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The right to health of the child: an analytical exploration of the international normative framework

Spronk, S.I.

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Author: Spronk, S.I.

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III. CHILDREN'S RIGHT TO HEALTH IN THE RECOMMENDATIONS OF THE COMMITTEE ON THE RIGHTS OF THE CHILD IN THE CONCLUDING OBSERVATIONS ON THE COUNTRY REPORTS

3.1. INTRODUCTION

Interpreting the concept of the 'highest attainable standard of health of the child encompasses the question what basic necessities of health children are entitled to. Article 24 of the UN CRC and the General Comments of the Committee on the Rights of the Child concomitantly lay down the fundamentals of children's right to health in the children's rights domain. In this body of law, it has been identified that the highest attainable standard of health (article 24-1 CRC) must be achieved to the maximum extent of available resources (article 4 CRC). Several priorities are set, aiming to ensure the survival of (new-born) children, the prevention of disease, access to primary health care for all children and basic knowledge on children's health and nutrition.⁵⁰⁷ Based on article 44 CRC and the priorities set in article 24 CRC, State Parties have to regularly report to the Committee on the progress made in ensuring children's right to health. The Committee on the Rights of the Child (further the CRC Committee), is thereby in the position to assess the degrees of implementation of countries in ensuring children's right to health, among other rights, over time.

One approach to measure compliance of countries is to compare the performance on child health indicators between countries with a similar level of per capita income, for example by comparing the under-five-mortality rate between countries or the percentage of children under five years who are underweight. This approach is often applied by UNICEF in the annual series

⁵⁰⁷ See Convention on the Rights of the Child, Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49.

of UNICEF reports entitled ‘The Progress of Nations’.⁵⁰⁸ Another approach is to gain knowledge from historical and analytical⁵⁰⁹ reports on the status of children’s right to health. This second approach is followed in this analysis of the Concluding Observations of the CRC Committee on the Country Reports submitted to it. The reason for this approach is that the Concluding Observations contain a wealth of information about the interpretation of children’s rights by the CRC Committee, including the right to highest attainable standard of health of the child. This information is not quantitative and therefore of additional value for the annual UNICEF series, containing predominantly statistical data.

In order to gain further insight into the Committee’s interpretation of the right to the highest attainable standard of health of the child, this contribution analyses the Concluding Observations of the CRC Committee. Primarily, the possible existence of systematically recurring recommendations is identified and secondly, it is investigated whether according to the CRC Committee the different levels of human development in countries lead to different standards of health right measures.

The Concluding Observations are used as a starting point for answering the questions how the right to the highest attainable standard of health of the child as laid down in the CRC domain is explained for four groups of countries selected on the basis of their size and level of human development and whether these standards lead to a similar or different system of prioritization of health measures, reflecting the notion of article 4 CRC that States must progressively achieve the highest attainable standard of health in line with the maximum extent of available resources. It is assumed that countries with different levels of human development are in different phases of ensuring children’s right to health. It is further assumed that this is reflected in the Concluding Observations of the CRC Committee with regard to the right to health of the child.

The UN Human Development Index is used to categorize countries in one of four levels of development. This index was initially developed by Amartya Sen and Mahbub ul Haq and it is considered as one of the most influential capability metrics used. Although it does not fully reflect the complete range of opportunities of the capability approach, it does show how capability related information such as longevity and literacy can be used to supplement strictly economic methods of measurement.⁵¹⁰ As such, it creates room for the use of non-economic indicators for the assessment of well-being in a country. Since children’s rights are intended

⁵⁰⁸ See for example the 2010 Edition: Progress for Children, Achieving the MDGs with equity, Number 9, September 2010, UNICEF. Accessed through: www.unicef.ca/portal/Secure/Community/502/WCM/Reports/Progress%20for%20Children.pdf.

⁵⁰⁹ Different types of analytical reports can be taken as a starting point. However, countries compared must be assessed on the basis of similar types of reports (e.g. NGO reports, legal reports). The advantage of taking the Concluding Observations of the CRC Committee as a starting point is that reports are available on almost all countries of the world.

⁵¹⁰ Sen’s Capability Approach. Internet encyclopaedia of Philosophy. Available at: www.iep.utm.edu/sen-cap/.

to primarily improve the quality of life of children and not to increase the gross domestic product of a country, this index is better suited for the comparison of recommended measures for the realization of the right to the highest attainable standard of health between countries with different levels of development.

After describing the reporting procedure of the Committee on the Rights of the Child with respect to the right to health in paragraph 2, the methodology for analysing the Concluding Observations on the Country Reports will be explained in paragraph 3, followed by the results and a discussion of these results in paragraphs 4; an explanation of the right to have access to health care as interpreted by the Committee, 5; systematically recurring recommendations on the right to have access to health and 6; different standards for the implementation of the right to the highest attainable standard of health for country groups with different levels of human development. Paragraph 7 concludes by translating the results to practical recommendations to the Committee on the Rights of the Child.

3.2. THE REPORTING PROCEDURE ON BASIC HEALTH AND WELFARE IN THE COUNTRY REPORTS

Article 44-1a CRC obliges all member States to the CRC to submit regular reports to the Committee on the Rights of the Child on the implementation of its provisions. Initially, submission must be done two years after ratification of the CRC. Thereafter, a report must be submitted every five years. These reports are consequently commented upon by the CRC Committee in its Concluding Observations on the Country Reports.

Since 2003 and in accordance with article 43 of the Convention on the Rights of the Child the CRC Committee consists of 18 independent experts chosen by the member States to the Convention on the Rights of the child for a term of four years.⁵¹¹ In order to achieve a structured reporting process, a set of guidelines has been developed and adjusted by the CRC Committee,⁵¹² in which information on relevant legislative, judicial, administrative and other information, including statistical data⁵¹³ and indicators, is requested in the

⁵¹¹ Website of the Office of the United Nations High Commissioner for Human Rights.

⁵¹² See UN Doc. CRC/C/5 of 30 October 1991 for the original version and the revised versions in UN Doc. CRC/C/58 Rev. 1 of 3 June 2005 and the latest version UN Doc. CRC/C/58 Rev. 2 of 23 November 2010. The latest Set of Reporting Guidelines replaces the previous one. See UN Doc. CRC/C/58 Rev. 2, § 5.

⁵¹³ With regard to the thematic cluster on health and well-being of children, disaggregated statistical data are required regarding a) rates of infant and under-five mortality, b) the proportion of children with low birth weight, c) the proportion of children being moderate and severe underweight, stunting and wasting, d) rate of child mortality due to suicide, e) % of households with access to safe drinking water and hygienic sanitation, f) % of 1-year olds

reports to provide the Committee with a good basis for analysis. The latest set of UN guidelines takes into account the requirements of reporting on the Optional Protocols to the Convention⁵¹⁴ and the General Comments adopted by the UN Committee on the Rights of the Child⁵¹⁵ and the harmonized guidelines on reporting to international human rights treaty bodies.⁵¹⁶ Subsequent reports must contain updated information and special references to previous periodic reports, including explanations on insufficient levels of implementation and measures taken to overcome challenges encountered.

Information on children's rights in countries is required on the categories 'factors and difficulties encountered', 'progress achieved', 'implementation priorities' and 'specific goals'. The guidelines group the different CRC articles according to content, such as (a) general measures of implementation of children's rights, (f) basic health and welfare and (h) special protection measures. Included in the cluster on general measures of implementation must be information on the efforts to bring domestic legislation into conformity with the Convention on the Rights of the Child and to adopt, implement and evaluate a comprehensive national action plan, information on the responsible government authorities for particular themes (such as health care) and the budget allocated to, for example, (primary) health care services and health personnel.⁵¹⁷

With regard to the protection and provision of health services for children, the CRC Committee specifically demands States to provide an overview of the measures taken to realize articles 6.2 (survival and development), 23 (disabled children), 24 (health and health services), 18.3 (the role of parents), 26 (social security and the availability of child care services and facilities) and 27 (standard of living and measures to ensure quality nutrition, clothing and housing to ensure the healthy development of the child) CRC.⁵¹⁸ Furthermore, information must be included on the States' efforts to address the most prevalent health challenges, including communicable and non-communicable diseases, the promotion of physical and mental health and well-being of children and to address the promotion of a healthy lifestyle of adolescents and the measures taken to prohibit

fully immunized, g) rates and main causes of maternal mortality, h) proportion of pregnant women with access to pre- and postnatal health care, i) the proportion of children born in hospital, j) proportion of personnel trained in hospital care and delivery and k) proportion of mothers giving exclusive breastfeeding. Other data required under this thematic cluster refer to disabled children, adolescent health, child victims of drug and substance abuse and children incarcerated with their parents.

⁵¹⁴ U.N. Doc. A/RES/54/263, 25 May 2000, entry into force 12 February 2002: Optional Protocol I to the Convention on the Rights of the Child on the involvement of children in armed conflict and Optional Protocol II to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography.

⁵¹⁵ General Comment 3 on HIV/AIDS, General Comment 4 on Adolescent Health and General Comment 9 on Children with Disabilities are specifically referred to in the 2010 Reporting Guidelines to be included in the Country Reports.

⁵¹⁶ U.N. Doc. HRI/GEN/2/Rev.6, 3 June 2009.

⁵¹⁷ Ibidem supra note 512, § 18–21.

⁵¹⁸ Ibidem supra note 516, § 34–36.

and eliminate harmful traditional practices and to prevent children from abusing drugs.⁵¹⁹

This list of themes that must be included in the report reflects the broad scope of article 24 CRC to both health, health care and prevention of health problems for children and their parents. By working on thematic clusters of articles, such as the cluster on basic health and welfare, the comprehensive nature of the Convention is taken into consideration.⁵²⁰ A holistic approach is applied by addressing governmental budget allocations (art. 4 CRC) in the context of the best interests of the child (art. 3 CRC) in the medical sector (art. 24 CRC).⁵²¹

In addition to the actual implementation of the rights in the CRC, States are also requested to specify the nature and extent of their cooperation with governmental and non-governmental organizations.⁵²² Prior to consideration of a State's report, the CRC Committee holds a pre-sessional working group with non-governmental stakeholders, such as NGOs, UN bodies, youth organizations and other relevant organizations.⁵²³ During this session, a list of prioritized issues is compiled for the country involved, which will be discussed during the following constructive dialogue between representatives of the State and the CRC Committee in the presence of relevant UN agencies. The CRC Committee collaborates intensively with other United Nations agencies and bodies on the implementation of the CRC as far as that falls within their particular mandates. As a final step in this evaluative process, the CRC Committee will give suggestions and recommendations in the Concluding Observations on the Country Reports at the end of the reporting process. As a follow-up, the State is expected in its subsequent report to provide detailed information on the measures taken and implemented to meet the recommendations of the CRC Committee, as well as the provision of information on new developments in the implementation of children's rights in the country.

In the Manual on Human Rights Reporting, it is elaborated that the CRC Committee emphasizes the need for detailed information on the relevant legal texts and statistical information on the status of children's rights that is disaggregated by sex, age, ethnic or national background and rural or urban environment.⁵²⁴ This information is needed to allow for the consideration of individual rights for

⁵¹⁹ U.N. Doc. HRI/GEN/2/Rev.6.

⁵²⁰ U.N. Office of the High Commissioner for Human Rights, *Manual on Human Rights Reporting Under Six Major International Human Rights Instruments*, 1997, HR/PUB/91/1 (Rev.1), p. 408. available at: www.unhcr.org/refworld/docid/428085252.html [accessed 23 February 2011].

⁵²¹ J.E. Doek, 'Children and their right to enjoy health: A brief report on the monitoring activities of the Committee on the Rights of the Child.', *Health and Human Rights* 2001, 5 (2), p. 156.

⁵²² Ibidem supra note 5, § 19-j.

⁵²³ Overview of the working methods of the Committee on the Rights of the Child. Found on the website of the Office of the United Nations High Commissioner for Human Rights: www2.ohchr.org/english/bodies/crc/workingmethods.htm.

⁵²⁴ UN Office of the High Commissioner for Human Rights, *Manual on Human Rights Reporting Under Six Major International Human Rights Instruments*, 1997, HR/PUB/91/1 (Rev.1), p. 406. available at: www.unhcr.org/refworld/docid/428085252.html.

different groups of children.⁵²⁵ It is further acknowledged that the continuing reporting process is intended to ensure the continuous attention of States to improving the respect and implementation of children's rights, as it creates the possibility to evaluate the progress in implementation of children's rights over time, thus instigating the actual realization of children's rights over time.⁵²⁶

The thematic cluster on basic health and welfare in the Concluding Observations of the CRC Committee provides additional insight into the interpretation of the right to the highest attainable standard of health by the CRC Committee.⁵²⁷ The principle of non-discrimination in article 2 CRC has been identified as central in ensuring access to health services for all groups of children.⁵²⁸ Reports must therefore specify the existing network of health services and health personnel and the distribution of health facilities over urban and rural areas and the actual access of health services to the most vulnerable and disadvantaged groups of children.⁵²⁹ Furthermore, within the thematic cluster on basic health and welfare three main areas have been prioritized: 1) the reduction of infant and child mortality and the provision of medical assistance and health care, 2) support for pregnant women and 3) the prevention of health problems, such as diseases and malnutrition, by providing families with information on healthy behaviour and survival competencies. Much attention in the area of prevention is paid to the prevention of AIDS. It is remarkable that several topics related to the prevention of health problems are categorized in the first area and not in the third; the necessity to provide information about existing programs of universal immunization, about the level of implementation of vaccination programs, and on the balance between curative and preventive health programs. It seems to be more logical to place them in the third category being focused on prevention. Other, separate topics that must be reported upon include the impact of environmental problems on children's health, the abolishment of harmful traditional practices and international cooperation in realizing the highest attainable standard of children's right to health through the support of UN agencies and other relevant organizations or in the framework of bilateral cooperation.⁵³⁰

In addition to the treaty-specific guidelines to report to the CRC Committee, the Implementation Handbook for the Convention on the Rights of the Child 'provides a detailed reference for the implementation of law, policy and practice to

⁵²⁵ Manual, p. 406.

⁵²⁶ Manual, p. 504.

⁵²⁷ Manual, pp. 454–462.

⁵²⁸ Manual, pp. 454–462.

⁵²⁹ Manual, p. 458.

⁵³⁰ Manual, p. 460.

promote and protect children's rights'.^{531,532} In addition to the articles enumerated in the treaty-specific guidelines on reporting (6.2, 18.3, 23, 24, 26 and 27) the UNICEF Implementation Handbook also qualifies the general principles of the CRC (articles 2, 3, 6 and 12) and articles 5 (parental guidance), 17 (right to information), 19 (protection from all forms of violence), 25 (right to periodic review of treatment), 28 and 29 (right to education and its aims), 32–36 (protection from various forms of exploitation) and 39 (recovery and reintegration for child victims) of particular relevance for interpreting article 24 CRC. Whereas not official, the implementation checklist is intended as a basis from which more detailed and sensitive checklists can be developed for national or local use, providing a framework to collect all relevant information for reporting.⁵³³ Whereas the Checklists provide a clear overview and a practical basis for reporting, the additional value depends on the amount of pages attributed to each subtheme in the Country Reports, on the choices made by the governmental department responsible for reporting and taking into account the indivisibility and interdependence of the different rights in the Convention on the Rights of the Child.

The inclusion of article 18–3 CRC in the cluster on health and well-being indicates that the family has a central role to play in ensuring children's health and development. It furthermore underlines that the States Parties have to provide assistance to parents in fulfilling their responsibilities in the upbringing of their children as specified in article 18. Thirdly, it appears from the Manual that there is concern for the conciliation of the role of parents as educators of their children and the role of parents as employees.⁵³⁴ The importance of the role of families in ensuring the right to the highest attainable standard of health of the child also appears from the phrasing in other articles. For example, article 26 specifies that children have the right to *benefit from* social security.⁵³⁵ The phrasing implies that children have a right to social security that is derogative to derived from their family's right. Article 27 CRC recognizes the child's right to an adequate standard of living to ensure the child's full and harmonious development, including at the physical, mental, spiritual, moral and social levels.⁵³⁶ It is identified in the Manual

⁵³¹ Implementation Handbook for the Convention on the Rights of the Child, prepared for UNICEF by Rachel Hodgkin and Peter Newell, fully revised third edition, September 2007, pp. XI–XXI. www.unicef.org/publications/files/Implementation_Handbook_for_the_Convention_on_the_Rights_of_the_Child.pdf.

⁵³² Each chapter discusses a separate CRC article in view of the collected interpretations of the CRC Committee in its General Comments and Concluding Observations on the Country Reports and in relation to other key UN treaties and policy documents. Each chapter is furthermore concluded with a non-official implementation checklist, being divided in general measures of implementation and specific issues in implementing article 24 CRC (and other articles).

⁵³³ Ibidem supra note 531, p. XIX.

⁵³⁴ Manual, p. 454.

⁵³⁵ Manual, p. 461.

⁵³⁶ Manual, p. 462.

on Human Rights Reporting that article 27 CRC specifically embodies the holistic nature of the CRC.⁵³⁷ Here again, the primary responsibility for providing for such a standard of living is attributed to the parents, who have a common responsibility to take care of their children on the basis of article 18 CRC. In addition to this primary role of parents, the State has the duty to provide assistance to the parents to ensure the core elements of an adequate standard of living for the child. Thus, ensuring the right to the highest attainable standard of health of the child is a shared responsibility between parents and the State. For children without a family, the State's responsibility goes even further, namely to ensuring a safe and healthy place to live for children and be cared for appropriately.

3.3. RESEARCH METHOD

In order to gain insight into the CRC Committee's interpretation of the right to the highest attainable standard of health of the child, a study into the Committee's Concluding Observations on the Country Reports of 35 countries was conducted. A selection of 35 countries was made, based on country area, population size, human development indicators and geographical spread. Based on the United Nations Human Development Index for 2010,⁵³⁸ four categories of countries were formed of 8 countries each; I. Very High Human Development, II. High Human Development, III. Medium Human Development and IV. Low Human Development. The Human Development Indices as established by the United Nations are based on the following indicators: life expectancy at birth, mean years of schooling, expected years of schooling and gross national income (GNI) per capita (PPP 2008 \$). Attributed to these four categories of human development were the countries that were ranked highest on population size in 2010⁵³⁹ and with a maximum of three countries per continent. To all categories, one small country (less than 10 million inhabitants) in a post-conflict situation was attributed, so that the groups remained comparable, while taking into account another range of countries that would otherwise remain completely out of sight.⁵⁴⁰

Countries were excluded when no Concluding Observations of the CRC Committee or data on human development indicators were available, as was the case for the United States of America, Afghanistan, Iraq and North-Korea (HDI). Of the countries analysed, all available Concluding Observations on the Country Reports, approximately 2–4 reports per country, were taken into consideration for the interpretations of and recommendations on the right to the highest attainable standard of health of the child in that particular country.

⁵³⁷ Manual, p. 462.

⁵³⁸ United Nations Human Development Index: <http://hdr.undp.org/en/statistics/>.

⁵³⁹ World Atlas: www.worldatlas.com/aatlas/populations/ctypopls.htm.

⁵⁴⁰ Notwithstanding relatively high levels of human development in countries, the existence of armed conflicts seriously affects the performance on the implementation of children's rights.

In Table 1, an overview is provided of the selected countries per category. Remarkably absent in the selection is the USA (ranked 3 on population size and 4 on developmental level), as this country has not ratified the CRC. Therefore, no Concluding Observations of the CRC Committee were available. It is also remarkable to see that the first category contains no African or Southern-American countries. The reason for this is that no countries in these continents were qualified as very high developed under the United Nations Human Development Indices. On the other hand, no European, North-American and very few Asian and Southern-American countries were qualified as low developed, being reflected in the high proportion of African countries in that category. The Netherlands, Lebanon and Cuba were separately considered, as they could not be included in the selection on the basis of the selection criteria, though there was another interest in researching these countries: the Netherlands is the homeland of the author, Lebanon is interesting given its mixed population on the basis of socio-economic, cultural and religious indicators and Cuba is particularly interesting as it is ranked medium on the general list of developmental levels, though general health indicators (e.g. life expectancy at birth) are comparable to those in countries qualified as showing very high human development.⁵⁴¹ The health indicators in Cuba are thus remarkably high compared to those of countries with similar level of human development.

Table 1. Selection of countries by population size per category of human development (HD) in 2010

I. Very High HD	II. High HD	III. Medium HD	IV. Low HD
10. Japan (11)	5. Brazil (73)	1. China (89)	7. Bangladesh (129)
14. Germany (10)	9. Russia (65)	2. India (119)	8. Nigeria (42)
20. France (14)	11. Mexico (56)	4. Indonesia (108)	19. DR Congo (68)
22. United Kingdom (26)	17. Iran (70)	16. Egypt (101)	24. Myanmar (32)
26. South Korea (12)	18. Turkey (83)	25. South Africa (110)	33. Sudan (54)
36. Canada (8)	29. Colombia (79)	56. Sri Lanka (91)	37. Uganda (43)
52. Australia (2)	35. Algeria (84)	66. Guatemala (16)	82. Haiti (45)
95. Israel (15)	123. Bosnia (68)	125. Moldova (99)	126. Liberia (62)

⁵⁴¹ See United Nations Human Development Index: <http://hdr.undp.org/en/countries/profiles/CUB.html>.

Table 2. Additional selection of countries based on an ad hoc variety of characteristics

I. Very High HD	II. High HD	III. Medium HD	IV. Low HD
60. The Netherlands (7)	Lebanon (n.a.)	74. Cuba (n.a.)	

Legenda for tables 1 and 2:

- a. The numbers before the country names refer to the ranking on population size for the year 2010.
 b. The numbers behind the country names refer to developmental level as found in the ranking of the UN Human Development Indices for 2010.

The Concluding Observations on the Country Reports were particularly analysed for recommendations relating to children's right to the highest attainable standard of health. Focus was placed on measures to ensure primary health care, as this level of health care should be present as a very minimum standard in countries with all different levels of human development (article 24-b CRC). Also, a General Comment further elaborating the right to health of the child had not been issued yet.⁵⁴² Primarily, the data were analyzed for the possible existence of systematically recurring recommendations in the Concluding Observations of the Country Reports related to children's access to primary health care. From this information, the question was answered how the standard of children's right to the highest attainable standard of health as laid down in article 24-b CRC is explained by the Committee on the Rights of the Child as evidenced by the Concluding Observations of the selected Country Reports. In doing so, focus was placed on recommendations related to the right to the highest attainable standard of health of children under 5, as this indicator constitutes one of the most important indicators to assess the degree to which the right to health of children is prioritized within a country.⁵⁴³ This selection resulted in a limited consideration of the paragraphs on adolescent health, namely only as far issues were relevant for the realization of the right to the highest attainable standard of health of young children's health, as is the case with teenage pregnancies and mother-to-child transmission of HIV/AIDS.

We also investigated whether the different levels of human development lead to different standards of health right measures on the basis of article 24 CRC. Given the questions identified, the results were grouped in the following categories, elaborated in the following paragraphs:

⁵⁴² In December 2011, a call for submissions was issued by the International Federation of Health and Human Rights Organisations to prepare for a General Comment on children's right to the highest attainable standard of health. Submissions were subsequently published at www2.ohchr.org/english/bodies/crc/calls/submissionsCRC_received.htm. On 17 April 2013, General Comment no. 15 on the right of the child to enjoy the highest attainable standard of health was adopted.

⁵⁴³ A. Eide & W.B. Eide, *A Commentary on the UN CRC Article 24: The right to health*, Leiden: Martinus Nijhoff Publishers 2006, p. 17.

- I. Explanation of the right of the child to have access to health in the Concluding Observations of the CRC Committee on the Country Reports (paragraph 4).
- II. Systematically recurring recommendations in the Concluding Observations related to children's right to the highest attainable standard of health (paragraph 5).
- III. Different standards for the implementation of children's right to health for country groups with different levels of human development (paragraph 6).

3.4. RESULTS I: EXPLANATION OF CHILDREN'S RIGHT TO HAVE ACCESS TO HEALTH CARE IN THE CONCLUDING OBSERVATIONS OF THE CRC COMMITTEE

3.4.1. ACCESS AS A PREREQUISITE FOR REALIZING THE HIGHEST ATTAINABLE STANDARD OF HEALTH

The Concluding Observations of the CRC Committee contain recommendations to ensure children's right to health in different paragraphs of the Reports. It must be noted that the Recommendations of the Committee are non-binding, although the almost universal ratification of the UN Convention on the Rights of the Child and the systematic prioritization of the right to health of the child in both the Concluding Observations of the Committee on the Rights of the Child and the regional treaties⁵⁴⁴ seem to lead to the existence of an *opinio iuris* that all children should at least be provided with a basic level of health care.⁵⁴⁵

In the first place, the paragraph on general principles, emphasizing children's right to non-discrimination as laid down in article 2 CRC, systematically mentions the right of all groups of children to have access to adequate and appropriate health care facilities as an example of basic services that must be ensured in implementing the CRC. The right to non-discrimination in having access to health care is further elaborated in the Concluding Observations by consequently emphasizing that particular attention must be paid to the most vulnerable groups in ensuring access to health care.

Earlier Concluding Observations on the Country Reports (1993–1997) do not mention the particular importance of guaranteeing the rights of vulnerable groups of children. In later Reports, extensive enumerations are found of

⁵⁴⁴ See the European Social Charter, the African Charter on the Rights and Welfare of the Child, the American Convention on Human Rights, the Asian Human Rights Charter and the Covenant on the Right of the Child in Islam and the Declaration of Rabat.

⁵⁴⁵ See for a more elaborate discussion on the universality of children's rights also: K. Arts, '21 Jaar VN-Verdrag voor de Rechten van het Kind: Een volwassen bijdrage aan kinderrechten in de wereld?', *Internationale Spectator* 2011, year 65, no. 6, June, p. 337.

vulnerable groups of children. In those later Reports, not only the thematic cluster on health and well-being, but also separate paragraphs on the ‘protection of children’ contain recommendations to ensure an adequate standard of living (nutrition, clothing and housing) and adequate access to health and education for vulnerable groups of children, such as street children, (former) child soldiers, refugee children and children in residential institutions.⁵⁴⁶ Whereas the central idea is that all children have the right to have access to adequate and appropriate health care, there is a relatively strong focus on ensuring access to health care for vulnerable groups of children. However, this does not mean that only vulnerable children should receive adequate health-care. In order to ensure the right to have access to adequate health care for all children, particular measures are needed for vulnerable groups of children. What these measures should be is not extensively elaborated in the Concluding Observations. Still, several indications can be discerned. These will be discussed in section 5.

3.4.2. ACCESS TO HEALTH CARE FOR VULNERABLE CHILDREN

Whereas all Concluding Observations contain the recommendation that adequate access to health care facilities for all vulnerable groups of children must be ensured, the identified groups of children differ per country. Ennew observed that the Committee does not seem to have a systematic and consistent data collection, as is exemplified by the missing of a defined terminology for different groups of vulnerable children at all.⁵⁴⁷ This finding is also found in the Concluding Observations on the Country Report on the UK mention is made of the particular needs of children living in poverty, Gypsy and Roma Travellers, refugee children living in detention centres, migrant and asylum-seeking children and gay/lesbian children.⁵⁴⁸ Australia is urged to pay particular attention to take measures to ensure the access to adequate health facilities for homeless children, children in foster care, children living in remote and rural areas, indigenous children (Aboriginals and Torres Strait Islanders), minority children (Arabs and Muslims), asylum-seeking children and children with temporary visas.⁵⁴⁹ For Canada it is acknowledged that the relatively high standard of health is not shared by all

⁵⁴⁶ See for example the Concluding Observations on Canada, CRC/C/15/Add.215, 27 October 2003, § 53 and on the United Kingdom, CRC/C/15/Add.188, 9 October 2002, § 49 and 50.

⁵⁴⁷ J. Ennew, ‘Has Research Improved the Human Rights of Children? Or have the Information Needs of the CRC Improved Data about Children?’ in: A. Invernizzi, *The Human Rights of Children*, p. 143. Ennew investigated 20 Country Reports from the period 1992–1993 and 7 Country Reports submitted in 2010.

⁵⁴⁸ See for example the Concluding Observations on Canada, CRC/C/15/Add.215, 27 October 2003, § 53; United Kingdom, CRC/C/15/Add.188, 9 October 2002, § 15.

⁵⁴⁹ Concluding Observations on Australia, CRC/C/15/Add.268, 20 October 2005, § 49, 63, 72 and 88.

children; indigenous children and rural children often remain (partially) deprived of basic services.⁵⁵⁰ Other vulnerable groups of children identified in Canada include street children, disabled children,⁵⁵¹ children in juvenile institutions, abused children, indigenous children and refugee and asylum-seeking children. In the Concluding Observations regarding Israel, only Palestinian children are particularly identified as having problems in having access to adequate health facilities.⁵⁵² Particular problems for Palestinian children in having access are related to the permanent conflict situation in which they live, resulting in road closures, curfews, mobility restrictions, destruction of infrastructure, delay of medical convoys and shortages of medical supplies, malnutrition and high prices of foods.⁵⁵³ It can be assumed however, that Palestinian children are not the only group of children in Israel requiring specific attention in having access to health care. Other vulnerable groups of children that are not explicitly mentioned by the Committee include refugee children,⁵⁵⁴ children from minority groups such as the children in the unrecognized Bedouin villages of the Negev desert in Southern Israel,^{555, 556} orphaned children, children living in rural, border or conflict affected areas,⁵⁵⁷ disabled children and more. Presumably, the fact that the Concluding Observations depend on the information provided by the governments and NGOs involved, while being considered through the lens of the Committee's members, may lead to the (partial) exclusion of children who are not brought under the attention of the Committee. For example in the Netherlands,

⁵⁵⁰ Concluding Observations on Canada, CRC/C/15/Add.215, 27 October 2003, § 34.

⁵⁵¹ Ennew notes that the Committee on the Rights of the Child puts a strong focus on the need for protection as a way to prevent disabilities in children, thereby ignoring the fact that disabilities are principally caused by congenital conditions or accidental injuries.

⁵⁵² U.N. Doc. CRC/C/15/Add.195, Concluding Observations of the Committee on the Rights of the Child on Israel, 9 October 2002, § 44 and 45.

⁵⁵³ U.N. Doc. CRC/C/15/Add.195, Concluding Observations of the Committee on the Rights of the Child on Israel, 9 October 2002, § 44.

⁵⁵⁴ In 2010, there were an estimated 1500 refugees in Israel.

⁵⁵⁵ The Report 'The Bare Minimum Health Services in the Unrecognized villages in the Negev' by the NGO Physicians for Human Rights – Israel, 7 July 2009 demonstrates that there are significant differences in available health services and personnel for Muslim and Jewish communities. Other barriers include the limited office hours and the lack of roads and public transportation, the lack of electricity for refrigerating the medical supplies, running water and sewage disposal and the language barrier between Hebrew speaking doctors and predominantly Arab speaking patients, especially affecting the health care to mothers and children. Children living in the 11 unrecognized villages have extremely high levels of illness and death. For more information see www.phr.org.il/default.asp?PageID=130&ItemID=407.

⁵⁵⁶ The NGO Physicians for Human Rights – Israel, 27 April 2011 published a report on the limited access for Israeli Bedouin women. The infant mortality rate in Muslim Bedouin villages is 11.2 per 1000 births compared to 2.7 per 1000 births in Jewish communities. For more information see www.phr.org.il/default.asp?PageID=134&ItemID=973.

⁵⁵⁷ Between January and November 2010, 294 out of 3546 application by children for medical assistance were delayed and 11 denied. For more information see: CAAC Bulletin composed by UNICEF in collaboration with a wide range of other international organizations, Children Affected by Armed Conflict, Israel and the occupied Palestinian territory, 2010 Annual Review, p. 7.

it is important to consider that the joint report of NGOs in the Netherlands (the Child Rights Collective – het Kinderrechtcollectief) does not report on problems in the implementation of children’s right to health. The predominant issues that are brought to the attention of the Committee on the Rights of the Child traditionally focus on a limited number of themes: child maltreatment and protection, protection against child trafficking and sexual abuse, juvenile justice, refugee children, children living in poverty, targeting children in development aid, participation of children, children’s rights to play and education in children’s rights.⁵⁵⁸ Not either in the yearly report on children’s rights mention is made of the implementation of children’s right to health in the Netherlands.⁵⁵⁹ However, the lack of reporting by the Dutch NGO Coalition on Children’s Rights is not completely reflected to in the Concluding Observations of the Committee on the Rights of the Child on the Netherlands, because the information provided by the Dutch government on children’s health is quite extensive.⁵⁶⁰ However, when countries do not provide complete and reliable information on the implementation of children’s right to health, it is more difficult for the Committee to make a complete report, especially in countries where NGOs are not allowed to work truly independently. The opportunity for NGOs to work independently from a State’s supervision or even interference- both with respect to their funding as to the determination of agenda setting- is an essential requirement in achieving evidence-based evaluations. In addition, if available in a country, independent monitoring of governmental activities, as well as organizations and institutions working with children such as day-care, schools, child care and health care institutions and youth prisons by the National Child Ombudsperson constitute an important channel through which children’s rights can be monitored.⁵⁶¹

In order to achieve adequate access to health care, the Committee elaborates that existing legislation may need to be adapted when it excludes certain groups

⁵⁵⁸ Report: Children’s rights in the Netherlands, The third periodic report of the Dutch NGO Coalition for Children’s Rights on the Implementation of the Convention on the Rights of the Child; Jantje Beton, The Foundation for Children’s Welfare Stamps Netherlands, UNICEF Netherlands, Save the Children Netherlands, Plan Netherlands, National Youth Council, National Association for Child and Youth Legal Advice Centres, Defence for Children International Netherlands, Netherlands Youth Institute (advice member), July 2008.

⁵⁵⁹ Jaarbericht Kinderrechten, Voorburg/Leiden 1 May 2011, see p. 6 for contents. www.ecpat.nl/images/20/1452.pdf.

⁵⁶⁰ See the Concluding Observations on the Netherlands, U.N. Doc. CRC/C/15/Add.114, 26 October 1999, § 18–20; U.N. Doc. CRC/C/15/Add.227, 26 February 2004, § 8, 33, 34, 43, 45, 47, 53; U.N. Doc. CRC/C/NLD/CO/3, 27 March 2009, § 23, 31, 48b, 50–52, 59, 60, 70.

Recommendations are made by the Committee on the provision of breastfeeding, the protection against female genital mutilation, access to medical advice and treatment without parental consent, the practice of euthanasia and the termination of life of newborn infants, infant and child mortality rates, access to basic services for unaccompanied asylum seeking children, for disabled children, universal vaccination, training for health personnel and the duty to report cases of child abuse for medical professionals.

⁵⁶¹ See the link www.crin.org/enoc/members/index.asp for an overview of the Child Ombudspersons in Europe that are members of the European Network of Ombudspersons for Children.

of children from having adequate access to health care, as is the case for Roma children in Bosnia.⁵⁶² Furthermore, adequate access to health care implies having de facto access.⁵⁶³ This notion is highlighted in the Concluding Observations on the Country Report of the Netherlands, wherein it is stated that the Report focuses too much on legislation, policies and programmes and too little on the actual enjoyment of rights.⁵⁶⁴ Also, it elaborates that affirmative action may be required to ensure access for discriminated groups of children,⁵⁶⁵ and that appropriate measures must be taken to ensure access to health care for migrant children, even if they do not have a residence permit.

Other causes for limits to access that have been identified by the Committee include physical barriers for disabled children, non-registration of refugee children, minority children and others, a lack of money for medical insurances to pay for medical care and hindered access to humanitarian convoys in cases of armed conflicts.⁵⁶⁶ Access to health services may also be hampered as a result of climatic circumstances and even natural disasters. For example, health services in remote areas in Myanmar are especially inaccessible during the rainy season, resulting in big differences in the availability of health services between rural and urban areas and consequently in higher mortality rates in those areas due to inadequate access to health services.⁵⁶⁷

Whereas the general principle of non-discrimination of children in having adequate access to health facilities is structurally emphasized in the Concluding Observations, little information is found in the Concluding Observations on the practical barriers to provide children with access to health care, notwithstanding the fact that the Committee requires individual countries to specify the practical measures taken to realize children's rights in addition to the legislative and policy measures in place. This lack of specific, practical information in the Country Reports on the particular (barriers to) implementation of children's right to health makes that many reports seem to be more identical than can be expected on the basis of the actual situation of countries. For example, identical paragraphs are included in the Concluding Observations on the Country Reports of the Netherlands (1999, § 9 and 14), Iran (2005, § 21), Lebanon (2002, § 20), Bosnia (2005, § 24) and Columbia (2000, § 31), countries of different sizes, with different levels of development, highly divergent cultures and geographic characteristics. Whereas it must be said that the Recommendations of the

⁵⁶² Bosnia, U.N. Doc. CRC/C/15/Add.260, 21 September 2005, § 47.

⁵⁶³ China, U.N. Doc., CRC/C/15/Add.56, 7 June 1996, § 2.

⁵⁶⁴ See U.N. Doc. CRC/C/15/Add.114, Concluding Observations of the Committee on the Rights of the Child on the Netherlands, 26 October 1999, § 2.

⁵⁶⁵ U.N. Doc. CRC/C/15/Add.227, 26 February 2004, § 30 and U.N. Doc. CRC/C/NLD/CO/3, 27 March 2009, § 27, both on the Netherlands.

⁵⁶⁶ See for example the Concluding Observations on Bosnia U.N. Doc. CRC/C/15/Add.260, 21 September 2005, § 26; Colombia U.N. Doc. CRC/C/COL/CO/3, 8 June 2006, § 95c; Lebanon U.N. Doc. CRC/C/LBN/CO/3, 8 June 2006, § 27.

⁵⁶⁷ Myanmar, CRC/C/15/Add.237, 30 June 2004, § 52.

Committee become more elaborate over time, especially since 2000, it is still required that Recommendations of the Committee on the Rights of the Child are further concretized and that more time bound and measurable targets are set for countries to achieve.

Partial conclusion: In all countries there are vulnerable groups of children in need of particular attention to ensure their right to have access to health care services. However, the specific groups identified differ per country, region and in some instances per period of the year. The problems identified lay both in the legislative and in the practical domain, so that ensuring children's right to have access to basic health care requires approaches on different organizational and technical levels. Countering legislative and practical instances of discrimination are key to ensuring adequate access to health care for all groups of children.

3.5. RESULTS II: SYSTEMATICALLY RECURRING RECOMMENDATIONS ON THE RIGHT OF THE CHILD TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH IN THE CONCLUDING OBSERVATIONS

Several recommendations were made by the Committee in the Concluding Observations for countries of all different human development levels. A few recommendations were only found in separate categories of countries. These recommendations are discussed in paragraphs 5.5 to 5.8.

3.5.1. LACK OF DATA IN DEVELOPING AND DEVELOPED COUNTRIES

From the analysis of the Country Reports, it appears that the Committee systematically recommends that the States' Parties should 'strengthen and centralize the mechanism to compile and analyze systematically disaggregated data on all children under 18, with special emphasis on the most vulnerable groups'.⁵⁶⁸ In line with the requirements laid down in the guidelines on reporting to the

⁵⁶⁸ See the Country Reports on Lebanon, CRC/C/LBN/CO/3, 8 June 2006, § 20; China, U.N. Doc. CRC/C/CHN/CO/2, 24 November 2005, § 22; Egypt U.N. Doc. CRC/C/15/Add.145, 21 February 2001, § 16; South-Africa, U.N. Doc. CRC/C/15/Add.122, 22 February 2000, § 14; Sri Lanka, U.N. Doc. CRC/C/15/Add.207, 2 July 2003, § 18c; Guatemala U.N. Doc. CRC/C/15/Add.154, 9 July 2001, § 16; Moldova, U.N. Doc. CRC/C/MDA/CO/3, 20 February 2009, § 19 and 20; CRC/C/SDN/CO/3-4, § 20; Uganda, U.N. Doc. CRC/C/15/Add.80, 21 October 1997, § 22.

Committee on the Rights of the Child, all Concluding Observations investigated contain paragraphs on the need to ensure systematic and disaggregated data collection on all areas covered by the Convention. Also in the discussions of the Committee itself on several particularly sensitive topics it was acknowledged that 'A common characteristic of the many recommendations formulated at the end of the discussion was the need for more collection, dissemination, awareness campaigns and access to information'.⁵⁶⁹ In order to stimulate this practice, the Committee adopted General Comment 5, specifying the information required and the way in which this information should be gathered: sufficient and reliable data, disaggregated data, data over the whole period of childhood and all areas covered by the Convention, national coordination of data collection and national distribution of the States' Reports.⁵⁷⁰ Following the identification of the need to enhance a system of disaggregated data collection, the Committee recommended that the collection of (health) data and indicators must be used as a basis to effectively formulate and evaluate policies and programmes for the implementation and monitoring of the Convention, including children's right to health.⁵⁷¹ The disaggregation will be helpful in mapping the gaps in the realization of the right to health for vulnerable groups of children. It is interesting to see that in some Concluding Observations, the recommendation was made to broaden the data collection to 'other areas than health and education, as was the case in Guatemala'.⁵⁷² This suggests that these themes were considered to be priorities in implementing children's rights in that country. Whereas information must be disaggregated, health must not be the only theme covered in the report. The holistic nature of the CRC requires an integrated approach of children's well-being.

An example of an initiative helpful to the Committee in presenting well-founded recommendations to the States is given by the former chair of CRC Committee Doek 'the establishment of an office to gather information on children with disabilities into the monitoring activities of the Committee'.⁵⁷³ The necessity to gather information taking into account the particular characteristics of different groups of vulnerable children is supported by Kasper in her statement that 'applying the tenets of the CRC requires disaggregation of national data by age, gender, rural or urban living environment and ethnic background, so that at-risk groups can be identified and equitable policies developed'.⁵⁷⁴ However,

⁵⁶⁹ J.E. Doek, 'Children and their right to enjoy health: A brief report on the monitoring activities of the Committee on the Rights of the Child.', *Health and Human Rights* 2001, 5 (2), p. 158.

⁵⁷⁰ U.N. Doc. CRC/GC/2003/5, 27 November 2003, General Comment 5 on General measures of implementation of the Convention on the Rights of the Child, § 48–50.

⁵⁷¹ *Ibidem* supra note 570.

⁵⁷² Guatemala U.N. Doc. CRC/C/15/Add.154, 9 July 2001, § 16 and 17.

⁵⁷³ J.E. Doek, 'Children and their right to enjoy health: A brief report on the monitoring activities of the Committee on the Rights of the Child.', *Health and Human Rights* 2001, 5(2), p. 159.

⁵⁷⁴ J. Kasper, 'The Relevance of U.S. Ratification of the Convention on the Rights of the Child for Child Health: A Matter of Equity and Social Justice', *Child Welfare* 2010, no. 89, Volume 5,

Ennew observes that the majority of data in the Country Reports is quantitative and often not even child-centred,⁵⁷⁵ thereby systematically neglecting the additional value of qualitative data, including the highly valuable insights that can be derived from actually talking to children and have them participate in the reporting process.⁵⁷⁶

Also in the developed countries, it has been identified by the Committee that a lack of information on the health status of all vulnerable groups of children such as children in minority groups, asylum seeking children, indigenous children and children with an illegal status, prohibited the full assessment of their health status by the Committee.⁵⁷⁷ This lack of data on particular groups of children may reflect the low prioritization of their health care needs in comparison to other groups of children, both in countries with high as in countries with low levels of development. Children's vulnerability as a group that is hardly able to participate in public debate and decision-making, presumably limits the budget allocated to realizing their right to health.⁵⁷⁸ This effect is even stronger for children that are vulnerable in several respects.

3.5.2. BUDGET ALLOCATION FOR THE IMPLEMENTATION OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS

Without any exception, all the investigated Concluding Observations of the Committee contain recommendations to ensure sufficient budget allocation to ensure equal access to basic services for all (vulnerable) groups of children in all areas and regions of a country.⁵⁷⁹ Quite remarkably, children's right to health (and children's right to education) is systematically emphasized as a priority

p. 27.

⁵⁷⁵ Ennew observes that in childhood data, the unit of analysis is often the family. Whereas the family unmistakably plays a central role in ensuring (access to) health care for the child, data should also be available of the child as a person in its own right. See the earlier discussion of the role of the parents.

⁵⁷⁶ Ennew observes that little progress has been made in the use of data between 1992 and 2010. Her criticisms are relevant, though considerable expansion in the amount of has been noted. Further disaggregation and involvement of children in data compiling will be required. J. Ennew, 'Has Research Improved the Human Rights of Children? Or have the Information Needs of the CRC Improved Data about Children?', in: A. Invernizzi, *The Human Rights of Children*, p. 143, 145, 148 and 151.

⁵⁷⁷ See the Country Reports on Japan, CRC/C/15/Add.231, 26 February 2004, § 16; Australia, CRC/C/15/Add.268, 20 October 2005, § 70; United Kingdom, CRC/C/15/Add.188, 9 October 2002, § 18; Bosnia, CRC/C/15/Add.260 21 September 2005, § 19.

⁵⁷⁸ A. Nolan, 'The child's right to health and the courts', in: *Global health and human rights*, p. 138.

⁵⁷⁹ Nigeria, U.N. Doc., CRC/C/15/Add.61, 30 October 1996, § 10.

area for allocating sufficient resources.⁵⁸⁰ This is elaborated in the Concluding Observations of the Committee, wherein emphasis is placed on the fact that all children, notwithstanding their age, gender, physical or mental condition, ethnicity, nationality, residence, minority, indigenous background or illegal status should have access to basic health services. To ensure the right to health, the available budget must be equally distributed over the different regions and (vulnerable) groups of children in a country.⁵⁸¹ Hereto, countries must develop and implement a coherent and comprehensive national plan at all levels: national, regional, federal, local and involving all vulnerable groups of children. Even in developed countries with existing health infrastructure 'a coordinated approach across all governmental departments to address the inequalities in access to health services⁵⁸² or adequate measures 'to address prevailing disparities in living standards and in the quality of services of the different Länder (regions in Germany)⁵⁸³ is highlighted. To be able to evaluate the practical implementation of this right, the consequences of processes of decentralization of health care systems must be analysed.⁵⁸⁴

In the Concluding Observations it is not only mentioned that budget allocation should be prioritized to ensure equal access to health for all groups of children, it is also emphasized that budget must be allocated to the maximum extent of available resources. This means that the total country budget may need to be revised to allocate sufficient resources to the implementation of children's right to health. For example, in the Concluding Observations on the Country Reports of Sudan it is specified that more budget should be allocated to ensuring basic services, including health and less on military expenditure.⁵⁸⁵ Also, in the time that Russia decided to reduce its military expenditure, the Committee on the Rights consequently advised to allocate the extra budget to the realization of children's rights, including the right of all children to access to basic health care services.⁵⁸⁶ In the Concluding Observations on Cuba, on the other hand, it appears that even though the level of human development is relatively low, health

⁵⁸⁰ Democratic People's Republic of Korea, U.N. Doc. CRC/C/15/Add.239, 1 July 2004, § 18; Sudan, CRC/C/15/Add.10, 18 October 1993, § 27a; DRC, U.N. Doc. CRC/C/15/Add.153, 9 July 2001, § 12 and 13; Nigeria, U.N. Doc., CRC/C/15/Add.61, 30 October 1996, § 10.

⁵⁸¹ Iran, U.N. Doc. CRC/C/15/Add.123, 28 June 2000, § 14; Russia, CRC/C/15/Add.110, 10 November 1999, § 12, 14, 17 and 22; Brazil, U.N. Doc. CRC/C/15/Add.241, 3 November 2004, § 22; Egypt, U.N. Doc. CRC/C/15/Add.145, 21 February 2001, § 32 and 40; South-Africa, U.N. Doc. CRC/C/15/Add.122, 22 February 2000, § 15; India, U.N. Doc. CRC/C/15/Add.228, 26 February 2004, § 5; Indonesia, U.N. Doc. CRC/C/15/Add.223, 28 February 2004, § 55 and 57a; Sri Lanka, U.N. Doc. CRC/C/15/Add.207, 3 July 2003, § 18a; Moldova, U.N. Doc. CRC/C/MDA/CO/3, 20 February 2009, § 18.

⁵⁸² See for example U.N. Doc. CRC/C/GBR/CO/4., 20 October 2008, Concluding Observations of the Committee on the Rights of the Child on the United Kingdom, § 55.

⁵⁸³ See for example U.N. Doc. CRC/C/GBR/CO/4., 27 November 1995, Concluding Observations of the Committee on the Rights of the Child on the Germany, § 18.

⁵⁸⁴ Russia, U.N. Doc. CRC/C/RUS/CO/3, 23 November 2005, § 9 and 10a.

⁵⁸⁵ Sudan, CRC/C/SDN/CO/3-4, 22 October 2010, § 17 and 18.

⁵⁸⁶ Russia, U.N. Doc. CRC/C/15/Add.4, 18 February 1993, § 4.

indicators (such as low infant or child mortality rates and high percentages of immunizations) can be excellent if sufficient budget is allocated to health care.⁵⁸⁷ This poses a clear example that adjusting the allocation of (limited) resources within a country can be beneficial to ensuring children's right to health.

Budget allocation is also relevant in the context of the processes of decentralization and privatization. It is explicitly stated by the Committee, that high costs in private medical institutions should not lead to the exclusion of groups of children and their families unable to pay for their medical treatments.⁵⁸⁸ The removal of health care costs as a barrier to acquiring access to health for children is also at stake in the combat of corruption in having access to social services.⁵⁸⁹ This is particularly troublesome for countries of medium and low levels of human development, wherein salaries are often insufficient to provide for an adequate standard of living, raising the vulnerability of people to fall for corruption.

In later reports (later than 2007), the Committee has provided several indications of ways to achieve sufficient allocation of resources for the establishment of quality health infrastructure for all groups of children. In the first place, specific budget lines must be defined for children in disadvantaged groups so that birth registration, IMCI (integrated management of childhood illnesses), nutrition interventions and early childhood care can be prioritized.⁵⁹⁰ These strategic budget lines must be based on the child's rights approach and include a comprehensive assessment of children's needs.⁵⁹¹ The budget lines can consequently be used to assess and improve investments and prevent disparities based on gender, ethnicity, socioeconomic conditions or geographical location. Hereto, a tracking system of the budget allocated must be established to identify the differential impact on different groups of children.⁵⁹² With respect to budget allocated to international cooperation, it has been explicitly established that this must be guaranteed in times of economic crises or emergency situations.⁵⁹³

In the second place, the Committee recommends to thoroughly investigate existing social safety programmes for children, to identify incidences of inequality and discrimination, proposes remedies and to pay close attention to the possible short and long-term effects of the existing social safety programs on children's access to health care. In establishing the selection criteria for beneficiaries of social safety programmes, discriminatory provisions must be avoided. For example, if

⁵⁸⁷ Cuba, U.N. Doc. CRC/C/15/Add.72, 18 June 1997, § 3.

⁵⁸⁸ Lebanon, U.N. Doc. CRC/C/15/Add.169, 21 March 2002, § 42.

⁵⁸⁹ Bangladesh, U.N. Doc. CRC/C/BGD/CO/4, 26 June 2009 § 22 and 23.

⁵⁹⁰ Bangladesh, U.N. Doc. CRC/C/BGD/CO/4, 26 June 2009 § 21d and e.

⁵⁹¹ Canada U.N. Doc. CRC/C/CAN/CO/3-4, 27 September 2012, § 16-17, Liberia U.N. Doc. CRC/C/LBR/CO/2-4, 18 September, § 16b-d, Egypte U.N. Doc. CRC/C/EGY/CO/3-4, 6 June 2011, § 20a-b.

⁵⁹² Liberia U.N. Doc. CRC/C/LBR/CO/2-4, 18 September, § 16d.

⁵⁹³ Algeria, U.N. Doc. CRC/C/DZA/CO/3-4, 19 September 2006, § 20; Canada U.N. Doc. CRC/C/CAN/CO/3-4, 27 September 2012, § 18-19.

birth registration is ensured for refugee children, this must be guaranteed for all different groups of children and not only to a particular subgroup.⁵⁹⁴

3.5.3. TRAINING ON CHILDREN'S RIGHTS FOR PROFESSIONALS IN THE HEALTH SECTOR

The Committee elaborates that in order to achieve a truly integrated children's rights approach in ensuring children's health, systematic education and training programs on children's rights must be undertaken for professional health personnel.⁵⁹⁵ In countries with a low level of human development, training is often completely absent.⁵⁹⁶ This education will need to emphasize the need for non-discriminatory and culturally appropriate health facilities. Furthermore, the training should address both the general principles of the CRC for implementation in the health care sector as guidelines for health professionals to identify, report and manage cases of child abuse.⁵⁹⁷ In the third place it is established that even if training on children's rights has previously been provided, additional training is required under changing circumstances, shifts of power, after a certain period of time and for specific subgroups such as disabled children.⁵⁹⁸ Training for health professionals on the principles of the CRC must therefore be systematic and ongoing⁵⁹⁹ and in order to be understandable for professionals in all regions, the training must be done in all existing languages in a country.⁶⁰⁰ Last but not least, training must not only be directed at children, parents and health professionals in the youth sector, but also at traditional community leaders involved⁶⁰¹ and at birth attendants and midwives.⁶⁰² Training on the principles of the CRC and on the specific implications of the right to health of the child is relevant for traditional healers

⁵⁹⁴ Bangladesh, U.N. Doc. CRC/C/BGD/CO/4, 26 June 2009 § 71, 72, 78 and 79b.

⁵⁹⁵ See for example: U.N. Doc. CRC/C/15/Add.268, Concluding Observations of the Committee on the Rights of the Child on Australia, 20 October 2005; U.N. Doc. CRC/C/15/Add.241, Brazil, 3 November 2004, § 25 and 26; United Kingdom, U.N. Doc. CRC/C/15/Add.34, 15 January 1995, § 26; U.N. Doc. CRC/C/15/Add.195, 9 October 2002, Israel, § 23; Sudan, CRC/C/15/Add.10, 18 October 1993, § 23b; DRC, U.N. Doc. CRC/C/COD/CO/2, 10 February 2009, § 23, 48e and 51e.

⁵⁹⁶ Sudan, U.N. Doc. CRC/C/15/Add.10, 18 October 1993, § 10.

⁵⁹⁷ See for example the Concluding Observations of the Committee on the Rights of the Child on the United Kingdom U.N. Doc. CRC/C/GBR/CO/4., 20 October 2008, § 51; Israel, U.N. Doc. CRC/C/15/Add.195, 9 October 2002, § 39e; Egypt, U.N. Doc. CRC/C/15/Add.145, 21 February 2001, § 38.

⁵⁹⁸ Algeria U.N. Doc. CRC/C/15/Add.76, 18 June 1997, § 31 and U.N. Doc. CRC/C/15/Add.269, 12 October 2005, § 161e; Federal Republic of Yugoslavia, U.N. Doc. CRC/C/15/Add.49 13 February 1996, § 25; Moldova, U.N. Doc. CRC/C/MDA/CO/3, 20 February 2009, § 51f.

⁵⁹⁹ India, U.N. Doc. CRC/C/15/Add.115, 23 February 2000, § 23.

⁶⁰⁰ China, U.N. Doc. CRC/C/CHN/CO/2, 24 November 2005, § 25c.

⁶⁰¹ South-Africa U.N. Doc. CRC/C/15/Add.122, 22 February 2000, § 16.

⁶⁰² Guatemala, U.N. Doc. CRC/C/15/Add.58, 7 June 1996, § 22; Haiti, U.N. Doc. CRC/C/15/Add.202, 18 March 2003, § 45d.

and traditional midwives, because they have an important role in ensuring and allowing adequate access for children of all (minority) groups, in preventing FGM, early marriages and other harmful traditional practices directed at children, including child maltreatment and in reporting violations of children's right to have access to adequate health care facilities.

The necessity to educate politicians, health professionals and civil society about the rights enshrined in the CRC in order to integrate its tenets in concrete policies, budget priorities, child advocacy, new approaches to children's health care and assessing future health outcome, is also promoted from the side of paediatricians.^{603, 604} Goldhagen establishes that the evolving concept of childhood and the incorporation of a broad notion of health, including economic and social dimensions of health care, should lead to a redefinition of the roles and responsibilities of paediatricians so that youth health care can become truly rights-based.^{605, 606} Ideally, this should lead to the adoption of health care practices that involve children in decisions about pain relief, medical treatments and privacy and also to the establishment of a proactive responsibility of *all* health professionals and other professionals involved with children's health and well-being to make a case for all those children who do not have access to adequate health care. In my opinion, advocating for and explicit incorporation of all identified groups of vulnerable children in the daily medical practice should be interpreted as a duty to care of every health professional working with children, realizing access for all groups of children.

In order to respond to the identified need for child rights education for professionals, the international initiative of CRED-PRO, Child Rights Education for Professionals, supported by both the CRC Committee and the Office of the High Commissioner on Human Rights has been developed to provide for systematic children's rights training for professionals aiming to facilitate the actual implementation of children's rights.⁶⁰⁷ It is acknowledged that the implementation of a rights-based approach in health care for children requires a radical shift in the attitude and role of medical health professionals.⁶⁰⁸ This Boulton

⁶⁰³ J. Kasper, 'The Relevance of U.S. Ratification of the Convention on the Rights of the Child for Child Health: A Matter of Equity and Social Justice', *Child Welfare* 2010, Number 89, Volume 5, p. 32.

⁶⁰⁴ J. Goldhagen, 'Children's rights and the United Nations Convention on the Rights of the Child', *Pediatrics* 2003, 112-(3), pp. 742-745.

⁶⁰⁵ Ibidem supra note 603.

⁶⁰⁶ A similar standpoint is promoted in another article by Goldhagen and Mercer, stating that 'Child health professionals will need to move beyond their limited roles as clinicians to conceptualise themselves as child advocates functioning in the advocacy domains of practice, community and systems development and public policy formulation.' See: Goldhagen & Mercer, 'Child Health Equity: From Theory to Reality', in: A. Invernizzi, *The Human Rights of Children*, p. 322.

⁶⁰⁷ G. Landsdown, C. Heykoop & S. Hart, *CRED-PRO Child Rights Curriculum for Health Professionals*, International Institute for Child Rights and Development 2008, p. 4.

⁶⁰⁸ Ibidem supra note 607.

Initiative was established in partnership with the University of British Columbia Department of Pediatrics, the British Columbia Children's Hospital and the International Institute on Child Rights and Development (IICRD) resulting in the Child Rights Education for Professionals initiative (CRED-PRO). It brought together key partners in child health to set up a strategy to achieve realization of children's rights in health care practices. In this initiative, potential opportunities were identified for the incorporation of a child rights framework in the medical curriculum⁶⁰⁹ providing for general recommendations and elucidating practical guidelines for achieving a child rights based approach in clinical practice.

The recommendations from the Boulton initiative are practically oriented, including the integration of child rights education in the existing training programs for medical students, so that children's rights-based health care is portrayed as an integral part of existing clinical medicine.⁶¹⁰ For example, it was found that some aspects of a child rights based approach, such as themes as refusal, informed consent, confidentiality and professional relationships with children can be integrated in the discussion of case studies of children presented with acute or chronic illnesses, requiring medico-legal, ethical and emotional considerations. In the second place, it is recommended to identify and build on synergies with other academic programs, as different academic fields compete for space in the curriculum. Particular electives can be offered to students on themes such as safe motherhood, child maltreatment, budget allocation to child health programs and communication with children and their families.⁶¹¹ A third recommendation as formulated in the conclusions of the Boulton initiative is the incorporation of child rights based working skills in the general competency frameworks of (future) doctors.

The Boulton initiative also provides for practical building blocks to evaluate medical curricula for the existence of a child (and human) rights based approach. For example, curricular elements proposed include modules on the effects of violence on children, being differentiated between domestic violence and gross health and human rights violations (e.g. torture, rape and trauma as often found in conflict situations).^{612, 613} The results of the Boulton initiative seem to provide

⁶⁰⁹ The specializations paediatrics, psychiatry and emergency medicine were taken as a starting point.

⁶¹⁰ G. Landsdown, C. Heykoop & S. Hart, *CRED-PRO Child Rights Curriculum for Health Professionals*, International Institute for Child Rights and Development 2008, p. 26.

⁶¹¹ The International Federation of Medical Student Associations is a good example of a platform in which medical students have access to newsletters, conferences, additional trainings, medical projects, international exchange projects and internships. For example, the project 'Teddy Bear Hospital' aims to reduce fear for doctors among young children by 'curing' upon their teddy bears and dolls.

⁶¹² U.N. Doc. CRC/C/GC/13, 17 February 201, General Comment No. 13 of the Committee on the rights of the Child on Article 19: The right of the child to freedom from all forms of violence.

⁶¹³ Modules include methods to recognize the different kinds of violence inflicted upon children, risk factors, possible reactions of health professionals, (local) legislation for the protection of children and the professional duty of care to address identified problems. Other basic

a useful specification of the general recommendations of the Committee on the Rights of the Child to provide training to health professionals to establish a children's rights based approach in children's health care. It will be interesting to evaluate the results of this initiative after implementation in different countries and social contexts. The requirements of children's right to health may then increasingly be realized in the daily health care for children.

3.5.4. BIRTH REGISTRATION AS A PREREQUISITE FOR SOCIAL SECURITY AND ACCESS TO HEALTH CARE

Birth registration is required to be accepted for social insurance policies and to be admitted to health care facilities. Without birth registration, children remain invisible to the authorities responsible for ensuring access to health care services, so that they can not be included in general prevention strategies, check-ups and vaccination programs. Therefore, birth registration is an essential prerequisite in ensuring children's access to health.

It is concluded from the Concluding Observations of the CRC Committee on the selected Country Reports, that the CRC Committee strongly recommends that all children receive a birth certificate immediately after birth and that this registration should be free of charge.⁶¹⁴ In situations in which (large amounts of) children have not been registered, the Committee provides several solutions to address the problem of unregistered children not having access to health care facilities. In the first place, if not yet existing, legislation must be adapted to ensure that all groups of children in all regions of a country can be registered as soon as possible after birth, including refugee children having a temporarily residence permit.⁶¹⁵

In the second place, the provision of health insurances to children should not be dependent on the employment of parents.⁶¹⁶ Neither should it be dependent

modules proposed address the assessment of the normal development of the child (gross and fine motor development, language development and personal, social and adaptive skills), while acknowledging the uniqueness of each child, history taking (relationship between the child and its parents, observation and study), communicating about medical interventions and participation in scientific trials, the potential of advocacy of paediatricians for children encountered whose rights are violated and ethical questions such as informed consent, autonomy and paternalism, confidentiality, euthanasia and the treatment of children with special needs.

⁶¹⁴ See for example Germany U.N. Doc. CRC/C/GBR/CO/Add.226, 26 February 2004, § 54e and 55e; Guatemala, U.N. Doc. CRC/C/15/Add.154, 9 July 2001, § 29; Mexico CRC/C/MEX/CO/3, 8 June 2006, § 32; Sudan 2010, CRC/C/SDN/CO/3-4, 22 October 2010, § 38; DRC. U.N. Doc. CRC/C/COD/CO/2, 10 February 2009, § 36.

⁶¹⁵ Indonesia, CRC/C/15/Add.223, 18 February 2004, § 39; Bangladesh, U.N. Doc. CRC/C/15/Add.221, 27 October 2003, § 67.

⁶¹⁶ Lebanon, U.N. Doc. CRC/C/15/Add.169, 21 March 2002, § 43b. China, U.N. Doc., CRC/C/15/Add.56, 7 June 1996, § 16.

on the issuing of visa or residence permits.⁶¹⁷ The Committee urges that even if children do not have official documentation, they should be allowed access to social services, such as health care.⁶¹⁸

Thirdly, to ensure that de facto discrimination in the issuance of birth certificates does not occur, awareness-raising campaigns may need to be conducted and existing registration systems may need to be reviewed. Because special emphasis must be placed on reaching children in all rural and remote areas of a country, the Committee urges that innovative and accessible methods must be used to ensure birth registration for all children.⁶¹⁹ For example, birth registration could be achieved by deploying mobile birth registration units⁶²⁰ and by allowing older children to be registered.⁶²¹ Also, manual birth registration systems could be replaced by national electronic systems.⁶²²

3.5.4.1. Recommendations for countries categories in groups II-IV

In the Concluding Observations on countries with lower levels of human development than category I several additional recommendations have been identified. These recommendations generally reflect the more limited budgets to ensure children's rights and an adequate standard of living in general in these countries.

3.5.5. STANDARD OF LIVING

In the Concluding Observations on countries in group II-IV of human development, the Committee has expressed its concern over the standard of living of (groups of) children affecting their health status and also their access to health care.⁶²³ In the Low Human Development countries, child poverty and inequality pose serious problems, exacerbated by rapid urbanization, resulting in increasing numbers of children living in slums and substandard housing.⁶²⁴ In countries with a high or medium level of human development, a poor standard of living is predominantly identified in particular groups of children or children living in particular areas or circumstances. In Mexico for example, children in

⁶¹⁷ Colombia, U.N. Doc. CRC/C/COL/CO/3, 8 June 2006, § 67 and 69.

⁶¹⁸ Bangladesh, U.N. Doc. CRC/C/BGD/CO/4, 26 June 2009, § 41.

⁶¹⁹ Mexico CRC/C/MEX/CO/3, 8 June 2006, § 32.

⁶²⁰ South-Africa U.N. Doc. CRC/C/15/Add.122, 22 February 2000, § 20; India, U.N. Doc. CRC/C/15/Add.115, 23 February 2000, § 37; India, U.N. Doc. CRC/C/15/Add.228, 26 February 2004, § 39; Iran, U.N. Doc. CRC/C/15/Add.254, 31 March 2005, § 38; Nigeria, U.N. Doc. CRC/C/15/Add.257, 13 April 2005, § 36 and 37.

⁶²¹ China, U.N. Doc. CRC/C/CHN/CO/2, 24 November 2005, § 43.

⁶²² Bangladesh, U.N. Doc. CRC/C/BGD/CO/4, 26 June 2009 § 40 and 41.

⁶²³ Colombia, U.N. Doc. CRC/C/15/Add.30, 15 February 1995, § 11; U.N. Doc. CRC/C/COL/CO/3, 8 June 2006, § 66.

⁶²⁴ Bangladesh, U.N. Doc. CRC/C/BGD/CO/4, 26 June 2009 § 71.

juvenile institutions are identified as suffering from very low standards of living, including limited or no access to health care facilities and personal counselling. In other countries there are great disparities in standards of living of children between different regions of the country. In Algeria for example, there is concern about the living conditions of refugee children from the Western Sahara.⁶²⁵ As a result of the low standards of living, there is limited access to health care facilities which is of great concern to the Committee. Therefore, the Committee recommends that countries guarantee the right to an adequate standard of living for all children.⁶²⁶

In countries with low levels of human development, the extremely poor living conditions of children and their families impede the holistic development of children.⁶²⁷ This is especially true for conflict affected areas, where economic and social conditions are extremely poor and access to health care services is seriously hampered.⁶²⁸ The need to ensure the basic necessities of living is therefore of paramount importance to ensure children's health and well-being.⁶²⁹ Integrated in the thematic cluster on health and well-being of the Concluding Observations on countries with medium and low human development levels, the need to combat malnutrition and to ensure safe drinking water and sanitation for all children is prioritized, in combination with issues directly related to health such as the reduction of infant, child and maternal mortality rates and the prevention and curation of childhood illnesses.⁶³⁰

The scale of the problems of low developed countries makes it difficult to prioritize approaches to improve standards of living. Both an increase in human and financial resources, for example with support of the international community, is required and a revised allocation of the available resources, for example from military expenditure to the provision of social services.⁶³¹

⁶²⁵ Algeria, U.N. Doc. CRC/C/15/Add.269, 12 October 2005, § 79.

⁶²⁶ China, U.N. Doc. CRC/C/15/Add.115, 23 February 2000, § 7,8,52 and 54.

⁶²⁷ Sudan, CRC/C/SDN/CO/3-4, 22 October 2010, § 60; Uganda, U.N. Doc. CRC/C/15/Add.80, 21 October 1997, § 5.

⁶²⁸ DRC, U.N. Doc. CRC/C/15/Add.153, 9 July 2001, § 6, 7 and 48.

⁶²⁹ DRC, U.N. Doc. CRC/C/15/Add.153, 9 July 2001, § 58 and 59.

⁶³⁰ India, U.N. Doc. CRC/C/15/Add.228, 26 February 2004, § 53; Indonesia, U.N. Doc. CRC/C/15/Add.223, 28 February 2004, § 57b; South-Africa U.N. Doc. CRC/C/15/Add.122, 22 February 2000, § 29; Sri Lanka, U.N. Doc. CRC/C/15/Add.207, 2 July 2003, § 38 and 39b; DRC, U.N. Doc. CRC/C/COD/CO/2, 10 February 2009, § 63, 64 and 67.

⁶³¹ See for a more extensive elaboration of the role of international cooperation in implementing social children's rights: M. Wabwile, 'Implementing the Social and Economic Rights of Children in Developing Countries: The Place of International Assistance and Cooperation', *International Journal of Children's Rights* 2010, Volume 18, pp. 355-385. See also: W Vandenhoele, 'Economic, Social and Cultural rights in the CRC: Is there a legal obligation to cooperate internationally for development?', *International Journal of Children's Rights* 2009, Volume 17, pp. 23-63.

3.5.6. PRIMARY HEALTH CARE INFRASTRUCTURE

In the Concluding Observations on countries with lower levels of human development (category II-IV), the importance of establishing primary health care facilities is systematically highlighted.⁶³² In the Concluding Observations on the Democratic Republic of the Congo, the improvement of health services is even mentioned as one of the top three priorities in improving children's living conditions.⁶³³ Health services in very poor countries (category IV), especially in remote and rural areas, often remain insufficient due to a lack of adequate financial and human resources.⁶³⁴ Therefore, health services and medical supplies must be distributed equally between and within regions.⁶³⁵ It is stimulated to provide free health care for children under six and pregnant and lactating women and to adopt the UNICEF strategy to Integrated Management of Childhood Illnesses (IMCI).⁶³⁶ Such a system is intended to benefit the nutritional status of children, the sanitary situation, to develop the skills of parents to prevent injuries and stimulate healthy behaviour for their children by ensuring universal access to maternal and child health-care services.⁶³⁷

In some instances, countries are recommended to reform the existing health sector to ensure access to quality primary health care for all children instead of excellent health care for a few and absent health care for the mass.⁶³⁸ Suggested is that this could be done by decentralization of the healthcare system or by using mobile clinics or by establishing clinics in schools.⁶³⁹ Also, the CRC Committee identifies that insufficient numbers of qualified health or traditional workers may result in limited access to adequate health facilities.⁶⁴⁰ To ensure sufficient numbers of adequate health workers, sufficient budget must be allocated,

⁶³² Egypt, U.N. Doc. CRC/C/15/Add.145, 21 February 2001, § 42; South Africa, U.N. Doc. CRC/C/15/Add.122, 22 February 2000, § 29; India, U.N. Doc. CRC/C/15/Add.115, 23 February 2000, § 48; Russia, U.N. Doc. CRC/C/RUS/CO/3, 23 February 2005, § 52; Sri Lanka, U.N. Doc. CRC/C/15/Add.207, 2 July 2003, § 39a; Sudan, CRC/C/SDN/CO/3-4, 22 October 2010, § 50a and 53a; DRC, U.N. Doc. CRC/C/15/Add.153, 9 July 2001, § 48 and 49.

⁶³³ DRC, U.N. Doc. CRC/C/15/Add.153, 9 July 2001, § 3.

⁶³⁴ South-Africa, U.N. Doc. CRC/C/15/Add.122, 22 February 2000, § 29; DRC, U.N. Doc. CRC/C/COD/CO/2, 10 February 2009, § 53a, d-f; Haiti, U.N. Doc. CRC/C/15/Add.202, 18 March 2003, § 45b; Liberia, U.N. Doc. CRC/C/15/Add.236, 1 July 2004, § 46 and 47.

⁶³⁵ Nigeria 1997, U.N. Doc. CRC/C/15/Add.61, 30 October 1996, § 41.

⁶³⁶ South-Africa, U.N. Doc. CRC/C/15/Add.122, 22 February 2000, § 29; India CRC/C/15/Add.115, 23 February 2000, § 49; Haiti, U.N. Doc. CRC/C/15/Add.202, 18 March 2003, § 44 and 45c; Nigeria, U.N. Doc. CRC/C/15/Add.257, 13 April 2005, § 48 and 49.

⁶³⁷ Federal Republic of Yugoslavia, U.N. Doc. CRC/C/15/Add.49 13 February 1996, § 36; Guatemala, U.N. Doc. CRC/C/15/Add.154, 9 July 2001, § 40 and 41.

⁶³⁸ Lebanon, U.N. Doc. CRC/C/LBN/CO/3, 8 June 2006, § 53; Colombia CRC/C/COL/CO/3, 8 June 2006, § 67a and 69a; Guatemala, U.N. Doc. CRC/C/15/Add.154, 9 July 2001, § 40 and 41.

⁶³⁹ Sudan, CRC/C/SDN/CO/3-4, 22 October 2010, § 50c; Guatemala, U.N. Doc. CRC/C/15/Add.154, 9 July 2001, § 40 and 41; Sudan, CRC/C/15/Add.10, 18 October 1993, § 12.

⁶⁴⁰ India, U.N. Doc. CRC/C/15/Add.115, 23 February 2000, § 48; India, U.N. Doc. CRC/C/15/Add.228, 26 February 2004, § 52 and 53; Sudan, CRC/C/SDN/CO/3-4, 22 October 2010, § 44 and 50b.

including for salaries for child health-care professionals.⁶⁴¹ In conflict situations, access should primarily be ensured by allowing national and international humanitarian missions.⁶⁴²

The CRC Committee elaborates in the Concluding Observations on countries of medium and low human development level that particular attention is required to ensure access to primary health care facilities for vulnerable groups of children,⁶⁴³ including street children,⁶⁴⁴ displaced and refugee children,⁶⁴⁵ former child soldiers⁶⁴⁶ disabled children,⁶⁴⁷ children living in rural and remote areas⁶⁴⁸ and children of minority and ethnic groups⁶⁴⁹ and children in alternative care.⁶⁵⁰ These vulnerable groups of children are often completely neglected, lacking access to all basic services and requirements for an adequate standard of living. Access to basic health care is prioritized as one of the minimal requirements that must be ensured for these children.

3.5.7. CHILDREN AFFECTED BY ARMED CONFLICT

Whereas there are no Concluding Observations available (nor Country Reports submitted) on countries in the midst of very harsh armed conflicts, such as Afghanistan and Iraq, it is acknowledged that armed conflicts have devastating effects on the access of children to health facilities. The CRC Committee emphasizes the need to ensure access to health care facilities for children in armed conflicts and for children affected by armed conflicts in the Concluding Observations of countries in (post-) conflict situations.⁶⁵¹

⁶⁴¹ Moldova 2002, § 33 and 34.

⁶⁴² India, U.N. Doc. CRC/C/15/Add.228, 26 February 2004, § 71c; Sudan, CRC/C/15/Add.10, 18 October 1993, § 60f.

⁶⁴³ Moldova 2002, § 33 and 34; Uganda 1997, § 14; Haïti, U.N. Doc. CRC/C/15/Add.202, 18 March 2003, § 13, 25, 26.

⁶⁴⁴ India 2000, § 54, 55, and 62; India 2004, § 77b; Guatemala 2001, § 55; Moldova 2002, § 48a; Moldova 2009, § 67a and 73i; Sudan 2002, § 67; Sudan 2010, § 81f; DRC, U.N. Doc. CRC/C/15/Add.153, 9 July 2001, § 71. Interestingly, no reference is made of the need to ensure access to health care for street children in the Committee's Observations on Indonesia.

⁶⁴⁵ Sri Lanka, U.N. Doc., CRC/C/15/Add.40, 21 June 1995, § 20, 24 and 38; Sudan, CRC/C/SDN/CO/3-4, 22 October 2010, § 71a; DRC 2001, § 62; DRC 2009, § 76; Uganda 1997, § 21 and 37; Liberia, U.N. Doc. CRC/C/15/Add.236, 1 July 2004, § 60.

⁶⁴⁶ DRC, U.N. Doc. CRC/C/COD/CO/2, 10 February 2009, § 72-75.

⁶⁴⁷ India 2000, § 46 and 47; India 2004, § 56, Indonesia 2004, § 53; Moldova 2009, § 51a; Sudan 1993, § 45; DRC 2001, § 51; Haïti, U.N. Doc. CRC/C/15/Add.202, 18 March 2003, § 51b.

⁶⁴⁸ Guatemala 2001, § 40 and 41.

⁶⁴⁹ Indonesia 2004, § 90; Guatemala 2001, § 40 and 41; Moldova 2002, § 49 (Roma children); Bangladesh, U.N. Doc. CRC/C/15/Add.221, 27 October 2003, § 79.

⁶⁵⁰ DRC, U.N. Doc. CRC/C/15/Add.153, 9 July 2001, § 45.

⁶⁵¹ Israel, U.N. Doc. CRC/C/15/Add.195, 9 October 2002; § 45. Bosnia, U.N. Doc. CRC/C/15/Add.260, 21 September 2005, § 5 and 17 and 43-g; Lebanon, U.N. Doc. CRC/C/15/Add.169, 21 March 2002, § 50; Sri Lanka, U.N. Doc. CRC/C/15/Add.40, 21 June 1995, § 20, 24 and 38; Colombia, U.N. Doc. CRC/C/COL/CO/3, 8 June 2006, § 94; Sudan, U.N. Doc. CRC/C/SDN/

It is acknowledged that specific challenges are identified in ensuring access to primary health care for children in conflict affected areas.⁶⁵² In Liberia for example, overwhelming challenges have been identified to rebuild the destroyed infrastructures and basic social services and to replace the vast majority of doctors, nurses and physician assistants that have left the country.⁶⁵³ Also in Colombia, primary health care infrastructure has been strongly reduced by the devastating consequences of the ongoing civil war.⁶⁵⁴

Access to health care in conflict affected areas is directly hampered by the dangers of entering the conflict zones.⁶⁵⁵ Medical professionals flee the conflict zones and humanitarian workers are denied access to patients of conflicting parties. In Sudan, humanitarian workers were directly attacked.⁶⁵⁶ Conflicting parties deliberately block vital supplies of foods and medicines. The Committee therefore strongly urges conflicting parties to maintain the humanitarian principle of distinction between combatants and civilians and to admit humanitarian convoys to civilians of all parties, to refugees and internally displaced people under all circumstances.⁶⁵⁷ This must particularly be guaranteed for discriminated groups of children affected by the conflict, such as (former) child soldiers,⁶⁵⁸ refugee children,⁶⁵⁹ street children, orphaned children⁶⁶⁰ and minority children, as denial of humanitarian assistance increases the vulnerability of these groups of children.⁶⁶¹

The Committee expresses its concern that conflict situations impact upon the availability of birth registration, thereby indirectly hampering access to health care services.⁶⁶² Last but not least, the Committee identifies that whereas conflicts increase the amount of children with mental health problems and disabilities, access to appropriate health care services is significantly reduced.⁶⁶³

Several of the most recent conflict situations have not been covered yet in Country Reports and Concluding Observations, such as the hostilities in Ivory Coast, Libya, Yemen, Syria and other Arab countries that are currently

CO/3-4, 22 October 2010, § 50, 53a and 71a; DRC, U.N. Doc. CRC/C/COD/CO/2, 10 February 2009, § 53, 67, 72-76; Liberia, U.N. Doc. CRC/C/15/Add.236, 1 July 2004, § 60.

⁶⁵² Sri Lanka, U.N. Doc. CRC/C/15/Add.207, 2 July 2003, § 39a; India, U.N. Doc. CRC/C/15/Add.228, 26 February 2004, § 57a; Sudan, CRC/C/15/Add.10, 18 October 1993, § 9.

⁶⁵³ Liberia, U.N. Doc. CRC/C/15/Add.236, 1 July 2004, § 5 and 46.

⁶⁵⁴ Colombia, U.N. Doc. CRC/C/15/Add.137, 16 October 2000, § 10.

⁶⁵⁵ Sri Lanka, U.N. Doc. CRC/C/15/Add.40, 21 June 1995, § 24.

⁶⁵⁶ Sudan, U.N. Doc. Sudan, CRC/C/SDN/CO/3-4, 22 October 2010, § 72 and 76.

⁶⁵⁷ Colombia, U.N. Doc. CRC/C/COL/CO/3, 8 June 2006, § 79c and 94.

⁶⁵⁸ Sri Lanka, U.N. Doc. CRC/C/15/Add.40, 21 June 1995, § 12; Lebanon, U.N. Doc. CRC/C/LBN/CO/3, 8 June 2006, § 69 and 70.

⁶⁵⁹ Lebanon, U.N. Doc. CRC/C/LBN/CO/3, 8 June 2006, § 27; Iran, U.N. Doc. CRC/C/15/Add.254, 31 March 2005, § 62 and 63; Colombia, U.N. Doc. CRC/C/COL/CO/3, 8 June 2006, § 79c, 80 and 81.

⁶⁶⁰ Sri Lanka, U.N. Doc. CRC/C/15/Add.40, 21 June 1995, § 24.

⁶⁶¹ Colombia, U.N. Doc. CRC/C/COL/CO/3, 8 June 2006, § 79c.

⁶⁶² Colombia, U.N. Doc. CRC/C/COL/CO/3, 8 June 2006, § 94.

⁶⁶³ Liberia, U.N. Doc. CRC/C/15/Add.236, 1 July 2004, § 44 and 45b.

occurring.⁶⁶⁴ It is to be expected that these situations have serious detrimental effects on the access of children to adequate health care services. In Libya for example, international media have reported indifferent targeting of any moving civilians, humanitarian convoys, hospitals and other facilities necessary to ensure adequate health care for all, including children.⁶⁶⁵

3.5.8. EMERGING THEMES

Since 2000, several new issues related to health have been addressed in the Concluding Observations. Among these, obesity is a problem that is identified predominantly in countries with high human development levels.⁶⁶⁶ Also, increased attention for mental health problems is recognized in countries of all levels of development.

In the most recent Concluding Observations on Country Reports several topics related to the health of infants and young children have been integrated. In the first place, the importance of providing for baby-friendly hospitals is highlighted, including the stimulation of breastfeeding from the moment of birth of the child.⁶⁶⁷ Repeatedly, the CRC Committee expresses its concern over low or decreasing numbers of children who are exclusively breastfed during the first six months of their lives.⁶⁶⁸ Therefore, States are recommended to adopt and implement legislation, so that mothers have maternity leave and opportunities at work to continue breastfeeding their children for at least six months.⁶⁶⁹ Measures required to stimulate mothers to breastfeed their children, include the implementation of awareness raising campaigns on the benefits of breastfeeding and further include the implementation of the International Code of Marketing

⁶⁶⁴ The developments in the course of the 'Arab Spring; a revolutionary wave of demonstrations and protests that has been taking place in the Middle East and North Africa since 18 December 2010'.

⁶⁶⁵ Integrated Regional Information Networks (IRIN), *Libyan Arab Jamahiriya: Aid workers call for access to the vulnerable*, 29 March 2011, available at: www.unhcr.org/refworld/docid/4d9572a8c.html [accessed 6 April 2011].

'Libya: 1 million children at risk' Wednesday 2 March 2011, Message by Save the Children UK, www.savethechildren.org.uk/en/libya-crisis.htm, 'Libya crisis' Call for help from the NGO Save the Children UK, www.savethechildren.org.uk/en/libya-crisis.htm, 'Children of the Libyan revolution', <http://nos.nl/video/223510-de-kinderen-van-de-libische-revolutie.html>; 'FLEEING LIBYA: HUNDREDS OF CHILDREN CAUGHT IN ITALY'S MIGRANT CRISIS' <http://getstopic.com/fleeing-libya-hundreds-of-children-caught-in-italys-migrant-crisis-172186.html>.

⁶⁶⁶ Mexico, U.N. Doc. CRC/C/MEX/CO/3, 8 June 2006, § 49 ; China, U.N. Doc. CRC/C/CHN/CO/2, 24 November 2005, § 62. Canada U.N. Doc. CRC/C/CAN/CO/3-4, 27 September 2012, § 63.

⁶⁶⁷ Egypt, U.N. Doc. CRC/C/EGY/CO/3-4, 6 June 2010, § 63c; Bosnia, U.N. Doc. CRC/C/BIH/CO/2-4, 19 September 2012, § 54.

⁶⁶⁸ Bosnia, U.N. Doc. CRC/C/BIH/CO/2-4, 19 September 2012, § 54d-e.

⁶⁶⁹ Canada U.N. Doc. CRC/C/CAN/CO/3-4, 27 September 2012, § 61.

of Breast-milk Substitute.⁶⁷⁰ This Code is an excellent example of the recognition of the impact the business sector has and can have on the realization or violation of the highest attainable standard of children's right to health. Therefore, the CRC Committee demands States to adopt a legislative framework to hold private companies responsible for violations of children's rights both within and outside the country, such as marketing unhealthy foods or using child labourers in the production process.⁶⁷¹ Therefore, the CRC Committee recommends that business plans must be disclosed and that child rights impact assessments must be done before trade agreements can be concluded.⁶⁷² Lastly, remedies must be done in case of violation of children's rights by the business sector.⁶⁷³

Closely related to the health of young children is the provision of sexual and reproductive health rights training and services to adolescents. Such training and services not only benefit their own health, but they also impact upon the health of their (future) children, because it helps inter alia to prevent teenage pregnancies, unsafe abortions and mother-to-child transmissions of HIV/AIDS.⁶⁷⁴

Increasingly addressed is also the impact of environmental health and natural disasters on children's health.⁶⁷⁵ To prevent the harmful effects of environmental pollution, it is recommended to facilitate the implementation of sustainable development programs.⁶⁷⁶ The role of the business sector in refraining from activities that have detrimental effects to the environment in which children live is at stake here. Also, the impact of natural disasters on children's living circumstances is considered. In the past few years, the highly devastating tsunamis in Indonesia (2005) and Japan (2011), the floods in Pakistan (2010), the cyclones Nargis in Burma (2008) and Katrina in the US (2005) and the earthquake in Haiti (2010) have completely destroyed existing health infrastructure, posing enormous challenges to the countries affected to rebuild houses, roads and medical facilities.

⁶⁷⁰ Egypt, U.N. Doc. CRC/C/EGY/CO/3-4, 6 June 2010, § 63d; U.N. Doc. CRC/C/BIH/CO/2-4, 19 September 2012, § 55d; Cuba U.N. Doc. CRC/C/CUB/CO/2, 8 June 2010, § 47; Myanmar U.N. Doc. CRC/C/MMR/CO/3-4, 19 January 2011, § 63f.

⁶⁷¹ Liberia U.N. Doc. CRC/C/LBR/CO/2-4, 18 September 2012, § 29b; U.N. Doc. CRC/C/BIH/CO/2-4, 19 September 2012, § 28; Canada U.N. Doc. CRC/C/CAN/CO/3-4, 27 September 2012, § 29a and 63-64; Myanmar U.N. Doc. CRC/C/MMR/CO/3-4, 19 January 2011, § 21-22 and 85.

⁶⁷² Liberia U.N. Doc. CRC/C/LBR/CO/2-4, 18 September 2012, § 29b; Turkey, U.N. Doc. CRC/C/TUR/CO/2-3, 15 June 2012, § 23.

⁶⁷³ Turkey, U.N. Doc. CRC/C/TUR/CO/2-3, 15 June 2012, § 23d.

⁶⁷⁴ Liberia U.N. Doc. CRC/C/LBR/CO/2-4, 18 September 2012, § 59, 64, 65, 66, 68; Myanmar U.N. Doc. CRC/C/MMR/CO/3-4, 19 January 2011, § 66-68; Algeria U.N. Doc. CRC/C/DZA/CO/3-4, 19 June 2012, § 33 and 60; Egypt U.N. Doc. CRC/C/EGY/CO/3-4, 6 June 2010, § 64-65; Cuba U.N. Doc. CRC/C/CUB/CO/2, 8 June 2010, § 45.

⁶⁷⁵ Bangladesh, U.N. Doc. CRC/C/15/Add.221, 27 October 2003, § 7; Colombia, U.N. Doc. CRC/C/COL/CO/3, 8 June 2006, § 72 and 73; India, U.N. Doc. CRC/C/15/Add.115, 23 February 2000, § 8;.

⁶⁷⁶ South-Africa, U.N. Doc. CRC/C/15/Add.122, 22 February 2000, § 30. Bosnia, U.N. Doc. CRC/C/BIH/CO/2-4, 19 September 2012, § 56.

Last but not least, the Committee has commented upon narrow interpretations of the CRC, as found in certain legalistic or Islamic interpretations⁶⁷⁷ and interpretations based on customary law and local traditional practices, discriminating between children of different groups in providing access to health care. These interpretations are found in countries with different levels of development.

3.6. RESULTS III: DIFFERENT STANDARDS FOR THE IMPLEMENTATION OF CHILDREN'S RIGHT TO HEALTH FOR COUNTRIES WITH DIFFERENT LEVELS OF HUMAN DEVELOPMENT?

3.6.1. IMPLEMENTATION OF THE RIGHT TO HEALTH OF THE CHILD IN DIFFERENT CIRCUMSTANCES AND REGIONS

From the analysis of the Concluding Observations on the Country Reports, several more or less 'universal' recommendations have been identified that are applicable in countries with different levels of human development. However, explanations on the particular ways to implement these recommendations for different countries, contexts and in different groups of people are rather casuistic. In many Concluding Observations, there is little explanation at all to be found. For example, it is elaborated that the establishment of primary health care infrastructure needs to be adapted to the specific requirements of local circumstances, such as mountainous areas, areas with much water, high or very low population density and conflict affected areas. The way in which this diversified infrastructure of primary health care should be established is not specified, neither are guidelines or possible solutions provided to identify the responsible organization or (non-) governmental institution for establishing the necessary health care facilities. The consequence is that the Concluding Observations of the CRC Committee remain a relatively weak instrument in guiding the implementation of children's rights in individual countries, especially when neither the government nor the medical professionals take ownership of the responsibility for the right to health of children, also resulting from unawareness of children's rights. Secondly, recommendation for countries as diverse as the Netherlands and Colombia are identical, which does underline the rather universal approach to countries and

⁶⁷⁷ South-Africa, U.N. Doc. CRC/C/15/Add.122, 22 February 2000, § 41; Iran, U.N. Doc. CRC/C/15/Add.123, 28 June 2000, § 2 and 6; Egypt, U.N. Doc. CRC/C/15/Add.145, 21 February 2001, § 6; India, U.N. Doc. CRC/C/15/Add.115, 23 February 2000, § 9 and 31.

places with highly diversified characteristics. Both aspects of the Concluding Observations may lead to a situation in which children remain fully or completely deprived of health care or in which no minimum standards are developed according to which the available health care must be organized, for example to treat children well and protect them against over-hospitalization⁶⁷⁸ or practices of abuse in medical institutions. This lacunae are all the more remarkable, as the implementation checklist for article 24 CRC in the UNICEF Implementation Handbook for the Convention on the Rights of the Child starts with enumerating the need to identify and coordinate the responsible departments and agencies at all levels of government (particular relevance is attributed to the departments of health, welfare, education, planning and environment) in the first and the need to identify relevant non-governmental organizations and civil society partners in the second bullet.⁶⁷⁹ Even when countries have not fulfilled their duty to identify the responsible governmental departments, the CRC Committee is in the position to suggest organizational structures, given its broader insight in the organization of health care systems in countries with different levels of development.

The recommendations of the Committee in its Concluding Observations should therefore be further translated to be relevant for specific circumstances and regions, both on the organizational level of establishing an infrastructure of primary health care facilities, as on the more practical level of guideline elaboration for the provision of health care for children and in a clear attribution of responsibilities to all actors involved, including medical professionals and policymakers. Lastly, measurable and timebound targets help to concretize and put into perspective the findings in different countries, which also allows for a more accurate assessment of progress achieved over time in the realization of the right to the highest attainable standard of health.

3.6.2. ACCESS TO HEALTH CARE FOR CHILDREN IN DEVELOPING AND DEVELOPED COUNTRIES

A second difference between the interpretation of children's right to health that can be discerned from the Concluding Observations are the prioritized (vulnerable)

⁶⁷⁸ L. Shields e.a. 'A review of the literature from developed and developing countries relating to the effects of hospitalization on children and parents', *International Council of Nurses* 2001, Number 48, p. 30.

In this literature review on the effects of hospitalization on children it was found that several factors were found to have adverse effects on the emotional trauma suffered by children when admitted to hospital: a hospital stay longer than 2 weeks; painful or traumatic illnesses or injuries; inadequate preparation for admissions; previous adverse experiences; non-presence of the parents or a high level of anxiety of the parents; and lack of training of the pediatric staff.

⁶⁷⁹ Implementation Handbook for the Convention on the Rights of the Child, prepared for UNICEF by Rachel Hodgkin and Peter Newell, fully revised third edition, September 2007, p. 376.

groups of children that are identified as being in greatest need to receive adequate health care. In countries with (very) high levels of development, attention is primarily drawn to ensuring access to health care for certain excluded groups of children, because the majority of the children are provided with adequate health care. In countries with lower levels of human development, however, attention is similarly drawn to particularly vulnerable groups of children, but it is also recognized that all children suffer from a lack of access to adequate health care services and that the establishment of adequate primary health care infrastructure must be prioritized for all children in that country. Therefore, the benchmark from which progress is measured differs for countries with lower and countries with higher levels of human development. Any progress made to improve access of (groups of) children to health care in countries with lower levels of development, can be considered as a step forward in the realization of children's right to have access to health. In countries with (very) high development levels, it can be assumed that progress made to ensure access to health care services, must at least include all groups of children.

On the basis of the provision in article 24 CRC that countries must progressively realize the highest attainable standard of health for all children, it is required that the realization of the right to health of the child gradually increases. Because access to health facilities can actually be reached, *all* children in countries with (very) high levels of human development are entitled to adequate health care. Although the minimum core content of the right to health includes the element to have access to primary health care, this is not always an achievable first step for countries with low levels of development. Therefore, it can be concluded that the highest attainable standard of health to be reached by countries, as laid down in article 24 CRC, varies according to the level of human development of countries: countries with (very) high levels of development must ensure children's right to health as an obligation of immediate result. Countries with medium or low levels of human development must show considerable improvement in ensuring access to health care for at least part of the population, for example by providing for mobile health clinics that visit areas without permanent health clinics on a regular basis. In this way, it is prevented that certain groups of children are prioritized in receiving health care, whereas other groups do not have access at all.

The human development level of countries is not the only factor determining the realization of the right to the highest attainable standard of health of the child. As identified in the recommendations on budget allocation, the percentage of the gross domestic product that is allocated to the establishment of adequate health infrastructure has a significant influence on the opportunity of children to have adequate access to health care services. Therefore, all countries should allocate *the maximum extent of available* resources to implement children's right to health, notwithstanding their level of development. Several suggestions can be made to determine the percentage of the Gross Domestic Product that should be allocated to the realisation of the right to health of the child. In the first place, the budget

allocated should at least reflect the percentage of children in a population: for countries with relatively many children, such as Iran, Brazil or India,⁶⁸⁰ the budget allocated to children's health care should be adjusted comparatively. Furthermore, an assessment of the health needs of children could provide further insight in the required resources for specific subgroups or the combat of highly prevalent diseases so that the allocated budget can be adjusted in line with the findings of that assessment. Attention must be paid to the fact that the allocated budget is spread equally over the different groups of children, so that all children will actually benefit from it. A way in which this can be achieved is by giving priority to ensuring access to primary health care for all children over costly individual treatments for just a few children. This suggestion is supported by findings of a study from Brazil on the influence of right-to-health litigation on the realisation of the right to health: it appeared that access to this type of litigation was easier accessible for more privileged members of society, resulting in worsening health inequities, as the more privileged gained access to better health care, whereas less budget remained available for the worst off.⁶⁸¹

3.6.3. PRIORITIES SET FOR DEVELOPING AND FOR DEVELOPED COUNTRIES

In the third place, there seems to be a discrepancy between a child rights based approach in developed and in developing countries. For developing countries, recommendations on the provision of health care usually focus on the most elementary level of health care, including prevention, immunization, perinatal health care, health education and the basic underlying determinants of health. These are also the elements that are most extensively elaborated in article 24 of the Convention on the Rights of the Child. In developed countries, on the other hand, important discussions concerning the right to health of the child predominantly evolve around issues such as access to age-appropriate information for children, refusal to autonomy and refusal of medical treatment, informed consent, participation in research etc. Whereas children formally have a wide range of information and participation rights, these rights predominantly come into play when basic health care needs have been met. However, this second category of issues related to children's right to health is hardly reflected in the Concluding Observations on the Country Reports. For example, for the Netherlands, mention is made of the practice of euthanasia, without giving detailed comments on its

⁶⁸⁰ See the website www.indexmundi.com/ for 2011 demographics profiles of countries in the world. The percentage of children between the age of 0–14 is 26.2% in Brazil, 29.7% in India and 24.1% in Iran as compared to 13.8% in Italy, 17% in the Netherlands, 17.3% in the United Kingdom, 20.1% in the United States and 17.6% in China.

⁶⁸¹ O. Luiz Motta Ferraz, 'The right to health in the courts of Brazil: worsening health inequities?', *Health and Human Rights* 2009, Volume 11, no. 2, pp. 33–45.

connection to children's right to health. Recent regional developments with respect to the requirements of 'child-friendly' health care have not been covered at all.⁶⁸² Therefore, it may be concluded from the analysis of the Concluding Observations that the Committee on the Rights of the Child –quite logically– prioritizes the access to adequate health care services over the participation rights of (groups of) children as long as universal access has not been achieved for all children. This position, however, does not fully take into account the actual situation that countries are responsible for *gradually improving* the level of health care and the health status of children within their country borders. For this reason, further elaboration of the progressive steps required by developed states is necessary, specifying whether priority must be given to enhancing the more elaborated health rights of children within the country borders of the developed states or to increasing the budget allocated to international development. Given the emphasis of the Committee on ensuring access to primary health care for all children in conjunction with the provisions in article 4 and article 24-4 CRC, explicitly promoting international cooperation for the realization of economic, social and cultural rights, this would be a laudable step forward in the realization of children's right to health.⁶⁸³

3.7. CONCLUSION AND RECOMMENDATIONS

In this chapter, the Concluding Observations of the CRC Committee have been used as a starting point for answering the question how the right to the highest attainable standard of health of the child as laid down in article 24 of the Convention on the Rights of the Child is interpreted by the CRC Committee for four groups of countries selected on the basis of their size and gross domestic product (GDP) and in what way these standards lead to different systems of prioritization of health measures.

3.7.1. IDENTIFIED PRIORITIES IN INTERPRETING THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

It is remarkable that for all countries, even within those with extremely low levels of development, the element of ensuring access to necessary health, including maternal and new born health and to underlying determinants of

⁶⁸² See for example the guidelines adopted by the Council of Europe on child-friendly health care, Lisbon, 21 September 2011.

⁶⁸³ See for a similar statement also Arts, K., '21 Jaar VN-Verdrag voor de Rechten van het Kind: Een volwassen bijdrage aan kinderrechten in de wereld?' in: *Internationale Spectator*, year 65, number 6, June 2011, p. 337.

health is structurally mentioned as a priority area for improving children's living conditions. The particular realization of this right is dependent upon the level of development of countries and on cultural values in interpreting this right. From the Concluding Observations of the CRC Committee on the Rights of the Child, although relatively general, several priority measures have been distinguished to ensure children's right to health. These include both direct and indirect measures.

Several recommendations are directed at all countries, namely the necessity to eliminate all forms of discrimination hampering access for all (vulnerable) groups of children to health care, the duty to ensure access to social security in order to be able to pay for health care, the provision of birth registration and residence permits to ensure visibility of all children and admittance to health facilities, the requirement of disaggregated data collection and specific allocation of available budgets to making health care facilities available and accessible and the need for establishing training for health professionals. Whereas these recommendations are rather general, the specific elaboration differs between different countries. For example in developing countries, training for health professionals must include basic knowledge on child health, the recognition of the most prevalent diseases, healthy nutrition and healthy behaviour. In addition, training on the integration of child-rights in health must be provided. In developed countries, training of doctors on basic health care has generally been achieved. The focus therefore shifts to the further elaboration of principles of participation, respect for the views and autonomy of the child and the provision of child-friendly health care in daily medical practices.

In the recommendations specifically oriented towards countries with lower levels of development, it is acknowledged that the right to health of children is seriously violated by inadequate standards of living and a deficient or even completely absent system of primary health care infrastructure. Therefore, it is recommended in situations of extreme scarcity and in even more problematic situations of violent conflicts to establish mobile health clinics to be able to reach all children, even in the most inadmissible and remote areas.

Another striking difference between countries with (very) high levels of development and countries with medium to low levels of development is the different groups of children that are most specifically identified to be in greatest need of provided with adequate access to health care. Whereas all children are entitled to the right to the highest attainable standard of health in article 24 CRC, much explicit attention is paid in the Concluding Observations to the most vulnerable groups of children. For more developed countries, this implies that most attention is paid to several particular groups of children, such as refugee children, disabled children and indigenous children. Access for children in general is, if at all, only marginally mentioned.

In countries with lower levels of development, deprivation of children of all basic necessities is often so extreme, that almost all children are vulnerable, whereas several particular groups are extremely vulnerable, such as orphans,

refugee children, HIV/AIDS infected children and children living on the street. All in all, the right of children to non-discrimination as laid down in article 2 CRC is key to realizing the highest attainable standard of health of the child.

The second focus of the recommendations made by the Committee is the mentioning of concrete measures to ensure the health of infants and young children. This is exemplified by the type of services that are prioritized: maternal, postnatal and primary health care services and also in the requirement to provide for baby-friendly hospitals. It must be clearly understood that in many countries hospitals are the first line of health care encountered for women delivering their baby. One of the key characteristics of baby-friendly hospitals is that mothers are stimulated to breastfeed their children from the very beginning and to continue doing so for at least six months. Other interventions include the supplementation of nutritional deficits (e.g. iron deficiency) and the prevention, early identification, intervention and rehabilitation for easily preventable diseases and injuries.⁶⁸⁴

3.7.2. RELATING THE CRC FRAMEWORK TO THE CONCLUDING OBSERVATIONS OF THE COMMITTEE

The right to health of the child has been extensively elaborated in article 24 CRC and the interpretative General Comments issued by the Committee on the Rights of the Child. This paragraph answers the question whether the Recommendations made by the Committee in the Concluding Observations reflect the priorities set in the legal framework on the right to health of the child as elaborated in chapter II.

Over the last decade, the legal framework on the right to health of the child in the CRC has increasingly developed towards a community-based approach in which many different actors, including the child, its parents, extended family, medical professionals and a variety of private actors such as NGOs and private companies are identified as important stakeholders, contributors or violators of the right to health of the child. The active contribution of children and their families is sought in the identification and prioritization of the key elements of the right to health. General Comment 15 to the CRC makes ample reference to the need to actively involve all stakeholders in the implementation of the right to health of the child, including an elaborated list of items on which children's input must be sought (see paragraph 5.8.2). However, the active involvement of children and their parents or other caretakers is only marginally addressed in the Concluding Observations. Furthermore, the Concluding Observations do not reflect the opinions of the relevant stakeholders on the level of realization of their

⁶⁸⁴ Baby-Friendly Hospital Initiative, WHO and UNICEF, 2009. Available at: www.who.int/nutrition/publications/infantfeeding/bfhi_trainingcourse/en/.

own rights. There is very limited inclusion of the actual level of realization of the right to health of the child in the countries assessed by the Committee and the reports suffer from a fairly high level of abstraction. Still, the need to actively seek children's input in the reporting procedure to the Committee is evident, since they are the only ones who can truly testify how they experience their own health status. Such involvement would furthermore allow for a more specified and locally adjusted monitoring practice, in which children, their parents and or caretakers acquire more influence in the fulfilment of their own right to health.

The need to define a concrete framework of reference for States on which to base their health policy is found both in General Comment 15 and in the Concluding Observations. The Committee in the Concluding Observations does give specific recommendations to be better able to perform an accurate assessment of the progress made by the State in implementing the right to health of the child. These priorities are:

- I. Establish a national plan with strategic budget lines.
- II. Identify the responsible government departments responsible for the right to health of the child.
- III. Set clear, time-bound and measurable targets.
- IV. Ensure disaggregated data collection and analysis.

General Comment 15 elaborates on these requirements by establishing that children's health must be integrated in all policies and that interaction with civil society must be sought in the development of a sustainable national plan. Furthermore, the newly adopted General Comment 15 offers a more elaborated framework for assessing the measures taken, including the specification of the different levels of health care that should be provided, the health problems that must be addressed, the health interventions that must be made and the medicines that must be provided as a minimum. Not surprisingly, these recommendations have not found their way to the Concluding Observations yet, since General Comment 15 was adopted in March 2013, after the assessment of the most recent Country Reports in January 2013.

Both article 24 CRC and General Comment 15 to the CRC clearly prioritize the need to prevent health problems. This focus on prevention is reflected most remarkably in the Concluding Observations in the discussion of several subthemes, namely the need to ensure access to the underlying determinants of health and to primary health care and the need to provide for (sexual and reproductive) health education. However, not all elements of prevention that are distinguished in General Comment 15 (combating malnutrition and easily preventable diseases, early identification & intervention, awareness of health risks through education and promoting healthy lifestyles) are visibly assessed by the Committee in its Concluding Observations.

The Concluding Observations of the Committee are directed towards States. Although several references are made of the role of other non-state actors, these references are very limited. Only in the latest Concluding Observations does the Committee point to the role of the private sector. Similarly, scarce attention is given to the role of the family in providing for examples of healthy behaviour to their children. Both article 24.2 (d and f) CRC, focusing on the need to educate families about children's health and the prevention of health problems through healthy behaviour and General Comment 15 acknowledges the need to engage all different stakeholders in the implementation process on children's right to health.

Lastly, General Comment 15 establishes that the realization of children's right to health requires a high degree of flexibility and adaptability of measures taken to the changing needs of children and the changing circumstances in which children live, grow and develop. This general requirement is sporadically reflected in concrete recommendations on the need to establish mobile clinics for children who do not have access to regular health services. However, modern issues such as urbanization and welfare diseases do call for a more elaborated response, including a multisectoral approach as well as the direct involvement of all stakeholders, including children and their families in assessing their rights and needs. The involvement of stakeholders in the reporting procedure could be beneficial for better reflecting the differing health problems that children encounter.

3.7.3. RECOMMENDATIONS TO THE CRC COMMITTEE

The actual task of the CRC Committee with respect to realizing children's right to health is threefold:

I) Assessment of the available data

In the first place, a thorough assessment of all efforts and challenges of countries to implement the right to health of the child in daily practice is required. Hereto, a well-functioning method of disaggregated data collection that is based on child-centred statistics must be established which can be used by the Committee as a basis for assessing the status of children's rights in a country. The resulting Concluding Observations should contain measurable and timebound indicators that can be used as a reference for governments to base its policy on, for measuring progress over time and between countries with similar levels of human development. Existing schemes of indicators for assessing the status of children's right to health and the budget allocated to it, deriving both from qualitative⁶⁸⁵ as

⁶⁸⁵ See for an extensive example of health indicators: G. Backman, P. Hunt a.o., 'Health systems and the right to health: an assessment of 194 countries', *The Lancet* 2008, Volume 372,

well as from quantitative studies can be used as a basis for further elaboration. Experience in State Parties with establishing schemes of indicators, for example by children's Ombudspersons, can be useful to assessing the Country Reports delivered to the CRC Committee. Furthermore, significantly more efforts must be made to stimulate State Parties to involve children in the gathering of data and the construction of reports submitted to the CRC Committee. In addition to the concretization of targets, the attribution of responsibilities to different governmental departments and other responsible actors must be clearly identified to allow for establishing accountability for the (lack of) progress achieved in the realization of the right to the highest attainable standard of health of the child.

With respect to the reporting procedure on the realization of children's right to the highest attainable standard of health, this process should at least include the involvement of children with chronic diseases and regular contacts in hospitals⁶⁸⁶ as well as healthy children on their vision and wishes on what is required in their living circumstances to be a healthy or healthier child and what aspects of health care are important to them and what changes they would like to see. In the words of the Committee: 'In many cases, only children themselves are in the position to indicate whether their rights are being fully recognized and realized.'⁶⁸⁷ To enable (sick) children to be involved in this process, interviews and other communication methods should be available within the medical facilities. Furthermore, the best interests of the child should be guiding, so that interviews are only held when the child feels well enough to communicate and not when the moment fits best into the agenda of the interviewer. Sometimes, it is required to postpone interviews after undergoing the treatment. Possibly, the communication procedure for children and their representatives as laid down in Optional Protocol III tot the CRC (see chapter 6), provides for an additional avenue to bring such issues under the attention of the CRC Committee.

II) Monitoring of budget allocated, legislative measures taken and implemented

The second task of the CRC Committee with respect to the right to the highest attainable standard of health of the child consists of the monitoring of the organizational structure of the relevant actors involved, including medical professionals, on their particular roles and responsibilities in ensuring children's right to health. All Concluding Observations analysed contain paragraphs on

pp. 2047–2085, most specifically pp. 2057 and 2058. In this article, 72 indicators are proposed for assessing the progressive realization of the right to health and for monitoring health systems. This list must be adapted to meet the specific needs of assessing *children's* right to health.

⁶⁸⁶ See for an example of research involving children in research and medical treatment the dissertation of C. Dedding, 'Delen in macht en onmacht: Kindparticipatie in de (alledaagse) diabeteszorg', University of Amsterdam, 30 September 2009.

⁶⁸⁷ U.N. Doc. CRC/GC/2003/3, General Comment 3 on HIV/AIDS and the rights of the child, 17 March 2003, § 1–3.

the necessity to train professionals working with and for children, including health professionals, on the implications of the CRC for their work activities. The challenge of translating the recommendations of the Committee to the daily medical practice in local situations is thereby partly attributed to the professionals directly working with children in the health sector. In doing this, practical problems will be encountered for which concrete, practical solutions must be sought, partially depending on the local situation and the particular context of those problems. Medical professionals, being closer to the patients, have a more realistic insight into the actual needs of sick children. As a next step, medical professionals need to give feedback to the Committee on their assessment of the practical applicability of the Committee's recommendations in individual countries and to identify barriers encountered in ensuring the right to the highest attainable standard of health of the child. This can be done directly or through mediation of medical associations, NGOs, Ombudspersons and governmental bodies.

III) Interpretation and development of the rights of the child

The third task of the Committee entails the further development and interpretation of the health related rights in the Convention. The recent adoption of General Comment 15 to the CRC on the right to the highest attainable standard of health of the child is an example of this influential function. The CRC Committee is in a central position to receive and share experiences from countries all over the world in the interpretation and implementation of the right to the highest attainable standard of health of the child. When the acquired knowledge is digested, new insights from one country may help to find solutions for realizing the different elements of children's right to health in another country. The Committee is therefore in the position to give valuable recommendations to countries on the progressive steps to be taken to realize the right to the highest attainable standard of health, for example with a view to raising the standard of the health services provided to obtain the predicate of child-friendly health care. This should at least involve insights obtained from both the legal domain and from (young) children themselves.⁶⁸⁸ The CRC Committee can also play a role in identifying ways in which more developed countries can contribute to developing the right to the highest attainable standard of health in other countries, without losing sight of the achievements made on the realization of the right to health of the child within its own borders. This includes questions over the prioritization between realizing the right to health on the domestic or on the international level as is specified in article 24.4 and article 4 CRC. Although ways to (re-)allocate budget to the health

⁶⁸⁸ Ennew quite rightly comments that the requirement to perceive children's rights (such as the highest attainable standard of health) as a positively formulated target, is more motivating for countries, so that they will feel less inclined to compile defensive reports. This can result in a more constructive basis for improvement. See *supra* note 519 p. 137.

of children in both national and international situations, it should be kept in mind that there are many more effective ways to share best practices and valuable experiences between children, parents and professionals in the realization of the right to the highest attainable standard of health, such as the sharing of knowledge and human resources with less developed countries to develop the necessary health services for children.

Given the enormous burden of the CRC Committee to evaluate the actual progress of the 194 States that have ratified the UNCRC on a large number of themes that must be progressively achieved, the requirement to assess the progress achieved in the realization of the right to the highest attainable standard of health of the child constitutes a big challenge. Close cooperation with other UN Committees, (I) NGOs, State Parties, youth organizations and other institutions is not only required in the consultation session, but also in the preparation phase of the Concluding Reports. This requires the opportunity for NGOs to work independently and report on their findings to the CRC Committee. The Committee will therefore need to criticize a State not hesitantly if it limits people and organizations in working and reporting freely on the achievements in implementing children's right to health. Individuals and private organizations must have the opportunity to safely report to the Committee (for example through safe internet connections, private meetings, Facebook etc.). On the other hand, the CRC Committee has the opportunity to identify violations of children's rights by private companies.

Although not falling within the direct mandate of the CRC Committee, it is highly recommendable for NGOs working in the field of children's rights to clearly coordinate which organization focuses on what children's rights, to prevent overlap in reporting on a limited number of rights and neglecting other rights.

Through the combination of measures, the CRC Committee should produce Concluding Observations that contain measurable and time bound targets in its recommendations that can be used as practical tools for countries and medical or children's rights organizations to clearly determine who is responsible for realizing the separate elements of the right to health of the child and through what stepwise and progressive plan this can be achieved. In such a way the right to health as laid down in the UNCRC can be further developed and translated for implementation in the daily lives of children.

Lastly, given the limited possibility of the Committee to hold States accountable for complying with the CRC, it should stimulate the incorporation of the provisions of the CRC in regional treaties and in national legislation to ensure that any violations of children's right to health can be brought before the existing regional or national courts. In the future, the communications procedure for children before the CRC is expected to become a valuable additional tool for holding States accountable for their achievements in the realization of children's right to health.

