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

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VII. CONCLUSIONS

When a mother gives birth to a child, the new born has a wealth of innate opportunities that can be brought to life. Therefore, it is essential to ensure that the child is born and raised in the best possible circumstances. The right to the highest attainable standard of health of the child encompasses the key notion that children are enabled and supported from the very beginning to realize the capabilities that they value most in life. In doing so, it is essential to acknowledge that every child has its own unique combination of capabilities that it wishes to achieve in life.

In the introductory chapter it was established that the concept of the highest attainable standard of health of the child remains vague, since it depends on situational and individual circumstances, financial resources and political will. As a result, it remains unclear who has the responsibility to implement its constitutive elements and what the legal effect is of the right to health of the child. Therefore, in this thesis we analysed:

- (a) What priorities derive from the concept of the highest attainable standard of health of the child, the definition and interpretation of the key constituent elements of this concept on the basis of international human rights law;
- (b) How this concept should be further implemented in the light of the international human rights standards.

In order to answer these questions, a literature research was conducted of the relevant international legal documents, the *travaux préparatoires*, General Comments, Country Reports, UN documents, EU documents and relevant scientific literature. These legal documents were considered from the perspective of Amartya Sen's capability approach, which focuses on the intrinsic (or innate) opportunities that people have. The level of realization of these opportunities, referred to as peoples' 'functionings' is effectuated by the interplay of individual choices and situational circumstances. In the following sections, the priorities or key constituent elements required to realize the highest attainable standard of health of the child (the capability of the child to be healthy) as found in international law are presented. The implications of these priorities for defining the concept of the highest attainable standard of health of the child are discussed in section 7.1.4.

7.1. PRIORITIES SET TO ACHIEVE THE HIGHEST ATTAINABLE STANDARD OF HEALTH OF THE CHILD

7.1.1. PRIORITIES SET IN THE CHILDREN'S RIGHTS DOMAIN

- I. What priorities relating to the right to the highest attainable standard of health of the child can be derived from the interpretations found in the international children's right domain?
- II. How are these priorities explained in the Concluding Observations of the Committee on the Rights of the Child?

In analysing the right to the highest attainable standard of health of the child as laid down in article 24 CRC and elaborated in the newly adopted General Comment 15 to the CRC and interpreted for specific countries in the Concluding Observations of the Committee on the Rights of the Child, core priorities can be identified which are critical for ensuring that children can achieve a basic level of health. The approach taken in this research can also be used to identify the different standards applicable for other social rights, such as the right to education or the right to an adequate standard of living. In doing so, different balances can be expected for those responsible such as the parents, the state and other professionals.

Although the Concluding Observations are meant to contain country specific explanations of children's rights, the elaboration remains at such a high level of abstraction, that paragraphs are often identical for countries as diverse as Colombia and the Netherlands. Therefore, it is not possible to further explain the priorities identified. The identified priorities following from the right to health in the children's rights domain, i.e. the CRC and the General Comments of the Committee on the Rights of the Child, are:

1. Non-discrimination (art. 2 CRC) should be a high priority in all actions of governments in order to ensure that all children are included in health programming. Special attention should be given to all groups of vulnerable children, such as very young children, girls, sick children, orphaned children, children from minority groups, indigenous children, children with handicaps and all children living in vulnerable situations, such as street children, children living in rural areas and children living in crises. This requirement extends to all of the following elements of the right to health of the child. The principle of discrimination also prohibits discrimination of children on the basis of the status or behaviour of their parents.

2. Prevention: in establishing health programmes a first priority must be given to prevention of health problems. Several approaches are identified, namely prevention and combating malnutrition by providing for the underlying determinants of health, early identification and intervention in case of disease, combating easily preventable diseases, the provision of (sexual and reproductive) health education and health promotion.
3. Primary health care: provision of primary health care requires that health services are close to the places where children live and play. This increases the accessibility and the affordability of health services for all. Furthermore, health services must be continuously available and include as a minimum:
 - Provision of health care and information to the mother during pregnancy.
 - Obstetric health care around the birth of the child.
 - Neonatal health care for the mother and the child immediately after birth.
 - Quality health care during childhood.
4. Health education: this enables both children and their parents to adopt a healthy lifestyle. Health education should include information on hygiene, healthy nutrition, sunburn, prevention of transmission of diseases (e.g. the use of malaria bed nets) and sexual and reproductive health information. Also, education on traffic regulations and other safety measures can significantly reduce the number of injuries resulting from accidents.
5. Training on child rights: this should be provided for children, parents and medical professionals in order to ensure that children's rights are respected and implemented in the health care setting. Examples are the provision of age-appropriate, full and quality information to both the child and its parents on the diagnosis, prognosis, possible interventions and side effects of medical treatments. This enables children to practice their right to participation and to be involved in the health care process. Since medical professionals are trained in medical ethics, it is recommended to elaborate on the different implications of medical ethics and children's rights in the health care setting. Also, particular training is required on child-friendly communication, the particular needs of vulnerable groups, such as young children and children with disabilities and the prevention, identification and addressing of violence against children.
6. Birth registration must be ensured for all children, so that children can have direct access to (primary) health care services. However, if children do not have an official birth certificate, this should not exclude them from receiving medical care. Even then, birth registration is also required so that doctors can better assess the age and level of development (or stagnation in the development) of children.
7. Social security is required to ensure that the costs for the underlying determinants of health and for the provision of medical services can be borne. This right to social security of the child as laid down in articles 26 and

27 CRC is also applicable when the parents do not apply for the child. This is especially important for refugee children, orphaned children and children living on the street. Furthermore, it is required to inform children and their parents on the availability of social insurances, so that medical services are not only accessible in theory, but also in practice.

The additional value of the Concluding Observations to the CRC Convention is that several additional priorities are mentioned (points 8–11):

8. In its Concluding Observation to the Country Reports (see chapter 3) the Committee on the Rights of the Child identifies the priority to stimulate breastfeeding of infants for a minimum of six months. To realize this target, several measures are required:
 - The establishment of baby-friendly hospitals, where mothers are stimulated to breastfeed their children from the moment of birth.
 - The adoption of legislation that enables mothers to have maternity leave and to have opportunities at work to continue breastfeeding.
 - The implementation of awareness raising campaigns on the benefits of breastfeeding.
 - The implementation of the International Code of Marketing Breast milk Substitutes.
9. Governments should define a concrete and coordinated health policy. This must include:
 - The adoption of a national plan with strategic budget lines.
 - Identify the responsible governmental departments.
 - Set clear, time-bound and measurable targets.
 - Ensure disaggregated data collection on health indicators for all children.In the newly adopted General Comment 15 to the CRC, the Committee has further specified that a national plan must specify as a matter of priority:
 - The different levels of health care that must be provided.
 - The health problems that need to be addressed.
 - The health interventions that must be made available.
 - The medicines that must be provided.
10. In its Concluding Observations, the Committee on the Rights of the Child gives increasing attention to the need to ensure healthy living circumstances for children. To prevent environmental pollution, sustainable development programs must be implemented. Furthermore, efforts must be made to prevent the business sector from activities that pollute the environment in which children live and to stimulate working in healthy conditions.
11. The provision of basic health care to children in humanitarian crises is found as a matter of priority in the Concluding Observations of the CRC Committee. Natural disasters and conflict impact heavily on the availability of health services for children. Also, infectious diseases, violence, malnutrition

and a rise in trauma related mental health problems significantly hamper the realization of the highest attainable standard of health of children. Furthermore, children are among the most vulnerable persons, because of their size, limited capacities to flee from sudden danger and developmental needs. Therefore, it is crucial to prioritize the provision of necessary health services to children in crisis situations. In some areas or (crisis) situations, it is necessary to set up mobile health clinics or other types of flexible health services (e.g. flying doctors) to ensure accessible health care for all.

12. The Committee also considers as a priority in General Comment 15 that all stakeholders must be involved in the implementation of the right to health. Thereby, a community based approach to realizing the right to health of the child can be established that involves many different actors, including the child, its parents, extended family, medical professionals and a variety of private actors such as NGOs and companies. States are encouraged to seek active contribution of children and their families in the identification and prioritization of the key elements of the right to health of the child. These can be obtained by regular consultations and by research with children, which is adapted to their age and maturity and which includes the possibility to do this without the parents being present. GC 15 to the CRC provides suggestions for elements on which children's opinions must be sought (see section 2.5.8.2).

The right to health of the child as laid down in article 24 CRC sets clear priorities. However, as found in the analysis of the Concluding Observations of the Committee on the Rights of the Child on the Country Reports, these priorities are best suited for countries with medium and high levels of development (see section 3.3). In countries with low levels of development and in conflict and disaster areas, even the most basic levels of health are scarcely achieved. Notwithstanding, governments – and the international community – do have the obligation to ensure the minimum level of health care to children necessary for their survival, if necessary by actively seeking support from the international community. For countries with very high levels of development, more ambition is expected to raise the health standards, in terms of health indicators, to a higher standard. An example is found in the European region (see section 7.1.3).

Resulting from the analysis of the Concluding Observations of the Committee on the Rights of the Child, three additional recommendations are relevant with regard to the functioning of the Committee:

13. The Committee on the Rights of the Child has a central role in the assessment of child-sensitive and disaggregated data on the basis of which measurable and time bound targets must be set. In doing so, it is crucial to involve children themselves and their family in the gathering and (self-)assessment of available data. In order to ensure the involvement of (chronically) ill children,

it is required that interview and communication opportunities are available within medical institutions. Furthermore, the best interests of the child must be leading, which implies that timing, duration and location of interviews must be exercised in a way that takes into account the medical condition of the child.

14. The Committee on the Rights of the Child has a central role in holding States accountable for the development of a national health plan, which specifies the way in which its health sector is organized and what budget is allocated for the different departments involved in the realization of the right to health of children.
15. Given the regular assessment of Country Reports, the Committee on the Rights of the Child has a central role in the interpretation of health related rights. New insights from one country may help to find solutions for identifying the necessary steps to realize children's right to health in another country. The Committee is therefore in the position to give valuable recommendations to countries on the progressive steps to be taken to realize the right to the highest attainable standard of health.

7.1.2. PRIORITIES SET IN INTERNATIONAL HEALTH AND HUMAN RIGHTS LAW

- III. What priorities related to the right to the highest attainable standard of health of the child can be derived from the interpretation found in the international health and human rights law? What is the additional value of this body of law for the interpretation of the right to the highest attainable standard of health in the children's rights domain?

The international legal framework on health and human rights identifies several elements that can be considered as the minimum core content, i.e. the priorities to be achieved to realize the right to the highest attainable standard of health of the child (see section 4.8). These minimum essential levels can be further raised with increased budget made available.

In the first place four principles should be guiding in the interpretation and implementation of the general right to health, namely the principles of availability, accessibility, acceptability and quality (see section 4.5 for a detailed overview). A trend is visible in which the principles of participation, adaptability and accountability are increasingly taken into account. The application of these principles gives room for the development of a more flexible, adaptive health care system that places the child and its family at the heart instead of the functionalities of medical organizations. Furthermore, the application of these principles allows

for an approach that focuses not only on the health outcome, but also on the health process itself. This is especially important for children who can't be cured.

The legal framework established in the international health and human rights domain has been translated in essential building blocks of a rights-based health system by the former UN Special Rapporteur on the right to health. A rights-based health system lies at the heart of the right to the highest attainable standard of health. A central priority of such a system is effective coordination between health services and schools in addition to services for the provision of safe drinking water, food, housing, transport and sanitary facilities. For example, primary health care services could be located in the vicinity of schools to improve accessibility.

A rights-based health system furthermore requires – as a matter of priority – a bottom-up approach. A bottom-up approach means that the community participation is an important factor in the process of realization of the right to health of the child. The government can invite and support communities to take healthy initiatives in a large variety of ways, which can contribute to the realization of the right to health of the child. However, the actual set up of health programs and services should be done with close consultations of local communities. In order to enable children and their families to be involved in their own health care process, the provision of child-friendly health information is required. This information must be sensitive to the special needs of children of different ages, with different cultural backgrounds and with varying needs. Furthermore, transparency in the health system and the possible referrals is required, which could be accomplished if children who have plural encounters with medical professionals are guided by one person during the entire process.

Lastly, the right to health as laid down in the international health and human rights law domain also requires international cooperation. Hereto, it is necessary to establish shared international health standards and indicators that can be used as a basis for comparison and to measure progress over time. Furthermore, national foreign policies must include health impact assessments. Improving and realigning international health agreements can be further achieved by deploying health diplomacy: identifying and negotiating mutual health needs and finding common grounds on which health policies are based on. Health diplomacy can also contribute significantly to coordinating the provision of humanitarian help and identifying the different actors responsible.

7.1.3. PRIORITIES SET IN EUROPEAN HUMAN RIGHTS LAW

IV. What priorities in the interpretation of the right to the highest attainable standard of health of the child are found in human rights law in Europe?

The elaboration of the right to health of the child in Europe provides a good example of an extended interpretation of the right to the highest attainable standard of health of the child.

Both the relevant EU legislation and the European Social Charter give room for a flexible interpretation of the right to health of the child. In the EU, access to preventive health care and medical services must be established *under the conditions established by national law and practices*. Different member states thus have a broad margin of appreciation to determine the measures that should be given high priority on the basis of their national health indicators. Such an interpretation is in line with the children's rights domain, because therein it is established that health policies for children must be based on disaggregated data. In the ESC, a flexible interpretation is made possible through the dependence of the right to health on the development of medical knowledge.

- In the European Union, a high level of human health protection is required. Prevention of health problems is obviously of clear priority and measures in this regard must include:
 - Promote research into the causes of disease.
 - Prevent transmission of disease.
 - Provide health information and education.
 - Ensure monitoring and early warning.
 - Combat serious cross-border threats.
 - Ensure immunization of children against the major childhood diseases.
 - Prevent injuries and violence against children.
- The development of child-friendly health care is another matter of priority. Guidelines have been issued which contain many suggestions or recommendations for measures inter alia to ensure that hospitalization is minimized and that health care must be organized around the rights, needs and characteristics of children. This requires a coordinated, integrated, comprehensive and continuous approach. Whereas the Guidelines take into account several changing factors (for a further specification see section 7.1.4), both the Guidelines and the WHO strategy underline the importance of continuity of health care. Usually, continuity is interpreted as the transition from primary to secondary to tertiary care. However, both the guidelines on CFHC and the WHO strategy provide for different systems to distinguish different forms of continuity in health care (see section 5.6.3).

The Guidelines on CFHC assume that a child lives in a social context. Therefore, it is a matter of priority to establish a healthy family environment and provide for family-friendly healthcare. By working through families, continuity of experience is created for the child and the bonding between the child, its parents and other family members is stimulated. Still, it is important not to submerge the best interests of the child on the broader set of family-oriented rights and interests. On the other hand, targeting children through their families with health education may increase their exposure to necessary health information. Both the Council of Europe and the WHO establish that children – and in the long term adults – must be stimulated to take responsibility for their own health. Empowerment must be achieved as a matter of priority through continuous health education that is in line with their evolving capacities.

7.1.4. THE HIGHEST ATTAINABLE STANDARD OF HEALTH IS A MOVING TARGET

The priorities necessary for achieving the highest attainable standard of health of the child have been identified in the previous part of this chapter. However, the concept of ‘the highest attainable standard of health’ has the inherent capability to extend beyond the basic level of health care. In fact, the concept of the ‘highest attainable standard of health’ varies significantly according to different personal and situational circumstances. Therefore, the highest attainable standard of health of the child is in constant motion. As such, the right to the highest attainable standard of health can be qualified as a *moving target*, because it is dependent on several changing factors. These factors are:

First of all, children are in a permanent state of development. Children’s healthy growth is in itself characterized by constant change. From the moment of conception and continuing after birth, children experience the gradual development of new physical, mental and social skills. This constant change influences their nutritional needs, susceptibility to infectious diseases and abilities to cope with external stressors. The varying needs deriving from the changing life course of children require health services that are adaptive to these different phases: maternal, antenatal, obstetric, new born, infant and child and adolescent health care. Also, health services must be adaptive to the changing needs of children in different stages of disease and include primary, secondary, tertiary prevention, curation, rehabilitation and palliative care.

Secondly, all individuals are different. Some basic capabilities are necessary for survival, such as food, drinking water, shelter and basic health care. However, the amount and type of nutrition required vary per individual. In addition, there is a great interpersonal variation in the intrinsic opportunities that children have. These variations in intrinsic opportunities are augmented or mitigated by the

level of health education that children receive and the circumstances in which they live. Therefore, different (groups of) children have different health needs and make different health choices. This influences the interpretation of the highest attainable standard of health and the measures required to achieve that level of health.

Thirdly, children live in continuously changing circumstances. Being healthy requires constant adaptation of the body to its natural habitat. This adaptation takes into account changes in nutrition and sleeping patterns, the prevalence of infectious diseases and other health challenges, such as seasonal cycles and challenges such as traffic, travels, stress, deprivation or crises. The Guidelines on CFHC specifically refer to the changing epidemiology of childhood.

Lastly, changing health insights continuously augment the opportunities for prevention of health problems, (early) diagnosis, treatment and mitigation of the impact of health threats. These new insights influence both the quality of health care and the total costs of health care. The highest attainable standard of health thus also changes when the availability of effective health interventions changes.

Therefore, in order to attain the highest attainable standard of health, the health care and guidance provided to children must be responsive to the changing intrinsic and extrinsic circumstances in which children live. This requires flexibility of medical professionals and ongoing involvement of both children and their caretakers.

7.2. REALIZING THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

V. How does the process of realization influence the interpretation of the highest attainable standard of health of the child?

To answer this question, the role of the different actors involved in the realization of the right to health has been elucidated. Secondly, the cyclical process of law enforcement and the interaction with the social reality in which children live has been clarified.

The realization of the right of the child to the highest attainable standard of health requires the involvement of different actors, specified inter alia in General Comment 15 to the CRC and in other documents such as the Guidelines on child-friendly healthcare. The results of the findings from this research are presented below.

7.2.1. CHILDREN AS RIGHTS-HOLDERS: EMPOWERMENT

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). 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) *'How should the concept of the highest attainable standard of health of the child be implemented in light of international human rights standards?'*, 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 interpretation of 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 position of children as rights holders requires that their own views upon their health must be taken into consideration from the beginning of their lives, notwithstanding their age or limited verbal capacities. The new concept of health as introduced by Huber is exemplary, since it takes people's abilities for self-management and adaptability to changing circumstances as a starting point. This approach to health, in which children's capabilities and evolving capacities are elementary, is crucial to realizing the right to the highest attainable standard of health as a moving target. *The right to the highest attainable standard of health of the child is in fact the ability of the child to adapt to continuously changing circumstances.*

Therefore, children must be stimulated and enabled to live harmoniously in a continuously changing environment. This requires that children gradually take ownership for their own health. This can be achieved by listening to the child and involving its views from the very beginning in the appreciation of its best interests. For children in their early childhood, the support, guidance and appreciation of their parents or caretakers is pivotal in this process. Listening to children in their early childhood is respectful of their rights and it shows them that they are taken seriously from the very beginning. Also, young children have additional information that can be crucial in establishing an accurate diagnosis. Specific age-appropriate communication methods can add to increasing the reliability of their answers and the accuracy of any diagnoses made.

Empowerment of children and their parents/caretakers is central to the realization process of the right to health of the child. This must be achieved by involving them in individual health decisions and in shaping the organization of health

care services. 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 any proposed laws, policies and budget allocations. The Committee places great emphasis on the involvement of children in data collection and interviewing them, so that their interests are directly reflected. With respect to the involvement of very young children, this requires age-appropriate interview techniques as well as interviewing their parents or caretakers.

7.2.2. THE ROLE OF THE STATE IN REALIZING THE RIGHT TO HEALTH OF THE CHILD

States have a wide range of possible legislative, administrative and policy measures to meet their obligations following from the right to health of the child. Appropriate measures pass the test of reasonableness and are taken within a reasonable time. A distinction is made between obligations of immediate and obligations of progressive nature.

The obligations to respect and protect the right to health of the child require less resources than the obligation to fulfil the right to health. Therefore, the obligation to respect and the obligation to protect should fall within the scope of States' immediate obligation to fulfil. The obligation to fulfil the right to health of the child however, such as the provision of medicines and the provision of health services to reduce infant and maternal mortality, require considerable investments to be realized and thus place a larger burden on a States' available resources. This element must be realized progressively.

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. Considerations to be made by Courts and Tribunals in assessing the reasonableness of time frames include:

- The nature and purpose of the health measure.
- The circumstances of the country.
- The intentions of the States Parties to the CRC.
- The potential damage caused by not taking the identified measure.
- The achievements made in comparable countries.

The right to health must be included in national legislation and people must be informed about it. Measures must include (General Comment 5 to the CRC):

- i. The provision of information on the right to health of the child (and the CRC).
- ii. A comprehensive review of existing domestic legislation.
- iii. The adoption of new laws or codes or amendments made to existing ones.
- iv. 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.
- v. The possibility of invoking the CRC in national courts.

States have the obligation to provide for the necessary health infrastructure, health education and underlying determinants of health. These requirements can be best achieved if they are organized collectively. Furthermore, States must ensure quality and disaggregated data collection on the basis of which comprehensive and integrated national health programs can be formulated. The realization of these health programs must be enabled by allocating sufficient financial and human resources (see § 6.3.3).

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.

In developing a national strategy on children's health, specific goals for sectoral action plans must be set (see section 7.1.1 point 9). The implementation of general measures to realize the right to health must be attributed to one designated governmental department, that coordinates the different programs in place that contribute to realizing the right to health of the child. A national strategy should take into account the health sector, but also the activities of other sectors that impact upon the realization of the right to health of children.

In addition to providing for collective health measures and setting appropriate standards for the private sector, States must stimulate private actors to contribute to the realization of the right to health of the child. In this way, more actors can take ownership and become involved in realizing children's right to health, which will increase the overall impact of the measures taken.

To identify the impact of the measures taken, data must be gathered about the budget allocated to:

- The number of health professionals that have been trained in children's rights.
- A large variety of other health indicators, including:
 - i. Infant, child and maternal mortality rates.
 - ii. The proportion of children with low birth weight.
 - iii. The number of children that is immunized.

- iv. The proportion of children that have access to safe drinking water and sanitation.
- v. The number of pregnant women who have access to perinatal health care.
- vi. The number of children born in hospital.
- vii. The number of children receiving exclusive breastfeeding.

7.2.2.1. *Effective remedies*

The right to health of the child is increasingly laid down in national legislations. However, 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 of 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. On the other hand, the right to health of the child occasionally does influence the interpretation of this right when referral is made to the facts and circumstances of the case.

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. Also, many private actors are more closely connected to the daily realities in which children live and can therefore have a more direct impact on the realization of their right to health.

Notwithstanding the choices made to enforce the right to health of the child through judicial or quasi-judicial means, it is important to establish child-sensitive procedures. Special considerations may be necessary to enable children with health problems to be involved in (quasi-)judicial procedures.

Quasi-judicial effectuation of children's rights norms in daily life furthermore requires active deliberation with local institutions, authorities and other influential actors, such as the elders in a family, traditional leaders etc., in the negotiation process to transform the CRC principles into lived realities of children. Given the highly divergent circumstances in which children live, this process can take many different forms. It is important to identify and ensure that children, women and other traditionally less dominant groups are included in the decision-making processes.

As soon as Optional Protocol III to the CRC on a communications procedure for children enters into force in the different member states to the CRC, children and their representatives will have an additional remedy at their disposal to hold States accountable for not meeting their responsibilities to ensure the right to health of the child. However, given the collective nature of many health measures

required to realize the right to health of the child, it is highly recommendable to enable children to apply collectively for this procedure. Furthermore, since children apply many different forms of communication to make themselves heard, it is recommended to extend the admissibility of cases beyond the submission of written complaints to better enable them to become directly involved in such procedures if they wish to.

The CRC Committee has a central role in assessing the progress achieved in the realization of the right to health of the child. Its role entails the following tasks:

- I. Assessment of available data on health indicators.
- II. Monitoring of measures taken and progress achieved.
- III. Interpretation and development of child rights.
- IV. Suggest measurable, time bound targets
- V. Identify responsible actors and governmental departments.
- VI. In the future: receive complaints through the communications procedure.

7.2.2.2. International cooperation

Article 24.4 CRC 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. 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.

Developing countries primarily have the obligation to maximize their domestic available resources and secondly to actively seek assistance from the international community. 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, such as health.

The Committee on the Rights of the Child advises developed countries to allocate at least 20 percent of foreign aid to human priority goals such as primary health care. Measures include the creation of employment opportunities, investments through microcredits, investments in infrastructure, debt relief, stimulating commercial activities and private-public partnerships and through bilateral and multilateral agreements. The Committee furthermore endorses agreements reached that States Parties need to allocate at least 0.7% of its GDP to foreign aid within a children's rights framework. Developed countries thus 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 on health.

7.2.3. ACTORS RESPONSIBLE IN THE PROCESS OF IMPLEMENTATION

7.2.3.1. *Parents*

Whereas States are responsible for taking collective health measures to realize the right to health of the child, the primary responsibility for realizing the right to health of the child lies with the parents and if applicable the extended family of the child. Furthermore, other actors, such as medical professionals, local communities, (i)NGOs, civil society organizations and private actors have a shared responsibility to contribute to the realization of the right to health of the child.

In international health law, the concept of the child focuses on its vulnerability and on its dependence on especially the mother. Article 18 CRC establishes that both parents have the 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.

Providing parents with necessary health information and information on the rights of the child is essential to enable them to set examples of healthy behaviour, to seek medical assistance and to engage in advocacy to ensure a healthy living environment for the child. Providing such information can support parents to continuously adapt to the changing health needs and life cycle of their children.

7.2.3.2. *Medical professionals*

Although the root causes of many childhood illnesses lie in the wider socioeconomical context, the activities of medical professionals are largely confined to the medical domain. 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.

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. This implies that health professionals must be continuously (re-)educated on the requirements of child-friendly health care, so that they can become agents of change – directly or through the involvement in medical organizations. Also, inclusion of children's rights in work protocols is essential.

The interaction between medical professionals, children and their parents is an influential factor in identifying health problems and achieving treatment compliancy. Training on effective communication which takes into account the personality, attitude and communication skills of the health professionals,

the availability of sufficient time and the creation of a supporting physical environment all contribute to the establishment of constructive relations to realize the right to health of the child.

Medical professionals 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.

7.3. CHILDREN'S RIGHT TO HEALTH: A LIVING REALITY

The central question of my research was which priorities can be derived from the CRC, the Concluding Observations of the CRC Committee and its General Comments and from other relevant international and regional instruments for realizing the right to the highest attainable standard of health of children under twelve.

It is not easy to summarize the findings of my research given the fact that the wide variety of priorities not only emerge from these instruments but because they are also influenced by the national context in which the right to the highest attainable standard of health is implemented as is shown by the Concluding Observations of the CRC Committee. As indicated before, the right to health of the child is a moving target because children are in a permanent state of development, children are different and live in continuously changing circumstances and health insights are changing. Therefore, the right to the highest attainable standard of health of the child is qualified as a living reality.

Notwithstanding, from my research it can be concluded that States parties to the CRC should in their efforts to progressively implement the rights of the child to the highest attainable standard of health consider the following measures as priorities:

- I. The implementation of a continuous and well-coordinated national health policy for children which should include legislative, administrative and social measures to develop an infrastructure of services of health care. Such a health policy should contain the following elements:
 - Domestic legislation on the right to health of the child.
 - Identify responsible actors.
 - Establish strategic budget lines.
 - A system for disaggregated data collection on health indicators for children.
 - Set clear and measurable targets on:
 - health services;

- medicines;
 - health interventions;
 - number of health professionals trained in children's rights.
- Mechanisms for monitoring and review.
- II. Prevention of health problems:
- Provide for underlying determinants of health.
 - Immunization program.
 - Program to stimulate breastfeeding.
 - Early identification and intervention in disease.
- III. Community-based Primary Health Care
- Available, accessible, affordable, acceptable and quality health services.
 - In close proximity to the beneficiaries.
 - Involving children, parents and community stakeholders.
 - Adequate referral system.
- IV. Information and training for children, parents and medical professionals
- Child-friendly health information (e.g. diagnosis, treatment, side effects).
 - Child rights training in health care to ensure child-sensitive procedures (age-appropriate, specific needs, participatory modes of communication).
- V. Child impact assessments and evaluations to identify:
- Most pressing health problems and solutions.
 - Barriers to having access to health services.
 - Impact of health interventions.
 - Impact of commercial activities.
 - Organization of health care (e.g. level of hospitalization, play facilities).
- VI. Involvement of the private sector in:
- Identification of pressing health problems and solutions.
 - Increasing availability of child-appropriate medicines, prostheses, health services and special devices for disabilities.
 - Provision of healthy foods, sporting equipment, etcetera.
- VII. Effective remedies
- Accessible and child-sensitive (quasi-)judicial procedures and institutions.
 - Access to (non-)written complaints mechanism before the CRC Committee.
- VIII. International cooperation between developing and developed countries
- 20/20 initiative (see section 7.2.2).
 - 0.7% of GDP to foreign aid within children's rights framework.
 - Actively seek/offer assistance, share knowledge and experiences.