and in any event minimizing, incidental harm to civilians and civilian objects. This requires an attacking party to assess, in advance, the full range of consequences that may foreseeably result from a planned operation, including the indirect effects on civilian health infrastructure and the population’s access to medical care.
19. Restrictions on movement and access of humanitarian and medical personnel compound harm caused by attacks. Where siege-like conditions are imposed or access for medical and humanitarian teams is obstructed, the capacity of the civilian

²⁴ *Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I)* (adopted 8 June 1977, entered into force 7 December 1979) 1125 UNTS 3, art. 51(5)(b).

²⁵ “Report on Violations of International Humanitarian and Human Rights Law, War Crimes and Crimes against Humanity Committed in Ukraine since 24 February 2022,” Organization for Security and Co-operation in Europe, April 22, 2022, p. 29, <https://www.osce.org/files/f/documents/f/a/515868.pdf>; see also Isabel Robinson and Ellen Nohle, “Proportionality and precautions in attack: The reverberating effects of using explosive weapons in populated areas,” *International Review of the Red Cross*, 2016, 98 (1), 107–145, https://international-review.icrc.org/sites/default/files/irc_97_901-9.pdf

²⁶ “International Humanitarian Law and the Challenges of Contemporary Armed Conflict in 2019,” ICRC, para.50, <https://casebook.icrc.org/case-study/icrc-international-humanitarian-law-and-challenges-contemporary-armed-conflict-2019>

²⁷ “Report on Violations of International Humanitarian and Human Rights Law, War Crimes and Crimes against Humanity Committed in Ukraine since 24 February 2022,” Organization for Security and Co-operation in Europe, April 22, 2022, p. 29, <https://www.osce.org/files/f/documents/f/a/515868.pdf>. See also Isabel Robinson and Ellen Nohle, “Proportionality and precautions in attack: The reverberating effects of using explosive weapons in populated areas,” *International Review of the Red Cross*, 2016, 98 (1), 107–145, https://international-review.icrc.org/sites/default/files/irc_97_901-9.pdf; “International Humanitarian Law and the Challenges of Contemporary Armed Conflict in 2019,” ICRC, para.38, 36, 50, <https://casebook.icrc.org/case-study/icrc-international-humanitarian-law-and-challenges-contemporary-armed-conflict-2019>.

population to receive care is diminished. In such circumstances, the systematic undermining of the conditions necessary for realizing the right to health must be taken into account and the cumulative effects of attacks, restrictions, and access denial assessed as a whole when applying the principles of proportionality and precaution.

20. Discharging the obligations to respect, protect, and fulfill the right to health requires States to undertake comprehensive, context-specific, and interdisciplinary collateral damage assessments that include analysis of the civilian harm that may occur not just from the strike itself but also from the degradation of the health facility. While such analysis adds complexity to targeting decisions, measures such as integrating medical advisors into strike assessment teams can play a critical role in ensuring that attacks do not violate the right to health. At minimum, documentation must systematically collect evidence not only of the immediate incident but also of foreseeable downstream health effects, such as treatment interruption, maternal and neonatal outcomes, disease burden, disability-related harms, mental health impacts, and displacement-related barriers to care.

III. Accountability, remedies, reparations, and reconstruction

21. Accountability and related remedies and reparations frameworks must likewise address the totality of injuries suffered, including delayed, cumulative, and indirect health consequences. Victims, for these purposes, include all persons who individually or collectively suffered harm, including physical or mental injury, economic loss, or substantial impairment of their fundamental rights. In the context of attacks on health, victims include patients denied access to care, women of reproductive age – including women trying to conceive, pregnant, postpartum, and lactating – as well as newborns and infants who suffer harm as a result of the targeting of healthcare facilities, restrictions on essential medical supplies, and acute malnutrition due to limits on humanitarian food aid. Reparations frameworks should take into account the circumstances of each victim, including age, sex, and health status, as well as the physical, mental, and moral effects of the wrongful act upon the victim.²⁸
22. Reparation must, so far as possible, “wipe out all the consequences” of the internationally wrongful act and reestablish the situation that would probably have existed absent the breach.²⁹ For attacks on health, this may encompass preventable disability, untreated chronic illness, psychological trauma, reproductive harms, interrupted maternal and child care, and long-term degradation of public health

²⁸ Kordic and Cerkez, (Trial Chamber), February 26, 2001, para. 271-272.

²⁹ Factory at Chorzów Case, *Factory at Chorzów (Germany v Poland) (Merits)*, PCIJ Series A No. 17, Judgment of 13 September 1928, p. 47.

capacity. Effective reparation may include restitution, compensation, rehabilitation, satisfaction, and guarantees of non-repetition.³⁰

23. Post-conflict responses that focus on restoring infrastructure without addressing depleted personnel, damaged supply chains, interrupted preventive care, etc. will fail to repair the underlying harm. Reconstruction and recovery efforts should therefore integrate a right-to-health approach that prioritizes resilient and accessible health systems, incorporates underlying determinants of health, and responds to the needs of groups disproportionately affected by reverberating impacts, including children, pregnant and postpartum women, older people, people with disabilities, and others.
24. Accountability for attacks should not be limited to individual incidents or isolated facilities. Where patterns of conduct foreseeably degrade the health system as a whole, States should investigate systemic impacts, disclose relevant information, provide effective remedies, and adopt guarantees of non-repetition, including reforms to targeting practices, protection measures, and civilian harm monitoring. The duty to investigate such serious violations must be genuine and effective.³¹
25. The obligation to provide an effective remedy requires that remedies be practical, accessible, prompt, and capable of addressing both individual and systemic dimensions of violations. Serious violations affecting life, bodily integrity, and essential services may require remedial measures extending beyond monetary awards,³² including medical and psychological care, investigations, public acknowledgment, community measures, and institutional reform. Where attacks impair the functioning of healthcare systems, redress should not be confined to *ex gratia* payments or compensation for immediate injury alone but include measures to restore access to essential healthcare, medicines, rehabilitation, psychosocial support, and other services indispensable to the enjoyment of economic, social, and cultural rights.
26. Accountability mechanisms should apply evidentiary approaches responsive to the realities of conflict. Destruction of hospitals, displacement of populations, collapse of civil registration systems, and loss of medical records often make individualized proof of downstream injury impossible. Evidentiary standards should not be so rigid as to render foreseeable civilian harm legally invisible in practice. Competent bodies should be able, where appropriate, to rely on reasonable inferences drawn from patterns of conduct, epidemiological evidence, excess mortality analysis, service-interruption data, and other contextual indicators capable of demonstrating likely health consequences. If direct proof is unavailable, this can be done through

³⁰ E.g., United Nations Human Rights Committee, *General Comment No. 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, UN Doc. CCPR/C/21/Rev.1/Add.13 (26 May 2004), para. 16; European Court of Human Rights, *Papamichalopoulos and Others v Greece (Article 50)*, App. No. 14556/89, Judgment of 31 October 1995, para. 34.

³¹ E.g., Inter-American Court of Human Rights, *Velásquez Rodríguez v Honduras*, Judgment of 29 July 1988, Series C No. 4, paras. 166, 174-177; United Nations Human Rights Committee, *General Comment No. 31*, para. 15.

³² E.g., IACtHR, *Plan de Sánchez Massacre v. Guatemala (Reparations)*, Judgment of 19 November 2004, Series C No. 116, paras. 94-101, 106-111; ECtHR, *Papamichalopoulos and Others v Greece (Article 50)*, App. No. 14556/89, Judgment of 31 October 1995, para. 34.

circumstantial evidence and presumptions and reasonable inferences. Where a State impedes fact-finding, adverse inferences may be warranted.³³

IV. Recommendations

The draft general comment should expressly recognize the following:

27. The core obligations under Article 12, including non-discriminatory access to health facilities, goods and services, minimum essential food, basic shelter, sanitation, safe water, and essential drugs, are non-derogable and apply in situations of armed conflict and occupation, alongside IHL, and extraterritorially, including in occupied territories and wherever a State exercises effective control over territory or persons.
28. In situations of armed conflict, Article 12 obligations encompass not only direct interference with access to care, but also foreseeable indirect and cumulative harms that compromise availability, accessibility, acceptability, and quality of health services. This is particularly important in prolonged conflicts, where repeated attacks and restrictions accumulate over time and gradually erode the health system's capacity. Article 12 must be interpreted in conjunction with the underlying determinants of health, including water, sanitation, food, housing, electricity, transportation, and access to information, especially where damaging those systems predictably disrupts care.
29. States are obligated not only to refrain from directly impairing access to healthcare, but also to prevent, mitigate, and remedy foreseeable conflict-related harms to health systems and their enabling conditions to the maximum given available resources and, where relevant, through international assistance and cooperation.
30. Monitoring, reporting, and decision-making frameworks should include indicators capable of capturing reverberating effects of attacks on health and health-enabling infrastructure.
31. Accountability, remedies, and reparations frameworks should be prioritized and be capable of addressing the full scope of health harm in conflict, including delayed, cumulative, and indirect consequences. Particular attention should be given to groups disproportionately affected by reverberating harm, including children, pregnant and postpartum women, newborns, older persons, persons with disabilities, and people with chronic illnesses.
32. Post-conflict reconstruction and recovery efforts should integrate a right-to-health approach that goes beyond rebuilding physical infrastructure to restore health workforce capacity, supply chains, preventive and primary care, and the underlying determinants of health.

³³ Inter-American Court of Human Rights *Velásquez Rodríguez v Honduras*, Judgment of 29 July 1988, Series C No. 4, paras. 127–130 (circumstantial evidence and presumptions); European Court of Human Rights *El-Masri v the former Yugoslav Republic of Macedonia* [GC], App. No. 39630/09, Judgment of 13 December 2012, paras. 151–153 (where events lie wholly or largely within the knowledge of authorities, presumptions of fact and burden shifts).