Chapter 22

Article 24: The Right to Health

Christian Whalen

Article 24

1. 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.
2. 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, through, 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

(continued)

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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.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international cooperation 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.

What Did Children Say?

‘Parents—instead of making additions like—I know that this is beliefs that stems with it, but they should use logical decisions. They shouldn’t like put their child in risk. Again the vaccination thing. They should think twice before saying no, we are going to do it because even if that autism thing is an actual thing, we rather have a child living in autism than not living at all.’ (Asia-Pacific)

‘Providing free vaccines and vaccinations in schools, colony and societies.’ (Asia-Pacific)

‘Don’t give children only information, but give them pictures, do some activity or play as a way of spreading awareness.’ (Asia-Pacific)

To ensure this right, every child, especially those isolated/living in reserves, or small communities, should have access to health care with hospital that have enough staff. (Western Europe/Other)

Overview

Article 24 sets out a fundamental right to the maximum attainable standard of health. This language is consistent with the human rights standards embodied in the International Covenant on Economic Social and Cultural Rights, but also with Article 6 and its insistence that States Parties ensure ‘to the maximum extent possible the survival and development of the child.’ The basic economy of this provision reflects the first draft of the Polish delegation of 1989 (S. Detrick et al., 1992, p. 344).

Following non-governmental organisation submissions, paragraph 3 was inserted to abolish traditional practices harmful to children. Express reference to female circumcision was left out in favour of the broader language adopted, on the understanding that these terms were well established and defined in the 1986 report of the

Working Group on Traditional Practices affecting the Health of Women and Children (S. Detrick et al., 1992, p. 352).

Paragraph 4 was added later to address the concerns of some states that the vast majority of premature infant death resulting from disease occurs in developing countries (S. Detrick et al., 1992, p. 353).¹ A further paragraph prohibiting medical experimentation, investigation, or treatment harmful to children was dropped from the final text due to the lack of consensus on language.

In its final form, Article 24 reflects the perspective of the drafters that the right to health cannot be understood in narrow bio-medical terms or limited to the delivery of health services. Rather, in its reference, for example, to food, water, sanitation, and environmental dangers, it recognises the wider social and economic factors that influence and impact on the child's state of health (Tobin, 2019, p. 909). Thus, the text of Article 24 sets out:

- a broad right to health for all children combined with a right of access to health services
- a priority focus on measures to address infant and child mortality, the provision of primary health care, nutritious food and clean drinking water, pre-natal and post-natal care, and preventive health care, including family planning
- the need for effective measures to abolish traditional practices harmful to children's health
- a specific obligation on States Parties to cooperate internationally towards the realisation of the child's right to health everywhere, having particular regard to the needs of developing countries (Kilkelly, 2015).

While the provision is framed in relation to pressing priorities at the time of drafting, like all human rights provisions in the Convention, Article 24 is part of a living tree; recent General Comments and Concluding Observations have emphasised the significance of Article 24 not just for physical health but also, for example, for 'new morbidities' (2013, para. 5)² related to mental and emotional well-being (2013, paras. 5, 38, 39, 109), and for rights to sexual and reproductive health (2013, para. 24). Furthermore, the Committee has endorsed the respect, protect, and fulfil, typology, adopted by the Committee on Economic, Social and Cultural Rights, that the right to health imposes obligations to ensure that States Parties do not violate the child's right to health, take measures to prevent third parties violating the right to health, and take appropriate measures to fulfil health rights through provision of services (2013, para. 71).

¹Regrettably, the problem remains pervasive since 1989, as WHO estimated in 2017 that children in sub-Saharan Africa are 15 times more likely to die before 5 years of age than children in the developed world (World Health Organization, 2017). See also, current Facts Sheets (World Health Organization, 2020).

²See also, Leading the realization of human rights to health and through health: report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents (High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents, 2017).

General Principles

Article 2 Children's right to health is often compromised by their minority status or by other discrimination in health services, whether overt or unintentional. The obligation to ensure equal access to health services requires that specific measures be taken to reach children in vulnerable sectors, such as infants, children with disabilities, children in remote or rural areas, living in poverty, or in institutionalised care, as well as children with minority gender identities or sexual orientations. Providing health services in multilingual and multi-ethnic states requires accommodations to ensure that health services, including proper instructions to consent to care and for post discharge care, can be properly administered. The Convention itself and the Committee in its General Comment draw particular attention to gender-based discrimination, in relation to sex selection practices in reproductive health, harmful traditional practices, feeding practices, etc. (UN Committee on the Rights of the Child, 2013, para. 9; UN General Assembly, 1990, Article 24, (3)).

Article 3 Determining a child's best interests in a health care setting requires a holistic rights-based approach that goes beyond a purely medical framework (Kilkelly, 2015, p. 219). The Committee has stated that the determination of a child's best interests needs to be based upon 'their physical, emotional, social and educational needs, age, sex, relationship with parents and caregivers, and their family and social background, and after having heard their views according to Article 12 of the Convention' (2013, para. 12). This principle must guide decision-making in policy matters as well as in individual case plans (UN Committee on the Rights of the Child, 2013, para. 12). It should be a primary consideration and supersede economic considerations (UN Committee on the Rights of the Child, 2013, para. 12). The integrity of the family and parent child bonds are important best interests' considerations and should not lightly be disrupted (UN Committee on the Rights of the Child, 2013, para. 15).

Article 6 This General Principle requires States Parties to ensure the child's right to survival and development to the maximum extent possible and serves as a capstone right to the health rights set out in Articles 23, 24 and 25. As Kilkelly has observed, it 'makes it clear that children are entitled to a standard of health that is commensurate with their healthy development' (2015, p. 218). This requires a commitment to child rights, together with a public health and social determinants approach. In the Committee's view, this includes 'individual factors such as age, sex, educational attainment, socio-economic status and domicile; determinants at work in the immediate environment of families, peers, teachers and service providers, notably the violence that threatens the life and survival of children as part of their immediate environment; and structural determinants, including policies, administrative structures and systems, social and cultural values and norms' (2013, para. 17).³ Specifically, Article 6 supports health policy in relation to all matters addressing infant

³See also, General Comment no. 3 on HIV/AIDS (UN Committee on the Rights of the Child, 2003).

mortality, including maternal health in the perinatal period and parental health behaviours (UN Committee on the Rights of the Child, 2013, para. 18). The *2018 Nurturing Care Framework* reinforces, with the lens of economic impacts, the benefits of this holistic approach to development, which extends well beyond survival interests and requires a much higher level of commitment from States Parties in terms of resources and political will (Puras, 2015, paras. 14–23; World Health Organization et al., 2018).

Article 12 The child’s right to express their views and to have them considered is important in informing health service provision in individual cases, but equally important in informing the development of health policy (Kilkelly, 2015, p. 19). The Committee insists that the child’s voice needs to be considered on the broadest range of health policy matters: ‘including, for example, what services are needed, how and where they are best provided, barriers to accessing or using services, the quality of the services and the attitudes of health professionals, how to strengthen children’s capacities to take increasing levels of responsibility for their own health and development, and how to involve them more effectively in the provision of services, as peer educators’ (2013, para. 19). The age of consent to medical treatment in each state is not determinative of the duty health care providers have to consult young patients, in respect of information or understanding about their treatment (Kilkelly, 2015, p. 19).⁴ The Committee recognises that children’s evolving capacities have a bearing on their independent decision-making on their health issues but invites States Parties to recognise that some children may be provided fewer opportunities to exercise autonomy in various health care decisions (2013, para. 21).

Articles Related or Linked to Article 24

Article 5, recognises the parents’ rights and obligations to provide guidance and direction to their children, including in health matters

Article 7 affirms the child’s right to be registered at birth, without which some children may be denied access to health care

Article 9, the right to not be separated from one’s parents, has implications for hospitals and health care providers

Articles 13 and 17, the child’s right to receive information, both in care settings and more generally aimed at the promotion of their well-being and physical and mental health

Article 14, the child’s freedom of conscience, thought and religion often intersects with health care provision

Article 16, the child’s right to privacy and the inviolability of his or her family life in relation to health records and health care services is of universal concern

⁴See also, *Child Friendly Health care: The Views and Experiences of Children and Young People in the Council of Europe* (Kilkelly, 2011)

Article 19 and the several specific protection rights of children, protecting them from all forms of violence and abuse including drug endangerment (Article 33), sexual abuse (Article 34), trafficking (Article 35), or other exploitation (Article 36), have significant intersection and implications for the child's right to health

Article 23 sets out the specific rights of inclusion of children with physical and mental disabilities

Article 25 guarantees the right of children in any form of state care, including in health services care, to periodic review of their treatment and all aspects of their placement

Article 26, child's right to social security provides for children to access benefits that will contribute to their health and well-being

Article 27, the child's right to a standard of living adequate for the child's physical, mental, spiritual, moral, and social development

Articles 28 and 29, the child's right to education directed to the development of the child's mental and physical abilities to the fullest potential as determinants of health

Article 31, the child's right to rest, play, physical activity, and cultural and artistic activities contributes to the child's state of health

Article 39, the child's right to recovery and reintegration as a victim of neglect, abuse, exploitation, torture or any other form of cruel treatment or armed conflicts, in an environment that fosters the health, self-respect and dignity of the child

Relevant Instruments

UN Declaration of the Rights of the Child (1959), Principles 2, 4, 5, and 8

International Covenant on Civil and Political Rights (1966), Articles 6, 9, and 17

International Covenant on Economic, Social and Cultural Rights (1966), Article 12

International Convention on the Elimination of All Forms of Racial Discrimination (1966), Article 5

UN Convention on the Elimination of All Forms of Discrimination against Women (1979), Article 12

UN Convention on the Rights of Persons with Disabilities (2006), Article 25

European Convention on Human Rights (1950), Article 8

European Social Charter (1961), Articles 11 and 13

American Convention on Human Rights 'Pact of San Jose, Costa Rica' (B-32) (1978), Articles 11, 17 through 20

African Charter on Human and Peoples' Rights (1981), Article 16

Social Charter of the Americas (2012), Article 17

Attributes

Attribute One: A Right to the Enjoyment of the Highest Attainable Standard of Health

Article 24 outlines the essence of the right to health, expressed as a right to the enjoyment of the highest attainable standard of health. It is an exacting standard which reflects the language of the right to health guaranteed under Article 12 of the International Covenant on Social Economic and Cultural Rights and affirms that these rights are programmatic in nature and require progressive implementation. It includes the right of access to facilities for treatment and rehabilitation as well as the freedom to make fundamental choices with respect to one's own health and body (UN Committee on the Rights of the Child, 2013, para. 24).

Under the Convention, health is understood as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (Preamble to the Constitution of the World Health Organization, qtd. in UN Committee on the Rights of the Child, 2013, para. 4). The highest attainable standard of health for any child takes into account the child's own biological, social, cultural, and economic preconditions as well as the state's available resources, supplemented by all available sources (UN Committee on the Rights of the Child, 2013, para. 23). The Committee has argued that this must be achieved by programmes that address the underlying determinants of health (2013, para. 2). These include:

- road and environmental safety
- racial prejudice
- access to education
- persistence of forced and early marriage
- corporal punishment
- social, economic, political, cultural, and legal barriers to health services, including sexual and reproductive health services
- inadequate social protection
- institutionalisation
- punitive drug laws
- absence of comprehensive sexuality education
- criminalisation of exposure, non-disclosure of HIV status and transmission of HIV
- criminalisation of same-sex relationships
- lax legal frameworks governing the sale of tobacco, alcohol and fast foods (UN Human Rights Council, 2016, para. 36).

The Committee has drawn particular attention to the challenges faced by adolescents in respect of the right to health, highlighting that health services are rarely designed to accommodate their needs and that their 'health outcomes are predominantly a consequence of social and economic determinants and structural inequalities, mediated by behaviour and activity, at the individual, peer, family, school,

community and societal levels.’ Accordingly, they call on States Parties to invest in a collaborative approach to analysis of their needs to inform health policies, strategies and services (2016, paras. 56–57).

Health services include prevention, promotion, treatment, rehabilitation, and palliative care services. These should be available to every child at the primary care level, while secondary and tertiary care services should be available to the extent possible, consistent with progressive realisation (UN Committee on the Rights of the Child, 2013, para. 26). This entails substantial investment in the development of professional staff to support services at all levels of care. Recourse must be available to challenge any denial of access to such services, together with educational and administrative efforts to ensure access to remedies. Ensuring the right to access to health care entails working with parents and communities to create an environment and knowledge base around how to seek appropriate care. It also requires adequate consent-based management systems for parents and competent children, and the removal of financial, cultural, and institutional barriers to care (UN Committee on the Rights of the Child, 2013, paras. 23–31). For adolescents, specific guidance is also available from the World Health Organization’s *Global Health Standards for Quality Health Care Services for Adolescents* (World Health Organization, 2015).

Attribute Two: A Right to the Basic Minimum Standards of Child Health

The core aspect of the right to health set out in the first attribute is developed further in paragraph 2 of Article 24, which has been analysed as establishing basic minimum standards in relation to the child’s right to health (Kilkelly, 2015, p. 218). Universal access to primary health care requires robust financial investment and professionalisation of practice within well-administered facilities with strong quality assurance. States Parties can be assessed in relation to their ability to make progress in implementing each of the goals to:

- diminish infant and child mortality
- provide primary health care to all children
- combat disease and malnutrition by proper means including adequate nutritious food supply and clean drinking water
- ensure peri-natal maternal health care
- provide child and infant public health education and promotion
- develop preventive child health care, including family planning.

Through its Concluding Observations and General Comments, the Committee has provided detailed guidance in relation to the requirements of each of these areas of focus. For example, the goal of diminishing infant and child mortality requires a host of interventions to address pre-term birth complications and low birth weight,

mother to child transmission of HIV, diarrhoea, malaria and measles, and traffic accidents and suicide. Neonatal deaths and adolescent morbidity are identified by the Committee as priority areas of focus. The Committee has also underscored the importance of efforts to address the mental health needs of adolescents and the health care needs of child victims displaced by natural disasters or conflict as crucial concerns in the provision of universal access to primary care. Efforts to eradicate disease and malnutrition must make use of innovative but proven treatments and technologies. They must ensure access to nutritious food, clean drinking water and sanitation while supporting public health education around all these subjects.

Article 24 (2) (c) outlines critical environmental rights of children and the Committee has called upon States Parties to ensure that efforts to mitigate environmental impacts on child health look beyond controls on environmental pollution to broader impacts, including efforts to put children's health concerns at the centre of climate change adaptation and mitigation strategies. General Comment no. 15 provides equally detailed advice in relation to the implementation of Article 24 (2)'s priority focus on perinatal care, for both mothers and children, from pre-natal education classes for parents and child health public education efforts in general to preventive health measures particularly in providing guidance for parents and family planning. As stated above, all of the basic minimal criteria enumerated in paragraph 2 needs to be interpreted in light of emerging concerns with social and emotional learning and resilience as pathways to well-being and a more holistic understanding of child health (Puras, 2015, paras. 14–23).

Finally, while the obligation to take all effective measures to abolish traditional practices harmful to child health is set out separately in paragraph 3, its inclusion there only augments the global consensus on this priority area of focus for child health implementation efforts. Much work has been done to advance the consensus on the definition of the term 'harmful traditional practices' (Connors, 2011), but clear priorities for the Committee in this area are female genital mutilation and early marriages (UN Committee on the Elimination of Discrimination against Women and UN Committee on the Rights of the Child, 2014).⁵

Attribute Three: Child Health Accountability Mechanisms

A third attribute of Article 24's guarantee of the child's right to health is what the Committee refers to as a framework for implementation and accountability (2013, paras. 90–120). Inherent in broad programmatic rights like the right to health or education, or social security, is an obligation on governments to develop robust frameworks for implementation. States Parties must have a plan of action that

⁵In many countries in central Africa, rates of FGM are estimated to be as high as 75% and the problem is therefore one of making a lasting cultural change that goes well beyond mere law reform (Vučković-Šahović et al., 2012, p. 197).

addresses the many general measures of implementation specific to the right as elaborated under Article 4. The plan must involve a cyclical system of evaluation of programmes leading to improved policy and new investment and new programmes that in turn require further evaluation in what the Committee terms an action cycle of rights enforcement. In the health sector, following the example of the Committee on Economic, Social and Cultural Rights, the Committee of the Rights of the Child has adopted the Availability, Accessibility, Acceptability, and Quality approach to accountability which establishes the goals against which child health policies and programmes should be assessed (UN Committee on the Rights of the Child, 2013, paras. 112–116):

- Availability in ensuring sufficient quantity of health services to ensure that every child has access to the services they need, including measures to address underlying social determinants of health (UN Committee on Economic, Social and Cultural Rights, 2000, para. 12(a))
- Accessibility in terms of non-discrimination, as well as physical, informational and financial accessibility
- Acceptability in ensuring that services are respectful of every child's health needs
- Quality in ensuring that services are based on the best possible science and medical practice standards.

The above accountability measures must be accompanied by broad public education efforts and accessible remedies for violations of the child's right to health (UN Committee on Economic, Social and Cultural Rights, 2000, paras. 119–120).

Attribute Four: International Cooperation for Child Health in Developing Countries

Finally, Article 24 closes with a call for international cooperation to respect, protect, and fulfil the child's right to health, with specific regard to the needs of developing countries. More than half of the world's early child deaths are due to preventable conditions that could be easily treated (World Health Organization, 2017). The Committee has not elaborated the implications of this obligation in detail but regularly recommends that States Parties seek the assistance of UN bodies such as UNICEF, WHO, and UNAIDS. International cooperation is critically important and guidance in this area can be found in global commitment documents such as *A World fit for Children*, the *Sustainable Development Goals* and the *WHO Global Strategy for Women's, Children and Adolescent Health* (Vučković-Šahović et al., 2012, p. 195).⁶

⁶See also, *Leading the realization of human rights to health and through health: report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents* (High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents, 2017).

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