

Health and Poverty or How to Ensure the Right to Health in Situations of Economic Crisis. Response from the Convention on the Rights of the Child

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Salud y pobreza o cómo asegurar el derecho a la salud en situaciones de crisis económica. Una respuesta desde la Convención de Derechos del Niño

ABSTRACT: It is certainly a huge challenge determining the content and scope of the child's right to health, especially in contexts of poverty or economic crisis. To broach this issue and try to offer some answers, this study will refer to the Convention on the Rights of the Child, the obligatory reference in all matters concerning children. Regarding the Convention's legal status, its universality and the holistic nature of the rights set forth within it, the doctrine of the Committee on the Rights of the Child offers important guidelines for interpreting the wide-reaching right of the child to health contained within the Convention. Also discussed are the obligations concerning States Parties to it for its effective implementation, including in situations of economic difficulty.

RESUMEN: Intentar determinar el contenido y alcance del derecho del niño a la salud y hacerlo además en contextos de pobreza o de crisis económica es sin duda un enorme reto. Para intentar afrontarlo y ofrecer algunas respuestas nuestro trabajo acude a la Convención sobre los derechos del niño, instrumento de obligada referencia en todo asunto que concierna a los niños. Desde la naturaleza jurídica de la Convención, su universalidad y el carácter holístico de los derechos que proclama, la doctrina del Comité de derechos del niño nos ofrecerá importantes pautas para la interpretación del concepto amplio del Derecho del niño a la salud que la Convención proclama y de las obligaciones que conciernen a los Estados Partes en ella para su efectiva implementación, también en situaciones de dificultades económicas.

KEYWORDS: Convention on the rights of the child; the right of the child to health; the highest attainable standard of health; committee on the rights of the child; States's obligations; "progressive fulfillment"; maximum extent of the available resources

PALABRAS-CLAVE: Convención sobre los derechos del niño; derecho del niño a la salud; más alto nivel posible de salud; comité de derechos del niño; obligaciones de los Estados; realización progresiva; máximos recursos disponibles

1. Introduction

It is certainly a huge challenge determining the content and scope of the right to health, both in relation to the child as a holder of this right and in the contexts of poverty or economic crisis. This difficulty is highlighted by certain economic and social situations, the shortcomings of the law in this area, and the matter of States' political will. Attempting to provide an answer or, at least, identify guidelines or key references, is the aim of this academic work. Child health care is up against critical situations, be they circumstantial, such as the worldwide economic crisis of the last few years, or in contexts where poverty or lack of resources are more pronounced due to underdevelopment. With an approach based firmly in legal matters, this text aims to add to the ethical and philosophical debate on this matter through its analysis of the legal instruments supporting matters of child justice and health.



To attempt this task we begin with the obvious difficulty that the right to health – as a social and economic right – is faced with in order to realise the potential of both the right itself and that of the corresponding State requirements, so as to guarantee effectiveness and, where necessary, compensation. Alongside this, we keep in mind the progressiveness that prevails when interpreting human rights. This allows us to move forward in identifying their content, their adaptation to modern requirements and the demands of those entitled to them, and therefore, in specifying State responsibilities with respect to them.

Our work will focus on the child as an individual and on his/her rights. For this reason we will pay particular attention to the Convention on the Rights of the Child (hereinafter also “the Convention”), the treaty adopted by the United Nations which today is the obligatory reference in all matters concerning children¹. However, as with all universal treaties, the Convention and the rulings therein are subject to potential vagueness or ambiguity. This can affect the political will of States Parties in their adaptation to the rulings when adhering to them, but does not alter the Convention’s legally binding nature and the fact States Parties are obliged to adhere to it.² For that reason, in this study it will be essential to refer to the Committee on the Rights of the Child (hereinafter also “the Committee”), the legitimate body for the Convention’s interpretation and control.³ This will offer key elements to aid our interpretation of the child’s right to health⁴. Our observations will therefore mainly concern the jurisprudence of this Committee, which, at times, repeats that of other UN human rights organs, such as the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women. We will also refer to recent observations made by the Committee on reports submitted by States Parties to the Convention. This will enable us to provide concrete examples of its recommendations on how to protect children’s health in situations of poverty, discrimination or economic crisis, through measures whose implementation, in many cases, is more likely to require political will and awareness about the rights of the child than economic resources. In providing these examples we seek to demonstrate the Committee’s legal doctrine and overall position with regard to implementing the Convention, both in situations of economic disadvantage, and in our case, with particular reference to the right to health.

In line with this approach, our observations will be guided by three main themes. Firstly we will explain the importance of referencing the Convention on the Rights of

the Child in our analysis; secondly we will try to define the content and meaning of the right set forth in article 24 of the Convention (*"the right of the child to enjoy the highest attainable standard of health"*). Lastly we will address the complex matter of defining the scope and principles that govern States Parties' obligations in the implementation of this right, including in situations of economic crisis or poverty. At the end of the report we will draw some brief conclusions.

Before we proceed, let us make a point with regard to terminology. While at times we will refer back to terms such as *"the right of the child to the enjoyment of the highest attainable standard of health"* or *"the right of the child to the protection of health"*, we will generally use the broadest and most helpful wording, the *"right of the child to health"*. In doing this we hope to distance ourselves from terminology which identifies health as the absence of illness, therefore transforming the right to health into an undertaking that is not always possible for individuals nor attainable through State actions. We will instead be working with a more comprehensive vision of health that encourages a broad and positive concept of the right to health consolidated by the human rights doctrine (Medina, 2014). Article 24 of the Convention reflects this perspective by focusing the right to health *"on the establishment, access and support in the use of a wide variety of child health care programmes"* (Van Bueren, 1998, 298), all the while emphasising the child be recognised as holder of that right. This approach is also confirmed by the Committee on Economic, Social and Cultural Rights in its interpretation of the *"right to the highest attainable standard of health"* (*"The right to health is closely related to and dependent upon the realization of other human rights...embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life ... contains both freedoms and entitlements"*) (UN, Economic and Social Council, General Comment No. 14, &4,5).

2. The 1989 Convention, universal reference on the rights of the child

The Convention is undoubtedly an essential reference in all actions concerning children and their rights, both in international law and national legal systems. In addition, as established in its article 41 and as is befitting of international instruments of human rights⁵, the Convention represents the minimum standard to be applied, without affecting any international or national provisions that are more conducive to the rights of the child. Lastly, and again befitting of human rights, the Convention allows its content to be interpreted progressively.

The reasons for this due attention to the Convention are fundamentally its compulsory legal nature, its universality and the holistic nature of its rulings.

With regard to the nature of the Convention, the fact it is an international treaty means States Parties to it are legally bound to comply to it. This universality of the treaty derives not only from the fact it was adopted within the framework of the United Nations, which is universal, but also, as we will specify, because this universality extends to the number of States Parties to it, to the rights set forth within it and to the holders of these rights. And the Convention's holistic nature means it is part of the interdependence of human rights⁶.

The above points invite us to recognise the Convention as the international treaty of *all rights, for all children and with respect to all States* (Carmona, 2011, 62).

However, this all-encompassing phrase must be broken down in order to explain its somewhat ambitious content. It is to this we will dedicate the below comments, paying special attention to our subject matter, the right of the child to health.

2.1. "All rights"

The Convention is the first and only international treaty to bring together the full range of human rights with regard to children. This represented a new aspect of international law, in that it surpassed the sectoral nature of such matters that had previously affected the child (for example in the areas of health; education; work; and armed conflicts), and also the lack of legal enforceability of instruments that had previously hoped to treat such rights generally (as is the case with the 1969 Declaration of the Rights of the Child⁷). In addition, the Convention does not merely reproduce rights already set forth in other international human rights texts. Instead, it qualifies these rights by referring specifically to children; introducing new elements and allowing a dynamic interpretation of these rights in such a way that all the individual needs of the child, in all situations, are covered. It has thus been indicated that the Convention's drafters *could change the language to accommodate the need for a slightly different approach in relation to children* (Rishmawi 2006, 16). With regard to the right to health, demonstrations of this dynamic interpretation and accommodating the individual needs of children in situations of poverty or discrimination can be found in the Committee's observations of reports from States

Parties to the Convention. One example is the Committee's concern about the effect of environmental conditions on the health of marginalised and economically disadvantaged children⁸.

The Convention unites civil and political rights with economic, social and cultural rights. It addresses situations of particular risk or seriousness in relation to the vulnerability of the child, and considers the rights of the child and parents within the family environment. From this set of rights, inextricably linked to a child's welfare, mental and psychological growth and development (Rishmawi 2006), four general principles have been derived. These serve as a guide to any interpretation and application of the treaty. They are: non-discrimination towards the child when applying the Convention (article 2); the right of the child to life, survival and development (article 6); the consideration of the child's best interest in all actions concerning him or her (article 3.1); and the right of the child to express views in all matters affecting him or her (article 12).

The holistic nature of this treaty prevails with regard to each and every one of the rights set forth within it. This holistic element strengthens the interdependence of human rights with regard to the child.

Thus, with regard to protecting the child's right to health (article 24) it is easy to understand the close relationship between this and the general principles of the Convention (articles 2; 3.1; 6 and 12). We can also note links, to a greater or lesser extent, to other rights, situations or circumstances in the life of the child also contemplated in this treaty, for example the registry of births (article 7)⁹, the protection of the child against all violence (article 19), child refugees (article 22), children with disabilities (article 23), children in care (article 25), the right to social security (article 26), the right to an adequate standard of living (article 27), right to and objectives of education (articles 28 and 29), children in minority groups (article 30); protection against different forms of exploitation: work; drugs; sexual exploitation; trafficking, etc (articles 32 to 36), children deprived of their freedom (article 37), children affected by armed conflicts (article 38), recovery and reintegration of child victims of neglect, exploitation or abuse (article 39); and even third party participation in the application of and adherence to the Convention, as is concerned by parental guidance and responsibility (articles 5 and 18) or the function of the mass media (article 17).

The Committee on the Rights of the Child has emphasised the close relationship between these rights and situations relating to the protection of the health of the child, as the following examples illustrate. The observations of reports from States Parties to the Convention included in this study also underline this.¹⁰

Here it is worth indicating the benefit of health services in schools as a means of promoting health, detecting diseases and increasing children's access to health services. Secondly, school meals are important to increase the child's attention and learning, and sometimes the child's only chance of one proper daily meal. Thirdly, providing information and education about health in schools is important for encouraging healthy lifestyles and eating habits and to prevent violent and sexist behaviour¹¹, etc (CRC, General Comment No. 15, &36, 46, 49; and General Comment No. 4, &17).

Registering births in order to monitor children's health is also clearly important, especially in rural areas or those that are located a long way from larger towns. It is also important for children who, for cultural or other reasons, such as disability or simply through a lack of awareness on the part of their parents or family members, do not have access to registry services (CRC, General Comment No. 7, &25 and General Comment No. 9, &35).

Educating parents or legal guardians about child health is another action that would seem essential for children's survival and development. Another example is educating mothers during pregnancy and after childbirth (CRC, General Comment No. 15, &18 and General Comment No. 7, &20.c).

Particular vulnerability and discrimination with regard to the right to health frequently affects children in minority groups; children who live far away from densely populated zones where resources and health care are found; children with disabilities; girls; children discriminated against because of their sexual orientation, gender identity, or health condition, as occurs with young victims of HIV/AIDS; etc (CRC, General Comment No. 15, &8; General Comment No. 11, &51, and General Comment No. 3, &30).

Lastly, certain contexts or circumstances alluded to in the Convention in which specific attention is required, or may even represent a serious threat or danger to the health of the child, are of considerable importance. Here we are referring to situations of

child labour; children in prison¹²; children in armed conflicts; unaccompanied and separated children outside their country of origin; and cultural practices that are damaging to the child's health, etc (CRC, General Comment No. 6, &47).

2.2. "All children"

The Convention is also the first international treaty that proclaims the child to be the holder of such wide-reaching rights, not only in respect of the range of rights, but also in terms of the Convention's own definition of the term "child". According to article 1: *"For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier"*.

It is clear that this description permits certain variations in terms of the both the lower and upper age limit. These may be found in International Law – perhaps in the Convention itself – or in States' internal laws (*"...unless under the law applicable to the child, majority is attained earlier"*). This has even lead to the questioning of the Convention's universal scope regarding all children, in all circumstances (Díaz Barrado, 1991). However there is no doubt that the explicit reference to 18 years reflects the majority viewpoint of the Convention's drafters, who through this specification hope to recognise *"the need to ensure special protection to human beings to under that age"* (HR/1995/Ser.1/article 1, p.7). This age is also established as a universal reference when defining a child, both internationally¹³ and in national legal systems.

Regarding the lower age limit, while the Convention's article 1 does not specify such a limit, more precise wording can be found in paragraph 9 of the Preamble (*"...the child ... needs special safeguards and care, including appropriate legal protection, before as well as after birth"*) and in paragraph 2.d of article 24 (*"To ensure appropriate pre-natal ... care for mothers"*). These discrepancies are easy to understand when imagining the debate that would have occurred during the writing of the Convention, between the those States in favour of recognising and providing protection to the child before birth, and those who only wanted to apply this to children who had already been born and therefore prevent creating questions on abortion legislation (Carmona, 2011; UNCHR,HR/1995/Ser.1/preamble). The wording eventually adopted in article 1 as a compromise hopes to settle this matter

by leaving it to each State to decide whether or not to extend the Convention's protection to the child before birth.

With regard to health care, article 24.2.d leaves no doubt that children are to be included before their birth through its mention of pre-natal health care for mothers. In addition, the Committee requires that States give attention to the child's experience throughout different periods of childhood, with reference to the cumulative character of the stages in a child's development, in that each stage affects those that follow (CRC, General Comment No. 15, &18, 52). Nevertheless, the contentious issue of abortion puts the Committee in a difficult position. Thus, in its 8, the Committee rejected selective abortions that were carried out because of female gender or evidence of disability found in the embryo or fetus. It expressed concern about the excessive use of abortion in some States, its use as a family planning method, and its use in cases of early pregnancy in teenagers (Hodgkin and Newell, 2001), as is often the case in contexts of poverty or discrimination.¹⁴ To counter these last points, the Committee urged States to provide better education to young people on sexual health and reproduction and insisted, in its most recent literature, on family planning services. And with questionable wording in terms of its effectiveness, it asked States to "*ensure access to safe abortion and post-abortion care services, irrespective of whether abortion itself is illegal*". The Committee also highlights the interdependence of the rights of the child by urging that "*girls can make autonomous and informed decisions in their reproductive health*" and "*discrimination based on adolescent pregnancy, such as expulsion from schools be prohibited, and opportunities for continuous education should be ensured*" (CRC, General Comment No. 15, &56, 70). It is apparent, therefore, that the Committee's position is vague with regard to protecting a child's health before birth, perhaps because of the diversity of States Parties' positions in their internal regulations. The result of this could be a general protection of the unborn child that ceases when these rights are confronted with other rights concerning the life, survival or other basic rights of a child who is already born.

Without wishing to extend our discussion to these questions, it is useful to highlight that the lack of definition of the term "child" in the Convention may have an impact on other technical and scientific actions carried out during the prenatal period. It could bring up possible conflicts in rights, possibly also with respect to children who are already born. Here we are referring to, for example, methods that involve

manipulating or killing embryos, or the use of gametes from anonymous donors for assisted reproduction and the potential conflict this may have in relation to the following: "...as far as possible, the right to know and be cared for by his or her parents" (article 7) or "...the right of the child to preserve his or her identity" (article 8).

With regard to the upper age limit, we have said that possible deviations from the general rule of 18 years may occur as a result of the Convention and also from the States' internal legislation. In that regard, the text of the Convention itself contains vague or unfortunate wording in relation to children's admission into hostile environments or those that put their health at risk, such as employment: (article 32.a: "...Provide for a minimum age or minimum ages for admission to employment") or armed conflicts (article 38.2: "... persons who have not attained the age of fifteen years do not take a direct part in hostilities"). However, it is worth pointing out the importance of ILO treaties on prohibiting or regulating child labour – the Committee regularly invites the States to ratify or comply with these treaties – as well as the adoption of the Optional Protocol of the Convention on children's participation in armed conflicts, which overcomes the inaccuracies or lower age limits described in the Convention.

In any case, when it comes to the child's right to health, the Convention's protection until the upper limit of 18 years stems from its own article 24.1: ("... no child is deprived of his or her right...") and the Committee's interpretation of this. The Committee requires States Parties to the Convention to provide regular disaggregated data in its reports about under-18s relating to all areas of the Convention, which therefore includes health. The Committee gives particular attention to matters of health affecting the various stages of the child's life, spanning early childhood to adolescence¹⁵.

As well as the fact the upper age limit of 18 has become a universal reference when defining a child, the Convention has also entailed a shift of paradigm in the way a child is defined traditionally, in that the child has shifted away from being merely a recipient of protection and towards also being recognised as a subject of rights (Cardona, 2012; Santos Païs, 1992). With this has come the child's capacity to demand that these rights be realised. Undoubtedly this is one of the Convention's most significant contributions to the development and progress of human rights in

the international order. In relation to the health of the child, this notion can be seen in article 24 of the Convention, which describes the enjoyment of health facilities not only as a consequence of obligatory services provided by States but, above all, as a subjective right of the child.

In accordance with this viewpoint, the Committee has obliged States Parties to the Convention to develop a child's own ability to claim his or her right to health (CRC, General Comment No. 15, &5), and in light of the general principle expressed in article 12, it has included in the right of the child to be heard the need to "*strengthen children's capacities to take increasing levels of responsibility for their own health and development*" (CRC, General Comment No. 15, &19).

We can therefore conclude by confirming that "all children" allows us to identify those under 18 years old, as a general rule and according to the requirements of the Convention, subject to the jurisdiction of States Parties to the Convention (which almost all the States in the international community are). Limitations to this specific age limit are possible in certain areas.

2.3. "All States"

The Convention is the human rights treaty with the highest number of State ratifications (197). Today it represents practically the entire international community¹⁶.

The universality of the States Parties to the Convention translates into the universal application of the obligations laid out within it. In effect, according to article 2.1 of the Convention, "*States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction*". This means that the obligation of the States Parties to the Convention extends not only to its nationals but also to foreign or stateless children under their jurisdiction. In addition, the Convention urges States Parties to it to respect and implement it for the benefit of children in developing countries, by means of international cooperation. This can be derived from the last paragraph of the Preamble ("*...importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries*"), from article 4 *in fine* ("*With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within*

the framework of international co-operation”) and from article 24.4 (“...promote and encourage international co-operation with a view to achieving progressively the full realization of the right...particular account shall be taken of the needs of developing countries”).

Here we can recognise the States’ principal obligation to respect and apply the Convention to children under their jurisdictions and a shared obligation towards children of developing countries, which they must carry out through international cooperation. (Carmona, 2012)

The Committee itself has summarised this obligation on the subject of health by affirming that “*States parties to the Convention have obligations not only to implement children’s right to health within their own jurisdiction, but also to contribute to global implementation through international cooperation*”. Additionally, the Committee indicates the Convention as the guiding resolution for all international activities, and all donor and recipient State programmes relating to the health of the child; declaring that “*States have individual and joint responsibility, including through the United Nations mechanisms, to cooperate in providing disaster relief and humanitarian assistance in times of emergency*” and reminds States of the States’ common target of allocating 0.7% of their gross national income to international development assistance (CRC, General Comment No. 15, &86-89).

3. The child’s right to health in the Convention

Article 24 of the Convention¹⁷, tasked with regulating the child’s right to health, uses vague wording (“...the highest attainable standard of health...”), highlights the entitlement of all children (“...no child is deprived...”) and provides a non-exhaustive (“...in particular...”) list of measures to be adopted by the States Parties in order that this right be fully implemented. This list includes primary health care (“...emphasis on the development of primary health care”). The complementarity between the entitlement of the child as the subject of rights, and the State obligations in respecting and making effective these rights, appears in a setting where this dependency is clear. Also, the article emphasises international cooperation as a means of attending to the needs of developing countries; and encourages the abolishment of traditional practices prejudicial to the health of children using a broad-based approach, as it

was decided during the preparatory works of the Convention (UNCHR, HR/1995/Ser.1/article 24)¹⁸

It is certain that the health of the child was present in international law before the Convention – in particular the International Covenant on Economic, Social and Cultural Rights (ICESC) which declared the “*right of everyone to the enjoyment of the highest attainable standard of physical and mental health*” and specified measures to be adopted by the States with regard to children such as “*the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child*” (article 12). However, there is no doubt that the 1989 treaty represents significant progress and one further step in interpreting the human right to health in international law. It does this by incorporating a more detailed and specific concept of the child’s right to health which will be interpreted by the Committee on the Rights of the Child, and which other legitimate bodies will reference in their interpretation.¹⁹ (Medina, 2014; Van Bueren, 1998).

Article 24 of the Convention takes refuge in the positive concept of health put forth in the World Health Organisation (WHO) Constitution (“*state of complete physical, mental and social well-being*”) and grants special emphasis and legal enforceability to primary health care. This is in accordance with the approach on which the Declaration of Alma-Mata was established, which was adopted in the Conference hosted by UNICEF and the WHO itself in 1978 (Van Bueren, 1998). Following that line, and since it is the only possible way, the Convention addresses child health *from a child-rights perspective* (CRC, General Comment No. 15, &4) and in accordance with its universality and holistic nature.

This wide-reaching concept of child health led the Committee to recognise in article 24 an “*inclusive right, extending not only to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services, but also to a right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of programmes that address the underlying determinants of health*” (CRC, General Comment No. 15, &2)

This viewpoint highlights the close relationship between article 24 of the Convention and the general principle proclaiming the child’s right to life, survival and development

(article 6)²⁰. But also, that link extends to the rest of the Convention's principles and rights, as indicated by the Committee when it states that "*the realization of the right to health is indispensable for the enjoyment of all the other rights in the Convention. Moreover, achieving children's right to health is dependent on the realization of many other rights outlined in the Convention*" (CRC, General Comment No. 15, &7).

Therefore, the definition of the right to health is closely linked to two specific concepts that we have highlighted as main themes of article 24: *the highest attainable standard of health* and primary health care.

With regard to the former, although article 24 does not replicate the more thorough wording that can be found in the ICESCR, there is no doubt that it includes physical as well as mental health. It can therefore be deduced from the discussion in the Convention's *travaux préparatoires*, HR/1995/Ser.1/article.24) and from the Committee's explicit mention of child mental health, which is given a broad scope, at times with respect to certain groups such as adolescents²¹, girls²², children with disabilities²³, etc.

The Committee has specified that "*the notion of the highest attainable standard of health takes into account both the child's biological, social, cultural and economic preconditions and the State's available resources, supplemented by resources made available by other sources*" (NGOs, international community, private sector) (CRC, General Comment No. 15, &23). That is, this wording covers both what is attainable with regard to each child and the progressive implementation of State resources. And this last point leads to us to consider the obligation of the States to, on the one hand, offer all children equal opportunity of enjoying the highest possible level of health²⁴ (CRC, General Comment No. 15, &24) and on the other, to implement this right progressively, establishing their own priorities and using article 24 and the measures indicated within it as a reference²⁵.

Regarding primary health care, the Committee requires services that are available in sufficient quantity and quality, functional, acceptable and within the physical and financial reach of all sections of the child population (CRC, General Comment No. 15, &25). However, although such services are required for "all children", special attention is given to under-served areas and populations. This leads our discussion to the general principle of non-discrimination regarding child health benefits from

two perspectives: firstly, stopping a child's condition or state of health being a reason for discrimination (such as sexual orientation, mental health, gender identity, or exposure to infectious diseases such as HIV/AIDS); and secondly, favouring children in disadvantaged situations and under-served areas (CRC, General Comment No. 15, &8, 11).

The reason for giving such importance to primary health care is easy to understand when we consider the fact that the highest proportion of health problems (80%) is resolved at this stage. Primary health care is comprised of various components: health education and promotion of health; adequate food supply and encouraging good eating habits; adequate water supply and basic sanitation; maternal and infant health services and reproductive health; immunization against the major infectious diseases; prevention and control of endemic diseases; adequate treatment of common diseases and injuries; and provision of essential medicines (Medina, 2014). These are the basic principles of primary health care: equitable allocation of resources (economic and geographic access for all groups in society); community participation through active involvement in decisions about one's own health and community services; appropriate and affordable technology; cooperation between the different sectors that relate to health (agriculture, education, housing); prevention through education and health education without neglecting curative treatment (*ibidem*).

4. State obligations when implementing the child's right to health

It is clear that, given the legal nature of the Convention as an international treaty, the States Parties in it are the main obligation holders with regard to its fulfillment. However, when we focus the study of this obligation on the child's right to health, article 24 seems to show a close relationship between the actual conditions and situations of the child who is the holder of that right, and State obligations to achieve this and to guarantee it at the highest possible level: "*the notion of 'the highest attainable standard of health' takes into account both the child's biological, social, cultural and economic preconditions and the States' available resources*".

Thus, appropriate responses from the States that ensure the Convention is fulfilled with respect to the child's right to health will not only have to deal with specific situations or circumstances that may affect children as individuals or as part of a particularly

vulnerable group, but also to the economic conditions and resources available in the States themselves. Plus, as we have already indicated in our discussion, health care and health protection, and recognising these as human rights, confronts us with the economic and social nature of this right, and its constraints - but also the baseline requirements imposed by respecting it and carrying it out.

In the Convention's case, and as previously mentioned, in order to summarise State obligations to protect the health of the child we need to consider not only article 24 of the Convention but also, and more importantly, article 4, whereby: "*States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation*".

The reading of this article seems to suggest the need to adopt measures giving effectiveness to the rights within the Convention absolutely and generally; but remaining subject to the maximum resources available in States Parties, and even to international cooperation, in terms of economic, social and cultural rights. However, this must be counteracted with other baseline aspects of the Convention, such as its interdependent and holistic nature, as we discussed earlier.

From article 4's description of economic, social and cultural rights the Committee has developed the concept of "progressive fulfillment". This takes into account structural, economic or other limitations that may prevent States' from responding fully and satisfactorily to the Convention's requirements. However, "progressive fulfillment", does not grant States exemption. On the contrary, it obliges them to adopt specific and immediate measures so as to achieve the fulfillment of the rights of the child in the most industrious and effective manner possible, whatever their level of development or economic situation²⁶. The Committee underlines that whatever circumstances States find themselves in, they must be able to demonstrate that they have allocated the maximum resources available and, where necessary, made appeals to international cooperation in order to guarantee at least minimum essential levels of the rights. Where resources are demonstrably inadequate, States may adopt selective measures on behalf of the most underprivileged children, but should never take retrogressive steps which may hamper the enjoyment of children's

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right to health (CRC, General Comment No. 5, &7,8, and General Comment No. 15, &71, 72).

Ultimately, these criteria in the Convention's interpretation present us with real and effective obligations that are imperative and/or programmatic; with a universal scope and which set its application from the perspective of the rights of the child, which forces the States Parties, in line with the principle of effectiveness, to adopt positive measures for its implementation (Carmona, 2012, 75)²⁷, regardless of the economical context²⁸. At the time of taking and adopting these measures - whether they be legislative, administrative, judicial or otherwise - it is important to remember that the individuality and specific vulnerability of the child requires adaptation not only to the content of his/her rights, but also to the assessment of any violation (Rishmawi, 18). This is the only way to ensure the suitability of not only the measures adopted to guarantee the rights of the child, but also those that aim to remedy any cases of violation. On this last point, it is worth highlighting the importance of recognising the self-executing nature of the Convention in the internal orders, that is, the possibility of individuals appealing to judicial authorities and national administrations²⁹. This allows the diplomatic control mechanism to be strengthened (Alen and Pas, 1996), representing the system whereby States present reports to the Committee (article 44) and may mean States and society are generally more equipped to recognise other international instances of the control of these rights, that in the case of the Convention directs us to its Optional Protocol on a Communications Procedure³⁰. In this regard, it is worth pointing out the importance that this protocol of the Convention represents in establishing a mechanism whereby individuals can submit complaints to the Committee when rights set out within it are breached by States Parties to it. The Convention is therefore placed above the main United Nations human rights treaties that already included this mechanism.

Regarding the health of the child specifically, the Committee has indicated the following core State obligations (CRC, General Comment No. 15, &72, 73): "*Reviewing the national and subnational legal and policy environment and, where necessary, amending laws and policies; ensuring universal coverage of quality primary health services, including prevention, health promotion, care and treatment services and essential drugs; providing and adequate response to the underlying determinants of children's health; and developing, implementing, monitoring and evaluating policies and budgeted plans of actions that constitute a human rights-based approach to*

fulfilling children's right". And because there is no other option, the child's best interest must be at the centre of all decisions affecting his/her health, including the allocation of resources and the development of policies that affect the underlying determinants of the health of the child (CRC, General Comment No. 15, & 13). The Committee offers greater precision on the scope of State obligations in implementing the Convention in the general guidelines for producing the periodic reports that States have to present. Included, among other measures, are indicators to evaluate the progress achieved when exercising this right, or an indication of the measures adopted to ensure a universal immunization system.

Although clearly the configuration and content of primary health care services will vary from country to country, the Committee insists on effective health systems, which include robust financing mechanisms³¹ (CRC, General Comment No. 15, &36). In addition, the Committee highlights sustainability as key to the States' progressive fulfillment of obligations under article 24, even in contexts of economic crisis or emergency situations. And according to the Committee, *"this requires that children's health and related policies, programmes and services be planned, designed, financed and implemented in a sustainable manner"* (CRC, General Comment No. 15, & 74).

Therefore, the objectives of sustainability and effectiveness in children's health policies will be supported by specific State actions, such as the adoption of national plans that are long-term and entrenched as a priority; the analysis of problems affecting the health of the child and the assessment of the institutional capacity and the availability of resources; the coordination and cooperation between government ministries and different levels of government, as well as the interaction with the civil society; the adoption of rights-based States budgets, that make visible the investment in and cost of the health of the child; the availability of relevant, reliable and disaggregated data that pays due attention to more vulnerable children; and the establishment of strategies for monitoring and evaluating policies, programmes and services relative to the health of the child; as well as complaints mechanisms that allow children to seek and obtain reparations when their right to health is violated or at risk, including access to courts, directly or through legal representatives (CRC, General Comment No. 15, &97-120).

Lastly, and in conclusion, we need to mention the importance of intervention from third, non-State countries, for the child's right to health to be realised fully³².

Alongside the fact the child's parent or legal guardians have a clear central role in the health of the child, the professionals who work with or for children are also hugely important, both within health care itself and in schools and institutions - and even the private sector (CRC, General Comment No. 15, &42). In that regard, the State, as the main body responsible for the fulfillment of the Convention, has an obligation to ensure they have the sufficient education, knowledge and skills to perform their duties and responsibilities³³. The work carried out by scientists and researchers, such as that bringing us here today, plays a key role in the study and diffusion of knowledge about the rights of the child.

5. Conclusion

The Convention's holistic nature derives from its clear contribution in recognising the child as holder of his/her own rights (including the possibility of submitting complaints to the Committee for breaches by States Parties to the Convention under the Optional Protocol); the universal scope of the rights it contains (all the rights), the children entitled to those rights (all those under the age of 18 under the jurisdiction of the States Parties), and the States forced to respect and effectuate them in accordance with their necessary interdependence (practically all the States in the international community as States Parties to the Convention). This holistic nature provides the elements needed to interpret the scope of the child's right to health and to identify the correct lines of action to be taken to ensure its implementation, in any circumstances. The work of the Committee on the Rights of the Child, through its legal doctrine and observations on reports submitted by States Parties to the Convention, is an important means of specifying the content of this right and its minimum contents (ensuring "essential levels" of rights and in the case of economic rights, the "maximum extent of their available resources". It also bolsters the political will of the States when adopting the legislative, administrative and other measures (plans of action, political measures, regulations, complaints systems etc) that enable the improvement of not only welfare benefits but also the justiciability of this right (with the possibility of invoking the Convention before judicial authorities and internal administrations).

Economic and social contexts, and even children's personal circumstances, can be very diverse and may determine whether a satisfactory response to the requirements of the Convention is achieved. The Committee is aware of this fact, and recognises the need for each State to adapt to the circumstances. We should never forget that children's rights and their status as holders of these rights is universal and unique to each child. This principle should guide the actions of States Parties to the Convention, who are obliged to effectuate all the rights laid out within it – including therefore the child's right to the health – with respect to all children under its jurisdiction and, by means of international cooperation, to children of developing countries.

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CRC/C/SWE/CO/5: Concluding observations on the fifth periodic report of Sweden, 6 March 2015

Website

Committee on the rights of the child: <http://www2.ohchr.org/spanish/bodies/crc/index.htm>

Notes

1. The Convention on the Rights of the Child was adopted by consensus by General Assembly resolution 44/25 of 20 November 1989. Later, the following three Optional Protocols were added: Optional Protocol on the sale of children, child prostitution and child pornography and Optional Protocol on the involvement of children in armed conflict, both adopted by resolution A/RES/54/263 on 25 May 2000 and in force from January and February 2002 respectively; and Optional Protocol on communications procedure, adopted by A/RES/54/138, on 19 December 2011 and in force from April 2014.
2. Vienna Convention on the law of treaties, 23 may 1969, Article 26: *Pacta sunt servanda. A party may not invoke the provisions of its internal law as justification for its failure to perform a treaty.*
3. For information about the Committee, see Articles 43 and 44 of the Convention.
4. Of particular importance will be *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health* (article 24). Other General Comments that

will also prove useful are: No. 3 (2003): *HIV/AIDS and the Rights of the Child*; No. 4: *Adolescent health and development in the context of the Convention on the Rights of the Child*; No. 5 (2003): *General Measures of Implementation of the Convention on the Rights of the Child*; No. 7 (2005): *Implementing child rights in early childhood*; No. 9 (2006): *The rights of children with disabilities*; No. 11 (2009) *Indigenous children and their rights under the Convention*; No. 12 (2009): *The right of the child to be heard*; No. 13 (2011) *The right of the child to freedom from all forms of violence*; No. 14 (2013) *The right of the child to have his or her best interests taken as a primary consideration*; No. 16 (2013) *on State obligations regarding the impact of the business sector on children's rights*; and *Joint general recommendation/general comment No. 31 of the Committee on the Elimination of Discrimination against Women and No. 31 of the Committee on the Rights of the Child on harmful practices*, etc, as well as Concluding observations on the report submitted by States Parties. Both document types can be viewed at: <http://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIntro.aspx>

5. Convention on the Rights of the Child, Article 41: *"Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of the child and which may be contained in: (a) The law of a State party; or (b) International law in force for that State"*.
6. Vienna Declaration and Programme of Action (adopted by the World Conference on Human Rights in Vienna on 25 June 1993) doc A/CONF.157/23: 5. *"All human rights are universal, indivisible and interdependent and interrelate"*.
7. There is much information on the actions and philosophy of pioneers in child rights protection, both on the scope of international institutions and within the civil, non-government framework, and on the adoption of the first international texts on the rights of the child, in the following work: Veerman, Philip 1992; Garibo Peyró, Ana Paz, 2004; y Cots i Moner, 1979.
8. CRC Concluding Observations Brazil (2015), par. 69-70: *The Committee is worried because the proportion of children living in poverty remains high. It is particularly concerned about the high number of indigenous children affected by poverty, and the high vulnerability of Afro-Brazilian children as well as children living in marginalized urban areas, including favelas, and in rural areas, to poverty. The Committee also notes with concern the lack of access to adequate housing, safe drinking water and sanitation, for children living in these areas and makes recommendations to "...increase investment in water supply and sanitation infrastructure in marginalized urban areas, including favelas, and in rural areas... amending its Constitution to include the right to water and sanitation... and establish a mandatory fair affordability standard for water and sanitation services and regulate subsidy policy by law, with clear criteria and responsibilities for granting subsidies to low-income individuals"*.
9. The Committee demonstrated its concern about undocumented *Rohingya* children in Bangladesh, who are from the Northern Rakhine State in Myanmar, many of whom have fled persecution and are in need of humanitarian aid. CRC Concluding Observations Bangladesh (2015) par. 70, 71: *Despite the decision to provide birth certificates to children born inside two refugee camps in the State party, the Committee is concerned that refugee children born outside the camps do not have birth certificates and have limited access to basic services, education and recreation. The Committee recommends that the State party provide birth registration and access to basic rights, such as to health and education, for all undocumented Rohingya children and their families on the State party's territory, irrespective of their legal status. Likewise, CRC Concluding Observations Dominican Republic (2015), par.25: *The Committee is concerned that in 2012 one fifth of children under 5 years of age, mostly from families living in poverty, had no birth certificate.**
10. To better understand the relationship between the right to health and other rights and situations regulated in the Convention, of particular interest are the Committee's *Concluding Observations* of reports from States Parties on how the Convention is to be implemented. These can be consulted on the Committee's website (see *supra* note 4).
11. CRC Concluding Observations Bangladesh (2015), par. 56, 57: *The Committee is concerned about the high prevalence of adolescent pregnancy and the lack of adolescent-friendly health services and menstrual hygiene management facilities and services. It recommends that the State party Raise awareness in schools and communities about improving hygiene practices, while ensuring access to menstrual hygiene management facilities and services. In a similar meaning: CRC Concluding Observations Eritrea (2015), par. 59, 60: *The Committee is concerned that the drop-out rate for girls is high owing to excessive domestic duties, early marriage and pregnancy and the frequent lack of gender-sensitive sanitation facilities forces girls to stay away from school when they are menstruating. It recommends that the State party ensure that girls who are married, pregnant or**

rearing children are supported and assisted in continuing their education and strengthen its efforts to ensure that all schools are provided with gender-sensitive sanitation facilities.

- 12.** CRC Concluding Observations Eritrea (2015), par. 51, 52: *The Committee is concerned that Lactating mothers are having difficulties in providing proper nutrition for their infants owing to the poor quality of food provided in the detention facilities. It recommends that the State party take effective and urgent measures to ensure that living conditions for children in prison with their mothers, including access to food, water and sanitation, as well health and education services, are adequate for the children's physical, mental, moral and social development and seek alternative measures to institutional confinement for pregnant women and mothers with young children, wherever possible.*
- 13.** *i.e.* African Charter on the Rights and Welfare of the Child, 1990 (article 2); European Convention on the Exercise of Children's Rights, 1996 (art.1); Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, 2007 (art. 3); Statute of the International Criminal Court, 1998 (article 26); ILO Convention nº182 on Eliminating Worst Forms of Child Labour, 1999 (article 2); and Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict, 2000 (article 1).
- 14.** Concluding Observations Brazil (2015): *The Committee is concerned about the high and increasing rates of pregnancy, particularly among girls aged 10 to 14 years who are in socioeconomically vulnerable situations ... clandestine and unsafe abortions. It makes recommendations to "... conduct awareness-raising programmes, targeting adolescents, on the negative consequences of early pregnancies, including with the involvement of teenage parents, and guarantee access to adolescent-friendly information on contraception; develop and implement a policy to protect the rights of pregnant teenagers, adolescent mothers and their children and to combat discrimination against them; decriminalize abortions in all circumstances and review its legislation with a view to ensuring access to safe abortion and post-abortion care services".*
- 15.** General Comments No. 4 and No. 7. *See supra* note 4.
- 16.** The US has not ratified the Convention, although it did sign it on 16 February 1995, and is Party to the Optional Protocols on the involvement of children in armed conflict and on the sale of children, child prostitution and child pornography. The status and date of ratifications of the Convention and its Optional Protocols can be consulted at <http://indicators.ohchr.org>.
- 17.** Article 24 of the Convention on the rights of the child:

States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

- (a) To diminish infant and child mortality;
- (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- (c) To combat disease and malnutrition, including within the framework of primary health care, though, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- (d) To ensure appropriate pre-natal and post-natal health care for mothers;
- (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
- (f) To develop preventive health care, guidance for parents and family planning education and services.

States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

- 18.** The Senegalese delegation suggested that the Convention include the term “to abolish” to refer generally to traditional practices that are detrimental to the health of the child, which would bring about a broader concept of health and avoid referral to female circumcision only, as was being proposed by other delegations, such as the United States.
- 19.** See *Economic and Social Council, General Comment No. 14, on.... cit. supra.*
- 20.** CRC Concluding Observations Senegal (2016), par. 27: *The Committee is concerned that Children are affected by high levels of malnutrition, abuse, exploitation, poverty and socioeconomic disparity, all of which compromise the inherent right of the child to life, survival and development.*
- 21.** CRC Concluding Observations Bangladesh (2015), par. 58, 59: *The Committee reiterates its previous concern about the lack of adequate facilities and counselling services for mental health for adolescents and expresses concern at the reported increased number of suicides among adolescents. It recommends that the State party take urgent action to strengthen its efforts to prevent suicide among children and youth, including by increasing psychological counselling services and social workers in schools and communities, and ensure that all professionals working with children are adequately trained to identify and address early suicidal tendencies and mental health problems.*
- 22.** CRC Concluding Observations Bangladesh (2015), par. 45: *The Committee urges the State party to Develop awareness-raising campaigns and programmes on the harmful effects of early marriage on the physical and mental health and well-being of girls, targeting households, local authorities, religious leaders and judges and prosecutors.*
- 23.** CRC Concluding Observations Brazil (2015), par. 51: *The Committee is concerned about the widespread sexual violence, abuse and exploitation carried out against children with disabilities, particularly girls; the Act No. 9263/1996, which permits the sterilization of children with disabilities without their free and informed consent; and the difficulties in obtaining medical examinations for children with disabilities, which are often a prerequisite for access to medical care or support measures. It urges the State party immediately revise this Act, explicitly prohibit the sterilization of children with disabilities and ensure access to medical care and to support measures for all children with disabilities.*
- 24.** CRC Concluding Observations Sweden (2015), par. 41, 42, 47: *The Committee notes with concern that a relatively large number of children are living in poverty. While welcoming the provision of equitable health care for asylum-seeking children, the Committee is concerned that there continue to be considerable disparities in the physical and mental health of children from different economic backgrounds. For this reason, the Committee draws the State party’s attention to its general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health and recommends that the State party step up its efforts to improve the health status of children from disadvantaged and marginalized groups, and allocate sufficient financial, human and technical resources to guarantee their right to health, without discrimination. Also CRC Concluding Observations Latvia (2016), par. 60, 61: *The Committee is concerned that: Asylum-seeking children in detention facilities are entitled to primary health care and essential treatment only and It recommends that the State party Review the Medical Treatment Law to provide asylum-seeking children in detention with necessary advanced health treatment on an equal basis with other detained persons.**
- 25.** CRC Concluding Observations Ethiopia (2015), par.56: *The Committee draws the State party’s attention to its general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, and recommends that the State party: (a) Raise the annual per capita expenditure on health and eliminate regional disparities in the provision of health services, including prenatal and postnatal care, immunization coverage, and the management of communicable diseases and malaria; (b) Implement and apply the OHCHR Technical Guidance on the application of human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under five years of age (A/HRC/27/31) and pay particular attention to rural and remote areas in the combat against infant, under-five and maternal mortality; (c) Effectively address malnutrition in terms of stunting, wasting and low weight, particularly in rural and remote areas, continue the programme of salt iodization, develop public awareness programmes on food diversity consumption of nutritious food and benefits of breast-feeding and engage with World Health Organization (WHO) and the United*

Nations Children's Fund (UNICEF) in this respect; (d) Provide training to health professionals to detect ulcerative gingivitis, the first signs of noma; (e) Develop and implement policies to improve health infrastructures, and intensify training programmes for all health professionals, including the pastoralist health extension workers.

- 26.** CRC Concluding Observations Netherlands (2015), par.14,15: *The Committee is concerned about significant cutbacks in the State party's budget that affect families and children living with minimum income. It is also concerned that with the decentralization of child care services in the Netherlands, resources aimed at children will be used at the discretion of municipalities which can thus create unequal access to such resources by children in different municipalities. It recommends that the State party ensure that the cutbacks in its budget do not adversely affect the rights of children, in particular children in marginalized and disadvantaged situations. The Committee also recommends that the State party establish a central mechanism to monitor and evaluate the adequacy, efficacy and equitability of the distribution of resources and services provided to children throughout the Kingdom. i.e. CRC Concluding Observations Benin (2016), par. 14: While the budget allocation to social sectors (health, education and social development) was expected at a rate of 36 per cent of the State Budget in 2014 in the context of the Growth and Poverty Reduction Strategy (2011-2015), the Committee is concerned that the budget allocation to social sectors remains low, at only 29 percent of the State budget. The Committee recommends that the State party ... ensure that the commitment to fighting poverty is translated in terms of budget allocation and social spending, and make the achievement of the Sustainable Development Goals and action on behalf of children an important part of the forthcoming poverty reduction strategy.*
- 27.** CRC Concluding Observations Dominican Republic (2015), par. 10-12: *The Committee reiterates its recommendation and encourages the State party to prepare a comprehensive policy on children and, on the basis of the policy, to develop a strategy with the elements for its application, including indicators and a monitoring mechanism provided with sufficient human, technical and financial resources. It recommends that the State party Conduct a comprehensive assessment of the budget needs of children and allocate adequate budgetary resources for the implementation of children's rights. This includes, in particular, increasing the budget allocated to health, education and other social sectors and addressing disparities on the basis of indicators relating to children's rights; adopt a child-rights approach in preparing the State budget, by implementing a tracking system for the allocation and use of resources for children throughout the budget; and carry out impact assessments on how the best interests of the child are taken into consideration in investments or budget cuts in any sector.*
- 28.** CRC Concluding Observations France (2016), par. 69, 70: *The Committee welcomes the adoption of the multi-year poverty reduction and social inclusion plan but is concerned about the situation of the 20per cent of children who live in poverty and the large numbers of homeless children. It is particularly concerned about the worsening situation of children and families affected by the economic crisis living in poverty, particularly children in families headed by single parents and children living in shantytowns or in "sensitive urban areas", as well as children living in "emergency lodging" for periods extending to years. The Committee recommends that the State party make the eradication of child poverty a national priority and that it allocate the necessary human, technical and financial resources to programmes to support those children and families in most need of support, particularly children and families affected by the economic crisis who are living in poverty...*
- CRC Concluding Observations Ireland (2016), par.15,16: *The Committee welcomes the State party's successful exit from the financial bailout programme of the International Monetary Fund and the European Union. However, the Committee is concerned that the State party does not have specific budget allocations for the implementation of the Convention. The Committee is also concerned that the budgets of numerous government departments and State agencies, including the Ombudsman for Children's Office and the Department of Health, have been reduced since the economic down turn of 2009. In the light of its day of general discussion in 2007 on the theme "Resources for the rights of the child: responsibility of States", the Committee recommends that the State party ... utilize a child rights approach in the formulation of the State budget by implementing a tracking system for the allocation and use of resources for children throughout the budget at all levels of government ...*
- CRC Concluding Observations Iran (2016), par. 76: *The Committee recommends that the State party strengthen its efforts to further reduce poverty and extreme poverty, in particular in provinces populated by ethnic minorities, such as Sistan and Baluchestan, Khuzestan and Kurdistan. The Committee recommends that the State party take immediate steps, inter alia by increasing*

budgetary allocations, to improve housing and living conditions in these regions, including the provision of access to safe drinking water, adequate sanitation, electricity, transportation facilities, schools and health-care centres.

- 29.** CRC Concluding Observations Dominican Republic (2015), par. 8: *Guarantee systematic accountability for all children's rights, including by facilitating effective access to justice and ensuring that the relevant laws, policies and programmes are monitored and evaluated.*

CRC Concluding Observations Netherlands (2015), par. 36, 37: The Committee is concerned about sexual abuse of children in residential institutions and foster care, in particular abuse of children with mental health conditions. It recommends ensure access of all children, including children with mental health conditions, to justice, including by providing legal support and making available child-friendly and confidential complaint mechanisms in residential care and mental health institutions, foster care systems and any other relevant settings.

- 30.** See *supra* note 1.

- 31.** CRC Concluding Observation France (2016) par.61, 62: *Despite noting with appreciation that the health of children is one of the priorities of the national health-care strategy defined in 2013, the Committee is concerned by the inadequacy of resources, the lack of specialized child health personnel and the general deterioration of services and structures. The Committee draws the State party's attention to its general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, and recommends that the State party urgently address deficiencies in resources and medical staff, services and structures, particularly at school and in maternal and child welfare protection centres, and consider the specific needs of children, especially children living in the overseas departments and territories, in shantytowns and in refugee camps.*

- 32.** CRC Concluding Observations Latvia (2016), par. 55: *The Committee recommends that the State party consider holding targeted consultations with families, children and civil society organizations dealing with children's rights on the issue of child poverty, with a view to strengthening the strategies and measures for fulfilling children's rights in the context of poverty and financial and fiscal policies.*

- 33.** CRC Concluding Observations of Benin (2016) par. 28, 29: *The Committee notes that the current legislation punishes all forms of infanticide and that certain measures have been taken to prevent them. However, it remains concerned that children born with disabilities and so-called "sorcerer's" children are likely to be killed or abandoned by their parents. It is also concerned at the lack of information on legal action taken against the perpetrators of such infanticides and on sentences handed down. The Committee reiterates its previous recommendation and urges the State Party to prevent and eradicate infanticide, and to take prompt and active measures to protect infants' right to life and to ensure that all perpetrators of infanticide are brought to justice. It recommends that the State Party ensure the promotion of medically assisted deliveries in health centres by trained midwives; the monitoring of newborns in the community; the provision of community education on child rights, including through literacy classes and primary schools; and the provision of adequate support to non-governmental organizations and religious associations active in the field.*

CRC Concluding Observations Peru (2016) par.46: The Committee recommends that the State party strengthen its support and services for parents and legal guardians, particularly those in situations of poverty, in order to enhance their capacities in assuming their child-rearing responsibilities, including through counselling, parental education and other awareness-raising.