

CRC General Comment on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Article 24)

Further to the call for submissions on the child's right to health please find below the response from the Centre for Rural Childhood, Perth College University of the Highlands and Islands, Scotland, UK, to the questions raised.

1. The basic premises for the realisation of children's right to health

The right to health is an inclusive right and contains freedoms as well as entitlements, and the right to health should be premised on the principle of non-discrimination. Of course non-discrimination does not mean treating everyone the same, but of taking account of the particular needs of individuals and groups, especially those who are marginalised. The right to health should not be confused with a right to be healthy. It is rather having fair and equal access to services and facilities which enable an individual to attain the best state of health possible.

Health must be broadly interpreted as not meaning merely the absence of disease or infirmity but encompassing complete physical, mental, social and spiritual well-being. As highlighted by the World Health Organisation (WHO) in its preamble emphasis must be given to: the importance of each state's achievements in the promotion and protection of health; unequal development in different countries in the promotion of health and control of disease, especially communicable disease, being a common danger; the basic importance of the healthy development of children; and governments having a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Children and young people are not a homogenous group and will have individual needs and wants based on age, maturity, experiences and circumstances. These factors must be taken into account in realising their right to health. It should be recalled that a child under the 1989 UN Convention on the Rights of the Child (CRC) is an individual from birth to 18 years of age. Special consideration should be given to those within the 15 – 18 years age bracket, as this group often appears to be overlooked despite evidence showing it remains vulnerable.

The right to health must be enjoyed by all children and young people in a non-discriminatory manner regardless of gender, age, ethnicity, socio-economic standing, disability, geographic location (rural or urban) or immigration status, including the status of a parent or guardian. Health must be interpreted to include mental and spiritual as well as physical well being.

There is a need to understand the health of a population is intricately linked to other issues and thus the realisation of the right to health needs to be approached holistically taking into account *inter alia* structural inequalities, marginalisation of certain groups, environmental degradation, armed and post-conflict and emergency and disaster situations.

2. How particular principles of the CRC can be applied to designing, implementing and monitoring interventions to address child and adolescent health challenges

For the right to health to be applied in a non-discriminatory manner, as required by CRC Article 2, information must be provided in a style that is appropriate for the age and maturity of the child. It should also be culturally appropriate. Access to information and services needs to be accessible to those in urban and rural environments. As well as access to health care services and professionals this also includes availability of interpreters, and the provision of public health campaigns in a variety of formats for different target groups. This should extend to the provision of alternative therapies, dental care, immunisation programmes and mental health services as well as more conventional medical care.

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Confidentiality is of the utmost importance and must be respected at all times by health care professionals involved in the treatment of a child or young person to ensure against discrimination or stigmatisation. This is especially important in any cases dealing with sexual health in order to give the child confidence to seek treatment and advice and to lessen the possibility of any discrimination he or she might face for using such services.

Article 3 of the CRC relating to the best interests of the child must be given cognisance but decisions and the accompanying discussions as to what constitutes a child's best interest must be transparent with evidence provided as to who and what factors have contributed towards decisions. It is not desirable to have too rigid an interpretation of what constitutes the best interests principle, but should be considered on an individual, case by case basis. This was endorsed by the Canadian Supreme Court in the case of *Gordon v Goertz*, SCC, No.24622, 1996, in which Madame Justice McLachlin highlighted that:

The best interests of the child test has been characterised as “indeterminate” and “more useful as legal aspiration than as legal analysis”...The multitude of factors that may impinge on the child's best interest make a measure of indeterminacy inevitable. A more precise test would risk sacrificing the child's best interest to expediency and certainty.

This has been echoed more recently by the UK Supreme Court in the case of *ZH (Tanzania) (FC) (Appellant) v. Secretary of State for the Home Department (Respondent)*, UKSC 4, 1February 2011.

Article 6 of the CRC does not simply recognise the right to life, but also provides for the development of the child, implying it is not addressing a basic minimum standard of survival, but aspiring to provide the best possible services and facilities for children to flourish and fulfil their potential health and well being to its fullest.

Article 12 of the CRC and the provision of the child's view being given due weight is of great import and applies as much to those children and young people who may not be able to articulate their views through language. Young people's views, individually and as a group, should be listened to and feedback collected about the services they receive. The information gleaned from children and young people can then be used for the design of services as well as monitoring and evaluating existing ones. Children and young people can be involved at various levels, including identifying areas for future research and wider consultation to improve the services for other young people. Any information children receive needs to be fully articulated and may require the use of picture books and other visual aids to supplement verbal explanations. Medical practitioners should be trained in alternative communication methods.

In relation to mental health and therapeutic support, children should have choices over whether they wish to engage in support and the nature of that support. In addition to western based talking therapies, alternative therapeutic support such as dance movement therapy and art therapy for example should also be offered. Priority should be given to measuring the effectiveness of such interventions for children and young people in order to provide a solid evidence base as to what does or does not work. There is a need for more trained and sensitive interpreters who are able to work with children and medical practitioners to ensure the child's voice is heard.

Regard should be given to the special provisions relating to health care and listening to the voice of the child as contained in General Comment No. 12 on the right of the child to be heard, 20 July 2009, paragraphs 98 – 104, inclusive.

3. The normative content of Article 24; state obligations; and responsibilities of non-state actors

In order to have an impact on infant and child mortality as per Article 24(a), gender discrimination must be tackled to ensure women have access to the best health care, particularly in this context pre and post natal care. Gender-based violence must be addressed as this has a detrimental impact on the Submission to Office of the United Nations High Commissioner for Human Rights (OHCHR) Committee on the Rights of the Child (CRC) by the Centre for Rural Childhood, Perth College UHI

right to health. This demands the education of men and women, boys and girls. The health and education of women has repercussions on a child's right to health. Gender discrimination also diminishes the health of the girl child who may not receive the same level of nutrition and health care as boys. Also as literacy levels remain lower among girls than boys, public health campaigns need to be aimed more imaginatively at this target group.

The right to health involves having access to quality health care. For quality to be achieved a firm evidence base has to be established as to what actually works in relation to provisions and interventions. States should actively promote research and evaluations and encourage the establishment of communities of practice.

As the UN Committee on Economic, Social and Cultural Rights highlighted in General Comment No. 14, 11 August 2000, on the right to the highest attainable standard of health, it is the responsibility of states to devise and implement a national health policy which details how the right to health is to be realised. Any such policy and the framework in place to implement it must be child friendly.

States should sign up to the Optional Protocol to the Convention on the Rights of the Child on a Communications Procedure, adopted 20th December 2011, opened for signature in 2012. Any child or young person whose right to health has been violated will be able to make an individual complaint against the state in question, provided that state accepts the Optional Protocol.

Non-state actors:

- NGOs can inform rights holders of the existence of rights and the tools and services available to realise those rights. NGOs should have a role in publicising the 3 Ps – protection, promotion and participation in health related matters. This is particularly important for those individuals who may not realise there is treatment available that can improve or cure specific diseases and conditions and so will not demand the appropriate treatment.
- NGOs can also advocate to state actors to develop and implement health services, especially ones targeted at marginalised individuals and groups who are often overlooked and ignored by those in power.
- Business – pharmaceutical companies should have a specific role in attaining the right to health by making medicines available at affordable prices. Pharmaceutical companies should also carefully choose what research and development to fund and ensure resources are aimed at diseases that affect large numbers of children. All pharmaceutical companies should respect the Doha Declaration on the TRIPS Agreement and Public Health. Companies should consult relevant organisations and civil society groups on enhancing their contribution to researching neglected diseases, i.e. those ones affecting those living in poverty, in rural areas and in low income countries.
- Businesses also have responsibility for human rights in relation to working conditions which if poor or dangerous can have an impact on health. Businesses therefore must comply with those standards as set out in, for example, the ILO Convention No. 182 on the worst forms of child labour, 1999 and ILO Convention No. 138 on the minimum age for admission to employment and work, 1973. Businesses should also consider signing up to the UN Global Compact of 2000.

4. Priority concerns for the implementation of Article 24:

- Rural and remote access

Given the Centre's focus on rural childhood, one priority which should be highlighted is the lack of medical support and services children and young people in rural and remote areas face globally. The issues that need addressed include the availability of services; the cost of accessing services (including travel, accommodation and time taken off work by the carers and family); and access to

information. The building blocks to good health may also be limited in rural areas, such as the availability of a variety of affordable, fresh food.

- **Particularly vulnerable groups of children**

Certain groups of children face additional vulnerabilities which may affect their right to health, including asylum seeking and refugee children, children who have been trafficked, children with disabilities, children in care and children of migrant workers. These children may have additional health care needs and problems accessing services. This includes mental health care services which are culturally appropriate.

- **Mental health service provision**

There is generally a lack of children and adolescent mental health care services and referrals can involve relatively long waiting periods before treatment begins. This is again particularly an issue in rural and remote areas.

- **Lifestyle – problems of obesity, substance and alcohol misuse**

Despite public health campaigns these continue to be a problem. Although problems may not come to light until adulthood risky behaviour or patterns often begin in childhood and adolescence.

- **Palliative care**

This is an increasingly complex issue as children with life limiting conditions are now living into young adulthood when previously they would not have survived. Medical advances have outstripped the provision of care which is appropriate for the age and maturity of the child or young person. Even where there is good hospice provision for children, resources are being stretched beyond their original and intended remit.

5. Concrete measures to implement Article 24

- **Campaigns on birth registration**

Birth registration is important to access health services, as well as monitoring rates of infant mortality. States therefore need to have effective and accessible systems for registering births and deaths. Introducing legislation is not enough in itself, but must be accompanied by effective public awareness raising as to the benefits of birth registration and the training of officials. Mobile units could be sent out to geographically remote areas.

- **Rural access**

There is a lack of evidence as to what models deliver effective health care in rural and remote areas. In the case of disseminating information and public health education to those groups who are hard to reach this could be addressed by more innovative use of technology using mechanisms of delivery designed to minimise the disadvantages of distance and inaccessibility.

In relation to rural access and travel, states could increase the use of mobile technology, e.g. M-PESA system in order to enable those in remote areas to access the resources to reach health care facilities.

Incentives could be offered to health care professionals in order to increase qualified workers in rural areas. Incentives could include financial bonuses, compulsory rural service and scholarships for young people in rural areas.

The development of more peripatetic health facilities should be encouraged to increase the accessibility to services for those in rural and remote areas. Successful models which could serve as blueprints include India's Lifeline Express, replicated in China and Zimbabwe, and the river boat hospital in Bangladesh.

- Advocacy by and for children

Every health service should develop an advocacy service for children. This service should be set up with regard to the opinion of children on how such a service should operate. Advocates should be educated in the needs of children and understand especially the needs and rights of children with disabilities.

- Multi-agency working

The importance of partnerships on the ground for the delivery of health care and services should be emphasised and networks developed. In addition various actors from academia, NGOs, business and government should be brought together to research, fund, implement and monitor innovative models of health support.

- Encourage due diligence

States should be held accountable for non-action in the realisation of the right to health by way of the principle of due diligence.

The foregoing will only be realised optimally through regard being given to Articles 2, 3, 6 and 12 of the CRC. However account needs to be taken of other Articles in the Convention, such as 13, 23, 25 and 27. Similarly cognisance must be given to other international human rights instruments, including:

- UN Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly, 24 January 2007, A/RES/61/106
- Relevant articles in the ICCPR, ICESCR, CEDAW and CAT
- The UN Millennium Development Goals, especially number 4
- Organisation of African Unity, African Charter on the Rights and Welfare of the Child OAU Doc. Cab/Leg/24.9/49 (1990), *Entered Into Force* Nov. 29, 1999, especially Article 14
- General Comments/Recommendations as appropriate

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The Centre for Rural Childhood, Perth College University of the Highlands and Islands is a research centre established in 2007. The Centre's activities include research, consultancy, teaching, training and the provision of an evidence-based approach to the development of policy and practice at a local, national and international level. The Centre is transdisciplinary and deals with issues of human trafficking, migration, refugee children, health, education, juvenile justice, restorative practice and human rights and business (corporate social responsibility). Centre staff members have a background in anthropology, health, psychology, philosophy, education and law, with a particular emphasis on international human rights law.