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

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VI. REALIZING THE RIGHT TO HEALTH OF THE CHILD

6.1. INTRODUCTION

The question in this chapter is how and by whom the right to health of the child can be realized in practice and how the process of realization influences upon the interpretation of the right to the highest attainable standard of health of the child.

Whereas the children's right to health has been laid down in numerous international and regional treaties, the realization of this right is largely dependent on the modes of enforcement that have been established.⁹⁸⁴ For example, the realization or 'home-coming' of human rights,⁹⁸⁵ requires the necessary translation of human rights principles into national law systems, more specifically in the legal response to violations of children's right to health in domestic cases. Secondly, the realization of children's right to health requires translation of its key constituent elements to non-legal work fields, such as the medical and child protection sectors, school systems, the housing sector, the activities of private companies that impact upon children's health^{986, 987, 988} and many other stakeholders. The 'hard' or normative rules of children's right to health have to be translated into solid policies which ultimately lead to a comprehensive health system that is rooted in the children's rights framework and to the application of soft or child-sensitive skills of (medical) professionals working with children.

⁹⁸⁴ U.N. Doc. CRC/GC/2003/5, 27 November 2003. General Comment 5 to the Convention on the Rights of the Child on General Measures of Implementation defines implementation as 'the process whereby States parties take action to ensure the realization of all rights in the Convention for all children in their jurisdiction.'

⁹⁸⁵ B. Oomen, Inaugural lecture, Utrecht University chair in the 'Sociology of Human Rights', *Small places: the home-coming of human rights*, delivered at Utrecht University Roosevelt Academy in Middelburg, the Netherlands on 2 December 2011.

⁹⁸⁶ See U.N. Doc. CRC/C/GC/16, 17 April 2013 General Comment 16 on State obligations regarding the impact of the business sector on children's rights.

⁹⁸⁷ For the UN Guiding Principles on Business and Human Rights see: www.crin.org/docs/FileManager/ruggie_guiding_principles_21-mar_2011_1.pdf. For an interpretative guide of Guiding Principles by the Office of the High Commissioner of Human Rights see: www.ohchr.org/Documents/Issues/Business/RtRInterpretativeGuide.pdf.

⁹⁸⁸ GlaxoSmithKline, the biggest pharmaceutical company, in 2012 settled charges for 3 billion dollars in the United States for illegal marketing of dangerous antidepressant drugs to children that made them suicidal and that had not been approved by safety regulators. See: www.independent.co.uk/news/business/news/glaxosmithkline-pays-3bn-for-illegally-marketing-depression-drug-7904555.html. Website last accessed on 9 July 2014.

This contribution discusses the possible modes of enforcement of the right to health of the child. Paragraph 6.2 locates the right to the highest attainable standard of health of the child in the social reality in which children live. It discusses recent interdisciplinary approaches to the realization of children's rights, more particularly of the right to health of the child. Paragraph 6.3 discusses the obligations of the state in realizing the right to the highest attainable standard of health of the child. It does so by focusing on the concepts of 'available resources' and 'all appropriate measures' as specified in article 4 CRC and by looking at the implementation of the right to health in Dutch domestic cases. The possibilities of implementing the right to health of the child depend on the justiciability of social rights.^{989, 990} The question will be discussed whether these entitlements of children to the right to health amount to States' obligations of effort or of result. Paragraph 6.4 will identify non-state actors that (can) have an impact on the realization of the right to health of the child. It addresses the way in which non-state actors can be held responsible for (non-)interfering with the right to health of the child. In paragraph 6.5, the obligations of States for international cooperation in realizing the right to health of children his discussed. As a measure of last resort, the additional value of the newly adopted Optional Protocol to the Convention on the Rights of the Child on a Communications Procedure for realizing the right to the highest attainable standard of health for children is discussed in paragraph 6.5. In the concluding paragraph 6.6, the question will be discussed how the process of realization influences the interpretation of the highest attainable standard of health of the child.

6.2. CHILDREN'S RIGHT TO HEALTH AND THE SOCIAL REALITY IN WHICH CHILDREN LIVE

In 2010 a comment was published in the *Lancet* that 'despite important gains, there is a substantial gap between ideals aspired to by human rights advocates

⁹⁸⁹ The distinction between civil and political rights on the one hand and economic, social and cultural rights on the other, is reflected in the two basic international human rights law treaties: the International Covenant on Civil and Political Rights (ICCPR), which entails freedom rights such as the right to freedom of speech, the right to private property and the right to a fair trial and the International covenant on Economic, social and Cultural Rights (ICESCR). However, both the Committee on Economic, Social and Cultural Rights and the Committee on the Rights of the Child acknowledge that both sets of rights are indivisible and interdependent. See *supra* note 989 and 990.

⁹⁹⁰ See for example a discussion on enforcing social rights for children and their families Sachs, A., 'Enforcement of Economic, Social and Cultural Rights', *American University International Law Review*, Volume 22, Issue 5, 2007, pp. 673–708. Available at: http://heinonline.org/HOL/Page?handle=hein.journals/amuilr22&div=35&collection=journals&set_as_cursor=6&men_tab=srchresults.

and realities on the ground.⁹⁹¹ Amartya Sen similarly states that ‘More attention has been paid to ‘niti’ = development of rules and behavioural norms of justice, than to ‘nyaya’ = the actual social realisations of justice – the lives people lead, regardless of whether or not the institutional architecture and laws have been perfectly rendered.’⁹⁹² This process of realization thus goes beyond the strictly legal domain, as is also acknowledged by UNICEF commentators in stating that ‘Legal measures and abstract principles provide scant guidance for real-world decision making around resource allocation and programme strategies.’⁹⁹³ Legal provisions must be translated to practical tools and guidelines that are accepted and integrated in daily work practices. Thereto, the involvement of actors directly affected by the rules and procedures such as children, their families and medical professionals in the translation and implementation process of children’s rights in health systems and practices is essential to ensure acceptance and adjustment of the rights to the medical reality in which the actors operate. Sen and others speak of ‘a continual process of public engagement and rational analysis to improve the lives of the most vulnerable’.⁹⁹⁴ Hanson goes even further by introducing the concept of ‘living rights’. In his words, ‘The concept of living rights highlights that children, while making use of notions of rights, shape what these rights are – and become – in the social world. The concept challenges the idea that children’s rights are exclusively those defined by international institutions or States. We look at children’s rights as a ‘living practice’ shaped by children’s everyday concerns.’⁹⁹⁵ He speaks of a cyclical process in which children’s rights are implemented and thereby impact upon the social reality which in its turn impacts upon the ways in which children’s rights are further developed and implemented.⁹⁹⁶ This process thus integrates the social reality as a constitutive element of the development of children’s rights. Obviously, this would have the consequence that different social realities in different countries all have a different impact on the implementation of the same standardized children’s rights provisions as laid down in the Convention on the Rights of the Child. Hanson acknowledges this effect and elaborates that ‘rights are put into effect through social practices in particular contexts and time

⁹⁹¹ Comment made by Asha George, Mickey Chopra, Daniel Seymour, Paolo Marchi, working for UNICEF Health Section and Gender and Rights Unit, New York, in: *the Lancet* 2010, Volume 375, May 22, p. 1764, available at: www.sum.uio.no/english/research/doctoral-degree/doctoral-courses/2012/the-political-determinants-of-health/syllabus/a-george-et-al-hu-rt-s-of-h-workers-lancet-2010.pdf.

⁹⁹² A. Sen, *The idea of justice*, Cambridge, MA: Harvard University Press 2009.

⁹⁹³ Ibidem supra note 991.

⁹⁹⁴ Ibidem supra note 991.

⁹⁹⁵ ‘Reconceptualizing children’s rights in International Development’, edited by Karl Hanson and Olga Nieuwenhuys, 2013, Cambridge University Press, introduction.

⁹⁹⁶ Lecture by prof.dr. K. Hanson in the International Interdisciplinary Course: Human Rights for Development at the University of Antwerp, 17 August 2012. In this lecture, he referred to the book ‘Reconceptualizing children’s rights’, edited by Karl Hanson and Olga Nieuwenhuys, 2013, Cambridge University Press.

frames and that they therefore do not always carry the same meaning.^{997, 998} Also, he suggests a change of paradigm in contemplating children's rights from an abstract top down exercise to a permanent bottom-up development in children's minds and day to day activities, which is more empowering towards children. In his words, 'children engage with, interpret and give meaning to their rights: it is from this perspective that rights can be seen as living'. Therefore, Hanson claims, that children should be part of the shaping and implementation process instead of being passive recipients of rights. In approaching rights as a living reality that is influenced by the beneficiaries themselves, the interaction of children as 'interdependent agents' in their families and broader social structures must be taken into account, because, as argued by Hanson, 'Children become aware of their rights as they struggle with their families and communities to give meaning to their daily existence'.⁹⁹⁹ However, one of the main questions that rise is what the additional value is of the universally phrased articles in the CRC if their implementation is so dependent on the actual realities in which they are realized. Secondly, the influence that can be exercised on the development of children's rights by very young children is limited. As clarified in section 4, this influence is present, although not deliberately oriented towards the development and implementation of children's rights, but resulting from their direct and indirect behaviour in health care settings and at home.

Vice versa, the implementation of child rights in its turn effects on the social reality of children's lives, being defined as 'the actual daily situation of people and the way they experience the standards and their implementation'.¹⁰⁰⁰ Whereas the mutual influencing between written provisions and social realities may occur both consciously by making deliberate choices (e.g. medical professionals who actively involve children and their parents in the medical decision-making process) and unconsciously (e.g. doctors who primarily address the parents without taking into account the opinion of the child) it is important to make the actors involved aware of their potential to impact upon their own treatment.¹⁰⁰¹ Therefore, in order to ensure the lived through and conscious acceptance of children's rights,

⁹⁹⁷ K. Hanson, 'Does practice also work in theory?', in: A. Alen, H. Bosly, M. De Bie, J. Van de Lanotte (Eds.), *The UN Children's Rights Convention: Theory meets practice. Proceedings of the International Interdisciplinary Conference on Children's Rights, 18-19 May 2006, Ghent, Belgium*, Antwerp/Oxford: Intersentia 2007, p. 642.

⁹⁹⁸ Ibidem supra note 996. Hanson elaborates that 'children's rights have multiple geographical centres. Even if they are undeniably codified in international and national legal documents and further specified in international jurisprudence and development programmes, they were already alive in the minds and lived realities of children throughout the globe before that'.

⁹⁹⁹ Ibidem supra note 996.

¹⁰⁰⁰ Ibidem supra note 996, p. 638.

¹⁰⁰¹ Depending on the particular context an enormous variety of examples can be given of this distinction, such as: the deliberate in- or exclusion of groups of (marginalized) children in programs to overcome access to primary health care facilities.

the implementation process must take into account the opinions of those actors involved.¹⁰⁰²

Tobin provides for an elaborate motivation for the need to involve beneficiaries of the right to health in the implementation process. He argues that the identified elements of the right to health – availability, accessibility, acceptability and quality – remain at a fairly high level of abstraction and that States are therefore free to exercise their margin of appreciation in determining the measures that are required to meet the requirements under those four elements of the right to health.¹⁰⁰³ Tobin therefore argues that the involvement of beneficiaries themselves in determining the most appropriate measures for realizing children's right to health is required. He states that 'the process of identification, design, construction, and delivery of services to address the health needs of various groups within a state must be based on a collaborative process which engages not just health care providers and medical practitioners but also the intended beneficiaries themselves (or their advocates) to determine both the nature and form that specialist facilities should take'.¹⁰⁰⁴ This notion is also found in article 12 CRC and in General Comment 12 to the CRC, which deals with the obligation to involve children in all matters affecting them as well as in General Comment 14 to the ICESCR, noting that 'an important aspect of the right to health is the participation of the population in all health-related decision-making at the community, national and international levels'.¹⁰⁰⁵ Tobin acknowledges that 'the requirement to involve beneficiaries of health care services and the associated determinants of health will challenge dominant social and cultural expectations within elements of the interpretative community of the right to health (...) to not only consent to but also refuse medical treatment'.¹⁰⁰⁶ Therefore, notwithstanding any explicit or intrinsic refusal from medical professionals to engage children in the structuring and provision of their health care, such hesitance should not be tolerated if the outcome of children's deliberations run contrary to the dominant views of medical professionals, e.g. if children persistently refuse a medical treatment. UNICEF similarly encourages health professionals to internalize human rights, more particularly the right to health, and operationalize its elements in their daily health programming challenges.¹⁰⁰⁷ An example is when clinicians develop routine strategies for asking their juvenile patients about pain

¹⁰⁰² Ibidem supra note 995.

¹⁰⁰³ Tobin, *The right to health in international law*, Oxford Scholarship Online, January 2012, Chapter 4, p. 35.

¹⁰⁰⁴ Ibidem supra note 1002, p. 37.

¹⁰⁰⁵ General Comment No. 14 (2000) The right to the highest attainable standard of health: 11/08/2000. E/C.12/2000/4. CESCR, § 11.

¹⁰⁰⁶ Tobin, *The right to health in international law*, Oxford Scholarship Online, January 2012, Chapter 4, p. 48. In line with this statement, UNICEF emphasized that the role of power relations as a mitigating factor for recognition of children's rights must be acknowledged. Supra note 990.

¹⁰⁰⁷ Ibidem supra note 990.

and noting this in their medical records. Parents and from a certain age children themselves can contribute by noting all pain episodes in a diary.¹⁰⁰⁸ Also, the design of a model that includes children or their representatives in the decision-making process should be sensitive towards any wishes of children *not* to be involved. Some children indicate that they would rather have limited information and just surrender to the medical process they are undergoing. For example, in a recent interview with a 19-year old girl who had been treated for cancer as a child, she explained that she didn't want to hear much about her chances for survival, but preferred to maintain her hope for the future. In hindsight, she recalled that it helped her to undergo the treatment step by step.¹⁰⁰⁹ Such wishes should be clearly respected. However, caution must be taken to ensure that children are withheld medical information or treatment only if they indicate so themselves instead of being denied access to medical information or treatment by their parents or legal representatives as may be the case in strictly religious families.¹⁰¹⁰ The particular capabilities of very young children and their parents to shape the medical health care they are provided with is discussed in paragraph 6.3.4 on the opportunities of non-state actors in realizing the right to health of the child.

This section has elucidated that the involvement of the beneficiaries of health services is crucial to realizing the highest attainable standard of health of the child (e.g. in the identification, design, construction and delivery of health services). In fact and in response to subquestion (a) of this thesis, it appears that the social reality in which children live is a constitutive element of the right to health of the child. In response to subquestion (b), it appears that the social reality is part of a continuous process in which the right to health of the child is translated into daily practice and in which the daily practice in its turn influences the interpretation of the right to health of the child. As such, the right to health of the child is dependent on a particular context and time. Furthermore, it appears that children are active participants in the process of realizing their own right to health, because they consciously or unconsciously influence the way in which their own right to health is interpreted. The particular role of children and other actors involved will be further elaborated in section 4 of this chapter.

¹⁰⁰⁸ K. Herr, *Pain Assessment in the Patient Unable to Self-Report, Position Statement with Clinical Practice Recommendations*, American Society for Pain Management Nursing, July 2011, Available at: www.aspmn.org/organization/documents/UPDATED_NonverbalRevisionFinalWEB.pdf.

¹⁰⁰⁹ The interview was conducted on Wednesday 17 October 2012 in the Hague. Previously, the now 19 year old girl had been successfully treated for a large tumor in her back in the Sophia Children's Hospital in Rotterdam.

¹⁰¹⁰ See for example: S. Asser & R. Swan, 'Child Fatalities From Religion-motivated Medical Neglect', *Pediatrics* 1998, Volume 101, no. 4, April. Available at: <http://childrenshealthcare.org/wp-content/uploads/2010/07/Pediatricsarticle.pdf>.

6.3. THE ROLE OF THE STATE IN REALIZING THE RIGHT TO HEALTH OF CHILDREN

6.3.1. THE RIGHT TO HEALTH OF CHILDREN: REALIZING ECONOMIC, SOCIAL, CULTURAL RIGHTS

Although several domestic and international courts have dealt with the issue of enforcing economic, social and cultural rights, Langford and Clark comment that the legal principles developed, predominantly set the boundaries for enforcing these rights and that little is said on actual actions and inactions to be executed by the States involved.¹⁰¹¹ States therefore have a fairly broad margin of appreciation in prioritizing the measures to realize the different elements of children's right to the highest attainable standard of health. The question of enforceability of these rights is still subject to much debate, notwithstanding repeated confirmations of both the Committee on Economic, Social and Cultural Rights and the Committee on the Rights of the Child, that both categories of rights are indivisible and interdependent^{1012, 1013} and that 'economic, social and cultural rights, as well as civil and political rights, should be regarded as justiciable'.^{1014, 1015}

As laid down in article 4 CRC, two elements are central in the assessment of the level of realization of economic, social and cultural rights, such as the right to the highest attainable standard of health of the child, namely the concept of the 'available resources' of a country to realize that standard of health and the prioritization of 'appropriate measures' that can be taken to achieve that standard of health. These concepts will be further discussed in the following. Article 24 CRC furthermore speaks of the concept of 'progressive realization' in relation to international cooperation with a view to achieving progressively the full realization of the right to health of the child.

¹⁰¹¹ Langford & Clark, 'The new kid on the block: A complaints procedure for the Convention on the Rights of the Child', Working Paper, no.1, Socio-Economic Rights Programme, Norwegian Centre for Human Rights, University of Oslo, January 2010. Available at: www.jus.uio.no/smr/english/people/aca/malcolml/new-kid-on-the-block-langford-clark.pdf.

¹⁰¹² General Comment 2 to the ICESCR on International technical assistance measures, 2 February 1990, § 6.

¹⁰¹³ U.N. Doc. CRC/GC/5/2003/5, 27 November 2003, § 6. In General Comment 5, it is discussed that although the distinction in article 4 CRC implies a division between economic, social and cultural rights and civil and political rights, 'There is no simple or authoritative division of human rights in general or of Convention rights into the two categories'. It is specifically noted that 'Enjoyment of economic, social and cultural rights is inextricably intertwined with enjoyment of civil and political rights.'

¹⁰¹⁴ Ibidem supra note 1012, § 6.

¹⁰¹⁵ In the Preamble of Optional Protocol III to the Convention on the Rights of the Child, the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms is reaffirmed.

6.3.2. 'AVAILABLE RESOURCES'

Article 4 CRC elaborates that 'the maximum extent of the available resources of States Parties', must guide the measures taken to realize economic, social and cultural rights. Also, as identified in chapter III, the Committee on the Rights of the Child systematically recommends States Parties to the Convention on the Rights of the Child 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. In doing so, providing access to health is prioritized among other social rights.¹⁰¹⁶

The question therefore is how the available resources of a country for realizing the highest attainable standard of health of the child can be determined. This question can be answered by looking at the total de facto domestic budget of a country or by looking at the partial budget that has been allocated to human rights, more particularly to children's right to health.¹⁰¹⁷ The phrasing in article 4 that '*the maximum extent* of available resources' must be made available implies that all efforts must be made to increase the available budget for children's rights beyond the budget that has already been allocated to children's rights. The recommendations of the Committee on the Rights of the Child to reallocate budget from military expenditure towards children's rights, support this conclusion. Vandenhoe has indicated that the total available resources in a country are generally sufficient to realize all children's rights.¹⁰¹⁸ It is the allocation of resources that creates discrepancies between the resources available and the resources required for the realization of children's rights. Guideline 10 of the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights identifies that compliance with the obligations deriving from economic, social and cultural rights may be undertaken by most States with relative ease, and without significant resource implications.¹⁰¹⁹ It furthermore emphasizes that 'resource scarcity does not relieve States of certain minimum obligations in respect of the implementation of economic, social and cultural rights.' This provision is

¹⁰¹⁶ See also chapter 3.5.2 on the Recommendations of the Committee on the Rights of the Child on making available sufficient resources to realize children's rights.

¹⁰¹⁷ See M. Rishmawi, *A Commentary on the United Nations Convention on the Rights of the Child, Article 4: The Nature of States Parties' Obligations*, Martinus Nijhof Publishers 2006, p. 28, § 74.

¹⁰¹⁸ Lecture by W. Vandenhoe at the Tobias Asser Institute in the Hague as a keynote speaker at the Research Seminar on Economic, Social and Cultural Rights: Vehicles for Social Justice?, organized by the Working Group on Economic, Social and Cultural Rights, The Netherlands School of Human Rights Research, 21 November 2012. See also: S. Skogly, 'The requirement of Using the Maximum Available Resources' for Human Rights Realisation: A Question of Quality as well as Quantity?', *Human Rights Law Review* 2012, pp. 1–28.

¹⁰¹⁹ The Maastricht Guidelines on Violations of Economic, Social and Cultural rights were adopted on the occasion of the 10th anniversary of the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights. A group of experts met in January 1997 and unanimously agreed on the adoption of the guidelines. Available at: www1.umn.edu/humanrts/instree/Maastrichtguidelines_.html.

important because it establishes that countries are under the obligation to ensure the minimum core content (see chapter 4) of the right to health when they have signed the relevant treaties and thereby accepted the legal obligation to do so.

Approaching the question of the available resources from the side of children's needs, the available resources can be balanced against the resources required to realize the highest attainable standard of health of children in a country. The absence of 'a maximum of resources' that must be provided to ensure the highest attainable standard of health seems to suggest that 'the sky is the limit' for countries with (hypothetically) unlimited resources.¹⁰²⁰ Nolan has demonstrated that the lack of clarity of standards in implementing economic, social and cultural rights weakens the relevance of budget analyses of resources allocated to economic, social and cultural rights and the legal obligations of States.¹⁰²¹ Conclusions of budgetary practitioners consequently remain rather broad and unspecified. Additionally, Nolan establishes that this lack of clear standard constitutes a problem for advocates that intend to use the Convention on the Rights of the Child as a standard for monitoring and for holding governments accountable.¹⁰²²

Several targets can be suggested for determining a minimum level of resources that should be required. First of all, the absolute amount of resources that is necessary for ensuring the minimum core content of the right to health of children must be calculated.¹⁰²³ In calculating the exact budget required in a particular country, both the number and spread of children living in the country and in its different regions must be taken into account, as well as their basic health needs and the costs for ensuring the different components of their right to health. For example, the total health costs must be calculated for ensuring access to underlying determinants of health, access to primary health care, emergency health care and perinatal health care, an immunization campaign covering all children and the provision of health education about easily preventable diseases and family planning. This target is in line with the viewpoint of the Committee that children should be prioritized in allocating the maximum extent of available resources. Hereby, universal protection of children and access to basic but good

¹⁰²⁰ In absolute terms, all countries have limited resources, but countries such as Norway and Qatar, have so many resources at their disposal, that the concept of the 'highest attainable standard of health' can be stretched beyond actual levels within their own national borders. However, when looking at health from an international perspective, article 4 CRC indicates that States Parties have an obligation to contribute to the realization of the right to health of the child within the framework of international cooperation. It may be argued therefore, that the highest attainable standard of health can be extended to including the right to health in other, less affluent countries.

¹⁰²¹ A. Nolan, 'Economic, social and cultural rights, budgets and the CRC', in: *International Journal of Children's Rights*, Martinus Nijhoff Publishers, 2013, Volume 21, issue 3, p. 270.

¹⁰²² Ibidem supra note 1020.

¹⁰²³ See chapter V on the right to health of the child in international health and human rights for a discussion of the core content of the right to health of children.

quality social services must be guaranteed.¹⁰²⁴ Even in circumstances in which the available resources are inadequate, the Committee on the Rights of the Child reiterates that States retain the obligation to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances, notwithstanding the availability of limited resources.¹⁰²⁵ The rationale behind this is that countries have deliberately signed the Convention and that they are thereby under the obligation to do everything they can to ensure its provisions. This obligation even extends to situations as the current political or economic crisis or emergency situations.¹⁰²⁶

In order to evaluate a country's preparedness to realize the right to health of children, comparisons can be made with countries with similar levels of development.¹⁰²⁷ This can be helpful in making a distinction between a country's inability and either its unwillingness to realize children's right to health. A division as made in chapter 4 can be helpful by integrating several relevant comparative factors, including gross domestic product, income per capita, a long and healthy life, access to knowledge and a decent standard of living. In making comparisons between countries periodical reviews based on data and indicators should be enriched by including the opinions of children, parents and other caretakers in the assessment.¹⁰²⁸ In this way, any possible instances of (large-scale) manipulation of data can be better signalled. Also, it gives room for individuals to ventilate their experiences and take up their own responsibility, so that every citizen can contribute to the development of the health care system. It can contribute to increasing the awareness of all actors involved in the realization process of the right to health of the child and in enforcing their own role in reflecting upon the way in which the health care system takes into account their preferences.

As a second step, given the fact that available resources are generally limited, policy choices must be made by local, regional or national governments over the allocation of resources to different regions and to high quality (and often more expensive) health care for a limited number of individuals or either to a much bigger number of individuals that only have basic health care requirements. On the basis of article 24 CRC, prioritizing basic levels of health requirements and access to health care, read in conjunction with the core principle of non-discrimination in article 2 CRC, the choice for allocating the available resources to basic health

¹⁰²⁴ CRC Committee, 10th Anniversary Commemorative Meeting (UN Doc. CRC/C/87, 1999, Annex IV, § 291).

¹⁰²⁵ See conclusion made by: M. Rishmawi, *A Commentary on the United Nations Convention on the Rights of the Child, Article 4: The Nature of States Parties' Obligations*, Martinus Nijhof Publishers 2006, note 1066.

¹⁰²⁶ U.N. Doc. CRC/C/GC/15 on the right of the child to the enjoyment of the highest attainable standard of health, 14 March, § 74.

¹⁰²⁷ Ibidem supra note 1024, notes 1058, 1073–1074.

¹⁰²⁸ U.N. Doc. CRC/GC/2003/5, 27 November 2003, General Comment 5 to the CRC on General measures of implementation of the Convention on the Rights of the Child, 27 November 2003, § 50.

care facilities seems to be favourable. However, when judges are confronted with individual children who are in need of high quality health care, the decision becomes much more troublesome. Refusing such a child a necessary treatment, may lead to further deterioration of his health condition and potential chances for survival. It thereby jeopardizes the highest attainable standard of health of the individual child's right to health and its right to life and survival. Sachs, a retired judge in South-Africa commenting upon this dilemma from experience, even transfers the responsibility of making such difficult medical choices and 'to have ethical standards and criteria for making those determinations' to 'the medical community, in conjunction with the families and individuals concerned'.¹⁰²⁹ However, for medical professionals it can be highly awkward to refuse medical care to patients in need, especially since they have a duty to care and because they have direct encounters with the patients concerned. Also, individual medical ethical decisions will often conflict with ethical choices on a macro level.¹⁰³⁰ Therefore, a more direct relation is necessary for identifying the implications of abstract policy choices on allocation of resources for child health for the real and daily lives of individual people and the professionals who are responsible for communicating such implications in practice. Also, this close relation requires the involvement of health care providers and (representatives of) patients in deciding upon the resources allocated to children's health care to ensure practical applicability and integrating a human voice in the decision-making process. Such a link could for example be strengthened by providing people the choice to opt for different treatments under their health insurance.

In allocating budget for the realization of the right to health of the child, the question comes into play whether budget should be allocated to one overall, integrated children's rights program or whether the budget should be divided over all different governmental Departments that are involved in realizing children's rights, such as Departments of Health, Education, Justice and Family. Rishmawi draws attention to several comments made by the Committee in its Concluding Observations in which concern is expressed that the total budget allocated to

¹⁰²⁹ A. Sachs, 'Enforcement of social and economic rights', *American University International Law Review* 2007, Volume 22, Issue 5, p. 679. Available at: http://heinonline.org/HOL/Page?handle=hein.journals/amlr22&div=35&collection=journals&set_as_cursor=6&men_tab=srchresults. The example is discussed of the case of Soobramoney (1998) in which an applicant with chronic renal failure was refused access to health care by the hospital because 'it deemed that the best use of a limited amount of equipment would be to serve others that had better chances of benefiting from renal transplants'. The Court ruled that 'the selection process used was not discriminatory, except on pure health grounds and that it could not order the hospital to act otherwise'. Sachs adds that 'moving the applicant to the head of the queue would be to prejudice other people who had greater health claims, by saying that government must take money away from dealing with HIV, immunizing children, health education programs, victims of trauma, and all other diseases such as cancer and tuberculosis. We decided that, as judges, we could not interfere with the priorities in that particular area'.

¹⁰³⁰ See the discussion instigated by Motta Ferraz and elaborated in chapter 5 on balancing the costs of individual lawsuits versus costs of ensuring access to health care for a large proportion of the population.

children is insufficient or that there is no integrated budget for children.¹⁰³¹ This thus seems to point to the recommendation that States must ensure that there is a designated department that specifically looks after the interests of children. The answer to this question is also related to the question which actors and departments are responsible for taking the distinctive appropriate measures that are required to realize children's right to health. This question is discussed in the following section.

In addition to financial resources, States must ensure that sufficient human resources are made available to realizing the right to health of the child. Sufficient medical professionals must be available in all types of urban and rural health facilities and they must be adequately trained to ensure the key components of the right to health of the child.

In this section it was identified that States must allocate sufficient budget to realizing the right to health of the child. Hereto, the total costs for realizing the minimum core content of the right to health must be calculated. This includes the costs for (§ 43 and 44 GC 14 ICESCR):

1. Non-discriminatory access to essential primary health care.
2. Access to nutritious and safe food.
3. Access to shelter, housing, sanitation and safe and potable drinking water.
4. Access to essential drugs.
5. Equal distribution of health facilities, goods and services.
6. Adopt and implement a national public health strategy and plan of action.
7. Ensure reproductive, maternal and child health care.
8. Ensure immunization against the major infectious diseases.
9. Measures to prevent, treat and control epidemic and endemic diseases.
10. Provide education and access to health information.
11. Provide appropriate training for health personnel.
12. Provide international assistance and cooperation.

As a next step, the available resources must be allocated to address the most pressing health problems. This logically differs per country and region and thus depends on the particular context in which the measures are taken. Periodical reviews of both statistical data and personal assessments must be done to assess whether the measures prioritized by a country contribute to realizing the envisaged effect.

¹⁰³¹ Concluding Observations of the CRC Committee on Chile, U.N. Doc. CRC/C/15Add.173, 2002, § 14; Burkina Faso U.N. Doc. CRC/C/15 Add.193, 2002, § 16(a) and Republic of Korea, U.N. Doc. CRC/C/15 Add 197, 2003, § 13; Poland U.N. Doc. CRC/C/15 Add. 194, 2002, § 17 and Sri Lanka, U.N. Doc. CRC/C/15 Add. 207, 2003, § 17. See also: M. Rishmawi, *A Commentary on the United Nations Convention on the Rights of the Child, Article 4: The Nature of States Parties' Obligations*, Martinus Nijhoff Publishers 2006, p. 31.

The implementation of general measures to realize the right to health must be attributed to one designated governmental department. This department must coordinate the different programs in place that concomitantly contribute to realizing the right to health of the child, such as the departments that deal with education (health education), traffic safety (prevention of accidents), social affairs (provision of social protection and underlying determinants of health) and care (health care and prevention of violence).

6.3.3. APPROPRIATE MEASURES

The second question that should be answered in identifying the steps to be taken by States to realize the right to the highest attainable standard of health of the child is what measures are deemed appropriate in relation to the available resources. Article 4 of the Convention states that: 'States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention.' Article 10.4 of the Optional Protocol on a communications procedure for children furthermore states that: 'When examining communications alleging violations of economic, social or cultural rights, the Committee shall consider the reasonableness of the steps taken by the State party in accordance with article 4 of the Convention. In doing so, the Committee shall bear in mind that the State party may adopt a range of possible policy measures for the implementation of the economic, social and cultural rights in the Convention.' From these provisions, it appears that States have a broad range of possible legislative, administrative and policy measures that can be taken to ensure children's right to health and that they should pass the test of 'reasonableness'. Sachs comments that 'reasonableness is a concept that lawyers are very familiar with, although they are not familiar with the concepts of 'available resources' and 'progressive realization'.¹⁰³² Sachs argues that a minimum standard of reasonableness should include 'appropriate arrangements for people in situations of extreme scarcity – such as flood or fire victims, people who for one reason or another have got nothing at all'.¹⁰³³ A similar reference is found in paragraph 18 of General Comment 14 to the ICESCR, stating that 'even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes'.¹⁰³⁴ These vulnerable people clearly include children under five. Sachs furthermore

¹⁰³² A. Sachs, 'Enforcement of social and economic rights', *American University International Law Review* 2007, Volume 22, Issue 5, p. 679. Available at: http://heinonline.org/HOL/Page?handle=hein.journals/amuilr22&div=35&collection=journals&set_as_cursor=6&men_tab=srchresults.

¹⁰³³ Ibidem supra note 1031.

¹⁰³⁴ The same is noted by: H.S. Aasen in 'Children and the Right to Health Protection', *Health and Human Rights in Europe*, Groningen: Intersentia 2012, January, p. 236.

argues that in judging upon the possible measures that are taken by governments to ensure social rights, a legal obligation is imposed upon governments to develop a reasonable program, within a reasonable time to meet reasonable obligations.¹⁰³⁵ Three elements are thus discerned for assessing the reasonableness of measures taken to realize the right to health of the child. In the following, only the concepts of reasonable time and reasonable program will be discussed, because these obligations have been discussed in the previous chapters.

6.3.3.1. *Within a reasonable time*

The element of reasonable time is dependent on the qualification of the obligations to achieve the right to health of the child. Nolan distinguishes between obligations of immediate and obligations of progressive nature.¹⁰³⁶ The obligations to protect and to respect the right to health of the child can generally be qualified as obligations of an immediate nature. The obligation to fulfil has elements of both categories. However, as identified by Rishmawi, ‘the obligation to take steps to progressively realize economic, social and cultural rights is an immediate one’.¹⁰³⁷ States thus have an obligation of result to make progress in the realization of the right to health of the child. However, there is a broad margin of appreciation in determining the steps that lead to that progress. These steps all relate to the duty to protect, respect and fulfil the right to health of the child.

Although the right to health of the child as laid down in the Convention on the Rights of the Child is qualified as a provisional right, interpretation in line with the other CRC articles and with the elaboration of the right to health in international human rights law (see chapter 5), also reveals protective and participatory elements, such as children’s right to be protected against harmful medical practices (e.g. art. 24.3 CRC, art. 19 CRC) and the right to refrain from a medical treatment. The realization of these protective and participatory elements of children’s right to the highest attainable standard of health does not need to pose an enormous burden on States’ available resources. Therefore, these elements should fall within the scope of States’ immediate obligation of result. The provisional aspects of the right to health of the child however, such as the provision of health services to reduce infant and maternal mortality, the provision of health education, healthy food and drinking water, require proactive measures to be realized and thus place a larger burden on a States’ available resources. The wide array of possible measures to fulfil children’s right to the highest attainable standard of health include giving medicines or providing affordable health care (direct or through freely accessible insurances) to people and to building medical facilities.

¹⁰³⁵ Ibidem supra note 1031.

¹⁰³⁶ A. Nolan, ‘The child’s right to health and the courts’, in: J. Harrington & M. Stuttaford, *Global Health and Human Rights*, Routledge 2012, p. 140.

¹⁰³⁷ Ibidem supra note 1016, p. 28.

Nolan has argued that not only the regulatory role of States in preventing and punishing violations of the right to health of the child by non-state actors must be considered by the Committee on the Rights of the Child, but also its potential to stimulate non-state actors to provide for health-related goods and services.¹⁰³⁸ In this way, more actors can take ownership and become involved in realizing children's right to health, which will increase the overall capacity to reach the highest attainable standard of health for children.

Although the obligation to fulfil must be realized progressively, the obligation to ensure the minimum core content of the right to health of the child is an obligation of immediate nature. The requirement to take measures within a reasonable time thus only applies to measures that go beyond the minimum core content of the right to health of the child towards the *full* realization of the highest attainable standard of health, because those are the rights that are dependent upon progressive realization instead of immediate realization.

The element of reasonable time also appears in various domestic law systems. As such, the concept has been criticized for being too vague and subjective.¹⁰³⁹ Whereas the concept must become clear in the particular context in which it is applied, this poses a particular challenge in international law, because people can argue for a variety of time frames and they have done so in litigation in both national and international courts.¹⁰⁴⁰ Therefore, it would be recommendable to specify further guidelines on what constitutes a reasonable time or either to give specific deadlines for some of the main health measures that must be taken, such as within 1, 5, 10 or 20 years time. This could help governments to develop a realistic plan to progressively realize the separate elements of the right to health of the child to which they can be held accountable. However, in achieving transnational uniformity of the application of the concept of reasonable time, agreement must be reached on a common baseline or yardstick from which progress in realizing the right to health of the child can be measured, e.g. the status quo.¹⁰⁴¹

In private law, the concept of the reasonable time has been interpreted by courts in light of the nature (i.e. particular health condition at stake), purpose (realize good health in one particular child or group of children) and

¹⁰³⁸ Ibidem supra note 1012. See also submission for the development of CRC General Comment 15 on the right to health of the child by Nolan, Eli Yamin and Meier, p. 3. Available at: www2.ohchr.org/english/bodies/crc/docs/CallSubmissions_Art24/ProfNolan-DurhamUniversity-ProfElyYamin-HarvardUniversityandProfMeier-UniversityofNorthCarolina.docx.

¹⁰³⁹ S.E. Smith, *In law, what is reasonable time?*, 2013. Available at: www.wisegEEK.com/in-law-what-is-reasonable-time.htm.

¹⁰⁴⁰ Ibidem supra note 1038. For a further discussion of the concept of 'reasonable time in international and various domestic law systems see: C. Baasch Andersen, *Reasonable Time in Article 39(1) of the CISG – Is Article 39(1) Truly a Uniform Provision?*, University of Copenhagen, 1998, available at: www.cisg.law.pace.edu/cisg/biblio/andersen.html. CISG = United Nations Convention on Contracts for the International Sale of Goods. Generally, the actual meaning of reasonable time is determined by the application of the provision in International Courts and Tribunals.

¹⁰⁴¹ Ibidem supra note 1038 and 1039, chapter VI.2.

circumstances (e.g. depending on country, region, health situation, situation of war/peace, other infrastructure and climate) of the case as well as the intentions of the parties when signing the contract.¹⁰⁴² Other considerations that can be made in assessing the reasonable time include the damage that is caused by not taking the particular health measure at stake (maternal, infant and child mortality rates, lost DALYs or QALYs,¹⁰⁴³ burden of disease and lost work force), deliberations on prior delays in taking health measures, and comparing a situation to results in other countries. Baasch Andersen argues that the list of factors that can influence the reasonableness or unreasonableness of time is not exhaustive, but that it falls under the discretion of Courts and Tribunals to include them in the assessment of reasonableness, as long as the factors are relevant to the objective of the measures at stake.¹⁰⁴⁴ In determining the reasonableness, it can be argued that the reasonable time extends ‘so long as the delay is attributable to causes beyond the control of the State and that the State has neither acted negligently or unreasonably’.¹⁰⁴⁵ On the basis of guideline 13 of the Maastricht Guidelines States have the burden of proof in demonstrating that causes for non-compliance lie beyond their control.¹⁰⁴⁶ Causes beyond the control of the State may include natural disasters or infectious diseases that impact upon the health of its population. However, such circumstances do not dismiss States from taken all measures required to mitigate or prevent the harmful impact of such events.

6.3.3.2. *Reasonable program*

The second element of reasonableness is the requirement to develop a reasonable program. On the basis of articles 4 and 24 CRC such a program should include at least all appropriate legislative, administrative and other measures. The element

¹⁰⁴² The concept of reasonable time is a Reasonable Time Law and legal definition, uslegal.com, available at: <http://definitions.uslegal.com/r/reasonable-time/>.

¹⁰⁴³ The disability-adjusted life year (DALY) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death. Potential years lost due to premature death are combined with the healthy years lost due to disease or disability. Both the concept of mortality and morbidity are therefore integrated in one single parameter of health, which is increasingly used in public health. The quality-adjusted life year (QALY) is a measure of disease burden, including both the quality and the quantity of life lived. It is used in assessing the value for money of a medical intervention. The QALY is based on the number of years of life that would be added by the intervention. Each year in perfect health is assigned the value of 1.0 down to a value of 0.0 for being dead. Years lived with deficits are assigned a value between 1.0 and 0.0 dependent on the loss of the quality of life. See also ‘Measuring effectiveness and cost effectiveness’, National Institute for Health and Clinical Excellence: www.nice.org.uk/newsroom/features/measuringeffectivenessandcosteffectiveness/qaly.jsp.

¹⁰⁴⁴ Ibidem supra note 1038.

¹⁰⁴⁵ Ibidem supra note 1017, guideline 13. The example is given that the closure of educational facilities may be justified in the event of an earthquake. The same can be argued for the closure of medical facilities. However, if the State neglected to take preventive measures to mitigate the impact of an earthquake or refrained from warning people timely, the measures that could have been taken should be qualified as falling in the control of the State.

¹⁰⁴⁶ Ibidem supra note 1018.

‘other measures’ has been incorporated to include any possible measures that contribute to realizing the rights of children, including their right to health.¹⁰⁴⁷ Such measures may go beyond legislation and include all child-specific measures and practices.

General Comment 5 to the CRC on General Measures of Implementation and the General Guidelines provide for a wide array of possible measures, including the provision of information i) any comprehensive review of domestic legislation, ii) the adoption of new laws or codes or amendments made to existing ones, iii) the status of the CRC in domestic law, including the recognition of the CRC in the constitution or in other legislation and the status of the CRC in the event of conflict with national legislation, iv) the possibility of invoking the CRC in national courts and v) the conclusion of any bilateral or multilateral agreements in the field of children’s rights.^{1048, 1049}

From these recommended measures, it appears that the Committee focuses on the one hand on the explicit recognition of the provisions of the CRC in the constitution or in one comprehensive children’s law and on the other hand in the different sectorial laws that codify domestic children’s rights.¹⁰⁵⁰ Children’s rights must thus be integrated on all possible levels and in all relevant sectors. With respect to the realization of the right to health of the child, the holistic character of the CRC thus requires the integration of provisions in national health law, housing law, social security law, protection law, environmental law and other fields of law. Hereto, a full review of all existing and proposed national legislation is required as well as consideration of any applicable customary or religious laws in a country.¹⁰⁵¹ Furthermore, the review of legislation must be continuous and cover all different levels of the government, such as the national, federal and provincial levels.¹⁰⁵²

Although administrative and other measures cannot be spelt out in full detail, the Committee provides several guidelines for effective implementation. Key in these guidelines is the need for cross-sectorial coordination between different levels of the government and civil society, in particular children themselves.¹⁰⁵³

¹⁰⁴⁷ See also: M. Rishmawi, *A Commentary on the United Nations Convention on the Rights of the Child, Article 4: The Nature of States Parties’ Obligations*, Martinus Nijhof Publishers 2006, p. 4.

¹⁰⁴⁸ U.N.Doc, CRC/C/GC5, CRC Committee General Comment 5 on General Measures of Implementation, § 18–22.

¹⁰⁴⁹ UN Doc. CRC/C/58/Rev.1, 29 November 2005. General Guidelines regarding the form and content of periodic reports to be submitted by States Parties under article 44, § 44, 1b of the CRC, Adopted by the Committee at its thirty-ninth session on 3 June 2005. Available at: [www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/af20808817648df4c12570fa002ba893/\\$FILE/G0545289.pdf](http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/af20808817648df4c12570fa002ba893/$FILE/G0545289.pdf).

¹⁰⁵⁰ In General Comment 5 the Committee welcomes the adoption of consolidated children’s rights statutes, but also reminds States of the need to ensure that all relevant sectoral laws reflect consistently the principles and standards of the Convention. See § 22.

¹⁰⁵¹ Ibidem supra note 1049, § 20.

¹⁰⁵² Ibidem supra note 1049, § 5. See also ibidem supra note 30, § 18.

¹⁰⁵³ Ibidem supra note 1049, § 27.

Secondly, the need for monitoring of implementation by the government itself, national human rights institutions and NGOs is deemed highly important.¹⁰⁵⁴ Furthermore, the Committee has specified several priority measures that should be integrated in the realization process.¹⁰⁵⁵ In these measures, several specific references are made to ensuring children's health. First of all, in developing a national strategy on children's health, specific goals for sectoral action plans must be set. Such a sectoral plan on health must contain time bound and measurable targets, implementation measures, specification of human and financial resources allocated and mechanisms for monitoring, review, updates and periodic reporting. Although prioritization of policy targets is necessary, these priorities must include the minimum requirements as laid down in the CRC.¹⁰⁵⁶ Under the Reporting Guidelines States Parties are furthermore expected to identify the impact of the measures taken on the actual realization of economic, social and cultural rights by providing a wide set of indicators on health. With respect to children's health, data must be included about the budget allocated to health, the number of health professionals that have been trained in children's rights and a large variety of other health indicators, including, infant, child and maternal mortality rates, the proportion of children with low birth weight, the number of children that is immunized, the proportion of children that have access to safe drinking water and sanitation, the number of pregnant women who have access to perinatal health care, the number of children born in hospital and the number of children receiving exclusive breastfeeding.¹⁰⁵⁷ States are further held to set appropriate standards for the private sector in the area of health, such as the number and suitability of staff and the establishment of permanent monitoring mechanisms. The effectiveness of child rights education to both professionals and children and their families must not only be reviewed for knowledge transmission, but also for changes in practice and attitudes.¹⁰⁵⁸

¹⁰⁵⁴ Ibidem supra note 1049, § 27.

¹⁰⁵⁵ Measures include: A. adoption of a comprehensive national plan that is endorsed by all governmental levels; B. coordination of implementation measures; C. ensuring sufficient allocation of resources in decentralization and delegation; D. engagement of the private sector; E. the monitoring of the implementation by child impact assessments and evaluations; F. quantitative and qualitative data collection to get a complete picture of progress, including by engaging children in the process as interviewers and researchers; G. identify the proportion of the budgets that are allocated to children; H. Training and capacity building for children, caretakers and professionals; I. cooperation with civil society; J. international cooperation; K. Independent human rights institutions.

¹⁰⁵⁶ Ibidem supra note 1049, § 28.

¹⁰⁵⁷ UN Doc. CRC/C/58/Rev.2, 23 November 2010, Reporting Guidelines Treaty-specific guidelines regarding the form and content of periodic reports to be submitted by States parties under article 44, paragraph 1(b), of the Convention on the Rights of the Child, adopted by the Committee at its fifty-fifth session (13 September–1 October 2010). See Annex for an overview of the statistical data that are required, specifically § 3b, 4d, C1c&f, F. Other indicators include the number of children infected with HIV/AIDS and the proportion of those that receives medical care and counselling, different health problems in adolescents and the available health services to tackle those problems.

¹⁰⁵⁸ Ibidem supra note 1049, § 55.

Generally, children must be considered as independent rights holders.¹⁰⁵⁹ Therefore, the involvement of beneficiaries of health, young children or de facto their caretakers or representatives, must be sought in all phases of the realization process, including the development of a national plan, the implementation measures, data collection, monitoring and evaluation, for example by integrating data gained from interviews with children in the monitoring reports.¹⁰⁶⁰ The Committee on the Rights of the Child therefore recommends that there should be a continuous process of child impact assessments and child impact evaluations, which consequently predict and evaluate the effects of proposed laws, policies or budget allocations.¹⁰⁶¹ The Committee places great emphasis on the involvement of children in data collection and interviewing them, so that their interests are directly reflected.¹⁰⁶² With respect to the involvement of very young children, this requires age-appropriate interview techniques as well as interviewing their parents.

6.3.4. JUSTICIABILITY OF CHILDREN'S RIGHT TO HEALTH IN DOMESTIC COURTS

In addition to the obligation to take legislative and policy measures, States must ensure that effective remedies are in place for children or their representatives to effectuate their right to health. Effective remedies in the domestic law of States Parties are essential in ensuring the effective implementation of children's right to health at the national level. Therefore, States Parties must provide information on the remedies available and their accessibility towards children.¹⁰⁶³ The provisions of the CRC must be directly applicable and appropriately enforced. The Committee on the Rights of the Child has established that legislation should meet several criteria to be directly applicable. In addition, the Committee has elaborated that effective remedies have a child rights based approach and that these remedies are widely published and accessible to all children, including those of marginalized groups.¹⁰⁶⁴ The child rights based approach requires as a minimum that child-friendly procedures are in place, that child-friendly information and legal assistance is provided and that appropriate reparation, including compensation, physical and psychological recovery, rehabilitation and reintegration, as required by article 39 are provided.¹⁰⁶⁵

¹⁰⁵⁹ Ibidem supra note 1049, § 21, 66–70.

¹⁰⁶⁰ Ibidem supra note 1049, § 29, 46, 50, 54 and 58.

¹⁰⁶¹ Ibidem supra note 1049, § 45.

¹⁰⁶² Ibidem supra note 1049, § 50.

¹⁰⁶³ Ibidem supra note 1049, § 14.

¹⁰⁶⁴ Ibidem supra note 1049, § 24 and 66–69.

¹⁰⁶⁵ Ibidem supra note 1049, § 24.

Nolan notes that worldwide, a growing tendency is discerned in which economic, social and cultural rights are incorporated in the national constitution.¹⁰⁶⁶ She establishes that out of a survey of 86 national constitutions, 18 explicitly contain a provision on children's right to health. Also, plural constitutions contain a reference to the child's right to protection, which contains components that relate to the right to health of the child.¹⁰⁶⁷ Sloth-Nielsen identifies a similar development in the recently adopted constitutions of several African countries.¹⁰⁶⁸ However, she also points out that although children's rights have increasingly been integrated in national constitutions, the actual realization of these rights sets a working agenda at least for the coming 30 years.¹⁰⁶⁹

6.3.4.1. *Application of the right to health in Dutch domestic law cases*

In an analysis of the application of children's rights principles in Dutch domestic courts, Pulles has argued that the provisions of the CRC can be directly applied because they provide for a clear and precise standard and because they are very similar to provisions in other human rights treaties, such as the ICESCR that are applied directly.¹⁰⁷⁰ However, there still is a highly diversified application of CRC provisions in Dutch domestic courts.¹⁰⁷¹ Although this diversified application of CRC provisions was previously attributed to the relatively new status of the CRC as an interpretative tool, this argument is increasingly becoming outdated, because the CRC is becoming increasingly well-known among different professionals.¹⁰⁷² The recent research conducted by the Centre on Children's Rights Amsterdam (CCRA) has provided additional insight into the possibilities of and the ways in which children's rights, most particularly children's right to health, are applied in domestic cases. Although it is concluded that a relatively positive development can be discerned with respect to the direct application of CRC provisions in Dutch

¹⁰⁶⁶ A. Nolan, 'The child's right to health and the courts', in: J. Harrington & M. Stuttaford (eds.), *Global Health and Human Rights*, Routledge 2012, p. 142. Nolan establishes that out of a survey of 86 national constitutions, 18 explicitly contain a provision on children's right to health.

¹⁰⁶⁷ Ibidem supra note 1065, p. 142.

¹⁰⁶⁸ Lecture delivered by Professor Sloth-Nielsen on 19 November 2012 on the occasion of the inauguration of professor Ton Liefwaard at the University of Leiden.

¹⁰⁶⁹ Ibidem supra note 1065.

¹⁰⁷⁰ G. Pulles, 'Onduidelijkheid over de rechtstreekse werking van het VN-kinderrechtenverdrag', *Nederlands Juristenblad* 2011, Volume 4, 28 January 2011, p. 233. Differences identified sometimes raised the level of child protection.

¹⁰⁷¹ The finding that the direct application of CRC provisions in Dutch courts is very variable, has been reaffirmed and well-established in an extensive research by the Centre for Children's Rights in Amsterdam on the application of CRC provisions in Dutch law cases between 1 January 2002 and 1 September 2011. See: J. de Graaf & M.M.C. Limbeek, *De toepassing van het Internationaal Verdrag inzake de Rechten van het Kind in de Nederlandse Rechtspraak*, Nijmegen: Ars Aequi Libri 2012, p. 275. Available at: www.defenceforchildren.nl/images/20/2073.pdf.

¹⁰⁷² Ibidem supra note 1070, p. 234.

domestic law, this conclusion is explicitly not true for the right to health.¹⁰⁷³ In all different legal sections researched and in all cases in which article 24 CRC was evoked, the Court implicitly (by not referring to article 24) or explicitly decided that the right to health of the child as laid down in article 24 CRC is not directly applicable.¹⁰⁷⁴ In one case, the Court elaborated that ‘article 24 CRC cannot be directly applied, because it addresses the State Party and not the individual citizen’.¹⁰⁷⁵ Similarly, the Court in Zwolle stated that Article 24 CRC provides for generally described social targets, from which no unconditional and precisely defined individual rights can be derived.¹⁰⁷⁶ In yet another case the Court held that ‘Given the phrasing, nature and scope of the right to health of the child as laid down in article 24, it cannot be directly applied, nor can other rights be derived from it’.¹⁰⁷⁷ The case involved a Romanian family that was removed from the house in which they were illegally living. The family argued that their only option was to go back to Romania, where there would be no adequate medical treatment available for their child. Although the court did not consider article 24 CRC directly applicable, it did consider the question whether an immediate emergency situation resulted from the removal. It found that that would not be the case. Whereas article 24 was not considered directly applicable, its contents did influence the consideration of the child’s situation in this case. This influence of article 24 CRC is discerned in several other cases across the different legal disciplines researched. For example, in an immigrant law case, the court decided that a previous decision made by the IND (immigration body that decides upon the admission of asylum seekers to the Netherlands), did not sufficiently take into account the interest of the severely sick child.¹⁰⁷⁸ The Court held that a heavier duty of motivation is required when sending back children to their home country and that this duty is even heavier with respect to a severely sick child.¹⁰⁷⁹ Therefore, the

¹⁰⁷³ Ibidem supra note 1070, pp. 77–79.

¹⁰⁷⁴ Ibidem supra note 1070, pp. 62–64, 90–92, 142–145 and 194–196. Legal sectors researched included civil and family law, immigrant law, administrative law and juvenile law. See law cases Rb. Alkmaar 20 July 2005, LJN AT 9598, Rb. Rotterdam, 6 September 2010, LJN BO1013, Rb. Zwolle-Lelystad (vzr), 9 June 2011, LJN BR 3569, ABRvS 12 April 07, LJN BA 3394, Rb. Den Haag, 24 February 2008, LJN BF 0906, Rb. Den Haag, 2 March 2010, LJN BM 2383, Rb. Den Haag, 19 December 2005, AWB 04/19508, Rb. Zwolle-Lelystad, 19 April 2011, LJN BQ 3967, CRvB 20 October 2010, LJN BO 3581 and Rb. Utrecht (vzr) 6 April 2010, LJN BM 0846.

¹⁰⁷⁵ Rb. Alkmaar, 20 July 2005, LJN AT 9598. The case involved a single mother who had given permission to perform a medical treatment on her daughter on the basis of her right to health. However, it was decided that the lack of permission by the father was not justified, *inter alia* because the right to health of the child is not directly applicable.

¹⁰⁷⁶ Rb. Zwolle-Lelystad, 19 April 2011, LJN BQ 3967.

¹⁰⁷⁷ Rb. Zwolle-Lelystad (vzr), 9 June 2011, LJN BR 3569. The case involved a Romanian family that was removed from the house in which they were illegally living. The family argued that their only option was to go back to Romania, where there would be no adequate medical treatment available for their child. Although the judge did not consider article 24 CRC directly applicable, it did consider the question whether an immediate emergency situation resulted from the removal. It found that that would not be the case.

¹⁰⁷⁸ Rb. Den Haag, 19 December 2005, AWB 04/19508.

¹⁰⁷⁹ Ibidem supra note 1077.

health of the child did play a role in the consideration of the case. Lastly, the Court of Utrecht held that providing emergency housing to an asylum seeking woman and her child, who suffered from asthma and epilepsy, was essential in ensuring the human dignity of the child.¹⁰⁸⁰ All these examples show that the lack of direct applicability of the right to health of the child in Dutch court practice, thus does not lead to the conclusion that there is no additional value of the right to health of the child in individual cases. Interpretation in conformity with the CRC did give prove of the additional value of the right to health of the child in the CRC in explaining the treaty in domestic procedures as well as in taking children's health situation into account in decisions.¹⁰⁸¹ De Graaf identifies that in order to increase the opportunity that children's rights are taken into account, referral to the facts and circumstances underlying the case often greatly contribute.¹⁰⁸² Thus, it is the daily circumstances in which children live that greatly influence the interpretation and effectuation of the right to health of the child.

Although the abovementioned examples of Dutch domestic law show that there may be some room for involving article 24 CRC in the interpretation of domestic cases, it is also clear that the Dutch State retains its primary responsibility for ensuring children's right to health. Therefore, its activities in realizing the right to health must be primarily considered by judicial and quasi-judicial institutions. So what is this role of the judiciary and how does it influence the interpretation of children's right to the highest attainable standard of health?

6.3.4.2. *Judicial and quasi-judicial decision-making*

Nolan has identified the role played by judicial and quasi-judicial decision-making bodies in evaluating the efforts made by states to take adequate positive steps to fulfil the right to health of the child, e.g. by allocating sufficient resources. She argues that a somewhat protective role is taken up by the courts,¹⁰⁸³ because children are excluded from the democratic process, that political organs therefore aren't held sufficiently accountable and that therefore 'they are less likely to be attentive to the rights and needs of children'.¹⁰⁸⁴ She therefore comes to the conclusion that evidence from international and domestic legislation shows that both drafters of human rights instruments and courts are more inclined to impose obligations on States with regard to the realization of the right to health

¹⁰⁸⁰ Rb. Utrecht (vzr), 6 April 2010, LJN BM 0846.

¹⁰⁸¹ Ibidem supra note 1070, pp. 275–280.

¹⁰⁸² Ibidem supra note 1070, pp. 275–280.

¹⁰⁸³ An example of this protective orientation towards children is found in the Constitution of South-Africa, in which elaborates that the right to health is dependent on available resources. However, with respect to children, this condition is left out, so that children benefit from a better, namely a less conditioned right to health than adults.

¹⁰⁸⁴ A. Nolan, 'The child's right to health and the courts', in: J. Harrington & M. Stuttford, *Global Health and Human Rights*, Rotledge 2012, p. 138.

of children than of adults.¹⁰⁸⁵ This particular position of courts *vis-à-vis* children is remarkable, given the often heard criticism that courts should be careful in judging upon the justiciability of economic, social and cultural rights, because this would involve them in budgetary or policy matters which would be a violation of the separation of powers in the *trias politica*.^{1086, 1087} Another significant criticism against justiciability of the right to health of the child follows from the argument made by Yash and Gill.¹⁰⁸⁸ Although Nolan argues that courts have a role to play in the delineation of the right to health and its enforceability, Yash and Gill's argument that justiciability of economic, social and cultural rights may detract from other ways of social enforcement is particularly true for the realization of children's right to health. When courts consider the efforts made by States to realize children's right to health, they determine the reasonableness of health measures taken and they do not consider possible alternatives. Especially with respect to the realization of children's right to health, many other non-legal measures are possible to ensure that children have access to underlying determinants of health and to health care. Also, many non-state actors are better equipped and more closely connected to the child and its family than States Parties to take such measures. In order to establish progressive standards for the realization of the highest attainable standard of health of the child that are rooted in the daily lives of children and their families, involvement of all public and private actors that operate close to the child is therefore required. Furthermore, as indicated previously, accepting justiciability of children's right to health may result in a flood of litigation, which could detract resources from the actual implementation of children's right to health.¹⁰⁸⁹ Therefore, it should be kept in mind that court intervention should remain a last resort in the realization process of children's right to health.

However, the importance of primarily considering non-judicial measures in ensuring children's right to health does not entail that the right to health in itself is or should be meaningless. On the contrary, as established by Nolan, the integration of the right to health of the child in national constitutions shifts the

¹⁰⁸⁵ Ibidem supra note 1083, p. 146.

¹⁰⁸⁶ Y. Ghai & J. Cottrell, 'The role of the Courts in the protection of Economic, Social and Cultural Rights', in: *Economic, Social and Cultural Rights in Practice, The Role of Judges in Implementing Economic, Social and Cultural Rights*, Interights 2004, p. 65.

¹⁰⁸⁷ For a clear overview of pro and contra arguments on the justiciability of economic, social and cultural rights, see: Maite San Giorgi, *The Human Rights to Equal Access to Health Care*, Intersentia 2012, pp. 80–84.

¹⁰⁸⁸ Ibidem supra note 1085.

¹⁰⁸⁹ The current 'tsunami' of cases that constitutes a real challenge for the functioning of the European Court on Human Rights is an example of this considerable and genuine threat. See: J.P. Costa, *Current Challenges for the European Court on Human Rights*, lecture delivered at the University of Leiden on 10 December 2011 as part of the series of Raymond and Beverly Sackler Distinguished Lectures in Human Rights at Leiden Law School.

discussion from ‘is the right to health of the child enforceable?’ to ‘how can this right be enforced?’.¹⁰⁹⁰

Last but not least, when remedies against violations of children’s right to health are in fact sought, States must ensure that effective, child-sensitive procedures are available to children and their representatives, which include the provision of child-friendly information, advice, advocacy and legal and other assistance when seeking access to independent complaints procedures and to the courts.¹⁰⁹¹ With respect to the application of cases concerning the right to health of the child, special attention must therein be given to children who are physically unable to leave the medical facilities due to their medical condition or of parents who have difficulty in visiting their children in hospital and also attending law suits.

In addition to the formal legal procedures, Kaime argues that the realization of children’s rights should not only entail the incorporation of these rights in national legislation and policy measures, but also the translation of these rights to local circumstances, i.e. the effective influence on children’s daily realities.¹⁰⁹² Kaime identifies that in addition to the formal ways to legally enforce children’s rights, such as state courts and other law enforcement mechanisms, the effectuation of children’s rights norms in daily life requires active deliberation with local institutions, authorities and other influential actors such as the elders in a family.¹⁰⁹³ However, in the negotiation process to transform the CRC principles into lived realities of children, it is important to identify and ensure that children, women and other traditionally less dominant groups are included in the decision-making processes.¹⁰⁹⁴ The discussion on the way in which they contribute and how children’s rights are put into practice has in itself an awareness-raising effect.

Kaime acknowledges that different communities all have different structures, legal procedures and institutions and that the involvement of different local actors in the realization of children’s rights thus also takes many different forms. However, he does identify a few guidelines that should be taken into account when translating children’s rights to the local practice:¹⁰⁹⁵

1. Understand the basic structure of the institution that is sought to be involved. This includes the identification of key actors that have a role in gatekeeping and in introducing and influencing decision-making processes.
2. Understand basic procedures and structure any new proposal in terms that conform to the standard procedures. The introduction of new ideas will be more likely to be accepted.

¹⁰⁹⁰ A. Nolan, ‘The child’s right to health and the courts’, in: J. Harrington & M. Stuttford, *Global Health and Human Rights*, Routledge 2012, pp. 152–153.

¹⁰⁹¹ Ibidem supra note 1007, § 5.

¹⁰⁹² T. Kaime, *The Convention on the Rights of the Child: A Cultural Legitimacy Critique*, Europa Law Publishing 2011, pp. 137–140.

¹⁰⁹³ Ibidem supra note 1091, pp. 137–140 and 148.

¹⁰⁹⁴ Ibidem supra note 1091, p. 149.

¹⁰⁹⁵ Ibidem supra note 1091, pp. 151–153.

3. Understand the sphere of influence of the institutions involved and its relation to the realization of children's rights. This enable advocates of children's rights to engage with the institution that has the biggest impact on the improvement of children's rights implementation.
4. Respect local customs and traditions and show sincere interest. The process of building trust often requires less talking and more listening.

Kaime establishes that by respecting these guidelines, a more organic and locally accepted way of implementing children's rights can be achieved, which in the long term has a more lasting effect on the improvement on the lived reality of children.¹⁰⁹⁶ He concludes by stating that the involvement of local institutions in addition to formal and more centralized legal enforcement mechanisms increases the accessibility, the affordability and the legitimacy.¹⁰⁹⁷ In my opinion, these guidelines have significant added value in bridging the gap between the rights of children as written down in international and national legislation and the effectuation of these rights in the daily lives of children.

In this section the justiciability of the right to health of the child was discussed. Although this right is increasingly laid down in national legislations, the possibility of direct application of the right to health in individual law cases is not clear cut. Direct applicability may be assumed in cases in which a State did not meet its obligation to respect and to protect. However, a study on the application of children's rights in the Netherlands showed that whereas many rights are directly applied, this is explicitly not the case for the right to health of the child. This points to the conclusion that the justiciability of the right to health of the child is limited to the duties to respect and to protect.

The second issue discussed is whether it is desirable to directly apply the right to health of the child. It was concluded that this should be a measure of last resort, since law suits detract resources from the allocation of resources to actual health care measures and that there are alternative ways to enforce the right to health that benefit the right to health more directly, such as through quasi-judicial institutions that are more closely connected to the daily realities in which children live or through the efforts made by private actors.

6.3.5. INTERNATIONAL COOPERATION FOR ENSURING THE RIGHT TO HEALTH OF THE CHILD

Health crosses borders. Not only do infectious diseases easily overcome manmade boundaries between countries and regions, the enormous flows of travellers due to

¹⁰⁹⁶ Ibidem supra note 1091, p. 153.

¹⁰⁹⁷ Ibidem supra note 1091, p. 153.

tourism, business, immigration and refugee flows enable viruses to quickly spread among and infect people in virtually all corners of the world. This phenomenon simply obliges States to collaborate and mutually define the steps required to mitigate the impact of potentially life threatening viruses that spread the world on the basis of their own want for survival.¹⁰⁹⁸ Following the outbreak of a new strain of avian flu in 2004, the WHO issued the International Health Regulations (IHL 2005), which set international rules for responding to international outbreaks of infectious diseases.¹⁰⁹⁹ In addition, with respect to the right to health of the child in the international children's rights domain, article 24.4 CRC specifically obliges States Parties to promote and encourage international cooperation with a view to progressively achieving the right to health of the child. Such cooperation can be divided in regular development aid and emergency care in humanitarian situations such as natural disasters and conflict situations.

International cooperation involves donor countries and recipient countries. However, as identified by Wabwile, there is no definition of developing countries in international law and macro-economic indicators for ranking states are not static.¹¹⁰⁰ Therefore, the identification of donor or developing countries is not simply determined. With respect to children's health, developing countries are generally characterized by low government investments in health infrastructure resulting in high numbers of ill health, infant and child mortality rates and malnutrition. It has been found that child deaths from easily preventable causes amount to 49% of the total number of child deaths. Also, high rates of population growth are often reported.¹¹⁰¹ Article 4 CRC elaborates that all measures for realizing economic, social and cultural rights must be taken to the maximum extent of the available resources of the States Parties and 'where needed, within

¹⁰⁹⁸ In response to the outbreak of swine flu in 2009, the Director-General of the WHO declared a public health emergency of international concern and established an Emergency Committee. This outbreak of swine or Mexican flu posed particular challenges for newborns and young children, because they had never experienced a previous, similar strain of flu that had spread the world several decades earlier.

¹⁰⁹⁹ World Health Organization [WHO], *International Health Regulations 2005*, (2nd ed. 2008), at http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf. See also See David P. Fidler, *Global Outbreak of Avian Influenza A (H5N1) and International Law*, ASIL Insights, Jan. 2004, at www.asil.org/insigh125.cfm. The IHL 2005 authorize the Director-General of the WHO to declare a state of public emergency of international concern under article 12 (1), which is defined in article 1 IHL 2005 as 'an extraordinary event which is determined ... (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response'. Consequently, on the basis of articles 15 and 18 IHL 2005, the Director-General must issue temporary recommendations, which depend on the nature of the threat and may include surveillance and reporting new incidents of the disease to WHO, information-sharing, travel and trade restrictions. Although the guidelines are authoritative, they are not binding on States Parties.

¹¹⁰⁰ M. Wabwile, 'Implementing the Social and Economic Rights of Children in Developing countries: the place of international assistance and cooperation', *International Journal on Children's Rights* 2010, Volume 18, pp. 357–358.

¹¹⁰¹ UNICEF *Children in an Urban World: The State of the World's Children 2012*. See also: Todaro & Smith, *Economic Development*, London: Pearson Addison Wesley 2006, pp. 65–66.

the framework of international co-operation.’ Article 24.4 CRC speaks of the obligation to progressively achieve the full realization of the right to health of children and to take particular account of the needs of developing countries. Both articles thus refer to the obligation to gradually fulfil the right to health of the child, if necessary with support of the international community. Therefore, in order to tackle pressing health problems in children, developing countries primarily have the obligation to maximize their domestic available resources and secondly to actively seek assistance from the international community.¹¹⁰² Also, the Committee on the Rights of the Child encourages recipient countries to allocate a substantive part of the international aid and assistance it receives to children and to yearly indicate the amount and proportion that has been allocated for the implementation of children’s rights.¹¹⁰³ The Committee on the Rights of the Child endorses the 20/20 initiative, which entails that recipient countries must allocate at least 20 percent of its public expenditure to realize universal access to basic social services.¹¹⁰⁴ On the other side, developed countries must allocate at least 20 percent of foreign aid to human priority goals such as primary health care, education and the provision of underlying determinants of health.¹¹⁰⁵ In doing so, the Committee advises developed countries to apply the Convention on the Rights of the Child as the framework for international development.¹¹⁰⁶ The Committee furthermore endorses agreements reached that States Parties need to allocate at least 0.7% of their GDP to foreign aid.

Vandenhoele has convincingly established that the extraterritorial obligations of States Parties to realize the right to health of the child in other, less developed countries include the duties to respect and protect, though not to fulfil the right to health.¹¹⁰⁷ This means that States should not interfere with economic, social and cultural rights in other countries. Also, it means that States should refrain from embargos that target water, food, medicines or medical equipment.¹¹⁰⁸ Furthermore, it means that States should prevent third parties under their control to interfere with children’s right to health. Given the jurisdiction clause as expressed by the CRC Committee, this includes activities within the territory of the State, but also activities in other States by individuals who are subject to the States’ jurisdiction.¹¹⁰⁹ With respect to the duty to fulfil the right to health of the child in other countries, the duty of States is complementary to the domestic

¹¹⁰² Ibidem supra note 1099, pp. 367–368.

¹¹⁰³ Ibidem supra note 1047, § 61.

¹¹⁰⁴ Ibidem supra note 1047, § 62. For a further discussion of the 20/20 initiative see *Implementing the 20/20 initiative*, 1998.

¹¹⁰⁵ Ibidem supra note 1100.

¹¹⁰⁶ Ibidem supra note 1017, § 61.

¹¹⁰⁷ Vandenhoele, ‘Economic, Social and Cultural Rights in the CRC: Is there a legal obligation to cooperate internationally for development?’, *International Journal on Children’s Rights* 2009, Volume 17, pp. 23–63.

¹¹⁰⁸ Ibidem supra note 1106, Vandenhoele, p. 53. See also Committee on ESCR 1999b, par. 37.

¹¹⁰⁹ U.N.Doc, CRC/C/GC5, CRC Committee General Comment 5 on General Measures of Implementation, § 12.

State obligations.¹¹¹⁰ This means that all measures should only be taken with the approval of the recipient State. Interestingly, although no general legal obligation has been established for States to engage in international cooperation, there is a shared responsibility between donor and recipient countries to exchange information on preventive health care and treatment of disabled children and the right to the highest attainable standard of health.¹¹¹¹

Although measures to fulfil the right to health need to include measures to improve access to health facilities and underlying determinants of health, many other measures in other sectors should be considered that can significantly influence the health status of children. Such measures could include the creation of employment opportunities, making available investments through microcredits, investments in infrastructure, debt relief, stimulating commercial activities and private-public partnerships and through bilateral and multilateral agreements. More developed countries therefore have the responsibility to strengthen the capacity of developing countries to progressively realize the right to health of the child by providing funding, sharing knowledge and experiences. In doing so, caution must be taken to ensure that developing countries do not become fully dependent upon external aid.¹¹¹² In conclusion, all States Parties to the CRC have the obligation to cooperate to progressively realize the right to health of the child.

6.4. RESPONSIBILITIES FOR NON-STATE ACTORS TO CONTRIBUTE TO REALIZING THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH OF THE CHILD

The Committee on the Rights of the Child has acknowledged that the realization of children's rights is achieved by the public sector, the private sector and voluntary actors concomitantly. For example, General Comment 5 establishes that the States task to realize children's rights needs to engage all sectors of society and, of course, children themselves.¹¹¹³ Therefore, the Committee has repeatedly requested States to provide insight into the division of responsibilities and into the allocation of resources to the different sectors involved in the provision of services to children.¹¹¹⁴ Specifically, both the CESCR Committee and the Committee on the Rights of the child have indicated that all members of society, including medical

¹¹¹⁰ Ibidem supra note 1106, Vandenhoe, p. 53.

¹¹¹¹ Ibidem supra note 1106, pp. 34 and 61, see also *Travaux Préparatoires*, Working Group 1985.

¹¹¹² UN Doc CRC/C/15/Add.177, § 11 and 12.

¹¹¹³ Ibidem supra note 1047, § 1.

¹¹¹⁴ M. Rishmawi, *A Commentary on the United Nations Convention on the Rights of the Child, Article 4: The Nature of States Parties' Obligations*, Martinus Nijhoff Publishers 2006, p. 32, § 84.

professionals, families, local communities, (i)NGOs, civil society organizations, private companies and individuals, all have responsibilities in realizing the right to health.¹¹¹⁵ However, in involving non-state actors in the realization process of children's rights, the Committee has explicitly cautioned against delegating responsibilities to NGOs without providing them with the necessary resources to meet those responsibilities.¹¹¹⁶

This section takes a bottom-up approach by analysing how all actors involved, including children and their families themselves, can contribute to realizing the right to health of children in their daily lives. It starts with the discussion of the extent to which very young patients can be involved in their own health situation and it continues with discussing the role of their parents or other caretakers and other actors in their direct environment. Thirdly, the role of medical professionals is discussed for as far as they do not operate as a representative of the state.

6.4.1. THE INVOLVEMENT OF CHILDREN IN THE MEDICAL PROCESS

Children, in the first place, are the holders of the right to health and the other connected rights as laid down in varying international legal documents on the right to health, most predominantly the Convention on the Rights of the Child.¹¹¹⁷ In international health law, namely the Constitution of the World Health Organization and the International Covenant on Economic, Social and Cultural Rights, the concept of the child focuses on its vulnerability and on its dependence on especially the mother. This is exemplified by the concomitant incorporation of the necessity to take measures to ensure 'children's and maternal health'. For example, the elaboration of the right to health in General Comment 14 ICESCR, article 12.2 (a), elaborates that 'the provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child' as laid down in the ICESCR 'may be understood as requiring measures to improve *child and maternal health*, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.' Child and maternal health are thus closely connected and focus is primarily placed on the services required during pregnancy and in the period immediately surrounding childbirth. This connection is especially relevant in the realization

¹¹¹⁵ Ibidem supra note 1047, § 56. See also General Comment No. 14 (2000) The right to the highest attainable standard of health: 11/08/2000. E/C.12/2000/4. CESCR, § 2.

¹¹¹⁶ UN Doc CRC/C/87, CRC Committee, Report on the 21st session, Annex IV, § 291.

¹¹¹⁷ See for two contrasting views on the issue of children as rights-holders: L. Purdy, 'Why children shouldn't have equal rights', *International Journal of Children's Rights* 1994, Volume 2, pp. 223–241 and A. McGillivray, 'Why children do have equal rights: In reply to Laura Purdy', in: *International Journal on Children's Rights* 1994, Volume 2, pp. 243–258.

of the right to health of very young children who are fully or to a very large extent dependent on both the health and care-taking of their mothers and other primary caretakers.

On the other hand, notwithstanding the vulnerability of the very young ones, there is an increasing call for empowerment of vulnerable children in general, such as girls, children from minority or indigenous groups, street children etcetera. Whereas very young children are only vulnerable on the basis of their level of development, they do have the capability to grow into healthy and empowered adults. Therefore, there is no reason to withhold a minimum level of empowerment from children that inspires and stimulates their potential for growth and development. Even more, it is essential for children to grow and develop in good health and to be listened to from the very beginning. Furthermore, by taking the innate capabilities of children as a starting point, their empowerment can be achieved gradually in the course of their lifetime. This idea is in line with the notion laid down in article 12 CRC, which provides that children's views must be heard in all matters affecting the child and that these views must be given due weight in accordance with the age and maturity of the child. No maximum or minimum age limit is specified, so that children of all ages, including the youngest ones must be – literally – heard in the realization process of their rights.

Similarly, the Committee on the Rights of the Child has indicated that it is essential to hear children's voices or the voices of their representatives in order to assess how their rights have been implemented. For example, the Committee has established that 'While it is the State which takes on obligations under the Convention, its task of implementation – of making reality of the human rights of children – needs to engage all sectors of society and, of course, children themselves.'¹¹¹⁸ Hereto, the Committee has established that there must be continuous child impact assessments and evaluations on any laws, policy or budget allocation that impacts upon the actual implementation of children's right to health.¹¹¹⁹ However, with respect to the opportunities of children in their early childhood to be involved in their medical treatment, significant limitations are clear as a result of their limited verbal and cognitive capacities. Therefore, this paragraph undertakes to identify the abilities of very young children to influence and be informed about their medical condition and possible treatments and the ways in which the views of very young children can and should be taken into account in realizing the right to health of children.

Although, infants and toddlers clearly have limited verbal capacities to express themselves, their physical appearance as well as other ways of expression can be highly indicative of discomfort such as incessant crying, sleeping and withdrawal, restlessness, irritability, lack of interest or appetite and unnatural

¹¹¹⁸ Ibidem supra note 1047, § 1.

¹¹¹⁹ Ibidem supra note 1047, § 45.

clinging to the parents.¹¹²⁰ Facial expressions in babies have shown that they clearly have the capacity to experience and communicate feelings of comfort and discomfort or pain.¹¹²¹ Thereby, they are able to directly and non-verbally influence the behaviour of the people around them, with their parents at the forefront.¹¹²² Also, by means of forcefully and persistently refusing medicines, they are able to influence the actual treatment they receive.

In earlier years, and still in some areas of the world, presumptions were held that infants and neonates are not able to experience pain. However, as demonstrated in more recent researches, infants often have a more intense experience of pain than adults do.¹¹²³ Nevertheless, due to the difficulties in reading the body language of young children and infants, their pain often remains undertreated. Several scales have been developed to identify the level of pain experienced by this group of very young patients. However, in premature children and severely ill children, these scales are not always adequate, because they are unable to produce a robust cry due to their lack of physical strength.¹¹²⁴ However, findings from older children than those in their infancy show that also children below the age of 5 should be carefully listened to in the medical process. Not only because this is respectful of their rights and shows them that they are taken seriously from the very beginning, but also because young children do have additional information that can be crucial in establishing an accurate diagnosis.¹¹²⁵ For example, children aged 2 are increasingly able to report and localize pain, although they are not yet capable of rating the intensity of their pain.¹¹²⁶ Children who develop rapidly have been proven able to quantify pain at the age of 3 using simple and creative pain assessment tools, such as pictures with facial expressions or different amounts of coins to explain the intensity of pain.¹¹²⁷ However, in children aged 3–5 years, report bias is still very common, which complicates the interpretation of their pain scores. Specific communication methods can add to ensuring maximum

¹¹²⁰ B.F. Fuller, 'Infant behaviors as indicators of established acute pain', *Journal of the Society of Pediatric Nurses: JSPN* 2001, 6(3), pp. 109–115.

¹¹²¹ McGrath (a.o.), 'Core outcome domains and measures for pediatric acute and chronic/recurrent pain clinical trials: PedIMMPACT recommendations', *The Journal of Pain: Official Journal of the American Pain Society* 2008, 9(9), pp. 771–783.

¹¹²² K.D. Craig & K.M. Prkachin, 'Expressing pain: The communication and interpretation of facial pain signals', *Journal of nonverbal behavior* 1995, Volume 19, Issue 4, p. 191–205.

¹¹²³ S. Ratnapalan, R. Srouji & S. Schneeweiss, 'Pain in Children: Assessment and Nonpharmacological Management', *International Journal of Pediatrics* 2010, Volume 2010, Article ID 474838, 11 pages doi:10.1155/2010/474838. Available at: www.hindawi.com/journals/ijped/2010/474838/.

¹¹²⁴ Ibidem supra note 1121.

¹¹²⁵ P.J. Mesko, 'Use of picture communication aids to assess pain location in pediatric postoperative patients', *Journal of Perianesthesia Nursing* 2011, 26, 6, December, pp. 395–404. Available at: [www.jopan.org/article/S1089-9472\(11\)00421-7/abstract](http://www.jopan.org/article/S1089-9472(11)00421-7/abstract).

¹¹²⁶ Pain Measurement in Children, in: Clinical updates on Pain, Volume III, Issue 2, International Association for the Study of Pain, July 1995, available at: www.iasp-pain.org/AM/AMTemplate.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&SECTION=Home&CONTENTID=2549.

¹¹²⁷ Ibidem supra note 1122.

reliability of their answers, for example by posing open questions instead of implying or broadly explaining medical problems as a result of which children will often feel inclined to confirm.

As laid down in articles 12 and 13 CRC, children ‘shall be provided the opportunity to be heard in any proceeding affecting the child, either directly or through a representative or an appropriate body’ on the basis of article 12-2 CRC and the child shall have the freedom to receive information, either orally, in writing or in print, in the form of art, or through any other media of the child’s choice. Even very young children have the right to be directly informed about the medical treatment they are undergoing, even in very short wordings. Therefore, challenges in establishing reliable answers, should not be used as a pretext for not informing and not involving children in their own medical treatments. It should be used as a motivational factor to further elaborate on the communication skills and techniques in medical care to very young children.

Furthermore, dependent on their level of development and comprehension, they either have a direct influence on the medical process through their own visions or behaviour (e.g. refusal) and indirectly through a representative, such as the parents, the medical professional or a third party who particularly envisages the best interests of the child in the determination of the medical treatment he or she is undergoing. By accurately observing the behaviour of (very) young children in the medical context, indications can be obtained over the way in which child-friendly health care services should be designed. In doing so, observations and communication methods must go far beyond verbal and written communications, but pay particular attention to body language, behaviour and reporting by children, parents and other proxy caregivers of the young child. For example, children can be given the opportunity to signal if they want a medical treatment to be stopped or interrupted when they feel they cannot bear the pain. Furthermore, the ideas and primary responsibility of parents or primary caretakers for the health and well-being of the child as laid down in articles 5 and 18 CRC should be taken seriously in the health care process, because they have day-to-day interaction with their children and generally know best whether their children appear sicker or better than they normally do. The abilities and responsibilities of parents and primary caretakers to identify the health needs of their children will be discussed in the following paragraph.

6.4.2. THE RESPONSIBILITIES OF PARENTS

As laid down in articles 5 and 18 CRC, parents and if applicable the extended family and communities of the child, have the primary responsibility to ensure the health of their children by providing the underlying determinants of health and ensuring a healthy lifestyle and a healthy living environment. In the preamble to the Convention on the Rights of the Child the family is defined as

‘the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children’. In General Comment 7 on the rights of children in early childhood, the Committee elaborates on the concept by recognizing that ‘family’ refers to a variety of arrangements that can provide for young children’s care, nurturance and development, including the nuclear family, the extended family, and other traditional and modern community-based arrangements, provided these are consistent with children’s rights and best interests.¹¹²⁸ Both article 5 CRC and the interpretations made by the CRC Committee thus explicitly acknowledge that worldwide there is a wide variety of family arrangements in which children grow up and which thus have the possibility to directly influence the level of realization of the right to health of children.

As established in chapter 2 of this thesis, the health of the mother directly influences the health of the unborn and the new-born child and indirectly the rest of the child’s lifespan.

Article 18 CRC establishes that both parents have the primary responsibility for the upbringing and (healthy) development of the child. The focus of this provision thus makes a shift from the exclusive focus on the relation between the child’s health and the health of the mother to a focus on the role of both the mother and the father or the legal guardians. After birth, both parents are primarily responsible for their children’s health by ensuring the provision of healthy and nutritious foods, drinking water, prevention of accidents and a hygienic and smoke-free environment within the home and in other places where children spend time. Also, the health behaviour of both parents plays a crucial role in the example-setting and subsequent health behaviour of their children. Article 18 CRC provides that States ‘shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child.’ It is therefore remarkable that article 24 CRC only addresses the need to prevent maternal mortality.

Whereas the health of the child is heavily influenced by the health status of both parents, the way in which other family members treat the mother, by sharing nutritious food with her, taking over potential harmful work and treating her with respect (e.g. no domestic violence) also has a very important impact on the healthy development of the foetus. In the second place, parents play a central role in seeking access to health care for their children, including preventive and basic health care, mental health care, specialized health care, dental health care and more. Thirdly, parents have the responsibility to ensure and advocate for a healthy living environment of their children in a broader sense: they may need to advocate for a healthy and hygienic living environment in schools, recreation facilities and outdoor playgrounds where their children spend time. However, due

¹¹²⁸ U.N. Doc. CRC/C/GC/7/Rev.1, General Comment 7 on Child rights in early childhood, 20 September 2006, § 14.

to limits in the level of health-related knowledge, personal incapacity, financial means or other resources, the State has the additional responsibility under article 18 CRC to ensure the development of institutions, facilities and services for the care of children.

It was repeatedly found that educating mothers, significantly increases children's health status and survival, as they are thereby enabled to apply basic knowledge on healthy nutrition, hygiene, prevention of accidents and infections to preventing health problems of their children.^{1129, 1130}

In addition to ensuring the necessary health facilities for children, prevention of health problems starts with enabling parents to take good care of their children. This requires enabling them to continuously adapt to the changing life cycle and stages of development of their children, both physically and mentally. For example, when a toddler learns to walk, parents must be more alert on preventing accidents such as falling of the stairs or running on the streets. Changing nutrition and sleep patterns, timely recognition of serious or typical child diseases and social interaction with siblings and peers will all require flexibility and empathy of the parents, especially when they have children with severe health problems or learning disorders. Therefore, specific health information must be readily available for young parents so that they can respond timely and adequately to the health needs of their children. However, the ways in which such health information can be obtained are diverse. In developing health institutions it is important to acknowledge that family and other social networks can and do make a significant contribution to shaping the ways in which necessary health information and healthy behaviour are transferred to new parents. Also, the genetic make-up of children can be partly disclosed by undertaking extensive family anamnesis on existing diseases, allergies and other relevant medical conditions in a family. This can be crucial in preventing the development or deterioration of these health problems in the children.¹¹³¹

¹¹²⁹ The health of the child is inextricably linked to the health and the health practices of their mothers. The World Bank found that 'at least 20% of the burden of disease among children less than 5 years old is attributable to conditions directly associated with poor maternal health, nutrition and the quality of obstetric and newborn care.' Safe Motherhood and the World Bank: Lessons from 10 Years of Experience, Washington, D.C., World Bank, Human Development Network, Health Nutrition, and Population Division, 1999 Jun. 42, Volume 12: Available at: www.k4health.org/popline/safe-motherhood-and-world-bank-lessons-10-years-experience, information discussed in: D.L. Parker & S. Bachman, 'Economic exploitation and the health of children: Towards a rights-oriented public health approach', *Health and Human Rights*, Volume 5, no. 2, p. 100.

¹¹³⁰ In order to tackle problems deriving from the intricate relation between mothers and their newborn children, the Save Motherhood Initiative was launched in 1987 by the World Health Organization and other international agencies aiming to reduce the maternal and infant mortality rates caused by pre- and perinatal circumstances.

¹¹³¹ For example, knowledge on the genetic predisposition for a mutation in BRCA 1 or BRCA 2 can stimulate girls to closely monitor their breasts and thereby identify any instances of breast cancer so that early intervention becomes possible.

Furthermore, in contacts with medical professionals, the primary responsibility of parents and other primary caretakers as laid down in articles 5 and 18 CRC for their children must be respected and enhanced, because they see their children most often and therefore usually know best what their children need. Therefore, especially for very young children, parents and primary caretakers must be given sufficient time and opportunity to communicate their observations on their children's health needs. By truly acknowledging this primary responsibility of parents to ensure their children's health, parents are better enabled to take responsibility over their children in the health care process.

A clear distinction thus appears between the responsibilities of the parents on the one hand, namely to provide the individual child with care and guidance and the general responsibilities of the States Parties to render assistance to all parents in their child-rearing responsibilities by providing for institutions, facilities and services for child care. Parents thus are responsible for ensuring the right to health of their individual children, whereas States Parties have the responsibility to support parents in meeting these obligations. Only in exceptional circumstances, in which parents do not or cannot meet their primary responsibility of ensuring the right to health of their children, does the State acquire the primary and direct responsibility for realizing the right to health of the child.

6.4.3. THE ROLE OF MEDICAL PROFESSIONALS IN REALIZING CHILDREN'S RIGHT TO HEALTH

In the attribution of responsibilities to the different professionals involved in children's health care, two important points of distinction are identified: the division of responsibilities between State Parties and medical professionals and the division of responsibilities between medical professionals and the child and its family.

The first intersection concerns the relation between the responsibilities of the State and the responsibilities of medical professionals in applying children's rights principles in practice. Several scholars have righteously argued that the medical approach to ensuring children's health is principally focused on clinical diagnosis and intervention, involving the identification of morbidities, such as asthma, obesitas, diabetes, infant mortality etc.¹¹³² The subsequent steps taken are usually also confined to the medical domain, consisting of establishing incidence, prevalence, mortality, etc. to characterize mortality. However, it has also repeatedly been demonstrated that the root causes of many childhood illnesses

¹¹³² Goldhagen & Mercer, 'Child Health Equity: From Theory to Reality', in: A. Invernizzi, *The Human Rights of Children*.

lay in a much wider context, involving different economic, cultural, social and political domains.¹¹³³

The need to approach the right to health of children from different perspectives is the domain in which States Parties have to coordinate different policy areas that all contribute to the realization of the right to health of children. At the same time, the health related articles of the CRC and its translation to the practice of medical professionals can help to expand the approach taken by medical professionals in ensuring children's right to health beyond the limited scope of the biomedical approach.

Therefore, crucial in the realization of children's rights in health care is the translation of children's rights legislation to the daily practices of medical professionals. Both from General Comment 5 of the Committee on the Rights of the Child on the General measures of implementation of the Convention (art. 4, 42 and 44.6) and from the analysis of the Concluding Observations of the Country Reports, it appears that health professionals must be continuously (re-)educated on the requirements of child-friendly health care. This can be achieved through specific education for medical students and professionals on the implications of children's rights for their daily medical practice. The role of medical professionals in realizing the highest attainable standard of health of children is crucial. When medical professionals truly apply children's rights in their daily practices, 'they become implementers and agents of social justice and human rights in the communities in which they work.'¹¹³⁴ In order to enable educational institutions to provide for children's rights education to medical professionals, sufficient resources must be allocated to such education.

Equally important is the integration of children's rights and the implications following from these rights in work protocols and practices in the medical sector. For example, whereas blood values of infants in hospital can be determined at one pre-set moment, for example at 8 o'clock in the morning, the best interests of the child are usually better met when they are tested once the baby has woken up. The same goes for planning appointments for babies during their daily nap. Simple, but significant changes in daily routines can greatly contribute to putting the interests of the child first, instead of taking the working methods in the medical sector as a starting point.

It is at this second intersection between the actions, communications and responsibilities of medical professionals in the daily health care practice that the input of children and families becomes important. Whereas professionals compare the appearance of a child (e.g. colour, heart rate, blood values) with standard health or disease indicators, children and their parents are among the first to notice any changes in the normal functioning of the child. A child is the

¹¹³³ E. Riedel, 'The Right to Life and the Right to Health, in particular the obligation to reduce child mortality', in: C. Tomuscat, *The right to life*, Martinus Nijhoff Publishers 2010, p. 365.

¹¹³⁴ Ibidem supra note 1131.

first to experience pain and express this (or to become silent), whereas parents are usually well-able to compare the behaviour of the sick child with its normal behaviour. Notwithstanding standardized measurements by or impressions of the medical professionals, different children can have different more or less expressive ways to communicate their feelings of comfort or discomfort. Therefore, it is important to take parents' appraisal of their child's symptoms seriously, because they can give crucial additional information that is not directly visible or measurable and can definitely not be standardized.¹¹³⁵ On the other hand, medical professionals are better able to compare the peculiarities of the symptoms with similar disease patterns in other children. They can also play a significant role in establishing good relations with children and their parents. Research findings have identified several key factors that are influential to the effectiveness of communication with children, including the personality and attitude of the health professional, sufficient time and opportunity and physical environment and the lack of training in communication skills.¹¹³⁶ Research on the interaction between families and health professionals have confirmed that the dynamic between them and parents is a hugely significant factor in how they communicate with their child patients.¹¹³⁷

This section identified the role of medical professionals in realizing the right to health of the child. Whereas their work is largely confined to the strictly medical domain, they are among the first to signal instances of violations of the right to health of children. Through the interference of medical organizations such violations can be systematically identified and addressed before courts and in the (in)ternational political arena.

6.5. OPTIONAL PROTOCOL III TO THE CRC ON A COMMUNICATIONS PROCEDURE FOR CHILDREN

In the preparation phase to the third Optional Protocol to the CRC on a communications procedure for children, the Special Representative of the Secretary-General on Violence against Children commented that 'the right to an effective remedy provides the bridge between theoretical recognition and

¹¹³⁵ See also Recommendations on Communication between health care professionals children and their parents or carers. Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5258136.

¹¹³⁶ D. Kamin, 'Hospital rounds: How's the doctor-patient communication system?', *Vector* 2011. Available at: <http://vectorblog.org/2011/09/hospital-rounds-hows-the-doctor-patient-communication-system/>.

¹¹³⁷ Ibidem supra note 1135.

meaningful enforcement of human rights'.¹¹³⁸ Newell phrased this same point negatively by stating that 'the gap between the obligations taken up by States and the extent to which children's rights are realized and enjoyed in reality (...) owes much to the lack of effective mechanisms at national, regional and international level to enable children and their representatives to challenge violations and gain remedies'.¹¹³⁹ The Committee on the Rights of the Child had previously stated that 'for rights to have meaning, effective remedies must be available to redress violations'.¹¹⁴⁰ The idea of the adoption of an Optional Protocol to the Convention on the Rights of the Child on a Communications procedure for children was to fill in this lacuna.

On 19 December 2011, Optional Protocol III to the Convention on the Rights of the Child on a Communications Procedure for children was adopted by the UN General Assembly.¹¹⁴¹ Although welcomed as an important milestone in the emancipation and acknowledgement of children's rights,^{1142, 1143} there is one important deficit in the resulting document: no children were involved in its drafting process.^{1144, 1145} This is at least remarkable given the qualification of the

¹¹³⁸ U.N. Doc. A/HRC/WG.7/1/CRP.7, 14 December 2009, Human Rights Council Working Group on an Optional Protocol to the Convention on the Rights of the Child to provide a communications procedure. Marta Santos Pais, Special Representative of the Secretary-General on Violence against children, p. 2.

¹¹³⁹ U.N. Doc. A/HRC/WG.7/1/CRP.2, 9 December 2009. Submission by Newell, P. to the First session of the Open-Ended Working Group of the Human Rights Council considering the possibility of elaborating an Optional Protocol to provide a communications procedure for the Convention on the Rights of the Child, § 1, p. 1.

¹¹⁴⁰ U.N. Doc. CRC/GC/2003/5, General Comment 5 General measures of implementation of the Convention on the Rights of the Child, 27 November 2003, § 24.

¹¹⁴¹ U.N. Doc. GA/11198, 19 December 2011.

¹¹⁴² Y. Lee, 'Celebrating important milestones for children and their rights', *The International Journal of Children's Rights* 2010, Volume 18, The Hague: Kluwer Law International.

¹¹⁴³ S. Lembrechts, 'Wiens klachtrecht? Het kind-concept in het derde Facultatief Protocol bij het Verdrag inzake de Rechten van het Kind betreffende de instelling van een communicatieprocedure', *Tijdschrift voor Jeugd- en Kinderrechten* 2012, Issue 2, p. 97.

¹¹⁴⁴ Only in a joint submission by several NGOs to the first Open-ended working groups there is included a 2-page Annex that includes a statement signed by 27 adolescents from England, Sweden and Moldova. See all documents of the drafting process of the Optional Protocol at: www.ohchr.org/EN/HRBodies/HRC/WGCRC/Pages/OpenEndedWorkingGroupIndex.aspx.

¹¹⁴⁵ The issue of involving children in the drafting process of Optional Protocol III to the Convention on the rights of the child was mentioned by several delegations and independent experts. Switzerland commented that 'article 12 is a key article in this process'; Portugal reiterated the right to be heard of children; Syria asked whether there are any best practices of how children can be involved in the drafting of legislation that includes their basic rights; Yanghee Lee, Chair of the CRC Committee said that 'General Comment 12 on the right of the child to be heard was a key introduction to pave the way for the OP'; Slovenia particularly mentioned the need for 'an innovative approach in order to make the communications procedure comprehensive and accessible' and highlighted the need to seek the views of children. This was followed by a comment made by Ireland that they 'would like to echo the comments made by Slovenia that children should be informed about the work of this working group and get their input on the drafting of a procedure, what it means and how it can be used'. See Meeting of the UN Working Group for the Communications Procedure, December 2009, available at: www.crin.org/docs/OP_CRC_WG_Meeting_Dec2009.pdf.

children's right to participation as one of the key principles in the Convention on the Rights of the Child.¹¹⁴⁶ The same is true for the Convention on the Rights of the Child itself: no children were involved in its drafting process.^{1147, 1148} Therefore, additional research is required on ways to involve children in conceptualizing and realizing their rights, including their right to health and their right to participation. Nevertheless, the adoption of Optional Protocol III to the Convention on the Rights of the Child does offer an opportunity for children to become involved in the realization of their own rights.¹¹⁴⁹ The Protocol entered into force in January 2014, when Costa Rica was the 10th Member State to sign the Protocol.¹¹⁵⁰

A complaints procedure allows individuals, groups and their representatives to bring alleged violations of their rights before a competent Human Rights Committee. This is especially important when domestic or regional complaints mechanisms are insufficient or don't exist.¹¹⁵¹ In addition to the monitoring activities of the Committee in its Concluding Observations in the Country Reports and the issuing of General Comments and Days of General Discussion, it provides for an additional tool to put pressure on States Parties to ensure children's rights and to provide for effective remedies at the national level.¹¹⁵² Thereby, it would be a necessary tool to enhancing State accountability for ensuring children's rights.

The absence of a communications procedure for children was criticized to be discriminatory towards children, given the fact that all other Human Rights Treaties had or were in the process of obtaining a complaints mechanism,

¹¹⁴⁶ U.N. Doc. CRC/GC/2003/5, § 12.

¹¹⁴⁷ Legislative history of the Convention on the Rights of the Child, Volume I and II, United Nations, New York and Geneva, 2007.

¹¹⁴⁸ Detrick, *The Convention on the Rights of the Child: A Guide to the Travaux Préparatoires*, Dordrecht/Boston/London: Martinus Nijhoff Publishers 1992, p. 23. Chapter on Participants in the Drafting Process, available at: <http://books.google.nl/books?hl=nl&lr=&id=65TCU0N9fksC&oi=fnd&pg=PR9&dq=guiding+principles+convention+on+the+rights+of+the+child&ots=KXLEfgVPsG&sig=fRITjSKxGqxh2QxCN9DrXuGnqT8#v=onepage&q=guiding%20principles%20convention%20on%20the%20rights%20of%20the%20child&f=false>.

¹¹⁴⁹ See article 19 of the Optional Protocol III, which stipulates that the Protocol shall entry into force three months after the deposit of the tenth instrument of ratification or accession. For States who ratify the Protocol after that moment, the Protocol shall entry into force three months after the date of the deposit of its own instrument of ratification or accession.

¹¹⁵⁰ On 28 February 2012, the Optional Protocol on a communications procedure for children was opened for signature in a ceremony in Geneva. It was signed by 20 States, including Brazil, Costa Rica, Peru, Uruguay, Chile, Spain, Italy, Portugal, Austria, Belgium, Germany, Finland, Luxembourg, the Slovak Republic, Slovenia, Serbia, Montenegro, Maroc, Mali and Maldives. Since June 2013 the Optional Protocol is ratified by 6 States: Albania, Bolivia, Gabon, Germany, Spain, Thailand, Available at: www2.ohchr.org/english/bodies/crc/OPIC_Ceremony.htm.

¹¹⁵¹ U.N. Doc. A/HRC/WG.7.1.CRP.2, 9 December 2009, it was commented by Newell that in addition to the domestic legal procedures, requiring the provision of child-friendly information, access to courts and independent children's ombudsmen could also play a role in receiving and dealing with complaints made by children.

¹¹⁵² See the arguments made in the online campaign on the children's rights information network to call for petitions: www.crin.org/petitions/petition.asp?PetID=1007.

most notably the ICESCR.^{1153, 1154, 1155} Furthermore, the application of already existing procedures for children, would not take into account the entire range and holistic character of all children's rights.¹¹⁵⁶ Therefore, there was a need adopt a communications procedure that would be child-sensitive. Furthermore, the establishment of a separate complaints procedure for children would allow for the assessment of alleged children's rights violations by Members of the CRC Committee, being experts on the rights of the child and their particular vulnerabilities.¹¹⁵⁷ Last but not least, it was assumed that existing complaints mechanisms were hardly known among children.

6.5.1. DRAFTING HISTORY

The initiative for an Optional Protocol to the CRC on a communications procedure for children was taken in 2002 by a German NGO, Kindernothilfe.¹¹⁵⁸ When the communications procedure to the ICESCR was adopted on 19 June 2008, the international campaign had grown to more than 400 organizations and the Committee on the Rights of the Child expressed its support in stating that 'The Committee had 'weighed the pros and cons' and was 'now inviting all stakeholders

¹¹⁵³ Ibidem supra note 1151.

¹¹⁵⁴ The Optional Protocol to the ICCPR entered into force on 23 March 1976; the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment allows for an inquiry procedure under article 20 and for a communications procedure under article 20. It entered into force on 26 June 1987; the International Convention on the Elimination of All Forms of Racial Discrimination contains a communication procedure in article 14, which entered into force on 4 January 1982 following acceptance of the competence of the monitoring Committee by 10 States; the Optional Protocol to the Convention on the Elimination of Discrimination against Women entered into force on 22 December 2000; the Convention on the Rights of Persons with Disabilities and its Optional Protocol, will enter into force after ratification by 10 States; the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families contains a communication procedure under article 77; the International Convention for the Protection of All Persons from Enforced Disappearance contains a provision on a communication procedure under article 31 for which the competence of the monitoring Committee can be recognized by States. The Optional Protocol to the ICESCR was adopted by the General assembly by resolution A/RES/63/117 on 10 December 2008, available at: www2.ohchr.org/english/law/docs/a.RES.63.117_en.pdf.

¹¹⁵⁵ Several regional courts also provide for a complaints mechanism including the African Commission on Human and People's Rights under article 56 of the African Charter on Human and Peoples' Rights; the African Committee of Experts on the Rights and Welfare of the Child under article 44 of the African Charter on the Rights and Welfare of Children (individual, group or recognized organizations); the Inter-American Commission and Court of Human Rights under article 44 of the American Convention on Human Rights (individual, group and organizations); the European Court of Human Rights (individual complaint procedure) and the European Committee of Social Rights (collective complaint procedure by certain approved NGOs).

¹¹⁵⁶ Ibidem supra note 1025.

¹¹⁵⁷ Ibidem supra note 1025.

¹¹⁵⁸ See Report: U. Müller, *Children as strong as nations*, Kindernothilfe. Available at: Background, reasons and arguments for introducing a right of petition.www.crin.org/docs/Children_as_Strong_as_Nations.pdf.

to come forth and seriously work together on the drafting process'.¹¹⁵⁹ Thereupon, they requested the General Assembly of the United Nations to establish a working group to draft such a Protocol,¹¹⁶⁰ which was soon thereafter established by a resolution of the Human Rights Council in June 2009.¹¹⁶¹ The mandate was to 'explore the possibility of elaborating an Optional Protocol to the Convention on the Rights of the Child to provide a communications procedure complementary to the reporting procedure under the Convention'.¹¹⁶² After a three-day discussion with children's rights experts, NGOs, and members of the Committee on the Rights of the Child, the Working Group was mandated by a resolution of the General Assembly to write a draft for the Optional Protocol on a communications procedure for children.¹¹⁶³

The second working group was held in two parts: from 6–10 December 2010 devoted to debating the draft optional protocol as prepared by the chairperson of the working group and from 10–16 February 2011 to debate a revised version of the draft optional protocol.¹¹⁶⁴ The session was opened by the High Commissioner for Human Rights and she informed the working group about a special expert meeting that had been organized in June 2010. The experts had acknowledged the value of existing communications procedures and they were generally in favour of an innovative protocol that suited the needs of children, that was transparent and widely disseminated to its users and that would cover the rights enshrined in the CRC and in its Optional Protocols.¹¹⁶⁵ Furthermore, the experts were in favour of providing for both an individual and a collective communications procedure and they argued the need to allow the Committee to request interim measures in cases pending before it. Lastly, they would include 'a procedure for friendly settlements between the parties in a communication, taking into account the best interests of the children involved'. The Chairperson, who prepared the draft version of the optional protocol, clarified that his intention was to seek consistency with existing communications procedures, while taking into account the specificities of children.^{1166, 1167}

¹¹⁵⁹ See CRIN: Communications procedure: Committee on the Rights of the Child endorsed campaign, www.crin.org/resources/infoDetail.asp?ID=17602&flag=news.

¹¹⁶⁰ U.N. Doc A/HRC/8/NGO/6, 26 May 2008.

¹¹⁶¹ U.N. Doc A/HRC/RES/11/1, 17 June 2009. Resolution of the General Assembly to establish an open-ended working group on an Optional Protocol to the Convention on the Rights of the Child to provide a communications procedure, 17 June 2009.

¹¹⁶² Ibidem supra note 1038, § 1.

¹¹⁶³ U.N. Doc General Assembly, A/HRC/RES/13/3, 14 April 2010.

¹¹⁶⁴ U.N. Doc. A/HRC/17/36, 25 May 2011, § 3.

¹¹⁶⁵ U.N. Doc. A/HRC/17/36, 25 May 2011, § 5.

¹¹⁶⁶ U.N. Doc. A/HRC/17/36, 25 May 2011, § 16.

¹¹⁶⁷ U.N. Doc. A/HRC/WG.7/1/CRP.2, 14 December 2009. Peter Newell provided for a useful overview of the provisions included in the existing communications procedures for other treaties, including the ICCPR, CEDAW, ICESCR, CRPD. See Annex II. Available at: www.ohchr.org/EN/HRBodies/HRC/WGCRC/Pages/OpenEndedWorkingGroupSession1.aspx.

Initially, the intention was to include three kinds of procedures: an individual, a collective and an interstate complaints procedure.¹¹⁶⁸ Several arguments were made to incorporate not only an individual but also a collective complaints mechanism. First of all, it would be in line with the African Charter on the Rights and Welfare of the Child.¹¹⁶⁹ Secondly, it would enhance the accessibility of the procedure,¹¹⁷⁰ because it would give children the opportunity to remain anonymous in the filing of a complaint.¹¹⁷¹ Thirdly, it would allow for a more efficient procedure in the Committee on the Rights of the Child, having the opportunity to investigate and condemn plural violations at the same time.¹¹⁷² However, the second draft contained an 'opt-in clause', which led to much debate.^{1173, 1174, 1175} This clause entailed that States should explicitly recognize the collective complaints mechanism when ratifying the Protocol.¹¹⁷⁶ The incorporation of this clause was heavily criticized in the discussion of this second draft document in February 2011. Notwithstanding the support of NGOs, the Committee on the Rights of the Child and several children's rights experts,¹¹⁷⁷ the strong opposition of a significant number of Member States led to the complete removal of the collective complaints procedure for children in the final draft.^{1178, 1179}

Given the collective nature of economic, social and cultural rights, the removal of the collective complaints procedure for children is a serious deficit in the new Optional Protocol for realizing children's right to health. This is

¹¹⁶⁸ See articles 2 and 3 of the draft proposal for the Optional Protocol discussed in the open-ended working group. UN Doc. A/HRC/WG.7/2/2, 1 September 2012, available at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G10/157/81/PDF/G1015781.pdf?OpenElement>.

¹¹⁶⁹ UN General Assembly, A/HRC/WG.7/2/2, 1st September 2010.

¹¹⁷⁰ Joint NGO Submission to the Open-ended Working Group on an Optional Protocol to the Convention on the Rights of the Child to provide a Communications Procedure, October 2010, p. 6–7.

¹¹⁷¹ C. Phillips, 'Klachtrecht bij het Comité inzake de rechten van het Kind', *Tijdschrift voor Familie- en jeugdrecht* 2012, Issue 4, April, p. 93.

¹¹⁷² Ibidem supra note 1170.

¹¹⁷³ Langford & Clark argued that an opt-out clause would be better than an opt-in clause upon ratification of the Optional Protocol. However, ultimately, the collective complaints procedure was completely left out. See: Langford & Clark, *A complaints Procedure for the Convention on the Rights of the Child: Commentary on the Second Draft*, Norwegian Centre for Human Rights (University of Oslo), 7 February 2011, p. 4. Available at: www.ohchr.org/Documents/HRBodies/HRCouncil/WGCR/Session2/NCHR_Commentary.pdf.

¹¹⁷⁴ Langford & Clark, *The new kid on the block: A complaints procedure for the Convention on the Rights of the Child*, Working Paper, No.1, Socio-Economic Rights Programme, Norwegian Centre for Human Rights, University of Oslo, January 2010. Available at: www.jus.uio.no/smr/english/people/aca/malcolml/new-kid-on-the-block-langford-clark.pdf.

¹¹⁷⁵ Preliminary Joint NGO Submission to the Open-ended Working Group on an Optional Protocol to the convention on the Rights of the Child to provide a communications procedure, February 2011.

¹¹⁷⁶ UN General Assembly, A/HRC/WG.7/2/4, 13 January 2011, p. 4.

¹¹⁷⁷ UN General Assembly, A/HRC/17/36, 16 May 2011, pp. 12–13.

¹¹⁷⁸ Final version of the Optional Protocol on a communications procedure for children. Available at: http://treaties.un.org/doc/source/signature/2012/CTC_4-11d.pdf.

¹¹⁷⁹ Complaints Mechanism: Summary of Final Draft Meeting www.crin.org/resources/infodetail.asp?id=24180.

especially so for the obligation to fulfil children's right to health, because it is difficult to establish the necessary health infrastructure for separate individuals. If complaints can be brought before the Committee in concomitance, it is easier to establish the possible existence of systematic or widespread violations of children's economic, social and cultural rights, including their right to health.¹¹⁸⁰ Newell confirms this by stating that 'a collective complaints mechanism could be helpful in encouraging States to develop CRC-compliant laws as well as policies'.¹¹⁸¹ Although no objections were made in the Open-ended Working Group on the justiciability of economic, social and cultural rights, the participants did not translate this point of view in an actual enforcement mechanism.¹¹⁸² With respect to the more passive obligation to respect children's right to the highest attainable standard of health, the Optional Protocol may therefore be more effective than it is with respect to the enforcement of its active obligations to protect and to fulfil the right of the child to the highest attainable standard of health. Whereas individual children do have the opportunity to make an individual complaint over a breach of their personal right to health, the lack of teeth of the Protocol for enforcing economic, social and cultural rights, more particularly children's right to the highest attainable standard of health thus remains a lacuna to be filled.

6.5.2. EXHAUSTION OF NATIONAL REMEDIES

The Preamble of Optional Protocol III to the Convention on the Rights of the Child states that States Parties are encouraged 'to develop appropriate national mechanisms to enable a child whose rights have been violated to have access to effective remedies at the domestic level'. Article 7e OP III furthermore establishes that 'The Committee shall consider a communication inadmissible, when all available domestic remedies have not been exhausted.' Before acquiring access to the communications procedure for children as laid down in Optional Protocol III to the CRC, children's rights violations must be first dealt with at the national

¹¹⁸⁰ Although the specific text was debated, the first draft stated that only grave or systematic violations were justiciable in a collective communications procedure. However, now this provision was left out, the Committee on the Rights of the Child will need to keep a register of all children's rights violations, especially of a similar type within a certain country to be able to establish such a systemic, systematic or widespread practice of children's rights violations.

¹¹⁸¹ U.N. Doc. A/HRC/WG.7/1/CRP.2, 9 December 2009. Submission by Newell, P. to the First session of the Open-Ended Working Group of the Human Rights Council, considering the possibility of elaborating an Optional Protocol to provide a communications procedure for the Convention on the Rights of the Child, § 48.

¹¹⁸² Langford & Clark comment that the previous resolution of the debate had been solved in the extensive discussions on the Optional Protocol to the ICESCR. This Optional Protocol was adopted by consensus in December 2008. See: Langford & Clark, *The new kid on the block: A complaints procedure for the Convention on the Rights of the Child*, Working Paper, no. 1, Socio-Economic Rights Program, Norwegian Centre for Human Rights, University of Oslo, January 2010, p. 10. Available at: www.jus.uio.no/smr/english/people/aca/malcolm/new-kid-on-the-block-langford-clark.pdf.

level. Although the point of departure for establishing admissibility of the Committee for receiving complaints is the exhaustion of national remedies,¹¹⁸³ article 7e of OP III provides for an emergency exit when ‘the application of remedies is unreasonably prolonged or unlikely to bring effective relief’. Taking the health related cases in the Dutch study on enforceability of children’s rights in domestic courts as an example, this means that the cases in which no direct justiciability of the right to health of the child was established, may give room to starting a communications procedure before the Committee on the Rights of the Child on the basis of a violation of the right to health of the children at hand. Another entrance may develop, when children are not granted legal capacity within domestic law. Proving this however, may constitute a significant threshold for children to make a complaint before the Committee. Especially for very young children aged 0–5, representation at both the national and the international level is required to make a case for violations of their right to health. Another option is that violations of children’s rights superannuate only after a considerable period of time. Problematic, however, in this option is that present day violations may only be dealt with in the future and that children therefore continue to suffer from them. With respect to the enjoyment of the right to health, this may have long-lasting and even irrevocable consequences for the health and even the survival of the child. Therefore, it is more recommendable to ensure that procedures for addressing violations of children’s right to health truly take into account the best interests of the child.

6.5.3. CHILDREN’S RIGHTS IN OPTIONAL PROTOCOL III: ROOM FOR PARTICIPATION?

Optional Protocol III to the Convention on the Rights of the Child contains 24 articles and a Preamble. The provisions are grouped in four parts. Part I entails general provisions and establishes the admissibility of the Committee in article 1, the general principles that guide the functioning of the Committee in article 2, the rules of procedure in article 3 and protection measures in article 4. It is remarkable that in this part, no separate article is included on participatory measures to involve children in the process. Given the required balancing in the Convention between the protection rights of children and their participation rights,¹¹⁸⁴ it would have been more balanced to incorporate an explicit article on

¹¹⁸³ It is considered in the Preamble that Optional Protocol III ‘will reinforce and complement national and regional mechanisms allowing children to submit complaints for violations of their rights’ and thereto States Parties are encouraged ‘to develop appropriate national mechanisms to enable a child whose rights have been violated to have access to effective remedies at the domestic level’. Article 7e OP III furthermore establishes that ‘The Committee shall consider a communication inadmissible, when all available domestic remedies have not been exhausted.’

¹¹⁸⁴ See *supra* note 1139.

children's participation rights in the actual Protocol in addition to the relatively strong focus on protective measures, such as the protection measures in article 4. Although now included in paragraph 19 of the Rules of Procedure of the Committee, inclusion in the Protocol itself would have had more standing and it could have established a significant point of reference for regional and national communications procedures for children.¹¹⁸⁵ The left-out of such a provision is a missed opportunity in enabling children to stand-up for their rights.

Part II provides for the actual communications procedure in articles 5-12. Two separate routes are possible, namely a communications procedure of individuals in article 5 and an inter-state communications procedure in article 12 OP III. On the basis of article 1 OP III, complaints are lodged against States that satisfy two conditions: the State must be a party to the CRC and to the Optional protocol III and the State must have recognized the competence of the Committee to consider complaints from individuals. In response to these distinct communications procedures, the Committee has several responses at its disposal. In the first place and under article 8 OP III, the Committee confidentially brings the complaint to the attention of the State Party, who thereupon has the opportunity 'to submit a written explanation or statement clarifying the matter or any remedy that it provided'. Article 10-4 provides that in reviewing any violations of economic, social and cultural rights, the Committee 'considers the reasonableness of the steps taken by the State, bearing in mind that the State Party may adopt a range of possible policy measures for the implementation of economic, social and cultural rights in the Convention. Secondly, the Committee has the possibility to request the State to take interim measures to avoid possible irreparable damage to the child on the basis of article 6 OP III. The rationale behind this article is that minimizing harm in children by violations of their rights may require immediate action on the basis of their developing capacities. Thirdly, the Committee has the option to settle complaints in a friendly way for complaints made by individuals in article 9 and for interstate procedures in article 12-3. In responding to individual communications, this last option poses an interesting opportunity for the Committee to support children in standing up for their own rights, while mediating between the State Party and the children who make a complaint. Through this route, children can become involved in the process of problem-solving themselves, experiencing and elaborating upon the

¹¹⁸⁵ In preparation to the Optional Protocol on a communications procedure for children, Newell has provided an overview of the regional human rights mechanisms that are available to children. He found that there are 'African, Inter-American and European mechanisms that can be used to challenge violations of children's rights'. He furthermore commented that 'although there has been relatively little use of them by or on behalf of children, this is certainly not an indication that children are enjoying general respect for their rights, nor that they have adequate remedies at national level'. U.N. Doc. A/HRC/WG.7/1/CRP.2, 9 December 2009. Submission by P. Newell to the First session of the Open-Ended Working Group of the Human Rights Council, considering the possibility of elaborating an Optional Protocol to provide a communications procedure for the Convention on the Rights of the Child.

realization of their own rights. However, caution must be taken that children's communications are taken seriously in this route, because this route closes the initial communications procedure and because the Committee is not permitted to consider communications which it has dealt with before (article 7d). Also, this route may be difficult in situations of grave or systematic violations of children's rights as referred to in article 13 OP III, but it could be an innovative route to establish good and child-friendly practices in countries where the government is willing to collaborate and improve its policy and working methods not only to the benefit, but, more importantly, with the active involvement of its minor inhabitants. The fourth and last option that the Committee has at his disposal is to conduct an inquiry in a State under article 13 when there is reliable information that children's rights as laid down in the Convention and/or its Optional Protocols are gravely or systematically violated. If required thereto, the Committee may designate one or more of its members to conduct such an inquiry, confidentially and if necessary including a field visit. Part IV eventually contains final provisions dealing with practical issues such as signature, ratification and entry into force and also with international assistance and cooperation in article 15 OP III.

In the Preamble of OP III it is recognized that 'children's special and dependent status may create real difficulties for them in pursuing remedies for violations of their rights.' It is furthermore stated that remedies for violations of children's rights should take into account the need for child-sensitive procedures at all levels. All delegations present emphasized the need to include child-friendly procedures, as currently laid down in article 3 OP III. The specificities of these procedures are to be elaborated by the Committee on the Rights of the Child in its rules of procedure.¹¹⁸⁶ In addition, delegations reached consensus over the inclusion of a provision to protect children within their domestic jurisdiction against human rights violations, ill-treatment or intimidation as a consequence of having submitted communications procedures.¹¹⁸⁷ This was eventually laid down in article 4 OP III. Lembrechts argues that whereas the traditional image of childhood in the Convention on the Rights of the Child shifts along the lines of its developing capacities as laid down in article 5 CRC from an emphasis on 'the child as a passive recipient of protection and care' in article 3 CRC to 'the child as an active participant' in article 12 CRC, the interconnected nature of these three rights, is reflected in the final draft of the Optional Protocol. Especially article 2 is exemplary in mentioning elements of all three rights:

Article 2 OP III to the CRC: 'In fulfilling the functions conferred to it by the present Protocol, the Committee shall be guided by the principle of the best interests of the child. It shall also have regard for the rights and views of the child,

¹¹⁸⁶ UN General Assembly, A/HRC/WG.7/2/4, 13 January 2011 § 29.

¹¹⁸⁷ Ibidem *supra* note 1185, § 31–33.

the views of the child being given due weight in accordance with the age and maturity of the child.’

Lembrechts argues that whereas the mentioning of children’s right to be heard is limited to this provision, the broad support for the participatory dimension of the child-concept in the drafting phase, reflects the intention to involve children in the communications procedure.¹¹⁸⁸ In line with the many declarations of intent for involving children in advocating for their own rights,¹¹⁸⁹ this intention has recently be included in paragraph 19 of the Rules of Procedure of the Committee on the Rights of the Child. Given the history of *not* involving children in the drafting of the Convention on the Rights of the Child, in its Optional Protocols nor in the General Comments or the Concluding Observations of the Committee on the Country Reports, it is time that the Committee on the Rights of the Child itself provides for a good example of involving children in the drafting of its own rules of procedure. This would be a much more convincing example of involving children in the enforcement of their own rights, than repeatedly stating that children’s right to be heard should be respected.¹¹⁹⁰

The main issue that remains to be resolved in the Rules of Procedure is the determination of who is capable of making complaints before the Committee: children, their parents, legal guardians or other representatives. In general, article 5 OP III provides that an individual or a group of individuals whose rights as laid down in the CRC or its Optional Protocols have been violated can make a complaint. Secondly, when someone makes a complaint on behalf of an individual, this must be done with their consent or the author must be able to justify acting without the consent of that person (e.g. when acting on behalf of a baby, who is not able to give consent, but who have suffered violations of his or her rights). Newell righteously recalls that children are not the only group who may be dependent on others to bring a complaint before an international Committee. He states that ‘the lack of capacity is not unique to children. It is equally true for many adult rights holders who are considered to lack the capacity to act on their own behalf – for example adults with severe learning disabilities, elderly and confused adults.’¹¹⁹¹ Lessons can therefore be learned from experiences of these groups to include children either directly or indirectly in the communications procedure.

¹¹⁸⁸ S. Lembrechts, ‘Wiens klachtrecht? Het kind-concept in het derde Facultatief Protocol bij het Verdrag inzake de Rechten van het Kind betreffende de instelling van een communicatieprocedure’, *Tijdschrift voor Jeugd- en Kinderrechten* 2012, Issue 2, p. 99–103.

¹¹⁸⁹ See supra note 1186.

¹¹⁹⁰ See for an extensive elaboration of the Committee’s explanation of the right of the child to be heard, General Comment 12. U.N. Doc. CRC/C/GC/12, 20 July 2009.

¹¹⁹¹ U.N. Doc. A/HRC/WG.7/1/CRP.2, 9 December 2009. Submission by P. Newell to the First session of the Open-Ended Working Group of the Human Rights Council considering the possibility of elaborating an Optional Protocol to provide a communications procedure for the Convention on the Rights of the Child, § 53, p. 12.

In order to genuinely involve children in the communications procedure, the modes of involvement should be taken into account. However, the requirement as laid down in article 7b OP III that complaints need to be submitted in written form poses a significant obstacle in genuinely involving children in the adjudication of violations of their rights, given the fact that many children have different modes of preferred communication, including drawing, talking or playing with dolls and communicating through music.^{1192, 1193} This requirement especially poses a barrier to children or their representatives who are not able to write. Also in other respects, caution must be taken to ensure that no legal or practical barriers are established in ensuring access for children to this communications procedure. Marta Santos Pais, the Special Representative of the Secretary-General on Violence against Children, sets several conditions for ensuring a communication procedure that is child sensitive.¹¹⁹⁴ According to her, a first requirement is that the information on the existing complaint mechanism to children and the way in which it can be used is widely disseminated to children and other actors involved, e.g. through incorporation in the school curricula of the child.¹¹⁹⁵ Thereto, the Protocol must be issued in a child-friendly version.¹¹⁹⁶ Thirdly, 'all relevant actors must be knowledgeable and skillful in the use of communications procedures and in the promotion of ethical principles when dealing with and supporting children in this regard'.¹¹⁹⁷ Fourthly, the right of the child to be informed must be realized 'in a form and language that is adapted to the age and level of understanding of the child'.¹¹⁹⁸ Last but not least, children who become involved in a communications procedure must be protected against 'any pressure

¹¹⁹² See for example: M. Delfos, *Luister je wel naar mij? Gespreksvoering met kinderen tussen vier en twaalf jaar*, [Do you listen to me? Communicating with children between 4–12 years], Amsterdam: Uitgeverij SWP 2007, pp. 149–156. Delfos establishes that for children both verbal and non-verbal modes of communication are important, as well as a combination of communication and playing techniques.

¹¹⁹³ See also the Guidelines on child-friendly justice of the Council of Europe, November 2010, available at: [https://wcd.coe.int/ViewDoc.jsp?Ref=CM/Del/Dec\(2010\)1098/10.2abc&Language=lanEnglish&Ver=app6&Site=CM&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383](https://wcd.coe.int/ViewDoc.jsp?Ref=CM/Del/Dec(2010)1098/10.2abc&Language=lanEnglish&Ver=app6&Site=CM&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383). General Principle A1 provides that children's level of maturity and any communications difficulties must be born in mind in order to make their participation meaningful. Furthermore in 3.44, it is stipulated that 'Means used for the hearing of children should be adapted to the child's level of understanding and ability to communicate and take into account the circumstances of the case'. Another example of child-friendly communications procedures is found in 5.59 'Interview methods, such as video or audio-recording or pre-trial hearings in camera, should be used and considered as admissible evidence.'

¹¹⁹⁴ In the UN Guidelines on Justice in Matters involving Child Victims and Witnessess of Crime the term 'child sensitive' is defined as: 'an approach that balances the child's right to protection and that takes into account the child's individual needs and views'. ECOSOC Resolution 2005/20, 22 July 2005.

¹¹⁹⁵ U.N. Doc. A/HRC/Wg.7/1/CRP.7, Submission of the Special Representative of the Secretary-General on Violence against Children, 14 December 2009, pp. 6–7.

¹¹⁹⁶ Ibidem supra note 1194, p. 6.

¹¹⁹⁷ Ibidem supra note 1194, p. 6.

¹¹⁹⁸ Ibidem supra note 1194, p. 6.

or manipulation, discrimination, intimidation or reprisal'.¹¹⁹⁹ Hereto, they should be entitled to support by a legal counsel and other forms of appropriate assistance. These requirements show overlap with the requirements set by the Victims and Witnesses Unit of the ICC,¹²⁰⁰ such as doing video-interviews by trained professionals, using screens, face and voice distortion and holding closed sessions,¹²⁰¹ in the sense that specific efforts must be made to critically evaluate and adapt the regular complaints procedures to the rights, needs and views of children. Given the qualification of the communications procedure as a quasi-judicial procedure, it is also important to prepare children and manage their expectations on the (limits of the) potential outcome of the procedure. All in all, the newly adopted Optional Protocol on a communications procedure for children is a good step forward on the way towards involving children in standing up for their rights. Receiving its 10th ratification on 14 January, Optional Protocol III has entered into force in April 2014.

6.6. CONCLUSION: HOW CAN THE HIGHEST ATTAINABLE STANDARD OF HEALTH OF THE CHILD, I.E. CHILD-CENTRED HEALTH-CARE BE REALIZED?

In this chapter the question was addressed how the process of realization influences the interpretation of the highest attainable standard of health of the child and which actors are responsible for realizing it. The right to health of the child gets meaning in the daily reality of children's lives. The interpretation of the right to health requires the active involvement of the beneficiaries as well as, in the case of children in their early childhood, their representatives. In such a way, the realization process reduces the level of abstraction and the right to health becomes a 'living right'.

From this chapter, it appears that plural actors are responsible for ensuring the right to the highest attainable standard of health of the child. These actors are States Parties and non-state actors, including children, their families and medical professionals. Furthermore, other private actors such as private companies and

¹¹⁹⁹ Ibidem supra note 1194, p. 6.

¹²⁰⁰ ICC Rules of Procedure and Evidence U.N. Doc. PCNICC/2000/1/Add.1 (2000). See also Working Paper no 3 of the Special-Representative of the Secretary General for Children in armed conflict: Children and justice during and in the aftermath of armed conflict, September 2011, p. 17, available at: www.un.org/children/conflict/_documents/Working%20Paper%20Number%203_Children%20and%20Justice.pdf.

¹²⁰¹ This last requirement is in line with the provision in article 4-2 of the Optional Protocol that 'The identity of any individual or group of individuals concerned shall not be revealed publicly without their express consent.'

(I)NGOs all can play a role in realizing the highest attainable standard of health of the child.

States have an immediate obligation to realize the minimum core content of the highest attainable standard of health without discrimination of any children. States must integrate the right to health of the child both in its constitution and governmental policies as well as in sector specific legislation and policy. The sector wide implementation of children's right to health furthermore requires solid cross-sectoral coordination. Although States have a broad margin of appreciation in determining the measures that are taken to realize the highest attainable standard of health, it is required that more concrete parameters are established to assess the measures prioritized, such as the formulation of concrete implementation measures, time bound measurable targets, clear deadlines, the identification of all human and financial resources, and the identification of the responsible actors. Thereby, Courts are enabled to better assess the reasonableness of the measures taken. Furthermore, States must conduct child impact assessments beforehand and a child impact evaluation afterwards, both including interviews with children and their family members to identify the impact of the measures selected. In this way, it can be assessed whether the peculiarities of the right to the highest attainable standard actually have an impact on the daily health care of the beneficiaries.

Although the right to health of children has increasingly been laid down in national legislation, there is still much debate over its justiciability in court proceedings. The principal argument against holding States directly accountable for violations of children's right to health are the limitations of States in the available resources they have at their disposal to realize the right to the highest attainable standard of health. However, the amount of available resources can be significantly increased by reallocating budget from military or other sectors to the social sector and the health sector. Furthermore, developing countries must seek active assistance from other countries to make sufficient resources available for the realization of the right to health of the child. In doing so, the process of making more resources available does not only refer to financial resources, but also to human and informational resources.

In addition to the requirement to make legal arrangements to effectuate the right to health of the child, it is recommended to translate these rights to the local realities in which children live. Kaime provides for several useful guidelines to bridge the gap between the legal provisions of children's rights and the norms used in traditional institutions in the communities where children live. Furthermore, although States have immediate responsibilities in ensuring the necessary health infrastructure, especially primary and emergency health care, providing for basic life necessities, such as safe drinking water, food, housing and health education, many other private actors can significantly contribute to making more resources available. The highest attainable standard of health can best be achieved if every individual contributes to its realization to the maximum extent of its individual

capabilities. Not only because this will help mobilize as much different resources as possible, but also because more flexibility and adaptability to the specific needs of individual children and their parents can be achieved.

In order to realize the active involvement of children and their parents, it is necessary that people take ownership for their own health and the health of their children. This conclusion is in line with articles 5 and 18 CRC that primarily hold parents accountable for the health and well-being of their children. States have the secondary responsibility in supporting parents to bring up their children in health.

The provision of health care to young children and their parents should take their capabilities for ensuring their own health as a starting point. This implies that even very young children must be respected as rights-holders. Even very young children have innate capabilities that should be stimulated so that children can grow into self-reliant, healthy adults. Therefore, they should be involved in their own health care from the very beginning. Using child-sensitive and creative methods can add significantly to bringing the best interests of very young children to the light. In practice, this means that sufficient opportunities must be created for children and their parents to ask questions, to share information and observations and to influence and criticize the decisions at hand.

All in all, the newly adopted Protocol to the CRC on a communications procedure for children, offers a significant step forward for individuals and their representatives to hold States accountable for violations of the right to the highest attainable standard of health of the child. Entering into force on 14 April 2014, it is now time for States to sign and ratify the Protocol.

