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

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Citation

Spronk, S. I. (2014, November 27). *The right to health of the child: an analytical exploration of the international normative framework*. Intersentia, Antwerpen. Retrieved from <https://hdl.handle.net/1887/29842>

Version: Corrected Publisher's Version

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Note: To cite this publication please use the final published version (if applicable).

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Issue Date: 2014-11-27

SUMMARY

Large numbers of children all over the world face significant health risks, such as infectious and chronic diseases, malnutrition, injuries and the consequences of natural disasters, protracted armed conflicts and poverty. Every year, 4 million babies die within the first month of their life and almost 8 million children under the age of five die from preventable diseases such as malaria, pneumonia, measles and diarrhoea. These general statistics do not reveal the underlying inequalities in health between and within countries. One of the causes of the inequalities is that, in many countries, vulnerable groups of children have no or only limited access to health services. This research aims to identify the standards in international law for realizing the right to the highest attainable standard of health of the child. The central questions that are analysed:

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

Chapter 1 sets out the central problem in realizing the right to health of the child. The vagueness of the concept of ‘the highest attainable standard of health’ makes it difficult to identify the elements of the right to health that must be prioritized for implementation in a country’s health policy. Secondly, the realization of the right to the highest attainable standard of health is dependent upon the limited financial resources available. Thirdly, the realization of children’s right to the highest attainable standard of health depends on both situational circumstances and individual characteristics such as the genetic predisposition and lifestyle of both the parents and the child. Unclear is therefore what elements of the right to the highest attainable standard of health fall under the responsibility of the State and what the responsibilities are of medical professionals, the parents and the child itself. Lastly, this chapter introduces the key concepts of this study, namely ‘health’, ‘health as a right’, ‘primary health care’ and ‘vulnerable children’.

Chapter 2 identifies the priorities that follow from the right to the highest attainable standard of health of the child in the international children’s right domain, namely the Convention on the Rights of the Child and the General Comments to the Convention. It identifies the key elements of article 24 CRC and its relation to other relevant articles in the Convention, namely the right to non-

discrimination (art. 2 CRC), the best interests of the child (art. 3), the right to life (art.6), the right to be heard (art. 12 CRC), the role of parents (art. 5 and 18) and the right to social security (art. 26) and to an adequate standard of living (art. 27).

The right to health of the child in the CRC has a clear focus on prevention of health problems and on ensuring basic health care for all children. On the basis of articles 6 and 24 CRC, health services must be continuous, adapted to the changing circumstances in which children live and to their changing needs. Health services must be accessible to all without discrimination and age-adjusted health information must be made available to both children and their parents. Four levels of priority have been identified in the organization of health care for young children:

1. Provision of health care and information to the mother during pregnancy.
2. Obstetric health care around the birth of the child.
3. Neonatal health care for the mother and the child immediately after birth.
4. Quality health care during childhood.

Chapter 2 looks into the dilemma between protecting the health of the child and in respecting its autonomy. It establishes that in assessing children's competency for participation in health care, a distinction must be made between their competency on the one hand and the willingness of others to accept children's choices on the other. This question is relevant, because it relates to the level of responsibility that can be attributed to children for realizing their own right to health in the healthcare setting. The role of parents in ensuring their children's right to health is discussed both in terms of their primary responsibility for ensuring healthy living circumstances and in guiding their children within the health care context. Lastly, chapter 2 relates the key principles of the right to health in the CRC to the four medical ethical principles. In order to realize the right to health of the child in the daily healthcare setting, all medical professionals encountering children in their (daily) work, must be educated about children's rights in health and trained in communicating with children and families in the health care sector.

Chapter 3 analyzes how the priorities deriving from the right to health of the child as set in the Convention on the Rights of the Child and in the General Comments are interpreted by the CRC Committee in its Concluding Observations on the Country Reports for countries with different levels of development. Hereto, a selection of 35 countries was made, based on country area, population size, human development indicators and geographical spread. These Concluding Observations on the Country Reports were particularly analyzed for recommendations relating to children's right to the highest attainable standard of health. This chapter also compares the priorities as set in the Convention with the recommendations made by the CRC Committee. The most striking difference is that the recommendations made by the CRC Committee predominantly address States Parties, whereas the Convention and General Comment increasingly stress the importance of involving

children, their parents and other individual stakeholders. In order to perform an accurate assessment of the progress made by the State in implementing the right to health of the child, the Committee recommends States to:

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

Chapter 4 investigates the priorities for realizing the right to the highest attainable standard of health of the child as found in international health and human rights law.

The chapter identifies several factors of uncertainty, which make it difficult to identify one universal standard for the right to the highest attainable standard of health of the child. Nevertheless, several priorities are found which should be realized, including the underlying determinants of health, inclusion of all vulnerable groups of children and a specified range of health services that respond to the changing needs of mothers and children during different stages of development.

General Comment 14 to the ICESCR further establishes that the health services should be in line with the key constituent elements of the right to health: availability, accessibility, acceptability and quality. The AAAQ structure for structuring and assessing the level of realization of the general right to health offers significant insight into the way in which the highest attainable standard of health of the child can be achieved. The framework applies to both the underlying determinants of health and to the provision of medical care itself. Chapter 4 discusses the inclusion of new elements to the AAAQ structure, namely adaptability, accountability and participation. Inclusion of these elements would be responsive to the current trend to better involve patients in their own health process and it would allow for a more flexible and adaptive health system that places the best interests of the child and its family at the heart.

Chapter 5 investigates the priorities that should be met as found in European human rights law. Both from the perspective of the EU and from the Council of Europe, a clear focus is visible on the need to prevent health problems from the very beginning: before conception, during pregnancy, birth and in the earliest years of life going on in school years and through adolescence. In addition, whereas the bodies of law investigated in chapters 2, 3 and 4 predominantly focus on basic health measures, the legal frameworks in the European region focus more on the way in which the different levels of health services are organized. Also, specific subthemes relevant to the European region are identified. Chapter 5 closely looks into the Guidelines on Child-Friendly Healthcare as adopted by the Council of Europe. These guidelines establish that health care must be centered

around the rights, needs and characteristics of children and their families. The elements required to meet this challenge are identified. Also, the central role of children in managing their own health status is expressly highlighted.

Chapter 6 addresses the question ‘How the process of realization influences the interpretation of the highest attainable standard of health of the child and which actors are responsible in the process of implementation?’ This chapter discusses the way in which the priorities found in the children’s rights domain and international health and human rights law should be implemented. Whereas international human rights legislation is primarily directed towards States Parties, an increasing role is attributed to individual actors in managing their own or their children’s health status. Chapter 6 makes a distinction between the obligations of States to provide for general health measures and legal remedies and the opportunities of individual actors to take responsibility for their own health and to hold States Parties accountable. This chapter looks into the value and counterarguments of legal remedies. It specifically looks into the additional value of the Optional Protocol to the Convention on the Rights of the Child to a communication procedure for children in realizing the highest attainable standard of health of the child.

The Conclusion in *Chapter 7* presents the priorities 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. The priorities presented include a range of concrete measures that should be taken by States, parents, medical professionals and other actors, while taking into account the changing needs of children and the changing circumstances in which children live. Therefore, the measures to be taken should result in an adaptive health system that places the best interests of the child and its family at the heart. This necessarily requires the active involvement of beneficiaries, other stakeholders and the communities in which children live. This concluding chapter furthermore addresses the question how the process of realization influences the interpretation of the highest attainable standard of health of the child. This results in a definition of the highest attainable standard of health of the child that takes into account the varying capabilities of individual children and which considers children as active rights-holders, notwithstanding their age or level of development.