**Submission on the Content of a Future General Comment on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art. 24)**

**Contributors:**

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**Introduction**

The authors applaud the leadership of the Committee in choosing to issue a General Comment regarding the right of the child to the highest attainable standard of health, building on the Committee’s extensive efforts to clarify the health-related obligations of States Parties.[[4]](#footnote-4) We arehonored to have this opportunity to share some thoughts with the Committee regarding the normative obligations relating to Article 24 of the Convention on the Rights of the Child (CRC).[[5]](#footnote-5)

Despite the many statements and rich domestic and supra-national jurisprudence regarding health rights, child health continues to be subject to neglect and political manipulation at both national and international levels. Thus, it is important that a robust understanding of the child’s right to health be firmly anchored in an authoritative interpretation of the binding legal commitments undertaken by States Parties to the CRC, facilitating the delineation and development of *child rights-specific* health obligations.

For this General Comment to add value to the normative development of health rights, it is imperative that the Committee forcefully reaffirm the broad array of standards that have already been established with respect to health rights obligations and clarify dimensions that remain subject to contestation. It must also signal where the right to health of children differs in important normative ways from that of adults. Finally, the General Comment enables the Committee to update critical areas and fill gaps in the normative framework for the child’s right to health where they exist. This includes emphasizing cross-cutting principles, such as accountability, participation and non-discrimination/equality. Our submission seeks to provide guidance to the Committee on a range of these issues.

**The General Comment should clarify the nature of governmental as well as other obligations with respect to children’s ESCR in the context of health rights**

This General Comment is welcome as it provides the Committee with an opportunity to engage with the substantive obligations imposed by Article 4 of the CRC, allowing the Committee to adopt a coherent, comprehensive framework for the progressive realization of economic, social and cultural (ESC) rights set out in the Convention. The Committee has previously linked the obligations imposed by Article 4 with those imposed by Article 2(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR).[[6]](#footnote-6) Such an approach is desirable in terms of ensuring consistency in approach to ESCR across the UN treaty-monitoring body system. However, this General Comment provides an opportunity for the Committee to more fully consider contested issues that exist in relation to that pre-existing framework.[[7]](#footnote-7) Given that the Committee wishes to include a section on the development and use of a set of structure, process and outcome indicators in the proposed General Comment, it is vital that it ensure that these indicators are based on clearly delineated obligations.

In this regard, the Committee should clarify the differences between the progressive realization of ESC rights of children and adults. For instance, in keeping with some leading national jurisprudence, the Committee might expand upon the child-specific obligations that are not subject to progressive realization.[[8]](#footnote-8)In keeping with the UN Committee on Economic, Social and Cultural Rights’ General Comments 3[[9]](#footnote-9) and 14, this General Comment should reaffirm the immediate obligations of States Parties to prioritize the universal attainment of ‘minimum essential levels’ in relation to children’s right to health. Although these minimum levels of goods and services will necessarily evolve as medical and scientific knowledge advances, there are elements of a minimum core that are already well-grounded in international law, for example: certain categories of primary health care services, including immunizations and nutritional programs; the obligation to provide certain *free services where necessary*; adequate information; the availability of skilled health professionals; essential medicines and technologies; and the adoption and implementation of a national strategy and plan of action.

The proposed General comment further provides an opportunity to clarify States Parties’ obligations related to the progressive realization of children’s right to health to the maximum extent of their available resources. With regard to the duty of States Parties to progressively realise the child’s right to health, the Committee should emphasise that this includes implementing progressive fiscal policies which permit the collection of adequate resources. Furthermore, it should specify that these resources must be allocated in an equitable manner, and in accordance with a transparent and participatory process, which gives special attention to marginalized and other disadvantaged groups of children. The lack of a clearly defined budget for programs relating to children’s and adolescents’ health, including child protection, undermines accountability. The Committee should also stress that States Parties’ duty to ensure maximum available resources are being devoted to fulfill children’s health without discrimination applies equally in the context of decentralization and privatization of health services. Correspondingly, the Committee might delineate more limited child-specific circumstances that would permit deliberate retrogressive measures than those addressed by the Committee on Economic, Social and Cultural Rights in its work thusfar.[[10]](#footnote-10)

In addressing the resource dimensions of the obligation to fulfill, this General Comment should also examine the extra-territorial obligations of States Parties and obligations of non-state actors. With respect to extra-territorial obligations, where States Parties are in a position to provide international assistance and cooperation to other states with limited capacity to meet their full obligations, the General Comment should emphasize that the duty to respect and protect the child’s right to health extends to ensuring policy coherence, and that States Parties’ trade, aid and investment policies do not undermine the realization of children’s right to health in other jurisdictions. With respect to non-state actors, the Committee should go beyond considering the regulatory role of the state in relation to preventing, controlling and punishing violations by non-state actors. It must consider the role of non-state actors with regard to the provision and fulfillment of health-related goods and services.[[11]](#footnote-11)

**The General Comment should reaffirm and clarify the inter-related elements of the right to health of children, including the appropriate understanding of ‘effectiveness’ in the context of health**

The authors welcome the continued employment of the AAAQ (Availability, Accessibility, Acceptability and Quality) framework used in General Comment 14 by the Committee on Economic, Social and Cultural Rights.[[12]](#footnote-12) In addition to the four overlapping dimensions of accessibility (physical, economic, information and non-discrimination), the Committee could usefully add ‘effective’ and clarify that bureaucratic obstacles often pose tremendous barriers to access to care for children. Furthermore, in the context of health, effectiveness can refer to clinical effectiveness, which should be an element of ‘quality’ of care.

We would, however, strongly caution against the proposed addition of ‘effectiveness’ as a separate criterion in this or any future General Comment. This is due to the fact that effectiveness may also be understood as cost-effectiveness, which, while a legitimate consideration in health policy-making, should not be understood as an integral element of the *right to health* of children. It would be particularly problematic if the inclusion of the language of ‘effectiveness’ in a General Comment rendered it possible for monetary cost-benefit understandings of ‘cost-effectiveness’ to limit the implementation of ESC rights under the CRC.

**The General Comment should update important domains left unaddressed by the existing normative framework on the right to health, in the context of children**

1. **Health systems**

###### Health systems are central to children’s right to health.[[13]](#footnote-13) Far more than simply constituting delivery infrastructures for goods and services, health systems are core social institutions—akin to justice systems or democratic political systems—and as such they both reflect and communicate norms and values.[[14]](#footnote-14) Health systems can too frequently exacerbate inequalities, stigmatization, and marginalization, and these forms of exclusion disproportionately affect children. Alleviating these risks, rights-based health systems, promoting inclusiveness and equality, can facilitate a deepening of substantive democracy.

This General Comment, provides an opportunity to clarify the principles supporting health systems, articulating how the building blocks of health systems outlined by WHO (leadership and governance; service delivery packages and models; financing, human resources for health; health information; and medical products, vaccines and technologies) can all be informed by human rights standards in addressing the needs inherent in child health.[[15]](#footnote-15)

1. **Social Determinants of Children’s Health**

Social determinants of health, ‘the conditions under which we live, work and grow,’[[16]](#footnote-16) are especially critical to child health. Moving beyond the ‘underlying determinants’ referenced in the Committee on Economic, Social and Cultural Rights’ General Comment 14,[[17]](#footnote-17) this General Comment should distinguish and underscore the importance of addressing these broader social determinants—such as gender-based, racial and ethnic discrimination—and the human rights implications in implementing children’s right to health through social determinants. In particular, this General Comment provides an opportunity to articulate explicitly how laws and policies act as social determinants of children’s right to health. For example, both the criminalization of services (including abortion) and the criminalization of activities (such as sex work and IV drug use) are causal factors to the distribution of morbidity and mortality among adolescents specifically. Similarly, the failure to enact laws that proscribe child labor, discrimination (e.g., forced pregnancy testing of school-age girls), child marriage and the like are also determinative of patterns of morbidity and mortality.

**The General Comment should emphasize cross-cutting principles, including accountability, participation and non-discrimination/equality**

1. **Accountability mechanisms, including rights-based indicators and judicial enforcement**

### The General Comment should provide guidelines for the establishment of systematic and effective monitoring and accountability systems within States Parties to assess the obligations to respect, protect and fulfill children’s right to health. Systems to monitor the fulfillment of children’s right to health should not only assess health outcomes in light of these principles; they should also assess States Parties’ policy efforts, including policy commitments and resource allocations, based upon indicators that are rights-sensitive and programmatically-relevant.[[18]](#footnote-18) This is particularly important given the Committee’s desire to develop indicators with regard to Article 24.

Monitoring alone, however, is not sufficient to facilitate accountability. In recent years, it has become increasingly evident that judicial remedies have a key role to play in facilitating deliberation as well as providing restitution, rehabilitation and compensation. Judicial remedies have proven critical in at least four areas related to children’s right to health: implementation of existing laws and policies; reform of policies and budgets that fail to meet standards required by the children’s right to health; removal of legal restrictions on care; and challenges to systemic violations of children’s right to health in practice.[[19]](#footnote-19)

It is critical, in keeping with the evolution in international law as well as national jurisprudence, for this General Comment to underscore the importance of establishing both accessible and effective accountability mechanisms with respect to children’s right to health, including judicial remedies and other institutions, such as National Human Rights Institutions consistent with the jurisprudence of the Committee.

1. **Meaningful Participation of children**

The General Comment should highlight the need to ensure the full participation of affected communities and individual children in the design, implementation and monitoring of policies relevant to children’s right to health. The authors believe strongly that this General Comment should reflect the concern encapsulated in provisions such as Article 5 and 12 of the CRC, giving effect to the existing capacity and/or ensuring the future capacity of child right-holders as related to health. As such, it is vital that the proposed General Comment provide guidance on maximizing opportunities for child participation and autonomous decision-making with regard to health. This is important not just in the context of decision-making involving individual children’s specific health needs (and ensuring the provision of information to children) but also at a systemic level relating to the development and implementation of health-related policy and service delivery. Such an approach will require building upon the statements of the Committee in General Comments 12,[[20]](#footnote-20) 3,[[21]](#footnote-21) and 4,[[22]](#footnote-22) and should include the provision of specific proposals with regard to effectively mainstreaming children in health decision-making processes.[[23]](#footnote-23) In doing so, in accordance with their evolving capacity, children must be treated as genuine participants rather than simply as providers of information through consultative processes that is subsequently mediated and acted on (or not) by adults.[[24]](#footnote-24)

1. **Equality and non-discrimination**

The jurisprudence of the Committee has signalled a strong support for both formal and substantive equality, ensuring that children and adolescents do not suffer discrimination and that they can enjoy full equality. This General Comment provides an opportunity to explicate in greater detail the two concepts. In reducing discrimination, children and adolescents are particularly subject to overlapping and intersecting forms of discrimination, and the Committee should clearly signal its understanding of such structural discrimination in the General Comment. Moving beyond the elimination of discrimination to achieve substantive equality (equality in law and fact), the relationship between formal equality and universality of services is critically important in the context of designing health policies and programs for children and adolescents. To this end, the Committee should consider the extent to which substantive equality demands positive action or temporary special measures for children (or particular groups of children), such as priority in health service delivery or the allocation of resources to previously underserved areas of child and adolescent health.

1. [www.dur.ac.uk/law/staff/stafflist/?id=8695](http://www.dur.ac.uk/law/staff/stafflist/?id=8695) [↑](#footnote-ref-1)
2. [www.hsph.harvard.edu/faculty/alicia-yamin/profile/](http://www.hsph.harvard.edu/faculty/alicia-yamin/profile/) [↑](#footnote-ref-2)
3. <http://bmeier.web.unc.edu/> [↑](#footnote-ref-3)
4. See, e.g., ComRC General Comment No.3 on HIV/AIDS and the rights of the child (2003); ComRC General Comment No.4 on Adolescent health and development in the context of the Convention on the Rights of the Child (2003); ComRC General Comment No.7 on Implementing child rights in early childhood (2005), paragraph 27.For a discussion of these statements, see W. Eide & A. Eide, *The Right to Health: Article 24* (Antwerp: Intersentia, 2006); and A. Nolan, ‘The Child’s Right to Health and the Courts’ in J. Harrington & M. Stuttaford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* (London: Routledge, 2010) 135. [↑](#footnote-ref-4)
5. It appears from the language of the ‘Scope and Outline’ document that the Committee is moving towards the employment of the language of ‘child and adolescent’ (as opposed to ‘child’) in its work. The authors recognise the very different levels of development, needs and positions of younger and older children. This is clearly recognised in provisions of the Convention such as Article 5. We are concerned, however, that the subdivision of ‘children’ into categories that are not explicitly delineated or defined (or indeed mentioned) in the text of the Convention is potentially counterproductive. We are conscious that national health programmes and child protection measures frequently focus on younger children to a much greater degree than older or teenaged children and that there is a need to ensure that the health-related rights of *all* children are given effect to by States Parties. Rather than entrenching adolescence as a sub-category of childhood to be dealt with separately in statements such as General Comments, it would be better for the Committee to emphasise the need to give effect to the different needs of all groups of children (whether age-based or otherwise). As the groups to be emphasised will vary depending on the right and the context at issue, the Committee would be most helpful in providing guidance on how this disaggregation of children should be done in relation to specific groups in particular contexts, as it has done, for instance, its General Comment Nos 4 and 7. [↑](#footnote-ref-5)
6. See, e.g., ComRC General Comment No.5 on General measures of implementation of the Convention on the Rights of the Child (arts. 4, 42 and 44, para. 6) (2003), paragraph 6; ComRC Recommendations from Day of General Discussion on Resources (2007). [↑](#footnote-ref-6)
7. For a discussion of some these contested issues, including debates around the meaning of ‘the minimum core’ and ‘retrogressive measures’, see QUB Budget Analysis Project, *Budgeting for Economic and Social Rights: A Human Rights Framework* (Belfast: QUB, 2010). [↑](#footnote-ref-7)
8. See Colombian Constitutional Court, T 760/08. Magistrado Ponente: Manuel Jose Cepeda [differentiating between immediate obligation to unify children’s health schemes and progressive obligation to unify that of adults]. [↑](#footnote-ref-8)
9. ComESCR General Comment No.3 on The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant) (1990). [↑](#footnote-ref-9)
10. See, e.g., A. Nolan, ‘‘The Committee’s Approach to ESR under the CRC: An Obstacle to Monitoring Efforts?’ (2012) *International Journal of Children’s Rights* (forthcoming). For example, the Committee’s concept of deliberately retrogressive measures should specify a range of actions (such as the adoption of increasingly restrictive abortion laws which place adolescent girls’ lives and health at risk, as well as the inequitable allocation of resources, goods and services in ways that widen health disparities between population groups) that apply particularly in relation to children and adolescents. [↑](#footnote-ref-10)
11. Examples of non-state actors who fulfil the right to the highest attainable standard of health of children are doctors and private hospitals. [↑](#footnote-ref-11)
12. ComESCR General Comment No. 14 on The right to the highest attainable standard of health (art. 12) (2000). [↑](#footnote-ref-12)
13. P. Hunt & G. Backman, ‘Health systems and the right to the highest attainable standard of health’ (2008) *Health and Human Rights* 10; and Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/HRC/7/11, 31 January 2008. [↑](#footnote-ref-13)
14. L. Freedman, ‘Achieving the MDGs: Health Systems as Core Social Institutions’, *Development*, V*.* 48, pp. 19-24 (2005). [↑](#footnote-ref-14)
15. WHO, *Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes – WHO’s Framework for Action* (Geneva: WHO, 2007). [↑](#footnote-ref-15)
16. Commission on Social determinants of Health. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.* (Geneva: WHO, 2008). http://www.who.int.social\_determinants/final\_report/eng. [↑](#footnote-ref-16)
17. ComESCR General Comment No. 14, paragraph. 45 (including as underlying determinants of health: safe water and adequate sanitation, adequate nutritious food and housing, healthy occupational and environmental conditions, and access to health-related education and information). [↑](#footnote-ref-17)
18. See UN Economic and Social Council, Report of the High Commissioner for Human Rights on the Implementation of Economic, Social and Cultural Rights (E/2009/90), 8 June 2009. [↑](#footnote-ref-18)
19. For more, see Nolan above n4; A. Nolan, *Children’s Socio-Economic Rights & the Courts* (Oxford: Hart Publishing, 2011). [↑](#footnote-ref-19)
20. See in particular paragraph 104: ‘States parties should also introduce measures enabling children to contribute their views and experiences to the planning and programming of services for their health and development. Their views should be sought on all aspects of health provision, including what services are needed, how and where they are best provided, discriminatory barriers to accessing services, quality and attitudes of health professionals, and how to promote children’s capacities to take increasing levels of responsibility for their own health and development...’ [↑](#footnote-ref-20)
21. See paragraph 12: ‘Children are rights holders and have a right to participate, in accordance with their evolving capacities, in raising awareness by speaking out about the impact of HIV/AIDS on their lives and in the development of HIV/AIDS policies and programmes. Interventions have been found to benefit children most when they are actively involved in assessing needs, devising solutions, shaping strategies and carrying them out rather than being seen as objects for whom decisions are made…’ [↑](#footnote-ref-21)
22. See paragraph 39(d): ‘To this end, States parties must notably fulfil the following obligations: … (d) To ensure that adolescent girls and boys have the opportunity to participate actively in planning and programming for their own health and development;’ [↑](#footnote-ref-22)
23. See, e.g., the literature on child participation in health-related programmes and activities highlighted at http://www.unicef.org/adolescence/cypguide/resourceguide\_health.html. [↑](#footnote-ref-23)
24. It is arguable that such a ‘merely consultative’ approach is reflected in some of the Committee’s previous statements on health. See, e.g., paragraph 104 of ComRC General Comment No.4: ‘This information can be obtained through, inter alia, feedback systems for children using services or involved in research and consultative processes, and can be transmitted to local or national children’s councils or parliaments to develop standards and indicators of health services that respect the rights of the child.’ [↑](#footnote-ref-24)