Peacekeeping without Accountability

THE UNITED NATIONS' RESPONSIBILITY FOR THE HAITIAN CHOLERA EPIDEMIC

Transnational Development Clinic, Jerome N. Frank Legal Services Organization
Yale Law School

Global Health Justice Partnership of the Yale Law School and the Yale School of Public Health

and

Association Haitienne de Droit de L'Environnment.

The Transnational Development Clinic is a legal clinic, part of the Jerome N. Frank Legal Services Organization at the Yale Law School. The clinic works on a range of litigation and non-litigation projects designed to promote community-centered international development, with an emphasis on global poverty. The clinic works with community-based clients and client groups and provides them with legal advice, counseling, and representation in order to promote specific development projects. The clinic also focuses on development projects that have a meaningful nexus to the U.S., in terms of client populations, litigation or advocacy forum, or applicable legal or regulatory framework.

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L'Association Haïtienne de Droit de l'Environnement (AHDEN) is a non-profit organization of Haitian lawyers and jurists with scientific training. The organization's mission is to help underprivileged Haitians living in rural areas fight poverty through the defense and promotion of environmental and human rights. These rights are in a critical condition in places like Haiti where rural communities have limited access to education and justice.

Printed in the United States of America

Report design by Jessica Svendsen

Cover photograph was taken outside the MINUSTAH base in Méyè in March of 2013, during the research team's visit to Haiti.

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Acknowledgments

This report was written by Rosalyn Chan MD, MPH, Tassity Johnson, Charanya Krishnaswami, Samuel Oliker-Friedland, and Celso Perez Carballo, student members of the Transnational Development Clinic (a part of the Jerome N. Frank Legal Services Organization) and the Global Health Justice Partnership of the Yale Law School and the Yale School of Public Health, in collaboration with Association Haitienne de Droit de L'Environnment (AHDEN). The project was supervised by Professor Muneer Ahmad, Professor Ali Miller, and Senior Schell Visiting Human Rights Fellow Troy Elder. Professor James Silk also assisted with supervision. Jane Chong, Hyun Gyo (Claire) Chung, and Paige Wilson, also students in the Transnational Development Clinic, provided research and logistical support.

The final draft of the report incorporates comments and feedback from discussions with representatives from: AHDEN, Association des Universitaires Motivés pour une Haiti de Droits (AUMOHD), Bureau des Avocats Internationaux (BAI), U.S. Centers for Disease Control (CDC), Collectif de Mobilisation Pour Dedommager Les Victimes du Cholera (Kolektif), Direction Nationale de l'Eau Potable et de l'Assainissement (DINEPA), Médecins Sans Frontières (MSF); Partners in Health (PIH), and the United States Agency for International Development (USAID). The authors also wish to thank the residents of Méyè, Haiti who were directly affected by the cholera epidemic for sharing their experiences with the authors during their visit to Méyè.

The report has benefited from the close review and recommendations of Professor Jean-Andrè Victor of AHDEN and Albert Icksang Ko, MD, MPH, Professor of Epidemiology and Public Health at the Yale University School of Medicine. The authors are grateful for their time and engagement.

The authors would like to thank Yale Law School and the Robina Foundation for their generosity in funding this project.

Finally, the authors thank the following organizations and individuals for sharing their time and wisdom with the team: Joseph Amon, Director of Health and Human Rights at Human Rights Watch; Dyliet Jean Baptiste, Attorney at BAI; Jean-Marie Celidor, Attorney at AHDEN; Paul Christian Namphy, Coordinator at DINEPA; Karl "Tom" Dannenbaum, Research Scholar in Law and Robina Foundation Human Rights Fellow at Yale Law School; Melissa Etheart, MD, MPH, Cholera Medical Specialist, CDC; Evel Fanfan, Attorney and President of AUMOHD; Jacceus Joseph, Attorney and Author of *La MINUSTAH et le cholera*; Olivia Gayraud, Head of Mission in Port-au-Prince at MSF; Yves-Pierre Louis of Kolektif; Alison Lutz, Haiti Program Coordinator at PIH; Duncan Mclean, Desk Manager at MSF; Nicole Phillips, Attorney at Institute for Justice and Democracy in Haiti ; Leslie Roberts, MPH, Clinical Professor of Population and Family Health at the Columbia University Mailman School of Public Health; Margaret Satterthwaite, Professor of Clinical Law at New York University School of Law; Scott Sheeran, Director of the LLM in International Human Rights Law and Humanitarian Law at the University of Essex; Deborah Sontag, Investigative Reporter at the New York Times; Chris Ward, Housing and Urban Development Advisor at USAID; and Ron Waldman, MD, MPH, Professor of Global Health in the Department of Global Health at George Washington University. The authors are also grateful for the assistance of Maureen Furtak and Carroll Lucht for helping coordinate travel to Haiti.

While the authors are grateful to all of the individuals and organizations listed above, the conclusions drawn in this report represent the independent analysis of the Transnational Development Clinic, the Global Justice Health Partnership, and AHDEN, based solely on their research and fieldwork in Haiti.

Glossary of Acronyms and Abbreviations

CDC	Centers for Disease Control
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERD	International Convention on the Elimination of All Forms of Racial Discrimination
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CTC	Cholera Treatment Center
DINEPA	Haitian National Directorate for Water Supply and Sanitation
General Convention	Convention on the Privileges and Immunities of the United Nations
IACHR	Inter-American Commission on Human Rights
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICJ	International Court of Justice
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
HAP	Humanitarian Accountability Partnership
HRC	Human Rights Commission
ICCPR	International Convention on Civil and Political Rights
LNSP	Haitian National Public Health Laboratory
MINUSTAH	U.N. Stabilization Mission in Haiti (Mission des Nations Unies pour la Stabilisation en Haïti)
MSF	Médecin Sans Frontières (Doctors Without Borders)
MSPP	Haitian Ministry of Health (Ministère de la Santé Publique et de la Population)
NGO	Non-Governmental Organization
PAHO	Pan-American Health Organization
SOFA	Status of Forces Agreement
UDHR	Universal Declaration of Human Rights
U.N.	United Nations
UNCC	United Nations Compensation Commission in Iraq
V. cholerae	*Vibrio cholerae*
VCF	September 11th Victims Compensation Fund
WHO	World Health Organization

Executive Summary

This report addresses the responsibility of the United Nations (U.N.) for the cholera epidemic in Haiti—one of the largest cholera epidemics in modern history. The report provides a comprehensive analysis of the evidence that the U.N. brought cholera to Haiti, relevant international legal and humanitarian standards necessary to understand U.N. accountability, and steps that the U.N. and other key national and international actors must take to rectify this harm. Despite overwhelming evidence linking the U.N. Mission for the Stabilization in Haiti (MINUSTAH)[1] to the outbreak, the U.N. has denied responsibility for causing the epidemic. The organization has refused to adjudicate legal claims from cholera victims or to otherwise remedy the harms they have suffered. By causing the epidemic and then refusing to provide redress to those affected, the U.N. has breached its commitments to the Government of Haiti, its obligations under international law, and principles of humanitarian relief. Now, nearly four years after the epidemic began, the U.N. is leading efforts to eliminate cholera but has still not taken responsibility for its own actions. As new infections continue to mount, accountability for the U.N.'s failures in Haiti is as important as ever.

The Cholera Epidemic in Haiti and U.N. Accountability: Background

In October 2010, only months after the country was devastated by a massive earthquake, Haiti was afflicted with another human tragedy: the outbreak of a cholera epidemic, now the largest in the world, which has killed over 8,000 people, sickened more than 600,000, and promises new infections for a decade or more. Tragically, the cholera outbreak—the first in modern Haitian history—was caused by United Nations peacekeeping troops who inadvertently carried the disease from Nepal to the Haitian town of Méyè. In October 2010, the U.N. deployed peacekeeping troops from Nepal to join MINUSTAH in Haiti. The U.N. stationed these troops at an outpost near Méyè, approximately 40 kilometers northeast of Haiti's capital, Port-au-Prince. The Méyè base was just a few meters from a tributary of the Artibonite River, the largest river in Haiti and one the country's main sources of water for drinking, cooking, and bathing. Peacekeepers from Nepal, where cholera is endemic, arrived in Haiti shortly after a major outbreak of the disease occurred in their home country. Sanitation infrastructure at their base in Méyè was haphazardly constructed, and as a result, sewage from the base contaminated the nearby tributary. Less than a month after the arrival of the U.N. troops from Nepal, the Haitian Ministry of Public Health reported the first cases of cholera just downstream from the MINUSTAH camp.

Cholera spread as Haitians drank contaminated water and ate contaminated food; the country's already weak and over-burdened sanitary system only exacerbated transmission of the disease among Haitians. In less than two weeks after the initial cases were reported, cholera had already spread throughout central Haiti. During the first 30 days of the epidemic, nearly 2,000 people died. By early November 2010, health officials recorded over 7,000 cases of infection. By July 2011, cholera was infecting one new person per minute, and the total number of Haitians infected with cholera surpassed the combined infected population of the rest of the world. The epidemic continued to ravage the country throughout 2012, worsened by Hurricane Sandy's heavy rains and flooding

in October 2012. In the spring of 2013, with the coming of the rainy season, Haiti has once more saw a spike in new infections.

Haitian and international non-governmental organizations have called on the U.N. to accept responsibility for causing the outbreak, but to date the U.N. has refused to do so. In November 2011, Haitian and U.S. human rights organizations filed a complaint with the U.N. on behalf of over 5,000 victims of the epidemic, alleging that the U.N. was responsible for the outbreak and demanding reparations for victims. The U.N. did not respond for over a year, and in February 2013, invoking the Convention on Privileges and Immunities of the United Nations, summarily dismissed the victims' claims. Relying on its organizational immunity from suit, the U.N. refused to address the merits of the complaint or the factual question of how the epidemic started.

Summary of the Methodology

Research, writing, and editing for this report was carried out by a team of students and professors from the Yale Law School and the Yale School of Public Health. Desk research draws from primary and secondary sources, including official U.N. documents, international treatises, news accounts, epidemiological studies and investigations, and other scholarly research in international law and international humanitarian affairs. Over a one year period, student authors also conducted extensive consultations with Haitians affected by the epidemic, as well as national and international journalists, medical doctors, advocates, government officials, and other legal professionals with firsthand experience in the epidemic and its aftermath.

In March 2013, students and faculty traveled to Haiti to carry out additional investigations. They consulted stakeholders and key informants in both the Haitian capital of Port-au-Prince and near the MINUSTAH Méyè base where the outbreak started. The Yale student and faculty team presented stakeholders in and outside of Haiti with a draft summary and outline of the report for review, discussion and comment. The final draft of the report incorporates comments and feedback from all of these consultations.

Summary of Findings

This report provides the first comprehensive analysis of not only the origins of the cholera outbreak in Haiti, but also the U.N.'s legal and humanitarian obligations in light of the outbreak and the steps the U.N. must take to remediate this ongoing humanitarian disaster. This analysis has concluded the following:

1. The cholera epidemic in Haiti is directly traceable to MINUSTAH peacekeepers and the inadequate waste infrastructure at their base in Méyè.

2. The U.N.'s refusal to establish a claims commission for the victims of the epidemic violates its contractual obligation to Haiti under international law.

3. By introducing cholera into Haiti and denying any form of remedy to victims of the epidemic, the U.N. has failed to uphold its duties under international human rights law.

4. The U.N.'s introduction of cholera into Haiti and refusal to accept responsibility for doing so has violated principles of international humanitarian aid.

Chapter I examines the legal and political status of MINUSTAH before and during the epidemic, as well as the U.N.'s official response to the outbreak. From its establishment in 2004, MINUSTAH has been charged with a broad mandate encompassing peacekeeping, the re-establishment of the rule of law, the protection of human rights, and social and economic development. Moreover, following the January 12, 2010 earthquake, MINUSTAH troops also assisted in humanitarian recovery efforts in Haiti. After cholera broke out in October 2010, a number of independent studies and clinical investigations pointed to the MINUSTAH base in Méyè as the source of the epidemic. Cholera victims and their advocates have subsequently called on the U.N. for reparations to remedy the situation and requested meaningful accountability mechanisms to review claims, to no avail. Meanwhile, the national and international

response to the epidemic has been underfunded and incomplete.

In the years following the outbreak, the U.N. has denied responsibility for the epidemic. The U.N. has repeatedly relied on a 2011 study by a U.N. Independent Panel of Experts, which concluded that at the time there was no clear scientific consensus regarding the cause of the epidemic. However, these experts have since revised their initial conclusions. In a recent statement, they unequivocally stated that new scientific evidence does point to MINUSTAH troops as the cause of the outbreak. As **Chapter II** of this report establishes, epidemiological studies of the outbreak linking the outbreak to the MINUSTAH base in Méyè belie the U.N.'s claims. Four key findings confirm that MINUSTAH peacekeeping troops introduced cholera into the country. First, doctors observed no active transmission of symptomatic cholera in Haiti prior to the arrival of the MINUSTAH troops from Nepal. Second, the area initially affected by the epidemic encompassed the location of the MINUSTAH base. Third, the troops at the MINUSTAH base were exposed to cholera in Nepal, and their feces contaminated the water supply near the base. Finally, the outbreak in Haiti is traceable to a single South Asian cholera strain from Nepal. No compelling alternative hypothesis of the epidemic's origins has been proposed.

As **Chapter III** details, in refusing to provide a forum to address the grievances of victims of the cholera epidemic, despite clear scientific evidence tracing the epidemic to the MINUSTAH camp's inadequate waste infrastructure, the U.N. violates its obligations under international law. According to the U.N. Charter and the Convention on Privileges and Immunities of the U.N., the U.N. is immune from suit in most national and international jurisdictions. Because of this legal immunity, the U.N. must provide to third parties certain mechanisms for holding it accountable if and when it engages in wrongdoing during peacekeeping operations—an obligation the U.N. Secretary-General has publicly recognized. In a series of reports submitted to the General Assembly in the late 1990s, the Secretary-General explained that the U.N. has an international responsibility for the activities of U.N. peacekeepers. This responsibility includes liability for damage caused by peacekeepers during the performance of their duties.

The U.N. historically has addressed the scope of its liability in peacekeeping operations through Status of Forces Agreements (SOFAs) signed with host countries. The Haitian government signed such an agreement with MINUSTAH in 2004. In this SOFA, the U.N. explicitly promises to create a standing commission to review third party claims of a private law character—meaning claims related to torts or contracts—arising from peacekeeping operations. Despite its obligations under the SOFA, the U.N. has not established a claims commission in Haiti. In fact, the U.N. has promised similar claims commissions in over 30 SOFAs since 1990. To date, however, the organization has not established a single commission, leaving countless victims of peacekeeper wrongdoing without any remedy at law.

The U.N.'s refusal to establish a claims commission not only violates the terms of its own contractual agreement with Haiti; it also defies the organization's responsibilities under international human rights law. As **Chapter IV** explains, the U.N.'s founding documents require that the U.N. respect international law, including international human rights law, and promote global respect for human rights. In addition, the SOFA requires that MINUSTAH observe all local laws, which include Haiti's obligations to its citizens under international human rights law. International human rights law guarantees access to clean water and the prevention and treatment of infectious disease, forbids arbitrary deprivation of life, and ensures that when a person's human rights are not respected, he or she may seek reparation for that harm. By failing to prevent MINUSTAH from introducing cholera into a major Haitian water system and subsequently denying any remedy to the victims of the epidemic it caused, the U.N. failed to respect its victims' human rights to water, health, life, and an effective remedy. Furthermore, given the U.N.'s role as a leader in the development, promotion, and protection of international human rights law, it risks losing its moral ground by refusing to comply with the very law it demands states and other international actors respect.

The U.N.'s role in introducing cholera into Haiti is particularly troubling given the humanitarian role that MINUSTAH has played in Haiti. As **Chapter V** explains, through its conduct that led to the cholera epidemic in Haiti, MINUSTAH

violated widely accepted principles that most international humanitarian aid organizations pledge to follow. These principles have also been accepted and promoted by U.N. agencies. First, the U.N. violated the "do no harm" principle, which requires, among other general and specific duties, that humanitarian organizations observe minimal standards of water management, sanitation, and hygiene in order to prevent the spread of disease. Second, by denying victims of the epidemic any remedy for the harms it caused, the U.N. violated the principle of accountability to affected populations. Humanitarian relief standards emphasize that establishing and recognizing mechanisms for receiving and addressing complaints of those negatively affected by relief work is a critical responsibility of humanitarian aid organizations. In Haiti, the U.N. has refused to create a claims commission to receive and adjudicate third party claims. By not only rejecting its responsibility for the epidemic but also refusing to provide a forum in which its victims can make their claims, the U.N. continues to violate minimum standards of accountability.

Necessary Steps toward Accountability in Haiti

Having examined the U.N.'s derogation of its obligations to the victims of the cholera epidemic under international law, international human rights law, and international humanitarian standards, **Chapter VI** outlines the steps the U.N. and other principal actors in Haiti must take to meaningfully address the cholera epidemic and ensure U.N. compliance with its legal and moral duties. The U.N. will need to accept responsibility for its failures in Haiti, apologize to the victims of the epidemic, vindicate the legal rights of the victims, end the ongoing epidemic, and take steps to ensure that it will never again cause such tragically avoidable harm, in Haiti or elsewhere.

The first three proposed courses of action for the U.N. respond to the concerns raised in Chapters III-V: By accepting accountability when it errs, apologizing for its wrongs, and providing a remedy to victims of its wrongdoing, the U.N. will satisfy its obligations under the SOFA, international human rights law, and the humanitarian ethic of accountability. Furthermore, by taking concrete and meaningful steps to end the ongoing epidemic and guaranteeing that it will reform its practices to ensure that it does not again cause such a public health crisis, the U.N. will address the structural failures that led to the outbreak and will begin to fulfill its moral duty to repair what it has damaged. To accomplish this, the U.N. must commit to making all necessary investments—particularly in the areas of emergency care and treatment for victims of the disease and clean water infrastructure—to ensure that the epidemic does not claim more lives. In addition to reducing Haiti's vulnerability to future waterborne epidemics, investments in clean water can also help eliminate cholera from the country.

Other entities, starting with the Government of Haiti and including NGOs, foreign governments (notably the United States, France, and Canada), and other intergovernmental actors, are also key to remediating the cholera epidemic. These actors must help provide direct aid to victims, infrastructural support, and adequate funding for the prevention and treatment of cholera. This includes properly funding and supporting the recently completed National Plan for the Elimination of Cholera in Haiti. The Plan is the Haitian Ministry of Health's (MSPP) comprehensive program for the elimination of cholera in Haiti and the Dominican Republic over the next ten years.

Finally, prevention of similar harms in the future requires that the U.N. commits to reforming the waste management practices of its peacekeepers and complying with all provisions of the SOFAs it signs with countries hosting peacekeepers.

While the U.N. has played an important role in the Haitian post-earthquake recovery effort, it has also caused great harm. The introduction of cholera by U.N. peacekeepers in Haiti has killed thousands of people, sickened hundreds of thousands more, and placed yet another strain on Haiti's fragile health infrastructure. The U.N.'s ongoing unwillingness to hold itself accountable to victims violates its obligations under international law and established principles of humanitarian relief. Moreover, in failing to lead by example, the U.N. undercuts its very mission of promoting the rule of law, protecting human rights, and assisting in the further development of Haiti.

Recommendations Divided by Relevant Actor

1. The United Nations and its Organs, Agencies, Departments, and Programs

OFFICE OF THE SECRETARY-GENERAL

- Appoint a claims commissioner per the requirements of paragraph 55 of the SOFA.
- Ensure, per the requirements of Paragraph 51 of the SOFA, that a claims commission is established and that its judgments are enforced.
- Apologize publicly to the Haitian people for the cholera epidemic.
- Coordinate funding for the MSPP Plan.

SECURITY COUNCIL

- Ensure that peacekeepers are accountable for their actions in future missions.

DEPARTMENT OF PEACEKEEPING OPERATIONS

- Ensure that SOFAs are followed in all missions to promote peacekeeper accountability.
- Promulgate procedures consistent with Sphere Standards to guide peacekeeping operations and conduct.

MINUSTAH

- Apologize publicly to the Haitian people for the cholera epidemic.
- Ask the Secretary-General to establish a claims commission.
- Abide by compensation decisions as ordered by a claims commission or any other legal forum
- Vacate the Méyè peacekeeper base and allow the community to turn the land into a treatment center or memorial.

2. The World Health Organization and the Pan-American Health Organization

- Continue and increase funding of the MSPP plan.
- Provide technical expertise and ensure implementation of the MSPP plan.

3. National Governments

HAITI

- Fund and supply cholera treatment centers for primary care of cholera victims.
- Continue to monitor outbreaks and gather reliable data on the incidence of cholera.
- Appoint a claims commissioner under Paragraph 55 of the SOFA.
- Demand that the U.N. appoint a claims commissioner under paragraph 55 of the SOFA.
- Effectively implement the MSPP Plan.

UNITED STATES

- Fund immediate cholera treatment and prevention via grants to NGOs, the MSPP, and DINEPA.
- Fund the MSPP plan, both directly and via assistance to the U.N with fundraising from other countries.
- Request that the U.N. appoint a claims commissioner.
- Ensure that the CDC continues to support the MSPP Plan.

FRANCE, CANADA, AND OTHER NATIONAL GOVERNMENTS

- Fund immediate cholera treatment and prevention, via grants to NGOs, the MSPP, and DINEPA.
- Fund the MSPP plan, both directly and via assistance to the U.N. with fundraising from other countries.

4. Non-Governmental Organizations

- Provide supplies and technical expertise for immediate cholera relief.
- Help fundraise for and channel donations toward the MSPP plan.
- Continue to support the Government of Haiti in its public health efforts.

Methodology

The findings in this report are based on an investigation of the origins of the outbreak and U.N. legal accountability conducted over a one-year period. Researchers consulted U.N. treaties and resolutions, international law treatises, and epidemiological studies of the cholera bacterium causing the epidemic, news accounts, and academic research in international law and international humanitarian law. Researchers also consulted victims of the epidemic, activists, attorneys, journalists, aid workers, medical doctors, and government agency officials with first-hand knowledge of the epidemic and its aftermath.

Researchers conducted most of their investigation from the United States and were regularly in contact with experts in Haiti. In March 2013, researchers traveled to Haiti to consult stakeholders in both the Haitian capital of Port-au-Prince and in the town closest to the MINUSTAH base where the cholera epidemic began.

While in Haiti, researchers met with representatives from: Association Haitienne de Droit de L'Environnment (AHDEN), Association des Universitaires Motivés pour une Haiti de Droits (AUMOHD), Bureau des Avocats Internationaux (BAI), U.S. Centers for Disease Control (CDC), Collectif de Mobilisation Pour Dedommager Les Victimes du Cholera (Kolektif), Direction Nationale de l' l'Eau Potable et de l'Assainissement (DINEPA), Médecins Sans Frontières (MSF), Partners in Health (PIH), and the United States Agency for International Development (USAID). Researchers also consulted residents of Méyè, Haiti who were directly affected by the cholera epidemic and who filed claims against the U.N. seeking relief.

Researchers presented the stakeholders with a summary and outline of the report for critical discussion. The final draft of the report incorporates comments and feedback from the consultations made during the trip to Haiti, as well as from the close review of experts in international law and public health.

CHAPTER I

MINUSTAH and the Cholera Outbreak in Haiti

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Since the early 1990s, the United Nations has deployed several peacekeeping and humanitarian missions to Haiti in response to recurring periods of political unrest and socio-economic instability. In 2004, following a period of political turmoil, the U.N. Security Council established its current Haitian mission: the U.N. Stabilization Mission in Haiti, known as MINUSTAH.[2] The Security Council charged MINUSTAH with a broad mandate encompassing both peacekeeping and humanitarian operations. On January 12, 2010, a devastating earthquake struck Haiti, killing hundreds of thousands and further jeopardizing the country's already fragile infrastructure. In the wake of this tragedy, the Security Council expanded MINUSTAH's mandate to respond to the ongoing crisis. While MINUSTAH has contributed to Haiti's stabilization, the mission has also been criticized for its failures to protect human rights.

Between October 19–20, 2010, nine months after the earthquake, health officials confirmed eight cases of cholera in a remote region of central Haiti. Cholera had not been observed in the country in over a century. The disease spread at an alarming rate, rapidly causing severe cases of diarrhea, dehydration, and death. Even before the 2010 earthquake, Haiti suffered from a history of poor water, sanitation, and health infrastructure. While cholera can be easily prevented and treated, the country's scarce resources and socio-political instability have made the disease difficult to control. As of April 2013, over 650,000 Haitians had been infected by cholera and over 8,100 had died. The disease continues to spread through Haiti today, and the most optimistic estimates suggest it will take at least another decade to eliminate it from the country and the island.

Independent investigations by scientists and journalists have traced the source of the epidemic to MINUSTAH peacekeeping troops. An extensive body of evidence shows that between October 8–21, 2010, troops arriving from cholera-affected areas of Nepal carried the disease into Haiti. Due to poor sanitation facilities at the base where the troops were stationed, waste containing cholera contaminated the Artibonite River, Haiti's largest river, and spread to the local population. Scientific studies and firsthand accounts leave little doubt that MINUSTAH peacekeepers were the inadvertent source of the cholera outbreak.

Since the outbreak began, cholera victims and their advocates have repeatedly called on the U.N. to remedy past injuries and meaningfully address the ongoing crisis. The U.N., however, has refused to hear these claims and its overall response to the cholera epidemic remains inadequate. The U.N. has denied its role in the epidemic and refused to address victims' claims for redress, despite its obligations to do so under its own agreements with Haiti and under instruments and principles of international law. National and international actors have proposed plans to treat and eliminate cholera, but the plans lack sufficient funding to effectively prevent and treat the disease. Haitian health and water and sanitation officials and NGOs that have been essential to the provision of cholera treatment struggle to manage waves of the epidemic that spike during each rainy season. Haitians continue to suffer the consequences of the largest cholera epidemic in the country's history, while the party responsible for the outbreak—the U.N.—refuses to make a meaningful effort to contain, control, and eliminate the disease or to remedy the harm already done.

A. MINUSTAH Has Had an Expanding Mandate Marked by a Broad Peacekeeping Authority without Accountability.

The U.N. has had an intermittent peacekeeping presence in Haiti since the early 1990s.[3] In April 2004, following a period of political instability, the Security Council passed Resolution 1542, creating the U.N. Mission for the Stabilization of Haiti (MINUSTAH).[4] MINUSTAH was established as a joint military and civilian mission with a mandate to help Haiti address a broad range of

issues, including peace and political stability, the re-establishment of the rule of law, the protection of human rights, and social and economic development.[5] MINUSTAH's scope and operations have expanded since 2004, and the longstanding presence and activity of the mission have been met with local criticism.

MINUSTAH's administration and funding involve many players. In Resolution 1542, the Security Council supported the establishment of the Core Group, comprising representatives of the Organization of American States, the Caribbean Community and Common Market, international financial institutions, and other interested stakeholders.[6] The Core Group's purpose is to facilitate the implementation of MINUSTAH's mandate and states enhance the effectiveness of the role of the international community in Haiti. Several countries, including Argentina, Brazil, Canada, Chile, France, Peru, and the United States, have assumed lead roles in MINUSTAH's operations in Haiti pursuant to Resolution 1542.[7]

Since its establishment, MINUSTAH has been a multidimensional peacekeeping mission uniquely aimed at addressing a broad range of concerns.[8] Whereas U.N. peacekeeping operations are generally deployed in support of a peace agreement reached between parties to a conflict, MINUSTAH was deployed without such an agreement or ongoing conflict.[9] Instead, MINUSTAH was established in response to a complicated and sometimes violent political struggle among different factions in Haiti. In 2000, President Jean-Bertrand Aristide was voted into office during an election contested by political opponents and some members of the international community.[10] In February 2004, former soldiers training in the Dominican Republic invaded Haiti and took large areas of the country. President Aristide left Haiti on a plane controlled by the U.S. government. The U.S. government claimed that President Aristide left willingly; President Aristide claimed he was forced onto the plane. Boniface Alexandre, then President of the Supreme Court, was sworn in as Interim President.[11] Mr. Alexandre requested assistance from the United Nations in stabilizing the country in the aftermath of the insurrection, a request that eventually led to the establishment of MINUSTAH.[12]

The complicated politics of MINUSTAH's origins are reflected in the mission's broad mandate. The terms of MINUSTAH's mission have been defined by a series of Security Council Resolutions establishing and renewing the MINUSTAH mandate. MINUSTAH's original mandate, set forth in Security Council Resolution 1542, established three main mission goals: to ensure a secure and stable environment, to support the conditions for democratic governance and institutional development, and to support the promotion and development of human rights.[13] In the same resolution, the Security Council provided that MINUSTAH "shall cooperate with the Transitional Government [of Haiti] as well as with their international partners, in order to facilitate the provision and coordination of humanitarian assistance."[14] Subsequent resolutions between 2005 and 2009 renewed and provided minor adjustments to the original MINUSTAH mandate.[15]

MINUSTAH's mission structure and operations reflect the breadth of its mandate. The original 2004 mission plan envisioned three main components: a military force to establish a secure and stable environment throughout the country, a civilian affairs component responsible for overseeing a civilian police force and supporting initiatives to strengthen local governmental and civil society institutions, and a humanitarian affairs and development component.[16] The humanitarian affairs and development office was tasked with coordinating humanitarian aid among different national and international actors. Senior officers of all three components reported to the head of mission, the U.N. Special Representative of the Secretary-General.[17] Additionally, the mission as a whole received support from the U.N. Secretariat's Department of Peacekeeping Operations.[18] While the specific structure of the different components has changed since 2004, the basic organization remains.[19]

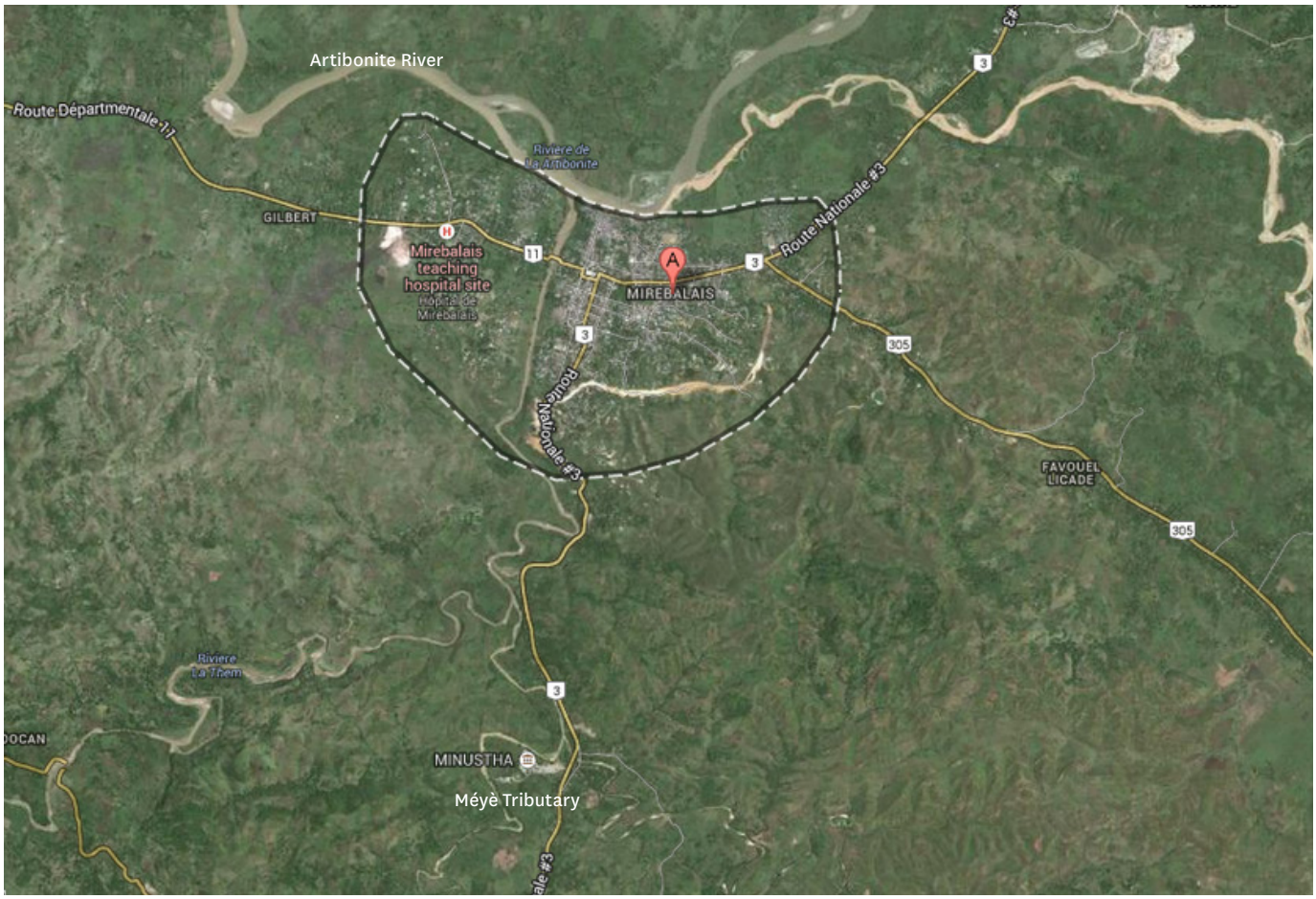
On January 12, 2010, a 7.0-magnitude earthquake struck Haiti, killing over 200,000, destroying much of the capital, and straining the country's already fragile social and political order.[20] In response to the earthquake, the Security Council passed Resolutions 1908 and 1927, raising MINUSTAH's in-country troop levels and adjusting the MINUSTAH mandate to include assisting

the Government of Haiti in post-disaster relief and recovery.[21] The Resolutions also reaffirmed MINUSTAH's obligation to promote and protect the human rights of the Haitian people.[22]

MINUSTAH troops were tasked with key roles in the immediate response to the earthquake, as well as the longer-term humanitarian effort.[23] Troops assisted in essential humanitarian functions including clearing debris, distributing food, and rebuilding local infrastructure.[24] MINUSTAH troops were also responsible for monitoring the human rights situation of particularly vulnerable Haitians. For instance, troops led security assessments and policing efforts to ensure the security of those living in spontaneous camps and in areas affected by the earthquake.[25] The mission was further charged with building capacity of local institutions to administer justice and ensure the rule of law.[26]

Despite MINUSTAH's role in Haiti's stabilization, the mission has drawn repeated criticism on several fronts.[27] Since the early days of the mission, Haitians have denounced alleged physical abuses by troop members[28]—and MINUSTAH's seeming unwillingness to investigate these claims. In November 2007, for instance, over 100 Sri Lankan troops were repatriated due to allegations of sexual exploitation and abuse.[29] In September 2011, media outlets released a video of Uruguayan troops harassing an 18-year-old boy, who later claimed that he had been raped by the troops.[30] In August 2010, 16-year-old Jean Gérald Gilles was found hanging outside the MINUSTAH base in Cap Haitïen.[31] MINUSTAH never initiated a public investigation.[32] These and other similar incidents have led to popular discontent among Haitians with MINUSTAH's presence.

The MINUSTAH base (misspelled “MINUSTHA” on Google Earth) in Méyè, on the banks of the Méyè Tributary.



The town of Mirebalais, located just north of Méyè, where the Méyè Tributary meets the Artibonite River.

B. The Outbreak of Cholera Has Had Devastating Consequences for the Haitian Population.

On October 19, 2010, Haitian health officials detected an unusually high number of cases of acute diarrhea, vomiting, and severe dehydration in two of Haiti's ten geographical regions known as administrative departments.[33] Officials sent stool samples for testing to the Haitian National Public Health Laboratory (LNSP), and four days later, the LNSP confirmed the presence of *Vibrio cholerae* (*V. cholerae*), the bacterium that causes cholera.[34] The first set of cases was localized in the upper Artibonite River region, where the Méyè Tributary meets the Artibonite. By late October 2010, Haitian officials reported a second set of cases in the lower Artibonite River region, near the river's delta.[35] By early November, cholera had reached the capital of Port-au-Prince.[36] Cholera had also spread to cities across the North-West and North Departments.[37] By November 19, the Haitian Ministry of Health (MSPP) reported positive cholera cases in all ten administrative departments.[38] By then, over 16,000 Haitians had been hospitalized with acute watery diarrhea and over 900 had died from cholera.[39]

As Chapter II details, cholera is transmitted by the consumption of food or water contaminated with *V. cholerae*.[40] The main sources of an outbreak are usually contaminated drinking water and inadequate sanitation; feces from those infected with *V. cholerae* contaminate the water supply, and the bacterium spreads when others drink the contaminated water.[41] A gastrointestinal disease characterized by vomiting, diarrhea, and dehydration, cholera is easily treatable. With aggressive electrolyte replacement—often simply delivered in drinking water—fatalities are reduced to less than 1%.[42]

In Haiti, poor water, sanitation, and health infrastructure has facilitated the spread of cholera and prevented its effective treatment. Even before the earthquake, the country had an ineffectual and institutionally fragmented water and sanitation sector.[43] Approximately 10% of Haitians had access to running water and only 17% had access to improved sanitation services.[44] Additionally, until August 2009, the water and sanitation sector had neither a single national coordination authority nor sufficient funds.[45] Instead, the sector was regulated by several governmental institutions that were unable to ensure quality water and sanitation services.[46] After a 2009 reform, the water and sanitation sector still lacked sufficient funding and was unable to prevent the spread of cholera in the early stages of the epidemic.[47] Meanwhile, the public health sector in Haiti has been unable to treat cholera effectively. The health system in Haiti is supervised and coordinated by a single entity, the MSPP.[48] Due to financial constraints and the lack of local capacity to coordinate health care services, the MSPP has been unable to guarantee adequate cholera treatment for all Haitians.

The Haitian cholera epidemic is one of the world's largest national cholera epidemics in recent history.[49] In 2010 and 2011, Haitians accounted for roughly half of cholera cases and deaths reported to the World Health Organization (WHO).[50] In the first year of the epidemic, over 470,000 Haitians were infected and over 6,600 died of cholera.[51] By October 2012, over 600,000 Haitians had been infected and over 7,400 had died from cholera.[52] As of April 2013, the MSPP has reported over 650,000 infections, and over 8,100 deaths.[53] Due to unreported cases in remote areas, these numbers likely underestimate the actual harm caused by the cholera epidemic in Haiti.[54]

Although more than two years have passed since the outbreak began, cholera still poses an ongoing threat to people in Haiti.[55] The disease continues to contaminate Haiti's drinking water sources. As rivers overflow with each rainy season, inadequate sewage systems allow for continued cross-contamination between infected feces and drinking water sources, perpetuating the cycle of disease. Additionally, treatment programs remain inadequate due to a shortage of funding.[56] Experts expect Haiti will suffer from cholera for at least a decade more.[57]

C. Independent Investigations Have Traced the Source of the Epidemic to MINUSTAH Peacekeeping Troops.

As Chapter II discusses, nearly every major investigation of the cholera crisis has identified

Top:
The MINUSTAH base in Méyè.

Below:
MINUSTAH peacekeepers entering the base.

U.N. peacekeeping troops from Nepal as the source of the outbreak.[58] Outbreak investigations, environmental surveys, molecular epidemiological studies, and journalistic accounts all demonstrate that the troops were exposed to cholera in Nepal and introduced *V. cholerae* bacterium into Haiti. These investigations highlight five key facts about the epidemic. First, there was no active transmission of cholera in Haiti prior to October 2010. Second, the epidemic began at a single point in an area that encompassed the MINUSTAH base where Nepalese peacekeeping troops were stationed. Third, these troops had been exposed to cholera in Nepal, and fourth, their feces contaminated the local water supply in Haiti. Finally, the Haitian outbreak involved a single strain of Nepalese origin.

Historical records show no reported cases of symptomatic cholera in Haiti before the arrival of MINUSTAH troops in October 2010.[59] Experts have identified three major cholera outbreaks in the Caribbean: in 1833–1834, 1850–1856, and 1865-

1872.[60] None of these three outbreaks affected Haiti, even though cholera cases were reported in the neighboring Dominican Republic in 1867.[61] As early as 1850, Haitian historians commented on the striking absence of cholera cases in the country. Additionally, no symptomatic cases of cholera were reported in the Caribbean during the 20th century.[62]

The 2010 Haitian outbreak began in a region encompassing the MINUSTAH base in Méyè, a small town in the Artibonite administrative department of central Haiti. Following the first stool samples from patients in this area sent for testing on October 19 and 20, 2010,[63] the LNSP confirmed the presence of *V. cholerae* on October 22.[64] Initial cases of cholera were clustered in an area surrounding the MINUSTAH base. The base is situated on the Méyè Tributary, which flows past the town of Mirebalais and into the Artibonite River. The initial cases of confirmed cholera occurred downstream from the base.[65]

Nepalese troops stationed at the Méyè base had been recently exposed to cholera in Nepal, and their feces contaminated the drinking water of local Haitians. As part of MINUSTAH's 2010 troop increase, a battalion of Nepalese soldiers arrived in Haiti between October 8–24, 2010.[66] The soldiers came from regions of Nepal recently afflicted by outbreaks of cholera.[67] The MINUSTAH base had poor sanitation conditions. The camp's waste infrastructure was haphazardly constructed, allowing for waste from the camp's drainage canal and an open drainage ditch to flow directly into the nearby Méyè Tributary.[68] The drainage sites were also susceptible to flooding and overflow into the tributary during rainfall.[69] Direct evidence that sewage from the base contaminated the Méyè Tributary of the Artibonite River exists.[70] On October 27, journalists caught MINUSTAH troops on tape trying to contain what appeared to be a sewage spill at the MINUSTAH base. Families in the area also confirmed that waste from the camp frequently flowed into the river.[71] Most of the initial cholera patients reported drinking water from the Artibonite River.

The close relationship between the Haitian cholera strain and the Nepalese strain further supports the conclusion that Nepalese troops brought cholera into Haiti.[72] Although there has been no medical documentation of the MINUSTAH troops carrying cholera, researchers have identified a common strain of *V. cholerae* causing cholera in Haiti.[73] Experts have compared this strain with a number of known cholera strains from around the world.[74] Genetic evidence shows that the Haitian strain is descended from a *V. cholerae* strain of Nepalese origin. In other words, the cholera that caused Haiti's epidemic originated in Nepal.[75]

D. National and International Efforts Have Been Unsuccessful in Eliminating Cholera.

A combination of Haitian national agencies, multilateral agencies, other countries, and international NGOs have responded to the cholera outbreak. Unfortunately for Haitians, this patchwork of services, training, and surveillance has proven inadequate. Much of the cholera response effort is not adequately funded and ineffective for either the short or longterm.

1. Short-term Response

In the immediate aftermath of the earthquake, national, international, and NGOs anticipated that the massive damage done to Haiti's fragile infrastructure would render the country vulnerable to disease and began to prepare accordingly. None of these organizations, however, expected an outbreak of cholera, given the disease's long absence from the country. As a result, local health workers had little more than basic training on cholera treatment. National health staff had an existing knowledge of cholera, how it was spread, its treatment, and proper modes of prevention, but few were trained in handling an emergency outbreak of the disease.

Because of this, during the first phase of the epidemic, an international NGO, Médecin Sans Frontières (MSF), was the lead provider of treatment. International humanitarian NGOs like MSF have provided medical services in Haiti throughout the cholera crisis. MSF established some of the first cholera treatment programs, rapidly expanding services in the months of the spiraling outbreak by deploying health workers to the country and opening cholera treatment centers

(CTCs). By November 2010, just a month after the first cases of cholera appeared in Haiti, MSF had set up 20 CTCs; by early December, 20 more CTCs had been built. CTCs providing oral rehydration solution, the primary course of treatment for cholera, were also created in all of the regions affected by the disease. MSF set aside some 3,300 beds in its facilities for cholera treatment, and by mid-December 2010, the organization had provided care for more than 62,000 people.[76] MSF's ability to provide cholera treatment, however, was soon overwhelmed by the volume of cholera cases as the outbreak proved worse than originally anticipated.

The treatment plan in the immediate aftermath of the outbreak focused on prevention of cholera infection and death. Local health authorities disseminated prevention information to inhabitants of the rural areas near Mirebalais and the Artibonite Delta where the first cases appeared. The prevention materials advised boiling or chlorinating drinking water and burying human waste in the hope of stemming the spread of cholera and avoiding further contamination of water sources. Due to the rapid spread of the disease and the high initial case fatality rate, MSPP and the U.S. government focused on five immediate priorities: preventing deaths in treatment facilities by distributing supplies and providing training; preventing deaths in communities by supplying oral rehydration solution sachets to homes and urging sick individuals to seek immediate care; preventing disease spread by promoting proper hygiene and sewage disposal; conducting field investigations and guiding prevention strategies; and establishing a national cholera surveillance system to monitor the spread of the disease.[77] Some training of field workers by international and bilateral organizations, including the U.S. Centers for Disease Control (CDC), contributed to the treatment of effected populations during the first months of the epidemic. However, neither the MSPP nor international NGOs were able to completely contain the outbreak.

2. Long-term Response

The long-term effort to treat cholera and eliminate the disease from Haiti has been less effective than the short-term response following the initial outbreak. The mere task of providing treatment supplies has proven daunting as people in Haiti continue to contract cholera. Difficulties in providing treatment at the onset of the epidemic were exacerbated by the fact that only one actor—the Program on Essential Medicine and Supplies, overseen by MSPP and the Pan-American Health Organization (PAHO)—distributed all donated health care materials.

Several medical organizations continue to provide prevention and treatment for cholera in partnership with the MSPP, but the initial funding for such work is nearly exhausted. Many aid groups have already withdrawn from the country due to a lack of funding, and emergency cholera funding from the CDC and World Bank is expected to decrease next year.[78]

In November 2012, the U.N. announced a $2.27 billion initiative to eliminate cholera in Haiti and the Dominican Republic in the next ten years.[79] A joint initiative among the WHO, PAHO, the CDC, and MSPP, the plan is comprehensive; it addresses water and sanitation, waste disposal, integration of cholera diagnosis and treatment into basic medical screening practices, and provision of cholera vaccinations to high-risk groups. However, the U.N. has yet to secure all but a small fraction of the funding necessary to complete the project from U.N. member states.[80] To date, the U.N. has only committed to supplying $23.5 million, less than 1% of the necessary funding.

Both the short-term and long-term plans for responding to cholera in Haiti have been criticized as unrealistically optimistic. International NGOs like MSF struggle to provide quality care as their basic treatment supplies dwindle. The mortality rate in some CTCs has recently risen to an alarming 4% as a result of diminishing supplies.[81] Although the plan to eliminate cholera in Haiti may be well-conceived in the abstract, it is of little practical value without proper funding.

E. The United Nations Has Failed to Provide Redress for Victims of the Epidemic.

Cholera victims and their advocates have called on the U.N. to redress the injuries of those harmed by the disease and take responsibility for the ongoing epidemic. A number of efforts to hold the U.N. accountable have been underway since the outbreak began, although to date they have not been successful

First, Haitian human rights organizations, activists, and lawyers have called for the U.N. to assume responsibility for its actions under the Status of Forces Agreement (SOFA) it signed with the Government of Haiti in July of 2004.[82] The SOFA defines the relationship between the U.N., including its agents in MINUSTAH, and the Government of Haiti. It also lays out the terms of the MINUSTAH mission, providing peacekeeping troops and U.N. personnel legal immunity from suit in national and international courts. In exchange, the SOFA provides for the establishment of a commission to hear claims from third parties injured as a result of MINUSTAH operations. Despite this, no such claims commission has been established for victims of the cholera epidemic.[83] In a letter to the Haitian Senate dated March 25, 2013, lawyers on behalf of Haitian victims called on the Government of Haiti to assert its right to a claims commission under the SOFA.[84] In response to the inaction of the U.N. and the Government of Haiti, these attorneys are also considering a suit to compel the Government of Haiti to initiate the establishment of a claims commission by appointing a commissioner.[85]

A second effort to hold the U.N. accountable for the epidemic was attempted through an appeal to the Inter-American Commission on Human Rights (IACHR). In October 2011, a team of Brazilian lawyers acting on behalf of Haitian cholera victims filed a case against the U.N. at the IACHR.[86] Petitioners claimed that the U.N.'s actions in Haiti violated a number of rights under the American Convention on Human Rights. Petitioners argued that the IACHR could receive the complaint because the U.N. was an organization acting within a territory under the IACHR's jurisdiction.[87] To date, the IACHR has not provided an official response to this petition.[88]

A third legal process began in November 2011, when Haitians infected by cholera and family members of those who had died of the disease submitted a petition for relief to the MINUSTAH claims unit in Haiti and U.N. headquarters in New York.[89] Petitioners alleged that MINUSTAH negligently maintained its waste management facilities at the MINUSTAH camp in Méyè, which led to the cholera outbreak.[90] Petitioners requested a fair and impartial adjudication of the claim according to the terms of the SOFA, compensation to petitioners, monetary reparations to victims of cholera at large, and a public apology including acceptance of responbility for causing the epidemic.[91] On December 21, 2011, the U.N. acknowledged receipt of the petition, and promised "a response in due course."[92] Fourteen months later, on February 21, 2013, petitioners received a response from the U.N. Under-Secretary-General for Legal Affairs, Patricia O'Brien.[93] The U.N. refused to consider the claims because such consideration "would necessarily include a review of political and policy matters."[94] Citing no precedent or authority, the U.N. response stated that this made the claim "not receivable" under Section 29 of the Convention on the Privileges and Immunities of the United Nations. Thus, the U.N. effectively invoked legal immunity to defeat the claims. On May 7, 2013, petitioners responded to the letter, challenging the U.N.'s argument that the claim was not receivable.[95] Additionally, petitioners stated that if they did not receive a timely a response within 60 days, they would file their claims in a court of law.[96]

Since the 2010 outbreak, Haitians have repeatedly expressed discontent with MINUSTAH and the U.N. for causing the cholera epidemic in the first instance and their management of it thereafter. Repeated protests since 2010 have called for U.N. withdrawal. The U.N., however, has not provided a meaningful response. The organization has refused to consider the petition for relief or to provide a forum to adjudicate repeated demands that it accept responsibility for the introduction of cholera into Haiti.[97] To this day, the U.N. continues to deny accountability for the epidemic or consider the merits of any claims made by its victims.

CHAPTER II

Scientific Investigations Identify MINUSTAH Troops as the Source of the Cholera Epidemic

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An extensive scientific literature has traced the source of the Haitian cholera epidemic to the MINUSTAH camp in Méyè. Outbreak investigations, environmental surveys, and molecular epidemiological studies—including those conducted by the U.N.'s own experts and some of the world's foremost experts on cholera and infectious disease—all demonstrate that cholera in Haiti was transmitted from a single source, the Méyè MINUSTAH base in central Haiti. These studies show that the peacekeepers stationed at the base, who had arrived from Nepal shortly before the first cases of cholera were reported in Haiti, were carriers of a strain of V. cholerae, the bacterium (*V. cholerae*), the bacterium that causes cholera, also from Nepal. Poor sanitation conditions at the MINUSTAH camp allowed for waste to flow into the nearby waterways, resulting in the inadvertent introduction of *V. cholerae* into the Méyè tributary. The bacterium spread through the Tributary into the Artibonite River and other connected water sources. As a result, individuals consuming water from the Méyè Tributary and the Artibonite River contracted cholera.

Four key findings confirm that the epidemic's point source transmission—or common origin—was the MINUSTAH peacekeeping troops:

- **There was no active transmission of cholera in Haiti prior to October 2010.** Historical records dating back to the 1800s report no cases of cholera in Haiti. No cholera epidemics were documented in the Caribbean during the 20th century. During the Caribbean epidemics of the 19th century, no cases were reported in Haiti.

- **The initial area affected by the epidemic encompassed the location of the MINUSTAH base.** Epidemiological modeling during the initial outbreak shows no symptomatic cholera cases other than in the areas surrounding the MINUSTAH camp in Méyè. Models suggest that the origin of the disease was near the MINUSTAH base, from which cholera then spread throughout the country.

- **The troops at the MINUSTAH base were exposed to cholera in Nepal, and their feces contaminated the water supply near the base.** The peacekeeping troops stationed at the MINUSTAH base in Méyè were deployed to Haiti from Nepal, where cholera is endemic and a outbreak had occurred one month prior to their arrival in Haiti. These troops were exposed to cholera in Nepal just prior to their departure to Haiti. Due to the poor sanitation infrastructure at the MINUSTAH base, feces from the troops contaminated the Artibonite River, one of Haiti's main water sources.

- **The Haiti cholera outbreak is traceable to a single cholera strain of South Asian origin found in Nepal.** Molecular studies of stool samples collected from multiple patients reveal a single cholera strain as the source of infection in Haiti. Genetic analyses show that the Haitian strain is identical to recent South Asian strains found in Nepal and is most likely a descendant of these strains. Outbreak investigations demonstrate that the initial cases were confined to the area near the MINUSTAH base in Méyè. Both sets of studies suggest that the outbreak began with the introduction of a single cholera strain endemic to parts of Nepal into the water source near the MINUSTAH base.

Separately, these various studies propose a link between the MINUSTAH peacekeepers from Nepal and the Haitian cholera epidemic. Combined, they provide compelling evidence of the causal relationship between the MINUSTAH troops and the introduction of cholera into Haiti.

The Méyè Tributary. The MINUSTAH camp is to the left of the tributary. The left-hand side of the picture shows barricades along the perimeter of the MINUSTAH camp.

Barricades along the perimeter of the MINUSTAH camp.

A. Historical Records Show No Evidence of an Active Transmission of Cholera in Haiti Before October 2010.

Historical records dating back to the 19th century show no evidence of cholera in Haiti prior to October 2010.[98] While it is difficult to confirm the historical absence of disease, no cholera epidemic was reported in the Caribbean region during the 20th century.[99] Historical accounts document three Caribbean pandemics of cholera in the 19th century: in 1833–1834, 1850–1856, and 1865–1872.[100] No medical reports document cholera in Haiti during these periods.[101] Researchers thus have concluded that there were no significant cases of cholera in Haiti during the 19th or 20th centuries.[102] Historical evidence therefore supports the conclusion that the 2010 outbreak was caused by the introduction of cholera into Haiti from a foreign source.

B. The Initial Area Affected by the Epidemic Encompassed the Location of the MINUSTAH Base.

Geographical and temporal analyses of the Haitian cholera outbreak show that the epidemic originated near the MINUSTAH base in Méyè and spread downstream through the Méyè Tributary and into the Artibonite River. Case analyses reveal that only individuals exposed to water from this river system initially contracted cholera.

The first cholera cases documented between October 14–18 arose in Méyè and Mirebalais, just 2 kilometers north of Méyè. Hospital admission records and anecdotal information from the Mirebalais Government Hospital showed that between September 1–October 17, sporadic diarrhea cases without death were seen at a consistent baseline rate in both adults and children.[103] The first recorded case of severe diarrhea necessitating hospitalization, and the first deaths from dehydration in adult patients occurred the night of October 17 and early morning of October 18. During these two days, the majority of the patient population was of adult age, a fact strongly suggesting that the cause of the diarrheal cases was cholera as severe diarrhea in adults is rare.[104] Staff reported that the first cases of cholera were attributed to an area located 150 meters downstream from the MINUSTAH camp in Méyè.[105]

On October 19, clusters of patients near the Artibonite Delta were hospitalized with severe acute diarrhea and vomiting, and deaths, including of three children, were reported by health centers and hospitals in the region.[106] Staff at the Albert Schweitzer Hospital reported that their first suspected case of cholera occurred on October 18, 2010, when a migrant worker arrived at the hospital already deceased. The first confirmed cases of cholera occurred at the hospital on October 20. After October 20, the number of cases admitted to the hospital was so high that exact record

keeping became difficult.[107] At St. Nicolas Hospital in St. Marc, a city located 70 kilometers southwest of Mirebalais, medical records showed that a consistently low level of diarrhea cases, mostly among children, remained stable until October 20, when 404 hospitalizations were recorded in a single day—one patient every 3.6 minutes—along with 44 deaths from cholera. These cases came from 50 communities throughout the Artibonite River Delta region, with an average of eight patients per community arriving at the hospital on October 20.[108]

Following the early reports of cholera, the MSPP and the CDC conducted an investigation of disease incidence at five hospitals in the Artibonite Department from October 21st to October 23. To establish a date of onset for the outbreak, investigators reviewed medical records from October 2010 for each hospital to identify cases that required hospitalization due to diarrhea and dehydration. Because detailed medical records were not available for the investigation, hospitalizations due to "severe diarrhea" were used as a proxy for cholera cases, with a particular focus on adult patients since severe diarrhea within this age group is considered rare.[109] From October 20–22, the majority of patients admitted with symptoms of cholera and the majority of those who died from these symptoms were older than 5 years old, strongly suggesting that the cause of their illness was in fact cholera.[110] In addition, stool samples from patients hospitalized in the administrative departments of Artibonite and Centre, southeast of Artibonite Department, were brought to the LNSP where rapid tests on eight specimens tested positive for *V. cholerae* O1.[111]

Epidemiologists have modeled the Haitian outbreak using data collected by the MSPP's National Cholera Surveillance System.[112] With an "explosive" start in the Lower Artibonite, the cholera epidemic peaked within two days, and then decreased drastically until October 31.[113] Once adjustments were made for population and spatial location, the risk of contracting cholera for an individual living downstream of the Méyè Tributary was calculated at 4.91 times higher than the average Haitian.[114]

By October 22, cholera cases were noted in fourteen additional communes,[115] most of them in the mountainous regions that border the Artibonite plain and in Port-au-Prince. In each commune, the incidence of cholera coincided with the arrival of patients from the bordering communes where affected individuals worked in rice fields, salt marshes, or road construction.[116] The southern half of Haiti, in contrast, remained cholera-free for as long as six weeks after the epidemic broke out, with clusters of the disease gradually occurring over a slightly staggered timespan in the North-West, Port-au-Prince, and North Departments.[117]

Cholera emerged in Port-au-Prince on October 22 with the arrival of patients from Artibonite, and remained surprisingly moderate in the capital city for some time after the beginning of the outbreak. From October 22–November 5, 2010, the incidence of cholera remained moderate with an average of only 74 daily cases. Although the epidemic eventually exploded in Cité-Soleil, a slum located in the floodplain near the sea, internally displaced person (IDP) camps in the city remained relatively free of cholera for up to six weeks after the epidemic broke out. Overall, despite the earthquake-related damage to the city and the presence of many IDP camps, cholera struck less severely in Port-au-Prince than in other departments in the country. In the Haitian capital, the incidence rate was only 0.51% until November 30. By contrast, during this same period, the following incidence rates were reported: 2.67% in the Artibonite Department, 1.86% in the Centre Department, 1.45% in the North-West Department, and 0.89% in North Department. The mortality rate in Port-au-Prince was also significantly lower (0.8 deaths/10,000 persons compared with 5.6/10,000 in Artibonite, 2/10,000 in Centre, 2.8/10,000 in North-West, and 3.2/10,000 in North).[118] As cholera is a disease commonly associated with poor water and sanitation, slum areas, over-crowding, and flooding, the low cholera incidence and mortality rates in Port-au-Prince, and the IDP camps in particular, were unexpected. Also contrary to expectations, data showed the highest incidence of disease in the rural Artibonite region.

The incredible speed at which cholera spread to all seven communes near the lower Artibonite River in Haiti strongly suggests that the contamination began at the Méyè Tributary.

2010		
	July 28–August 14	A 1,400-case outbreak of cholera occurs in mid-western region of Nepal.
	October 8–21	MINUSTAH troops arrive in Haiti after a 10-day leave visiting their families in Nepal.
	October 12	A 28-year-old man from the town of Mirebalais, located downstream from the Méyè MINUSTAH Base, is the first cholera patient of the 2010 epidemic. This man suffers from a psychiatric condition and regularly drank untreated water from a stream fed by the Méyè Tributary. The man develops profuse watery diarrhea. Less than a day after the onset of symptoms, he dies without medical attention. The man is not diagnosed with *V. cholerae* through laboratory methods.
	October 14–19	Outbreak investigations also identify several families living in Méyè as the first hospitalized cholera patients. These individuals exhibit cholera symptoms. Stool samples from a subset of these patients test positive for *V. cholerae*.
	October 19	Haitian health officials report unusually high numbers of patients with watery diarrhea and dehydration in two of Haiti's ten administrative departments.
	October 21–23	Additional cases of cholera are reported among the inhabitants of Mirebalais.
	October 23	National Public Health Laboratory (LNSP) confirms presence of *V. cholerae*.
	Late October	Haitian officials report an explosion of cases across the Artibonite River Delta.
	Early November	Cholera has spread to cities across the Haitian North-West and North Departments, which are roughly equidistant from the Artibonite Delta.
	November 19	The Haitian Ministry of Health (MSPP) reports positive cholera cases in all ten Haitian administrative departments.

The transmission of a waterborne disease like cholera across geographical regions takes as long as it would take for the water to travel the same distance. An Independent Panel of Experts, appointed by the U.N. to investigate the origins of the epidemic, calculated that it would take two to eight hours for water in the Méyè Tributary to flow from near the MINUSTAH camp's waste facilities to its junction with the Artibonite River.[119] The U.N. Independent Panel of Experts also found that a contamination of the Artibonite starting at the Méyè Tributary would be fully dispersed throughout the Artibonite River Delta within a maximum of two to three days. This timeline, the panel noted, was "consistent with the epidemiological evidence" showing that the outbreak began in Mirebalais, near the Méyè Tributary, and that cases of patients experiencing cholera-like symptoms appeared in the Artibonite River Delta area two to three days after the first cases of cholera were seen upstream in Mirebalais.[120]

C. The Troops at the MINUSTAH Base Were Exposed to Cholera in Nepal, and Their Feces Contaminated the Water Supply Near the Base.

Epidemiological studies report that the U.N. peacekeeping troops that arrived in Méyè just before the Haitian cholera outbreak had been exposed to the disease in Nepal shortly before their departure to Haiti. Poor sanitation infrastructure at the MINUSTAH camp in Méyè led to fecal contamination of the water supply near the camp and near the site of the first cases of cholera in Haiti. Locals regularly used this water for drinking, cooking, and bathing.

Nepalese peacekeeping troops arriving at the MINUSTAH camp in Méyè between October 8–24 had been exposed to cholera in Nepal. Cholera is endemic to Nepal and the country experiences sporadic outbreaks every year. In 2010, a 1,400-case outbreak occurred in the country, beginning around July 28 and lasting until mid-August, just prior to the Nepalese troops' deployment to Haiti.[121] During this outbreak, MINUSTAH

peacekeeping troops were training in Kathmandu. At the end of their training in late September and early October, the peacekeepers received a medical evaluation, and none showed symptoms of cholera.[122] The absence of symptoms, however, did not prove that the peacekeepers were cholera-free. Cholera has a two to five day incubation period and can be carried asymptomatically.[123] Prior to their departure for Haiti, the peacekeepers spent ten days visiting their families.[124] After this visiting period, none of the troops exhibited cholera symptoms.[125] Despite the recent cholera outbreak in Nepal and the high risk of exposure and infection during the ten-day visitation period, none of the peacekeepers were tested for *V. cholerae* immediately before their departure to Haiti.[126]

Once a water source like the Méyè Tributary becomes contaminated with cholera, human populations exposed to the contaminated water are prone to subsequent outbreaks.[127] The magnitude of such outbreaks varies according to the probability of secondary transmission.[128] A higher likelihood of such transmission exists in countries like Haiti with poor infrastructure and inadequate sewage systems and is also associated with the frequent arrival of foreign populations like troop deployments from overseas.

Environmental surveys conducted by the U.N. Independent Panel of Experts describe the MINUSTAH camp's inadequate waste infrastructure at the beginning of the epidemic. The experts identified a "significant potential for cross-contamination" of shower and cooking water waste with water waste containing human feces due to the poor pipe connections in the main showering and toilet area of the camp.[129] The experts also noted that the construction of the water pipes in these areas was "haphazard, with leakage from broken pipes and poor pipe connections."[130] The experts found that contamination was especially likely in an area where pipes "run over an open drainage ditch that runs throughout the camp and flows directly into the Méyè Tributary system."[131]

The U.N. Independent Panel of Experts' survey of the MINUSTAH base and its facilities further observed that disposal of human waste outside the camp contaminated the Méyè Tributary. Black water tanks, containing water contaminated with fecal matter from the camp, were emptied "on demand by a contracting company approved by MINUSTAH headquarters in Port-au-Prince."[132] According to MINUSTAH staff, the company collected the waste in a truck and deposited it in a disposal pit several hundred meters from the camp.[133] This pit was near the southeastern branch of the Méyè Tributary and was susceptible to flooding and overflow into the Méyè Tributary during rainfall.[134] The experts calculated that it would take roughly two to eight hours for water to flow from the septic pit to the junction with the Artibonite River.[135]

Haitians who contracted cholera in the early stages of the epidemic had consumed water from the Artibonite River. Almost no cases of cholera were reported in communities along the Artibonite that did not use water from the river. From October 21–23 the MSPP and CDC investigative team issued a standardized questionnaire to a sample of 27 patients in the five hospitals of the Artibonite Department. The majority of the surveyed patients reported living or working in rice fields in communities that were located alongside a stretch of the Artibonite River. Of the patients surveyed, 67% reported consumption of untreated water from the river or canals connected to the Artibonite prior to onset of symptoms, 67% did not practice clean water precautions (chlorination or boiling of water prior to use), and 27% practiced open defecation.

Furthermore, the U.N. Independent Panel of Experts found that in the Mirebalais market, seafood was neither sold nor consumed, making a route of infection originating in the ocean surrounding Haiti highly unlikely. This determination left the Artibonite River as the only potential source of the epidemic. The experts concluded that, based on the epidemiological evidence, the cholera epidemic began in the upstream region of the Artibonite River on October 17 and the most likely cause of infection in individuals was their consumption of contaminated water from the river. In their initial report in 2011, the U.N. Independent Panel of Experts concluded that there was insufficient evidence to attribute the epidemic to MINUSTAH

troops. However, in a follow-up study released in July 2013, this same group of experts revised their initial conclusion. They explained that additional evidence presented between 2011 and 2013 demonstrated MINUSTAH troops were in fact the cause of the outbreak.[136]

Researchers have thus concluded that the Haitian cholera epidemic's point source transmission is near the MINUSTAH base in Méyè, based on a combination of three factors: 1) the MINUSTAH peacekeeping troops were exposed to cholera in Nepal prior to their deployment to Méyè; 2) feces from these troops contaminated the local water supply due to poor waste infrastructure at the camp; and 3) a few days after the Nepalese peacekeeping troops' arrival to the MINUSTAH base in Méyè, Haitians drinking from the Méyè Tributary and the connected Artibonite River exhibited cholera symptoms.

D. The Haiti Cholera Outbreak Is Traceable to a Single Cholera Strain of Nepalese Origin.

Epidemiological research into the origins of the Haiti cholera outbreak has repeatedly confirmed that the Haitian strain is closely related to a family of cholera strains from South Asia. Specifically, the Haitian *V. cholerae* strain has a near identical genetic resemblance to the strain observed in Nepal in the summer of 2010.

Molecular epidemiological studies suggest the outbreak started with the introduction of a single strain into Haiti. *V. cholerae* strains are classified into sero-groups based on the structure of their bacterial membranes, and strains are further classified into serotypes, pulsotypes, and biotypes on the basis of various biochemical and microbiological tests. Samples from different specimens of the Haitian *V. cholerae* strain have repeatedly tested positive for the same sero-group O1, biotype El Tor, suggesting the epidemic had a common source.[137]

Whole genome sequencing of Haitian cholera samples also shows that the samples share a common genetic ancestry. Whereas sero-grouping, sero-typing, and bio-typing compare the larger molecular structures of *V. cholerae* cells, sequencing compares the highly specific genetic code of the cells. Thus, sequencing provides a more precise identification of *V. cholerae*. Due to the rapid evolution of bacteria over the course of an epidemic, different samples almost never present the exact same sequence. Instead, sequences that closely resemble one another will indicate that their samples have similar origins. Over the course of the epidemic, genetic material from various Haitian *V. cholerae* samples has been isolated and sequenced,[138] and analysis of these sequences consistently shows that the samples are closely related to one another and stem from a common ancestor.[139]

The ancestor *V. cholerae* strain of the Haitian strain responsible for the outbreak has been traced to Nepal. Molecular and epidemiological studies reveal that the Haitian and Nepalese El Tor O1 *V. cholerae* strains are closely related. Research also shows that the Haitian *V. cholerae* strain belongs to the same El Tor O1 family as the Nepalese strains.[140] Additionally, a comparison of genetic sequences from the 2010 Nepalese and Haitian strains found a close genetic resemblance between the two.[141]

The most contemporary strains from Nepal were compared with the whole genome sequences of isolates[142] from Haiti as well as those of other available strains. All Nepalese isolates were found to be similar to the Haitian isolates in both their antibiotic resistance and susceptibility.[143] One genetic cluster containing four Nepalese isolates was found to be identical to a minor variant of the main pulsotype from Haiti,[144] whereas another cluster of four Nepalese isolates was virtually indistinguishable from the most common pulsotype observed in Haiti.[145] One study found that only one Single Nucleotide Polymorphism[146] separates the Haitian and Nepalese isolates and that phylogenetic[147] patterns indicated a close relationship between the Haitian and Nepalese epidemic *V. cholerae* strains, thus "providing strong evidence that the source of the Haitian epidemic was from this [Nepalese] clonal group."[148] Notably, another study of the Haitian *V. cholerae* strains determined that the Haitian samples were markedly different from Latin American and African El Tor O1 strains, a result "strongly suggest[ing]" that the source of the epidemic was "the introduction of a *V. cholerae* strain into Haiti

by human activity from a distant geographic source."[149] This result, the study observed, countered hypotheses that "the Haitian strain arose from the local aquatic environment" or that "climatic events led to the Haitian epidemic."[150]

The most recent study of the origins of the cholera epidemic provides further evidence that the Haitian strain of cholera has a single, foreign source. Researchers investigating the evolutionary dynamics of *V. cholerae* O1 compared the whole genome sequence of Haitian isolates collected early in the epidemic with isolates collected near or after one year following the start of the outbreak, isolates recovered from more recent outbreaks, and isolates collected at other time points throughout the country during the CDC's routine laboratory surveillance of the epidemic.[151] The results of the comparison were consistent with previous findings that the Nepalese isolates are the closest relatives to the Haitian strain identified to date.[152] The researchers "observed remarkably few differences" in the genetic makeup of the population of Haitian isolates studied, despite the variance in the times and locations of their collection.[153] This genetic consistency provides further evidence that the observed Haitian isolates emerged from a single source. In addition, the study calculated a molecular clock model of the epidemic that supports the time frame of the outbreak proposed in earlier studies and discussed above.[154]

Multiple scientific studies have concluded that the close genetic similarities between the Nepalese and Haitian cholera strains support the hypothesis that cholera was introduced into Haiti from a Nepalese source.[155] The outbreak investigations and molecular epidemiological studies of the Haitian cholera epidemic also suggest that a single foreign strain of *V. cholerae* was introduced into Haiti in a single event.

A single study ("Hasan study") has proposed that the Nepalese peacekeeping troops were not the only source of the epidemic. The Hasan study argues that two strains—one local, one introduced by the Nepalese peacekeeping troops—were responsible for the cholera outbreak in Haiti. One strain, found in 48% of those infected, was *V. cholerae* O1, the strain most commonly linked to Nepal. The other strain, found in 21% of those infected, was *V. cholerae* non-O1/O139, a strain that the study postulated as local in origin. The study showed 7% of patients were infected with both.[156]

The scientific authority of the Hasan study, however, has been disputed. The study does not state the case definition of cholera—that is, it does not define its criteria for choosing the diarrheal cases it observes in its study. The lack of such a case definition calls into question the medical legitimacy of the cases studied and, as a direct result, the validity of the study's conclusions on the number of identified cholera patients. Diarrhea has multiple causes, but the Hasan study fails to explain how cholera, as opposed to other bacterial forms of diarrhea, was diagnosed in the cases it studies.[157]

Five epidemiologists, including the author of one of the first studies of the origins of the cholera epidemic in Haiti, have responded with skepticism to the Hasan study's results. In their response, they note that it is not unusual for humans to harbor several putative pathogens that cause diarrhea and question the study's proposal that *V. cholerae* non-O1/O139 could be the sole pathogen of 21% of clinical cholera specimens in Haiti.[158] The authors observe that among the 435 stool specimens collected by the LNSP between mid-October and November 2010, 249 harbored bacteria compatible with *V. cholerae*, and 243 were confirmed as being O1 and El Tor, leading to a diagnosis of the presence of *V. cholerae* O1, or the Nepalese strain, in the specimens. Based on this data, the authors argue, the maximum frequency of non-O1 *V. cholerae* collected by the LNSP was no more than 6 out of 435 samples, or 1.4%.[159] The authors thus conclude that the Hasan study "provided no evidence to counter that cholera was brought to Haiti by a contingent of Nepalese United Nations peacekeeping troops."[160]

Conclusion

Scientific study of the origins of the cholera epidemic in Haiti overwhelmingly demonstrates that U.N. peacekeeping troops from Nepal introduced the disease into the country. No cases of active transmission of cholera had been reported in Haiti for at least a century prior to October 2010. The foci of the epidemic encompasses the location of the MINUSTAH base in Méyè. The peacekeeping troops stationed at the MINUSTAH camp in Méyè at the time of the outbreak were deployed from Nepal, where cholera is endemic and an outbreak occurred just prior to their departure, increasing their likelihood of exposure and transmission. Lastly, molecular and genetic studies demonstrate that the Haitian cholera strain is genetically almost identical to the Nepalese strain, thus supporting the hypothesis that the outbreak originated from a single strain of cholera foreign to Haiti prior to October 2010. Although one study proposes that an additional strain of cholera local to Haiti contributed to the epidemic, other epidemiologists investigating the outbreak have questioned this study's methods and results. The most scientifically plausible explanation of the origin of cholera in Haiti, according to the majority of scientific research on the matter, continues to trace the epidemic to the U.N. peacekeepers from Nepal stationed at the MINUSTAH base in Méyè.

CHAPTER III

The Requirement of a Claims Commission

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By failing to hold itself accountable for causing the cholera outbreak in Haiti, the United Nations violates the very principles of accountability and respect for law that it promotes worldwide. Under international human rights and humanitarian norms, which Chapters IV and V demonstrate apply to all U.N. member states as well as the organization itself, the U.N. is accountable through appropriate mechanisms for certain wrongs it commits. This bedrock principle is reflected in every SOFA the U.N. has signed with countries hosting peacekeepers over the past two decades. These SOFAs require the creation of standing claims commissions to hear claims against U.N. peacekeepers and are one important measure for ensuring U.N. accountability.

However, in practice, the U.N. has refused to respect this principle of accountability, despite its place in the U.N.'s own governing law and its contractual agreements. Although the U.N. has promised a *standing* claims commission in the SOFA, it has never once honored this obligation in Haiti or anywhere else in the world, despite having entered into 32 such agreements since 1990. As a result, a meaningful mechanism to ensure peacekeeper accountability has been rendered a nullity.

The introduction of cholera by U.N. peacekeepers in Haiti exemplifies why such a standing claims commission is a vital part of any peacekeeping mission: Because U.N. peacekeepers enjoy immunity in courts of law, a claims commission is often the only avenue an injured civilian may have to redress injury caused by U.N. peacekeepers.

This chapter describes the U.N.'s obligation—in convention, charter, and contract—to hold itself accountable for wrongs it commits. In the peacekeeping context, the U.N. is required to establish adequate accountability mechanisms to address wrongs committed by peacekeepers. However, the U.N. routinely veers from these obligations, including the explicit provisions in SOFAs mandating that it create claims commissions and fulfill the accountability requirement. Instead, in the rare instances when the U.N. has taken any remedial steps for its peacekeepers' wrongdoing, the U.N. has relied on deficient, ex post substitutes in which it sits as both defendant and judge. Establishing a standing claims commission would address cholera victims' claims in an unbiased and meaningful manner, and it constitutes one step the U.N. must take to uphold its obligations of accountability.

A. The U.N. Charter and the General Convention Reflect a Bedrock Principle of Limited Immunity.

Although the U.N. enjoys immunity for official action, this immunity does not mean impunity. On the contrary, the same legal instruments that confer the U.N. with immunity contemplate the creation of accountability mechanisms to ensure that those injured by the organization will receive adequate redress.

Both the U.N. Charter and the Convention on the Privileges and Immunities of the United Nations (General Convention) contemplate a limited immunity checked by appropriate accountability mechanisms. The U.N. Charter recognizes that the organization and its representatives "shall enjoy . . . such privileges and immunities as *are necessary for the fulfillment of its purposes*."[161] Thus, the plain language of the Charter qualifies the scope of organizational immunity. While the Charter implies that the organization's immunity is not unbounded, the General Convention makes this explicit. Like the Charter, the General Convention generally immunizes the U.N. from legal process.[162] However, Section 29 of the General Convention, which is titled "Settlement of Disputes," provides that the United Nations

> *shall* make provisions for appropriate modes of settlement of: disputes arising out of contracts or other disputes of a private law character to which the United Nations is a party; disputes involving any official of the United Nations who by reason of his official position enjoys

immunity, if immunity has not been waived by the Secretary-General.[163]

The Article 29 provision has been characterized as "an acknowledgment of the right of access to court as contained in all major human rights instruments."[164] Thus, this provision qualifies the broad immunity the General Convention otherwise grants by requiring that the U.N. provide appropriate accountability mechanisms for disputes. As exemplified by this provision, such settlement resolution mechanisms are especially important where a U.N. official or organizational entity otherwise enjoys immunity, because internal settlement dispute mechanisms may be the *only* avenue for injured civilians to seek relief. Moreover, this limitation on immunity and the right of judicial redress it guarantees are in service of the U.N.'s human rights obligations, as discussed further in Chapter IV.

The U.N. Secretary-General has publicly recognized the organization's obligation to create accountability mechanisms under the regime of the Charter and the General Convention. In a series of reports interpreting Article 29, then-Secretary-General Kofi Annan explained that the U.N. has an "international responsibility" for the activities of U.N. peacekeeping forces, and that this responsibility is fulfilled by the assumption of liability through claims commissions.[165] This responsibility includes "liability for damage caused by members of forces during the performance of their duties."[166] The Secretary-General's acknowledgment that "damage caused by members of the United Nations is attributable to the organization" illustrates that the U.N. itself recognizes that it cannot decline responsibility for wrongs it commits, including wrongs committed by its peacekeeping forces.

B. The Principle of Limited Immunity Is Reflected in the U.N.'s SOFA, Which Requires Creation of a Claims Commission.

The principle of limited immunity established in these documents is also reflected in the U.N.'s SOFA with the Government of Haiti. The SOFA shields the organization from unrestricted liability while protecting innocent individuals who may be harmed by peacekeeper action. The SOFA "defines the relation between the force and the host state."[167] It specifies which actions can trigger organizational liability, what law governs peacekeeper action in the host country, and how civilians can receive redress if they are wronged by members of the organization. As written, the SOFA fulfills the U.N.'s obligations under the Charter and Section 29 of the General Convention.

Prior to 1990, no uniform agreement governing the legal arrangement between the host country and the peacekeeping troops existed. While some peacekeeping missions had mission-specific SOFAs, others had no SOFA at all. When no SOFA was in place, the law governing peacekeepers was unclear, creating uncertainty for both peacekeepers potentially subject to unnecessary liability as well as individuals injured by peacekeepers.[168]

To resolve this uncertainty, the General Assembly charged the Secretary-General in 1989 with drafting a SOFA that could serve as a template for mission-specific agreements and would be used in all future peacekeeping arrangements.[169] In 1990, the Secretary-General promulgated a model SOFA based on "established practices" and "drawing upon earlier and current agreements."[170] Although intended to serve as the basis for mission-specific agreements,[171] in practice the model SOFA has often been used without modification. Thus, the U.N. and a host country frequently enter into a peacekeeping arrangement using the model SOFA. Typically, the mandate creating the peacekeeping operation will simply incorporate the terms of the model SOFA.[172] Moreover, while peacekeeping mandates in the 1990s stated that the terms of the model SOFA "should" apply, mandates in the 21st century state that those terms "shall" apply, underscoring its importance to peacekeeping arrangements worldwide.[173]

While the SOFA contains several provisions that immunize peacekeepers[174] from certain forms of liability, such immunity is conditioned on the type of action in which peacekeepers are engaged.[175] Specifically, the SOFA shields peacekeepers from liability stemming from official acts, but also maintains the possibility of redress for civilians harmed by unlawful or unauthorized peacekeeper

behavior. The establishment of a claims commission makes this balance of interests possible.

Paragraph 51 of the model SOFA incorporates the U.N.'s legal obligations under Article 29 of the General Convention and requires the establishment of a standing claims commission:

> [A]ny dispute or claim of a private law character to which the United Nations peacekeeping operation or any member thereof is a party and over which the courts of [host country/territory] do not have jurisdiction because of any provision of the settled Agreement, shall be settled by a standing claims commission *to be established for that purpose*.[176]

Paragraph 51 also specifies that the claims commission be comprised of three members: one appointed by the Secretary-General, one by the host government, and a chairman jointly appointed by both.[177] Furthermore, the paragraph provides that in the event that the two parties cannot agree upon a chairman within 30 days of the appointment of the first member, either party may request that the president of the International Court of Justice (ICJ) appoint the chairman.[178] Two members constitute a quorum, and all decisions require approval by two members.[179]

To date, neither the Secretary-General nor the Government of Haiti has appointed a commissioner. Responding to this inaction, Haitian lawyers are considering a suit to compel their government to appoint a commissioner,[180] thereby triggering the creation of the commission.[181] The Haitian Government thus potentially holds the power to provide redress to its people under the SOFA. However, in light of its dependency on the U.N. for security and stability,[182] politically it may not be in a position to do so.

C. The U.N. Has Never Created a Claims Commission, and Its Reliance on Ex Post Substitutes Are Inadequate to Ensure Accountability.

Despite the clear obligation to create a claims commission under the SOFA, the U.N. has never done so for any of its peacekeeping missions. Although in the past it has created alternative mechanisms to respond to specific claims, such as claims review boards and mass settlement agreements, these alternatives are rarely granted and are in practice inferior to the claims commission guaranteed by the SOFA.[183]

1. The U.N. Has Never Honored the SOFA's Promise of a Claims Commission.

Though Paragraph 51 of the model SOFA has been incorporated into 32 peacekeeping arrangements since 1990, the Secretary-General has acknowledged that the U.N. has never once created a claims commission in practice,[184] even in the face of affirmative claims and demands for the establishment of commissions.[185] Instead, the U.N. has treated the establishment of commissions as optional, ignoring the mandatory language of Paragraph 51. For example, in a 1996 report, the Secretary-General stated that "two kinds of procedures" exist for the handling of third-party claims arising in peacekeeping operations: the SOFA claims commission and procedures "established internally." The report goes on to note that "to date, claims of a private law nature have been settled *without resort* to the establishment of standing claims commissions."[186] Rather than create a claims commission as it is required to do, the U.N. instead relies on procedures in which the "investigation, processing, and final adjudication of claims" is, in the Secretary-General's own words, "*entirely in the hands* of the Organization."[187]

2. Alternatives for Claims Commissions Are Deficient and Ineffectual and Cannot Be Viewed as an Adequate Fulfillment of the U.N.'s Contractual Obligations under the SOFA.

While the U.N. recognizes that it has never created a standing claims commission, it cites certain internally established procedures that purportedly satisfy its obligation to settle disputes.[188] These alternatives, however, are both procedurally and substantively inferior to the standing claims commission it is contractually obligated to establish, and as such are inadequate substitutes.

The first alternative is a "local claims review

board." Unlike a claims commission, which requires the independent appointment of three claims commissioners, the local claims review board is made up entirely of U.N. personnel.[189] Also unlike a claims commission, which should be a standing body, the claims review board is convened only after a dispute has arisen. In practice, claims review board determinations are shrouded in secrecy—their decisions are never made public—and face long backlogs in reviewing claims.[190] Many peacekeeping missions have at some time set up internal claims review boards to review private-law claims.[191] This reflects an understanding that disputes between such missions and civilians are common and foreseeable, underscoring the logic of establishing a standing commission rather than an ad hoc board.

A 2009 U.N. interoffice memorandum mentions the existence of a MINUSTAH Local Claims Review Board.[192] The memorandum notes that the board, in 2008, recommended an *ex gratia* payment (i.e., a payment made out of moral rather than legal obligation) to be disbursed to a Haitian civilian shot in the leg during a military operation involving local gang members. However, because the Local Claims Review Board's process is internal and not publicly disclosed, it is unclear how, to what extent, and on what legal grounds the MINUSTAH board regularly resolves disputes against MINUSTAH peacekeepers, or even if it still exists. Aside from this single mention of the Local Claims Review Board, no other information about it is known.

The U.N. has also participated in mass settlement agreements as alternatives to claims commissions. Unlike claims commissions or even local claims review boards, mass settlements lack any established process to guide claimants in seeking redress. Instead, settlement agreements depend on the host country's ability to negotiate with the U.N. for a lump-sum amount, which it then distributes to its injured citizens. However, "international diplomatic power is not a characteristic typical of states hosting peacekeepers."[193] Whereas Paragraph 51 seeks to mitigate such power imbalances through its three-member structure and appointments process, mass settlement agreements lack any such correctives.

No host country of U.N. peacekeepers has ever successfully negotiated such a settlement, although on at least one occasion, Western European countries have done so on behalf of their own citizens injured by peacekeepers in another country. Specifically, from 1965 to 1967, the United Nations acceded to demands from the governments of Belgium, Greece, Italy, Luxembourg, and Switzerland to pay compensation related to deaths and injuries of their citizens as a result of U.N. peacekeeping operations in the Congo.[194] No record of settlements on behalf of injured Congolese citizens, however, exists. Such history strongly suggests the inadequacy of mass settlement agreements as a fair substitute for a standing claims commission.

Predicating settlement of dispute on a country's power or on a panel made up entirely of U.N.-appointed officials when the U.N. is a party to the dispute is inconsistent with fair adjudication. By contrast, the standing claims commission envisioned in the SOFA promises fair judgment by requiring the appointment of impartial adjudicators, hearing claims individually, and, crucially, predating the damage caused by the U.N.

D. The SOFA Requires the U.N. to Establish a Claims Commission to Hear the Claims of Cholera Victims.

Had a claims commission been in place when the cholera outbreak occurred, the U.N. would have been required to address the victims' claims in a timely and meaningful manner. Like the model SOFA, the SOFA signed by the Government of Haiti and the U.N. states that claims of a "private law character . . . shall be settled by a standing claims commission."[195] Despite this plain and mandatory language, the claims commission was never set up.

In November 2011, over 5,000 Haitian victims of the outbreak filed a petition for relief with the chief of the Claims Unit of MINUSTAH. The petition alleged that the U.N. had failed to establish a standing claims commission as required by the SOFA. It argued that because claims arising from the cholera outbreak were "private law disputes" within the ambit of Paragraph 55 of the MINUSTAH SOFA, the claims commission, once established, should be the designated forum

to hear such a complaint.[196] The petition asked for the establishment of a fair and impartial standing claims commission as well as monetary compensation for injuries suffered.[197]

The U.N. acknowledged receipt of the claims after they were filed, but did not respond substantively until February 20, 2013, when it summarily rejected the complaint, claiming that it was "not receivable" because the claims touched on a "political and policy matter."[198] In its statement, the U.N. made no mention of its own contractual obligation to establish a claims commission to hear precisely the type of complaints Haitians seek to bring. As a result, Haitians affected by an outbreak stemming from the U.N.'s own actions may now have no forum in which to seek redress.

The SOFA's claims commission is vital to redressing the cholera outbreak for three reasons: (1) because the U.N. was contractually required to do so; (2) because the cholera victims' injuries are exactly the kind of claims such a commission should be tasked with hearing; and (3) because the U.N.'s failure to create a claims commission effectively forecloses all other avenues of relief.

1. MINUSTAH Was Required by Its Own Contract to Create a Claims Commission.

As it has in at least 32 peacekeeping agreements since 1990, the U.N. promised the creation of a claims commission in the SOFA it signed with the Government of Haiti when MINUSTAH was created in 2004.[199] In Paragraph 55, which is titled "Settlement of Disputes," the agreement promises that:

> Except as provided in paragraph 57 [which covers disputes between MINUSTAH and the Government of Haiti over interpretation of the SOFA], any dispute or claim of a private-law character, not resulting from the operational necessity of MINUSTAH, to which MINUSTAH or any member thereof is a party and over which the courts of Haiti do not have jurisdiction because of any provision of the present Agreement shall be settled by a standing claims commission to be established for that purpose. One member shall be appointed by the Secretary-General of the United Nations, one member by the Government and a chairman jointly by the Secretary-General and the Government.[200]

As in the model SOFA, the MINUSTAH SOFA contemplates a claims commission that is standing and mandatory. In addition, like the model SOFA, the MINUSTAH SOFA requires at least one adjudicator who is not appointed by the U.N. in order to ensure impartiality in the adjudication.

2. A Demand for Individual Redress for the Introduction of Cholera Is a Prototypical "Dispute of a Private Law Character" as Contemplated by the SOFA.

Paragraph 55 of the MINUSTAH SOFA limits the jurisdiction of claims commissions to "dispute[s] or claim[s] of a private law character." The cholera victims' complaints clearly constitute private-law claims squarely within the jurisdiction of the claims commission. The core of the claims—namely, requests for compensation for illness and death of private citizens resulting from improper actions by peacekeepers that led to contamination of the Haitian water supply—sound in tort, a classically private law domain.[201]

Characterizing the victims' claims as "disputes of a private law character" is consistent with accepted understanding of the distinctions between public and private law. For example, a key distinction between public and private law claims is the identity of the complainant. Public law claims may exist between governments or be initiated by a public authority. By contrast, private law claims are brought by private citizens.[202] The requested remedy also sheds light on whether the claim is public or private in nature. In this case, the victims' claims were for monetary compensation,[203] a traditional private law remedy.

This conclusion comports with guidance from the Secretary-General on the application of claims commissions to disputes of a private law character. This guidance cites "third party claims for compensation for personal injury/death or property loss/damage" as the kind of dispute a claims commission should hear.[204] Because the cholera victims' claims were claims for compensation for

personal injury or death, they are of an appropriate subject matter for a claims commission under the MINUSTAH SOFA. Although the U.N. statement rejected the victims' claims on the ground that they touched on a "political or policy matter," the claims are, in fact, quintessentially of a private law character and thus are appropriate for adjudication by a claims commission.

3. The Cholera Outbreak Did Not Arise out of an "Operational Necessity."

In addition to requiring that claims be of a "private law character," Paragraph 55 prohibits a claims commission from hearing claims that arise out of "operational necessity."[205] "Operational necessity" consists of those "necessary actions taken by a peacekeeping force in the course of carrying out its operations in pursuance of its mandates."[206] According to the Secretary-General, operational necessity takes into account four elements: (1) a good-faith conviction (in other words, a sincere belief that the course of action at issue was necessary to realizing the peacekeeping operation's mandates); (2) strict necessity, rather than mere convenience or expediency; (3) execution in pursuit of an operational plan; and (4) proportionality between damage caused and necessity for the operational goal.[207]

In the case of the cholera outbreak, none of these requirements are met. Dumping cholera-infected waste in a river cannot be deemed an "operational necessity." These actions were in no way necessary for the furtherance of the U.N.'s mission. At most, failing to outfit the MINUSTAH camp with adequate waste infrastructure might have been "convenient" or "expedient," but it was not "necessary" to the U.N.'s mission of stabilizing Haiti. The U.N.'s role in causing the outbreak simply cannot be classified an "operational necessity," particularly when considering the extent of the devastation caused by the cholera outbreak.

4. Without a Claims Commission, Haitian Victims May Never Have a Forum in Which to Bring Their Claims.

While the cholera victims have claims well within the purview of a judicial forum, without the creation of a claims commission, they may have no opportunity to have their grievances redressed due to the generous immunity afforded the U.N. and its employees (acting in their official capacity) from suit in courts of law.[208] Indeed, it is precisely because of this immunity that settlement dispute mechanisms were created.

Article 29 of the General Convention and Article 55 of the MINUSTAH SOFA carve out a narrow exception to the general rule that U.N. officials are protected from judicial scrutiny of their actions. Although scholars disagree about whether U.N. officials in Haiti enjoy only functional (that is, limited to actions stemming from official functions) immunity, it is still extremely difficult to overcome this immunity to sue them in a court of law.[209] Under the SOFA, civil suits can only proceed if the commander of the mission approves them, and even if the commander does so, it is "nearly impossible" to litigate within the Haitian legal system.[210]

While it is possible that the U.N. may set up an internal claims review board or enter into settlement negotiations with the Government of Haiti, it is unlikely that either of these avenues will vindicate the victims' right to a forum where they can have their grievances meaningfully redressed. As discussed above, these internal mechanisms are far inferior to a claims commission, both because they are set up *after* the injury—as opposed to "standing" throughout the course of a peacekeeping mission—and because they are not impartial.

Conclusion

Ultimately, a claims commission is the only meaningful forum in which victims may press their claims. Furthermore, it is the very process that the U.N. itself has contemplated in all of its peacekeeping agreements, as well as in its founding documents. Lastly, as Chapter IV emphasizes, it is also a concrete example of the U.N. fulfilling its obligation to provide access to remedies for violations of human rights, especially when, as here, the U.N.'s actions led to massive amounts of preventable death and illness. However, while establishing a claims commission is necessary for the U.N. to meet its obligations under the SOFA, it is neither a sufficient nor complete remedy for the U.N.'s introduction of cholera into Haiti. Chapter IV addresses the broader range of reparations to which victims of the cholera epidemic are entitled under international human rights law.

CHAPTER IV

The U.N. Has Failed to Respect Its International Human Rights Obligations

CHAPTER IV

The U.N. Has Failed to Respect Its International Human Rights Obligations

The United Nations is responsible under international human rights law for the cholera epidemic it has caused in Haiti. Although U.N. accountability for actions that disregard international human rights law was once considered a novel proposition, increasingly scholars and policymakers, including key figures within the U.N., have concluded that a blanket denial of legal obligations for the U.N. is incompatible with international law and international human rights law.[211] Reports of U.N. peacekeepers committing a range of human rights abuses in Haiti have been dismayingly frequent throughout MINUSTAH's presence in the country.[212] These reports have made the proposition that the U.N. need not answer for such violations all the more untenable.

The principle of U.N. accountability under international human rights law is rooted in two key premises. First, the U.N.'s capacity to incur legal obligations under international law, and international human rights law—its legal personality—is well-settled. Second, scholars, policymakers, and U.N. officials have highlighted that one of the U.N.'s institutional purposes is the promotion of human rights. Such promotion entails a duty on the part of the U.N. and its agents to respect the international human rights law that it promotes. MINUSTAH's specific charge to promote human rights and respect Haitian law—law that includes Haitian human rights obligations—further supports this conclusion.

The range of human rights that the U.N., operating through MINUSTAH, must respect is determined by standards established in human rights treaties and obligations under customary international law. Through its contractual commitment under the SOFA to respect Haitian laws, which includes Haitian treaty-based human rights obligations, the U.N. has assumed duties toward the Haitian people based on their rights under these treaties. In first bringing cholera to Haiti and then attempting to foreclose any remedy for harms caused by the epidemic, the U.N. has neglected its duties to respect and promote those rights set out in Haitian treaty obligations as well as accepted international norms and customary international law.

In Haiti, the U.N. has committed a series of failures. It negligently failed to prevent the introduction of cholera bacterium brought by its peacekeepers into a major Haitian waterway and then failed to provide any form of remedy to the victims. These failures are now compounded by the U.N.'s failure to guarantee non-repetition of similar harms, a guarantee that includes taking adequate steps toward ameliorating the epidemic. Each of these failures is also a failure to respect human rights—specifically, the rights to water, health, life, and an effective remedy. In failing to respect human rights, the U.N. has also failed to uphold its obligations under international human rights law.

The failures of U.N. actors to respect these fundamental human rights must have visible consequences if the U.N.'s global operations are to retain legitimacy. The need for such accountability is especially acute when these failures arise from the activities of peacekeeping operations like MINUSTAH, mandated to promote and respect human rights, in poor countries like Haiti that lack sufficient infrastructure to prevent or control the harms that stem from such failures. The recognition of this need adds a moral dimension to the argument for U.N. accountability under international human rights law: In light of the U.N.'s critical role in developing and promoting human rights globally, the U.N. must demonstrate the same commitment to comply with international human rights law that it demands from states and other non-state actors, or risk losing its moral authority to make these demands at all.

A. The U.N. Can Have Duties and Liabilities under International Law.

The U.N. has long acknowledged that it can possess legal obligations under international law. This possibility extends to international human rights law, which is a subset of international law. Article I of the General Convention codifies the organization's international legal personality.[213] The ICJ later affirmed that the U.N. is, "a subject of international law . . . capable of possessing international rights and duties."[214] These rights and duties "must depend upon [the U.N.'s] purposes and functions as specified or implied in its constituent documents and developed in practice."[215] As one of the U.N.'s purposes is the achievement of international cooperation "in promoting and encouraging respect for human rights,"[216] the U.N. cannot possess any right or duty under international law that hinders its ability to promote or encourage respect for human rights.

The U.N. has also formally recognized that its legal personality renders it liable for the actions of its peacekeeping operations. As noted in Chapter III, in a 1995 report discussing the scope of U.N. liability for peacekeeping troops, then Secretary-General Kofi Annan acknowledged that the "international responsibility" of the U.N. for the activities of its forces "is an attribute of its international legal personality and its capacity to bear international rights and obligations."[217] These international obligations and liability for their breach are

> a reflection of the principle of State responsibility—widely accepted to be applicable to international organizations—that damage caused in a breach of an international obligation and which is attributable to the State (or to the Organization), entails the international responsibility of the State (or of the Organization) and its liability in compensation.[218]

In 2004, United Nations Legal Counsel to the Director of the Codification Division reiterated this principle, stating that "an act of a peacekeeping force is, in principle, imputable to the Organization, and if committed in violation of an international obligation entails the international responsibility of the Organization and its liability in compensation."[219]

Thus, as the U.N. itself has recognized, when a peacekeeping force breaches an international obligation of the U.N., the organization is responsible both for the breach and for remedying it. This rule extends to MINUSTAH's activities in Haiti, and therefore the U.N. must be accountable for MINUSTAH's breaches of the U.N.'s international obligations.

B. The U.N. Is Obligated to Respect Human Rights.

The U.N.'s foundational commitments, as well as the contractual obligations of MINUSTAH to Haiti, give rise to its specific obligation under international law to respect international human rights. It is undisputable that one of the U.N.'s purposes includes the promotion and encouragement of respect for human rights; the U.N. Charter obligates the organization to "promote . . . universal respect for, and observance of, human rights," and requires member states of the U.N. to "pledge themselves" to cooperate with the U.N. in achieving this obligation.[220] Similarly, the Vienna Declaration and Programme of Action of 1993 identifies "[t]he promotion and protection of all human rights" as a "priority objective" of the U.N. and notes that the "processes of promoting and protecting human rights should be conducted in conformity with . . . international law."[221]

The MINUSTAH mandate promotes these human rights objectives in Haiti by requiring the peacekeeping operation to "support the Transitional Government and Haitian human rights institutions and groups in their efforts to promote and protect human rights."[222] While the precise meaning of "promote" is not supplied in the U.N. Charter or the MINUSTAH mandate, a human rights breach would obviously fall outside of its definition. As the ICJ has recognized, "[A] denial of fundamental human rights is a flagrant violation of the purposes and principles of the Charter."[223] Because the U.N. and MINUSTAH cannot fulfill their purposes to promote and support the

promotion of human rights while simultaneously acting in ways that disrespect human rights, the fulfillment of their mandate requires that their actions be guided by human rights standards.

The scope of human rights law that the U.N. must respect is determined in part by Haiti's international law obligations. The SOFA requires MINUSTAH to "respect all local laws and regulations" of Haiti.[224] These "local laws and regulations" include any treaty provisions to which Haiti has committed.[225] As the U.N. is liable for any breaches by MINUSTAH of its legal obligations,[226] it is responsible for the consequences of MINUSTAH's failure to respect Haitian laws and regulations, including its human rights treaty commitments.

Moreover, the U.N.'s legal personality alone suggests that it may be judged according to customary international law, including customary international human rights law.[227] The U.N. can be legally bound to customary international law, defined by the ICJ as "evidence of a general practice accepted as law,"[228] or any international human rights standards that have been similarly widely accepted as general principles of law,[229] because the force of customary international law comes from its practice, not from its codification in treaties.[230] Unlike treaty obligations, which only attach to parties if and when they consent by signing or acceding to the treaty,[231] customary international law obligations are conferred upon any entity that can possess international obligations.[232] Given its legal personality, the U.N. is one such entity, and thus can be legally obligated to comply with customary international law.[233]

Furthermore, if the U.N. fails to comply with international human rights law—law that it has helped to develop, promote, and protect—the U.N. risks losing its moral authority to demand that states and other international actors comply with it. One of the U.N.'s primary objectives, expressed in the preamble of its Charter, is to "reaffirm faith in fundamental human rights."[234] For decades, the U.N. has repeatedly institutionalized its commitment to the promotion of human rights.[235] Further, since its inception, the U.N. has overseen the development, ratification, and implementation of countless international human rights treaties and has issues even more resolutions, recommendations, and comments clarifying and elaborating those legal obligations that are concomitant with human rights protections.[236] Having committed to the global advancement of international human rights, the U.N.'s appeals to states to respect human rights carry a uniquely authoritative force. The U.N.'s refusal to similarly respect these rights, however, threatens to sap these appeals of their authority and legitimacy.

C. The U.N. Has Failed to Respect Human Rights in Haiti

By polluting a major Haitian water source with human waste contaminated with the cholera bacterium carried by U.N. troops, resulting in the deaths of thousands and the infection of hundreds of thousands, and subsequently refusing to provide any remedy for the injury its negligence caused, the U.N. has clearly contravened its obligations under international law to respect, promote, and protect human rights. MINUSTAH's depositing of cholera-laced human waste into the Artibonite River failed to respect the victims' human right to water. The victims' contraction of cholera from the polluted river water, and their resultant sickness and, in many cases, death, stemmed from a failure to respect their human rights to health and life. And the U.N.'s failure to provide any form of redress to its victims for their loss and injury fails to respect their human right to remedy.

1. The U.N. Has Failed to Respect the Right to Water.

The U.N. has led the international effort to develop and recognize the human right to water. In 2010, the General Assembly adopted a resolution on the human right to water and sanitation that "recognizes the right to safe and clean drinking water and sanitation as a human right that is essential for the full enjoyment of life and all human rights," and calls upon international organizations, among others, to provide financial and other resources to help developing countries expedite their efforts "to provide safe, clean, accessible and affordable drinking water and sanitation for all."[237] The Human Rights Council of the U.N. has also

issued a resolution acknowledging the human right to water and affirming its origins in the binding rights to an adequate standard of living, the highest attainable standard of health, and life.[238] The Inter-American Court of Human Rights, which judicially oversees the fulfillment of commitments made under the American Convention on Human Rights ratified by Haiti in 1977, has further interpreted the right to life under the American Convention to include access to safe drinking water and sanitation, and has attributed deaths resulting from lack of access to clean water to the state's failure to provide adequate water and sanitation.[239]

The U.N. Committee on Economic, Social, and Cultural Rights has set guidelines for the realization of the right to water. The committee, which has found that the right to health and right to an adequate standard of living established in the International Covenant on Economic, Social, and Cultural Rights (ICESCR) include access to safe drinking water and sanitation, has stated that "safe" water means water "free from micro-organisms, chemical substances and radiological hazards that constitute a threat to a person's health."[240] Violations of this right can occur through "the direct actions of State parties or other entities insufficiently regulated by States" and involve, among other things, "pollution and diminution of water resources affecting human health."[241] For states that have resource constraints limiting their ability to fully realize the right to water, the committee notes that they "have a constant and continuing duty under the Covenant to move as expeditiously and it effectively as possible" toward full implementation of the right.[242]

The U.N.'s negligent oversight of its own peacekeeping forces' water and sanitation practices, which caused human waste to leak into the tributary of a major Haitian water source and pollute the main source of water for hundreds of thousands of people, was a clear failure to respect the human right to water. The MINUSTAH camp's haphazardly constructed waste infrastructure, which allowed for waste from the camp's drainage canal and an open drainage ditch to flow directly into the Méyè Tributary,[243] virtually guaranteed contamination of the nearby water systems. As a result, the many people who relied on natural water resources for drinking, cooking, and bathing were deprived of their human right to water. Notably, MINUSTAH's pollution of the Artibonite was not the result of insufficient regulation by Haiti, as the Government of Haiti is not in a position to "regulate" the U.N., but rather the consequence of MINUSTAH's violation of Haitian laws prohibiting the disposal of human waste into natural water resources.[244]

The U.N.'s failure to respect the human right to water was especially troubling in Haiti, where treated or potable water was and remains a scare resource for many;[245] a 2006 study found that nearly 90% of Haitians lack access to piped water, and only 17% have access to improved sanitation.[246] The cholera epidemic has only diminished the availability of clean water, while increasing the need for it. Because cholera is a waterborne disease that causes illness and death through dehydration, access to clean water is essential to treatment and prevention.[247] Further, the U.N.'s negligent pollution of the Artibonite greatly impedes Haiti's ability to realize its own duty, under the ICESCR, to expeditiously realize the human right to water.

2. The U.N. Has Failed to Respect the Right to Health.

The human right to health is widely recognized in international human rights law and standards. The Universal Declaration of Human Rights (UDHR) states that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and his family."[248] The ICESCR acknowledges "the right of everyone to the enjoyment of the highest attainable standard of physical . . . health."[249] The Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention on the Rights of Persons with Disabilities (CRPD), and the Convention on the Elimination of All Forms of Racial Discrimination (CERD) all provide that children, women, racial minorities, and people with disabilities should enjoy the highest attainable standard of health without discrimination.[250] The American Declaration on the Rights and Duties of Man, which the Inter-American Court of Human Rights has held as a

source of binding international obligations for members of the Organization of American States, including Haiti, deems the "the preservation of . . . health through sanitary and social measures . . . to the extent permitted by public and community resources" an essential human right.[251]

The ICESCR, CRC, and U.N. Committee on Economic, Social, and Cultural Rights have all elaborated on what measures must be taken to comply with the right to health. The ICESCR provides for the achievement of the right to health through "[t]he improvement of all aspects of environmental and industrial hygiene [and] . . . [t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases."[252] Under the CRC, the right to health to which children are entitled must be protected by the "combat [of] disease . . . taking into consideration the dangers and risks of environmental pollution."[253] The Committee on Economic, Social, and Cultural Rights includes access to safe and potable water and adequate sanitation within the right to health.[254] Much like the right to water, the committee emphasizes that the right to health must be implemented as expeditiously and effectively as possible by resource-constrained states and notes that those whose right to health has been violated should have access to appropriate remedies.[255] The committee also acknowledges that when providing humanitarian aid, "given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem."[256]

By failing to prevent the introduction of cholera into Haiti, the U.N. failed to respect the human right to health. The MINUSTAH camp, which housed peacekeepers from a country where cholera is endemic and where multiple cholera outbreaks had occurred shortly before their deployment to Haiti,[257] lacked adequate water and sanitation infrastructure that the U.N. should have provided. Such conditions made the camp's pollution of the nearby Méyè Tributary with cholera-infected human waste nearly inevitable. The U.N.'s negligent introduction of cholera into Haiti disregarded its duty to prevent the transmission of communicable diseases that, as noted above, the U.N. Committee on Economic, Social, and Cultural Rights has determined the human right to health requires. Moreover, the U.N.'s creation of a major public health crisis in Haiti further hinders the country's attempts to comply with its own obligations under the human right to health.

3. The U.N. Failed to Respect the Right against the Arbitrary Deprivation of Life.

The right to life and the right against arbitrary deprivation of that life recur throughout international human rights law. Article 3 of the UDHR states, unequivocally, that "[e]veryone has the right to life, liberty and security of person." The CRC recognizes the "inherent right to life" that every child enjoys. The American Convention and the American Declaration of the Rights and Duties of Man both affirm the right of everyone to life and to the protection of this life by law. The ICCPR deems the right to life "inherent" in "[e]very human being," demands that "[t]his right . . . be protected by law," and forbids the arbitrary deprivation of life. The Human Rights Committee advises that the right to life not be "narrowly interpreted" and suggests that the right to life can be protected by adopting, among other things, "measures to eliminate . . . epidemics."[258]

With over 8,100 lives already claimed by the cholera epidemic, the U.N.'s role in causing the epidemic has undeniably demonstrated a failure to respect the human right to life. Rather than take measures to control and eliminate epidemics, as the U.N. Human Rights Committee has suggested states do to effectuate the right to life, the U.N. created an epidemic in Haiti. The U.N.'s failure to prevent cholera's introduction into the major waterway of a post-earthquake country, where an adequate water and sanitation system was still developing, arbitrarily deprived thousands of Haitians of their lives.

4. The U.N. Failed to Respect the Right to an Effective Remedy.

The human right to an effective remedy for the violation of an international obligation is well-established throughout international human rights law. The UDHR, understood to be the "international standard of human rights,"[259] with many of its components a critical part of customary international law,[260] recognizes that "[e]veryone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted to him by the constitution or by law."[261] Indeed, the right to an effective remedy has entered the catalog of customary international law norms.[262] The American Convention provides everyone the right to "simple and prompt recourse . . . to a competent court or tribunal for protection against acts that violate his fundamental rights recognized by the constitution or laws of the state concerned or by this Convention."[263] The ICCPR, CERD, CRC, and ICESCR, all treaties to which Haiti has acceded or ratified, affirm a right to remedy for victims of violations of international human rights law.[264]

The human right to remedy encompasses a number of substantive requirements, including restitution and the guarantee of non-repetition, developed by U.N. human rights organs. The Human Rights Committee has stated that the right to remedy requires reparation to those whose rights under the ICCPR have been violated, and that reparation "generally entails appropriate compensation" and "can involve restitution, rehabilitation and measures of satisfaction, such as public apologies, public memorials, guarantees of non-repetition and changes in relevant laws and practices . . . [and] bringing to justice the perpetrators of human rights violations."[265] The Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (Basic Principles), a General Assembly resolution of recommendations for state's implementation of the right, affirms that victims should be provided with "full and effective reparation," which includes compensation and guarantees of non-repetition.[266] The Basic Principles further provide that, "[i]n cases where a person, a legal person, or other entity is found liable for reparation to a victim, such party should provide reparation to the victim."[267] In adopting the Basic Principles, the General Assembly recognized that the right to remedy "reaffirms the international legal principles of accountability, justice and the rule of law."[268]

The ICJ and Inter-American Court both have acknowledged that the right to remedy entails guarantees of non-repetition. The ICJ has developed a doctrine for guarantees of non-repetition, most prominently in the *LaGrand* case,[269] that requires that specific steps toward preventing future repetition of a human rights breach be taken when the breach makes full restitution impossible. In *LaGrand*, Germany sued the U.S. for executing two German citizens after a legal technicality barred judicial consideration of their claim for release from imprisonment. After finding for Germany, the ICJ held that the case presented an "exceptional circumstance" where, because the victims had already been executed, the only effective remedy would be for the perpetrators to take concrete measures toward preventing the same fate from befalling others in the future. The Inter-American Court similarly has established that if full restitution, "which consists of restoring a previously-existing situation," is not practicable, the entity responsible for the breach of a duty under human rights must provide its victims compensation for the damages caused by the breach and take measures to prevent the breach from reoccurring.[270]

By attempting to foreclose any potential remedy for individuals in Haiti who contracted cholera from MINUSTAH,[271] the U.N. failed to respect the right to remedy. The U.N.'s refusal to implement a claims commission, waive its immunity, or apologize for the harms caused by its negligence denies the victims the possibility of redress or compensation for their suffering. The U.N.'s repeated denial of any responsibility for the introduction of cholera into Haiti deprives the victims of an apology. The U.N.'s unwillingness to make any effort to ensure that its peacekeeping forces do not create a similar crisis in the future

is no guarantee of non-repetition. Rather, the U.N. has thus far resisted implementing measures to prevent future introduction of cholera into cholera-free regions, as Haiti once was, by peacekeepers. As of May 2013, it has implemented only two of the U.N. Panel of Independent Experts' seven recommendations for responding to the outbreak.[272] This resistance greatly risks the possibility that peacekeepers in Haiti and elsewhere will continue to negligently dispose of their waste.

The remedy provisions of the General Convention and SOFA, which include the establishment of a claims commission in the event that the U.N. causes harm, are consistent with the U.N.'s obligation to respect the human right to remedy. The U.N.'s failure to establish such a commission to hear the cholera victims' claims, or waive its immunity so that the victims can bring their claims to a judicial forum, effectively denies the victims any remedy at law and thus fails to respect their right to remedy. The General Convention and SOFA require the U.N. to provide some form of remedy for civil disputes involving the U.N. and MINUSTAH, thus ensuring that the U.N.'s broad immunity from suit is not distorted into an abdication of legal accountability.[273]

While the U.N.'s obligations under the General Convention and SOFA are necessary in satisfying the right to remedy, they are not sufficient. The U.N.'s failure to take meaningful steps to respond to the ongoing epidemic in Haiti further compounds the harmful effects of its initial violations. At minimum, an acceptance of its obligations under the human right to remedy in Haiti should require the U.N. to redouble its efforts to ensure that future sickness and death do not result from its action or inaction.

Conclusion

MINUSTAH's introduction of cholera into Haiti, the U.N.'s subsequent denial of any redress to the victims, and its failure to effectively respond to the ongoing health crisis constitute actionable wrongs under international human rights law. The U.N.'s legal obligations under such law extend from its legal personality, its foundational purpose to respect, promote, and protect human rights, its liability under the SOFA for MINUSTAH's failures to respect Haitian laws, including Haitian treaty duties, and its duties under customary international law. By failing to respect the human rights to water, health, life, and remedy of the victims of the cholera epidemic, the U.N. breached these obligations. In so doing, the U.N. has undermined the moral authority it requires to ensure that states comply with and respect these same human rights. These U.N. failures have serious implications for the overall legitimacy of the U.N.'s peacekeeping authority in Haiti and elsewhere.

CHAPTER V

The U.N.'s Actions Violated Principles and Standards of Humanitarian Relief

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Humanitarian principles and standards serve as important tools to evaluate the U.N.'s actions in Haiti through its local mission. Over the past two decades, humanitarian relief organizations have established frameworks for delivering humanitarian assistance in emergencies that are now widely accepted in the international aid community. These frameworks developed to prevent relief organizations from unintentionally harming humanitarian aid recipients when giving aid. Historically, the International Committee of the Red Cross (ICRC) and other NGOs have primarily articulated these principles and standards. Increasingly, however, other humanitarian actors, including U.N. bodies and agencies, have begun to adopt and promote them. Indeed, the latter institutions have had an important role in developing these frameworks and have incorporated them into their own guidance and handbooks.

Today, these principles and standards provide a set of minimum voluntary obligations that the ICRC and NGOs have pledged to observe in humanitarian relief efforts. These frameworks for humanitarian relief serve an important regulatory function. Reflecting a concern for the dignity of populations receiving humanitarian aid, they seek to both promote delivery of quality aid and avoid harming populations in need. In addition, these principles and standards bridge a gap. Many humanitarian actors working in emergency settings perform state-like functions in the absence of a strong functioning state. Such non-governmental actors, in taking on state-like responsibility and authority, may unintentionally inflict harms on local populations. However, they are not governed by the same legal frameworks that render states liable for inflicting these same harms.

Since its formation in 2004, MINUSTAH has had a particularly broad mandate that encompasses both peacekeeping and humanitarian functions. Subsequent amendments to the original MINUSTAH mandate have reflected a similarly broad agenda for the mission. Particularly in the months following the 2010 earthquake, MINUSTAH took an active role in delivering humanitarian relief in Haiti. As a humanitarian actor, MINUSTAH has often performed state-like functions, including building infrastructure and delivering food aid. Such actions can potentially inflict unintended harm on the people receiving aid. The cholera epidemic is a tragic example of this potential. Had MINUSTAH followed the established principles and standards of humanitarian relief, it could have avoided causing this harm, improved the quality of its humanitarian assistance, and safeguarded the dignity of the Haitian people it intended to aid.

MINUSTAH's introduction of cholera into Haiti has violated widely agreed-upon principles and standards of humanitarian relief intervention. First, MINUSTAH has violated the "do no harm" principle. Compliance with this general principle entails observing minimum water, sanitation, and hygiene requirements to prevent the spread of disease. In Méyè, MINUSTAH's poor maintenance of the base's sewage facilities in a post-emergency situation introduced cholera into the Haitian water system, ultimately infecting hundreds of thousands. Second, after violating the do no harm principle, MINUSTAH violated the principle of accountability to affected populations. Humanitarian relief standards have emphasized the importance of establishing mechanisms for receiving and addressing complaints of those negatively affected by relief work. In Haiti, the U.N., which is responsible for MINUSTAH's operations, has refused to institute such a mechanism.

A. Humanitarian Organizations Have Developed Principles and Standards of Aid, Which U.N. Agencies Have Promoted, to Address the Unintended Harms That Often Arise from Relief Work.

Humanitarian relief principles address the obligations of organizations delivering aid in conflict and emergency settings. These principles stem from over a century of experience on the part of humanitarian actors in conflict settings and in complex humanitarian emergencies. Since the late 19th century, independent but authoritative organizations like the ICRC have articulated these humanitarian principles, many of which have been codified in international law. These principles limit how combatants may fight in war and govern the treatment of civilians, including requiring respect for their health and security needs. During the latter half of the 20th century, this focus on humanitarian principles expanded to encompass the obligations of relief organizations working in conflict and emergency situations.[274]

Humanitarian NGOs increasingly have sought to develop frameworks that address both the causes of unintended harmful consequences of relief and the lack of accountability humanitarian organizations otherwise have to populations receiving assistance.[275] These frameworks not only establish a broad principle of do no harm; they also prescribe a standard of professionalism against which actions causing harm can be measured. Humanitarian actors are not responsible for every harm caused by their presence; rather, they are accountable only when their actions fall below an accepted standard of professionalism. Finally, these principles hold accountability as a core principle, and some set up specific processes to ensure such accountability.

Three humanitarian aid frameworks have been particularly influential: the ICRC Code of Conduct, the Sphere Project Humanitarian Charter and Minimum Standards, and the Humanitarian Accountability Partnership (HAP) Standard. The ICRC Code, Sphere Standards, and HAP Standard play an important regulatory role in the field of humanitarian relief work. All three frameworks share a common humanitarian goal of respecting human dignity[276], which in turn entails a commitment to the do no harm principle and to improvement in the quality of aid delivered.[277] All three frameworks also reflect the belief that providing humanitarian relief requires meeting certain minimum criteria of acceptable aid. A number of other humanitarian actors, including U.N. agencies, have adopted and promoted the do no harm and accountability principles underlying all three frameworks.[278]

The ICRC Code of Conduct is one of the first codifications by the international community of humanitarian principles of relief response.[279] Published in 1994, the ICRC Code is one part of a long history concerning the role of non-governmental actors in conflict and emergency settings. This history dates back to at least as early as the ICRC's founding in 1863 and is informed by over a century of successes and shortcomings in humanitarian relief efforts.[280] The ICRC Code lays out broad principles of responsibility for organizations delivering aid. Among these are an obligation to protect local populations—or at minimum, to do no harm to them—and a commitment to establish mechanisms of accountability for these populations.[281] Despite debates about the effectiveness of the ICRC Code, today over 500 non-governmental relief organizations are signatories to the ICRC Code and agree to abide by these principles.[282]

The principles articulated in the ICRC Code of Conduct are foundational to standards of humanitarian aid developed by the Sphere Project.[283] In 1996, a loose coalition of humanitarian NGOs, funders, and other actors, including the ICRC, sought to develop minimum standards of aid delivery from more general principles of humanitarian relief response. These actors were motivated in part by the perceived failures of the humanitarian NGO community in the Rwandan genocide and the Great Lakes refugee crisis of the early 1990s.[284] In 1996, key humanitarian actors began wide-ranging consultations with other NGOs and international organizations, including U.N. agencies, and ultimately created the Sphere Project.[285]

The Sphere Project generated the Sphere

Humanitarian Charter and Minimum Standards in Disaster Response, first published in 1999 and revised in 2004.[286] The Sphere Standards are informed by international humanitarian law, human rights law, and guidelines from the U.N., other international organizations, and humanitarian NGOs.[287] Additionally, these principles explicitly incorporate the ICRC Code of Conduct.[288] The principles, in turn, inform a series of common minimum standards and sector-specific minimum standards in the areas of (1) water supply, sanitation, and hygiene promotion; (2) food security and nutrition; and (3) shelter, settlement, and non-food items. Today, the Sphere Standards are widely recognized as minimum requirements for organizations working in conflict and disaster relief.[289]

Debates over the enforceability of the Sphere Standards and the humanitarian community's perceived failures in Rwanda also gave rise to the Humanitarian Ombudsman Project and the HAP.[290] Initially conceived as a watchdog for humanitarian organizations, the Ombudsman Project was recast as a self-regulatory body that would establish standards for accountability among humanitarian relief organizations and certify NGOs as compliant with those standards. From this, the HAP was formed in 2003.[291]

The HAP developed a set of principles of accountability that emphasize a commitment to humanitarian standards and rights as well as the participation of all stakeholders—including populations receiving aid.[292] From these principles, the HAP Standard derives six benchmarks of humanitarian accountability that assess (1) the establishment of a humanitarian quality management system; (2) the availability of public information to all stakeholders; (3) the ability of aid beneficiaries to participate in program decisions; (4) the capacity of humanitarian relief staff to implement a quality management system; (5) the establishment of complaints-handling procedures; and (6) the establishment of a process for improving the internal accountability framework.[293]

The U.N. and its agencies have played an important role in developing and promoting all three frameworks of humanitarian relief response. First, as noted above, U.N. agencies were involved in the consultations that led to the development of both the Sphere Standards and the HAP Standard.[294] Second, U.N. bodies and agencies approvingly cite to the Sphere Standards in their own internal guidelines and handbooks. The Office of the U.N. High Commissioner for Refugees Handbook for Emergencies, for instance, repeatedly cites the Sphere Standards as a key reference in sections related to water, sanitation and hygiene, and health.[295] Similarly, World Health Organization guidelines on solid waste management and excreta disposal in emergency settings also reference the Sphere Standards.[296] Third, the U.N. Secretariat has promoted principles of accountability and do no harm through its Office for the Coordination of Humanitarian Affairs. The Office for the Coordination of Humanitarian Affairs' 2005 Humanitarian Response Review, for instance, evaluated the international humanitarian responses of NGOs and U.N. agencies in light of how accountable these organizations were to the populations they served.[297]

The ICRC Code, Sphere Standards, and the HAP Standard are critical to regulating humanitarian actors: Although humanitarian actors fulfill state-like functions in the basic services they provide, they are not subject to the same legal frameworks, that regulate states. As a result, humanitarian actors may face little or no consequences for inflicting great harm on the people they aim to help when delivering aid. Humanitarian relief principles and standards bridge that gap.

B. MINUSTAH's Role in the Cholera Outbreak Should Be Evaluated by Principles Governing Humanitarian Relief.

To the extent that the U.N. and MINUSTAH are concerned with delivering quality humanitarian assistance and respecting the dignity of populations receiving aid, principles and standards of humanitarian relief are useful and appropriate tools for evaluating MINUSTAH's role in the cholera outbreak. While U.N. missions are not formally bound to these frameworks, U.N. actors have supported their development and considered these principles applicable to their own activities.

Moreover, U.N. missions generally—and MINUSTAH specifically—actively participate in humanitarian relief work.[298] Furthermore, as is evident from the cholera outbreak, MINUSTAH operations can perpetrate the very harms humanitarian principles and standards aim to prevent.

MINUSTAH functions, in part, as a humanitarian relief organization. U.N. Security Council Resolution 1542 established MINUSTAH and explicitly laid out obligations for the peacekeeping troops encompassing both peacekeeping and humanitarian activity.[299] According to the resolution, MINUSTAH "shall cooperate with the Transitional Government [of Haiti] as well as with their international partners, in order to facilitate the provision and coordination of humanitarian assistance."[300] Additionally, after the January 2010 earthquake, Security Council Resolutions 1908 and 1927 explicitly tasked troops with assisting in post-disaster relief efforts.[301] MINUSTAH troops played a key role in the immediate response to the earthquake, as well as the longer-term humanitarian effort.[302] Until the beginning of the cholera outbreak, troops performed essential humanitarian functions including clearing debris, distributing food, and rebuilding local infrastructure.[303]

Given MINUSTAH's role in providing humanitarian relief in Haiti, the mission is susceptible to harming the populations they intend to help in ways that trigger concerns of humanitarian accountability. In the aftermath of the Haitian earthquake, MINUSTAH performed humanitarian functions for extremely vulnerable populations. MINUSTAH was charged with working with particularly vulnerable populations, such as displaced persons.[304] More generally, however, MINUSTAH was working in a country recently devastated by an unprecedented earthquake and lacking in basic water, sanitation, and health infrastructure, rendering its citizens especially vulnerable.[305] Additionally, when troops from various countries with diverse exposure risks to contagious diseases enter a vulnerable country like Haiti, inadequate control of sanitation for these troops poses serious dangers. The introduction of a foreign disease into a country with a weakened health, water, and waste infrastructure system led to devastating consequences for precisely those people MINUSTAH was established to aid. The humanitarian role MINUSTAH played in post-earthquake Haiti, coupled with its introduction of cholera into the country, counsels in favor of applying principles of humanitarian relief to evaluate MINUSTAH's harmful actions in Haiti and develop remedies to address them.

C. MINUSTAH's Actions in Haiti Violated Two Fundamental Principles of Humanitarian Aid and Fell Below Professional Standards of Relief.

1. MINUSTAH's Failure to Follow Minimum Guidelines of Adequate Sanitation at Its Camp in Méyè Violated the Do No Harm Principle.

MINUSTAH's introduction of cholera into Haiti violated the do no harm principle of humanitarian intervention. The do no harm principle includes an obligation to not expose individuals to physical hazards, violence, or other rights abuse, including disease.[306] MINUSTAH violated this principle by introducing an epidemic disease into a major waterway used by a vulnerable population, leading to severe illness and death for many Haitians.

MINUSTAH's failure to observe minimum sanitation standards at the base in Méyè violated the do no harm principle. The Sphere Standards specify widely observed minimum guidelines for the management of excreta disposal in humanitarian emergencies. These guidelines aim to reduce disease transmission from human waste.[307] To this end, the Sphere Standards emphasize the need to keep defecation systems at a safe distance from water sources.[308] U.N. agencies have already recognized the importance of basic sanitation standards like those outlined in the Sphere Standards, as U.N. specialized agencies have developed similar standards for excreta disposal in emergency situations that also emphasize the separation of human waste from water sources.[309] Although these standards are generally designed for excreta facilities for populations receiving aid, rather than aid workers or peacekeeping troops, the cholera epidemic in Haiti demonstrates that if the goal of the standards is to do no harm, they

must be observed in facilities for aid workers and peacekeeping troops as well.

Despite the U.N.'s awareness of these minimum guidelines and its role in developing and promoting them, MINUSTAH did not observe proper excreta disposal at the camp in Méyè. As the U.N. Independent Panel of Experts noted, the base's water and waste pipes were haphazardly constructed. This led to "significant potential for cross-contamination through leakage from broken pipes and poor pipe connections."[310] The report also observed how easily the waterway near the MINUSTAH camp was contaminated due to "an open drainage ditch that r[an] throughout the camp and flow[ed] directly into the Méyè Tributary System."[311] Moreover, the camp was known to flood regularly,[312] leading to an even greater likelihood of waste contaminating the water supply. In failing to ensure that its camp followed the most basic of sanitation guidelines and creating a significant possibility of water contamination, MINUSTAH violated the do no harm principle and thus failed to meet professional standards of humanitarian relief.

2. MINUSTAH Violated the Principle of Accountability to Affected Populations by Failing to Address the Claims of Victims of the Cholera Epidemic.

In failing to respond adequately to the claims for relief of the many cholera victims, MINUSTAH has not only violated legal responsibilities under international law, but also the principle of accountability to populations receiving aid.[313] Broadly defined, accountability is how humanitarian organizations answer to different stakeholders.[314] Traditionally, humanitarian organizations have answered mainly to donors,[315] but organizations increasingly have recognized a need to answer directly to the people affected by aid as well.[316]

Humanitarian organizations have voiced two rationales for holding themselves accountable to populations receiving aid. The first is moral: People receiving aid possess intrinsic human dignity,[317] and respect for human dignity requires that aid recipients be treated as active agents in the humanitarian aid process rather than as passive subjects. This, in turn, requires the meaningful participation of local populations in the humanitarian aid process and mechanisms for holding the humanitarian actor accountable to local populations in case of harm.[318] The second rationale is practical: Feedback from those receiving aid is instrumentally valuable. Populations receiving aid are often more attuned to the unintended harms of a particular intervention because they suffer the consequences of such harm. Acknowledging a local population's perspective on the relief it receives allows humanitarian aid organizations to better tailor their practices to community need, avoid courses of action that may cause harm, and improve their delivery of aid. Thus, when local populations participate in the humanitarian aid process, they can hold aid organizations accountable for their activities, leading to better, more effective humanitarian programming.[319]

As previously outlined in Chapters III and IV, MINUSTAH has refused to offer any remedy to the people it has harmed by bringing cholera to Haiti, and thus has violated—and continues to violate—the accountability standards observed by most humanitarian agencies. MINUSTAH has no effective complaints procedure available, and the U.N. has not established any other avenue of redress, compensation, or reparations for the cholera victims in Haiti.[320] This failure to act not only violates the U.N.'s obligations under international law; it also falls short of the basic principles and standards of humanitarian aid observed throughout the international humanitarian aid community. MINUSTAH and the U.N. thus have failed to meet the standard of accountability required of all organizations purporting to deliver humanitarian relief.

Conclusion

The U.N., through MINUSTAH, has provided much-needed humanitarian assistance in Haiti and, in so doing, is subject to those standards of international humanitarian aid that the international relief community has agreed must guide all humanitarian intervention. By causing a cholera epidemic in a still-developing country, harming the people it has promised to help, and then denying those it has harmed any redress for their injuries, the U.N. has violated fundamental principles of humanitarian relief. The following chapter outlines how the U.N. can be held to account for the totality of its failures under its SOFA with Haiti, international human rights law, and humanitarian principles and standards.

CHAPTER VI

Remedies and Recommendations

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As the previous chapters establish, MINUSTAH troops introduced the *V. cholerae* bacterium into the Méyè Tributary, causing the largest cholera outbreak in Haiti's history. Because of its responsibility for the outbreak, the U.N. is responsible for providing redress to the victims. This chapter outlines the steps the U.N. must take, in light of that accountability, to remedy the harms it has caused in Haiti. What follows is not a comprehensive program for fighting cholera; rather, it is a framework of the minimum steps the U.N. must take to fulfill its contractual, legal, and moral obligations to the people it has harmed in Haiti, as explained previously in this report. Other entities, starting with the Government of Haiti and including NGOs, foreign governments, and other intergovernmental actors, are also key to remediating the cholera epidemic. These actors must help provide direct aid to victims, infrastructural support, and adequate funding for the prevention and treatment of cholera. Ultimately, the Government of Haiti must be able to ensure the health and rights of persons within its borders. This chapter, however, focuses on the U.N.'s obligations to the victims of the cholera epidemic in Haiti because the U.N. is uniquely accountable for the epidemic.

To fully accept its responsibility, the U.N. must vindicate the legal rights of the victims, guarantee adequate treatment for those sickened, stop the cholera epidemic, and, finally, ensure that a similar tragedy does not reoccur—either in Haiti or anywhere else the U.N. sends its peacekeeping troops or other agents. The U.N. must first provide victims with the legal recourse to which they are entitled under international law. Given the scope of U.N. immunity in domestic courts, this recourse should take the form of the claims commission outlined in and required by the SOFA. Second, the U.N. must respond to the continuing cholera crisis, most crucially by funding the plan that the MSPP and PAHO, itself a specialized agency of the U.N., have developed. Finally, the U.N. must ensure that a similar wrong never again happens by reforming its peacekeeping procedures, particularly those related to waste disposal and disease transmission, enforcing the SOFA's requirement that a *standing* claims commission be set up for all missions, and taking all necessary steps to meet its duty to guarantee non-repetition of such harms. The following remedies are not simply charitable responses to a humanitarian crisis; they are what the U.N. must do to fulfill its basic contractual, legal, and moral duties.

A. Vindicating the Rights of Victims

As this report has explained, by failing to provide any meaningful forum for victims of the cholera epidemic to seek redress, the U.N. violates its own SOFA, human rights law, and principles of humanitarian intervention. To remedy this failure, the U.N. must establish a forum in which the victims' claims to relief can be heard. This forum could be a court of law—the U.N. could waive its immunity in most courts and provide victims with the right to sue under domestic and international law. Alternatively, the SOFA provides for such a forum in the form of a claims commission. Because the SOFA specifically contemplates the establishment of a claims commission for circumstances such as these, this section focuses on how to create a commission and provides suggestions, taken from examples of successful, large-scale claims processing bodies, for its structure and operation. The U.N. claims commission, if established, need not be structured exactly like these examples. Rather, the discussion of these precedents is instead intended to illustrate that creating an efficient, effective commission, even with large numbers of claimants and difficult issues of adjudication, is possible.

1. A U.N. Claims Commission

The SOFA requires that the U.N. establish a standing claims commission to hear claims of a private law nature like those of the victims of the

cholera epidemic. Thus far, despite the efforts of the victims and their advocates,[321] the U.N. has failed to create a commission and has instead declined any consideration of their claims by invoking the General Convention.

The SOFA outlines the necessary structure of such a commission, requiring that it include three members: one appointed by the U.N., one appointed by the Government of Haiti, and a chairman jointly appointed by both parties.[322] Thus, as a first step, either the Secretary-General or the Government of Haiti must appoint an initial commissioner. Then, both parties can choose a chairman, or one party can appeal to the president of the ICJ to appoint the chairman.[323] In practice, this means that the Government of Haiti or the Secretary-General must appoint a commissioner to establish a commission that can receive the victims' claims.

The SOFA does not specify procedures the commission should use to adjudicate claims, leaving that decision to the commissioners. However, two historical instances of successful claims processing bodies—the U.N.'s own post-Gulf War compensation commission and the United States' post-September 11 compensation fund—provide a useful guide for the U.N. commission. These commissions set up procedures for processing claims that were, in many ways, more difficult to adjudicate than the cholera victims' claims.

2. Historical Precedent—from the United Nations Compensation Commission to the September 11 Victims Compensation Fund

a. The United Nations Compensation Commission (UNCC) in Iraq

In the aftermath of the First Gulf War in Iraq, the U.N. set up the United Nations Compensation Commission (UNCC). The UNCC demonstrates that the U.N. is logistically capable of establishing claims commissions. Unlike the claims commission proposed for cholera victims in Haiti, the UNCC was unrelated to U.N. culpability. Rather, the UNCC was designed to compensate victims of the Iraqi invasion and occupation of Kuwai, and functioned as a special organ of the U.N. that held funds and determined how to allocate them.[324] The size and scope of the UNCC were unprecedented, and in the absence of prior commissions to provide a framework for adjudication, the commission adapted procedures and structures from international arbitration and past post-war claims commissions to the larger scale and different subject matter of the UNCC.[325]

The UNCC processed claims from its inception in 1991 until 2005, and completed compensation of victims in 2007. By 1996, the UNCC had already distributed over $4 billion to claimants, divided among over 980,000 awards.[326] After 1996, the pace of claims processing increased, and by 2007, the UNCC had paid $54.2 billion to settle over 1.5 million claims.[327] These payments were made for a broad range of harms attributed to the Iraqi invasion of Kuwait, including business losses, real and personal property losses, and personal injuries.[328] Payments were also made to governments and NGOs for evacuation costs and other incidental costs of the invasion.[329] Iraq was responsible for paying the commission's awards.[330]

The commission issued comparatively few awards for serious bodily injury or death due to financial limitations and the scale of war claims.[331] This highlights the critical difference between the UNCC and a claims commission for the cholera epidemic in Haiti: The UNCC addressed a wide range of claims arising from war, not the more limited claims resulting from an outbreak of disease. The UNCC, however, reveals that the U.N. can successfully adapt existing procedures and apply them to a complicated set of claims in a newly established claims commission. Furthermore, the UNCC belies potential objections that a cholera claims commission would take generations to complete its work, as the UNCC concluded a much more expensive and wide-ranging claims process within 14 years.[332] The fact that the UNCC compensation was paid by Iraq, of course, meaningfully distinguishes it from the U.N. itself compensating the victims of the epidemic in Haiti, but the source of compensation is an issue distinct from the U.N.'s proven ability to administer a claims commission.

b. The September 11th Victims Compensation Fund (VCF)

Similarly, the well-regarded claims process established after the September 11 terrorist attacks offers a model for how the U.N. could establish workable standards for assessing claims in a claims commission for victims of the cholera epidemic. Eleven days after the attacks, Congress established the September 11 Victim Compensation Fund (VCF),"to provide compensation to any individual (or relatives of a deceased individual) who was physically injured or killed as a result of the terrorist-related aircraft crashes of September 11, 2001."[333] In total, the commission awarded over $7 billion to 2,680 victims of physical injury and the survivors of 2,880 people who died in the attacks.[334] Upon filing a claim, victims waived their rights to most litigation arising out of September 11.[335] The VCF was non-adversarial; the procedures did not involve a finding of fault regarding any party and award computation did not depend on any such finding.[336] Kenneth Feinberg, the commission's special master, called it "an unprecedented expression of empathy from the American people toward their fellow citizens and others who the terrorist attacks victimized."[337]

A U.N. claims commission for the cholera epidemic should not be merely "an expression of empathy" but a forum in which a wrongdoer can compensate its victims. However, a non-adversarial process that does not include findings of fault might prove more politically feasible for a U.N. commission.

Although the substance of the claims resolved by VCF is distinct from those of a U.N. claims commission for Haitian cholera victims, the structure of the VCF is illuminating. The VCF's methodology for determining compensation demonstrates that consistent, pre-set formulas for calculating awards can lead to highly efficient claims processing. Pursuant to Congressional authorization, the VCF created a "presumed methodology" for calculating an award.[338] The presumed methodology used the victim's age, income, and number of dependents for the computation. While the income variable would need to be tailored to the Haitian context, age and number of dependents would be reasonable prima facie variables for the award calculation methodology in a U.N. claims commission for the cholera epidemic. Furthermore, a compensation methodology that is formula-driven, allowing for fairness and efficiency in calculation while still tailoring awards to individual circumstances, would afford victims of the cholera epidemic a measure of justice that U.N. immunity otherwise denies them.

B. Addressing the Public Health Crisis

Just as the U.N.'s actions require it to provide legal redress for the victims of the cholera epidemic, the U.N. also must address the ongoing health crisis that the introduction of cholera has created in Haiti. However, unlike its vindication of legal rights through a claims commission, the U.N. will not, for the most part, provide direct public health relief. The Government of Haiti, PAHO, the CDC, and NGOs are the key providers of treatment in the ongoing epidemic; the U.N.—by virtue of having caused the epidemic—bears the responsibility for ensuring the adequacy of the public health response to the outbreak. Most critically, this responsibility requires the U.N. to ensure that both immediate treatment intervention and the MSPP Plan for the long-term elimination of cholera are fully funded. The U.N. and MINUSTAH must also provide any technical and logistical support needed by the key public health actors treating cholera in Haiti.

1. Immediate Intervention

Cholera is an ongoing health crisis in Haiti. With each rainy season, the Government of Haiti and international aid organizations struggle to prevent another surge in mortality.[339] As a result, preventing the spread of disease and treating those currently infected is a constant and urgent need. The U.N. can best realize its responsibility to the people in Haiti it has harmed by ensuring that emergency efforts to treat and prevent the epidemic are properly funded.

Currently, immediate intervention suffers from sparse funding and supplies. The NGO Partners in Health has observed nearly twice the number of

cholera patients in its clinics this year compared to 2012, in part due to a decrease in cholera treatment and prevention funding that has led to the withdrawal of many other international NGOs from Haiti.[340] As NGOs—and their funding—leave the country, standards of care decline. Treatment centers face dwindling supplies, inadequate staff, and worn-out equipment, all of which cause mortality to increase.[341] Both the Government of Haiti and non-government actors must ensure that hospitals and CTCs are properly supplied and adequately staffed to effectively control the disease. This can be done by providing adequate funding for treatment and prevention, creating a more efficient chain for distributing supplies, training more community health workers, and promoting proper hygiene and sanitation within communities.

Proper surveillance systems to track disease occurrence must also be maintained to help prevent the further spread of cholera. A February 2013 study detailing the implementation of the National Cholera Surveillance System after the initial outbreak of cholera in 2010 illustrated the effectiveness of such surveillance measures.[342] The study provided a two-year summary of data for the epidemic through October 20, 2012, and concluded that the MSPP, by overseeing the collection and reporting of cholera-related data, established an important precedent for a national surveillance system that, if continuously well-funded and properly implemented, will effectively monitor both cholera incidence and the impact of public health efforts to reduce morbidity and mortality.

2. Cholera Elimination—The MSPP Plan

a. The Structure of the MSPP Plan

The MSPP Plan, announced in November 2012 as a comprehensive program to eliminate cholera in Haiti and the Dominican Republic, is divided into three phases, each of which includes a target for reducing the incidence rate of cholera. First, by continuing the emergency measures discussed above in Section B.1 and accelerating long-term health and sanitation projects, the incidence rate should fall from 3% of the population to below 0.5% by 2014. Second, by chlorinating public water supplies and otherwise improving water and sanitation systems to the level found in other Latin American and Caribbean countries, the cholera rate should fall to less than 0.1% by 2017. Finally, by dramatically increasing potable water access and Haiti's rates of proper sanitation and human waste disposal, the cholera rate should fall to less than .01% by 2022. The following chart outlines key details of each phase:

Phase # and Date	Metric of Success (as measured by cholera rate)	Plan Details / Additional Goals
Phase 1—end of 2014	Fall to at least .5%	• Continue emergency cholera management until 2015. • Increase hand-washing after defecation and prior to eating in areas of Haiti where there is active transmission. • Strengthen and expand primary health care systems. • Provide simple safe-water technologies in high-risk areas. • Construct excreta disposal facilities in high-risk areas and improve the cleaning of existing latrine pits.[343]

Phase 2—end of 2017	Fall to at least .1%	• Chlorinate and regularly monitor all public water supply systems. • All national research laboratories should be functional and gathering data. • The water and sanitation sector should be strengthened to be comparable to those of the Latin American and Caribbean countries. • Increase efficacy and reach of primary care. • Strengthen role of the Haitian National Directorate for Water Supply and Sanitation (DINEPA) in maintenance of sanitation and hygiene.[344]
Phase 3—end of 2022	Fall to at least .01%	• Increase access to potable water and sanitation to at least the average level of the countries in Latin America and the Caribbean. • Specifically, rates of access to potable water should move from the current 69% to 85%. • Access to adequate sanitation should sharply increase from the current 17% to 80%. • Risk of cross-contamination of feces and water will be reduced as a result of the proper disposal of human waste.

b. Funding and implementation challenges

As the actor responsible for the cholera outbreak, the U.N. must ensure full funding of the MSPP Plan. The plan is estimated to cost approximately $2.27 billion over its ten-year span. However, to date, U.N. members have pledged only 1% of the total cost.[345] Security Council members should take the lead in fundraising, particularly from those more developed countries with the strongest historical ties to Haiti—the United States, Canada, and France. These countries should also both appropriate money themselves for the MSPP Plan and fundraise with the U.N., doing everything necessary to encourage other member states to donate to ensure full funding.[346]

In implementing the MSPP Plan, it is critical that international organizations are available to provide the technical expertise, fundraising, and lobbying necessary for the plan's success. In particular, the CDC and PAHO/WHO have contributed to the development of the plan and pledged to continue to support its implementation.[347] Inasmuch as these organizations and other intergovernmental organizations can, they should provide direct budgetary support for the MSPP Plan. They should also lobby states to contribute to the plan.

Finally, it is critical that the plan be implemented by and for the communities in Haiti that the epidemic has most affected. Doing so will ensure respect for the principle of accountability for humanitarian aid discussed in Chapter V. To that end, Haitian community groups must be given formal channels to provide input and oversight to MSPP decisionmakers. Local input is not simply an abstract principle of development work: The MSPP plan recommends a number of changes to sanitation practices in communities and homes, recommendations that will require changing cultural practices and ensuring sufficient knowledge and experience of these practices to be successful.[348]

C. Dignitary Justice

The U.N. must work to re-establish its institutional legitimacy in Haiti. The role of the U.N. and MINUSTAH in causing the epidemic has created deep anger among the general public in Haiti, and the U.N.'s refusal to take any responsibility for its actions has eroded its already fragile reputation in the country. Indeed, many have questioned MINUSTAH's continued presence in Haiti after causing the epidemic.

An apology by the U.N. is an essential step toward repairing its legitimacy deficit in Haiti. Alhough MINUSTAH's presence in Haiti was controversial long before the cholera epidemic began,[349] an apology for the cholera epidemic need not resolve controversies about the MINUSTAH mission in its entirety. Rather, an apology would address the discrete wrong committed by the U.N. in bringing cholera to Haiti. In a report to the U.N. Human Rights Commission, Michel Forst, the U.N.'s own independent expert on human rights in Haiti, recognized that the U.N.'s refusal to acknowledge its responsibility for the epidemic is negatively affecting the legitimacy of the organization. According to Forst, "[S]ilence is the worst response."[350]

In conjunction with the other remedies outlined in this section, an apology is a crucial opportunity to begin repairing MINUSTAH's relationship with the people they have harmed, the same people with whom they must live and work as long as the mission remains in Haiti. As Chapter II illustrates, scientific consensus has long ago made the U.N.'s current denial of responsibility for the outbreak untenable. Thus, a public apology will not reveal anything not already publicly known. Given widespread knowledge of the U.N.'s malfeasance in Haiti, every simple, terse denial of responsibility it makes further diminishes its already weakened credibility. An apology offers the U.N. a virtually cost-free means of beginning to rebuild this diminished credibility. Furthermore, to the extent that the U.N.'s current refusal to publicly take responsibility and apologize for the epidemic is designed to avoid providing victims compensation, such avoidance will be unnecessary once the claims commission is established. A public apology would be complementary to the claims commission's work.

Finally, the U.N. should leave its current outpost at Méyè and relocate. The MINUSTAH base that introduced cholera into the Artibonite River remains within a few miles of the homes of families devastated by cholera. Although MINUSTAH has rotated the Nepalese soldiers who introduced the disease out of the mission in Haiti, the camp that they inhabited still stands. Victims of the cholera epidemic have expressed anger at having to walk by the MINUSTAH camp in Méyè.[351] The continued presence of the base serves as a painful reminder of both the U.N.'s role in causing the epidemic and its denial of responsibility for doing so. After vacating MINUSTAH from the base, the U.N. should offer it to the community for use as a medical center or as a location for a victims' memorial.

D. Looking toward the Future

1. A Guarantee of Non-Repetition

As discussed in Chapter IV, the guarantee of non-repetition is a critical component of redress under international human rights law for certain human rights violations. The human rights violator must guarantee—and take sufficient prophylactic measures to ensure—that it will make all necessary changes to ensure that it commits no similar human rights violation in the future.[352]

A guarantee of non-repetition cannot simply be a general commitment to not repeat the wrongdoing. Rather, the offending party must show specific steps it plans to take that will prevent repetition of the violation. Guarantees of non-repetition have been made recently, including by the U.N., in the form of allowing for civilian control of security forces to redress Turkish violations against Kurds living in Turkey[353] and ensuring that victims, including women, are given an opportunity to testify about state abuses against them during the Arab Spring to redress violations by the former government in Tunisia.[354]

The cholera epidemic in Haiti presents an exceptional circumstance, as defined in the *LaGrand* case discussed in Chapter IV, requiring a

guarantee of non-repetition. As with the lawless execution in that case, there is no prospective relief that will fully ameliorate the U.N.'s past wrong of introducing cholera into Haiti. Moreover, the U.N.'s evasion of responsibility for doing so and denial of a remedy for its victims, as well as the sheer magnitude of the injury caused, are exceptional. Finally, the U.N.'s oversight of a number of peacekeeping missions around the world presents the real possibility of a similar wrongdoing reoccurring. Following the ICJ's instruction in *LaGrand*, the U.N. must takes steps to guarantee non-repetition to the victims of the cholera epidemic in Haiti.

Insofar as poor supervision of peacekeepers allowed for the MINUSTAH camp to be built with inadequate sanitation infrastructure, the U.N.'s guarantee of non-repetition must include reform of MINUSTAH's operational supervision. Furthermore, reforming the composition, funding, and supervision of peacekeeping missions will help to ensure that MINUSTAH's malfeasance is not repeated in U.N. peacekeeping missions elsewhere. Similarly, the U.N.'s commitment to honoring the SOFAs it signs with countries that receive its peacekeepers and observing the limitations on its immunity under the General Convention may be the most potent guarantees of non-repetition available to the U.N.

The U.N., per its letter refusing to accept the claims filed by approximately 5,000 cholera victims, maintains that it cannot be held responsible for its wrongdoing, regardless of the harms it inadvertently inflicts in the world's most vulnerable countries. This position is not only legally groundless; but it also distorts incentive structures guiding the U.N.'s behavior by foreclosing external consequences for bad acts committed by its officials. Guarantees of non-repetition can correct this distortion. A guarantee of formal, legal accountability is necessary to encourage future U.N. agents to take reasonable care during peacekeeping missions in all of their activities, including managing waste disposal at their encampments. By holding itself accountable to those it injures, the U.N. and its peacekeepers will be less likely to harm people in the future.

2. Peacekeeping Reforms to Guarantee Screening and Sanitation

As outlined in Chapter V, the U.N.'s creation of the cholera epidemic in Haiti has violated principles of humanitarian relief. The epidemic demonstrates that the U.N. and its peacekeeping missions must follow the do no harm principle. To abide by this principle, it must ensure that U.N. peacekeeping camps have adequate sanitation infrastructure, regardless of whether the peacekeepers are likely to transmit any specific disease. To implement this principle, the U.N. can either adopt the Sphere Standards, which articulate globally accepted principles of humanitarian relief, in its oversight of peacekeeping missions or follow its own set of principles consistent with the Sphere Standards. Either way, the U.N. must actually ensure that its peacekeepers observe the existing framework of international humanitarian aid to ensure that their interventions do not cause inadvertent and avoidable harm.

3. Honoring the SOFA's Standing Claims Commission

To effectively balance the U.N.'s interest in its immunity from suit with principles of accountability consistent with its human rights obligations, the U.N. must honor the SOFA requirement that it establish a standing claims commission, as detailed in Chapter III, at the start of every peacekeeping mission it authorizes. The model SOFA currently in force calls for a standing commission for every mission; given the number of peacekeeping missions currently in operation, this requirement may be logistically challenging to realize and may partially explain why the U.N. has never set up a commission for any of its missions.

A revision of the model SOFA may help ensure that the U.N. upholds its obligation to hear claims from those harmed by its peacekeeping missions. In future SOFAs, the U.N. could establish one standing claims commission—with enough separation from U.N. Department of Peacekeeping Operations (DPKO) to ensure objectivity—to hear claims concerning all peacekeeping

missions. Either type of commission would need sufficient funding to speedily adjudicate claims. Furthermore, the claims commission process would need to be accessible to people injured in peacekeeping missions. Thus, a single standing claims commission may need a physical presence in locations where U.N. peacekeeping troops are deployed.

Either form of claims commission, established prior to any potentially wrongful conduct rather than afterwards, would promote fair and efficient processing of claims. Moreover, a true standing commission would not only avoid the need to set up a claims commission after injuries occur, but would also encourage the U.N. to take greater care when deploying of peacekeepers.

Endnotes

1 MINUSTAH is the French acronym for Mission des Nations Unies pour la stabilisation en Haïti.

2 The MINUSTAH website in French is here: http://www.minustah.org/. The website in English is here: http://www.un.org/en/peacekeeping/missions/minustah/.

3 Robert Muggah, *The Effects of Stabilisation on Humanitarian Action in Haiti*, 34 Disasters S444, S446 (2010).

4 U.N. Secretary-General, *Rep. of the Secretary General on Haiti*, ¶¶ 8-16, U.N. Doc. S/2004/300 (Apr. 16, 2004) [hereinafter *U.N. 2004 Haiti Report*]; S.C. Res. 1542, U.N. Doc. S/RES/1542 (Apr. 30, 2004).

5 U.N. 2004 Haiti Report, *supra* note 4, ¶ 72.

6 S.C. Res. 1542, *supra* note 4, ¶ 5.

7 Permanent Mission of *Canada to the U.N., Canadian Policy Positions: Haiti* (Jan. 2, 2013), *available at* http://www.canadainternational.gc.ca/prmny-mponu/canada_un-canada_onu/positions-orientations/regions/haiti.aspx?lang=eng.

8 *See* U.N. Dep't for Peacekeeping Operations & Dep't of Field Support, *United Nations Peacekeeping Operations: Principles and Guidelines* (2008), *available at* http://www.un.org/en/peacekeeping/operations/principles.shtml (noting the increasingly broad nature of peacekeeping mandates of U.N. missions).

9 Todd Howland, *Peacekeeping and Conformity with Human Rights Law*, 13 Int'l Peacekeeping 462, 478-469 (2006) (noting that unlike many peacekeeping operations, MINUSTAH was established in the absence of a "hot war" and was not "supported by, or grounded in, a peace accord or even a peace process"). *See also* Matt Halling & Blaine Bookey, *Peacekeeping in Name Alone: Accountability for the United Nations in Haiti*, 31 Hastings Int'l & Comp. L. Rev. 461, 463 (2008) (discussing the exceptionality of the MINUSTAH mission); Bri Kouri Nouvèl Gaye et al., *Submission to the U.N. Human Rights Council Twelfth Session of the Working Group on the Universal Periodic Review*, Oct. 3-13, 2011, ¶1-6 (arguing the MINUSTAH mandate is inappropriate under Chapter VII of the U.N. Charter) [hereinafter *2011 UPR Submission*].

10 *U.N. 2004 Haiti Report, supra* note 4, ¶ 8.

11 *Id.*

12 S.C. Res. 1542, *supra* note 4, ¶ 1; *U.N. 2004 Haiti Report, supra* note 4, ¶ 9.

13 S.C. Res. 1542, *supra* note 4, ¶ 7.

14 *Id.* ¶ 9.

15 S.C. Res. 1608, U.N. Doc. S/RES/1608 (June 22, 2005); S.C. Res. 1702, U.N. Doc. S/RES/1702 (Aug. 15, 2006); S.C. Res. 1743, U.N. Doc. S/RES/1743 (Feb. 15, 2007); S.C. Res. 1780, U.N. Doc. S/RES/1780 (Oct. 15, 2007); S.C. Res. 1840, U.N. Doc. S/RES/1840 (Oct. 14, 2008).

16 *U.N. 2004 Haiti Report, supra* note 4, ¶¶ 72-75.

17 *Id.* ¶¶ 73 (describing the overall mission structure), 94 (describing the civilian affairs component), 101 (describing the humanitarian affairs component), 105 (describing the military component).

18 Howland, *supra* note 9, at 471.

19 *See, e.g.*, U.N. G.A., *Rep. of the Advisory Committee on Administrative and Budgetary Questions*, U.N. Doc. A/67/780/Add.5, 67th Sess. (Apr. 29, 2013). (documenting staffing changes at the MINUSTAH base).

20 U.N. Secretary-General, *Rep. of the Secretary General on the United Nations Stabilization Mission in Haiti*, ¶¶ 2-4, U.N. Doc. S/2010/200 (Apr. 22, 2010) [hereinafter *MINUSTAH Apr. 2010 Report*]; U.N. Secretary-General, *Rep. of the Secretary General on the United Nations Stabilization Mission in Haiti,* U.N. Doc. S/2010/200/Corr.1 (Apr. 27, 2010).

21 S.C. Res. 1908, U.N. Doc. S/RES/1908 (Jan. 19, 2010); S.C. Res. 1927, U.N. Doc. S/RES/1927 (June 4, 2010).

22 S.C. Res. 1927, *supra* note 21, prmbl.

23 See U.N. Secretary-General, *Rep. of the Secretary General on the United Nations Stabilization Mission in Haiti,* ¶¶ 44-50, U.N. Doc. S/2010/446 (Sept. 1, 2010) [hereinafter *MINUSTAH Sept.*

2010 Report].

24 *MINUSTAH Apr. 2010 Report, supra* note 20, ¶ 30; *MINUSTAH Sept. 2010 Report, supra* note 23, ¶¶ 14, 57.

25 *MINUSTAH Apr. 2010 Report, supra* note 20, ¶¶ 42–43.

26 *Id.*

27 *2011 UPR Submission, supra* note 9, ¶ 16.

28 *See* Athena Kolbe & Royce Hutson, *Human Rights Abuses and Other Criminal Violations in Port-au-Prince, Haiti: A Random Survey of Households*, 368 Lancet 864 (2006) (documenting human rights violations in Port-au-Prince between 2004 and 2006).

29 *2011 UPR Submission, supra* note 9, ¶ 16.

30 Human Rights Watch, Haiti Country Summary 2012 4–5 (2012), *available at* http://www.hrw.org.

31 *2011 UPR Submission, supra* note 9, ¶ 33.

32 *Id.* ¶ 37.

33 Centers for Disease Control and Prevention, *Update: Cholera Outbreak–Haiti 2010*, 59 Morbidity and Mortality Weekly Report 1473 (2010) [hereinafter CDC Update].

34 *Id. See also* Deborah Jenson et al., *Cholera in Haiti and Other Caribbean Regions, 19th Century*, 17 Emerging Infectious Diseases 2130 (2011) (explaining cholera had not been observed in Haiti in over a century).

35 Renaud Piarroux et al., *Understanding the Cholera Epidemic, Haiti*, 17 Emerging Infectious Diseases 1163 (2011). The World Health Organization (WHO) defines cholera as acute watery diarrhea, with or without vomiting, in a patient aged 5 years or more. As cholera spread across the country, the Haitian Ministry of Health (MSPP) implemented the National Cholera Surveillance System. The System modified the definition of cholera to include persons of any age in a cholera-affected department. *See* Ezra J. Barzilay et al., *Cholera Surveillance During the Haiti Epidemic—The First 2 Years*, 368 New Eng. J. Med. 599, 600 (2013).

36 *Id.*

37 *Id.*

38 Barzilay, *supra* note 35, at 601.

39 CDC Update, *supra* note 33, at 1473. On October 28th, 2010, as part of the National Cholera Surveillance System, the health ministry distributed standardized reporting forms and case definitions to all Haitian administrative departments. By November 10th, 2010, the MSPP was receiving daily, standardized reports from all ten departments. *See* Barzilay, *supra* note 35, at 601.

40 CDC Update, *supra* note 33, at 1476.

41 *Id.*

42 *Id.* at 1477.

43 Gov't of Haiti, Ministry of Public Health and Population and National Directorate for Water Supply and Sanitation, National Plan for the Elimination of Cholera in Haiti 16 (2013) [hereinafter MSPP Plan]. *See also* Center for Human Rights & Global Justice, NYU Sch. of Law et al., Wòch Nan Soley [Rocks in the Sun]: The Denial of the Right to Water in Haiti 15 (2008), *available at* http://www.chrgj.org/projects/docs/wochnansoley.pdf [hereinafter The Denial of the Right to Water in Haiti].

44 Pan American Health Organization & WHO, Health in the Americas 397 (15th ed. 2012). An improved sanitation system is one where human excreta are effectively separated from human contact.

45 MSPP Plan, *supra* note 43, at 17. In 2009 the national government created the National Directorate for Water Supply and Sanitation (DINEPA) to coordinate and regulate water and sanitation service providers.

46 *Id.* at 18.

47 *Id.* at 21.

48 *Id.* at 28.

49 Edward T. Ryan, *Haiti in the Context of the Current Global Pandemic*, 17 Emerging Infectious Diseases 2175 (2011) (comparing the Haitian epidemic to other current epidemics).

50 Barzilay, *supra* note 35, at 606.

51 Centers for Disease Control and Prevention, *Cholera in Haiti: One Year Later* (Oct. 25, 2011), *available at* http://www.cdc.gov/haiticholera/haiti_cholera.htm.

52 Barzilay, *supra* note 35, at 599.

53 U.N. Office for the Coordination of Humanitarian Assistance, *Haiti: Cholera Snapshot* (May 6, 2013), http://www.unocha.org/where-we-work/haiti.

54 Barzilay, *supra* note 35, at 607.

55 Patrick Adams, *Cholera in Haiti Takes a Turn For the Worse*, 381 Lancet 1264 (2013).

56 *Id.*

57 MSPP Plan, *supra* note 43, at 39.

58 Jenson, *supra* note 34, at 2131. This evidence is further discussed in Chapter II. Most studies have identified MINUSTAH peacekeeping troops as the source of the outbreak. There are two notable exceptions: First, the expert U.N. report on cholera found that the evidence was insufficient to determine a single cause of the epidemic. Second, a study published by Hasan et al. suggested that there may have been additional sources of cholera in the environment. Both of these studies have been challenged.

59 Hasan et al. have claimed there were strains of asymptomatic cholera already present in Haiti before the arrival of the Nepalese troops. However, there is no evidence these strains caused cholera symptoms in patients. For a fuller discussion of this, see Chapter II.

60 Jenson, *supra* note 34, at 2131. The 1833 outbreak occurred in Cuba. The 1850 outbreak affected Jamaica, Cuba, Puerto Rico, St. Thomas, St. Lucia, St. Kitts, Nevis, Trinidad, the Bahamas, St. Vincent, Granada, Anguilla, St. John, Tortola, the Turks and Caicos, the Grenadines, and possible Antigua. The 1865 outbreak hit Guadeloupe, Cuba, St. Thomas, the Dominican Republic, Dominica, Martinique, and Marie Galante.

61 *Id.* at 2133.

62 *Id.* at 2130–2131.

63 CDC Update, *supra* note 33, at 1473.

64 *Id.*

65 Piarroux, *supra* note 35, at 1162–1163.

66 Alejandro Cravioto et al., Final Report of the Independent Panel of Experts on the Cholera Outbreak in Haiti 12 (2011), *available at* http://www.un.org/News/dh/infocus/haiti/UN-cholera-report-final.pdf. *See also* Piarroux, *supra* note 35, at 1162 (citing slightly different dates, October 9–16).

67 Cravioto, *supra* note 66, at 12–13.

68 *Id.*

69 *Id.*at 22.

70 Piarroux, *supra* note 35, at 1165.

71 *Is the UN repackaging Haiti's cholera aid?,* Al-Jazeera (Dec. 21, 2012, 1:22 PM), http://www.aljazeera.com/programmesinsidestoryamericas/2012/12/20121221131162458 40.html (video investigation citing earlier investigations by Al Jazeera).

72 Chen-Shan Chin et al., *The Origin of the Haitian Cholera Outbreak*, 364 New Eng. J. Med. 33 (2011); Rene S. Hendriksen et al., *Population Genetics of Vibrio Cholerae from Nepal in 2010*, 2 mBio 1 (2011); Anirban Dasgupta et al., *Evolutionary Perspective on the Origin of Haitian Cholera Outbreak Strain*, 30 Journal of Biomolecular Structural and Dynamics 338 (2012). This evidence is further discussed in Chapter II.

73 See, e.g., Hendriksen, *supra* note 72, at 2–3.

74 *Id.*

75 *Id.*

76 *Cholera Strikes Haiti*, MSF Alert Newsletter (Jan. 31, 2011).

77 J.W. Tappero & R.V. Tauxe, *Lessons Learned during Public Health Response to Cholera Epidemic in Haiti and the Dominican Republic*, 17 Emerging Infectious Diseases 2087 (2013), *available at* http://dx.doi.org/10.3201/eid1711.110827

78 *Id.*

79 MSPP Plan, *supra* note 43.

80 *UN launches new initiative to eliminate cholera in Haiti and Dominican Republic*, U.N. News Centre (Dec. 11, 2012), *available at* http://www.un.org/apps/news/story.asp?NewsID=43743&Cr=cholera&Cr1=#.UNoIapPjnKB.

81 Adams, *supra* note 55.

82 For a summary of the arguments made by Haitian lawyers, see Jacceus Joseph, La Minustah et Le Choléra (2012). For the SOFA, see Agreement Between the United Nations and the Government of Haiti Concerning the Status of the United Nations Operation in Haiti, July 9, 2004, 2271 U.N.T.S. 235 [hereinafter Haitian SOFA].

83 Letter from Patricia O'Brien, U.N. Under-Secretary-General for Legal Affairs, to Brian Concannon, Attorney for Haitian Cholera Victims (Dec. 21, 2011) (on file with Brian Concannon). (noting that as of May no standing claims

commission has ever been established). A more complete analysis of the obligations under the SOFA can be found in Chapter III.

84 Letter from Newton Louis St. Juste et al., Attorneys for Haitian Cholera Victims, to Brian Concannon, Attorney for the Haitian Cholera Victims (Dec. 21, 2011), *available at* http://www.touthaiti.com/touthaiti-actualites/2060-lettre-des-victimes-du-cholera-au-parlement-reclamant-l-implementation-de-l-accord-du-9-juillet-2009-avec-l-onu.

85 Interview with Maître Jacceus Joseph in N.Y.C., N.Y. (Apr. 19th, 2013). Mr. Joseph is a lawyer in Haiti and author of La Minustah et Le Cholera (2012).

86 *Denúncia à Commissão Interamericana de Direitos Humanos*, Claim before the Inter American Commission (Oct., 2011), *available at* http://www.brasilhaiti.com.

87 *Id.* ¶¶ 10–11.

88 Email from Professor Cristine Zanella, Attorney for Petitioners, to Authors (Jan. 17, 2013, 13:05 EST) (on file with authors).

89 Petition for Relief, MINUSTAH Claims Unit (Nov. 8, 2011), *available at* http://ijdh.org/archives/22916. U.N. missions have local review boards in the field that review third party claims for damages. U.N. Secretary General, *Administrative and Budgetary Aspects of the Financing of the United Nations Peacekeeping Operations: Financing of the United Nations Peacekeeping Operations: Rep. of the Secretary General*, ¶¶ 20–37, U.N. Doc. A/51/389 (Sept. 20, 1996) [hereinafter *Financing of the United Nations Protection Force*].

90 Petition for Relief, *supra* note 89, ¶¶ 36-37, 31-50, 105.

91 *Id.* ¶¶ 102–114.

92 Letter from Mario Joseph et al., Attorneys for Petitioners, to Patricia O'Brien, U.N. Under-Secretary-General for Legal Affairs (May 7, 2013).

93 Letter from Patricia O'Brien, U.N. Under-Secretary-General for Legal Affairs, to Brian Concannon, Attorney for the Haitian Cholera Victims (Feb. 21, 2013), *available at* http://opiniojuris.org/wp-content/uploads/LettertoMr.BrianConcannon.pdf.

94 *Id.* at 2.

95 Letter from Mario Joseph et al., *supra* note 92, at 3.

96 *Id.*

97 *See, e.g.*, Deborah Sontag, *Protest Closes New Cholera Treatment Center in Haiti*, N.Y. Times (Oct. 27, 2010), *available at* http://www.nytimes.com/2010/10/28/world/americas/28haiti.html; *Haiti: Protesters Stone U.N. Patrol*, N.Y. Times (Nov. 18, 2010), *available at* http://www.nytimes.com/2010/11/19/world/americas/19briefs-Haiti.html; Randal C. Archibald, *Haitians Train for a Future With a Military*, N.Y. Times (Oct. 25, 2012), *available at* http://www.nytimes.com/2011/10/26/world/americas/president-michel-martelly-seeks-to-re-create-haitis-army.html?pagewanted=all; Louise C. Ivers, Op-Ed., *A Chance to Right a Wrong in Haiti*, N.Y. Times (Feb. 22, 2013), *available at* http://www.nytimes.com/2013/02/23/opinion/a-chance-to-right-a-wrong-in-haiti.html.

98 Jenson, *supra* note 34.

99 *Id.* at 2130.

100 *Id.* at 2134.

101 *Id.* at 2133.

102 *Id.* at 2134.

103 Cravioto, *supra* note 66.

104 *Id.* at 13-14.

105 *Id.* at 14.

106 Piarroux, *supra* note 35.

107 Cravioto, *supra* note 66, at 15.

108 Cravioto, *supra* note 66, at 16.

109 CDC Update, *supra* note 33. This same form of diagnosis is used in the report released by the U.N.'s Independent Panel of Experts. Cravioto, *supra* note 66, at 17.

110 In children under five years old the two most likely causes of diarrhea in developing countries such as Haiti are Rotavirus and E. Coli infections. *Diarrheal Diseases: Factsheet No. 330*, World Health Organization (Apr., 2013), http://www.who.int/mediacentre/factsheets/fs330/en/index.html.

111 *See* CDC Update, *supra* note 33, at 1.

112 *See* Piarroux, *supra* note 35; Jean Gaudart et al., *Spatio-Temporal Dynamics of Cholera during the First Year of the Epidemic in Haiti*, 7 PLOS Neglected Tropical Diseases 1 (2013) (mapping

cholera cases from the start of the epidemic through December 2011).

113 Piarroux, *supra* note 35, at 1162.

114 *Id.* at 1163.

115 Communes are geographical subdivisions of the administrative departments in Haiti.

116 Piarroux, *supra* note 35, at 1164.

117 *Id.* Cholera in Haiti spread spatiotemporally, with initial cases centered at the location of the outbreak's explosive onset in Mirebalais and the Artibonite Valley and later cases expanding from that center to regions of the country bordering it. As discussed above, the first cases of the disease appeared in Méyè on October 14th, 2010. Shortly thereafter, from October 16th-19th, cases were reported in Mirebalais, just 2 kilometers north of Méyè. During October 20th-28th, the disease progressed throughout communes in or near the delta of the Artibonite. The movement of the disease in the early days of the epidemic suggests that the spread of cholera during this time period was closely linked to proximity to the Artibonite River. Cholera surfaced in the North-West Department of Haiti from November 11th-29th, the West Department (where Port-au-Prince is located) from November 14th-30th, and the North and North-East Departments from November 21st-30th. *Id.* at 1165. The outbreak's presence in these departments has been associated with the movement of individuals infected with the disease, including inhabitants of the Artibonite Delta who fled to neighboring communes to escape infection, deficiencies in water, sanitation, and health care systems, and Hurricane Tomas, which reached Haiti on November 5th and caused rapid flooding in some areas where cholera had already surfaced. Guardart, *supra* note 112, at 5.

118 Piarroux, *supra* note 35, at 1164.

119 Cravioto, *supra* note 66, at 22.

120 *Id.*

121 Hendriksen, *supra* note 72.

122 Cravioto, *supra* note 66, at 12-13.

123 A.A. King et al., *Inapparent Infections and Cholera Dynamics*, 454 Nature 877 (2008) (arguing that "asymptomatic carrier[s]"—i.e., people from cholera-endemic areas—*should* be treated with caution because they have a higher likelihood of being able to infect others even if they themselves show no symptoms of disease, and that scientific evidence and modeling demonstrates that the cholera strain driving the Haitian epidemic likely came from Nepal even though none of the MINUSTAH troops themselves were visibly ill with cholera prior to their deployment).

124 Cravioto, *supra* note 66, at 12.

125 *Id.*

126 The Nepalese Army's Chief Medical Officer, Brig. Gen. Dr. Kishore Rana, stated that none of the soldiers deployed as part of the MINUSTAH mission were tested for *V. cholerae* prior to entering Haiti. *Haiti cholera outbreak: Nepal troops not tested*, BBC News South Asia (Dec. 8, 2010, 10:48 P.M.), http://www.bbc.co.uk/news/world-south-asia-11949181. The U.N. has not disclosed medical records for the Nepalese troops.

127 Toxigenic cholera strains are those that produce toxins that cause symptoms. Toxigenic serogroups O1 and O139 of *V. cholerae* may cause cholera epidemics or pandemics. Nontoxigenic strains within these serogroups also exist in the environment, and also some may cause sporadic cases of disease. B. Pang et al., *Genetic Diversity of Toxigenic and Nontoxigenic Vibrio Cholera Serogroups O1 and O139 Revealed by Array-Based Comparative Genomic Hybridization*, 189 J. of Bacteriology 4837 (2007).

128 Cláudia T Codeço, *Endemic and Epidemic Dynamics of Cholera: The Role of the Aquatic Reservoir*, 1 BMC Infectious Diseases 1471 (2001).

129 Cravioto, *supra* note 66, at 21. *See also* Piarroux, *supra* note 35, at 1162.

130 Cravioto, *supra* note 66, at 21.

131 *Id.*

132 *Id.* at 22.

133 *Id.*

134 *Id.*

135 *Id.*

136 Daniele Lantagne et al., *The Cholera Outbreak in Haiti: Where and how did it begin?*, Current Topics in Microbiology & Immunology (May 22, 2013); *see also* Mark Doyle, *Haiti cholera*

epidemic caused by UN, say experts, BBC News (July 25, 2013, 11:01 PM), http://www.bbc.co.uk/news/world-latin-america-23460826; Colum Lynch, *Cholera outbreak in Haiti tied to U.N. peacekeepers, report says,* Wash. Post (July 25, 2013), http://www.washingtonpost.com/world/national-security/cholera-outbreak-in-haiti-tied-to-un-peacekeepers-report-says/2013/07/25/7732341e-f552-11e2-a2f1-a7acf9bd5d3a_story.html.

137 *See, e.g.*, CDC Update, *supra* note 33. In November 2010 the CDC tested 14 specimens isolated from patients in the Artibonite Department during the first month of the outbreak. All samples were serogroup O1, biotype El Tor, serotype Ogawa. Additionally, isolates were also characterized by a pulsed-field gel electrophoresis protocol developed by PulseNet international. All samples were PulseNet PFGE pattern combination KZGN11.0092/KZGS12.0088.

138 *See* Chin, *supra* note 72; Hendriksen, *supra* note 72; Dasgupta, *supra* note 72. *See also* Jazel Dolores & Karla J. F. Satchell, *Analysis of Vibrio Cholerae Genome Sequences Reveals Unique rtxA Variants in Environmental Strains and an rtxA-Null Mutation in Recent Altered El Tor Isolates*, 4 mBio 1 (2013) (documenting the increased toxicity of certain isolates from the Haitian epidemic).

139 Dasgupta, *supra* note 72.

140 Hendrikson, *supra* note 72, at 2.

141 Researchers have sequenced genetic material from 24 *V. cholerae* samples collected in different districts of Nepal between July 30th and November 1st, 2010. Hendrikson, *supra* note 72, at 2.

142 A genetic isolate is a "population of organisms that has minimal genetic mixing due to geographical isolation or to other mechanisms that prevented reproduction." *Genetic Isolates*, Biology Online (Jul. 10, 2008, 8:24 AM), http://www.biology-online.org/dictionary/Genetic_isolate.

143 Susceptible to tetracycline but resistant to trimethoprim-sulfamethoxazole, nalidixic acid, and with decreased susceptibility to ciprofloxacin. Hendrikson, *supra* note 72, at 3.

144 A pulsotype is a distinct genetic pattern created by pulse field gel electrophoresis.

145 Hendrikson, *supra* note 72, at 3.

146 Author's Note: A single nucleotide polymorphism indicates that between the two strains of cholera, the difference was so minimal that only a single element of their DNA was noted to be distinctly different.

147 "Phylogenetic" means "of or relating to the evolutionary development of organisms. WordNet Search - 3.1, http://wordnetweb.princeton.edu/perl/webwn?s=Phylogenetic&sub=Search+WordNet&o2=&o0=1&o8=1&o1=1&o7=&o5=&o9=&o6=&o3=&o4=&h=.

148 Hendrikson, *supra* note 72, at 2.

149 Chin, *supra* note 72.

150 *Id.*

151 L.S. Katz et al., *Evolutionary Dynamics of Vibrio Cholerae O1 Following a Single-Source Introduction to Haiti*, 4 mBio 2 (2013).

152 *Id.*

153 *Id.* at 6.

154 Id at 2. The study calculated the molecular clock based on the detected nuclear polymorphism and the observed epidemic behavior. Using an exponential model of population growth, they estimated a "most recent common ancestor" date of September 28th, 2010 (95% credibility interval, July 23rd, 2010-October 17th, 2010). The credibility interval encompasses the dates of the cholera outbreak in Nepal (July 28th-August 14th, 2010), the arrival of the Nepalese soldiers in Haiti (October 8th-21st, 2010), and the first reported hospitalization of a cholera case (October 19th, 2010), further supporting the time frame mentioned previously by Piarroux and others.

155 *Id.* at 4. Hendriksen, *supra* note 72. For additional genetic evidence, see R. Sealfon et al., *High Depth, Whole-Genome Sequencing of Cholera Isolates from Haiti and the Dominican Republic*, 13 BMC Genomics 468 (Sep. 11, 2012), *available at* http://www.biomedcentral.com/1471-2164/13/468.

156 N.A. Hasan et al., *Genomic diversity of 2010 Haitian cholera outbreak strains*, 109 PNAS 29 (Jul. 17, 2012), *available at* http://www.pnas.org/cgi/doi/10.1073/pnas.1207359109.

157 J.J. Mekalanos et al., *Non-O1 Vibrio Cholerae*

Unlinked to cholera in Haiti, 109 PNAS 47 (Nov. 20, 2012), *available at* http://www.pnas.org/content/109/47/E3206.full.

158 R.R. Frerichs et al., *Source Attribution of 2010 Cholera Epidemic in Haiti*. 109 PNAS 49 (Nov. 20, 2012), *available at* http://www.pnas.org/content/109/47/E3208.extract.

159 *Id.*

160 *Id.*

161 U.N. Charter art.105(1)-(2) (emphasis added).

162 *See* Convention on Privileges and Immunities of the United Nations, arts. II § 2, IV § 11, Feb. 13, 1946, 16 U.N.T.S. 1946-47, *available at* http://www.un.org/en/ethics/pdf/convention.pdf (emphasis added).

163 *Id.* art. VII § 29.

164 August Reinisch, *Convention on Privileges and Immunities of the United Nations, Convention on Privileges and Immunities of the Specialized Agencies*, United Nations Audiovisual Library of International Law (2009) at 2, http://untreaty.un.org/cod/avl/pdf/ha/cpiun-cpisa/cpiun-cpisa_e.pdf.

165 U.N. Secretary General, *Financing of the United Nations Protection Force, the United Nations Confidence Restoration Operation in Croatia, the United Nations Preventive Deployment Force and the United Nations Peace Forces Headquarters: Report of the Secretary-General,* Mar. 19, 2001, U.N. Doc. No. A/51/389, *available at* http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N96/249/39/PDF/N9624939.pdf?OpenElement.

166 *Id.*

167 Maarten Zwanenburg, Accountability of Peace Support Operations 36 (2005).

168 *Id.*

169 Comprehensive Review of the Whole Question of Peacekeeping Operations in All Their Aspects: Model Status-of-Forces Agreement for Peacekeeping Operations, Oct. 9, 1990, U.N. Doc. A/45/594, at 1 ("[T]he General Assembly requested the Secretary-General to prepare a model status-of-forces agreement between the United Nations . . . and to make that model available to Member States. . . . The model is intended to serve as a basis for the drafting of individual agreements to be concluded between the United Nations and countries on whose territories peace-keeping operations are deployed.") [hereinafter Model SOFA].

170 *Id.* at 1.

171 *Id.*

172 Zwanenburg, *supra* note 167, at 36.

173 *Id.* at 36 n.145-146.

174 See, e.g., Model SOFA, *supra* note 169, art. VI, §§ 24-50 (generally outlining privileges and immunities of peacekeepers).

175 Maria-Elena Kolovros & Beatrice Lindstrom, *U.N. Must Take Responsibility for Haiti Cholera Outbreak*, Jurist.com (Feb. 23, 2012), http://jurist.org/hotline/2012/02/kolovos-lindstrom-cholera-haiti.php.

176 Model SOFA, *supra* note 169, at 13 (emphasis added). The Model SOFA excepts from this general requirement arbitration procedures under Article 53. Article 53, which provides for a three-member arbitration panel, applies when both parties jointly agree to appeal a judgment from the claims commission or for other disputes not covered under Article 51. *See id.* ("Any other dispute between the United Nations peacekeeping operations and the government, and any appeal that both of them agree to allow from the award of a claims commission . . . shall . . . be submitted to a tribunal of three arbitrators.").

177 *Id.*

178 Haitian SOFA, *supra* note 82, ¶ 55.

179 *Id.*

180 Interview with Maître Jacceus Joseph, *supra* note 85.

181 The SOFA provides, "If no agreement as to the chairman is reached by the two parties within 30 days of the appointment of the first member of the commission, the President of the International Court of Justice may, at the request of either party, appoint the chairman." Model SOFA, *supra* note 169. In other words, as soon as either the Haitian Government or the Secretary-General appoint their claims commissioner, and 30 days pass following the appointment, the appointing party can petition the president of the ICJ to appoint a chairman. Once a chairman is appointed, the two-member quorum will be satisfied; as the SOFA specifies, "[t]he commis-

sion shall determine its own procedures, provided that any two members shall constitute a quorum for all purposes...and all decisions shall require the approval of any two members." *Id.*

182 *See, e.g.*, Richard Feinberg, *Review*: *Fixing Haiti: MINUSTAH and Beyond*, Foreign Affairs (Jan./Feb. 2012), *available at* http://www.foreignaffairs.com/articles/136913/fixing-haiti-minustah-and-beyond.

183 Tom Dannenbaum, *Translating the Standard of Effective Control into a System of Effective Accountability: How Liability Should Be Apportioned for Violations of Human Rights by Member State Troop Contingents Serving as United Nations Peacekeepers*, 51 Harv. Int'l L. J. 113, 126 (2010).

184 *See Financing of the United Nations Protection Force, supra* note 89.

185 *See* Amy Lieberman, *Haiti Cholera Case Raises Questions About UN Accountability*, World Politics Review (Dec. 1, 2011), *available at* http://www.worldpoliticsreview.com/articles/10808/haiti-cholera-case-raises-questions-about-u-n-accountability.

186 *Financing of the United Nations Protection Force*, *supra* note 89, at 7.

187 *Id.*

188 *Id.*

189 Dannenbaum, *supra* note 183, at 126.

190 Dahpna Shraga, *UN Peacekeeping Operations: Applicability of International Humanitarian Law and Responsibility for Operations-Related Damage*, 94 Am. J. Int'l L. 406 (2000).

191 Dannenbaum, *supra* note 183, at 126 ("Because the claims review board deliberations are made in secret, there is very little public information available about the kind of claims they deliberate.").

192 Assistant Secretary-General, Interoffice Memorandum dated Mar. 26, 2009 from the Office of Program Planning to the Controller, Budgets and Accounts regarding ex gratia payment to an injured Haitian civilian, United Nations Juridical Yearbook 428-432 (2009), *available at* http://books.google.com/books?id=upZ-WB-cUFYC&pg=PA429&lpg=PA429&dq=minustah+claims+review+board&source=bl&ots=sLSC9N-Ril&sig=AOPiCAK9tPage4cdh5VYKOVy-dY&hl=en&sa=X&ei=FxZ8UfGBFaLl4AOp-6oGAAg&ved=0CDQQ6AEwAA#v=onepage&q=minustah%20claims%20review%20board&f=false.

193 Dannenbaum, *supra* note 183, at 126.

194 *Id.* at 127 n.106.

195 Haitian SOFA, *supra* note 82, art. VIII, ¶ 55.

196 Petition for Relief, *supra* note 89, ¶ 4.

197 *Id.* ¶ 66.

198 Letter from Patricia O'Brian, *supra* note 93.

199 *See* Haitian SOFA, *supra* note 82.

200 *Id.* art. VIII, ¶ 55.

201 *See* Ernest Weinrib, The Idea of Private Law 8 (2012) ("On the institutional side, private law involves an action by plaintiff against defendant, a process of adjudication, a culmination of that process in a judgment that retroactively affirms the rights and duties of the parties, and an entitlement to specific relief or to damages for the violations of those rights or the breach of those duties. On the conceptual side, private law embodies a regime of correlative rights and duties that highlights, among other things, the centrality of the causation of harm of the distinction between misfeasance and nonfeasance.").

202 *See* Randy E. Barnett, *Four Senses of the Public-Private Law Distinction*, 9 Harv. J. L. & Pub. Pol. 267, 269-70 (1986).

203 *See* Petition for Relief, *supra* note 89.

204 *Financing of the United Nations Protection Force*, *supra* note 89, at 6.

205 *See, e.g.*, Kristin Boon, *UN Flatly Rejects Haiti Cholera Claim*, Opinio Juris (Feb. 22, 2013), http://opiniojuris.org/2013/02/22/un-flatly-rejects-haiti-cholera-claim/ ("Many elements of a "dispute of a private law character", however, would appear to be present: the claim itself was essentially one of tort, the claimants were private individuals (represented by an NGO), and the remedy sought was monetary compensation.").

206 *Financing of the United Nations Protection Force*, *supra* note 89, ¶ 13.

207 *Id.* ¶ 14.

208 Brzak v. United Nations, 597 F.3d 107 (2d Cir. 2010) (noting the various sources of law that

shield the UN from immunity in American courts).

209 *See, e.g.*, Dannenbaum, *supra* note 183.

210 Matt Halling & Blaine Bookey, *Peacekeeping in Name Alone: Accountability for the United Nations in Haiti*, 31 Hastings Int'l & Comp. L. Rev. 461, 481 (2008)

211 Dannenbaum, *supra* note 183 at 113. *See also* Jordan J. Paust, *The U.N. Is Bound By Human Rights: Understanding the Full Reach of Human Rights, Remedies, and Nonimmunity*, 51 Harvard Int'l L. J. 301 (2010). The United Nations International Law Commission recently adopted a series of draft articles on the responsibility of international organizations for committing an "internationally wrongful act." One general principle of the draft articles is that "[e]very internationally wrongful act of an international organization entails the international responsibility of that organization." Int'l Law Comm'n Draft Articles on the Responsibility of International Organizations, Report of the International Law Commission Sixty-third Session, art. 3, U.N. GAOR 66th Sess., U.N. Doc A/66/10, 77-88 (Apr. 26, June 3 & July 4-Aug. 12, 2011 [hereinafter Draft Articles].

212 See *supra* Chapter I.A at 5-6 for a description of accusations of physical abuse and sexual exploitation committed by MINUSTAH troops in Haiti.

213 "The United Nations shall possess juridical personality." Convention on the Privileges and Immunities of the United Nations, Feb. 13, 1946, 1 U.N.T.S. 15, art. 1, § 1[hereinafter General Convention].

214 Reparation for Injuries Suffered in the Service of the United Nations, Advisory Opinion, 1949 I.C.J. 174, 179 (Apr. 11).

215 *Id.*

216 U.N. Charter art. 1, para. 3.

217 *Financing of the United Nations Protection Force, supra* note 89, ¶ 6.

218 *Id.*

219 Draft Articles, *supra* note 211, at 86 (quoting Letter dated 3 February 2004 from the United Nations Legal Counsel to the Director of the Codification Division, A/CN.4/545, sect. II.G.).

220 U.N. Charter art. 55(c).

221 World Conference on Human Rights, June 14-25, 1993, Vienna Declaration and Programme of Action, ¶ 4, U.N. Doc. A/CONF.157/24 (July 12, 1993).

222 S.C. Res. 1927, *supra* note 21, prmbl.

223 *Legal Consequences for States of the Continued Presence of South-Africa in Namibia (South West Africa)* notwithstanding Security Council Resolution 276, Advisory Opinion, 1971 I.C.J. 16, 57 ¶ 131.

224 Haitian SOFA, *supra* note 82, ¶ 5.

225 "Once international treaties or agreements are approved and ratified . . . they become part of the legislation of the country and abrogate any laws in conflict with them." Constitution de la République d'Haïti 1987, art. 276-2.

226 *See supra* Chapter IV.A.

227 Customary international law includes those human rights provisions of the Universal Declaration of Human Rights (UDHR) that have achieved customary force. While the rights that arise under customary international law are evolving with practice, it is clear that the right to an effective remedy, which is found in the UDHR as well as other treaties, has reached customary status. International Human Rights Law: Cases, Materials, Commentary 50 (Olivier De Schutter ed., 2010). See Chapter IV for a detailed discussion of the right to an effective remedy.

228 Statute of the International Court of Justice art. 38(1)(b), Apr. 18, 1946. *See* Frédéric Mégret & Florian Hoffmann, *The UN as a Human Rights Violator? Some Reflections on the United Nations Changing Human Rights Responsibilities*, 25 Hum. Rts. Q. 314, 317 (2003). Mégret and Hoffmann additionally note that, "it has been contended that, in the case of 'treaties that have been drafted by representatives of nearly all States with the intention of creating universal law,' international organizations, whose 'constitutional roots are in international law' cannot invoke their non-party status." *Id.* (quoting Henry G. Schermers et al., International Institutional Law: Unity Within Diversity 824 (1995)). *See also* Dannenbaum, *supra* note 183, at 135, 135 n.161 (observing that customary international law binds to

the United Nations as, "a consequence of the United Nations' legal personality at international law," and arguing that objections to this application of customary international law on the grounds that customary international law is tailored to States "is significantly mitigated by the qualifier that customary law applies to the United Nations only *mutatis mutandis*," that is, with consideration for the respective differences between States and the United Nations).

229 Mégret & Hoffmann, *supra* note 228.

230 The Restatement (Third) of the Foreign Relations Law of the United States notes that customary international law, in contrast to treaties, "results from a general and consistent practice of states followed by them from a sense of legal obligation." § 102(2) (1987).

231 *Id.* at § 102(3), cmt. f; § 301(1).

232 See *supra* note 228 and accompanying text.

233 As noted in *supra* note 230, customary international law applies to the U.N. only mutatis mutandis, or only as is consistent with its nature as an entity. Hence, where the standard in question is one that the UN as an international entity has already committed itself to, holding the U.N. to its dictates does not run afoul of concerns that customary law is tailored to states, not international organizations. The right to remedy which notes that remedies under the General Convention must be consistent with the access to courts right found in human rights treaties), is one such instance of the appropriate application of customary international law to the UN. For an objection to the application of customary law to the UN on the grounds that its rules are meant for states, see Judith G. Gardam, *Legal Restraints on Security Council Military Enforcement Action*, 17 Mich. J. Int'l L. 285, 319 (1996); J.E. Alvarez, *Memo: ILC's Draft Articles on the Responsibility of International Organizations* (June 21, 2010), http://www.law.nyu.edu/ecm_dlv2/groups/public/@nyu_law_website__faculty__faculty_profiles__jalvarez/documents/documents/ecm_pro_066900.pdf.

234 U.N. Charter prmbl.

235 In 1993, it created the Office of the High Commission for Human Rights, which is mandated to, among other things, prevent human rights violations, secure respect for all human rights, and promote international cooperation to protect human rights. *Who We Are: Mandate*, Office of the High Commissioner for Human Rights, http://www.ohchr.org/EN/AboutUs/Pages/Mandate.aspx. In 2006, the General Assembly established the Human Rights Council, the responsibilities of which include "promoting universal respect for the protection of all human rights" and "address[ing] situations of violations of human rights." G.A. Res. 60/251, U.N. GAOR, 60th Sess., U.N. Doc. A/Res/60/251, ¶ 2 (Apr. 3, 2006).

236 José Ayala Lasso, *Human Rights in the United Nations: The Achievements So Far and Challenges Ahead*, 1 Int'l J. of Peace Studies (1996).

237 G.A. Res. 64/292, U.N. GAOR, 64th Sess., U.N. Doc. A/RES/64/292, ¶ 2 (Aug. 3, 2010). Although the Resolution does not itself establish a right to water binding on the states, it draws from the right of children, women, and people with disabilities to clean water that has been recognized in the Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and Convention on the Rights of Persons with Disabilities (CRPD), all treaties to which Haiti has either acceded or ratified. Convention on the Rights of the Child art. 24(2)(c), opened for signature Nov. 20, 1989, 1577 U.N.T.S. 3 (ratified by Haiti on June 8, 1995) [hereinafter CRC]; Convention on the Elimination of All Forms of Discrimination against Women art. 14(2)(h), *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13 (ratified by Haiti on July 20, 1981) [hereinafter CEDAW]; Convention on the Rights of Persons with Disabilities art. 28(2)(a), opened for signature Mar. 30, 2007, 2515 U.N.T.S. 3 (acceded to by Haiti on July 23, 2009) [hereinafter CRPD].

238 Human Rights Council, *Human rights and access to safe drinking water and sanitation*, 15th Sess., Sept. 24, 2010, U.N. Doc. A/HRC/15/L.14. The right to an adequate standard of living is codified in Article 25 of the Universal Declaration of Human Rights and Article 11 of the

International Covenant on Economic, Social, and Cultural Rights. Universal Declaration of Human Rights art. 25, G.A. Res. 217, U.N. GAOR 3d Sess., U.N. Doc. A/810 (1948) [hereinafter UDHR]; International Covenant on Economic, Social, and Cultural Rights art. 11, *opened for signature* Dec. 19, 1966, 993 U.N.T.S. 3 (ratified by Haiti on Feb. 2, 2012) [hereinafter ICESCR]. The rights to the highest attainable standard of health and life are discussed in infra Chapter IV.C.2 and C.3, respectively.

239 Sawhoyamaxa Indigenous Community v. Paraguay, Merits, Reparations and Costs, Inter-Am. Ct. H.R. (ser. C) No. 146, ¶¶ 168, 178 (Mar. 29, 2006).

240 International Covenant on Economic, Social and Cultural Rights: The Right to Water, Comm. on Economic, Social and Cultural Rights, 29th sess., gen. cmt. 15, ¶ 12, U.N. Doc. E/C.12/2002/11 (Jan. 20, 2003) [hereinafter The Right to Water].

241 *Id.* at ¶¶ 42, 44.

242 *Id.* ¶ 17.

243 *See* Cravioto, *supra* note 66.

244 *See, e.g.*, Constitution de la République d'Haïti 1987 arts. 253, 258 (forbidding "any practices that might disturb the ecological balance" of the environment and prohibiting the introduction of "wastes or residues of any kind from foreign sources" into the country).

245 Paul Farmer, former U.N. Deputy Special Envoy for Haiti and current Special Advisor to the U.N. Secretary-General for Community-based Medicine and Lessons from Haiti, described Haiti as the "most water insecure" country in the world in 2011. *AP Interview: Expert says Haiti has worst cholera*, The Guardian (Oct. 18, 2011), *available at* http://www.guardian.co.uk/world/feedarticle/9902077.

246 The Denial of the Right to Water in Haiti, *supra* note 43.

247 Brian Concannon Jr. & Beatrice Lindstrom, *Cheaper, Better, Longer-Lasting: A Rights-Based Approach to Disaster Response in Haiti*, 25 Emory Int'l L. R. 1145, 1168 (2011).

248 UDHR, *supra* note 238, art. 25(1).

249 ICESCR, *supra* note 238, art. 12(b)-(c).

250 CRC, *supra* note 237, art. 24; CEDAW, *supra* note 237, art. 12(1); International Convention on the Elimination of All Forms of Racial Discrimination, art. 5(e)(iv), *opened for signature* Dec. 21, 1965, 660 U.N.T.S. 195 (ratified by Haiti on Dec. 19th, 1972) [hereinafter CERD]; CRPD, *supra* note 237, art. 25.

251 American Declaration on the Rights and Duties of Man art. XI, O.A.S. Res. XXX, *adopted by* the Ninth International Conference of American States, Bogota, Colombia, Mar. 30-May 2, 1948, OEA/Ser. L./V/II.23/doc. 2 rev. 6 (1979).

252 ICESCR, *supra* note 238, art. 12(2)(b)-(c).

253 CRC, *supra* note 237, art. 24(c).

254 International Covenant on Economic, Social and Cultural Rights: The right to the highest attainable standard of health, Comm. on Economic, Social and Cultural Rights, 22d sess., gen. cmt. 14, ¶ 4, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

255 *Id.* ¶¶ 39, 59.

256 *Id.* ¶ 40.

257 *See supra* Chapter III.C.

258 International Covenant on Civil and Political Rights: The right to life, Human Rights Comm., 16th Sess., gen. cmt. 6, ¶ 5, U.N. Doc. HRI/GEN/1/Rev. 9 (Apr. 30, 1982) [hereinafter ICCPR].

259 *Digital record of the UDHR*, Office of the High Commissioner for Human Rights (Feb., 2009), *available at* http://www.ohchr.org/EN/NEWSEVENTS/Pages/DigitalrecordoftheUDHR.aspx.

260 *Id.* ("The UDHR was proclaimed by the General Assembly on 10 December 1948, and since then is widely regarded as forming part of customary international law.")

261 UDHR, *supra* note 238, art. 8. Scholars have argued that the U.N.'s legal personality renders it legally accountable under customary international law, including the UDHR.

262 International Human Rights Law: Cases, Materials, Commentary, *supra* note 227.

263 American Convention on Human Rights art. 25(1), OAS Official Records, OEA/Ser.K/XVI/1.1, Doc. 65, Rev. 1, Corr. 1 (1970).

264 ICCPR, *supra* note 258, art. 2(3); CERD, *supra* note 250, art. 6; CRC, *supra* note 237, art. 39. In recognizing a right to water within the

ICESCR, the UN Committee on Economic, Social, and Cultural Rights has also noted that victims of a violation of this right "should be entitled to adequate reparation." The Right to Water, *supra* note 240, ¶ 55.

265 International Covenant on Civil and Political Rights: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant, Human Rights Comm., 80th Sess., gen. cmt. 31, ¶ 16, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (May 26, 2004).

266 Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Violations of International Human Rights and Humanitarian Law, G.A. Res. 60/147, U.N. GAOR, 60th Sess., U.N. Doc. A/RES/60/147, ¶ 18 (Mar. 21, 2006). Restitution "includes, as appropriate, restoration of liberty, enjoyment of human rights, identity, family life and citizenship, return to one's place of residence, restoration of employment and return of property." *Id.* at ¶ 19. Compensation "should be provided for any economically assessable damage, as appropriate and proportional to the gravity of the violation and the circumstances of each case . . . such as: (a) Physical or mental harm; (b) Lost opportunities, including employment, education and social benefits; (c) Material damages and loss of earnings, including loss of earning potential; (d) Moral damage; (e) Costs required for legal or expert assistance, medicine and medical services, and psychological and social services." *Id.* at ¶ 20. Rehabilitation "should include medical and psychological care as well as legal and social services." *Id.* at ¶ 21. Satisfaction should include "[e]ffective measures aimed at the cessation of continuing violations . . . [v]erification of the facts and full and public disclosure of the truth . . . [a]n official declaration or judicial decision restoring the dignity, the reputation and the rights of the victim and of persons closely connection with the victim . . . [p]ublic apology, including acknowledgement of the facts and acceptance of responsibility . . . [j]udicial and administrative sanctions against persons liable for the violations . . . [c]ommemorations and tributes to the victims . . . [i]nclusion of an accurate account of the violations that occurred in international human rights law and international humanitarian law training and in education material at all levels." *Id.* at ¶ 22. Guarantees of non-repetition should include "[e]nsuring effective civilian control of military and security forces . . . [p]roviding, on a priority and continued basis, human rights and international humanitarian law education to all sectors of society and trainng for law enforcement officials as well as military and security forces . . . [p]romoting the observance of codes of conduct and ethical norms, in particular international standards, by public servants . . . [r]eviewing and reforming laws contributing to or allowing gross violations of international human rights law and serious violations of international humanitarian law." *Id.* ¶ 23.

267 *Id.* ¶ 15.

268 *Id.* at 4.

269 LaGrand (Ger. v. U.S.), 2001 ICJ Rep. 466.

270 La Cantuta v. Peru, Inter-Am. Ct. H.R., (ser. C) No.162 ¶ 201 (Nov. 29, 2006).

271 The U.N.'s refusal to remedy the harms it has caused in Haiti is discussed in Chapter I; the legal basis of its obligation to provide such a remedy is detailed in Chapter III.

272 The Final Report of the Independent Panel of Experts on the Cholera Outbreak in Haiti, released by the UN in 2011, issued seven recommendations to the UN for responding to the outbreak, including providing UN personnel and emergency responders traveling from cholera-endemic areas with prophylactic antibiotics and screening personnel and emergency responders for asymptomatic carriage of cholera bacteria prior to departure, immunizing personnel and emergency responders against cholera, and treating waste at worldwide UN installations using on-site treatment systems maintained by trained and qualified staff or by local providers with adequate UN oversight. Cravioto, *supra* note 66, at 30; *see also* Physicians for Haiti, Protecting Peacekeepers & Their Public: A report card on UN implementation of their recommendations for cholera in Haiti (May 2013), *available at*

http://physiciansforhaiti.org/wp-content/uploads/2013/05/P4H-UN-report-card-wo-PR.pdf. As of May 2013, the UN had only fully implemented two of the seven recommendations, and none of those listed above. Physicians for Haiti, *supra*. Notably, the unimplemented recommendations "would have prevented UN introduction of cholera into Haiti and would prevent similar introduction in the future . . . [and] could be implemented at either no or minimal cost to the UN." *Id.* The recommendations that were completely implemented, according to Physicians for Haiti, "rel[ied] heavily on action and funding outside UN agencies." *Id.*

273 See *supra* Chapter III for further discussion.

274 Nicholas Leader, *The Politics of Principle: The Principles of Humanitarian Action in Practice, in Overseas Development Institute*--Humanitarian Policy Group 5-6 (2000). *available at* http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/311.pdf

275 *Id.* at 5. *See also* Dorothea Hilhorst, *Dead letter or living document? Ten years of the Code of Conduct for disaster* relief, 19 Disasters 351 (2005); Nicholas Leader, *Proliferating Principles; or How to Sup with the Devil without Getting Eaten*, 22 Disasters 288, 289 (1998).

276 International Committee of the Red Cross, *Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations in Disaster Relief* art. 10 (1994) [hereinafter *ICRC Code of Conduct*], *available at* http://www.icrc.org (noting the concern to treat disaster victims as dignified humans, not hopeless objects); Sphere Project, Humanitarian Charter and Minimum Standards in Disaster Response 5 (2004 ed.) [hereinafter *Sphere Project 2004 ed.*] (stating Sphere is based on two base concepts a concern with alleviating suffering and recognizing those affected by a disaster have a right to life with dignity); HAP International, The Guide to the HAP Standard: Humanitarian Accountability and Quality Management 4–5 (2008) [hereinafter Guide to the HAP Standard] (explaining the HAP Standard seeks to protect the dignity of those affected by disasters).

277 *ICRC Code of Conduct, supra* note 276, arts. 8, 9 (expressing a commitment to reduce future vulnerability to disaster and ensuring appropriate monitoring of aid); Sphere Project 2004 ed., *supra* note 276, at 13 (affirming Sphere's commitment to the quality of aid), Guide to the HAP Standard, *supra* note 276, at 13 (noting the HAP Standard's concern with improving the quality of aid).

278 *See, e.g.*, Constanza Adionolfi et al., Office for the Coordination of Humanitarian Affairs, Humanitarian Response Review 10, 20 (2005) (noting the widespread acknowledgement of the importance of the ICRC Code of Conduct, the Sphere Standards, and the HAP Standard among humanitarian organizations, including U.N. agencies).

279 *ICRC Code of Conduct, supra* note 276, art. 9.

280 Leader, *supra* note 275, at 275.

281 *Id.* at 296. *See also, ICRC Code of Conduct, supra* note 276, arts. 1, 9. The ICRC's Code of Conduct does not include a formal do no harm principle. However, the "humanitarian imperative" articulated in Article 1 of the Code has been understood to encompass a principle of non-maleficence. For the accountability principle, see Article 9 of the Code.

282 International Committee of the Red Cross, *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief List of Signatories* (2012), *available at* http://www.ifrc.org/; Hilhorst, *supra* note 275, at 363–367.

283 Peter Walker & Susan Purdin, *Birthing Sphere*, 24 Disasters 100, 101 (2004).

284 *Id.* at 102. For the original evaluation of the response of humanitarian organizations during the Rwandan genocide, see John Eriksson et al., The International Response to Conflict and Genocide: Lessons from the Rwanda Experience (Mar. 1996), *available at* https://www1.oecd.org/derec/sweden/50189495.pdf.

285 *Id.* at 108.

286 The Sphere Standards were also revised in 2011, but this report discusses only the 2004 edition, as this was the edition in use during the 2010 cholera outbreak. Notably, however, the revisions make even clearer the funda-

mental obligations of protection. The 2011 edition incorporates a series of protection principles to: (1) avoid exposing people to further harm; (2) ensure access to impartial assistance; (3) protect people from harm arising from violence and coercion; (4) assist people to claim their rights and access remedies. *See* Sphere Project, Humanitarian Charter and Minimum Standards in Disaster Response 28 (2011 ed.).

287 *Sphere Project 2004 ed., supra* note 276, at 16-17.

288 *Id.* at 16.

289 Lotus McDougal & Jennifer Beard, *Revisiting Sphere: New Standards of Service Delivery for New Trends in Protracted Displacement*, 35 Disasters 87, 90 (2010).

290 Margaret L. Satterthwaite, *Indicators in Crisis: Rights-based Humanitarian Indicators in Post-Earthquake Haiti*, 43 N.Y.U J. of Int'l L. & Pol. 865, 887–888 (2011).

291 *Id.* at 888. HAP functions as a self-regulatory body seeking to promote good accountability practices among NGOs that offer humanitarian relief. The organization has 68 full members and 19 associate members ranging from agencies working in emergency relief to institutional donors. Additionally, HAP has its own General Assembly, Board, and Secretariat. Together, these different bodies function to promote the HAP standards and principles, and assist members to find solutions where complaints are raised. *See About us*, Hap Int'l (2013), http://www.hapinternational.org/about.aspx.

292 HAP International, *HAP 2007 Standard in Humanitarian Accountability and Quality Management* 5 (2007) [hereinafter *Hap 2007 Standard*]. The HAP Standard was revised in 2010, but this report discusses only the 2007 edition, as this was the edition in use during the 2010 cholera outbreak.

293 *Id.* at 11.

294 Walker & Purdin, *supra* note 283, at 102 (discussing the Sphere Project consultations); Satterthwaite, *supra* note 290, at 897 (discussing the HAP Standard consultations).

295 U.N. High Commissioner for Refugees, *Handbook for Emergencies* 262 (2007 3rd ed.), *available at*, http://www.unhcr.org [hereinafter *UNHCR Handbook*]. *See also* U.N. High Commissioner for Refugees, *Excreta Disposal in Emergencies: A Field Manual* 197 (2009), *available at*, http://www.unhcr.org (incorporating Sphere indicators in the excreta disposal guidelines) [hereinafter *UNHCR Disposal in Emergencies*],

296 World Health Organization & Water, Engineering and Development Centre at Loughborough University, Technical Notes on Drinking-Water, Sanitation and Hygiene in Emergencies 7.1, 7.4, 13.2, 13.1 (2011). *See also* United Nations Children's Fund, Handbook on Water Quality 129–130 (2008) (also citing the Sphere Standard as a key reference).

297 Adionolfi, *supra* note 278, at 8, 20.

298 U.N. Under-Secretary-General for Peacekeeping Operations, United Nations Peacekeeping Operations: Principles and Guidelines 23 (2008), *available at* http://www.un.org/en/peacekeeping/operations/principles.shtml (noting the changing nature of peacekeeping mandates of U.N. missions).

299 S.C. Res. 1542, ¶¶ 8–9, U.N. Doc. S/RES/1542 (Apr. 30, 2004).

300 *Id.* ¶ 9.

301 S.C. Res. 1908, U.N. Doc. S/RES/1908 (Jan. 19, 2010); S.C. Res. 1927, ¶¶ 5–8., U.N. Doc. S/RES/1927 (June 4, 2010).

302 *MINUSTAH Apr. 2010 Report, supra* note 20, ¶¶ 2–4; MINUSTAH Sept. 2010 Report, *supra* note 23, ¶¶ 44–50.

303 *MINUSTAH Apr. 2010 Report, supra* note 20, ¶14, 57; *MINUSTAH Sept. 2010 Report, supra* note 23, ¶ 30.

304 *See, e.g., MINUSTAH Apr. 2010 Report, supra* note 20, ¶ 10; *MINUSTAH Sept. 2010 Report, supra* note 23, ¶ 24.

305 MSPP Plan, *supra* note 43. *See also* The Denial of the Right to Water in Haiti, *supra* note 43.

306 In the peacekeeping context, the principle is not absolute, but rather weighted against the operational necessity of a particular objective. Likewise, the recognition of responsibility for damages to third parties applies a broader principle of accountability to affected populations. *See* Dapnha Shraga, *U.N. Peacekeeping Operations: Applicability of*

International Humanitarian Law and Responsibility for Operations-Related Damage, 94 Am. J. of Int'l L. 406, 409 (2000). For more on the principle generally, see Hugo Slim, *Doing the Right Thing: Relief Agencies, Moral Dilemmas and Moral Responsibility in Political Emergencies and War*, 21 Disasters 244, 244 (1997). For an early articulation of the principle, see Mary B. Anderson, Do No Harm: How Aid Can Support Peace—Or War (1999). *See also* Mary B. Anderson, *Aid: A Mixed Blessing*, 10 Development in Practice 495 (2000). The negative impacts of humanitarian operations have been well documented and range from creating dependency on aid, to unknowingly shifting balances of power in a host country, to spreading disease among vulnerable populations. *See, e.g.*, Aid Action, Real Aid: Ending Aid Dependency (2010); Alex de Waal, *The Humanitarians' Tragedy: Escapable and Inescapable Cruelties*, 34 Disasters S130, S131 (2010). Some of these phenomena have already been documented in Haiti. Matthew Aaron Moore, Do No Harm and the Convergence of Relief Development & Conflict Resolution 68 (2012) (unpublished M.S. dissertation, George Mason University) (on file with George Mason University).

307 Sphere Project 2004 ed., *supra* note 276, at 71–75.

308 *Id.*

309 *See, e.g.*, Peter Harvey, United Nations Children's Fund et al., Excreta Disposal in Emergencies: A Field Manual 2 (2007), *available at* http://www.unicef.org; UNHCR Handbook, *supra* note 295, at 295; UNHCR Disposal in Emergencies, *supra* note 295, at 197.

310 Cravioto, *supra* note 66, at 21.

311 *Id.* at 21.

312 *Id.*

313 *See, e.g.*, Humanitarian Accountability Partnership, The 2010 HAP Standard in Accountability and Quality Management 1 (2010); Sphere Project 2004 ed., *supra* note 276, at 41.

314 Humanitarian Accountability Partnership, *supra* note 313, at 1.

315 *Id. See also* Overseas Development Institute, Promoting Mutual Accountability in Aid Relationships 1 (2006) (recognizing the traditional power imbalance between donors and aid recipients)..

316 *Id.*

317 Austen Davis, Humanitarian Practice Network, Concerning Accountability of Humanitarian Action 4 (2007), *available at* http://www.odihpn.org/index.php?option=com_k2&view=item&layout=item&id=2867.

318 *Id.* at 1.

319 Paul Know-Clarke & John Mitchell, *Reflections on the Accountability Revolution*, 52 Humanitarian Exchange 3 (2011).

320 See Chapter VI for a complete elaboration of forms of effective remedy.

321 See Chapter I for a detailed discussion of the advocacy effort to hold the U.N. accountable for the cholera epidemic.

322 Haitian SOFA, *supra* note 82, at 55.

323 *Id.*

324 Elyse J. Garmise, *The Iraqi Claims Process and the Ghost of Versailles*, 67 N.Y.U. L. Rev. 840, 842 (1992). Note that the UNCC was also created to compensate governments and corporations for harms suffered in the war, but these claims were processed in separate categories from those by victims. See *The Claims*, United Nations Compensation Commission, http://www.uncc.ch/theclaims.htm.

325 *See, e.g.*, David J. Biederman, *The United Nations Compensation Commission and the Tradition of International Claims Settlement*, 27 N.Y.U. J. Int'l L. & Pol. 1, 2 (1994); John F. Murphy, *Foreign Claims*, 31 Int'l Law 579, 586 (1997).

326 *Id.* at 587.

327 *The UNCC At a Glance*, United Nations Compensation Commission, http://www.uncc.ch/ataglance.htm.

328 *The Claims*, United Nations Compensation Commission, http://www.uncc.ch/ataglance.htm.http://www.uncc.ch/theclaims.htm.

329 *Id.*

330 S.C. Res. 687 ¶ 19, U.N. Doc. S/RES/687 (Apr. 8, 1991).

331 Murphy, *supra* note 325, at 587.

332 A cholera claims commission would need to develop policies and procedures for cholera cases arising after the commission was established that are still traceable to the U.N. While these procedures might make

this commission more open-ended than the UNCC, the UNCC still provides a window into how long the cholera claims commission would take to complete the core of its work.

333 Air Transportation Safety and System Stabilization Act, 49 U.S.C. §40101 et seq. (2001).

334 *Id.* at 52.

335 Air Transportation Safety and System Stabilization Act at §405(c)(3)(B).

336 Kenneth Feinberg, et al., Final Report of the Special Master for the September 11th Victim Compensation Fund of 2001 1, 4-13 (2004) [hereinafter Final Report], *available at* http://www.justice.gov/final_report.pdf.

337 Kenneth Feinberg, *Compensating the Families and Victims of September 11th: An Alternative to the American Tort System, in* Redressing Injustices Through Mass Claims Processes 235, 236 (International Bureau of the Permanent Court of Arbitration, ed., 2006).

338 Final Report, *supra* note 336, at 241.

339 Adams, *supra* note 55.

340 *Id.*

341 *Id.*

342 Barzilay, *supra* note 35, at 599-609.

343 MSPP Plan, *supra* note 43, §7.3.

344 *Id.* §7.4.

345 Center for Economic and Policy Research, *Cholera Eradication Plan Announced, But Funding Still in Question* (Feb. 27, 2013), http://www.cepr.net/index.php/blogs/relief-and-reconstruction-watch/cholera-eradication-plan-announced-but-funding-still-in-question

346 Decreasing funds for cholera response and prevention is a growing challenge faced by Government of Haiti and the humanitarian community in combating the cholera epidemic. The Haiti Consolidated Appeal Process (CAP) for 2012, which underlined cholera response as a key priority, was revised from US$231 million to $128 million at the Mid-Year Review in July. It was again revised upwards to US$151 million in December to address the immediate needs of Haitians in the wake of Hurricane Sandy. As of December 11th, the Appeal has only been funded at 41 per cent or about US$61 million, making it one of the most under-funded CAPs worldwide. The critical Health and WASH response plans are funded at 47 per cent and 38 per cent, respectively. *U.N. Haiti Factsheet on Cholera Prevention and Response* (Dec. 2012), *available at* http://www.un.org/News/dh/infocus/haiti/Haiti%20Cholera%20Factsheet%20Dec%202012.pdf.

347 MSPP Plan, *supra* note 43. *See, e.g.*, Pan American Health Organization, *PAHO/WHO calls for new international funding of Haiti cholera plan* (Feb. 27, 2013), http://www.paho.org/hai/index.php?option=com_content&view=article&id=7117%3Alops-fait-appel-au-financement-international-pour-le-nouveau-plan-contre-le-cholera-en-haiti&catid=674%3Ahai.-press-releases&Itemid=255&lang=en.

348 World Health Organization, *Water, Sanitation and Health* §6 (2013), *available at* http://www.who.int/water_sanitation_health/sanitproblems/en/index5.html.

349 *See* Todd Howland, *Peacekeeping and Conformity with Human Rights Law: How MINUSTAH Falls Short in Haiti*, 13 Int'l Peacekeeping 462 (2006). *See also OAS rights commission hears testimony about situation in Haiti*, Associated Press (Mar. 6, 2006).

350 Michel Forst, *Report of the independent expert on the situation of human rights in Haiti*, Feb. 7, 2013, U.N. Doc. A/HRC/22/65.

351 Consultation with Victims of the Cholera Epidemic, in Meye, Haiti (Mar. 20, 2013).

352 *See generally* James Crawford et al, *The Law of International Responsibility*, ch. 39 (2010); Christian J. Tams, *Recognizing Guarantees and Assurances of Non-Repetition*, 27 Yale J. Int'l L. 441 (2002).

353 Dilek Kurban, *Reparations and Displacement in Turkey*, Brookings Project on Internal Displacement (2012).

354 United Nations Office of the High Com'r for Human Rights, *Statement by the United Nations Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence* (Nov. 16, 2012), *available at* http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=12800&LangID=E.